CHAPTER 503 BEHAVIORAL HEALTH REHABILITATION SERVICES

- The right to withdraw at any time.
- A description of the risks, benefits and consequences of telemedicine
- Application of all existing confidentiality protections
- Right of the patient to documentation regarding all transmitted medical information
- Prohibition of dissemination of any patient images or information to other entities without further written consent.

503.13 DOCUMENTATION

The WV Bureau for Medical Services recognizes that some providers use an electronic system to create and store documentation while other providers choose to use a hard copy based system. When services require documentation the Bureau will accept both types of documentation. Each service code in this manual describes the required documentation. All requirements must be met no matter the modality of system choice.

503.14 ASSESSMENT SERVICES

Assessment services include evaluative services and standardized testing instruments applied by suitably trained staff credentialed by the internal credentialing policies and procedures of the agency. Assessment services are designed to make determinations concerning the mental, physical and functional status of the member. Those identified as being in the Foster Care system should receive assessment as rapidly as possible.

503.14.1 Mental Health Assessment By Non-Physician

<table>
<thead>
<tr>
<th>Procedure Code:</th>
<th>H0031</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Unit:</td>
<td>Event</td>
</tr>
<tr>
<td>Telehealth:</td>
<td>Available</td>
</tr>
<tr>
<td>Service Limits:</td>
<td>Maximum of four per year for members with complex behavioral healthcare needs (Coordinated Care) and two per year per member with relatively simple behavioral healthcare needs (Focused Care). The provider may request more units if a critical treatment juncture arises, however not until all current authorizations for H0031 are expired/utilized. The provider may request authorization to conduct one global assessment per year to reaffirm medical necessity and the need for continued care/services. Change of payer source does not justify H0031.</td>
</tr>
</tbody>
</table>

Staff Credentials: Staff must have a minimum of a master’s degree, bachelor’s degree in a field of human services, or a registered nurse. Supervision and oversight by an individual with a minimum of a master’s degree is required (See Clinical Supervision). Staff must be properly credentialed by the agency’s internal credentialing committee.

Definition: Mental Health Assessment by Non-Physician is an initial or reassessment evaluation to determine the needs, strengths, functioning level(s), mental status and/or social history of a member. This code may also be used for special requests of the West Virginia Department of Health and Human Resources for assessments, reports, and court testimony on adults or children for cases of suspected abuse or neglect. The administration and scoring of functional assessment instruments necessary to determine medical necessity and level of care are included in this service.

Approved Causes For Utilization:

BMS Provider Manual
Chapter 503 Behavioral Health Rehabilitation Services

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.
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1. Intake/Initial evaluation;
2. Alteration in level of care with the exception of individuals being stepped down related to function of their behavioral Health condition to a lesser level of care;
3. Critical treatment juncture, defined as: The occurrence of an unusual or significant event which has an impact on the process of treatment. A critical treatment juncture will result in a documented meeting between the provider and the member and/or DLR and may cause a revision of the plan of services;
4. Readmission upon occurrence of unusual or significant events that justify the re-initiation of treatment or that have had an impact on the individual’s willingness to accept treatment. The provider may request authorization to conduct one global assessment per year to reaffirm medical necessity and the need for continued care/services.
5. No one under the age of three will have a H0031 conducted on them. The Medicaid member under the age of the three should be referred to the Birth to Three Program. If the child is aging out of the Birth to Three Program, an assessment allowing a smooth transition into other medically necessary behavioral health services may be conducted.

Documentation:

1. Initial/Intake (may include use of standardized screening tools):
   A. Demographic data (name, age, date of birth, etc.);
   B. Presenting problem(s) (must establish medical necessity for evaluation) including a description of frequency, duration, and intensity of presenting symptomatology that warrants admission;
   C. Impact of the current level of functioning (self-report and report of others present at interview), which may include an appropriate description of activities of daily living, social skills, role functioning, concentration, persistence, and pace; for children, current behavioral and academic functioning;
   D. History of behavioral health and health treatment (recent and remote);
   E. History of any prior suicide/homicide attempts, high risk behaviors, self-injurious behaviors, etc.;
   F. Medical problems and medications currently prescribed;
   G. Social history which may include family history as relevant, description of significant childhood events, arrests, educational background, current family structure, vocational history, financial status, marital history, domestic violence (familial and/or personal), substance abuse (familial and/or personal), military history if any;
   H. Analysis of available social support system at present;
   I. Mental status examination;
   J. Recommended treatment (initial);
   K. Diagnostic Impression, (must be approved/signed by licensed clinical professional with diagnostic privileges in scope of practice); and
   L. Place of evaluation, date of evaluation, start stop times, signature and credentials of evaluator.
   M. Efficacy of and compliance with past treatment. (If past treatment is reported)
   N. Past treatment history and medication compliance (If past treatment is reported)
   O. Completed SBIRT Assessment for ages 10 and older.

2. Re-assessment:
   A. Date of last comprehensive assessment;
   B. Current demographic data;

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### CHAPTER 503 BEHAVIORAL HEALTH REHABILITATION SERVICES

C. Reason for re-assessment, including description of current presenting problems (must document medical necessity for evaluation. If the re-evaluation is a global annual assessment it must be labeled as such).

