

Transforming Lives. Building Community Well-Being.

2024-2025 Medicaid Direct-Enrolled Provider Outpatient Behavioral Health Services Benefit Plan

Service Code(s): Services Included (Sorted by Alphabetical Order):

90791, 90792 Clinical Assessment

96110, 96112, 96113 Developmental Testing

99201 – 99255, 99304 – 99337, 99341 – 99350 <u>Evaluation & Management</u>

90846, 90847 <u>Family Therapy</u>

90849, 90853 Group Therapy

90832, 90833, 90834, 90836, 90837, 90838 <u>Individual Therapy</u>

96116, 96121, 96136, 96137, 96138, 96139, 96132, Neuropsychological Testing

96133

90785, 90791, 90832, 90834, 90837, 90839, 90840, Psychological Services Provided by Health Departments and School-

90846, 90847, 90853 Based Health Centers to the Under 21 Population

90839, 90840 <u>Psychotherapy for Crisis</u>

Codes / modifier combinations not mentioned for specialized services will be found within contracts.

For Medicaid services, Child services are available through age 21. Adult services are available from age 21 and older.

When state Medicaid coverage provisions conflict with the coverage provisions in a Trillium policy, state Medicaid coverage provisions take precedence.





2024-2025 Medicaid Direct-Enrolled Provider OPT BH Services Benefit Plan

Person-Centered Plan Requirements & Guidance

Providers can use the PCP template or develop their own template, but the PCP <u>must</u> contain all the required elements: 1) Assessment of life domains; 2) Person-Centered Interview Questions; 3) An action plan; 4) An enhanced crisis intervention plan, and; 5) A signature page. The PCP should be based on a comprehensive assessment that examines the individual's symptoms, behaviors, needs and preferences across the life domains listed below. Additional info can be found on the <u>NCDHHS Person-Centered Planning Training</u> webpage (PCP Guide). See the <u>JCB #445 Timelines for Implementation</u> for the implementation requirements for the new PCP guidance and templates.

<u>Life Domains</u> (PCP Guide)

Each life domain should provide a written picture of what is currently happening, what the individual's vision for a preferred life is for that area, and what the provider is doing to support the individual to move closer to living their preferred life.

- Daily Life and Employment Domain: What a person does as part of everyday life.
- Community Living Domain: Where and how someone lives.
- Safety and Security Domain: Staying safe and secure (finances, emergencies, relationships, neighborhood, legal rights, etc.).
- Healthy Living Domain: Managing and accessing health care and staying well.
- Social and Spirituality Domain: Building/strengthening friendships and relationships, cultural beliefs, and faith community.
- *Citizenship and Advocacy Domain*: Building valued roles, understanding personal rights, making choices, sexual orientation, self-identification, setting goals, assuming responsibility and driving how one's own life is lived.

Person-Centered Interview Questions (PCP Guide)

These identify what the person wants to work on, what they would like to accomplish, their identified strengths, and any identified obstacles preventing them from reaching their goals.

Action Plan (PCP Guide)

Revised: 12-27-2024

The Action Plan section of the PCP includes the individual's long-term goal, short-term goals, and interventions or the action steps to be taken to achieve these goals. For each desired long-term goal, the Action Plan will include short-term goal(s) as well as interventions.

- Long-Term Goal Development: what motivates the person to engage in services and make changes. These are personal to that individual, often reflect one or more Life Domains, and typically take time to achieve. Ideally, long-term goals are oriented toward quality-of-life priorities and not only the management of health conditions and symptoms.
- Short-Term Goals: help the person move closer to achieving their long-term goals. They reflect concrete changes in functioning/skills/activities that are meaningful to the person and are proof they are making progress. Short-term goals build on strengths while also addressing identified needs from the assessment that interfere with the attainment of the valued, long-term life goal(s). Short-term goals are written in SMART (Specific/Straightforward/Simple, Measurable, Achievable, Relevant, and Time-Limited) language.
- Interventions: reflect how all team members contribute to helping the person achieve their short-term goals. Interventions are the specific tasks the provider and individual agree on. The language of interventions should include: WHO is offering the intervention/support, WHAT specifically will be provided or done (e.g., title of service or action), WHEN it is being offered frequency and duration (e.g., once a month for 3 months), and WHY it is needed (i.e., how the intervention relates to the individual's specific goal).



