

Division of Medicaid State of Mississippi Provider Policy Manual	New: X Revised: Current:	Effective Date: 01/01/11
Section: Physician Subject: Mental Health/Psychiatry	Section: 55.19 Pages: 6 Cross Reference: Introduction 1.10 Maintenance of Records 7.03 Therapeutic Services 21.06 Prior Authorization 21.16 Medically Necessary 53.22	

Provider Qualifications

Psychiatric services outlined in this section are eligible for reimbursement by the Division of Medicaid (DOM) only when they have been personally and directly provided by a licensed physician (medical doctor or doctor of osteopathy) who is board-certified in psychiatry or by a licensed Psychiatric Mental Health Nurse Practitioner (PMHNP).

Definitions

Billing Provider: the entity (individual or group) who bills and receives payment for services delivered to Medicaid beneficiaries.

Medically Necessary: Refer to Section 53.22 of the Provider Policy Manual for definition and requirements for “medically necessary”.

Servicing Provider: the mental health professional who provides mental health services to a Medicaid beneficiary.

General Requirements

- All services must be personally and directly provided by the person who requests reimbursement for the service.
- Services must be based on beneficiary need and not the convenience of the beneficiary, the beneficiary’s family or the provider.
- A provider may bill only for the actual time spent in service delivery.

Covered Services

The psychiatric services listed in this section are eligible for reimbursement by Medicaid only when they have been personally and directly provided by a licensed physician (medical doctor or doctor of osteopathy) who is board-certified in psychiatry or by a licensed Psychiatric Mental Health Nurse Practitioner (PMHNP). Billing codes for each of the services listed are available for download from the Internet on the DOM web site at <http://www.medicaid.ms.gov> or at the website of the fiscal agent <https://msmedicaid.acs-inc.com>.

Evaluative Services

It is expected that the initial psychiatric service provided to any beneficiary will be of an evaluative nature.

Psychiatric Interview includes a history and mental status of the beneficiary. It should include the chief complaint, past and present medications, family history, social/developmental history,

and any psychiatric history. The interview may include communication with the beneficiary's family and/or other sources.

Interactive Psychiatric Interview includes play equipment, physical devices, a language interpreter, or other mechanisms of communication used to conduct the interview.

Therapeutic Services

Psychotherapy is defined as intentional, face-to-face interactions between a psychiatrist and a beneficiary (individual, family or group) in which a therapeutic relationship is established to help resolve symptoms of the beneficiary's mental and/or emotional disturbance.

- **Individual psychotherapy** is therapy that takes place between the psychiatrist and a beneficiary. Any individual psychotherapy that is provided with medical evaluation and management refers to the concurrent provision of the two services. Medical evaluation and management refers to a variety of responsibilities unique to the medical management of psychiatric beneficiaries, such as medical diagnostic evaluation e.g., evaluation of comorbid medical condition, drug interactions, and physical examinations, drug management when indicated, physician orders, interpretation of laboratory or other medical diagnostic studies and observations. Individual psychotherapy is coded differently depending upon whether it is provided in a hospital/residential (inpatient) or a community-based (outpatient) setting.
- **Family psychotherapy** is therapy that takes place between the psychiatrist and the beneficiary's family members for the purpose of improving the beneficiary's functioning. Family therapy may also include others with whom the beneficiary lives or has a family-like relationship.
- **Group psychotherapy** is therapy that takes place between the psychiatrist and no more than eight (8) beneficiaries at the same time. It is expected that most psychotherapy groups will consist of at least four (4) beneficiaries. However, since particular circumstances (absences among them) could prohibit a group of that size, the minimum number of beneficiaries allowed for group psychotherapy is two (2).

Generally, one (1) service of group therapy can be billed per day. However, no more than two (2) services in group psychotherapy may be eligible for reimbursement on any given day when the following criteria are met:

- Two (2) distinct sessions, each having mutually exclusive goals and objectives, are provided, **AND**
- Two (2) sessions per day are medically necessary, **AND**
- Two (2) sessions per day are appropriate and in accordance with the standards of medical practice, **AND**
- Documentation in the clinical record substantiates that the above criteria were met.

Day Treatment

Refer to Provider Policy Manual Section 21.06 for Therapeutic Services policy. The definition and requirements for Day Treatment are outlined in that section. Day treatment provided by a psychiatrist for beneficiaries under age twenty-one (21) may be eligible for reimbursement only when services: (1) meet the conditions outlined in Section 21.06, and (2) have been given prior authorization by DOM.

