Chapter 22

Mental Health & Substance Use Disorders Services

****South Country Health Alliance (South Country) follows all DHS Medicaid requirements**

NOTE: *Please review the following detail for specific processes and expectations with South Country Health Alliance (South Country). South Country may vary from the MHCP Manual and Minnesota Department of Human Services Guidelines. For additional detail on this chapter, please go to the Minnesota Health Care Programs Provider Manual at* MHCP Provider Manual.

Billing Information – Please review the South Country Provider Manual Chapter 4 Provider Billing for general billing processes and procedures.

Adult mental health level of care assessment policy change

Providers are no longer required to use the Level of Care Utilization System (LOCUS) to provide adult mental health services. Refer to the Level of Care Assessment section of the Minnesota Health Care Programs Provider Manual for more information.

Mental Health Services

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

Each ARMHS provider entity must be certified to provide ARMHS. Certification ensures that the provider is capable of providing directly, or contracting for, the full array of ARMHS.

Non-county entities must receive additional certification from each county in which they provide services. The additional certification must be based on the entity's knowledge of the county's local health and human services system, and the ability of the entity to coordinate its services with other services available in that county.

County-operated entities must receive additional certification from any other counties in which they will provide services.

ARMHS entities must be recertified every three (3) years.

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

- Mental health professional;
- Certified rehabilitation specialist;
- Mental health practitioner;
- Clinical trainee;
- Mental health rehabilitation worker*; and
- Certified peer specialist*.

*Mental health rehabilitation workers (MHRW) and certified peer specialist (CPS) level 1s cannot develop a Functional assessment (FA), level of care assessment, or individual treatment plan (ITP). MHRWs and CPS 1s can implement ITP interventions and develop a progress note.

The following providers are eligible to provide medication education services under ARMHS:

- Physician;
- Registered nurse;
- Physician assistant; and
- Pharmacist.

Eligible Members

A person who is eligible to receive ARMHS:

- Must be eligible for Medical Assistance (Medicaid);
- Be 18 years old or older;
- Primary diagnosis of a mental illness as determined by a Diagnostic Assessment;
- Have a completed Level of Care Assessment; and
- Have a significant impairment in functioning in three or more areas of the Functional Assessment domains specified in statute.

Covered Services

The following services are billable as ARMHS:

- Basic living and social skills;
- Certified peer specialist services;
- Community intervention;
- Functional assessment;
- Individual treatment plan;
- Medication education; and
- 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, including but not limited to:

- Member's home;
- Home of a relative or significant other;
- Member's job site; and
- 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 member residing in any of the following (except for services that meet the requirements under Transition to Community Living Services):

- Regional treatment centers;
- Nursing facilities;
- Acute-care settings (inpatient hospital); and
- Sub-acute settings (Intensive Residential Treatment Services [IRTS] program).

The following services are not covered ARMHS:

- Member transportation services;
- Services provided and billed by providers not enrolled to provide ARMHS;
- ARMHS 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 members;
- Activities that are primarily social or recreational, rather than rehabilitative;
- Job-specific skills services such as on-the-job training;
- Time included in case management services;
- Outreach services to potential recipients; and
- Room and board services.

Authorization

Prior authorization required after benefit threshold is met (Form #4381). Submit the authorization request for only the number of units in excess of the benefit coverage allowed.

Billing

Adult Rehabilitation Mental Health Services (ARMHS) Benefits

Code	Mod	Brief Description	Units	Service Limitations
H2017		Basic living and social skills - individual; mental health professional or practitioner	15 min	Authorization is required for more than 300 hours per calendar year combined

Code	Mod	Brief Description	Units	Service Limitations
	HM	Basic living and social skills - individual; mental health rehabilitation worker		total of H2017, H2017 HM and H2017 HQ.
	HQ	Basic living and social skills - group; mental health professional, practitioner, or rehabilitation worker		
	U3	Basic living and social skills, transitioning to community living (TCL), mental health professional or practitioner	15 min	Cannot be done concurrently with other ARMHS services. No threshold.
	U3 HM	Basic skills, transitioning to community living (TCL) by a mental health rehabilitation worker, less than bachelor's degree level		
90882		Environmental or community intervention, mental health professional or practitioner	1 session	Authorization is required for more than 10 sessions per month or 72 sessions per calendar year.
	HM	Environmental or community intervention, mental health rehabilitation worker		
	U3	Environmental or community intervention; transition to community living (TCL) intervention	1 session	Cannot be done concurrently with other ARMHS services No threshold
	U3 HM	Environmental or community intervention; transition to community living intervention, less than bachelor's degree level, mental health rehabilitation worker		
H0031		Mental health assessment, by non-physician	1 session	Authorization required for more than six (6) sessions per calendar year

Code	Mod	Brief Description	Units	Service Limitations
H0031	TS	Mental health assessment, by non-physician, follow-up service (review or update)	1 session	
H0032		Mental health service plan development by non-physician	1 session	Authorization required for more than four (4) sessions per calendar year
H0032	TS	Mental health service plan development by non-physician, follow-up services (review or update)	1 session	
H0034		Medication education, individual: MD, RN, PA or pharmacist	Per 15 min.	Authorization is required for more than 26 hours per calendar year of H0034 and 26 hours per calendar year of H0034 HQ
	HQ	Medication education, group setting		

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.. In this approach, normally used with members with severe and persistent mental illness, the treatment team typically provides all services using a highly integrated approach to care. Services are offered 24 hours per day, seven days per week, in a community-based setting.

Eligible Providers

An ACT team must:

- Have a contract with a host county;
- Be certified by DHS;
- Be an enrolled Minnesota health care provider (MHCP).

An ACT team is required to have the following:

- Team leader (licensed mental health professional);
- Psychiatric care provider;
- Registered or advanced practice registered nurse;
- Co-occurring disorder specialist;
- Vocational specialist;
- Mental health certified peer specialist; and
- Program administrative assistant.

Eligible Members

A person who is eligible to receive ACT services:

- Must be eligible for Medical Assistance (Medicaid);
- 18 years old or older; and
- Have a primary diagnosis of schizophrenia, schizoaffective disorder, major depressive disorder with psychotic features or other psychotic disorders or bipolar disorder.
- Have a significant functional impairment demonstrated by at least one (1) of the following:
    - Consistently performing the range of routine tasks required for basic adult functioning in the community or persistent difficulty performing daily living tasks without significant support or assistance.
    - Maintaining employment at a self-sustaining level or significant difficulty carrying out the head-of-household responsibilities.
    - Maintaining a safe living situation.
- Have a need for continuous high-intensity services.
- No indication that other available community-based services would be equally or more effective as evidenced by consistent and extensive efforts to treat the individual.
- Have the written opinion of a licensed mental health professional that the member has the need for mental health services that cannot be met with other available community-based services, or is likely to experience a mental health crisis or require more restricted setting if assertive community treatment is not provided.

Covered services

ACT teams must offer and have the capacity to provide the following services:

- Assertive engagement;
- Benefits and finance support;
- Co-occurring disorder treatment as defined in Minnesota Statutes 245I.02, subd 11;
- Crisis assessment and intervention;
- Employment services;
- Family psychoeducation and support;
- Housing access support;
- Medication assistance and support;
- Medication education;
- Mental health certified peer specialist services;
- Physical health services;
- Rehabilitative mental health services as defined in Minnesota Statutes 245I.02, Subd 33;
- Symptom management;
- Therapeutic interventions;
- Wellness self-management and prevention; and

- Other services based on client needs as identified in a client's assertive community treatment individual treatment plan.

Billing

Assertive Community Treatment Program

Code	Modifier	Description	Units
H0040		Assertive Community Treatment Program	1 Daily
H0040	HK	Forensic Assertive Community Treatment Program	1 Daily

Behavioral Health Homes (BHH) Services

The term “behavioral health home” services refers to a model of care focused on integration of primary care, mental health services, and social services and supports for adults diagnosed with mental illness or children diagnosed with emotional disturbance. BHH includes amulti-disciplinary team to deliver person-centered services designed to support a person in coordinating care and services while reaching his or her health and wellness goals.

Eligible Providers

- Must be certified by DHS to deliver BHH services;
- Must 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.

Eligible Members

- Must be eligible for Medical Assistance (Medicaid);
- Have a current diagnosis (within last 12 months) from a qualified health professional of a condition that meets the definition of mental illness or emotional disturbance;

*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.

Covered Services

- Care management;
- Care coordination;
- Health and wellness;
- Comprehensive transitional care;
- Individual and family supports; and
- 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; and
    - Moving home Minnesota (MHM).

Authorization

Notification to South Country is required. Use Form DHS-4797 found in behavioral health forms at www.mnscha.org. Start date will be the first of the month the notification is received unless provider indicates otherwise.

Providers are expected to review and follow the BHH and managed care roles and responsibilities as defined on Form 5387 found in behavioral health forms at www.mnscha.org.

South Country may complete retro review of utilization and payments.

Billing

Behavioral Health Home (BHH) Services Billing

Code	Service Description	Unit	Limitations
S0280 U5	BHH services care engagement, initial plan	1=month	One payment per month
S0281 U5	BHH services ongoing standard care, maintenance of plan	1=Month	One payment per month
Limitations on engagement rate (S0280 U5) – lifetime limit of six (6) payments in member's lifetime. No payment if prior payment for duplicative service was made in same calendar month. Provider is responsible for tracking limits. South Country retro review process may include taking back any enhanced payment that exceeds the lifetime six-month payment limit.			

Certified Community Behavioral Health Clinics (CCBHC)

An integrated community behavioral health model that aims to improve service quality, accessibility and 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

CCBHCs are enrolled Minnesota Health Care Programs (MHCP) service providers for all CCBHC services and have been certified by the state. See MHCP Provider Manual for a link to the CCBHC webpage for a list of current providers and full list of covered services.

Eligible Members

All South Country members who have not been served by the clinic in the six months before the current service and meet one of the following requirements are eligible for CCBHC services:

- Received a preliminary screening and risk assessment and one CCBHC service, or
- Received a crisis assessment

Covered Services

Covered services include services and expanded services as described in detail in the DHS – MHCP provider manual.

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

No authorization required for CCBHC unless the service code requires authorization.

Billing

Certified Community Behavioral Health Clinic (CCBHC) Services Billing
CCBHCs will be paid based on the current DHS payment methodology listed on the DHS Website. http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS-294813#bill

For CCBHC providers of MH-TCM only:

1. In addition to current state eligibility criteria, MH-TCM supports and services may be provided to both children and adults who do not meet the current criteria who are deemed at high risk of suicide by a mental health professional, particularly during times of transitions from acute care and residential settings. The mental health professional can establish medical necessity for MH-TCM utilizing an evidence-based tool to determine risk of suicide or determine risk based on clinical judgment.
2. The comprehensive evaluation does not need to be updated when a TCM referral occurs more than 180 days after it was completed. Instead, the comprehensive evaluation must be updated when there is a significant change in the child's or adult's life circumstances or a change in the child's or adult's diagnostics and annually.