2024-2025 Medicaid Direct-Enrolled Provider OPT BH Services Benefit Plan

Enhanced Crisis Intervention Plan (PCP Guide)

A crisis plan includes supports/interventions aimed at preventing a crisis and the supports/interventions to employ if there is a crisis. It must include:

- Significant event(s) that may create increased stress and trigger the onset of a crisis.
- Early warning signs which indicate a possible upcoming crisis.
- Crisis prevention and early intervention strategies
- Strategies for crisis response and stabilization
- Specific recommendations for interacting with the person receiving a crisis service.
- Diagnosis and insurance information,
- Name and contact information for medical and mental health provider
- List of medications including doses and frequency, allergies, and other medical and dental concerns.
- Living situation and planning for any pets and people, etc. in case of a crisis if applicable.
- Employment/ Educational status and plan for notification if applicable
- Preferred method of communication and language.
- Names and contact information of formal and informal support persons
- Suicide prevention and intervention plan, behavior plan, youth in transition plan and Psychiatric Advance Directive (PAD), if applicable.
- Crisis follow-up planning to include: 1) The primary contact who will coordinate care if the individual requires inpatient or other specialized care; 2) Name of the person who will visit the individual while hospitalized, and; 3) Provider responsible to lead a review/debriefing following a crisis and the timeframe.

Signature Page (PCP Guide)

Revised: 12-27-2024

Signatures are authenticated when the individual signing enters the date next to their signature. Check boxes left blank on the signature pages of the PCP will be returned as incomplete. A signature page must include:

- Person Receiving Services Dated signature is required when the person is his/her own legally responsible person. A provider may not bill
 Medicaid for services until this signature is acquired if the individual is his or her own legally responsible person.
- Legally Responsible Person Dated signature when the person receiving services is not his/her own LRP. A provider may not bill Medicaid for services until this signature is acquired, when applicable.
- Person Responsible for the Plan Dated signature is required. Inclusion of the required information on the signature page of the PCP template
 by the Person Responsible for the Plan is also required for individuals under the age of 21 (Medicaid) or under age 18 (State) who are receiving
 enhanced services and are actively involved with the Department of Juvenile Justice and Delinquency Prevention or the Criminal Court System.
- Service Order/Confirmation of Medical Necessity Dated signature is required, plus confirmation of medical necessity, indication of whether
 review of the comprehensive clinical assessment occurred, and indication if the LP signing the service order had direct contact with the
 individual.



2024-2025 Medicaid Direct-Enrolled Provider OPT BH Services Benefit Plan

General Benefit Plan Limits

- Auth to a Different Provider: The requested service cannot be authorized if another provider is currently authorized to provide the requested service, and two providers are not permitted to provide that service at the same time.
- Backdated Request: Service dates requested prior to the receipt of the authorization request cannot be authorized.
- Contract Issue: The requested service cannot be authorized if the provider is experiencing a contract related issue preventing the service from being approved.
- Insurance Coverage Expired: The requested service cannot be authorized if a member does not have active insurance coverage.
- Missing Individual Support Plan (ISP)/Care Plan/Person Centered Plan (PCP) Information: The requested service cannot be authorized if
 the ISP/ Care Plan/ PCP is missing any of the following: 1) The signature page, to include the check boxes not being complete, a missing
 signature, an undated signature, an electronic signature missing the date stamp, and/or if the signature is dated before the date of the
 ISP/ Care Plan/ PCP; 2) Is missing a goal for the service requested; 3) Is missing the units/frequency of service requested or if the units
 requested exceed the frequency detailed in the ISP/ Care Plan/ PCP, and/or; 4) Is missing the Comprehensive Crisis Prevention and
 Intervention Plan.
- More than 30 Days in Advance: The service cannot be authorized if requested more than 30 days in advance. A member's clinical picture can change over time, so medical necessity for a service cannot be established based on a clinical picture that is more than 30 days old.
- No Documentation: The requested service cannot be authorized because the request does not include the required documentation, as detailed in the applicable Clinical Coverage Policy, the service definition, or the Benefit Plan. If required, this can include: 1) A missing or invalid service order; 2) A missing ISP/ Care Plan/ PCP; 3) A missing discharge/ transition plan, and/or; 4) Missing information on an IDD member, like a missing SNAP or a missing psychological evaluation that supports the DD diagnosis.
- No ISP/Care Plan/PCP Update: The requested service reauthorization cannot be authorized if an updated or revised ISP/ Care Plan/PCP to not submitted.
- No New Annual ISP/ Care Plan/ PCP: The requested service cannot be authorized if the ISP/ PCP annual rewrite has not been completed. This includes when an ISP/ Care Plan/ PCP is submitted that is more than a year old.
- Out of Catchment: Trillium is unable to authorize the requested service if a member's Medicaid county of residence is outside of Trillium catchment area.
- Service Exclusion: The requested service cannot be authorized if the member is currently authorized for a service that is an exclusion to the requested service.
- Third Party Insurance: The requested service cannot be authorized if the member has private insurance, and the provider should seek authorization from primary insurance source. Medicaid is the payor of last resort.

