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.

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:

- Clinical nurse specialist in mental health
- Licensed independent clinical social worker (LICSW)
- Licensed marriage and family therapist (LMFT)
- Licensed psychologist (LP)
- Licensed professional clinical counselor (LPCC)
- Mental health rehabilitation professional
- Nurse practitioner with psychiatric specialty (NP)

- Psychiatrist
- Mental health practitioner
- Mental health rehabilitation worker
- Certified peer specialist

*Each ARMHS provider must be certified to provide this service, re-certification must be completed every three (3) years.

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

- Physician
- Registered nurse
- Physician assistant
- Pharmacist

Eligible Members

A person who is eligible to receive ARMHS:

- Must be eligible for Medical Assistance (Medicaid);
- Age 18+;
- Primary diagnosis of a serious mental illness as determined by a Diagnostic Assessment;
- Have a completed LOCUS assessment that indicates a Level 3 or a Level 2;
- Have a significant impairment in functioning in three or more areas of the Functional Assessment domains specified in statute.

Covered Services

The following seven (7) services are billable as ARMHS:

- Basic living and social skills
- Certified peer specialist services
- Community intervention
- Functional assessment
- Individual treatment plan
- Medication education
- Transition to community living services

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

ARMHS services may be provided in the following settings:

- Member’s home
- Home of a relative or significant other
- Member’s job site

- Community setting such as: clubhouse, drop-in center, social setting, classroom, other places in the community

Non-Covered Services

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

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

*except for services that meet the requirements under Transition to Community Living Services

The following services are not covered ARMHS:

- Recipient transporting 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
- Room and board services

Authorization

- **Prior authorization is required** (Form SCHA #4381) after benefit threshold is met
- If provided concurrently with ACT services.

Service Thresholds

See DHS MHCP provider manual

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

Adult Rehabilitation Mental Health Services (ARMHS) Benefits				
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	
	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	Authorization required 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

Adult Rehabilitation Mental Health Services (ARMHS) Benefits				
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 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	1 session	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 for a fixed group of members. In this approach, normally used with members with severe and persistent mental illness, the treatment team typically provides all member services using a highly integrated approach to care.

Eligible Providers

- Have a contract with a host county;
- Be certified by DHS;
- Meet specific fidelity standards, as detailed in the MN Assertive Community Standards;

An ACT team is required to have the following:

- Team leader (licensed mental health professional)
- Psychiatric care provider
- Licensed mental health professional
- Registered nurse
- Co-occurring disorder specialist
- Vocational specialist
- Mental health certified peer specialist
- Program administrative assistant

Eligible Members

A person who is eligible to receive ACT services:

- Must be eligible for Medical Assistance (Medicaid);
- Age 18+;
- Have a primary diagnosis of schizophrenia, schizoaffective disorder, major depressive disorder with psychotic features or other psychotic disorders or bipolar disorder.
- Have a completed Functional Assessment following the domains specified by statute with three or more areas of significant impairment in functioning.

Have a significant functional impairment demonstrated by at least one (1) of the following:

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.

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
- 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
- Symptom management
- Therapeutic interventions
- Wellness self-management and prevention
- Other services based on client needs as identified in a client's assertive community treatment individual treatment plan

Authorization

Notification is required (Form SCHA #4398)

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

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

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

Eligible Providers

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

*Provider must ensure that member has current MA coverage.

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

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

BHH Team members can be:

- Member
- Team leader
- Integration Specialist (case management)
- BHH Systems Navigator (case management/care coordination)
- Qualified Health Home Specialist (peer specialist, community health worker)
- Consulting physicians
- External professionals

Eligible Members

- Must be eligible for Medical Assistance (Medicaid);

- Eligibility for BHH services is determined by a MH Professional employed or under contract with a state certified BHH;
- Have a condition that meets the definition of serious mental illness or emotional disturbance;
- Have a current Diagnostic Assessment as performed or reviewed by a mental health professional employed by or under contract with the behavioral health home.

Covered Services

- Case management
- Care coordination
- Health and wellness
- Comprehensive transitional care
- Individual and family supports
- Referral to community supports

Non-Covered Services

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

Authorization

Notification 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 3387 found in Behavioral Health forms at www.mnscha.org.

South Country may complete retro review of utilization and payments. See also DHS MHCP Manual for details.

Service Thresholds

- Six (6)-month lifetime per member - member engagement for enhanced rate.

Billing

Behavioral Health Home (BHH) Services Billing		
Code	Service Description	Unit
S0280 U5	BHH services care engagement, initial plan	PMPM
S0281 U5	BHH services ongoing standard care, maintenance of plan	PMPM
Limitations on engagement rate (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 as meeting the required federal criteria (PDF) and state standards as CCBHCs. 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 are eligible for CCBHC services. However, CCBHC's only receive the PPS payment for members who are enrolled in the following major programs:
- For Demonstration CCBHC's, major programs MA and QM
- For SPA CCBHC's, major programs MA, IM, NM, RM, and EH
- Members considered "New" to CCBHC, meaning they have not been served by the clinic in the six (6) months before the current service, must meet one (1) of the following to become a person receiving CCBHC services:
    - Receive a preliminary screening and risk assessment and one CCBHC service, or
    - Receive a crisis assessment

Covered Services

South Country covered services include all services including expanded described in detail on 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.

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

Certified Peer Specialist Services (CPSS)

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

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

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

Eligible Providers

Certified Peer Specialist Level I:

- Age 21+;
- Have a primary diagnosis of mental illness;
- Is a current or former consumer of mental health services;
- Demonstrates leadership and advocacy skills;
- Successfully completes the DHS approved Certified Peer Specialist training and certification exam.

Certified Peer Specialist Level II:
Must meet all requirements of a Level I CPS and one or more of the following criteria: is qualified as a mental health practitioner:

- A CPS on a crisis stabilization team must complete at least 30 hours of crisis intervention and stabilization training during their first two years on the team.

Eligible Members

A member must be:

- Must be eligible for Medical Assistance (Medicaid);
- Age 18+;
- Receive ACT, ARMHS, IRTS or Crisis Services.

Covered Services

- Education and skill-building, including but not limited to the following:
    - Wellness planning
    - Crisis planning
    - Advanced Psychiatric Directives
    - Self-advocacy skills including connecting to professional services when appropriate
- Services that help recipients to do the following:
    - Identify their strengths and to use their strengths to reach their treatment goals
    - Identify and overcome barriers to participation in community resources
    - Connect with resources, including:
        - Visiting community resources to assist them in becoming familiar with potential opportunities
        - teaching and modeling the skills needed to successfully utilize community resources
- Building relationships and encouraging community-based activities, such as:
    - Work
    - Relationships
    - Physical activity
    - Self-directed hobbies
- Transition to Community Living (TCL) services when working for a certified Adult Rehabilitative Mental Health Service (ARMHS) provider.

