CHAPTER 537 LICENSED INDEPENDENT CLINICAL SOCIAL WORKER (LICSW)

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BACKGROUND

The West Virginia Medicaid Program offers a comprehensive scope of medically necessary services to diagnose and treat eligible members. Covered and authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all State and Federal regulations. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed otherwise, in writing, by the West Virginia Bureau for Medical Services (BMS).

This chapter sets forth BMS's requirements for payment of Services provided by providers to eligible West Virginia (WV) Medicaid members.

The policies and procedures set forth herein are promulgated as regulations governing the provision of Services in the Medicaid Program administered by the West Virginia Department of Health and Human Resources (WVDHHR) under the provisions of Title XIX of the Social Security Act and Chapter 9 of the Public Welfare Law of WV.

The Bureau for Medical Services has a joint goal with Medicaid Enrolled Providers to ensure effective services are provided to Medicaid Members.

Medicaid Enrolled Providers should give priority to children that have been identified as being in the foster care system. To uphold our responsibility to children in foster care, addressing children's needs must begin at entry and by making these foster children a priority especially with the assessment services stated in *Section 537.11* of this manual. Medicaid Enrolled Providers should make a good faith effort to complete assessments in a timely manner as well as work with Bureau for Children and Families (BCF) to ensure that information is shared in a timely manner with BCF, court systems, as well as other entities involved in the care and treatment process of the foster child while conforming to state and federal confidentiality requirements.

All Medicaid Members have the right to freedom of choice when choosing a provider for treatment. A Medicaid Member may receive one type of service from one provider and another type of service from a different provider. Providers that are found to be inhibiting freedom of choice to Medicaid Members are in violation of their provider agreement.

All Medicaid Enrolled Providers should coordinate care if a Medicaid Member has different Medicaid services at different sites with other providers to ensure that quality of care is taking place and that safety is the forefront of the Member's treatment. Appropriate Releases of Information should be signed in order that Health Insurance Portability and Accountability Act (HIPAA) Compliant Coordination of Care takes place.

POLICY

537.1 MEMBER ELIGIBILITY

Services are available to all Medicaid members with a known or suspected behavioral health disorder. Each member's level of services will be determined when prior authorization for services is requested through the utilization management contractor (UMC) authorized by BMS to perform administrative review. The Prior Authorization process is explained in *Section 537.15* of this manual.

537.2 MEDICAL NECESSITY

All Services covered in this chapter are subject to a determination of medical necessity defined as follows in the managed care position paper published in 1999 by the State of WV:

Services and Supplies that are:

1. appropriate and necessary for the symptoms, diagnosis or treatment of an illness;
2. provided for the diagnosis or direct care of an illness;
3. within the standards of good practice;
4. not primarily for the convenience of the plan member or provider; and
5. the most appropriate level of care that can be safely provided.

Medical Necessity must be demonstrated throughout the provision of services. For these types of services, the following five factors will be included as part of this determination.

- Diagnosis (as determined by a Licensed Independent Clinical Social Worker)
- Level of functioning
- Evidence of clinical stability
- Available support system
- Service is the appropriate level of care

Providers rendering services that require prior authorization must register with BMS' UMC and receive authorization before rendering such services. Prior authorization does not guarantee payment for services rendered. See *Section 537.15.1 Prior Authorization Procedures* and *Section 537.15.2 Prior Authorization Requirements*.

537.3 PROVIDER ENROLLMENT

In order to participate in the WV Medicaid Program and receive payment from BMS, providers of services must meet all enrollment criteria as described in *Chapter 300, Provider Participation Requirements*.

537.3.1 Enrollment Requirements: Staff Qualifications

All documentation for Licensed Independent Clinical Social Worker (LICSW) including college transcripts, certifications, credentials, background checks, and trainings should be kept in the LICSW personnel file and may be reviewed at any time by BMS or the Bureau's contractors or state and federal auditors.