Service & Code	Brief Service Description	Auth Submission/ Documentation Requirements	Authorization Parameters	Source
	Clinical	Pass-Through Period:	Units : The appropriate procedure code(s) determines the	Clinical Coverage
Clinical	Assessment	Prior authorization is not required for	billing unit(s). One service code = 1 unit of service.	Policy No. 8C:
Assessment	services are	this service.		<u>Outpatient</u>
	intended to		Age Group: Children/ Adolescents & Adults	Behavioral Health
Code(s):	determine a	Maintained in the Record (not all		<u>Services</u>
90791 -	member's	inclusive):	Level of Care : ASAM Level 1 or lower (if applicable). While	
Psychiatric	treatment	1. CCA: Required	the LOCUS/ CALOCUS are specifically no longer required,	<u>APSM 45-2</u>
Diagnostic	needs. In	2. Tx/ Service Plan: Required.	providers are still expected to use a standardized assessment	Records
Evaluation (No	general,	Complete PCP is required when the	tool when evaluating an individual for treatment services.	Management and
Medical Services;	outpatient	member is receiving multiple BH		<u>Documentation</u>
GT eligible)	behavioral	services in addition to the	Service Specifics, Limitations, & Exclusions (not all	<u>Manuals</u>
	health services	services in Clinical Coverage Policies	inclusive):	505.0
90792 -	focus on	8C. Updated PCP is required when this	1. The provider shall communicate and coordinate care with	PCP Guidance
Psychiatric	reducing	service is provided in conjunction with a	others providing care. When the member is receiving multiple	Documents &
Diagnostic	psychiatric and	service found in the Clinical Coverage	BH services in addition to this service, the PCP must be	<u>Templates</u>
Evaluation with	behavioral	Policies 8A, as well as the state-funded	developed, and outpatient behavioral health services are to be	
Medical Services	symptoms in	enhanced MH/SU services.	incorporated into PCP.	
(GT eligible)	order to	3. Service Order: Required	2. Provider must provide, or have a written agreement with	
Modifiers:	improve the member's	4. Submission of applicable records that support the member has met the	another entity, for access to 24-hour coverage for BH emergency services.	
GT: Telehealth	functioning in	medical necessity criteria.	3. A CCA that demonstrates medical necessity must be	
GT. Teleffealtif	familial, social,	Thedical necessity chiena.	completed by a licensed professional prior to provision of	
	educational, or	All services are subject to post-	outpatient therapy services.	
	occupational	payment review.	4. For services that require a PCP, a CCA must be completed	
	life domains	payment review.	prior to service delivery.	
	ine demand		5. Members w/ both MCD and Medicare, the provider shall bill	
			Medicare as primary before submitting a claim to MCD. For	
			members having both MCD and any other insurance	
			coverage, the other insurance shall be billed prior to billing	
			MCD. MCD is the payor of last resort.	
			6. For substance use disorders, ASAM level 1 outpatient	
			services are provided for less than nine hours a week for	
			adults and less than six (6) hours a week for adolescents.	



Service & Code	Brief Service Description	Auth Submission/ Documentation Requirements	Authorization Parameters	Source
	An in-depth look at a	Pass-Through Period:	<u>Units</u> :	Clinical Coverage
Developmental	member's	Prior authorization is not	1. The appropriate procedure code(s) determines the billing	Policy No. 8C:
Testing	development, usually	required for this service.	unit(s). One service code = 1 unit of service.	Outpatient Behavioral
	done by a trained			Health Services
Code(s):	specialist, such as a		Age Group: Children/ Adolescents & Adults	
96110: Developmental	developmental			APSM 45-2 Records
Testing - Limited (GT	pediatrician,		Level of Care: N/A	Management and
eligible)	psychologist, speech-			Documentation
96112: Developmental	language pathologist,		Service Specifics, Limitations, & Exclusions (not all	Manuals
Testing administrative -	occupational therapist,		inclusive):	
first hour	or other specialist. The		The provider shall communicate and coordinate care	PCP Guidance
96113: Developmental	specialist may observe		with others providing care. When the member is receiving	Documents &
Testing administrative -	the member, give the		multiple BH services in addition to this service, a tx plan	Templates
each additional 30	member a structured		must be developed, and outpatient behavioral health	
minutes. Must be used	test, ask the guardian		services are to be incorporated into the tx plan.	
with 96112.	questions, or ask them		2. Members w/ both MCD and Medicare, the provider shall	
	to fill out		bill Medicare as primary before submitting a claim to MCD.	
Modifiers:	questionnaires.		For members having both MCD and any other insurance	
GT: Telehealth			coverage, the other insurance shall be billed prior to billing	
			MCD. MCD is the payor of last resort.	