Non-Covered Services

- Transportation
- Services that are performed by volunteers
- Household tasks, chores, or related activities such as laundering clothes, moving, housekeeping, and grocery shopping
- Time spent “on call” and not delivering services to clients
- Job-specific skills services, such as on-the-job training
- Case management
- Outreach to potential clients

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

Authorization

Prior authorization **(Form SCHA #4381 is required after benefit threshold is met.Service Thresholds**

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

Billing

Entities eligible to bill for certified peer specialists are:

- ARMHS providers
- 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**
H0038	Self-help / peer services by Level I Certified Peer Specialist	15 min
H0038 U5	Self-help / peer services by Level II Certified Peer Specialist	15 min
H0038 HQ	Self-help / peer services in a group setting	15 min

Certified Family Peer Specialist MH 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.

Eligible Providers

Certified family peer specialists are employed by existing mental health community providers or centers who are enrolled in MHCP.

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
- Demonstrate leadership and advocacy skills
- Successfully complete the Department of Human Services-approved Certified Family Peer Specialist Training and certification exam

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
- Crisis services programs

Covered Services

The following activities are covered by CFPS services:

- Education to develop coping and problem-solving skills
- Non-adversarial advocacy
- Collaboration with others providing care or support to family
- Connection to other families, parents, community and school resources
- Identifying strategies and services that help promote resiliency and develop natural supports
- Establish and lead parent support groups
- Support parental self-advocacy skills, including accompanying parents to IEP and treatment planning meetings and community events

Noncovered Services

The following services are not covered as CFPS services:

- Transportation
- Services performed by volunteers
- Household tasks, chores or related activities such as laundering clothes, moving, housekeeping and grocery shopping
- Time spent “on call” and not delivering services to recipients
- Job-specific skills services such as on-the-job training
- Case management
- Outreach to potential recipients

- Services to family members
- Room and board
- Service by providers that are not approved to provide CFPS services
- CFPS services that are included in the daily rate may not be billed separately

Authorization Requirements

For CFPS services, no authorization required until benefit threshold is met. Complete Form #4381 for request beyond benefit limit.

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 until member reaches a combined 300 hours per year.
	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
- 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 notify South Country Behavioral Health of any pending placement in a CMHRT Facility.

The county representative (CMHTCM, Child Protection, etc.) assigned to the member must 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.

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

**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.

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

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. Providers must submit the Initial Behavioral Health Notification Form (Form #4398) by faxing it to 1-888-633-4052.

Upon notification, South Country will open an authorization for an initial 30-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 members 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

Clinical Care Consultation - Children's Mental Health

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

- Issues about the member's symptoms
- Strategies for effective engagement, care and intervention needs
- Treatment expectations across service settings
- Clinical service components provided to the member and family

Eligible Providers

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

Eligible Members

- Must be eligible for Medical Assistance (Medicaid);
- Between the ages of 0-21;
- Have a diagnosis of a mental illness determined by a diagnostic assessment.

Covered Services

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

- Home health care agencies
- 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
- 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

Prior Authorization is required after benefit threshold is met. (Form – DHS – 4695 – ENG)

Service Threshold

- 15 hours / calendar year

Billing

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

Crisis Services - Adult

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

Eligible Providers

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

Eligible Members

- Must be eligible for Medical Assistance (Medicaid);
- Age 18+;
- Experiencing a mental health crisis or emergency.

Covered Services

Adult Crisis Services may include a number of services:

- Crisis/Emergency screening
- Mobile mental health crisis assessment, intervention and stabilization
- Residential crisis stabilization
- Community intervention
- Rapid access to a psychiatrist or other medication prescriber
- Health care and benefit navigator
- Assistance in purchasing medications.

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

Non-Covered Services

Community intervention services do not include:

- Member transporting services
- Crisis response services performed by volunteers
- Provider performance of household tasks, chores or related activities such as laundering clothes, moving the recipient's household, housekeeping and grocery shopping for the member
- Time spent "on call" and not delivering services to member
- Activities primarily social or recreational in nature, rather than rehabilitative

- Job specific skills services such as on the job training
- Case management
- Routine communication among members of the treatment team, routine staffing, or a care conference
- Telephone contacts that do not conform to the definition of this service or that are not properly documented
- Clinical supervision or consultation with other professionals
- Developing a treatment plan
- Outreach services to potential members
- Crisis response services provided by a hospital, board and lodging or residential facility to a recipient of that facility
- Room and board

Authorization

Prior Authorization is not required. No notification required.

- Service Thresholds
  - Follow DHS MHCP provider manual guidance.

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	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
90882	HK HM	Community Intervention by a mental health rehabilitation worker		

				services as a part of crisis response.

Crisis Services – Children

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

Eligible Providers

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

Eligible Members

- Must be eligible for Medical Assistance (Medicaid);
- Under age 21;
- Experiencing a mental health crisis or emergency;
- Meet criteria for emotional disturbance (age 0-18) or mental illness (age 18-21).

Covered Services

- Crisis assessment
- Crisis intervention
- Crisis stabilization

Non-Covered Services

- Recipient transporting services
- Crisis response services performed by volunteers
- Provider performance of household tasks, chores or related activities such as laundering clothes, moving the recipient's household, housekeeping and grocery shopping for the recipient
- Time spent "on call" and not delivering services to recipients
- Activities primarily social or recreational in nature, rather than rehabilitative
- Job specific skills services such as on the job training
- Case management
- Outreach services to potential recipients
- Crisis response services provided by a hospital, board and lodging or residential facility to a recipient of that facility
- Room and board

Authorization

Authorization is not required. No notification required.

Service Thresholds

- None

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 time-limited interventions that are delivered using various treatment modalities and combinations of services designed to reach treatment outcome, identified in the individual treatment plan (ITP).

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

Eligible Providers

Must be enrolled MHCP provider certified to provide CTSS mental health rehabilitation services.

The following entities may request MHCP certification as CTSS providers:

- County-operated entities
- Community Mental Health Centers (CMHCs)
- Hospital-based providers
- Indian health services/638 facilities
- Non-county mental health rehabilitative providers
- School districts.

Eligible Members

- Must be eligible for Medical Assistance (Medicaid);
- Under age 18 diagnosed with an Emotional Disturbance (ED) or Severe Emotional Disturbance (SED)

- Adults ages 18 through 20 diagnosed with mental illness (MI) or Serious and Persistent Mental Illness (SPMI).

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

Covered Services

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

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

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

Non-Covered Services

CTSS does not cover services that are:

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

Authorization

- **Prior Authorization is required** (Form SCHA #4390) after benefit threshold is met.