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 and are characterized by a partnering approach between the certified peer specialist (CPS) and the member who receives the services (peer).

Eligible Providers

Certified peer specialists are employed in agencies approved to provide peer services within the following mental health rehabilitation services:

- Assertive community treatment (ACT);

- Intensive residential rehabilitative services (IRTS);
- Adult rehabilitative mental health services (ARMHS); and
- Crisis response services.

Minnesota has two levels of certified peer specialists: Level I and Level II.

Certified Peer Specialist Level I must meet the following criteria:

- Be at least 18 years of age;
- Have or have had a diagnosis of mental illness;
- Is a current or former consumer of mental health services; and
- Successfully completes the DHS approved Certified Peer Specialist training and certification exam.

Certified Peer Specialist Level II must meet the following criteria:

- Must meet all requirements of a Level I CPS and is a qualified mental health practitioner.

Eligible Members

A member must be:

- Must be eligible for Medical Assistance (Medicaid);
- Be aged 18 or older; and
- Receive ACT, ARMHS, IRTS, Adult Crisis Services or be enrolled in a CCBHC.

Scope

Certified peer specialists under treatment supervision of a mental health professional or certified rehabilitation specialists must:

- Provide individualized peer support to the member;
- Promote the member's recovery goals, self-sufficiency, self-advocacy, and development of natural supports; and
- Support the member's maintenance of skills learned from other services.

Authorization

No authorization required

Billing

Entities eligible to bill for certified peer specialists are:

- ARMHS providers; and
- Adult crisis service providers.

CPSS provided within an ACT team or IRTS facilities are included in the daily rate and may not be billed separately.

Certified Peer Specialist Services (CPSS) Billing

Code	Service Description	Unit	Service Limitations
H0038	Self-help / peer services by Level I Certified Peer Specialist	15 min	No authorization required
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	

MH Certified Family Peer Specialist (CFPS)

Work with the family of a child or youth who has an emotional disturbance or severe emotional disturbance (SED) and is receiving mental health treatment to promote the resiliency and recovery of the child or youth. They provide nonclinical family peer support building on the strengths of the family and help them to achieve desired outcome.

Eligible Providers

Certified family peer specialists are employed by existing mental health community providers.

The certified family peer specialist must meet all of the following qualifications:

- Be at least 21 years of age;
- Have raised or are currently raising a child with a mental illness;
- Be currently navigating or have experience navigating the children's mental health system; and
- Successfully complete the Department of Human Services-approved Certified Family Peer Specialist Training and certification exam.

Must be supervised by a mental health professional during the first 2,000 hours of employment, which includes direct onsite observation.

Certification

Family peer specialists must successfully complete the Minnesota-specific training, approved by the Department of Human Services (DHS), to become certified by DHS and must renew or recertify every two (2) years through continuing education requirements.

Eligible Recipients

To be eligible for CFPS services, a child or youth must be receiving any one of the following services:

- Inpatient hospitalization;
- Partial hospitalization;
- Residential treatment;
- Treatment foster care;
- Day treatment;
- Children's therapeutic services and supports; and
- Crisis services programs.

Scope

Certified family peer specialists under treatment supervision of a mental health professional must:

- Provide services to increase the child's ability to function in the child's home, school, and community.
- Provide family peer support to build on a member's family's strengths and help the family achieve desired outcomes.
- Provide non adversarial advocacy to a child and the child's family that encourages partnership and promotes the child's positive change and growth.
- Support families in advocating for culturally appropriate services for a child in each treatment setting.
- Promote resiliency, self-advocacy, and development of natural supports.
- Support maintenance of skills learned from other services.
- Establish and lead parent support groups.
- Assist parents in developing coping and problem-solving skills.
- Educate parents about mental illnesses and community resources, including resources that connect parents with similar experiences to one another.

Authorization Requirements

No authorization required

Billing

See the following table for CFPS benefit information:

Certified Family Peer Specialist (CFPS) Benefits

Code	Mod	Brief Descriptions	Units	Service Limitations
H0038	HA	Certified family peer specialist services	15 min.	No authorization required
	HA HQ	Certified family peer specialist services in a group setting.		

Children's Mental Health Residential Treatment (CMHRT)- 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.

CMHRT 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; and

- 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 (MA) or MinnesotaCare;
- 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 a state that borders Minnesota. 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. The facility must be inspected by the commissioner of the Department of Human Services and be certified to substantially meet the standards applicable to children's residential mental health treatment programs.

***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

For Counties*:*

Notification for pending placement required

The county must include South Country behavioral health during any juvenile treatment screening team when CMHRT placement is being pursued.

The county representative (CMHTCM, child protection, etc.) assigned to the member must also email South Country behavioral health department prior to member's placement.

If member is admitted for emergency care, the county representative must notify South Country as soon as it is possible.

The email must include member's name, South Country ID number, name of the provider(s) being considered for placement, and the placement date if it is known. This notification does not serve as authorization for placement, but an email will be sent in response to confirm receipt of notification. The email can be sent directly to a BH team member or to countyinfo@mnscha.org.

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

South Country 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.

For Providers:

Notification is required (Form SCHA #4398)

Providers are required to notify South Country behavioral health of member placement within 24 hours of admission.

Upon notification, South Country will open an authorization for an initial 45-day assessment period. The provider is then responsible for tracking the last covered day and submitting additional clinical documentation that supports the need for ongoing treatment every 30 days after.

Coordination of Continued Stay and Discharge Plans:

All parties should work for agreement between the child's family/legal representative, county, South Country behavioral health and facility staff on global goals related to the child's treatment.

South Country behavioral health case manager may collaborate with the facility, the case manager and the family regarding the member's progress.

Children's Mental Health Residential Treatment (CMHRT)

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

Children's Mental Health Residential Services Path

In compliance with legislation that passed in 2021, the state of Minnesota developed a new service designed to assist youth with a severe emotional disturbance (SED) and their families in gaining access to a residential treatment center (RTC).

When a youth or family choose the CMH residential services path, a voluntary placement agreement (VPA) is not utilized and the county or tribe does not have placing authority as with the traditional CMHRT placement process. Through this option, the youth and family choose if they would like to access Rule 79 children's mental health case management.

In order for a youth to receive CMH residential services, a parent or guardian initiates the following steps:

- The parent will obtain a level of care determination and the diagnostic assessment (DA) from a mental health professional (MHP) for their child. The DA must indicate that it is medically necessary for the youth to enter the CMH residential service. The DA will include the CASII. The MHP will evaluate the child's home, family, school and community situation and functioning. The CASII will be used to assess the child's status functionality, as well as cultural considerations when considering and assigning an appropriate level of care. If the DA with the CASII has been completed within the previous 180 days, a new DA does not have to be completed. The exception to this would be when the child's MHP believes the youth's condition has changed significantly since the prior report. In that case, a new DA would be required.
- After the parent has obtained the DA and CASII from the MHP, the parent will notify the county, initiative tribe, or prepaid health care plan/MCO that the child is in need of the CMH residential service and they will be using the service.

Confirm Funding Availability

The parent will contact South Country and South Country will review the DA. If the MHP has stated it is medically necessary for the youth to receive the CMH residential service, South Country will contact the county or initiative tribe. This collaboration is important as the county or initiative tribe will then need to confirm whether monies are available for the county or initiative tribe to fund the costs of room and board in a children's residential treatment facility.

If the funds are available, the parent can choose to locate the CMH residential service independently or ask the county, tribe or South Country for assistance. Once a bed becomes available, the provider will notify South Country by submitting the Initial Behavioral Health Notification Form #4398 to initiate an authorization. The authorization date span will coincide with the number of days of room and board funding that the county has available through the CMH residential services path allocation.

If funding is not available, the parent will need to remove the youth from residential placement or acquire a case manager to begin the process of traditional children's mental health residential treatment placement through the county.

Note: Some counties have opted out of accepting the allocation funds and therefore, the residential treatment services path is not an option in those counties.

Children's Mental Health Clinical Care Consultation

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; and
- Clinical service components provided to the member and family.

Eligible Providers

Only a mental health professional or clinical trainee can bill for this service.

Eligible Members

- Must be eligible for Medical Assistance (Medicaid);
- Be age 20 or under; and

Have a diagnosis of a mental illness determined by a diagnostic assessment that includes a statement that indicates the medical necessity that requires consultation to other providers working with the child to effectively treat the condition. 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;
- Childcare 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; and
- Mentors.

*Two (2) 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

Authorization required after threshold using Form #4381. Submit the authorization request for only the number of units in excess of the benefit coverage allowed.

Billing

Clinical Care Consultation Services Billing

Code	Service Description	Unit	Service Limitations
90899 U8	Clinical care consultation, face to face	5-10 min	Calendar year threshold, 15 hours. Upper limit of timed unit to be counted to the threshold.
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	

Adult and Children's Crisis Response Services

Community based services provided by a county, tribe, or other contracted crisis team to members age 18 or older who are experiencing a mental health crisis or emergency.

Eligible Providers

- A crisis response provider must be a county or tribe or have a contract with a county or tribe and be certified and enrolled with MHCP to provide crisis services in Minnesota.
- A mobile crisis intervention team must have at least one mental health professional on staff at all times and at least one additional staff member who is capable of leading a face-to-face crisis response.
- Mobile Crisis assessment and intervention services can be provided by a qualified:
    - Mental health professional;

    - Mental health practitioner;
    - Clinical trainee;
    - Certified family peer specialist; or

Certified peer specialist.Crisis assessment and intervention services must be led by a mental health professional, clinical trainee, or mental health practitioner. Interventions require at least two members of the intervention team to confer in person or by phone about the assessment, treatment plan, and action needed.

- Mobile Crisis Stabilization services can be provided by a qualified:
    - Mental health professional;
    - Mental health practitioner;
    - Certified rehabilitation specialist;
    - Clinical trainee;
    - Certified family peer specialist;
    - Certified peer specialist; or
    - Mental health rehabilitation worker.
- Additional certification and supervision requirements apply. Please check MHCP manual for details.

Eligible Members

To be eligible for crisis response services, a member must:

- Screen positive for potential mental health crisis during a crisis screening to be eligible for crisis assessment services.
- Be assessed as experiencing a mental health crisis to be eligible for crisis intervention and stabilization services.
- Members with co-occurring substance abuse and mental health disorders who do not need the level of a detoxification facility are also eligible to receive crisis response services.