Service & Code	Brief Service Description	Auth Submission/ Documentation Requirements	Authorization Parameters	Source
	Evaluation and	Prior authorization is not	<u>Units</u> : The appropriate procedure code(s) determines the	Clinical Coverage
Evaluation &	Management	required for this service. E/M	billing unit(s). One service code = 1 unit of service.	Policy No. 8C:
Management	provided by a	codes are not specific to		Outpatient Behavioral
	Psychiatrist / MD/	mental health and are not	Age Group: Children/ Adolescents & Adults	Health Services
Code(s):	DO or a Psych	subject to prior authorization.		
99202 – 99205	NP/PA.		Level of Care: N/A	APSM 45-2 Records
99211 – 99215				Management and
99305 - 99310			Service Specifics, Limitations, & Exclusions (not all	<u>Documentation</u>
99315 – 99316			inclusive):	<u>Manuals</u>
99341 – 99350			1. Outpatient BH does not cover: a) sleep therapy for	DCD Cuidenes
The GT			psychiatric disorders; b) medical, cognitive, intellectual or development issue that would not benefit from outpatient	PCP Guidance
(Telehealth)			treatment services, OR; c) when the focus of treatment does	Documents &
modifier can be			not address the symptoms of the diagnosis.	<u>Templates</u>
used with service			2. Members w/ both MCD and Medicare, the provider shall bill	
codes between			Medicare as primary before submitting a claim to MCD. For	
99202-99205,			members having both MCD and any other insurance	
99211-99215,			coverage, the other insurance shall be billed prior to billing	
99347-99350			MCD. MCD is the payor of last resort.	
			3. Physicians billing E/M codes with psychotherapy add-on	
			codes must have documentation supporting that the E/M	
			service was separate and distinct from the psychotherapy	
			service.	
			4. The provider will communicate and coordinate care with	
			other professionals providing care to the member.	

	Brief Service	Auth Submission/ Documentation		
Service & Code	Description		Authorization Parameters	Source
	Service is	Requirements Pass-Through Period:	<u>Units</u> : The appropriate procedure code(s) determines the billing	Clinical
Family Therapy	focused on	Prior authorization is not required for	unit(s). One service code = 1 unit of service.	
ганну петару		•	uriit(s). One service code = 1 uriit or service.	<u>Coverage</u>
Codo(o)	reducing	this service.	Age Creum, Children / Adelescente & Adulte	Policy No. 8C:
Code(s): 90846: Family	psychiatric and behavioral	Maintained in the Record (not all	Age Group: Children/ Adolescents & Adults	Outpatient
			Level of Care, ACAM Level 1 or lever (if applicable) While the	Behavioral
Therapy w/o	symptoms to	inclusive):	Level of Care: ASAM Level 1 or lower (if applicable). While the	
member.	improve the	1. CCA: Required	LOCUS/ CALOCUS are specifically no longer required, providers	Health Convince
00047: Family	member's	2. Tx/ Service Plan: Required.	are still expected to use a standardized assessment tool when	<u>Services</u>
90847 : Family	functioning in	Complete PCP is required when the	evaluating an individual for treatment services	A D C M 4 5 0
Therapy with	familial, social,	member is receiving multiple BH	Camiles Charifies Limitations & Evaluations (not all inclusive).	APSM 45-2
member. May not	educational, or	services in addition to the	Service Specifics, Limitations, & Exclusions (not all inclusive):	Records
be used with	occupational life	services in Clinical Coverage	1. Outpatient BH does not cover: a) sleep therapy for psychiatric	Management
90785.	domains. The	Policies 8C. Updated PCP is	disorders; b) medical, cognitive, intellectual or development issue	and December 1
The OT	member's needs	required when this service is	that would not benefit from outpatient treatment services, OR; c)	<u>Documentati</u>
The GT	and preferences	provided in conjunction with a	when the focus of treatment does not address the symptoms of the	on Manuals
(Telehealth) and	determine the	service found in the Clinical	diagnosis.	DOD
KX (Telephonic)	treatment goals,	Coverage Policies 8A, as well as the	2. Individual, Group, or Family Outpatient services cannot be billed	PCP
modifiers can be	frequency, and	state-funded enhanced MH/SA.	while a member is auth'd for: ACT, IIH, MST, Day Treatment,	Guidance
used with these	duration of	3. Service Order: Required	SAIOP, SACOT. Outpatient Med Management and Outpatient	Documents &
service codes.	services, as well	4. Submission of applicable records	Psychiatric Services cannot be billed while a member is auth'd to	<u>Templates</u>
Talanhania	as measurable	that support the member has met the	receive ACT.	
Telephonic	and desirable	medical necessity criteria.	3. For substance use disorders, ASAM level 1 outpatient services	
Services (KX) are	outcomes.	All complete one publication most	are provided for less than nine hours a week for adults and less than	
reserved for when		All services are subject to post-	six (6) hours a week for adolescents.	
physical or BH		payment review.	4. Members w/ both MCD and Medicare, the provider shall bill	
status or access			Medicare as primary before submitting a claim to MCD. For	
issues			members having both MCD and any other insurance coverage, the	
(transportation,			other insurance shall be billed prior to billing MCD. MCD is the	
telehealth			payor of last resort.	
technology) prevent			5. The provider shall communicate and coordinate care with others	
the member from			providing care. When the member is receiving multiple BH services	
participating in-			in addition to this service, the PCP must be developed, and	
person or telehealth services.			outpatient behavioral health services are to be incorporated into PCP.	
			6. Provider must provide, or have a written agreement with another	
			entity, for access to 24-hour coverage for BH emergency services.	