537.4 FINGERPRINT-BASED BACKGROUND CHECKS

All LICSW enrolled providers and their staff, that have direct contact with Medicaid members must, at a minimum, have results from a state level fingerprint-based background check. This check must be conducted initially and again every 3 years. If the current or prospective employee, within the past 5 years, has lived or worked out of state or currently lives or works out of state, an additional federal background check must be conducted by the Agency through the West Virginia State Police also upon hire and every 3 years of employment thereafter. Providers may do an on-line preliminary check and use

these results for a period of 3 months while waiting for state and/or federal fingerprint results to be received. Providers may only use on-line companies that check counties in which the applicant has lived and worked within the last 5 years. An individual who is providing services or is employed by a provider cannot be considered to provide services nor can be employed or continue to be employed if ever convicted of the following:

- Abduction;
- Any violent felony crime including but not limited to rape, sexual assault, homicide, or felonious battery;
- Child/adult abuse or neglect;
- Crimes which involve the exploitation, including financial exploitation, of a child or an incapacitated adult;
- Any type of felony battery;
- Felony arson;
- Felony or misdemeanor crime against a child or incapacitated adult which causes harm;
- Felony drug related offenses within the last 10 years;
- Felony Driving Under the Influence (DUI) within the last 10 years;
- Hate crimes;
- Kidnapping;
- Murder/ homicide;
- Neglect or abuse by a caregiver;
- Pornography crimes involving children or incapacitated adults including but not limited to, use of minors in filming sexually explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, legal representative or custodian, depicting a child engaged in sexually explicit conduct;
- Purchase or sale of a child;
- Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure;
- Healthcare fraud; and
- Felony forgery.

Fingerprint-based background check results, other than those listed above, which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider before placing an individual in a position to provide services to the member.

If aware of recent convictions or change in conviction status of an agency staff member providing services, the provider must take appropriate action, including notification to the BMS Program Manager for Services.

The Federal Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) must be checked by the provider for every agency staff who provides Medicaid services prior to employment and monthly thereafter. Persons on the OIG Exclusion List cannot provide Medicaid services.

It is the responsibility of the employer to check the list of excluded individuals/entities monthly at:

- (LEIE) at: http://exclusions.oig.hhs.gov/;

- (Formerly EPLS) https://www.sam.gov/;

A form may be printed from this website to verify that the check occurred. Any document that has multiple staff names may be kept in a separate file and made available to staff as needed and during agency audits.

The following web addresses are provided to assist the governing body or designee to check applicants against the sex offender registries for West Virginia and the National sex offender registry, upon hiring for employment. Results of this check must be present in the employee/volunteer personnel file and available for review upon request:

- West Virginia's state police offender registry is at http://www.wvsp.gov
- National sex offender registry is at http://www.nsopw.gov/

537.5 METHODS OF VERIFYING BUREAU FOR MEDICAL SERVICES' REQUIREMENTS

Enrollment requirements, as well as provision of services, are subject to review by BMS and/or its contracted agents. BMS' contracted agents may promulgate and update utilization management guidelines that have been reviewed and approved by BMS. These approved guidelines function as policy. Additional information governing the surveillance and utilization control program may be found in *Chapter 100, General Administration and Information*, of the Provider Manual and are subject to review by state and federal auditors.

537.6 PROVIDER REVIEWS

The primary means of monitoring the quality of services is through provider reviews conducted by the Contracted Agent as determined by BMS by a defined cycle. The Contracted agent performs on-site and desk documentation provider reviews and face-to-face member/legal representative and staff interviews to validate documentation and address CMS quality assurance standards.

Targeted on-site provider reviews and/or desk reviews may be conducted by the Contracted Agent in follow up to receipt of Incident Management Reports, complaint data, Plan of Corrections (POC), etc.

Upon completion of each provider review, the Contracted Agent conducts a face-to-face exit summation with staff as chosen by the provider to attend. Following the exit summation, the Contracted Agent will make available to the provider a draft exit report and a Plan of Correction to be completed by the provider. If potential disallowances are identified, the provider will have 30 calendar days from receipt of the draft exit report to send comments back to the Contracted Agent. After the 30-day comment period has ended, BMS will review the draft exit report and any comments submitted by the provider and issue a final report to the Provider's Executive Director. The final report reflects the provider's overall performance, details of each area reviewed and any disallowance, if applicable, for any inappropriate or undocumented billing of Services. A cover letter to the provider's Executive Director will outline the following options to effectuate repayment:

1. Payment to BMS within 60 days after BMS notifies the provider of the overpayment; or

2. Placement of a lien by BMS against further payments for Medicaid reimbursements so that recovery is effectuated within 60 days after notification of the overpayment; or
3. A recovery schedule of up to a 12-month period through monthly payments or the placement of a lien against future payments.