Service Thresholds – See DHS MHCP Provider manual for guidance

- 200 Cumulative hours per calendar year for any combination of: psychotherapy, skills training, crisis assistance, Mental Health Behavioral Aide (MHBA) services; service plan development

- 52 cumulative sessions per calendar year of group psychotherapy, including outpatient group psychotherapy services
- 26 cumulative sessions per calendar year of family psychotherapy, including outpatient family psychotherapy service
- 10 cumulative sessions per calendar year of multiple family group psychotherapy
- Up to 24 sessions per year of service plan development

Billing

For billing guidance see DHS MHCP Provider manual

Day Treatment - Adult

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

Eligible Providers

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

Eligible Members

Eligible recipients of adult day treatment must:

- Must be eligible for Medical Assistance (Medicaid);
- Be age 18 years or older (recipients age 18 - 20 years may receive adult day treatment, CTSS, or both, depending on medical necessity);
- Meet all criteria for admission or continuing stay, below:
    - Admission Criteria:
        - have a primary diagnosis of mental illness as determined by a diagnostic assessment, excluding dementia and other organic conditions;
        - have three (3) or more areas of significant impairment in functioning as determined by a functional assessment;
        - have a completed LOCUS assessment with a Level 3 indication;
        - be experiencing symptoms impairing thought, mood, behavior or perception that interfere with the ability to function with a lesser level of service;
        - have the cognitive capacity to engage in and benefit from this level of treatment;
        - reasonably be expected to benefit in improved functioning at work, school, or social relationships;
        - need a highly structured, focused treatment approach to accomplish improvement and to avoid relapse requiring higher level of treatment.
    - Continuing Stay Criteria:

        - condition continues to meet criteria as evidenced by active psychiatric symptoms and continued functional impairment;
        - treatment plan contains specific goals and documented measurable progress toward goals;
        - active discharge plan is in place;
        - attempts to coordinate care and transition to other services are documented, as clinically indicated.
    - Discharge Criteria:
        - treatment plan goals and objectives have been met;
        - no longer meets continuing stay criteria;
        - mental health disorder has decreased, and lesser level of service is appropriate;
        - voluntarily involved in treatment and no longer agrees to attend day treatment;
        - exhibits severe exacerbation of symptoms or disruptive or dangerous behaviors requiring more intensive level of service. Do not close chart if individual is expected to return to day treatment;
        - does not participate despite multiple attempts to engage the person and address nonparticipation issues;
        - does not make progress toward treatment goals and no reasonable expectation that progress will be made;
        - no longer meets the criteria for a LOCUS Level 3;
        - does not have or ceases to have the cognitive capacity to benefit 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;
- A group of at least three (3), but not more than 12, recipients.

The services must:

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

The ITP must:

- Be completed before the first session;
- Include attainable, measurable goals as they relate to day treatment services;
- Be reviewed by the provider and updated with member progress at least every 90 days, until discharge;

- Include an attainable discharge plan for the member.

Non-Covered Services

- Services provided to members residing in an inpatient or residential facility (except when following the discharge plan guidelines, listed under Admission Criteria)
- Primarily recreation-oriented, non-medically supervised services or activities, including, but not limited to:
    - Sports activities
    - Exercise groups
    - Craft hours
    - Leisure time
    - Social hours
    - Meal or snack time or preparation
    - Trips to community activities
    - Tours
- Social or educational services that do not have or cannot reasonably be expected to have therapeutic outcomes related to the member's mental health condition
- Consultations with other providers or service agency staff about the care or progress of a member
- Prevention or education programs provided to the community
- Day treatment for members with a primary diagnosis of alcohol or other drug abuse
- Day treatment provided in the member's home
- Psychotherapy for more than two (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.

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

Service Thresholds

- 115 hours per calendar year without authorization;
- Max 15 hours per week; may not obtain authorization for more day treatment hours in a week;

- Provide adult day treatment services concurrent with other services.

Billing

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

***See DHS provider manual for service limitations**

Day Treatment – Child CTSS

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

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

Eligible Providers

- Licensed outpatient hospitals with JCAHO accreditation
- MHCP-enrolled community mental health centers
- County agencies
- HIS / 638 facilities
- Entities under contract with a county to operate a day treatment program

Eligible Members

Eligible recipients of adult day treatment must:

- Must be eligible for Medical Assistance (Medicaid);
- Under age 18 and diagnosed with an emotional disturbance or meet severe emotional disturbance criteria;
- Between the ages 18 and 21 and diagnosed with a mental illness or meet serious and persistent mental illness criteria;
- Need intensity level of day treatment as identified in the diagnostic assessment.

Covered Services

- Psychotherapy provided by a mental health professional or a mental health practitioner qualified as a clinical trainee
- Skills training – individual or group, provided by a mental health professional or a mental health practitioner
- Follow the guidelines below:
    - Day treatment program must be available:
        - No less than one (1) day per week, two (2) hours per day;
        - No more than three (3) hours per day, 15 hours per week.

- Psychotherapy must be provided for:
  - No less than one (1) hour;
  - No more than two (2) hours, with the remaining time including skills training.

Non-Covered Services

- Services that are the responsibility of a residential or program license holder, including foster care
- Services in violation of Medical Assistance policy
- Treatment by multiple providers within the same agency at the same clock time
- MHBA services provided by a personal care assistant who is not qualified as a MHBA and employed by a certified CTSS provider entity
- Primarily recreation oriented or provided in a setting that is not medically supervised, such as:
  - Sports activities
  - Exercise groups
  - Craft hours
  - Leisure time
  - Social hours
  - Meal or snack time
  - Trips to community activities
  - Tours
- Social or educational service that does not have or cannot reasonably be expected to have a therapeutic outcome related to the child's emotional disturbance;
- Consultation with other providers or service agency staff about the care or progress of a child;
- Prevention or education programs provided to the community;
- Treatment for recipients with primary diagnoses of alcohol or other drug abuse or traumatic brain injury.

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

Authorization

Prior Authorization is required (Form SCHA #4381) after benefit threshold is met.

Service Thresholds

- 150 hours / calendar year

Billing

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

***See DHS provider manual for service limitations**

Diagnostic Assessment (DA)

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

Eligible Providers

- Clinical Nurse Specialist (CNS)
- Licensed Independent Clinical Social Worker (LICSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Psychologist (LP)
- Psychiatric Nurse Practitioner (NP)
- Psychiatrist

* In addition, an individual certified by tribal council as a mental health professional, serving a federally recognized tribe and a mental health practitioner who qualifies as a clinical trainee.

**Please see Standard Diagnostic Assessment Tool template on South Country Health Alliance website.

Eligible Members

- Must be eligible for Medical Assistance (Medicaid).