	Brief Service	Auth Submission/		
Service & Code	Description	Documentation Requirements	Authorization Parameters	Source
	Service is	Pass-Through Period:	<u>Units</u> : The appropriate procedure code(s) determines the billing	Clinical
Group Therapy	focused on	Prior authorization is not required	unit(s). One service code = 1 unit of service.	Coverage
,	reducing	for this service.		Policy No.
Code(s):	psychiatric and		Age Group: Children/ Adolescents & Adults	8C:
90849: Group	behavioral	Maintained in the Record (not all		Outpatient
Therapy (multi-	symptoms to	inclusive):	Level of Care: ASAM Level 1 or lower (if applicable). While the	Behavioral
family).	improve the	1. CCA: Required	LOCUS/ CALOCUS are specifically no longer required, providers are	<u>Health</u>
	member's	2. Tx/ Service Plan: Required.	still expected to use a standardized assessment tool when evaluating	<u>Services</u>
90853 : Group	functioning in	Complete PCP is required when the	an individual for treatment services	
Therapy	familial, social,	member is receiving multiple BH		APSM 45-2
	educational, or	services in addition to the	Service Specifics, Limitations, & Exclusions (not all inclusive):	Records
The GT	occupational life	services in Clinical Coverage	1. Outpatient BH does not cover: a) sleep therapy for psychiatric	<u>Management</u>
(Telehealth) and	domains. The	Policies 8C. Updated PCP is	disorders; b) medical, cognitive, intellectual or development issue that	<u>and</u>
KX (Telephonic)	member's needs	required when this service is	would not benefit from outpatient treatment services, OR; c) when the	<u>Documentati</u>
modifiers can be	and preferences	provided in conjunction with a	focus of treatment does not address the symptoms of the diagnosis.	on Manuals
used with these	determine the	service found in the Clinical	2. Individual, Group, or Family Outpatient services cannot be billed	
service codes.	treatment goals,	Coverage Policies 8A, as well as	while a member is auth'd for: ACT, IIH, MST, Day Treatment, SAIOP,	PCP
	frequency, and	the state-funded enhanced MH/SA.	SACOT. Outpatient Med Management and Outpatient Psychiatric	Guidance
Telephonic	duration of	3. Service Order: Required	Services cannot be billed while a member is auth'd to receive ACT.	Documents &
Services (KX) are	services, as well	4. Submission of applicable records	3. The provider shall communicate and coordinate care with others	<u>Templates</u>
reserved for when	as measurable	that support the member has met	providing care. When the member is receiving multiple BH services in	
physical or BH	and desirable	the medical necessity criteria.	addition to this service, the PCP must be developed, and outpatient	
status or access	outcomes.	All convices are subject to next	behavioral health services are to be incorporated into PCP.	
issues		All services are subject to post-	4. Provider must provide, or have a written agreement with another	
(transportation, telehealth		payment review.	entity, for access to 24-hour coverage for BH emergency services.	
			5. Members w/ both MCD and Medicare, the provider shall bill	
technology) prevent the member from			Medicare as primary before submitting a claim to MCD. For members having both MCD and any other insurance coverage, the other	
participating in-			insurance shall be billed prior to billing MCD. MCD is the payor of	
person or			last resort.	
telehealth services.			6. For substance use disorders, ASAM level 1 outpatient services are	
toloricaltii seivices.			provided for less than nine hours a week for adults and less than six	
			(6) hours a week for adolescents.	
			(v) hours a mook for addication.	