If the provider disagrees with the final report, the provider may request a document/desk review within 30 days of receipt of the final report pursuant to the procedures in *Chapter 100, General Administration and Information* of the West Virginia Medicaid Provider Manual. The Provider must still complete the written repayment arrangement within 30 days of receipt of the Final Report, but scheduled repayments will not begin until after the document/desk review decision. The request for a document/desk review must be in writing, signed and set forth in detail the items in contention.

The letter must be addressed to the following:

Commissioner
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301-3706

If no potential disallowances are identified during the Contracted Agent review, then the Provider will receive a final letter and a final report from BMS.

For information relating to additional audits that may be conducted for services contained in this chapter please see *Chapter 800, Program Integrity* of the BMS Provider Manual that identifies other State/Federal auditing bodies and related procedures.

Plan of Correction (POC)

In addition to the draft exit report sent to the providers, the Contracted Agent will also send a draft POC electronically. Providers are required to complete the POC and electronically submit a POC to the Contracted Agent for approval within 30 calendar days of receipt of the draft POC from the Contracted Agent. BMS may place a pay hold on claims if an approved POC is not received by the Contracted Agent within the specified time frame. The POC must include the following:

1. How the deficient practice for the members cited in the report will be corrected;
2. What system will be put into place to prevent recurrence of the deficient practice;
3. How the provider will monitor to assure future compliance and who will be responsible for the monitoring;
4. The date the Plan of Correction will be completed; and
5. Any provider-specific training requests related to the deficiencies.

537.7 TRAINING AND TECHNICAL ASSISTANCE

The Contracted Agent develops and conducts training for providers and other interested parties as necessary to improve systemic and provider-specific quality of care and regulatory compliance. Training is available through both face-to-face and web-based venues.

537.8 OTHER ADMINISTRATIVE REQUIREMENTS

- The provider must assure implementation of BMS' policies and procedures pertaining to documentation, and case record review. Uniform guidelines for case record organization should be used by staff, so similar information will be found in the same place from case record to case record and can be quickly and easily accessed. Copies of completed release of information forms and consent forms must be filed in the case record.
- Records must be legible.
- Prior to the retrospective review all records requested must be presented to the reviewers completing the retrospective review.
- If requested the providers must provide copies of Medicaid Members records within one business day of the request.
- Provider must facilitate the records access that is requested as well as equipment that may need to be utilized to complete the Comprehensive Retrospective Review Process.
- A point of contact must be provided by the provider throughout the Comprehensive Retrospective Review Process.
- In addition to the documentation requirements described in this chapter, Service providers must comply with the documentation and maintenance of records requirements described in *Chapter 100, General Administration and Information*, and *Chapter 300, Provider Participation Requirements* of the Provider Manual.
- Documentation of the services provided in this manual must demonstrate only one staff person's time is billed for any specific activity provided to the members
- Reimbursement is not available for a telephone conversation, electronic mail message (e-mail), or facsimile transmission (fax) between a Provider and a member.
- Services provided via Telehealth must align with *Section 537.9 Telehealth Services* of this Chapter. Medicaid will reimburse according to the fee schedule for services provided.

537.9 TELEHEALTH SERVICES

The West Virginia Bureau for Medical Services encourages providers that have the capability to render services via Telehealth to allow easier access to services for WV Medicaid Members. To utilize Telehealth providers will need to document that the service was rendered under that modality. When filing a claim the Provider will bill the service code with a GT Modifier. Each service in this manual is identified as "Available" or "Not Available" for Telehealth. Some services codes give additional instruction and/or restriction for Telehealth as appropriate.