Covered Services

Adult crisis services may include a number of services:

- Crisis assessment;
- Crisis intervention;
- Crisis stabilization;
- Community intervention (for adult crisis response services only); and
- Certified peer specialist (for adult services only) and certified family peer specialist (for children services only) may provide services during all phases of the crisis response.

Non-Covered Services

- 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;
- 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; and
- Crisis screening calls.

Authorization

Prior authorization is not required. No notification required.

- Service thresholds
    - Follow DHS MHCP provider manual guidance.

Billing

Adult Crisis Service Billing

Code	Mod	Service Description	Unit	Additional Requirements
H2011		Adult crisis assessment, intervention and stabilization – individual by a mental health professional	15 minutes	Except for community intervention (see below) there are no thresholds for crisis response services provided in the community. Authorization is not required for crisis assessment, stabilization and intervention. Rehabilitation workers can provide adult crisis stabilization services only.
	HN	Adult crisis assessment, intervention and stabilization – individual practitioner		
H2011	HM	Adult crisis stabilization – individual by mental health rehabilitation worker		
	HQ	Adult crisis stabilization - group		
90882	HK	Community intervention		

Code	Mod	Service Description	Unit	Additional Requirements
90882	HK HM	Community intervention by a mental health rehabilitation worker	1 session	Community intervention may be billed for each team member when one team member works directly with a family member or significant other while the other team member works face-to-face with the member. Follow ARMHS billing instructions - ARMHS authorization thresholds apply. The HK modifier is needed to identify community intervention services as a part of crisis response.

Child Crisis service Billing

Code	Mod	Service Description	Unit	Additional Requirements
H2011	UA	Child crisis assessment, intervention and stabilization – individual by a mental health professional	15 min.	There are no thresholds for crisis response services provided in the community. Authorization is not required for crisis assessment, stabilization and intervention.
H2011	UA HN	Child crisis assessment, intervention and stabilization – individual practitioner	15 min.	There are no thresholds for crisis response services provided in the community. Authorization is not required for crisis assessment, stabilization and intervention.

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 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, 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; and
- School districts.

Eligible Members

- Must be eligible for Medical Assistance (Medicaid).
- Be under 21 years old.
- Have a diagnostic assessment that documents:
    - A diagnosis of an emotional disturbance for children under 18 years old or mental illness for young adults 18 through 20 years old;
    - Medical necessity for CTSS; and
    - A completed CASII or ECSII.
- Have a completed and signed individual treatment plan that:
    - Documents specific goals and objectives for CTSS services; and
    - Is signed by the supervising mental health professional and the parent or guardian prior to service delivery.
- The diagnostic assessment used to establish eligibility for CTSS must be done by a mental health professional or clinical trainee within 365 days before CTSS services begin.
- In addition to the general MHCP requirements for a Diagnostic Assessment, CTSS requires that the DA document CTSS as medically necessary rehabilitation to address an identified disability or functional impairment, and the member's needs and goals.

Covered Services

The following services are billable as CTSS. CTSS providers must provide or offer the following core services as prescribed in the child's ITP. Required core services must be provided or offered by a certified community and school providers:

- Psychotherapy - with patient and/or family member, family, group and psychotherapy for crisis;
- Skills training - individual, family, or group;
- Crisis planning;
- Treatment plan development and review; and
- Administering and reporting standardized measures.

Optional services may be offered according to requirements listed in MHCP manual:

- MHBA services, including direction of a mental health behavioral aide; and
- Children's day treatment, a combination of psychotherapy and skills training.

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; and
- Treatment for recipients with primary diagnoses of alcohol or other drug abuse.

Authorization

Prior Authorization is required (Form SCHA #4390) after benefit threshold is met. Submit the authorization request for only the number of units in excess of the benefit coverage allowed.

Service Thresholds – See DHS MHCP Provider manual for guidance

Billing

For billing guidance see DHS MHCP Provider manual

Day Treatment - Adult

A short-term, community-based mental health program. The goal of day treatment is to reduce or relieve the effects of mental illness and provide training to enable the member to live and function more independently in the community.

Eligible Providers

- Licensed hospitals with JCAHO accreditation;
- MHCP-enrolled community mental health centers; and
- Entities under contract with a county to operate a day treatment program.

Individual members of the adult day treatment multidisciplinary team must meet, at a minimum, the standards for a mental health practitioner. Psychotherapy components of day treatment must be provided by a mental health professional or a clinical trainee.

Follow group psychotherapy guidelines for staffing and group size requirements.

A Minnesota Health Care Program (MHCP) provider must receive approval before starting ADT services. If providing children's day treatment to members 18-20 years old, providers must also be CTSS-certified.

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;
        - The DA must be completed following face-to-face evaluations of an individual's nature, severity and impact of behavioral difficulties, functional impairment, subjective distress, strengths and resources; and
        - A functional assessment (FA) should be completed before the Individual Treatment Plan and be updated at least every 90 days.
        - have a completed Level of Care assessment recommending the level of intensity and duration of ADT and:
            - Must be completed before receiving services and no sooner than 30 days before;
            - Are valid for 180 days; and
            - Must be updated when a person undergoes any significant change in functioning, a significant life event has occurred or within 10 days of discharge.
        - 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 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; and
        - 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 based on a Level of Care Assessment; and
- does not have or ceases to have the cognitive capacity to benefit from day treatment services.

Covered Services

Adult day treatment consists of:

- At least one (1) hour of group psychotherapy (maximum of two (2) hours);
- Group time focused on rehabilitative interventions, or other intensive therapeutic services, provided by a multidisciplinary staff; and
- A group of at least three (3), but not more than 12, recipients.

ADT services must:

- Stabilize the member's mental health status;
- Develop and improve the member's independent living and socialization skills; and
- 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 180 days, until discharge;
- Include an attainable discharge plan for the member;
- Must be a collaborative and person-centered process involving the member, and with the permission of the member, the member's family and others in the member's support system; and
- The ITP and subsequent revisions of the ITP must be approved by the member before treatment begins. The mental health professional or practitioner will request the client, or other person authorized by statute to consent to mental health services for the client, to sign the client's ITP or revision of the ITP.
    - If the client or authorized person refuses to sign the plan or a revision of the plan, the mental health professional or mental health practitioner will note on the plan the refusal to sign and the reasons for the refusal.

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; and
    - 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 (2) 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 South Country.

Authorization

Prior authorization is required (Form SCHA #4381) after benefit threshold is met. Submit the authorization request for only the number of units in excess of the benefit coverage allowed.

- When receiving concurrent DBT services (regardless of whether the 115 hours was met
- To provide concurrent partial hospitalization or residential crisis stabilization.

Billing

Day Treatment Services - Adult Billing

Code	Service Description	Unit	Limitations
H2012	Behavioral health day treatment	1 hour	Maximum 15 hours per week 115 hours per calendar year

Day Treatment – Children's

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.

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 or non-county - operated entity certified by the state;
- IHS / 638 facilities; and
- Children's Day treatment providers, including school districts, must submit an application and receive certification under CTSS.

Programs must provide adequate staffing and facilities to do the following:

- Promote member health;
- Ensure a safe environment;
- Protect member rights; and
- Provide service delivery to implement each member's individual treatment plan (ITP).

Eligible Members

Eligible recipients of children's day treatment must meet the following:

- Be 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; and
- Be eligible for up to five days of day treatment based on a hospital's medical history and presentation examination of the member according to Minnesota Statute 256B.0943, subdivision 3(b).

Covered Services

Day treatment is distinguished from day care by the structured therapeutic program that uses CTSS service components. The day treatment program includes:

- Psychotherapy (individual, family or group) 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.
- The program must be available year-round at least three to five days per week, two or three hours per day, unless the normal five-day school week is shortened by a holiday, weather-related cancellation, or other districtwide reduction in a school week. A child

transitioning into or out of day treatment must receive a minimum treatment of one day a week for a two-hour time block. The two-hour time block must include at least one hour of patient or family or group psychotherapy. The remainder of the structured treatment program may include patient or family or group psychotherapy, and individual or group skills training, if included in the member's individual treatment plan.

- Minimum group size for day treatment is two individuals. When a day treatment group that meets the minimum group size requirement temporarily falls below the minimum group size because of a member's temporary absence, including absence due to a declared public emergency, medical assistance covers a group session conducted for the group members in attendance.
- Interactive children's day treatment may use physical aids and nonverbal communication to overcome communication barriers because the recipient demonstrates one of the following:
    - Has lost or has not yet developed either the expressive language communication skills to explain his or her symptoms and response to treatment;
    - Does not possess the receptive communication skills needed to understand the mental health professional if he or she were to use adult language for communication; and
    - Needs an interpreter, whether due to hearing impairment or because the recipient's language is not the same as the provider's language.

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 mental health behavioral aide and employed by a CTSS provider.
- 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.
- 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.
- Prevention or education programs provided to the community.
- Children's Day Treatment services cannot be provided at the same time as the following services:

- Dialectical Behavior Therapy (DBT);
- Early Intensive Developmental and Behavioral Intervention (EIDBI); and
- Children's Intensive Behavioral Health Services.

Authorization

Prior Authorization is required (Form SCHA #4390) after benefit threshold is met. Submit the authorization request for only the number of units in excess of the benefit coverage allowed.

Billing

Day Treatment Services - Children Billing

Code	Service Description	Unit	Limitations
H2012 UA HK	Behavioral health day treatment	1 hour	Daily limit - minimum 2 hours, maximum 3 hours Weekly Limit - maximum 15 hours Calendar year threshold - maximum 150 hours
H2012 UA HK U6	Behavioral health day treatment (interactive)	1 hour	Daily limit - minimum 2 hours, maximum 3 hours Weekly Limit - maximum 15 hours Calendar year threshold - maximum 150 hours

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

Only a mental health professional or a clinical trainee can complete aspects of the diagnostic assessment.

Eligible Members

All members are eligible for a standard diagnostic assessment.

- To be eligible for payment, a diagnostic assessment must:
  - Identify a mental health diagnosis and recommend mental health 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 telehealth technology when appropriate);
  - Meet the conditions of a standard or brief diagnostic assessment according to Minnesota Statutes 245I, subdivisions 4 - 6;

- Document the medical necessity for mental health services in the diagnostic assessment; and
- Screen all enrollees 18 years of age or older upon initial access of behavioral health services for the presence of co-occurring mental illness and substance use disorder using either the CAGE-AID Questionnaire or the criteria in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

Diagnostic assessments completed before the Uniform Service Standards Acts effective date Oct. 17, 2022, are valid for authorizing the member's treatment and billing for one calendar year after the date of completed assessment.