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Service & Code	Brief Service	Auth Submission/	Authorization Parameters	Source
	Description	Documentation Requirements		011 1 1
	Service is	Pass-Through Period:	<u>Units</u> : The appropriate procedure code(s) determines the billing	Clinical
Individual Therapy	focused on	Prior authorization is not	unit(s). One service code = 1 unit of service.	Coverage
	reducing	required for this service.		Policy No. 8C:
Code(s):	psychiatric and		Age Group: Children/ Adolescents & Adults	Outpatient
90832: 30 Minutes (GT	behavioral	Maintained in the Record (not		<u>Behavioral</u>
& KX eligible)	symptoms to	all inclusive):	Level of Care: ASAM Level 1 or lower (if applicable). While the	Health Services
90833 : 30 Minute add	improve the	1. CCA: Required	LOCUS/ CALOCUS are specifically no longer required, providers	
on to E&M (GT eligible)	member's	2. Tx/ Service Plan: Required.	are still expected to use a standardized assessment tool when	<u>APSM 45-2</u>
90834 : 45 Minutes (GT	functioning in	Complete PCP is required when	evaluating an individual for treatment services	<u>Records</u>
& KX eligible)	familial, social,	the member is receiving multiple		<u>Management</u>
90836 : 45 Minute add	educational, or	BH services in addition to the	Service Specifics, Limitations, & Exclusions (not all inclusive):	<u>and</u>
on to E&M (GT eligible)	occupational	services in Clinical Coverage	1. Outpatient BH does not cover: a) sleep therapy for psychiatric	<u>Documentation</u>
90837 : 60 Minutes (GT	life domains.	Policies 8C. Updated PCP is	disorders; b) medical, cognitive, intellectual or development issue	<u>Manuals</u>
& KX eligible)	The member's	required when this service is	that would not benefit from outpatient treatment services, OR; c)	
90838: 60 Minute add	needs and	provided in conjunction with a	when the focus of treatment does not address the symptoms of the	PCP Guidance
on to E&M (GT eligible)	preferences	service found in the Clinical	diagnosis.	Documents &
	determine the	Coverage Policies 8A, as well as	2. Individual, Group, or Family Outpatient services cannot be billed	<u>Templates</u>
Modifiers:	treatment	the state-funded enhanced	while a member is auth'd for: ACT, IIH, MST, Day Treatment,	
GT: Telehealth	goals,	MH/SA.	SAIOP, SACOT. Outpatient Med Management and Outpatient	
KX: Telephonic	frequency, and	3. Service Order: Required	Psychiatric Services cannot be billed while a member is auth'd to	
	duration of	4. Submission of applicable	receive ACT.	
Telephonic Services	services, as	records that support the member	3. For substance use disorders, ASAM level 1 outpatient services	
(KX) are reserved for	well as	has met the medical necessity	are provided for less than nine hours a week for adults and less	
when physical or BH	measurable	criteria.	than six (6) hours a week for adolescents.	
status or access issues	and desirable		4. The provider shall communicate and coordinate care with others	
(transportation,	outcomes.	All services are subject to	providing care. When the member is receiving multiple BH services	
		post-payment review.		
prevent the member				
from participating in-				
person or telehealth			5. Provider must provide, or have a written agreement with another	
services.			entity, for access to 24-hour coverage for BH emergency services.	
			6. Members w/ both MCD and Medicare, the provider shall bill	
			Medicare as primary before submitting a claim to MCD. For	
			members having both MCD and any other insurance coverage, the	
			other insurance shall be billed prior to billing MCD. MCD is the	
			payor of last resort.	
telehealth technology) prevent the member from participating in- person or telehealth		post-payment review.	entity, for access to 24-hour coverage for BH emergency services. 6. Members w/ both MCD and Medicare, the provider shall bill Medicare as primary before submitting a claim to MCD. For members having both MCD and any other insurance coverage, the other insurance shall be billed prior to billing MCD. MCD is the	