Covered Services

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

- Adult Diagnostic Assessment Update
- Brief Diagnostic Assessment

Non-Covered Services

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

Authorization

- After threshold is met (Form SCHA #4381)

Service Thresholds

- Maximum of four (4) assessments per year

Billing

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

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

Dialectical Behavior Therapy 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;
- Other individual treating providers trained in DBT.

A team leader must meet all the following requirements:

- be an enrolled mental health professional;

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

A team member must be one of the following:

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

A team member must meet all the following requirements:

- be employed by, affiliated with or contracted by a DHS-certified DBT program;
- have appropriate competencies and knowledge of DBT principles and practice or obtain these competencies and knowledge within the first six (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;
- 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

An adult member must meet all the following admission criteria:

- Must be eligible for Medical Assistance (Medicaid);
- Be age 18 or older;
- Meet one (1) of the following two (2) criteria:
    - have a diagnosis of borderline personality disorder;
    - have multiple mental health diagnoses; exhibit behaviors characterized by impulsivity, intentional self-harm behavior or both; and be at significant risk of death, morbidity, disability or severe dysfunction across multiple life areas;
- Have mental health needs that can't be met with other available community-based services or that need services provided concurrently with other community-based services;
- Be at risk of one of the following:
    - a need for a higher level of care
    - intentional self-harm or risky impulsive behavior or be currently having chronic self-harm thoughts or urges
    - a mental health crisis
    - decompensation of mental health symptoms (a change in LOCUS score)

- Understand and be cognitively capable of participating in DBT as an intensive therapy program;
- Be able and willing to follow program policies and rules assuring the safety of self and others.

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

- Be 12-17 years old
- Have a 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
    - 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;
- 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;
- 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 individual DBT therapy or group DBT skills training and #4498 must be completed when DBT treatment is current in progress to request authorization for continued DBT services.

Service Thresholds

- Up to 26 hours (104 units) per six (6) months for individual skills training;
- Up to 78 hours (312 units) per six (6) months for group skills training.

Concurrent Therapy

Concurrent therapy is approved only for outpatient family therapy.

Exclusionary Services (adults)

DBT cannot be provided concurrently with the following services:

- Outpatient individual therapy
- Partial Hospitalization
- Day Treatment

Exclusionary Services (adolescents)

DBT cannot be provided concurrently with the following services:

- Outpatient individual psychotherapy (including under CTSS umbrella)
- Partial Hospitalization
- CTSS Children's Day Treatment
- Intensive Treatment in Foster Care
- Youth ACT

Billing

Dialectical Behavior Therapy Services Billing			
Code	**Service Description**	**Unit**	**Service Limitation**
H2019 U1	Individual DBT therapy	15 min	

H2019 U1 HA	Individual DBT therapy for adolescents	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 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	

Early Intensive Developmental and Behavioral Intervention (EIDBI)

Services offer medically necessary treatment to people under the age of 21 on Medical Assistance (MA) with autism spectrum disorder (ASD) or related conditions. The purpose of the EIDBI benefit is to provide medically necessary early intensive intervention to people with ASD and related conditions, as well as to:

- Educate, train and support their parents and families
- Promote people's independence and participation in family, school and community life
- Improve long-term outcomes and quality of life for people and their families

Eligible Providers

EIDBI providers must:

- Be an enrolled Minnesota Health Care Programs (MHCP) provider;
- Meet all provider qualifications on the EIDBI assurance statement for your provider type;

Eligible Members

- Have a diagnosis of Autism Spectrum Disorder (ASD) or other related condition;
- Has had a comprehensive multi-disciplinary evaluation (CMDE) that establishes his/her medical need for EIDBI services;
- Is enrolled in Medical Assistance (MA) or MinnesotaCare
- Is under age 21.

Covered Services

- Comprehensive Multi-Disciplinary Evaluation (CMDE)

- Individual Treatment Plan (ITP) development and monitoring
- Intervention – Group and Individual
- Intervention observation and direction
- Family/Caregiver Training and Counseling
- Coordinated Care Conference
- Telehealth
- Travel time

Non-Covered Services

- Provider training activities that do not meet the criteria for observation and direction
- Transportation for the person
- Group or individual intervention services delivered to one (1) person by two (2) or more EIDBI providers (of any level) at the same time
- Conducted over the telephone, or via mail or email
- For purposes of reporting, charting or record keeping (except when this is integral to a covered CMDE or ITP service)
- Not documented in member's health service record or ITP in the manner outlined by this policy manual or MN Rules Part 9505.2175
- Primarily custodial, day care or respite
- Primarily recreational and not supervised by a medical professional, such as:
    - Sports activities
    - Craft activities
    - Meal or snack time
    - Trips to community activities
    - Tours
- Services that are the responsibility of a residential or program license holder (foster care providers) per a service agreement or administrative licensing ruling

EIDBI benefit does not cover services that:

- Include or replace academic goals that are otherwise included in the member's IEP or FSP, as required under the Individual with Disabilities Education Improvement Act of 2004.

EIDBI benefit does not cover services that are provided:

- by a parent, legal guardian or another person legally responsible for the member;
- by a person who does not meet the provider qualifications;
- in violation of Medical Assistance policy as outlined in MN Rules 9505.0220;
- to the general community, such as prevention and education;
- when the member is sleeping or napping;

- without the required supervision.
- EIDBI benefit also does not cover services that are not provided (no-shows) or not provided directly to a member who is present, either physically or via interactive video with the exception of the following services:
    - coordinated care conference;
    - family / caregiver training and counseling;
    - ITP development.

Authorization - Cannot exceed a 180-day time span

Prior Authorization is required: Use form #4894 for the following services:

- EIDBI Intervention - member
- EIDBI Intervention - group
- Family/caregiver training and counseling; individual and group
- Individual Treatment Plan progress monitoring (after threshold is met)
- Individual observation and direction

NO Prior Authorization is required for the following services:

- Initial ITP
- Annual CMDE

Service Thresholds

- See EIDBI Benefit Grid found in the MHCP provider manual.

Billing

- See EIDBI Benefit Grid found in the MHCP provider manual

Telehealth

Certain EIDBI services are eligible to be provided via telehealth. Services provided via telehealth have the same service thresholds, reimbursement rates and authorization requirements as services delivered in -person. Bill for services delivered via telehealth with the place of service 02. South Country does not reimburse for connection charges, or origination, set-up or site fees.

Refer to EIDBI telehealth services webpage found in the MHCP provider manual for more information.

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 a 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);
- Age 17+;
- Present with a suspected mental health/substance use disorder.
- May not receive HPP concurrently with duplicative services such as MH-TCM, Behavioral Health Home and CCHBC.

