Medicaid Behavioral Health Clinic/Rehabilitation Services Manual




WV DHHR Bureau for Medical Services
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WEST VIRGINIA
Department of
Health & Human Resources

Clinic/Rehab Collaboration

Over the past year, BMS, BHHF, behavioral health providers from across the state, and contractors for DHHR held collaborative workgroups in an effort to revise and update the Behavioral Health Clinic and Behavioral Health Rehabilitation Services, Chapters 502 and 503.

This collaboration was vital in the development of the manuals. Meetings were held weekly to biweekly on average and are credited for the successful revisions. A statewide training and multiple webinars will be conducted over the next few weeks along with agency-specific trainings over the next year as needed to assist providers to learn and implement the new policy. This presentation will be placed on both the BMS and APS Healthcare websites.

Clinic/Rehab Manuals

Any provider of Medicaid and/or BHHF services will be expected to have working knowledge of Chapters 502 and 503 as well as other chapters relevant to the services provided (please see Chapters 100 through 900).
www.dhhr.wv.gov/bms/pages/providermanuals.aspx

For further clarifications, you may access the BMS and APS Healthcare websites where FAQs will be posted following these trainings. APS Healthcare trainer-consultants are also available for assistance.
www.dhhr.wv.gov/bms/hcbs/pages/default.aspx
www.apshealthcare.com/publicprograms/west_virginia/West_Virginia1.htm

Provider Manual Summary Part 4

503.16 SERVICE PLANNING REQUIREMENTS

503.16.1 MENTAL HEALTH SERVICE PLAN DEVELOPMENT

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503.21.2 COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT

Service Planning Definition

- Only available for Coordinated Care
- Conducted when multiple programs and services need to be coordinated by a treatment representative of the differing provider groups
- Developed by the primary clinician
- One comprehensive plan (Contains all services within one plan with one date)
- Development of the initial plan without the entire interdisciplinary team is not a billable service.
  - Case Manager cannot bill TCM during team meeting
- Plans (including updates) must be reviewed, signed and approved by Physician/Psychologist within 72-hours of meeting and prior to implementing services unless Physician/Psychologist is required to be physically present.

Service Planning Requirements

- Physician/Physician Extender, Psychologist or Supervised Psychologist must be physically present when ***one*** of the following present:
  - Member receives psychotropic medication from a physician within the agency
  - Member has diagnosis of Major Affective or Major Psychotic Disorder
  - Member has I/D Diagnosis
  - Member has an Autism Diagnosis
  - Member has major medical problems in addition to Major Psychotic Disorder and medications
  - Member requests their presence

Initial Plan Requirements

- Describes services and/or supports the member is to receive until the Master Plan is developed. Must contain:
  - Description of any further assessments or referrals that may need to be performed; and
  - Listing of immediate interventions to be provided along with objectives for the interventions; and
  - Date for the development of the Master Plan; and
    - Date of Master Plan must be appropriate for the plan length of the service but at no time will exceed 30 days from initial plan.
    - If program is an intensive service, Master Plan must be completed within 7 days.
  - Signature of the member and/or designated representative, intake worker, physician/psychologist and other persons participating in the development of the plan

Master Plan Requirements

- Developed within 30 days of admission (unless intensive program, then must be completed within 7 days), written for duration of service/program and must include:
  - Date of development of the plan; and
  - Participants in the development of the plan; and
  - Goal(s) of services; and
  - Specific, measurable, realistic objectives that the service providers and member hope to achieve or complete; and
  - Measures used to track progress toward objectives; and
  - Technique(s) and/or services (intervention) used for objectives; and
  - Individuals responsible for implementing services.
  - Discharge criteria
  - Date for review
    - Timed in consideration of expected duration of the program/service.
    - Cannot exceed 90 days
  - Signatures with credentials and start/stop times of those staff in attendance

Mental Health Service Plan Development

- Service Unit: 15 minutes
- Telehealth: Available
- Service Limits: 16 units per 90-day period.

- If Member is in focused Care H0032 cannot be billed.