Neuropsychological Testing is intended to assess cognition and behavior, examining the effects of any brain injury or neuropathological process that a person may have experienced. Neuropsychological Testing (Each Add'l Hour) 96136: Testing Administration (Each add'l 30 minutes) 96137: Testing Administration by Technician (Erist sting Administration by Technician (Each add'l 30 minutes) 96138: Testing Administration by Technician (Each add'l 30 minutes) 96138: Testing Administration by Technician (Each add'l 30 minutes) 96138: Testing Administration by Technician (Each add'l 30 minutes) 96138: Testing Administration by Technician (Each add'l 30 minutes) 96138: Testing Administration by Technician (Each add'l 30 minutes) 96138: Evaluation of Testing (Each add'l 50 minutes) 96138: Evaluation of Testing (Each add'l 50 minutes) 96138: Evaluation of Testing (Each add'l 10ur, GT eligible) 96138: Evaluation of Testing (Each add'l 10ur, GT eligible) Modifier(s): One may have experienced. Neuropsychological testing: hie beliling on the current diagnosis. 2. Limit of eight hours of Psychological Testing allowed to be billed per det of service. 3. Members w both MCD and Amdiciare, the provider shall bill Mediciare as primary before submitting a claim to MCD. For members having both MCD and any other insurance shall be billed prior to billing MCD. MCD is the payor of last resort. 4. Testing must include all elements detailed in the CCP. 5. The provider shall communicate and coordinate care with others providing care. When the member is receiving multiple BH services in addition to this service, a tx plan must be developed, and outpatient behavioral health services are to be incorporated into the tx plan.	Service & Code	Brief Service Description	Auth Submission/ Documentation Requirements	Authorization Parameters	Source
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	(Each add Friour, GT eligible)				
	Modifier(s):				
	GT: Telehealth				

Service & Code	Brief Service Description	Auth Submission/ Documentation Requirements	Authorization Parameters	Source
Psychological Services Provided by Health Departments and School- Based Health Centers to the Under 21 Population Code(s): 90791: Psychiatric Diagnostic Evaluation (No Medical Services) 90832: Individual Therapy, 30 Minutes 90834: Individual Therapy, 45 Minutes 90837: Individual Therapy, 60 Minutes 90839: Psychotherapy for Crisis, first 60 Minutes 90840: Psychotherapy for Crisis, for each additional 30 minutes 90846: Family Therapy w/o member. May not be used with 90785.		Documentation	Units: The appropriate procedure code(s) determines the billing unit(s). Age Group: Children/ Adolescents & Adults Level of Care: Outpatient behavioral health services must be provided in accordance with the requirements and procedures documented in Clinical Coverage Policy 8C: Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers and the applicable Trillium Benefit Plan. Service Specifics, Limitations, & Exclusions (not all inclusive): 1. The provider shall communicate and coordinate care with others providing care. When the member is receiving multiple BH services in addition to this service, a tx plan must be developed, and outpatient behavioral health services are to be incorporated into the tx plan.	Clinical Coverage Policy 8-1: Psychological Services Provided by Health Departments and School-Based Health Centers to the Under 21 Population Clinical Coverage Policy No. 8C: Outpatient Behavioral Health Services APSM 45-2 Records Management and Documentation Manuals PCP Guidance Documents & Templates
90847: Family Therapy with member. May not be used with 90785.90853: Group Therapy				

Service & Code	Brief Service Description	Auth Submission/ Documentation Requirements	Authorization Parameters	Source
Psychological	Psychological testing	Pass-Through Period:	Units: The appropriate procedure code(s)	Clinical Coverage
Testing (Hourly)	involves the culturally and	Prior authorization is not required	determines the billing unit(s). One service code = 1	Policy No. 8C:
	linguistically appropriate	for this service.	unit of service.	Outpatient
Code(s):	administration of			Behavioral Health
96136 : Testing	standardized tests to		Age Group: Children/ Adolescents & Adults	Services
Administration	assess a member's			
(First 30 minutes)	psychological or cognitive		Level of Care: N/A. For substance use disorders,	APSM 45-2 Records
	functioning. Testing results		clinical across the six ASAM criteria assessment	Management and
96137 : Testing	must inform treatment		dimensions is required.	<u>Documentation</u>
Administration	selection and treatment			<u>Manuals</u>
(Each add'l 30	planning.		Service Specifics, Limitations, & Exclusions (not	
minutes)			all inclusive):	PCP Guidance
			Psychological Testing does not cover testing for	Documents &
96138 : Testing			the purpose of educational testing; if requested by	<u>Templates</u>
Administration by			the school or legal system, unless MN exists for the	
Technician (First			psychological testing; if the proposed psychological	
30 minutes)			testing measures have no standardized norms or	
96139 : Testing			documented validity, or; if the focus of assessment is not the symptoms of the current diagnosis.	
Administration by			2. Limit of eight hours of Psychological Testing	
Technician (Each			allowed to be billed per date of service.	
add'l 30 minutes)			3. Members w/ both MCD and Medicare, the provider	
add 1 30 minutes)			shall bill Medicare as primary before submitting a	
96130 : Evaluation			claim to MCD. For members having both MCD and	
of Testing (First			any other insurance coverage, the other insurance	
hour, GT eligible)			shall be billed prior to billing MCD. MCD is the payor	
]			of last resort.	
96131: Evaluation			4. Testing must include all elements detailed in the	
of Testing (Each			CCP.	
add'l hour, GT			5. The provider shall communicate and coordinate	
eligible)			care with others providing care. When the member is	
			receiving multiple BH services in addition to this	
Modifier(s):			service, a tx plan must be developed, and outpatient	
GT: Telehealth			behavioral health services are to be incorporated into	
			the tx plan.	