Authorization

- Authorization required after threshold is met (Form SCHA #4381). Submit the authorization request for only the number of units in excess of the benefit coverage allowed.

Service Thresholds

- Maximum of four (4) assessments per year.

Billing

Diagnostic Assessment CPT Codes

Code	Modifier	Service Description	Unit	Limitations
90791		Standard diagnostic assessment	1 session	Maximum of four sessions, cumulative per calendar year
	52	Brief diagnostic assessment Standard diagnostic assessment with medical services	1 session	A member may not receive more than two brief diagnostic assessments in a calendar year. Interactive complexity add-on 90785 may be used with 90791 and 90792
90792	52	Brief diagnostic assessment with medical services	1 session	90792 may be provided by: Clinical nurse specialist-mental health (CNS-MH) Psychiatric nurse practioner (NP) Psychiatrist Clinical trainees associated with these mental health professional types; add modifier HN for services provided by a clinical trainee

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

Dialectical Behavior Therapy Intensive Outpatient Program (DBT IOP)

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; and
- 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; and
- Best practices recommend that a team leader provide some direct services to clients through individual therapy, skills training or both.

A team member must be one of the following:

- be an enrolled mental health professional;
- a mental health practitioner clinical trainee; or
- 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 (6) 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 (6) months of becoming part of a DBT program;
- participate in DBT consultation team meetings for the recommended duration of 90 minutes per week; and
- 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

All eligible members must:

- Be eligible for Medical Assistance (Medicaid).
- Have mental health needs that cannot be met with other available community-based services or that need services provided concurrently with other community-based services.

- Understand and be cognitively capable of participating in DBT as an intensive therapy program and be willing to follow program policies and rules to ensure the safety of self and others.
- Be at significant risk of one or more of the following, as recorded in the member's record:
    - A mental health crisis;
    - A need for a higher level of care, such as hospitalization or partial hospitalization;
    - Decompensation of mental health symptoms; and
    - Intentional self-harm (suicidal and non-suicidal) or risky impulsive behavior or be currently having chronic self-harm thoughts or urges (suicidal or non-suicidal) although the person has managed to not act on them. People with chronic self-harm thoughts and urges are at a greater risk of decompensation.

An adult member must meet all the following admission criteria:

- Be age 18 or older.
- Have either:
    - a diagnosis of borderline personality disorder; or
    - multiple mental health diagnoses and is exhibiting behaviors characterized by impulsivity or intentional self-harm, behavior and is at significant risk of death, morbidity, disability or severe dysfunction across multiple life areas.

An adolescent member must meet all of the following admission criteria to receive adolescent DBT:

- Be 12-17 years old.
- Have either:
    - a diagnosis of disruptive mood dysregulation disorder or borderline personality disorder; or
    - other mental health diagnosis including, but not limited to, a substance-related and addictive disorder.
- Have a documented assessment information showing functional deficits in three to five of problem areas:
    - Emotional dysregulation;
    - Impulsivity (including avoidance);
    - Interpersonal problems;
    - Teenager and family challenges; and/or
    - Reduced awareness and focus.

Adult and adolescent 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; and
- Have a continued need for treatment as indicated in the above criteria and by ongoing documented evidence in the member's record.

Adult and adolescent 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; and
- Provider will complete paperwork and refer member to needed services.

Covered Services

- Individual DBT Therapy Intensive Outpatient Program;
- DBT group skills training.
    - Standard treatment for adults includes two cycles. Each cycle lasts 24-26 weeks.
    - Standard treatment for adolescents includes one cycle which lasts 24-26 weeks.

Authorization

Prior Authorization is required (Form SCHA 4498)

- Authorization is required for initial DBT services as well as a separate authorization required when requesting additional DBT, following the initial six (6) months. Form SCHA #4498 must be completed when requesting prior authorization for initial and additional DBT.

Concurrent Therapy

Concurrent therapy is approved only for outpatient family therapy.

Exclusionary Services (adults and adolescents)

DBT cannot be provided concurrently with the following services:

- Outpatient individual therapy (including under CTSS umbrella);
- Partial hospitalization;
- Day treatment;
- Children's intensive behavioral health services (intensive treatment in foster care); and
- ACT/youth ACT.

Billing

Dialectical Behavior Therapy Services Billing

Code	Service Description	Unit	Service Limitation
H2019 U1	Individual DBT therapy	15 min	Up to 26 hours (104 units) per six months A one-time authorization for up to an additional 78 units for prolonged exposure protocol
H2019 U1 HA	Individual DBT therapy for adolescents	15 min	
H2019 U1 HN	Individual DBT therapy by clinical trainee	15 min	
H2019 U1 HN HA	Individual DBT therapy for adolescents by a clinical trainee	15 min	
H2019 U1 HQ	Group DBT skills training	15 min	Up to 78 hours (312 units) per six months
H2019 U1 HQ HA	Group DBT skills training for adolescents	15 min	
H2019 U1 HQ HN	Group DBT skills training by clinical trainee	15 min	
H2019 U1 HQ HN HA	Group DBT skills training for adolescents by a clinical trainee	15 min	

Healthy Pathways Program (HPP)

A program to assist South Country members in preventing mental health deterioration through early intervention and education. Healthy Pathways serves members who may not meet eligibility requirements for Mental Health Targeted Case Management. This service is intended to support members in the absence of qualifying for case management or care coordination.

Eligible Providers

- Must be a qualified mental health professional associated with South Country County partners to oversee goals/objectives. Only county contracted or county delegated providers for HPP are allowed to bill for this service.

Eligible Members

- Must be eligible for Medical Assistance (Medicaid) and enrolled with South Country Health Alliance;
- Age 17 and older;
- Present with a suspected mental health and/or substance use disorder and show a need for behavioral health support, coordination and/or education; and
- May not receive HPP concurrently with duplicative services such as MH-TCM, Behavioral Health Home (BHH) and CCBHC.

Authorization

Notification is required

Submit Healthy Pathways Notification and Initial Assessment form (form# 6021) to initiate payment of services.

Submit Healthy Pathways Renewal Request or End of Service Notification (form# 6023) every six months and when member has discharged from the program along with the Renewal or End of Service Assessment.

Notification is required at separate stages of service:

- Initial;
- Renewal- Six (6) months; and
- End of Service / Termination of service.

Service Thresholds

- None – no limit.

Billing

Healthy Pathways may not be provided concurrently with MH-TCM

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 members if provided by:

Eligible Providers

- Clinical nurse specialist-mental health (CNS-MH);
- Licensed psychologist (LP) (with a physician's order);
- Physicians;
- Psychiatric nurse practitioner (NP); and
- Psychiatrists.

Eligible Members

- Hospitalized South Country enrolled members;

Covered Services

- Hospital evaluation and management services;
- Psychiatric services when billed according to service requirements;

- Medical care during the same day that a psychiatrist, CNS-0MH or psychiatric NP provided mental health services; and
- One (1) visit per day, of the same service, by the same physician.

Authorization

Notification is required. Submit Behavioral Health Hospitalization Inpatient Admit & Discharge Notification (Form #5116) when member is admitted to the hospital. Send this form again once the member discharges along with the discharge summary.

Billing

Procedure Code	Brief Description	Service Limitations
99221—99223	Inpatient hospital care	• Psychiatrist is admitting physician for initial hospital visit or medical physician performs a physical exam as part of admission process • Only admitting physician uses initial hospital care code • Preliminary diagnosis and plan of care are part of the initial visit
99231—99233	Subsequent hospital care	Medical physician manages recipient's non-psychiatric medical care after initial inpatient hospital consultation
99251—99255	Initial inpatient consultation	A physician requests a consultation. Must see the patient face to face.

Institute of Mental Disease (IMD)

An IMD must be certified and licensed by the Minnesota Department of Health or the health department in the state in which it is located. An IMD is a hospital, nursing facility or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatments or care of persons with mental diseases. This includes treatment for mental health and substance use disorders.

Authorization

Notification for admission and discharge is required for residential treatment. Discharge notification must include member discharge summary See www.mnscha.org provider behavioral health forms to promptly notify South Country of admission and discharges. Claims require accurate place of service codes, admission and discharge dates, and admission/discharge and transfer codes.

Intensive Residential Treatment Services (IRTS)

Time-limited mental health services provided in a residential setting. 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 by DHS licensing to provide IRTS and/or residential crisis stabilization according to Minnesota Statutes 245I;
- Have five to 16 beds and not an institution for mental disease (IMD);
- Have a statement of need provided by the local mental health authority or a need determination from the DHS Commissioner; and
- Have a rate approved by DHS.

IRTS providers may provide adult residential crisis stabilization (RCS) within the same facility.

IRTS providers must have:

- Sufficient staff for 24-hour delivery of mental health services.
- Integrated services for chemical dependency, illness management services and family education.
- Medical professional services, provided by the provider or through a referral.
- Services provided by qualified staff (see MHCP Manual for staffing standards information).
- Appropriate staffing to implement member treatment plans, safely monitor and guide activities, and implement program requirements.
- Crisis prevention planning.
- Illness Management and Recovery (IMR) or Enhanced Illness Management and Recovery (E-IMR).
- Weekly treatment team meetings.
- Access to a mental health professional, clinical trainee, certified rehabilitation specialist or mental health practitioner in person or by telephone within 30 minutes.
- Immediate needs assessment completed within 12 hours of admission.
- Initial individual treatment plan completed within 24 hours of admission.
- Level of care completed within five days of admission and again within 60 days after admission to determine how the client's admission and continued services in IRTS are medically necessary.
- Diagnostic assessment completed within 10 days of admission.
- Functional assessment completed within 30 days and updated within 60 days.
- Individual treatment plan completed within 10 days of admission and updated at least within 40 and 70 days of admission, or more frequently to meet the member's needs.
- Substance use screening completed with the diagnostic assessment, and a substance use assessment completed within 30 days of admission for a member who's screening indicates a possibility of a substance use disorder.
- Individual abuse prevention plan completed within 24 hours of admission.
- Daily documentation including a daily summary and progress notes.
- Weekly review of the treatment plan and individual abuse prevention plan by a mental health professional or certified rehabilitation specialist.

IRTS must maintain a treatment team staffing ratio of at least one treatment team member to nine members. At least one treatment team member on the day shift must be a mental health

professional, clinical trainee, certified rehabilitation specialist, or a mental health practitioner, if serving nine or fewer members. If serving more than nine members, the evening shifts must also be staffed with at least one mental health professional, clinical trainee, certified rehabilitation specialist, or a mental health practitioner.