Authorization

Notification is required (Initial Form - Healthy Pathways Communication Form #4536 and Renewal/end of service form #5202 is required)

Notification is required at separate stages of service:

- Initial
- Six (6) months
- End of Service / Termination of service

Service Thresholds

- None – no limit

Billing

Healthy Pathways Program Billing		
Code	**Service Description**	**Unit**
G9006	Healthy Pathways Case Management Services • Face to Face Contact • Telephone Contact with member • Telephone Contact with providers / resources	per member per month (PMPM)

Inpatient Visits

Are covered for hospitalized South Country 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)

- 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
- One (1) visit per day, of the same service, by the same physician

Authorization

None required

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.

Intensive Residential Treatment Services (IRTS)

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

Eligible Providers

IRTS providers must comply with the following:

- be licensed with the Rule 36 Variance;
- not exceed 16 beds;
- have a Statement of need provided by the local mental health authority of a Need Determination from the DHS Commissioner;
- have a rate approved by DHS.

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

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

IRTS providers must have:

- sufficient staff for 24-hour delivery of mental health services, as described in the member's individual treatment plan (ITP);
- staff available to safely monitor and assist with activities of members;
- the capacity to respond to emergent needs and make staffing adjustments to assure the health and safety of members. This includes providing medical services directly (through its own medical staff) or indirectly (through referral to medical professionals);
- Staff are available to provide guidance and monitoring whenever members are present in the facility;
- Staff remain awake during all work hours;
- A staffing ratio of at least one (1) staff to nine (9) members each day and evening shift;
- At least one (1) staff member is a mental health professional or practitioner if more than nine (9) members are present.

Eligible Members

- Must be eligible for Medical Assistance (Medicaid);
- Age 18+;
- Meet the IRTS admission criteria (See MHCP for admission, continuing stay, and discharge criteria)

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

*Members may receive IRTS instead of hospitalization, if appropriate.

Covered Services

- Supervision and direction
- Individualized assessment and treatment planning
- Crisis assistance, development of health care directives and crisis prevention plans
- Nursing services
- Interagency case coordination
- Transition and discharge planning
- Living skills development, including:
    - Medication self-administration
    - Healthy living
    - Household management
    - Cooking and nutrition
    - Budgeting and shopping
    - Using transportation
    - Employment-related skills
- Integrated dual diagnosis treatment (mental health and substance abuse screening and assessment, with a team approach. Assesses treatment readiness, uses motivational interviewing and a non-confrontational approach)
- Illness management and recovery
- Family education (services to educate, inform, assist, and support family members in mental health illness and treatment, coping mechanisms, medication, community resources).

Non-Covered Services

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

Authorization

Notification is required (Form SCHA#4398)

- Notification upon admission will serve as authorization.

Prior Authorization is required (Form SCHA#4381) after benefit threshold is met.

Service Thresholds

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

- Request authorization for more than 90 days.

Billing

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

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

Intensive Treatment in Foster Care

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.

Eligible Provider

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

The following entities may request MHCP certification as an ITFC 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
- A non-county entity

Non-county or non-tribal providers must have a service provision contract with a county board or a tribal council.

All ITFC services provided to MHCP members must be provided by a qualified mental health professional or a clinical trainee working under the supervision of a licensed mental health professional.

Mental health professionals must be certified in one of the following evidence-based practices (EBP):

- Trauma Informed Child Parent Psychotherapy (TI-CPP), or
- Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

Clinical trainees must be trained in TI-CPP or TF-CBT, receiving supervision from and billing under an EBP certified mental health professional and within 1,000 hours of licensure.

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

- Psychotherapy
- Psychoeducation
- Crisis assistance
- Clinical care consultation
- Treatment team planning

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

Eligible Members

To be eligible for ITFC, members must have an extended diagnostic assessment that clearly documents the necessity for the type of mental health service requested, including intensity of treatment and medical necessity. Members must also:

- Have a documented diagnosis of mental illness,
- Be living in a family foster care setting,
- Be between the ages of birth through 20,
- Have a level-of-care evaluation completed by the placing county, tribe or case manager indicating that intensive intervention without 24-hour medical monitoring is required.

A mental health professional or clinical trainee must complete the diagnostic assessment establishing eligibility for ITFC within 30 days of enrollment unless the client has a previous extended diagnostic assessment (within 180 days) that the client, parent, and mental health professional agree still accurately describes the client's current mental health functioning.

Covered Services

- Psychotherapy (individual, family and group)
- Psychoeducation (individual, family and group)
- Crisis assistance
- Clinical care consultation

Non-Covered Services

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

- Inpatient psychiatric hospital treatment
- Mental health targeted case management
- Partial hospitalization
- Medication management
- Children's mental health day treatment services
- Crisis response services
- Transportation

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

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

Authorization

- No authorization is required.

Service Thresholds

- No limit.

Billing

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

Intensive Treatment in Foster Care			
Proc. Code	**Brief Description**	**Unit**	**Service Limitation**
S5145 HE	Intensive treatment in foster care (performed by mental health professional)	Per diem	No limit or authorization required
S5145 HE HN	Intensive treatment in foster care (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 an 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
- New immigrant case managers (CMs working with immigrant population)

CMs and CMAs must successfully complete the Department of Human Services (DHS) MH-TCM curriculum as part of the approved training; see TrainLink for more information. Certificates of completion must be maintained, and it is recommended they be stored in the CM's personnel record or similar file.

South Country Providers are expected to:

- Work with the hospitals, pre-petition screening teams, family members and current providers to assess the member and develop an individual care plan that includes alternatives consistent with the Commitment Act. This may include:
    - Testifying in court;
    - Preparing and providing requested documentation to the court.
- Report to the court within the court required timelines regarding the member's care plan status and recommendations for continued commitment, including as needed, requests to the court for revocation, of a provisional discharge;
- Provide input only for pre-petition screening, court appointed independent examiners, substitute decision makers or court reports for members who remain in the facility to which they were committed;
- Provide mental health case management coverage, which includes discharge planning for up to 180 days prior to a member's discharge from an inpatient hospitalization in a manner that works with, but does not duplicate, the facility's discharge planning services;
- Ensure continuity of health care and case management coverage for members in transition due to a change in benefits or a change in residence;
- Staffing ratios must be provided as specified in Minnesota Rules;
- Provide a copy of diagnostic assessment and certification of SPMI or SED (upon request);
- Provide a copy of functional assessment (upon request);
- Provide a copy of Individual Community Support Plan (ICSP) or the Individual Family Community Support Plan (IFCSP) (upon request).

Eligible Members

- Must be eligible for Medical Assistance (Medicaid);
- Age 18+ (for adult);
- Age 21 and under (for child);
- Diagnosed with a serious and persistent mental illness (SPMI);
- Determined eligible by the county;
- Appears to be eligible for case management but due to the member's initial refusal to participate in diagnostic assessment process, eligibility determination cannot be completed (these services are limited to four (4) months from the day member begins case management services);
- Adolescent who has received children's MH-TCM services within 90 days of turning 18 years old and upon turning 18 seeks adult MH-TCM services.