Mental Health Service Plan Development Definition

- Reimburses for team member participation to develop the member's Service Plan.
- Written service plan is product that substantiates that the process took place.
  - Team is responsible for the development of the plan.
- Individual program plans for Day Treatment, CFT, therapy plans, etc. are not billed as a separate activity but are considered part of the services that the plan is being developed for.

Service Plan Documentation Requirements

- Service plan signature page:
  - All participating members including member and guardian/representative.
  - Staff from another agency must meet listed documentation requirements.
    - Staff from other agencies participation is not reimbursable.

Service Plan Development by Psychologist

- Service Unit: 15 minutes
- Telehealth: Available
- Service Limits: One unit per month
- Performed by Psychologist or Supervised Psychologist directly related to service planning either in actual team meeting or review and approval of a service plan within 72 hours of the date of the meeting

Service Plan Documentation Requirements

- Signature on plan or plan update, date, and time spent including start/stop times.
- Supervised Psychologist may perform this service with oversight of their Supervising Licensed Psychologist.
  - Supervising Licensed Psychologist must indicate their oversight by their signature and date.

Physician Coordinated Care Oversight

- Service Unit: 15 minutes
- Telehealth: Available
- Service Limits: 2 units per 90-days

- Staff Credentials: Physician or Physician Extender's signature with credentials, time spent including start/stop time, and date

Physician Oversight Definition

- Activities performed by a Physician or Physician Extender directly related to service planning, either participation in the team meeting or review and approval of a plan within 72 hours of the date of the plan meeting

Assertive Community Treatment (ACT)

- **Procedure Code:** H0040
- **Service Unit:** 24 hours
- **Telehealth:** Available
- **Service Limits:** One per day - All units must be prior authorized
- **Payment Limits:** Payment for ACT services is all-inclusive. GT Modifier does not need to be billed when Telehealth is utilized. Documentation should reflect that Telehealth was utilized.
- No payment will be made for ACT services when the member is hospitalized for a psychiatric condition, or receiving Community Psychiatric Supportive Services (except for 84 hours per year). However, the ACT Team must maintain contact and be part of the hospital discharge efforts.
- No Psychiatric services other than 90887, Personal Care Services (procedure codes T1001, T1002, or T1019).
- **Prior Authorization:** Refer to Utilization Management Guidelines.

ACT: Definition

- ACT is an inclusive array of community-based rehabilitative mental health services for members with serious and persistent mental illness (who may have co-occurring substance use disorders or mild intellectual disabilities) who have a history of high use of psychiatric hospitalization and/or crisis stabilization and therefore, require a well-coordinated and integrated package of services, provided over an extended duration, in order to live successfully in the community of their choice. ACT is a very specialized model of treatment/service delivery in which a multidisciplinary team assumes ultimate accountability for a small, defined caseload of individuals. ACT is a unique treatment model in which the majority of direct services are provided by the ACT team members in the member's community environment.
- ACT combines clinical, rehabilitation, supportive, and case management services, providing direct assistance for symptom management, as well as facilitating a more supportive environment with direct assistance in meeting basic needs and improving social, family, and environmental functioning.

ACT Certification

Only qualified teams, certified by the Bureau of Behavioral Health and Health Facilities and the Bureau for Medical Services, may provide ACT services. Certification of the team must be renewed, following initial approval, at Bureau-designated intervals, or with any changes in personnel. All currently certified ACT Teams must submit for recertification by January 1, 2015.

ACT: Purpose

- To reduce psychiatric hospitalization for members.
- To provide an established clinical relationship with the member and support system.
- To compose and implement a mutually agreed service plan.
- To increase the cognizance of the member to the need for medication compliance, the nature of his or her disease, and early warning signs of psychiatric difficulty.
- To improve successful integration into the larger community .
- To ensure that the member's basic needs for sustaining community living are addressed, promoting acquisition of independent levels of adult living skills whenever possible.
- To maintain member engagement in treatment by providing supportive behavioral health and skill development services in a community environment so as to maximize generalization of learning.