Eligible Members

- Must be eligible for Medical Assistance (Medicaid).
- Age 18 years old or older.
- Meet the IRTS admission criteria (See MHCP for admission, continuing stay, and discharge criteria).
- Diagnosed with a mental illness.
- Functional impairment because of mental illness, in three or more areas, utilizing the functional assessment.
- One or more of the following:
    - History of recurring or prolonged inpatient hospitalizations in the past year;
    - Significant independent living instability;
    - Homelessness; and
    - Frequent use of mental health and related services yielding poor outcomes.
- Has the need for mental health services that cannot be met with other available community-based services, or is likely to experience a mental health crisis or require a more restrictive setting if intensive rehabilitative mental health services are not provided as determined by the written opinion of a mental health professional.

*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.
- Health services including administration of medication.
- 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; and
    - Employment-related skills.
- Co-occuring substance use disorder treatment.
- Illness management and recovery or Enhanced illness management and recovery.
- Family and other natural supports engagement (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..

Authorization

Notification is required: Submit Initial Behavioral Health Notification (Form# 4398) for initial 90 day authorization.

Prior Authorization is required to exceed benefit threshold . Submit Behavioral Health Authorization (Form# 4381) along with clinical documentation identifying medical necessity to request authorization.

Service Thresholds

- Maximum 90 days;
- Readmission within 15 days counts toward 90-day limit; and
- 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

For Billing IRTS and other concurrent services - See DHS MHCP manual for guidance.

Children's Intensive Behavioral Health Services (CIBHS)

Children's Intensive Behavioral Health Services (formerly known as Intensive treatment in foster care (ITFC)) is a comprehensive mental health service for children with significant mental health symptoms and impairments in their functional abilities who are living in a family foster care setting or who are living with their parents or other legal guardians and are at risk of out-of-home placement.

Eligible Provider

CIBHS services may only be provided by CIBHS certified agencies and their qualified employees enrolled as Minnesota Health Care Programs (MHCP) providers.

The following entities may request MHCP certification as an CIBS provider:

- A county-operated entity;

- An Indian Health Service facility or Rule 638 tribal organization under Title 25 or Title 3 of the Indian Self-Determination Act, Public Law 93-638; and
- A non-county entity.

Providers are limited to:

- Mental Health Professionals as defined in Minnesota Statutes 245I.04, subd 2.
- Clinical trainees as defined in Minnesota Statutes 245I.04, subd 5.

To be certified for CIBS, providers must be able to deliver the following core services:

- Psychotherapy;
- Psychoeducation; and
- Crisis planning.

****Refer to DHS MHCP Provider Manual for additional practitioner requirements and responsibilities. South Country follows DHS provider manual regarding certification requirements.**

Eligible Members

To be eligible for CIBHS,members must meet the following criteria:

- Be under the age of 21;
- Have a standard diagnostic assessment that documents a mental health diagnosis;
- Be living in a family foster care setting or residing with their parents or other legal guardian's and considered at risk of out-of-home placement; and
- Have a level-of-care evaluation completed that indicates a need for intensive intervention without 24-hour medical monitoring is required (level of care 4).

Covered Services

- Psychotherapy (individual, family and group);
- Psychoeducation (individual, family and group);
- Crisis planning;
- Clinical care consultation; and
- Individual treatment plan development.

Non-Covered Services

Services that are not covered in CIBHS, 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; and

- Mental health certified family peer specialist services.

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

- CTSS;
- Mental health behavioral aide services;
- Home and community-based waiver services;
- Mental health residential treatment; and
- Room and board costs.

Authorization

- No authorization is required.

Service Thresholds

- No limit.

Billing

For Billing with other Concurrent Services see DHS MHCP manual for guidance.

Children's Intensive Behavioral Health Services

Proc. Code	Brief Description	Unit	Service Limitation
S5145 HE	Children's Intensive Behavioral Health Services (performed by mental health professional)	Per diem	No limit or authorization required
S5145 HE HN	Children's Intensive Behavioral Health Services (performed by clinical trainee)		

Mental Health Targeted Case Management (MH-TCM)

Services help adults with serious and persistent mental illness (SPMI) and children with severe emotional disturbance (SED) gain access to medical, social, educational, vocational and other necessary services connected to the person's mental health needs. Targeted case management (TCM) services include developing a functional assessment (FA) and individual community support plan (ICSP) for an adult and an individual family community support plan (IFCSP), referring and linking the person to mental health and other services, ensuring coordination of services, and monitoring the delivery of services.

Eligible Providers

Agencies that provide targeted case management must be enrolled as a Minnesota Health Care Programs (MHCP) provider.

Eligible service providers are case managers (CM) or case manager associates (CMA) employed by MH-TCM agencies and meet the qualifications as stated in Minnesota Statutes.

The following case managers must complete 40 hours of training approved by the Behavioral Health Division under the authority of the commissioner:

- CMs with less than 2,000 hours of supervised service to adults with mental illness or children with severe emotional disturbance;
- New CMAs; and
- New immigrant case managers (CMs working with immigrant population).

Case Managers and CMAs must successfully complete the Department of Human Services (DHS) MH-TCM curriculum as part of the approved training; see MHCP provider manual for current training requirements.

Eligible Members

- Must be eligible for Medical Assistance (Medicaid).

Adult Mental Health:

- Age 18 years or older.
- Is a person with a serious and persistent mental illness (SPMI), as determined by a diagnostic assessment.
- Is determined by a county or tribe to be eligible for case management but due to the person's initial refusal to participate in the diagnostic assessment process, the eligibility determination cannot be completed. In these circumstances, eligibility is limited to four months from the day the person first received case management services.
- Is an 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 MH-TCM for up to 36 months and based upon the most recent diagnostic assessment when the youth transitioned to adulthood.

Children's Mental Health

- Children eligible to receive children's MH-TCM services must have a severe emotional disturbance (SED) and meet one of the following criteria:
    - The child has been admitted within the last three years or is at risk of being admitted to inpatient treatment or residential treatment for an emotional disturbance.
    - The child is a Minnesota resident and is receiving inpatient treatment or residential treatment for an emotional disturbance through the interstate compact.
    - The child has one of the following as determined by a mental health professional:
        - Psychosis or clinical depression;
        - Risk of harming self or others as a result of an emotional disturbance; and
        - Psychopathological symptoms as a result of being a victim of physical or sexual abuse or of psychic trauma within the past year.
    - The child, as a result of emotional disturbance, has significantly impaired home, school or community functioning that has lasted at least one year or that, in the written opinion of a mental health professional, presents substantial risk of lasting at least one year.

Covered Services

- Assessment;

- Planning;
- Referral and linkage; and
- Monitoring and coordination.

Interactive Video (ITV)

Interactive video means the delivery of targeted case management services in real time through the use of two-way interactive audio and visual communication, or accessible video-based platforms.

MH-TCM services may be provided through ITV according to Minnesota Statutes 256B.0625, Subd 20b. ITV or face-to-face contact meets the minimum face-to-face contact requirements for MH-TCM services with the exception of children in out-of-home placement who require an in-person or face-to-face visit only.

Children and youth in foster care for whom a responsible social service agency has placement and care responsibility, must be seen in person to claim targeted case management. Foster care is defined by Minnesota Statutes 260C.007 Subd 18 and 260D.02 Subd 10.

Providers must have a Targeted Case Management Provider Interactive Video Assurance Statement (DHS-8398) on their provider file to provide services via ITV.

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;
- a diagnostic assessment;
- Determining eligibility for MHTCM;
- Administration of member's medications;
- Services that are integral components of another service or direct delivery of an underlying medical, educational, social, or other service; and
- Transportation services.

Duplicative Services include Behavioral Health Home, Healthy Pathways and ACT.

Authorization

Notification is required for services rendered prior to April 1, 2023. (Use MHTCM Eligibility Notification Form# 4532) **No notification or authorization required for services after this date.**

Provider documentation guidelines:

MH-TCM providers must comply with federal and state regulations in the provision and ending of services based on county determination of eligibility of services. Additional requirements such as size of case manager caseload, face-to-face guidelines and documentation are referenced in the MHCP provider manual.

- A diagnostic assessment is required to determine whether a child or an adult is eligible for case management services under parts 9520.0900 to 9520.0926. If the child or adult has not had a diagnostic assessment within 180 days before the request or referral for case management services for the child or adult or if the child's or adult's mental health status has changed markedly, the child or the adult must obtain a new diagnostic assessment.
- For a transfer, a new DA may not be necessary, as long as the member has been continuously receiving TCM services with another health plan prior to the transfer..
- In the absence of a DA member may be eligible for TCM if: A psychological eval is substituted for a DA when all components of DA are met within the eval; or when the member meets SPMI plus one criteria listed in MN Statute: 245.462 Subp 20 (c); or member is presumptively eligible if all criteria are met as noted in MN Rule 9520.0909 Subp2; or Court Ordered TCM. A notification must be provided with the exception documented.

For CCBHC providers only:

1.) In addition to current state eligibility criteria, MH-TCM supports and services may be provided to both children and adults who do not meet the current criteria who are deemed at high risk of suicide by a mental health professional, particularly during times of transitions from acute care and residential settings. The mental health professional can establish medical necessity for MH-TCM utilizing an evidence-based tool to determine risk of suicide or determine risk based on clinical judgment.

2.) The comprehensive evaluation does not need to be updated when a TCM referral occurs more than 180 days after it was completed. Instead, the comprehensive evaluation must be updated when there is a significant change in the child's or adult's life circumstances or a change in the child's or adult's diagnostics and annually.

Billing guidelines – South Country follows DHS single rate schedule – one for children and one for adult.

Service limitations are noted in the billing grid below.

MH-TCM may only be billed concurrently during the admission to or discharge from ACT; MH-TCM providers must add modifier 99 to the claim to indicate admission/discharge month.

Mental health targeted case management services billing

Code	Modifier	Service Description	Unit
T2023	HE HA	Face-to- ace contact between case manager, the child, the child's parents or the child's legal representative.	1 unit / month
	HE	Face-to-face or ITV contact between case manager and member age 18 years or older	
	HE U4	Telephone contact (member age 18 years or older)	

Neuropsychological Services

Eligible Providers

- MHCP enrolled licensed psychologist with a post-doctoral neuropsychology specialty.

Covered Services

- Neuropsychological assessment;
- Neuropsychological testing;
- Neuropsychological rehabilitation; and
- Cognitive rehabilitation.

Eligible Members

See MHCP Manual for specific eligibility information

Authorization

Prior authorization is required (Form SCHA #4395) after benefit threshold is met. Submit the authorization request for only the number of units in excess of the benefit coverage allowed.