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

Covered Services

- Assessment
- Planning

- Referral and linkage
- Monitoring and coordination

Non-Covered Services

MHTCM services are not:

- Treatment, therapy or rehabilitation services
- Other types of case management (for example: Community Alternative Care [CAC]; Community Alternatives for Disabled Individuals [CADI]; Brain Injury [BI]; Developmental Disability [DD])
- Legal advocacy
- Conducting a diagnostic assessment
- Determining eligibility for MHTCM
- Administration or management of member's medications
- Services that are integral components of another service or direct delivery of an underlying medical, educational, social, or other service
- Transportation services

Authorization

Notification is required (MHTCM Eligibility Notification Form# 4532) **within 60 days of opening MHTCM services.**

Billing information:

- 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.
- Case Manager or the AHCP shall notify South Country of a member who is eligible for Mental Health Targeted Case Management promptly -within sixty (60) days of the diagnostic assessment being completed or within thirty (30) days of a request for Mental Health Targeted Case Management Services, whichever occurs first.
- South Country Health Alliance will enter an authorization date span matching the type of diagnostic assessment (DA). For Extended and Standard DA, the length of the authorization entered will be 36 months and for a brief DA the length will be 12 months / 12 units. As a general rule of thumb, South Country ends the authorization date span one month prior to when the current DA expires, allowing time to schedule and complete a new DA if necessary. 1 month is 1 unit.
- 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 and the Case Manager provides the previous DA date with the diagnosis code(s) on the notification form.
- In the absence of a DA member may be eligible for TCM if: A psychological eval substituted for a DA when all components of DA are met with in 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.

- Presumptive eligibility applies only to Initial requests for MHTCM services when a member is new to TCM services and does not have a current DA see MN Rule 9520.0909 Subp 2 for details. If the member has refused the DA at the time of the referral or request for Case Management, the Provider may request South Country provide 4 months of presumptive authorization allowing this time period for the completion of the DA. **For County contracted providers only: Healthy Pathways is an alternative program to support our member in the absence of TCM eligibility.*
- A child receiving children's MH-TCM upon turning 18 years old, is eligible to continue receiving MH-TCM. Targeted Case Management services may continue for young adults between 18 and 21 years of age and can be provided by the children's service system or by the adult service system.

Civil Commitment / Court Ordered Services

Provider will follow same procedures as for MHTCM Notification but will also submit the Pre-Petition Screening Report along with the Court Order to South Country. Civil commitment requests for MH- TCM will not require a current Diagnostics. Court ordered TCM requires provider send notification along with the full court order and prepetition screening; eligibility form should be faxed.

Termination of Case Management Services Process

The provider will fax the MH-TCM Recommendation for Action – DTR (Denial, Reduction, or Termination of Service (Form SCHA #4533) form and include the following in the notification to South Country Health Alliance within 5 days:

- Specify the reason for closing case management services:
    1. member is found to be ineligible for MH-TCM services
    2. member has requested to discontinue MH-TCM services (refusal or termination of services)
    3. member has had no Face to Face (F2F) contact with the case manager for:
        - 90 days (children only)
        - 180 days (adults only)
- Member information (name, address, date of birth, PMI, Prior Authorization (PA) number, dates of PA, dates of MH-TCM service, date of most recent diagnostic assessment
- Case manager name, agency and contact information, provider name, agency and contact information
- Date of discussion regarding potential denial, termination or reduction of service
- DO NOT ENTER A Date of Action, this date comes from South Country based on the date the letter is sent out to member giving notification of appeal rights
- The reason and description

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

Mental Health Targeted Case Management Services Billing		
Code	**Service Description**	**Unit**

T2023 HE	Face to Face Contact	1 unit / month
T2023 HE U4	Telephone Contact, including Telemedicine	1 unit / month

Neuropsychological Services

Eligible Members

- Members with neurological disorders that result in cerebral dysfunction.

Covered Services

- Assessment
- Testing
- Rehabilitation

Authorization

Prior Authorization is required (Form SCHA #4395) after benefit threshold is met.

Service Thresholds

- 15 cumulative hours of assessment and neuropsychological testing in a calendar year
- Five sessions of neuropsychological testing in a calendar year

Billing

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
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	

Procedure Code	Modifier	Brief Description	Unit	Service Limitations
96136		Neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests	30 minutes	sessions of 96146 in a calendar year
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

- Providers must be a Medicare certified outpatient hospital facility or a community mental health center and receive approval from DHS

Eligible Members

- Must be eligible for Medical Assistance (Medicaid);
- Be experiencing an acute episode of mental illness that meets the criteria for an inpatient hospital admission;
- Have appropriate family or community resources needed to support and enable the member to benefit from less than 24-hour care;
- Be referred for partial hospitalization by a physician who certifies the need for Partial Hospitalization;
- Have a completed LOCUS assessment with a Level 4 indication for adults age 18+;
- Must have the ability to participate in treatment;
- Must have completed a CASII and SDQ for children six (6) years old and older;
- Must have completed an ECSII and SDQ for children five (5) years old and younger.

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

Covered Services

- At minimum, one (1) session of individual, group or family psychotherapy and two (2) or more other services (such as activity therapy or training and education)
- 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 (via 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 – notification 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 number 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.

- See DHS MHCP manual for additional guidance

Psychiatric Consultation to Primary Care Providers

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

Eligible Providers

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

Eligible Members

- Must be eligible for Medical Assistance (Medicaid)

Covered Services

- Communication between a consulting professional and a primary care provider for the purpose of medical management, behavioral health care and treatment of a member
- A psychologist, independent clinical social worker and marriage and family therapists may provide consultation about alternatives to medication, medication combined with psychosocial treatment potential results of medication usage

*Provider may conduct the consultation without the member present

Billing

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

Psychiatric Residential Treatment Facility (PRTF)

Active treatment to children and youth under age 21 with complex mental health conditions. This is an inpatient level of care provided in a residential facility rather than a hospital. PRTFs deliver services under the direction of a physician, seven (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 contracted with and certified by the Department of Human Services as a PRTF provider.

Eligible Members

- Must be eligible for Medical Assistance (Medicaid);
- Under age 21 at time of admission. Services may continue until the individual meets criteria for discharge or reaches 22 years of age, whichever occurs first.

Have had a diagnostic assessment completed within 180 days of referral.

- Has a mental health diagnosis as defined in most recent edition of Diagnostic and Statistical Manual for Mental Disorders;
- Functional impairment and a history of difficulty in functioning safely and successfully in the community, school, home or job, an inability to adequately care for one's physical needs or caregivers/guardians are unable to safely fulfill the individual's needs;
- Services must be medically necessary
- Requires psychiatric residential treatment to improve the individual's condition or prevent further regression so that services will no longer be needed;
- Utilized and exhausted other community based mental health services or clinical evidence indicates that such services cannot provide the level of care needed; and
- Was referred for treatment in a psychiatric residential treatment facility by a qualified mental health professional.