- Minimum equipment standards are transmission speeds of 256kbps or higher over ISDN (Integrated Services Digital Network) or proprietary network connections including VPNs (Virtual Private Networks), fractional T1, or T1 comparable cable bandwidths. Software that has been developed for the specific use of Telehealth may be used as long as the software is HIPAA Compliant and abides by a federal code pertaining to Telehealth.
- The audio, video, and/or computer telemedicine system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through telemedicine. The telecommunication equipment must be of a quality to complete adequately all necessary components to document the level of service for the CPT or HCPCS codes that are available to be billed. If a peripheral diagnostic scope is required to assess the patient, it must provide

adequate resolution or audio quality for decision-making. The provider at the distant site is responsible to maintain standards of care within the scope of practice.

- All Medicaid conditions and regulations apply to Telehealth services unless otherwise specified in this manual.
- All providers are required to develop and maintain written documentation of the services provided in the form of progress notes. The notes must meet the same guidelines as those required of an in-person visit or consultation, with the exception that the mode of communication (i.e., Telehealth) must be noted.
- The operator of the Telehealth equipment must be an enrolled provider or an employee of the enrolled provider for compliance with confidentiality and quality assurance.
- The practitioner who delivers the service to a member shall ensure that any written information is provided to the member in a form and manner which the member can understand using reasonable accommodations when necessary.
- Member's consent to receive treatment via Telehealth shall be obtained, and may be included in the member's initial general consent for treatment.
- Members may utilize Telehealth through their personal computer by utilizing a VPN established and maintained by the provider and meeting the equipment standards stated in this policy.
- If the member (or legal guardian) indicates at any point that he or she wishes to stop using the technology, the service should cease immediately and an alternative method of service provision should be arranged.
- The provider who has the ultimate responsibility for the care of the patient must first obtain verbal and written consent from the recipient, including as listed below:

    - 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.

537.10 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.

537.11 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.

537.11.1 Psychiatric Diagnostic Evaluation (No Medical Services)

Procedure Code: 90791
Service Unit: Event (completed evaluation)
Telehealth: Available
Service Limits: Two events per year

Prior Authorization: Refer to Utilization Management Guidelines.

Staff Credentials: Must be performed by a West Virginia Licensed Independent Clinical Social Worker

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
- LICSW'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
- 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
- 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

537.12 PSYCHOTHERAPY

Psychotherapy is the treatment of mental illness and behavioral disturbances in which the LICSW through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. The psychotherapy codes 90832, 90834, and 90837 include ongoing assessment and adjustment of psychotherapeutic interventions and may include the involvement of family member (s) or others in the treatment process.

Psychotherapy times are face-to-face services with patient and/or family member. The patient must be present for all or some of the service. In reporting, choose the code closest to the actual time (i.e., 16-37 minutes for 90832, 38-52 minutes for 90834, and 53 or more minutes for 90837).

537.12.1 Individual Psychotherapy

Procedure Code: 90832
Service Unit: 1 unit = 16-37 minutes
Telehealth: Available
Service Limits: All units must be prior authorized

Prior Authorization: Refer to Utilization Management Guidelines

Staff Credentials: Must be performed by a West Virginia Licensed Independent Clinical Social Worker

Definition: Psychotherapy is the treatment of mental illness and behavioral disturbances in which the LICSW through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. The psychotherapy codes 90832, 90834, 90837, and 90853 include ongoing assessment and adjustment of psychotherapeutic interventions and may include involvement of family member(s) or others in the treatment process.

Documentation: Documentation must contain the following:

Documentation must indicate how often this service is to be provided. There must be a progress note describing each service provided, the relationship of the service to the identified mental health treatment needs, and the member's response to the service. The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment.

Documentation must also include the following:

- Signature with credentials
- Place of service
- Date of service
- Start-and-Stop times

Procedure Code: 90834
Service Unit: 1 unit = 38-52 minutes
Telehealth: Available
Service Limits: All units must be prior authorized

Prior Authorization: Refer to Utilization Management Guidelines

Staff Credentials: Must be performed by a West Virginia Licensed Independent Clinical Social Worker

Definition: Psychotherapy is the treatment of mental illness and behavioral disturbances in which the LICSW through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. The psychotherapy codes 90832, 90834, 90837, and 90853 include ongoing assessment and adjustment of psychotherapeutic interventions and may include involvement of family member(s) or others in the treatment process.