Service Thresholds

- 15 cumulative hours of assessment and neuropsychological testing in a calendar year
- See table below for additional service limitations

Billing

Procedure Code	Modifier	Brief Description	Unit	Service Limitations
96116		Neurobehavioral status exam by a physician or qualified neuropsychologist, includes face–to-face time with patient and interpreting test results	1 hour	• Authorization is required for more than 15 cumulative hours of 96116, 96121, 96132, 96133, 96136, 96137, 96138, 96139 and in a calendar year • The date of service for 96116, 96121, 96132, 96133, must be the date all components of the assessment are complete, including interpretation of test results and preparing the report • Authorization is required for more than five sessions of 96146 in a calendar year
96121		Each additional hour used in conjunction with 96116	1 hour	
96132		Neuropsychological testing evaluation administered by a physician or qualified neuropsychologist, interpretation, analysis, report	1 hour	
96133		Each additional hour used in conjunction with 96132	1 hour	
96136		Neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests	30 minutes	

Procedure Code	Modifier	Brief Description	Unit	Service Limitations
96137		Each additional 30 minutes used in conjunction with 96136	30 minutes	
96138		Neuropsychological test administration and scoring by a clinically supervised technician, interpretation and report by a qualified neuropsychologist	30 minutes	
96139		Each additional 30 minutes used in conjunction with 96138	30 minutes	
96146		Neuropsychological test administration, with single automated, standardized instrument via electronic platform with automated results only.	1 session	
H2012	HK	Cognitive rehabilitation Behavioral Health Day Treatment	1 hour	• An eligible member may receive up to four (4) 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

Partial Hospitalization Program (PHP)

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

Outpatient hospital facilities or community mental health centers that meet Medicare requirements to provide partial hospitalization services are eligible to provide partial hospitalization services.

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 family or community resources needed to support and enable the member to benefit from less than 24-hour care;
- Be admitted to partial hospitalization under the care of a physician who certifies the need for Partial Hospitalization;
- Have a completed Level of Care Assessment with a Level 4 indication for adults aged 18 and older; and
- Must have the ability to participate in treatment.

Covered Services

- At minimum, one (1) session of individual, group or family psychotherapy and two (2) or more other service components.
    - Individual and group psychotherapy;
    - Occupational therapy;
    - Services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients;
    - Drugs and biologicals furnished to outpatients for therapeutic purposes, but only if they cannot be self-administered;
    - Activity therapies but only those that are individualized and essential for the member's treatment condition;
    - Family counseling services; and
    - Patient education programs.
- Provide at least four (4) days but not more than five (5) out of seven (7) calendar days of partial hospitalization program services.
- Ensure a minimum of 20 service components and a minimum of 20 hours in a seven (7)-calendar day period.
- Provide a minimum of five (5) to six (6) hours of services per day for an adult age 18+.
- Provide a minimum of four (4) to five (5) hours of services per day for a child under age 18.

Authorization

Notification is required (Initial Behavioral Health Notification Form SCHA # 4398) for initial admission to program. This form will serve as authorization for 21 benefit days. A member may receive up to **21** calendar days of partial hospitalization program services without medical necessity review, howevernotification is required for claim to pay.

Prior authorization with medical necessity review is required for the following scenarios. Submit the Behavioral Health Authorization Form (South Country form #4381) for:

- Services provided after the 21st day following admission.
- When a recipient is receiving concurrent DBT (Dialectical Behavior Therapy) services.

- When a recipient has readmitted to a Partial Hospitalization Program within 45 days of previous discharge from PHP.
- To request authorization submit the following:
    - Behavioral Health Authorization Form (South Country form #4381);
    - Most recent diagnostic assessment;
    - Discharge plan;
    - Most recent progress notes; and
    - Statement from a treating physician that member requires PHP level of care.

Partial Hospitalization Program

Code	Service Description	Unit
H0035	Partial hospitalization services - age 18 and over	1 Session
H0035 HA	Partial hospitalization services - under age 18	1 Session

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

The following providers can provide psychiatric consultation to primary care providers:

- Psychiatrist;
- Licensed psychologist;
- Licensed independent clinical social worker;
- Licensed marriage and family therapist;
- Psychiatric nurse practitioner; and
- Clinical nurse specialist.

The following Primary Care providers are eligible to request a psychiatric consultation:

- Certified nurse midwives;
- Clinical nurse specialists;
- Nurse practitioners ;
- Physician's assistants;
- Registered nurse in a physician-directed clinic as defined in the Physician Extender section in the MHCP manual;
- Pediatricians;
- Family practice physicians;
- Psychiatrist; and
- Any other prescriber.

Services may be provided on the basis of a verbal agreement. The consulting professional and primary care provider must maintain documentation of the consultation in the patient record.

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.
- The provider may conduct the consultation without the recipient present.

Psychiatric Residential Treatment Facility (PRTF)

Code	Modifier	Provider	Service Description	Unit	Limitations
99499	HE AG	Primary care providers	Communication between a consulting professional and PCP, for consultation or medical management or behavioral health care and treatment of member.	1 session	Add the U4 modifier if not face-to-face Add the U7 modifier if provided by a Physician Extender
99499	HE AM	Consulting professionals	Communication between a consulting professional and PCP, for consultation or medical management or behavioral health care and treatment of member.	1 session	Add the U4 modifier if not face-to-face

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 (7) 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. For services outside the per diem, South Country follows DHS guidelines in MHCP manual.

PRTF services must be provided under the direction of a physician.

Eligible Providers

- Must be selected through the request for proposal (RFP) process and be enrolled with Minnesota Health Care Programs (MHCP).
- Must meet all of the following requirements to enroll with MHCP as a PRTF provider:
    - Certified by the Minnesota Department of Health as a PRTF and meet licensing requirements for supervised living facilities (SLF).
    - Licensed by the Department of Human Services.
    - Accredited by one of the following:
        - Joint commission;
        - Commission on Accreditation of Rehabilitation Facilities; or
        - Council on Accreditation of Services for Families and Children.

Eligible Members

- Must be eligible for Medical Assistance or MNCare.
- Under age 21 at time of admission. Services may continue until the individual meets criteria for discharge or reaches 22 years of age, whichever occurs first.
- Have a mental health diagnosis as defined in most recent edition of Diagnostic and Statistical Manual for Mental Disorders, as well as clinical evidence of severe aggression, or a finding that the individual is a risk to self or others.
- Functional impairment and a history of difficulty in functioning safely and successfully in the community, school, home or job.
- Have an inability to adequately care for one's physical needs or caregivers/guardians are unable to safely fulfill the individual's needs.
- Requires psychiatric residential treatment to improve the individual's condition or prevent further regression so that services will no longer be needed.
- Have utilized and exhausted other community based mental health services or clinical evidence indicates that such services cannot provide the level of care needed.
- Was referred for treatment in a psychiatric residential treatment facility by a qualified mental health professional.

Covered Services

- Individual therapy provided a minimum of twice per week.
- Family engagement activities provided a minimum of once per week.
- Consultation with other professionals, including case managers, primary care professionals, community-based mental health providers, school staff or other support planners.
- Coordination of educational services between local and resident school districts and the facility.
- 24-hour nursing services.
- Direct care and supervision, supportive services for daily living and safety, and positive behavior management.

Notification required for pending placement

If member is connected to their county by CMHTCM or other case management, the county representative (CMHTCM, Child Protection, etc.) must notify South Country's Behavioral Health Department of any pending placement in a PRTF facility.

The county representative assigned to the member must email South Country's Behavioral Health Department prior to member's placement.*

*If member is admitted for emergency care, the county representative must notify South Country as soon as it is possible to do so.

The email must include member's name, South Country ID number, name of the provider(s) being considered for placement, and the placement date if it is known. This notification does not serve as authorization for placement, but an email will be sent in response to confirm receipt of notification. The email can be sent directly to a BH team member or to countyinfo@mnscha.org.

Authorization

Once the member is accepted for admission, the PRTF must submit South Country's Initial Behavioral Health Notification Form (Form SCHA #4398) along with referring documentation and Diagnostic Assessment (DA) completed within the last 180 days.

- In lieu of a DA, the following documentation is acceptable, as long as components of a standard DA are included: Psychiatric Evaluation or Psychological Evaluation **completed by a licensed psychologist or medical doctor.**

After South Country has completed review of documentation submitted, the initial authorization will be for 90 days. The PRTF must then submit member's Plan of Care within 14 days of admission. Continued stay requests must be completed every 90 days by submitting a new Initial Behavioral Health Notification Form (Form SCHA #4398) and an updated Plan of Care. This documentation must be submitted 10 days before the end of the current authorization.

Leave Days

Therapeutic leave days

Therapeutic leave is used when the member is not discharged from the facility, but goes home to prepare for discharge and reintegration. Concurrent services may be delivered to PRTF members on therapeutic leave days. Therapeutic leave days are reimbured at 75 percent of the provider per diem rate.

Hospital leave days

Hospital leave is used when a member is admitted to the hospital for medical or acute psychiatric care and is temporarily absent from the PRTF. Hospital leave days are reimbursed at 50 percent of the provider per diem rate.

Authorization for leave days

The PRTF provider does not need to request separate authorization for therapeutic or hospital leave days. The provider must include documentation of therapeutic and/or hospital leave days within the plan of care. The provider must follow billing and coding guidelines when submitting claims for days that the member is on therapeutic or hospital leave days.

Billing

Service Description	Units	Revenue Code	Claim Format	Type of Bill	Limitations
All-inclusive room and board	1 day	0101	837I Institutional claim	086X	
Hospital leave days	1 day	0180	837I Institutional claim	086X	A hospital leave day will be a day when a recipient requires admission to a hospital for medical or acute psychiatric care and is temporarily absent from the psychiatric residential treatment facility.
Therapeutic leave days	1 day	0183	837I Institutional claim	086X	A therapeutic leave day to home will be to prepare for discharge and reintegration and will be included in the individual plan of care.
• Bill all PRTF claims on a 837I claim type • Bill for leave days (therapeutic and hospital) using the occurrence span code 74 (non-level of care absence days), Value Code 80.					

South Country follows guidance noted in DHS MHCP Manual for the following:

- Services Billed Outside the Per Diem and Limitations;
- Transitions in coverage;
- Third party liability and emergency medical assistance; and
- Continued stay coverage.

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.

Eligible Providers

- Only mental health professional or clinical trainees may provide family psychoeducation.

Eligible Members

- Must be eligible for Medical Assistance (Medicaid);
- Under age 21; and
- 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); and
    - Multiple families (family group).

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; and
    - Intensive treatment services in foster care.

Authorization

No authorization required.