ACT: Member Participation Criteria

- Three or more hospitalizations in a psychiatric inpatient unit or psychiatric hospital in the past 12 months;
- Five or more hospitalizations in a psychiatric inpatient unit, psychiatric hospital, or Community Psychiatric Supportive Treatment Program in the past 24 months; or
- 180 days total length of stay in a psychiatric inpatient unit or psychiatric hospital within the past 12 months.
- The BMS may authorize ACT services for members within other specific target populations who exhibit medical necessity for the service.
- A member must have an eligible diagnosis as determined by BMS's contracted authorization agent.
- An ACT Team may serve members on an on-going basis following authorization/re-authorization of eligibility based upon continuing need and clinical appropriateness of ACT services.

ACT Team Composition and Staff Qualifications

The ACT Team must include a multidisciplinary staff mix:

- 1.Psychiatrist or board certified physician with behavioral health experience.
- 2. One full time Team Leader/Supervisor with 3 years' experience in behavioral health services, 2 of which must be in a supervisory capacity, and a master's degree and valid West Virginia license in Counseling, Social Work, Psychology, or a Supervised Psychologist. A registered nurse may serve as a team leader if the team has an additional full time registered nurse.
- 3. One full time Registered nurse with one year of psychiatric experience.
- 4. Two full time staff at the Master's level in Counseling, Social Work, or Psychology and 2 years' experience in behavioral health services. At least one of which must have experience in substance abuse assessment/treatment and/or vocational rehabilitation.
- 5. One full time staff with a Bachelor's degree in Social Work or an alternative Behavioral Science, with one year of behavioral health experience.

ACT Team Daily Meetings

- The ACT Team must meet daily to review all cases in their caseload.

- Weekend and Holiday Team Meetings may be on a rotating basis.
  - Staff must be sufficient to meet ACT member needs including but not limited to:
    - medication delivery,
    - crisis response via phone or face to face,
    - and therapeutic services to promote stability.
  - The ACT staff person on call must review every member with the ACT team leader or the team leader's designee each weekend day and holiday.
  - The physician must be accessible for medication adjustments etc.

ACT: Role of the Physician

- The physician must be actively involved with members and the team. He/she must participate in the daily ACT Team meetings, though he or she may do so by means of tele-video conferencing when unable to be physically present. A suitably trained and experienced physician extender (Advanced Practice Registered Nurse or Physician's Assistant) may participate on the team in lieu of the physician; however the substitution on team meetings must be documented.
- The physician and/or physician extender must physically attend at least one team meeting per week.
- The physician must physically participate in the annual service planning session, and must demonstrate direct and on-going involvement with the ACT team and ACT members.
- The physician or physician extender must be actively involved with the team and the members for a minimum of 16 hours per week.

ACT: Caseload Mix and Ratios

- The certified ACT Team must always have the required minimum staffing unless temporary approval is obtained from the Bureau for Medical Services to operate the team in the absence of a member.
- The maximum number of members served by an approved ACT Team is 120.
- The team must preserve a staff/member ratio of at least 1:10 (i.e., one staff person to ten members, not counting the Physician or physician extender) when the number of ACT members served by the team exceeds 50.
- With the exception of the team physician and physician extender, if any, the ACT Team cannot serve non-ACT members.

ACT: Service Elements

- Assertive outreach
- Sustained effort to engage the member in treatment, medication education and prompting, and skill development activities
- Comprehensive and appropriate assessment
- On-going involvement with the member during stays in inpatient care, convalescent care facilities, etc. in order to assist in transition back to a community placement
- Member-specific advocacy
- Assistance with securing basic needs
- Facilitation of maintenance of living arrangements
- Counseling, problem solving, and personal support
- Psychiatric services and medication management

ACT: Service Elements Continued

- Assistance in obtaining necessary primary care services
- Facilitation, improvement of daily living/community living skills
- Behavior management
- 24-hour crisis response
- Transportation or facilitation of transportation
- Representative payee-ship or facilitation of such as needed
- Collaboration with family/personal support network
- Assistance with preparation of advanced psychiatric directives

Because ACT is a community focused treatment modality, a minimum of 75 percent of service must be delivered outside of program offices.