Other Psychiatric Services/Procedures

- **Medication management** entails management of the pharmacological aspects of the beneficiary's treatment regimen, including prescription, use, and review of medication with no more than minimal medical psychotherapy.
- **Electroconvulsive therapy** entails the induction of convulsions in a beneficiary to treat certain extreme mental/emotional conditions which have been unresponsive to other forms of treatment. This service includes the necessary monitoring of the beneficiary's condition throughout the procedure.

Exclusions

- Services are not eligible for reimbursement unless they are personally and directly provided by the servicing provider. Mental health services delivered by another professional may not be billed by the Medicaid provider, even when such services are under the direct supervision of the Medicaid provider or are incidental, though integral, to his/her services.
- Educational interventions of an academic nature are not eligible for Medicaid reimbursement.
- Medicaid will not reimburse more than once for the same service provided to any beneficiary on any given date, regardless of the setting(s) in which the service was provided. For example, if a beneficiary is seen in a community mental health center for individual therapy and is seen for individual therapy later that same day by a psychiatrist in independent practice, only one of these services will be eligible for reimbursement by Medicaid. It is the provider's responsibility to coordinate services with the beneficiary and/or his/her family member to insure that services are not duplicated.

Service Limits and Standards

Service Limits identify the maximum quantity of services per beneficiary that are eligible for reimbursement by DOM within a given time frame, either daily or yearly.

Service Standards identify the maximum quantity of services per beneficiary, under the age of twenty-one (21), that are eligible for reimbursement within a fiscal year unless an exception to the standard has been justified by the provider and approved by DOM through the prior authorization (PA) process. Refer to Provider Policy Manual Section 21.16 for Prior Authorization policy.

Daily Service Limits: Adults and Children

The following service limits apply to beneficiaries of all ages, regardless of the setting (hospital/residential or community-based) in which the services are provided.

- **Individual and Family Therapy:** No more than one (1) service in any of the categories of individual psychotherapy or family psychotherapy is eligible for reimbursement by Medicaid on any given day.
- **Group Therapy:** Generally, one (1) service of group therapy can be billed per day. However, no more than two (2) services in group psychotherapy may be eligible for reimbursement on any given day when the following criteria are met:
 - Two (2) distinct sessions, each having mutually exclusive goals and objectives, are provided,
AND

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- Two (2) sessions per day are medically necessary, **AND**
 - Two (2) sessions per day are appropriate and in accordance with the standards of medical practice, **AND**
 - Documentation in the clinical record substantiates that the above criteria were met.

Yearly Service Limits: Adults Aged Twenty-one (21) Years and Older

- **Psychiatric (Outpatient) Services**

Adult beneficiaries are limited to twelve (12) covered psychiatric services/procedures per fiscal year (July 1-June 30). This psychiatric service benefit is available separate from the twelve (12) covered outpatient physician visits allowed for each adult Medicaid beneficiary.

- **Hospital (Inpatient) Services**

Inpatient psychiatric services for adults are available only if certified as medically necessary by the Utilization Management/Quality Improvement Organization (UM/QIO). Refer to Provider Policy Manual Section 1.10 for Utilization Management/Quality Improvement Organization (UM/QIO) policy. A maximum of thirty (30) days of hospital stay are eligible for reimbursement by Medicaid per adult beneficiary per fiscal year, regardless of the nature of the problem (physical or psychiatric) for which the beneficiary is hospitalized. One (1) covered psychiatric service/procedure is eligible for reimbursement per beneficiary per certified day in a general hospital or acute freestanding psychiatric facility.

Yearly Service Standards: Children Under Twenty-one (21) Years Old

- **Psychiatric (Outpatient) Services**

The service standard of twelve (12) psychiatric services represents the number of services which may be eligible for reimbursement per fiscal year (July 1-June 30) without requiring prior authorization (PA) by DOM. If additional psychiatric services are medically necessary, the need must be justified by the provider and approved by DOM through the PA process in order to be eligible for reimbursement. Refer to Provider Policy Manual Section 21.16 for Prior Authorization policy.