Billing

Family Psychoeducation Services Billing

Code	Service Description	Unit	Service Limitation
H2027	Family psychoeducation - individual	15 min	104 units/calendar year Maximum 4 units/day
H2027 HQ	Family psychoeducation – group	15 min	52 sessions/calendar year Maximum 1 session (6 units)/day
H2027 HR	Family psychoeducation – family with member present	15 min	26 sessions/calendar year Maximum 1 session (6 units)/day
H2027 HS	Family psychoeducation – family without member present	15 min	26 sessions/calendar year Maximum 1 session (6 units)/day
H2027 HQ HR	Family psychoeducation – multiple families with members present	15 min	10 sessions/calendar year Maximum 1 session (8 units)/day
H2027 HQ HS	Family psychoeducation – multiple families without members present	15 min	10 sessions/calendar year

Code	Service Description	Unit	Service Limitation
			Maximum 1 session (8 units)/day

Psychological Testing

Used to determine the status of a member's mental, intellectual, and emotional functioning. 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;
- Clinical psychology trainee under the treatment supervision of a LP; and
- Psychological technicians, psychometrists, clinical psychology trainee or psychological assistants may administer or score psychological tests under clinical supervision of a LP.

Eligible Members

- All members are eligible for this service.

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.
- The resulting report must be:
    - Signed by the psychologist conducting the face-to-face interview;
    - Placed in the client's record; and
    - Released to each person authorized by the client.

Authorization

Prior Authorization is required (Form SCHA #4395) after benefit threshold is met. Submit the authorization request for only the number of units in excess of the benefit coverage allowed.

Billing

Psychological testing

Code	Description	Unit	Service Limitations
96130	Psychological testing evaluation services	1 hour	Eight (8) cumulative maximum hours per calendar year
96131	Each additional hour	1 hour	
96136	Psychological test administration and scoring of two (2) or more tests by physician or other qualified health care professional	30 minutes	
96137	Each additional 30 minutes	30 minutes	

Code	Description	Unit	Service Limitations
96138	Psychological test administration and scoring of two (2) or more tests, any method, by technician	30 minutes	
96139	Each additional 30 minutes	30 minutes	
96146	Psychological test administration, with single automated, standardized instrument via electronic platform with automated results only	1 Session	1 per day

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

- Only a mental health professional, clinical trainee or tribal certified professional can provide psychotherapy.

Eligible Members

- Must be eligible for Medical Assistance (Medicaid).
- Must have a diagnosis of mental illness as determined by a diagnostic assessment.

*The initial diagnostic assessment allows for a member to be eligible to receive up to three sessions of a combination of individual or family psychotherapy or family psychoeducation before the provider completes the diagnostic assessment.

Covered Services

- Psychotherapy – with member;
- Evaluation and management with psychotherapy – with member, family or both;
- Family psychotherapy;
- Multiple family group psychotherapy; and
- Group psychotherapy.

Interactive Complexity

Use the Interactive Complexity add-on code (90785) to designate a service with interactive complexity. Report interactive complexity for services when any of the following exist during the visit:

- Communication difficulties among participants that complicate care delivery, related to issues such as:
    - High anxiety;
    - High reactivity;
    - Repeated questions; or
    - Disagreement.

- Caregiver emotions or behaviors that interfere with implementing the treatment plan.
- Discovery or discussion of evidence relating to an event that you must report to a third party. This may include events such as abuse or neglect that require a mandatory report to the state agency.
- The mental health provider needs to overcome communication barriers by using any of the following methods:
    - Play equipment;
    - Physical devices (physical devices do not include standard telehealth equipment);
    - An interpreter; or
    - A translator.
- The mental health provider needs to overcome communication barriers for members who:
    - Are not fluent in the same language as the mental health provider.
    - Have not developed or have lost the skills needed to use or understand typical language.

The interactive complexity add on code should not be used for technical difficulties with telehealth equipment.

Noncovered Services

- Conversion therapy is not a covered service.

Authorization

No authorization required; no service limits on psychotherapy.

Billing

Code	Service Description	Unit	Service Limit
90832	Psychotherapy – with member	30 min	No limit or authorization required For prolonged psychotherapy services face to face with the member of 91 minutes or more, bill two units of 90837
90834	Psychotherapy – with member	45 min	
90837	Psychotherapy – with member	60 min	
Appropriate E/M and 90833	E/M and psychotherapy – with member	30 min	
Appropriate E/M and 90836	E/M and psychotherapy – with member	45 min	
Appropriate E/M and 90838	E/M and psychotherapy – with member	60 min	
90875	Individual psychophysiological therapy incorporating biofeedback with psychotherapy	30 min	

Code	Service Description	Unit	Service Limit
90876	Individual psychophysiological therapy incorporating biofeedback with psychotherapy	45 min	
90846	Family psychotherapy without member present	50 min	No limit or authorization required
90847	Family psychotherapy with member present	50 min	
90849	Multiple family group psychotherapy	1 session	
90853	Group psychotherapy	1 session	No limit or authorization required

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.

Eligible Providers

- Clinical nurse specialist in mental health;
- Licensed independent clinical social worker;
- Licensed marriage and family Therapist;
- Licensed professional clinical counselor;
- Licensed psychologist;
- Psychiatric nurse practitioner;
- Psychiatrist;
- Tribal certified professional; and
- 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 an emergency 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; and
    - Significant disruption of normal functioning in at least one life area such as self-care or housing.

A member may receive one session of psychotherapy (including psychotherapy for crisis) prior to receiving a diagnostic assessment.

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; and
- Development of a post crisis plan that addresses the member's coping skills and community resources.

Authorization

No authorization needed.

Billing

Code	Service Description	Unit	Service Limitation
90839	Psychotherapy for crisis	60 min	No limit or authorization required
90840	Psychotherapy for crisis (each additional 30 minutes)	30 min	No limit or authorization required

Telehealth Delivery of MH Services

Mental health services covered by medical assistance as direct face-to-face services may be provided via telehealth and are covered by South Country. For mental health services or assessments delivered through telehealth that are based on an individual treatment plan, the provider may document the client's verbal approval or electronic written approval of the treatment plan or change in the treatment plan in lieu of the client's signature.

For details on provider billing requirements for telehealth see chapter 33 of the South Country Provider Manual.

Youth Assertive Community Treatment (Youth ACT)/Intensive Rehabilitative Mental Health Services (IRMHS)

An intensive, comprehensive, non-residential rehabilitative mental health services team model. 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; and
- Available 24 hours per day, 7 days per week.

Eligible Providers

- Have a memorandum of understanding with the county(s) of service;
- Have a contract with the Minnesota Department of Human Services; and

- Follow all Minnesota Youth ACT/IRMHS Treatment Standards (please reference MHCP manual for details).

Eligible Members

To be eligible for Youth ACT/IRMHS, members must be 8 years old or older and under 21 years of age and have:

- Must be eligible for Medical Assistance (Medicaid);
- Diagnosis of serious mental illness or co-occurring mental illness and substance abuse disorder;
- A level of care determination of Level 4 on the CASII for ages 8 through 18. Ages 18-20 has received a level-of-care determination that indicates a need for intensive integrated intervention without 24-hour medical monitoring and a need for extensive collaboration among multiple providers, impairment, and a history of difficulty in function safely and successfully in the community, school, home or job;
- Likely need for services from the adult mental health system during adulthood; and
- 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;
- Transition services;
- Integrated dual disorders treatment; and
- Housing access support.

Service Standards

- An individual treatment team must serve youth who are either:
    - At least 8 years old and under 21 years old.
    - The treatment team must have specialized training in providing services to the specific age group of youth that the team serves.
- Members and/or family members must receive at least three face-to-face contacts per week that meet the following criteria:

- Face-to-face contacts must total a minimum of 85 minutes of services;
- The treatment team must use team treatment, not an individual treatment model;
- Services must be age-appropriate and meet the specific needs of the client;
- The initial functional assessment must be completed within 10 days of intake and updated at least every six months or prior to discharge from the service, whichever comes first; and
- Each member must have an individualized treatment plan. See MHCP manual for specific services standards related to the individualized treatment plan.

Authorization

No authorization required.

Service Thresholds

- Daily limit of one.

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 Health Alliance (South Country) follows DHS Medicaid requirements and coverage guidelines unless specified.**

Eligible Providers

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

- Be enrolled as a MHCP provider for Substance Use Disorder (SUD) services to provide, bill and receive payment for SUD services;
- Meet all provider qualifications as stated on the assurance statement for the provider type; and
- Enroll and participate in the Drug and Alcohol Abuse Normative Evaluation System (DAANES).

Eligible providers include the following:

- Licensed residential SUD treatment programs;
- Licensed non-residential (outpatient) SUD treatment programs;
- Counties and tribes;
- Recovery community organizations (RCO);
- Hospitals;
- Licensed professionals in private practice
- Federally qualified health clinics, and rural health clinics (As long as they also have a substance use disorder program license);
- Licensed professionals in private practice; and
- Licensed withdrawal management programs.

Eligible Members

- Assessments are covered for South Country members on any South Country product.
- Clinical eligibility is based on the results of a Comprehensive Assessment. The Comprehensive Assessment must be completed within required timelines described in Minnesota Statutes, §245G.05, subd. 1 [Minnesota Statutes, §254B.05, subd. 5]

Covered Services

- Comprehensive assessment;
- Medications for opioid use disorder;
- Outpatient treatment services - individual and group;
- Peer recovery support services;
- Residential treatment services;
    - ASAM level 3.1 clinically managed low-intensity.
    - ASAM level 3.3 clinically managed population-specific high-intensity.
    - ASAM level 3.5 clinically managed high-intensity.

- Treatment coordination;
- Hospital-based inpatient treatment;
- Residential withdrawal management service Level 3.2 (clinically managed) and Level 3.7 (medically monitored); and
- Smoking cessation - when provided as counseling by an alcohol and drug counselor can be provided in individual or group counseling (H2035 or H2035 HQ) and can also fall under the role of a treatment coordinator (T1016 HN U8).

Notification

Notification is required:

For residential SUD admissions (H2036) including IMD and hospital based inpatient treatment, use South Country's SUD Admission and Discharge Form (#4505). Submit discharge summary along with form #4505 when notifying South Country of member's discharge. Since this is a notification only and not a prior authorization requirement, no correspondence letter or confirmation of notification will be sent from South Country upon receipt of admission and discharge notification.

Notification is not required for outpatient treatment or for comprehensive assessments.

Authorization

Prior Authorization is required for non-contracted provider SUD services.