ACT: Fidelity Factors

- The team works with a small caseload (1:10).
- The team is cooperative and collaborative.
- Program meeting occurs daily.
- The team leader is a practicing clinician providing services at least 50% of the time.
- Program staff remain consistent over time.
- The program operates at 95% or more of full staffing on average over a 12 month period.
- The physician/physician extender works at least 16 hours per week on teams with 50 clients, proportionally more on larger teams;
- Each team has one full time registered nurse in a program of 50.
- At least one staff member has training or certification in working with members with substance abuse issues.

ACT: Fidelity Factors Continued

- The program is of sufficient size.
- The program has explicitly defined admission criteria.
- No more than 6 new members are admitted per month on average.
- The program is required to have the following five services: medication management, counseling/psychotherapy, housing support, substance abuse treatment, and employment/rehabilitative services.
- The program provides 24 hour services for crisis intervention.
- The team is actively involved in admission in 95% or more of hospital admissions.
- The team participates in discharge planning for 95% of members.
- All members are served on a time-unlimited basis with fewer than 5% of the population expected to graduate annually.
- 75% of member contacts occur outside the clinic setting.

ACT: Fidelity Factors Continued

- The team actively pursues engagement of treatment resistant members.
- The program is aggressive in assuring engagement and uses outreach and contacts with corrections and homeless programs to engage members.
- Each member receives two face to face contacts per week.
- Each member receives at least four contacts per week of any type.
- Team provides support and skills for the member's support network.
- Team provides direct treatment and substance abuse treatment, including group treatment for members with substance use disorders.
- The program uses a treatment model that is non-confrontational, follows behavioral principles, considers interactions of mental illness and substance abuse and has gradual expectations of abstinence.
- Stable recovering members may be involved as members of the team providing direct services.

ACT: Medication Delivery and Monitoring

- If a provider delivers medications to a member on a regular basis, the provider must have a policy that ensures that:
- Delivery date, time, person receiving and name of medication delivered is documented, including amount delivered (the list of medications and dosages may be contained in the member record however each delivery must be logged either in the member record or in a central location);
- If there are children or other incapacitated adults in the home, medications are at least initially stored properly in a secure location;
- If medications are delivered to a member at a location other than the home, the medications must be delivered in a manner that ensures the confidentiality of the member and shields the nature of the items delivered; and
- A system of monitoring the member's compliance with consumption of medications is created with the agreement and participation of the member. The nature of the monitoring system will be individualized and designed by the clinical team in conjunction with the member. This system may consist of the member logging consumption of his or her own medications. The member has the right to refuse participation in a monitoring system however the provider may then refuse to deliver medications to the member's residence and/or make alternative arrangements for the provision of medications if clinically appropriate.

ACT: Documentation

The program must have:

- Valid authorization for service.
- Comprehensive assessment.
- Initial service plan within 7 days of admission.
- Comprehensive service plan within 30 days. (Team may create a comprehensive plan upon admission without an initial).
- The service plan is a fluid document.
- All contacts with members of the ACT team must be documented.
- Each entry needs to include: date, place, purpose, content and outcome, start and stop times, signature, credentials, and title of the individual.
- A log documenting the discussion of each member in the daily team meeting.

ACT: Documentation Continued

- A weekly summary of member status.
- 90 day review.
- Each member enrolled in ACT must receive a minimum of two face to face contacts per week.
- Must provide evidence of the delivery of at least four separate ACT services per week (e.g., four days of medication delivery is inappropriate and insufficient to meet this standard).
- It is permissible for a member to receive more than one service during one member contact, however the documentation must clearly describe the two or more services provided.