Documentation: Documentation must contain the following:

Documentation must indicate how often this service is to be provided. There must be a progress note describing each service provided, the relationship of the service to the identified mental health treatment needs, and the member's response to the service. The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment.

The documentation must also include the following:

- Signature with credentials
- Place of service
- Date of service
- Start-and-Stop times

Procedure Code: 90837
Service Unit: 1 unit = 53 or more minutes
Telehealth: Available
Service Limits: All units must be prior authorized

Prior Authorization: Refer to Utilization Management Guidelines

Staff Credentials: Must be performed by a West Virginia Licensed Independent Clinical Social Worker

Definition: Psychotherapy is the treatment of mental illness and behavioral disturbances in which the LICSW through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. The psychotherapy codes 90832, 90834, 90837, and 90853 include ongoing assessment and adjustment of psychotherapeutic interventions and may include involvement of family member(s) or others in the treatment process.

Documentation: Documentation must contain the following:

Documentation must indicate how often this service is to be provided. There must be a progress note describing each service provided, the relationship of the service to the identified mental health treatment needs, and the member's response to the service. The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment.

The documentation must also include the following:

- Signature with credentials
- Place of service
- Date of service
- Start-and-Stop times

537.12.2 Group Psychotherapy (Other than of a multiple-family group)

Procedure Code: 90853
Service Unit: 1 unit
Telehealth: Available
Service Limits: All units must be prior authorized
Maximum limit of 12 individuals in a group setting

Prior Authorization: Refer to Utilization Management Guidelines

Staff Credentials: Must be performed by a West Virginia Licensed Independent Clinical Social Worker

Definition: Group Psychotherapy is the treatment of mental illness and behavioral disturbances in which the LICSW through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. The psychotherapy codes 90832, 90834, 90837, and 90853 include ongoing assessment and adjustment of psychotherapeutic interventions and may include involvement of family member(s) or others in the treatment process.

Documentation: Documentation must contain the following:

Documentation must indicate how often this service is to be provided. There must be a progress note describing each service provided, the relationship of the service to the identified mental health treatment needs, and the member's response to the service. The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment.

The documentation must also include the following:

- Signature with credentials

- Group Topic
- Place of service
- Date of service
- Start-and-Stop times

537.12.3 Non-Methadone Medication Assisted Treatment Guidelines

West Virginia Medicaid covers non-Methadone Medication Assisted Treatment Services under the following circumstances:

- Individuals seeking opioid addiction treatment for Suboxone®/Subutex® or Vivitrol® for the treatment of opioid/alcohol dependence must be evaluated by an enrolled physician as specified below, before beginning medication assisted treatment.
- An initial evaluation may be completed by a staff member other than the physician however no medication may be prescribed until the physician has completed their evaluation.
- Members seeking treatment must have an appropriate diagnosis for the medication utilized.
- All physicians agree to adhere to the Coordination of Care Agreement (*See Appendix 537A*) which will be signed by the member, the treating physician, and the treating therapist.
- Each member receiving non-methadone medication assisted treatment must also be involved in individual therapy and/or group therapy as specified in the Coordination of Care Agreement.
- If a change of physician or therapist takes place, a new agreement must be signed. This agreement must be placed in the member's record and updated annually.
- The agreement is not required if the member is receiving services at an agency where both the physician and therapist are employed.

Therapy Services: Psychotherapy is the treatment of mental illness and behavioral disturbances in which the LICSW through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. The psychotherapy codes 90832, 90834, and 90837 include ongoing assessment and adjustment of psychotherapeutic interventions and may include the involvement of family member (s) or others in the treatment process. Psychotherapy times are face-to-face services with patient and/or family member. The patient must be present for all or some of the service. In reporting, choose the code closest to the actual time (i.e., 16-37 minutes for 90832, 38-52 minutes for 90834, and 53 or more minutes for 90837. (***See 90832, 90834, and 90837 Psychotherapy Requirements***).

Provider Requirements: Any therapeutic intervention applied must be performed by a Licensed Independent Clinical Social Worker.

Documentation: Documentation will require a treatment strategy, the signature, and credentials of the staff providing the service, place of service, and date of service. The activity note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment.

Consumer compliance with treatment and other information must be shared with the physician as per the Coordination of Care Agreement.