- Outpatient programs that are outside of Minnesota are considered non-contracted. Non-contracted providers should submit the Out-of-Network SUD Authorization Form (#5991) along with the most recent comprehensive assessment.
- Residential programs that are outside of Minnesota AND all surrounding states (ND, SD, IA, WI) are considered non-contracted. Non-contracted providers should submit the Out of Network SUD Authorization Form (#5991) along with the most recent Comprehensive Assessment.

For South Country members who are in the Minnesota Restricted Recipient Program (MRRP) and in need of medications for opioid use disorders (MOUD), members do not need a referral if participating in an Opioid Treatment Program. The member's primary care provider (PCP) must submit South Country's Managed Care Referral Form (#2298) if the member receives Buprenorphine from a provider which will process through the pharmacy benefit system.

1115 Substance Use Disorder System Reform Demonstration

Minnesota is implementing a Substance Use Disorder (SUD) System Reform Demonstration that incorporates the American Society of Addiction Medicine (ASAM) criteria to establish specific residential and outpatient levels of care for SUD treatment services for Medical Assistance (MA) under the authority of section 1115(a) of the Social Security Act. The demonstration, through the implementation of ASAM criteria, seeks to enhance evidence-based assessment and placement criteria for the purpose of matching individual risk with the appropriate ASAM level of care. The demonstration also increases standards for treatment coordination to ensure transitions to needed services across a comprehensive continuum of care.

Eligible Providers

Providers must enroll and meet the requirements to be eligible to provide, bill and be paid within the 1115 SUD System Reform Demonstration.

- Licensed residential SUD treatment programs (required to enroll by 1/1/2024);
- Licensed Nonresidential (outpatient) SUD treatment programs;
- Licensed Withdrawal Management programs (required to enroll by 1/1/2024);
- Tribes; and
- Out-of-state residential SUD providers enrolled in MHCP (required to enroll by 1/1/2024).

Outpatient SUD providers and tribally licensed providers may elect to participate. This is in accordance with Minnesota Statute 256B.0759 Subd 2.

Eligible Members

All members are eligible for SUD services delivered by enrolled providers.

Covered Services

All SUD services provided by enrolled providers must meet the standards for each level of care. See MHCP Manual for more information on service requirements.

Noncovered Services

- Services delivered before the completion of a comprehensive assessment;
- Room-and-board services
- Detoxification services;
- Comprehensive assessment, treatment coordination, peer support and outpatient treatment services when provided by the same residential provider receiving a per diem payment for the same date of service and for the same member;
- Substance Use Disorder services provided by counties, recovery community organizations, and licensed professionals in private practice before the comprehensive assessment is completed.
- Substance use disorder treatment with medications for opioid use disorder services guest dosing; and
- Federally qualified health clinics and rural health clinics are not eligible for 1115 rate enhancements.

Recovery Community Organizations (RCO)

An independent organization led and governed by representatives of local communities of recovery.

An RCO must meet fidelity standards through Association for Recovery Community Organization (ARCO) membership, Council on Accreditation of Peer Recovery Support Services (CAPRSS) accreditation, or approval of reconsideration by the Commissioner. RCOs are eligible to provide peer recovery support services. Recovery peers have a high school diploma or its equivalent and have a minimum of one year recovery from a substance use disorder hold a current credential from the Minnesota Certification Board, the Upper Midwest Indian Council on Addictive Disorders, or the National Association for Alcoholism and Drug Abuse Counselors.

Peer recovery support services must be provided one to one and can include:

- Education;
- Advocacy;
- Mentoring;

- Attending recovery and other support groups with members;
- Accompanying the member to appointments that support recovery; and
- Assistance with attaining housing, employment, or education.

You must be a recovery peer to provide peer recovery support services. Recovery peers have a high school diploma or its equivalent; have a minimum of one year recovery from a substance use disorder; hold a current credential from the Minnesota Certification Board, the Upper Midwest Indian Council on Addictive Disorders, or the National Association for Alcoholism and Drug Abuse counselors.

An individual may also receive a credential from a tribal nation when providing peer recovery support services in a tribally licensed program. The credential must demonstrate skills and training in the domains of ethics and boundaries, advocacy, mentoring and education, and recovery and wellness support; and receive ongoing supervision in areas specific to the domains of the recovery peer's role by an alcohol and drug counselor.

Screening, Brief Intervention, Referral to Treatment (SBIRT)

Substance use disorder services may include utilization within a primary care clinic, hospital, or other medical setting or school setting. A member may be screened within one of these settings using a valid and reliable tool approved by the Department of Human Services. If a screen result is positive for substance use disorder, the SBIRT will establish medical necessity and approval for an initial set of SUD services prior to the completion of a Comprehensive Assessment.

Covered Services

- Screening, brief intervention and referral to treatment (SBIRT).
- 6 hours of a combination of SUD services (must be completed at an enrolled provider contracted with DHS to provide SUD services):
    - Up to 4 hours of individual (H2035) or group treatment (H2035 HQ).
    - Up to 2 hours of peer support (H0038 U8) or treatment coordination (T1016 U8 HN).

Eligible Members:

All South Country members are eligible to receive an SBIRT screening. Only those that screen "positive" may access the 6 hours of SUD services. Positive SBIRT screening must have been completed within last 3 months of initiating the SUD services.

Eligible Providers of SBIRT screening:

- 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;
- Licensed alcohol and drug counselor (LADC);

- Mental health practitioners working as clinical trainees under the supervision of a mental health professional;
- Tribal certified professionals;
- Physician;
- Nurse practitioner;
- Advanced practice registered nurse;
- Physician assistant (PA); and
- Nurse midwife.

Eligible SBIRT Screening Tools:

- ASSIST - Alcohol, Smoking, and Substance Involvement Screening Test;
- AUDIT - Alcohol Use Disorders Identification Test;
- AUDIT-C;
- CAGE - Cut Down, Annoyed, Guilty, Eye-Opener;
- CRAFFT -Car, Relax, Alone, Forget, Family or Friends, Trouble;
- DAST - Drug Abuse Screening Test;
- DAST-A;
- MAST - Michigan Alcohol Screening Test;
- NIDA Drug Use Screening Tool;
- POSIT - Problem- Oriented Screening Instrument for Teenagers; and
- TWEAK - Tolerance, Worried, Eye-Openers, Amnesia, (K) Cut Down.

Authorization

No authorization required for SBIRT or the corresponding 6 hours of SUD treatment.

Billing

SBIRT Billing Codes

Procedure Code	SBIRT Modifier	Service
G2011		Alcohol and/or substance abuse screening and brief intervention, 5-14min
G0396		Alcohol and/or substance abuse screening and brief intervention, 15-30 mins
G0397		Alcohol and/or substance abuse screening and intervention, greater than 30 mins
SUD Billing Codes		
H2035	U1	Individual treatment
H2035 HQ	U1	Group treatment

T1016 U8 HN	U1	Treatment coordination
H0038 U8	U1	Peer support

Withdrawal Management Services

Withdrawal management services are designed to assist patients in safely withdrawing from alcohol or other substances. American Society of Addiction Medicine (ASAM) defines multiple levels of withdrawal management. The following two ASAM-based levels of residential withdrawal management were added to the state's Medicaid benefit set.

Level 3.2 Clinically Managed is defined as a residential setting with staff comprised of a medical director and a licensed practical nurse (LPN). An LPN must be on site 24 hours a day, seven days a week. A qualified medical professional must be available by telephone or in person for consultation 24 hours a day. Patients admitted to this level of service receive medical observation, evaluation and stabilization treatment services. A licensed staff administers medications for a successful withdrawal by conducting a comprehensive assessment pursuant to Minnesota Statutes 245G.05.

Level 3.7 Medically Monitored is defined as a residential setting with staff that includes a registered nurse and a medical director. A registered nurse must be on site 24 hours a day. A medical director must be on site seven days a week, and patients must have the ability to be seen by a medical director within 24 hours. Patients admitted to this level of service receive medical observation, evaluation and stabilization treatment services. During detoxification process, a licensed staff administers medications for a successful withdrawal and conducts a comprehensive assessment pursuant to section Minnesota Statutes 245G.05.

Eligible Providers

- Licensed 245F Withdrawal Management programs.
- Must be enrolled as a MHCP provider for withdrawal management services.
- Each facility must be enrolled as an eligible provider of specific level of (3.2 or 3.7) withdrawal management services.
- Providers must enroll and participate in the Drug and Alcohol Normative Evaluation System (DAANES).

Providers applying for a withdrawal management license may also be:

- Chemical dependency licensed treatment facilities;
- Detox providers;
- Tribally licensed programs;
- Hospital-based programs;
- Intensive residential treatment services facilities; and
- Mental health crisis facilities.

Eligible Members

All enrolled South Country members are eligible for withdrawal management services if they meet clinical eligibility requirements.

Authorization

Authorization is not required for Withdrawal Management services.

Revenue Code	Service Description	Unit	Service Limitation
0900	Withdrawal Management Clinically Managed level 3.2	Day	No limit or authorization required
0919	Withdrawal Management Medically Monitored level 3.7	Day	No limit or authorization required

Additional Substance Use Disorder Information

- Refer to MHCP Provider Manual for billing freestanding and residential program room-and-board charges.
- Civil Commitment:
    - Comprehensive 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:
    - Counties, tribes, and MCO's are all "placing authorities."
    - Comprehensive assessors are responsible for coordination of individual placement and treatment based upon member need.
- 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.
- A Comprehensive Assessment must be completed within three calendar days from the day of service initiation:
    - If the comprehensive assessment is not completed within the required time frame, the person-centered reason for delay and the planned completion date must be documented in the client's file.
    - The comprehensive assessment is considered completed upon a qualified staff member's dated signature.
- If a person received a comprehensive assessment that authorized the treatment service, an alcohol and drug counselor may use the comprehensive assessment for initiation of services but must document a review and update the assessment as clinically necessary.
- Information related to the 1115 Substance Use Disorder System Reform Demonstration can be found on the MHCP manual page under Substance Use Disorder (SUD) Services
- For more information on billing SUD services for Medicare enrolled members please visit the link listed below.

https://www.cms.gov/files/document/otp-billing-and-payment-fact-sheet.pdf

Telehealth Delivery of SUD Services

Telehealth is the delivery of health care services or consultations through the use of real time, two-way interactive audio and visual communications. Telehealth provides or supports health care delivery and facilitates the assessment, diagnosis, consultation, treatment education and care management of a patient's health care while the patient is at originating site and the licensed health care provider is at a distant site.

- South Country allows payment for telehealth services in substance use disorder treatment for services that are otherwise covered as direct face-to-face services. For details on provider billing requirements for telehealth see chapter 33 of the South Country Provider Manual.