Service & Code	Brief Service Description	Auth Submission/ Documentation Requirements	Authorization Parameters	Source
Psychotherapy for Crisis Code(s): 90839: First 60 Minutes 90840: For each additional 30 minutes. Must be used with 90839. The GT (Telehealth) and KX (Telephonic) modifiers can be used with these service codes. Modifiers: GT: Telehealth KX: Telephonic	On rare occasions, licensed outpatient service providers are presented with individuals in crisis situations which may require unplanned extended services to manage the crisis in the office with the goal of averting more restrictive levels of care. This service is used only in those extreme situations in which an unforeseen crisis situation arises, and additional time is required to manage the crisis event. Services are restricted to outpatient crisis assessment, stabilization, and disposition for acute, life-threatening situations.	Prior authorization is not required for this service.	Units: The appropriate procedure code(s) determines the billing unit(s). One service code = 1 unit of service. Age Group: Children/ Adolescents & Adults Level of Care: N/A Service Specifics, Limitations, & Exclusions (not all inclusive): 1. Psychotherapy for Crisis is not covered: a) if the focus of tx does not address the symptoms of the DSM-5 dx or related symptoms; b) in emergency departments, inpatient settings, or facility-based crisis settings, OR; c) if the member presents with a medical, cognitive, intellectual or development issue that would not benefit from outpatient tx services. If Psychotherapy for Crisis is billed, no other outpatient therapy services can be billed on that same day for that member. 2. For members having both Medicaid and Medicare, the provider shall bill Medicare as primary before submitting a claim to Medicaid. For beneficiaries having both Medicaid and any other insurance coverage, the other insurance shall be billed prior to billing Medicaid, as Medicaid is considered the payor of last resort. 3. The provider will complete an assessment prior to the delivery of any subsequent services following the provision of this service. 4. When receiving multiple BH services in addition to outpatient, a PCP must be developed. 5. The provider shall communicate and coordinate care with others providing care. When the member is receiving multiple BH services in addition to this service, a tx plan must be developed, and outpatient behavioral health services are to be incorporated into the tx plan. 5. Provider must provide, or have a written agreement with another	Clinical Coverage Policy No. 8C: Outpatient Behavioral Health Services APSM 45-2 Records Management and Documentation Manuals PCP Guidance Documents & Templates
(Telehealth) and KX (Telephonic) modifiers can be used with these service codes. Modifiers: GT: Telehealth	extreme situations in which an unforeseen crisis situation arises, and additional time is required to manage the crisis event. Services are restricted to outpatient crisis assessment, stabilization, and disposition for acute, life-threatening		other outpatient therapy services can be billed on that same day for that member. 2. For members having both Medicaid and Medicare, the provider shall bill Medicare as primary before submitting a claim to Medicaid. For beneficiaries having both Medicaid and any other insurance coverage, the other insurance shall be billed prior to billing Medicaid, as Medicaid is considered the payor of last resort. 3. The provider will complete an assessment prior to the delivery of any subsequent services following the provision of this service. 4. When receiving multiple BH services in addition to outpatient, a PCP must be developed. 5. The provider will complete an assessment prior to the delivery of any subsequent services following the provision of this service. 6. The provider shall communicate and coordinate care with others providing care. When the member is receiving multiple BH services in addition to this service, a tx plan must be developed, and outpatient behavioral health services are to be incorporated into the tx plan.	