Program Guidelines:

Note: These are the minimum requirements that are set forth in this manual. Physicians and/or agencies may have more stringent guidelines set forth in their internal policy.

Phase 1: Members in phase 1 (less than 12 months of compliance with treatment) will attend a **minimum** of four (4) hours of psychotherapy services per month. The four hours must contain a **minimum** of one (1) hour individual psychotherapy session per month. Frequency of therapeutic services may increase based upon medical necessity.

Phase 2: Members in phase 2 (12 months or more of compliance with treatment) will attend a minimum of (1) hour of psychotherapy services per month with individual, family, or group modalities. Frequency of therapeutic services may increase based upon medical necessity.

Drug Screens: A minimum of two (2) random urine drug screens per month are required for members in phase 1. A minimum of one (1) random urine drug screen per month is required for members in phase 2. A record of the results of these screens may be requested from the physician. The drug screen must test for, at a minimum, the following substances:

- Opiates
- Oxycodone
- Methadone
- Buprenorphine
- Benzodiazepines
- Cocaine
- Amphetamine
- Methamphetamine

Instructions for non-compliance with treatment:
Non-compliance is defined as failure of a drug screen or failure to meet the monthly requirement of therapeutic services.

Members in phase 1 must demonstrate increased treatment frequency after two instances of non-compliance such as: two failed drug screens, two months of not meeting therapeutic requirements, or a combination of one failed drug screen and one month of failed therapeutic requirements. If increase in treatment frequency is not demonstrated consistently within seven days, the patient may be terminated from the program at the physician's discretion. The physician and/or treatment program has the option to allow the patient to reapply to the program after 30 days with proven participation in professional therapies. With three violations within six months, the physician will terminate the individual from the program. The program has the option to allow the patient to reapply after 30 days during which time the patient must demonstrate compliance with professional therapies. An exception is made for pregnant women at physician discretion.

Members in phase 2 will be returned to phase 1 of treatment after one instance of non-compliance (see Phase 1 required timelines).

Individuals discharged for non-compliance and ineligible for re-start must receive information describing alternative methods of treatment and listing contact information for alternative treatment providers as appropriate.

Titration Policy: Titration due to non-compliance is per Physician order when the Medicaid Member is found to be non-compliant during treatment. Titration must be completed within four (4) weeks of the physicians order to stop medication assisted treatment. Vivitrol® will be discontinued immediately due to non-compliance.

Any physician that prescribes medication under the Non-Methadone Medication Assistance Treatment must have a plan in place for when they are unavailable to address any medical issues or medication situations that should arise. At no time is a Nurse Practitioner or a Physician's Assistant to prescribe Suboxone®.

537.12.4 Psychotherapy for Crisis

Psychotherapy for crisis is an urgent assessment and history of a crisis state, a mental status exam, and a disposition. The treatment includes psychotherapy mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma. The presenting problem is typically life threatening or complex and requires immediate attention to patient in high distress. Codes 90839 and 90840 are used to report the total duration of time face –to –face with the patient and/or family spent by the LICSW providing psychotherapy for the crisis, even if the time spent on that date is not continuous. For any given period of time spent providing psychotherapy for crisis state the LICSW must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during the same time period. The patient must be present for all or some of the service. Do not report with 90791.

Procedure Code: 90839
Service Unit: 60 Minutes
Telehealth: Unavailable
Service Limits: All units must be prior authorized

Prior Authorization: Refer to Utilization Management Guidelines

Staff Credentials: Must be performed by a West Virginia Licensed Independent Clinical Social Worker.

Documentation: Documentation must contain the following:

There must be a progress note for this service. The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment for the crisis

The documentation must also include the following:

- Signature with credentials
- Safety Plan

- Place of service
- Date of service
- Start-and-Stop times
- 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 Homicidally
    - Insight and Judgment

Service Exclusions:

- Response to a Domestic Violence Situation
- Admission to a Hospital
- Admission to a Crisis Stabilization Unit
- Time awaiting for Transportation or the transportation itself
- Removal of a minor or an incapacitated adult from an abusive or neglectful household.
- Completion of certification for involuntary commitment.