Covered Services

- 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
- Discharge planning

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 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, Psychological Evaluation, and Neuropsychological Evaluation. 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.

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. Hospital leave days may not exceed seven consecutive days without prior authorization.
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. A therapeutic leave visit may not exceed three days per visit without prior authorization.

- 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
- 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. It supports the member and family in understanding these factors:

- Member's symptoms of mental illness
- Impact on member's development
- Needed components of treatment
- Skill development

Eligible Providers

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

Eligible Members

- Must be eligible for Medical Assistance (Medicaid);
- Under age 21;
- Diagnosis of emotional disturbance or mental illness as determined by a diagnostic assessment.

Covered Services

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

- multiple families (family group)

*These services may be provided via telemedicine

Non-Covered Services

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

Authorization

Prior Authorization is required (Form SCHA #4398) after benefit threshold is met.

Service Thresholds

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

Billing

Family Psychoeducation Services Billing		
Code	**Service Description**	**Unit**
H2027	Family Psychoeducation - Individual	15 min
H2027 HQ	Family Psychoeducation – Group	15 min
H2027 HR	Family Psychoeducation – Family with Member Present	15 min
H2027 HS	Family Psychoeducation – Family without Member Present	15 min
H2027 HQ HR	Family Psychoeducation – Multiple Families with Members Present	15 min
H2027 HQ HS	Family Psychoeducation – Multiple Families without Members Present	15 min

Psychological Testing

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

Eligible Providers

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

Covered Services

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

Authorization

Prior Authorization is required (Form SCHA #4395) after benefit threshold is met.

Service Thresholds:

- 8 hours max per member / calendar year.

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	
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	1 Session	1 per day

Psychological testing			
Code	**Description**	**Unit**	**Service Limitations**
	via electronic platform with automated results only		

Psychotherapy

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

Eligible Providers

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

Eligible Members

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

*A new member may receive one (1) session of psychotherapy prior to completing the diagnostic assessment.

Covered Services

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

Authorization

Prior Authorization is required (Form SCHA #4381) after benefit threshold is met.

Service Thresholds

- Individual – 26 hours / calendar year
- Group – 52 sessions / calendar year

- Family – 26 sessions / calendar year
- Family Group – 10 sessions / calendar year

Billing

Psychoeducation Services - Family Billing		
Code	**Service Description**	**Unit**
90832	Psychotherapy – with member, family or both	30 min
90834	Psychotherapy – with member, family or both	45 min
90837	Psychotherapy – with member, family or both	60 min
Appropriate E/M and 90833	E/M and psychotherapy – with member, family or both	30 min
Appropriate E/M and 90836	E/M and psychotherapy – with member, family or both	45 min
Appropriate E/M and 90838	E/M and psychotherapy – with member, family or both	60 min
90875	Individual psychophysiological therapy incorporating biofeedback with psychotherapy	30 min
90876	Individual psychophysiological therapy incorporating biofeedback with psychotherapy	45 min
90846	Family psychotherapy without member present	50 min
90847	Family psychotherapy with member present	50 min
90849	Multiple family group psychotherapy	1 session
90853	Group psychotherapy	1 session

The Minnesota Department of Human Services (DHS) allows the use of R diagnosis codes R45-R45.89 for outpatient psychotherapy and psychoeducation sessions beginning Feb. 5, 2019.

Psychotherapy for Crisis

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

Psychotherapy for crisis services must include:

- Emergency assessment of the crisis situation;
- Mental status exam;
- Psychotherapeutic interventions to reduce the crisis;
- Development of a post-crisis plan that addresses the member's coping skills and community resources.

Eligible Providers

- Clinical Nurse Specialist

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

Eligible Members

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

Covered Services

- Emergency assessment of the crisis situation (does not take the place of a diagnostic assessment)
- Mental status exam
- Psychotherapeutic interventions to reduce the crisis
- Development of a post crisis plan that addresses the member's coping skills and community resources

Authorization

Prior Authorization is required (Form SCHA #4381) after benefit threshold is met.

Service Thresholds

- Three (3) occurrences / calendar month
- 10 occurrences / calendar year
  *total time billed for psychotherapy for crisis is also included in the:
- 26 hours / year benefit limit
- 200 hour CTSS benefit limit

Billing

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

Telemedicine Delivery of MH Services

The delivery of health care services or consultations while the member is at an originating site and the licensed health care provider is at a distant site. Telemedicine may be provided by real-time two-way, interactive audio and visual communications, including secure videoconferencing or store-and-forward technology to provide or support health care delivery. The telemedicine services facilitate the member's assessment, diagnosis, consultation, treatment, education, and care management.

Eligible Providers

- Mental Health professionals who are qualified under MN Statute 245.462 Subd. 18 or mental health practitioners working under the supervision of a mental health professional;
- Must have completed the self-attestation that they meet all of the conditions of MHCP telemedicine policy by completing the Provider Assurance Statement for Telemedicine (DHS-6806)

Eligible Members

- Eligible for Medical Assistance (Medicaid);
- Telemedicine has been determined medically appropriate for; and
- Member has consented to using a telemedicine method before receiving services.

Covered Services

- Medically necessary mental health services delivered by a health care provider via telemedicine
- Payment limited to three (3) visits /calendar week / member

Non-Covered Services

- Children's day treatment
- Partial hospitalization programs
- Mental health residential treatment services
- Case management services delivered to children

Billing

- Place of service code should be 02 to indicate the service was provided via telemedicine;

- Services provided via telemedicine have the same service thresholds, authorization requirements and reimbursement rates as services delivered face-to-face.

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;
- Available 24 hours per day, 7 days per week.

Eligible Providers

- Have a memorandum of understanding with the county(s) of service
- Follow all Minnesota Youth ACT/IRMHS Treatment Standards (please reference MHCP manual for details)

A core Youth ACT/IRMHS team must maintain at least four full-time equivalent direct care staff which must include:

- Mental health professional
- Licensed alcohol and drug counselor trained in mental health interventions
- Certified Peer Specialist
- One of the following, credentialed to prescribe medications:
    - Advanced Practice Registered Nurse certified in psychiatric or mental health care
    - Board-certified child and adolescent psychiatrist

Based on member needs, the team may include:

- additional mental health professionals
- a vocational specialist
- an educational specialist
- a child and adolescent psychiatrist retained on a consultant basis
- mental health practitioners
- mental health case manager
- a housing access specialist
- a family peer specialist

Eligible Members

To be eligible for Youth ACT/IRMHS, members must be 8 years old or older and under 26 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 addiction;
- A level of care determination of Level 4 on the CASII for ages 8 through 18 and Level 4 on the LOCUS for ages 19 through 26. The level of care must indicate a need for intensive integrated intervention without 24-hour monitoring.
- Functional impairment and a history of difficulty in functioning safely and successfully in the community, school, home or job;
- Likely need for services from the adult mental health system during adulthood.
- Have a current diagnostic assessment indicating the need for intensive nonresidential rehabilitative mental health services.