ACT Discharge Criteria

- Member no longer meets eligibility criteria.
- All program goals are met and member is at maximum level of functioning.
- Member has moved outside the team's geographical area.
- Member is no longer participating or refuses despite attempts to engage. (Must document at least weekly attempts to visit the member and to establish phone contact)
- The member would be better served by an alternative program of care.
  - The member can be placed on an inactive roster or discharged 30 days after no contact.
  - The member must be discharged after 60 days on the inactive roster.
  - The ASO contracted agent must be notified within 72 hours of discharge.
  - Billing must cease after 7 days of no services provided to the member.

ACT: Team Certification Process

- All ACT Teams require initial approval through the completion of the ACT Team Certification form.
- Certification packet may be requested from BMS **(See Attachment D**).
- Certification is valid for 2 years from the approval date stated on the certification letter issued by BMS.
- BMS will issue a denial or acceptance of a certification team within 30 days of receipt of completed certification packet.
- A provider must apply for certification of each ACT Team.
- No ACT services may be billed without written certification of the ACT Team by BMS. Billing may commence after receiving approval from BMS. After initial approval, a site review will be conducted to validate the approval.
- Re-certification shall occur each two years through a process developed by BMS in conjunction with BHHF.
- All teams must be based at a site listed on the provider's Behavioral Health License.

ACT: Team Certification Process Continued

- BMS reserves the right to review any program at any time for the purpose of certifying or de-certifying a program. Programs not receiving approval may appeal the decision as per the policy contained in Chapter 800, Medicaid regulations.
- Variations from the original certification must be submitted with corresponding rationale for changes.
- When a team member resigns or is no longer associated with the Certified ACT Team, the ACT Team must replace the team member within 30 days of the team member's last day. The provider is responsible for notification of the BMS in writing within two working days of the resignation of the team member. A team is considered then to be provisionally certified until the team member is replaced. The provider may apply for extended provisional certification if an appropriately credentialed individual cannot be found within the original 30 day period. The BMS will notify the provider in writing of the acceptability of the proposed replacement team member after review of the individual's credentials as submitted by the provider. If more than one team member resigns or is terminated, the 30 day provisional status will be reinitiated at the loss of the subsequent team member.

Community Psychiatric Supportive Treatment (CSU)

- **Procedure Code:** H0036
- **Service Unit:** 15 minutes
- **Telehealth:** Available – for medical services provided by a physician or physician extender only. Daily face to face meeting with physician must be in person.
- **Service Limits:** 288 units per six months
- **Payment Limits:** No payment will be made for any other Behavioral Health Rehabilitation Services, except for Targeted Case Management (procedure code T1017). Billing for Community Psychiatric Supportive Treatment cannot exceed 48 units in a 24 hour period (midnight to midnight) and must be utilized on consecutive days.
- **Prior Authorization:** Refer to Utilization Management Guidelines.

Community Psychiatric Supportive Treatment

- Community Psychiatric Supportive Treatment (CSU) is an organized program of services designed to stabilize the conditions of a person immediately following a crisis episode.
- An episode is defined as the brief time period of days in which a person exhibits acute or severe psychiatric signs and symptoms. (If a member experiences more than one crisis, each is considered a separate crisis episode).
- This physician driven service is intended for persons whose condition can be stabilized with short-term, intensive services immediately following a crisis without the need for a hospital setting and who, given appropriate supportive care, can be maintained in the community.
- Due to the comprehensive nature of this service, no other services (other than Targeted Case Management) may be reimbursed when Community Psychiatric Supportive Treatment is on-going.

Definition of CSU Continued

- These services are not intended for use as an emergency response to situations such as members running out of medication, or loss of housing. These are non-reimbursable.
- Since this service is intended to address an episode, it must be rendered on consecutive days of service.
- Community Psychiatric Supportive Treatment is an acute and short-term service.
- Availability may include mornings, afternoons, evenings, etc.
- There must be a minimum of two staff present onsite at all times Community Psychiatric Supportive Treatment is provided, one of which must have at least high school degree or equivalency, trained in systematic de-escalation, and must have training related to the targeted population being treated (i.e. substance abuse, mental health). The other staff must have an LPN or higher degree in the medical field (See Definitions for further clarifications). Additional staff must be added as necessary to meet the needs of increased utilization and/or increased level of need. Staffing must be sufficient to assure that each member receives appropriate individual attention, as well as assure the safety and welfare of all members.
- The program must have access to a psychiatrist/physician or physician extender to provide psychiatric evaluations, medication orders at all times.
- Community Psychiatric Supportive Treatment must be provided at a site licensed by WVDHHR for the delivery of Behavioral Health Rehabilitation Services.