Procedure Code:	90840
Service Unit:	Add on code for each additional 30 minutes of psychotherapy for crisis, used in conjunction with 90839
Telehealth:	Unavailable
Service Limits:	All units must be prior authorized

Prior Authorization: Refer to Utilization Management Guidelines

Staff Credentials: Must be performed by a West Virginia Licensed Independent Clinical Social Worker.

Documentation: Documentation must contain the following:

There must be a progress note for this service. The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment for the crisis

The documentation must also include the following:

- Signature with credentials
- Safety Plan
- Place of service

- Date of service
- Start-and-Stop times
- 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 Homicidally
    - Insight and Judgment

Service Exclusions:

- Response to a Domestic Violence Situation
- Admission to a Hospital
- Admission to a Crisis Stabilization Unit
- Time awaiting for Transportation or the transportation itself
- Removal of a minor or an incapacitated adult from an abusive or neglectful household.
- Completion of certification for involuntary commitment.

537.12.5 Family Psychotherapy (without the patient present)

Procedure Code: 90846
Service Unit: 45-50 minutes
Telehealth: Available
Service Limits: All units must be prior authorized

Prior Authorization: Refer to Utilization Management Guidelines

Staff Credentials: Must be performed by a West Virginia Licensed Independent Clinical Social Worker.

Definition: Psychotherapy is the treatment of mental illness and behavioral disturbances in which the LICSW through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. This code is specific to family psychotherapy without the patient present in the therapeutic session.

Documentation: Documentation must contain the following:

Documentation must indicate how often this service is to be provided. There must be a progress note describing each service provided, the relationship of the service to the identified mental health treatment needs, and the member's response to the service. The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment.

The documentation must also include the following:

- Signature with credentials
- Place of service
- Date of service
- Start-and-Stop times

537.12.6 Family Psychotherapy (with the patient present)

Procedure Code: 90847
Service Unit: 45-50 minutes
Telehealth: Available
Service Limits: All units must be prior authorized

Prior Authorization: Refer to Utilization Management Guidelines

Staff Credentials: Must be performed by a West Virginia Licensed Independent Clinical Social Worker.

Definition: Psychotherapy is the treatment of mental illness and behavioral disturbances in which the LICSW through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. This code is specific to family psychotherapy with the patient present in the therapeutic session

Documentation: Documentation must contain the following:

Documentation must indicate how often this service is to be provided. There must be a progress note describing each service provided, the relationship of the service to the identified mental health treatment needs, and the member's response to the service. The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment.

The documentation must also include the following:

- Signature with credentials
- Place of service
- Date of service
- Start-and-Stop times

537.13 SERVICE LIMITATIONS

Service limitations governing the provision of all WV Medicaid services will apply pursuant to *Chapter 100, General Administration and Information* of the Provider Manual.

537.14 SERVICE EXCLUSIONS

In addition to the exclusions listed in *Chapter 100, General Administration and Information*, BMS will not pay for the following services:

- Individual and Group Psychotherapy services for members with a diagnosis of dementia which has progressed to a severe cognitive deficit.
- Individual and Group Psychotherapy services for members with a diagnosis of severe and profound mental retardation.
- Group Psychotherapy services which only consist of activities such as socialization, music therapy, recreational activities, art classes, excursions, dining together, sensory stimulation, cognitive stimulation, and motion therapy.
- Telephone consultations.
- Missed appointments, including but not limited to, canceled appointments and appointments not kept.
- Services not meeting the definition of Medical Necessity
- Time spent in preparation of reports
- Experimental services or drugs.
- Services rendered outside the scope of a provider's license.
- Any activity provided for the purpose of leisure or recreation
- Services completed by an employee other than a LICSW
- If a facility is reimbursed for LICSW services, the LICSW cannot be reimbursed separately.
- Family Psychotherapy services when the service constitutes taking a history or documenting evaluation and management services.
- An unlisted LICSW service is subject to review and pricing. The completed reports must be attached to the claim form and submitted for consideration to the Bureau.
- Hypnotherapy

537.15 PRIOR AUTHORIZATION

Prior authorization requirements governing the provision of all WV Medicaid services will apply pursuant to *Chapter 300, Provider Participation Requirements* of the Provider Manual. In addition, the following limitations also apply to the requirements for payment of Services described in this chapter.