Covered services

- Individual, family, and group psychotherapy
- Individual, family, and group skills training
- Crisis assistance
- Medication management
- Mental health case management
- Medication education
- Care coordination with other care providers
- Psychoeducation to, and consultation and coordination with, the member's support network (with or without member present)
- Clinical consultation to the member's employer or school
- Coordination with, or performance of, crisis intervention and stabilization services
- Assessment of member's treatment progress and effectiveness of services using outcome measurements
- Transition services
- Integrated dual disorders treatment
- Housing access support

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

Service Standards

- An individual treatment team must serve youth who are either:
- At least 8 years old or older and under 16 years old; or
- At least 14 years old or older and under 26 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.
- Each member must have an individualized treatment plan. See MHCP manual for specific services standards related to the individualized treatment plan.

Notification is required **(Form SCHA #4398)**

Service Thresholds

- Daily limit of 1

Billing

Travel time for Mental Health Service Providers may be a covered service for members on Medical Assistance. See Minnesota Statutes 2018, section 256B.0625, subdivision 43 for requirements for paid travel time.

For billing with other Concurrent Services – See DHS MHCP manual for guidance.

Non-covered Mental Health Services

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

- Mental health services provided by a non-psychiatrist, except psychological testing, to a member who is inpatient and has a mental illness diagnosis (these services are included in the hospital's payment)
- Mileage (provider travel time is not the same as mileage); Provider travel time may be covered as detailed in Sec. 55. Minnesota Statutes 2018, section 256B.0625, subdivision 43
- Transporting a member, except for case managers
- Telephone calls, unless otherwise specified in service coverage sections (example: adult MH-TCM)
- Written communication between provider and member
- Reporting, charting and record keeping
- Community planning or consultation, program consultation/monitoring/evaluation, public information, training and education activities, resource development, and training activities
- Fund-raising
- Court-ordered services for legal purposes
- Mental health service not related to the member's diagnosis or treatment for mental illness

- Services dealing with external, social, or environmental factors not directly addressing the member's physical or mental health
- Staff training
- Mental health case management for members receiving similar services through the Veterans Administration (VA)
- Duplicate services (for example, mental health case management for members receiving case management services through a home and community-based services)
- Mental health services provided by a school or local education agency, unless the school or agency is an MHCP enrolled provider and the services are medically necessary and prescribed in the child's ITP
- Mental health services provided by an entity whose purpose is not health service related (for example, services provided by the Division of Vocational Rehabilitation or Jobs and Training)
- Legal services, including legal advocacy, for the member
- Information and referral services included in the county's community social service plan
- Outreach services through the community support services program
- Assistance in locating respite care, special needs day care and assistance in obtaining financial resources, except when these services are provided as part of case management
- Client outreach
- Recreational services, including sports activities, exercise groups, craft hours, leisure time, social hours, meal or snack times, trips to community activities, etc.

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

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

For additional information on:

Mental Health Services

Case Manager – Minnesota Statutes 245.462m subds,4 and 4(a) and Minnesota Rules 9520.0912.

Staffing ratios - Minnesota Rules 9520.0903, subp.2.

Children's residential mental health treatment program standards - Minnesota Rules, Chapter 2960 and by the Department of Corrections, in accordance with Minnesota Statues, section 260B.198, subd. 11 (a).

Out-of-state facilities - Minnesota Statute, Section 256B.0945 (in a state that borders Minnesota and that have met all of the requirements are eligible to receive both Title IV-E and MA reimbursement)

Substance Use Disorder Services

****South Country 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 alcohol and drug abuse.
- Meet all provider qualifications as stated on the assurance statement for the provider type.
- Enroll and participate in the Drug and Alcohol Abuse Normative Evaluation System (DAANES).

Eligible providers include the following:

- Residential SUD treatment programs
- Nonresidential (outpatient) SUD treatment programs
- Counties and tribes
- Recovery Community Organizations (RCO)
- Hospitals
- Qualified Substance-use disorder professional
- Medication-assisted treatment program

Eligible Members

- Assessments are covered for South Country members on any South Country product.
- Clinical eligibility is based on the results of a Rule 25 chemical health assessment or Comprehensive Assessment. This is required for any member seeking treatment services, whether the member is assessed by the county, tribe of residence or through an enrolled MHCP provider for alcohol and drug abuse.

Covered Services

- Rule 25 Assessment or Comprehensive Assessment
- Medication assisted therapies. (Suboxone, Methadone, Injectable for example)
- Outpatient Treatment Services
- Peer Recovery Support Services
- Residential Treatment Services (Low, Moderate and High Intensity Rule 31)
- Treatment Coordination
- Hospital-based inpatient treatment
- Residential Withdrawal Management Service Level 3.2 (clinically managed) and Level 3.7 (medically monitored)

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. Non-contracted residential (outside the five-state area) must send form #4505.

Notification is not required for contracted providers (within the state of MN) **Outpatient** programs (H2035).

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 SUD Request Form (#4506) along with the most recent Rule 25 or 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 SUD Residential Admission and Discharge Form (#4505) along with the most recent Rule 25 or Comprehensive Assessment.

For South Country members who are in the Minnesota Restricted Recipient Program (MRRP) and in need of Medicated Assisted Therapy (MAT) for Opioid Use Disorders, 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.

Additional Substance Use Disorder Information

- Refer to MHCP Provider Manual for billing freestanding and residential program room-and-board charges.
- Civil Commitment

  A Rule 25 assessment or 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;”
  - Rule 25 and 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 Rule 25 assessment must be updated if 45 calendar days have elapsed between the interview and the initiation of services. An update does not require a face-to-face contact and may be based on information from the client, collateral source, or treatment provider.
- A new Rule 25 assessment must be completed if six months have passed since the most recent assessment or assessment update.

- 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.
- Rule 25 and Comprehensive Assessments are limited to two (2) in rolling six (6) months.
- 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 additional information on Substance Use Disorder Services see:

- Chemical Dependency Licensed Treatment Facilities - Minnesota Statutes, Chapter 245G
- Chemical Dependency Services – Minnesota Statute 254B
- Civil Commitment – Minnesota Statutes 253B.02, 253B.065, 253B.09 or 253B.095
- Chemical Use Assessments – Minnesota Rules 9530.6615
- Risk Descriptions – Minnesota Rules 9530.6622 subparts 3,4,5 and 6