D. Changes in situation, behavior, functioning since prior evaluation;

E. Summary of treatment since prior evaluation including a description of treatment provided over the interval and response to treatment;

F. Mental status examination;

G. Suggested amendments in treatment/intervention and/or recommendations for continued treatment or discharge;

H. Specific rationale for any proposed amendment in diagnosis which must be analyzed and approved/signed by licensed clinical professional; and

I. Place of evaluation, date of evaluation, start stop times, signature and credentials of evaluator.

Note: H0031, T1023HE and 90791 or 90792 are not to be billed at the same initial intake or re-assessment unless the H0031 is performed first and the evaluator recommends more specific assessment by a medical or psychological professional for further evaluation of the need for medical or other specialty treatment. Documentation must justify need for further evaluation using 90791 or 90792.

### 503.14.2 Psychiatric Diagnostic Evaluation (No Medical Services)

<table>
<thead>
<tr>
<th>Procedure Code:</th>
<th>90791</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Unit:</td>
<td>Event (completed evaluation)</td>
</tr>
<tr>
<td>Telehealth:</td>
<td>Available</td>
</tr>
<tr>
<td>Service Limits:</td>
<td>Two events per year</td>
</tr>
</tbody>
</table>

**Prior Authorization:** Refer to Utilization Management Guidelines.

**Staff Credentials:** Must be performed by a West Virginia licensed psychologist in good standing with the WV Board of Examiners of Psychology, a Physician, a Physician Extender, or a Supervised Psychologist who is supervised by a Board Approved Supervisor.

**Definition:** An integrated bio-psychosocial assessment, including history, mental status, and recommendations. The evaluation may include communication with family or other sources and review and ordering of diagnostic studies.

**Documentation:** Documentation/Report must contain the following and be completed in 15 calendar days from the date of service.

- Date of Service
- Location of Service
- Purpose of Evaluation
- Psychiatrist's/Psychologist's signature with credentials
- Presenting Problem
- History of Medicaid Member's presenting illness
- Duration and Frequency of Symptoms
- Current and Past Medication efficacy and compliance
- Completed SBIRT Assessment for ages 10 and older
- Psychiatric History up to Present Day

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**DISCLAIMER:** This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.
CHAPTER 503 BEHAVIORAL HEALTH REHABILITATION SERVICES

- Medical History related to Behavioral Health Condition
- Mental Status Exam - The Mental Status Exam must include the following elements:
  - Appearance
  - Behavior
  - Attitude
  - Level of Consciousness
  - Orientation
  - Speech
  - Mood and Affect
  - Thought Process/Form and Thought Content
  - Suicidality and Homicidality
  - Insight and Judgment
- Members diagnosis per current DSM or ICD methodology
- Rationale for Diagnosis
- Medicaid Member's prognosis for treatment
- Rationale for Prognosis
- Appropriate Recommendations consistent with the findings of the evaluation

503.14.3 Psychiatric Diagnostic Evaluation With Medical Services *(This Includes Prescribing of Medications)*

<table>
<thead>
<tr>
<th>Procedure Code:</th>
<th>90792</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Unit:</td>
<td>Event (completed evaluation)</td>
</tr>
<tr>
<td>Service Limits:</td>
<td>Two events per year</td>
</tr>
<tr>
<td>Telehealth:</td>
<td>Available</td>
</tr>
</tbody>
</table>

Prior Authorization: Refer to Utilization Management Guidelines

Staff Credentials: Must be completed by a physician or a physician extender

Definition: An integrated bio-psychosocial and medical assessment, including history, mental status, other physical examination elements as indicated, and recommendations. The evaluation may include communication with family and other sources, prescription of medications, and review and ordering of laboratory or other diagnostic studies.

Documentation: Documentation/Report must contain the following and be completed in 15 calendar days from the date of service.

- Date of Service
- Location of Service
- Purpose of the evaluation
- Psychiatrist's signature with credentials
- Documentation that Medicaid Member was present for the evaluation
- Documentation that Medical Evaluation was completed
- Presenting Problem
- History of the Medicaid Member's presenting illness

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.
CHAPTER 503 BEHAVIORAL HEALTH REHABILITATION SERVICES

- Duration and Frequency of symptoms
- Current and Past Medication including efficacy and compliance
- Completed SBIRT Assessment for ages 10 and older
- Psychiatric history up to present day
- Medical History related to behavioral health condition
- Mental Status Exam - The Mental Status Exam must include the following elements:
  - Appearance
  - Behavior
  - Attitude
  - Level of Consciousness
  - Orientation
  - Speech
  - Mood and Affect
  - Thought Process/Form and Thought Content
  - Suicidality and Homicidality
  - Insight and Judgment
- Medicaid Member’s diagnosis per current DSM and ICD Methodology
- Rationale for Diagnosis
- Medicaid Member’s prognosis for treatment
- Rationale for Prognosis
- Appropriate recommendations consistent with the findings of the evaluation

503.14.4 Screening By Licensed Psychologist

Procedure Code: T1023 HE
Service Unit: Event (completed evaluation)
Telehealth: Available
Service Limits: One event every six months

Prior Authorization: Refer to Utilization Management Guidelines.

Staff Credentials: Must be performed by a West Virginia Licensed psychologist or Supervised Psychologist in good standing with WV Board of Examiners of Psychology

Definition: This is a screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol. Procedure codes 96101 or 90791 must be used when a more in-depth assessment is indicated.

Documentation: Documentation/Report must contain the following and be completed in 15 calendar days from the date of service:
- Date of Service
- Location of Service
- Purpose of Evaluation
- Start/Stop Times
- Practitioner signature and credentials
- Appropriate recommendations based on clinical data gathered in the evaluation