537.15.1 Prior Authorization Procedures

- The Bureau for Medical Services requires that providers register and/or prior authorize all Services described in this manual.
- Prior Authorization must be obtained from the BMS' UMC.
- General information on, prior authorization requirements for additional services, and contact information for submitting a request may be obtained by contacting BMS' UMC.

537.15.2 Prior Authorization Requirements

- Prior authorization requests for Services must be submitted within the timelines required by BMS' UMC.

- Prior authorization requests must be submitted in a manner specified by BMS' UMC.

537.16 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

Documentation and record retention requirements governing the provision of all WV Medicaid services will apply pursuant to *Chapter 100, General Administration and Information* and *Chapter 300, Provider Participation Requirements* of the Provider Manual.

Providers of Services must comply, at a minimum, with the following documentation requirements:

- Providers must maintain a specific record for all services received for each WV Medicaid eligible member including, but not limited to: name, address, birth date, Medicaid identification number, pertinent diagnostic information.
- Signature and credentials of staff providing the service, designation of what service was provided, documentation of services provided, the dates the services were provided, and the actual time spent providing the service by listing the start-and-stop times as required by service.
- All required documentation must be maintained for at least five years in the provider's file subject to review by authorized BMS personnel. In the event of a dispute concerning a service provided, documentation must be maintained until the end of the dispute or five years, whichever is greater.
- Failure to maintain all required documentation may result in the disallowance and recovery by BMS of any amounts paid to the provider for which the required documentation is not maintained and not provided to BMS upon request.
- Providers of services must also comply with the specific documentation requirements for the program or service procedure, as described in this chapter.

537.17 BILLING PROCEDURES

- Claims from providers must be submitted on the BMS designated form or electronically transmitted to the BMS fiscal agent and must include all information required by BMS to process the claim for payment.
- The amount billed to BMS must represent the provider's usual and customary charge for the services delivered.
- Claims must be accurately completed with required information.
- By signing the BMS Provider Enrollment Agreement, providers certify that all information listed on claims for reimbursement from Medicaid is true, accurate, and complete. Therefore, claims may be endorsed with computer-generated, manual, or stamped signatures.
- Claim must be filed on a timely basis, i.e., filed within 12 months from date of service, and a separate claim must be completed for each individual member.

GLOSSARY

Definitions in *Chapter 200, Definitions and Acronyms* apply to all West Virginia Medicaid services, including those covered by this chapter. Definitions in this glossary are specific to this chapter.

Abuse and Neglect: As defined in West Virginia Code §49-1-3

Behavioral Health Condition: A mental illness, behavioral disorder and/or substance use disorder which necessitates therapeutic treatment.

Coordination of Care: Sharing information between relevant parties to plan, arrange, implement, and monitor provision of services to a Medicaid Member.

Designated Legal Representative (DLR): Parent of a minor child, conservator, legal guardian (full or limited), health care surrogate, medical power of attorney, power of attorney, representative payee, or other individual authorized to make certain decisions on behalf of a member and operating within the scope of his/her authority.

Freedom of Choice: The guaranteed right of a member to select a participating provider of their choice.

Foster Child: The West Virginia Department of Health and Human Resources defines a foster child as a child receiving 24-hour substitute care while placed away from his or her parents or guardians and for whom the State agency has placement and care responsibility. This includes, but is not limited to, placements in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, child care institutions, and pre-adoptive homes.

Licensed Independent Clinical Social Worker: An individual who has obtained Level D status as defined by the West Virginia Board of Social Work and by West Virginia Code §30-30-9

Physician: As defined in West Virginia Code Annotated, §30-3-10, an individual who has been issued a license to practice medicine in the state of WV by the WV Board of Medicine and is in good standing with the board; or an individual licensed by the WV Board of Osteopathy in accordance with West Virginia Code Annotated §30-14-6.

Plan of Correction (POC): A template form that will list the quality deficiencies that were identified during a retrospective review of a LICSW provider.

Utilization Management Contractor (UMC): The contracted agent of BMS.

CHANGE LOG

REPLACE	TITLE	CHANGE DATE	EFFECTIVE DATE
Entire Chapter			7/1/2015