Definition of CSU Continued

- Much of the structured, staff-directed activity or face-to-face activity which has been documented in an activity note can be considered billable time. Some examples of billable versus non-billable time are as follows:
- Billable activities:
  - Structured, staff-directed activities such as therapies and counseling
  - Time spent by staff in the process of interviewing/assessing members whether for social history, discharge planning, psychological reports, etc.
  - Time spent in treatment team meetings or staff consultation
  - Time spent by staff monitoring one member when specifically ordered by the physician/psychiatrist for reasons of clinical necessity (The physician/psychiatrist's order must state the frequency and duration of the time to be spent monitoring.)
  - Routine observation/monitoring by staff ordered by physician/psychiatrist limited to 10 minutes per hour (can include member's sleep, meal, grooming time). Routine observation time cannot exceed two hours per day. The physician must document the need for the observation as related to the Medicaid Member's qualifying behavioral health condition/crisis episode.

Definition of CSU Continued

- Non-billable activities:
  - Activity which is recreation or leisure in nature, such as basketball, exercise, reading a newspaper, watching television and or videos
  - Social activity such as talking with other members, visiting with family members or significant others, releasing the member from the program on pass
  - Time in which the member is sleeping, eating, grooming (except as outlined above).

CSU: Required Components

- Comprehensive Psychiatric Evaluation
- Daily psychiatric review and examination
- On going psychotropic medication evaluation and administration
- Intensive one-on-one supervision, when ordered by a physician/psychiatrist
- Individual and small group problem solving/support as needed
- Therapeutic activities consistent with the member's readiness, capacities, and the service plan
- Disability-specific interdisciplinary team evaluation and service planning before discharge from Community Psychiatric Supportive Treatment. Discharge service planning must include consideration of the antecedent condition that led to admission to Community Psychiatric Supportive Treatment.
- Psychological/functional evaluations specific to the disability population where appropriate and;
- Family intervention must be made available to the families of members as appropriate

CSU Admission and Continued Stay Criteria

To receive or to continue to receive Community Psychiatric Supportive Treatment Services, the following corresponding criteria must be satisfied.

- **Psychiatric Signs and Symptoms**
  - The member is experiencing a crisis due to a mental health condition or impairment in functioning due to acute psychiatric signs and symptoms.
- **Danger to Self/Others**
  - The member is in need of an intensive treatment intervention to prevent hospitalization
- **Medication Management/Active Drug or Alcohol Withdrawal**
  - The member is in need of a medication regimen that requires intensive monitoring/medical supervision or is being evaluated for a medication regimen that requires titration to reach optimum therapeutic effect.
  - There is evidence that the member is using drugs that have produced a physical dependency as evidenced by clinically significant withdrawal symptoms which require medical supervision.

CSU: Documentation

- **Daily Documentation criteria:**
  - Number of treatment hours per day and participation
  - Summary of the member's status – need for continued CSU
  - Symptoms related to the crisis that are being addressed
  - For detox; vitals and use of nationally recognized withdrawal protocol
- Services Provided:
  - Individual, Group, Family Therapy and Individual, Group Supportive Counseling: notes at a minimum need to contain:
    - Specifics of admission criteria to substantiate appropriate level of care
    - Substantiation of daily/appropriate treatment services
    - Intervention
    - Member's response
    - Relate back to treatment plan

Follow Up Training

As follow up to the webinars being offered on the Medicaid manual, APS trainer consultants will be available for onsite trainings, simulated reviews, and phone and email consultation regarding site specific questions.

APS Trainer Consultant Staff Available for Trainings/Simulated Reviews

Christy Gallaher	(304) 533-8862	cgallaher@apshealthcare.com
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