- **Hospital/Residential (Inpatient) Services**

All hospital/residential services to beneficiaries under twenty-one (21) years of age must be certified by the UM/QIO as medically necessary in order to be eligible for reimbursement by Medicaid. Refer to Provider Policy Manual Section 1.10 for Utilization Management/Quality Improvement Organization (UM/QIO) policy. There is a general expectation that most acute psychiatric problems requiring hospitalization can be adequately addressed within seven to ten (7-10) days of stay and that most problems requiring residential care can be adequately addressed within one hundred eighty (180) days of stay. One (1) covered psychiatric service/procedure is eligible for reimbursement per beneficiary per certified day in a general hospital or acute freestanding psychiatric facility. No psychiatric services are eligible for separate reimbursement during a beneficiary's stay in a residential treatment facility.

Prior Authorization

Prior Authorization (PA) refers to the verification of medical necessity for a particular procedure or service which must be obtained prior to the delivery of that procedure/service in order for it to be eligible for reimbursement. It is the Medicaid Provider's responsibility to secure prior authorization before delivering any service that requires PA.

Prior Authorization Process

Refer to Provider Policy Manual Section 1.10 for Utilization Management/Quality Improvement Organization (UM/QIO) policy related to outpatient psychiatric services for beneficiaries up to age twenty-one (21). Refer to Provider Policy Manual Section 1.10 for Utilization Management/Quality Improvement Organization (UM/QIO) policy related to inpatient psychiatric services.

Documentation

Physicians are required to maintain auditable records that will verify any or all services provided and billed under the Medicaid program. Records must, upon request, be made available to representatives of the Division of Medicaid or Office of the Attorney General in substantiation of claims. Records should be maintained for a minimum of five (5) years in order to comply with all state and federal regulations and laws. Refer to Section 7.03 of the Provider Policy Manual for additional Maintenance of Records policy.

Evaluative Services

It is expected that the initial psychiatric service provided to any beneficiary will be of an evaluative nature. Documentation of the evaluation must be in the case record and must include, at a minimum:

- Dates, including beginning and ending session times, and the amount of time spent.
- Chief complaint.
- Referral source.
- History of present illness.
- Past psychiatric history.
- Past medical history.
- List of the beneficiary's current medications (including prescription, non-prescription, and over-the-counter).
- Social and family history.
- Comprehensive mental health status examination.
- Treatment plan formulation/prognosis.
- Assessment of the patient's ability to adhere to the treatment plan.
- A multi-axial diagnosis.
- Identification of the clinical problems that are to be the focus of treatment.
- Treatment modalities and/or strategies that will be employed or are recommended to address each problem. If medications are prescribed, documentation must include the name of the drug, strength and dosage. The method of administration must be included for injectable medications. Medication prescriptions must be identified as issued in writing, electronically, or by telephone.
- The signature of the person who provided and documented the service. Any note that is "signed" by computer must be initialed by hand.

Treatment Plan

A treatment plan must be developed and implemented for each beneficiary no later than the date of the third therapy session and must include, at a minimum:

- A multi-axial diagnosis.
- Identification of the beneficiaries' and/or family's strengths.
- Identification of the clinical problems, or areas of need, that are to be the focus of treatment.
- Treatment goals for each identified problem.
- Treatment objectives that represent incremental progress towards goals, coupled with target dates for their achievement.
- Specific treatment modalities and/or strategies that will be employed to reach each objective.
- Date of implementation and signatures of the provider and the beneficiary or parent/legal guardian.

Treatment plans must be kept in the case record and must be reviewed and revised as needed, or at least every three (3) months. Each review must be verified by the dated signatures of the provider and beneficiary/parent/legal guardian. The physician, nurse practitioner, psychologist, and clinical social worker must sign the treatment plan for the services each will provide to the beneficiary.

Therapeutic Services

A clinical note for each service provided must be in the case record and must:

- Include the date of service, type of service provided, the length of time spent delivering the service, who received or participated in it, as well as a brief summary of what transpired. If medications are prescribed, documentation must include the name of the drug, strength and dosage. The method of administration must be included for injectable medications. Medication prescriptions must be identified as issued in writing, electronically, or by telephone.
- Indicate whether Evaluation and Management services are provided.
- Relate to the problems identified in clinical record.
- Identify whether the service occurs in an inpatient or outpatient setting.
- Be authenticated by the signature of the person who provided and documented the service. Any note that is "signed" by computer must be initialed by hand.

Note: This section does not apply to psychologists. Please refer to Section 21 of the Provider Policy Manual for services that may be provided by psychologists.