Kansas
Department of Health and Environment
Division of Health Care Finance

KANSAS MEDICAL ASSISTANCE PROGRAM

Certified Community Behavioral Health Clinic (CCBHC) Services Provider Manual

Certified Community Behavioral Health Clinic (CCBHC)

Updated 05.2024

Introduction

FORMS All forms pertaining to this provider manual can be found on the public website and on the secure website under Pricing and Limitations.

DISCLAIMER: This manual and all related materials are for the Medicaid Prospective-Payment-System program only. For provider resources available through the KanCare Managed Care Organizations, reference the KanCare website. Contact the specific health plan for managed care assistance.

7000. BILLING INSTRUCTIONS

This is the provider specific section of the provider manual. This section (Part II) was designed to provide information and instructions specific to mental health providers. It is divided into three subsections: **Billing Instructions, Benefits and Limitations,** and **Appendix.**

The Kansas Department for Aging and Disability Services (KDADS) shall certify as a Certified Community Behavioral Health Clinic (CCBHC) any Community Mental Health Center (CMHC) licensed by the department. The Kansas Department of Health and Environment (KDHE) has established a prospective payment system under the medical assistance program for funding the Community Mental Health centers who have become CCBHCs.

Billing Instructions
The Billing Instructions subsection gives instructions for completing and submitting the billing for mental health providers and Substance Use Disorder (SUD) providers when the individual is **not assigned** to a Managed Care Organization (MCO). If the individual is assigned to an MCO, contact the specific health plan for managed care assistance.

Benefits and Limitations
The Benefits and Limitations subsection defines specific aspects of the scope of CCBHC services allowed within the Kansas Medical Assistance Program (KMAP).

Appendix
The Appendix subsections contain information concerning codes. The appendix was developed to make finding and using codes easier for the biller.

Access to Records
Kansas Regulation K.A.R. 30-5-59 requires providers to maintain and furnish records to KMAP upon request. The provider agrees to furnish records and original radiographs and other diagnostic images which may be requested during routine reviews of services rendered and payments claimed for KMAP individuals. If the required records are retained on machine readable media, a hard copy of the records must be made available.

The provider agrees to provide the same forms of access to records to the Medicaid Fraud and Abuse Division of the Kansas Attorney General's Office upon request from such office as required by K.S.A. 21-3853 and amendments thereto.

Confidentiality & HIPAA Compliance
Providers shall follow all applicable state and federal laws and regulations related to confidentiality as part of the Health Insurance Portability and Accountability Act (HIPAA) in accordance with section 45 of the code of regulations parts 160 and 164.

Compliance with 42 U.S.C. 290dd-2(g)
Similarly, providers are required to comply with restrictions placed upon the disclosure and use of SUD patient records which are maintained in connection with the performance of any SUD program. Reference the Substance Abuse Confidentiality Regulations section of the Substance Abuse and Mental Health Services Administration (SAMHSA) website for the definition of a federally assisted program and additional guidance.

7000. BILLING INSTRUCTIONS

Introduction to the CMS-1500 Claim Form

CCBHC providers must use the CMS 1500 Claim From or equivalent claim form when requesting payment for medical services and supplies provided under KMAP. Claims can be submitted on the KMAP secure website, through Provider Electronic Solutions (PES), or by paper. When a paper form is required, it must be submitted on an original, red claim form and completed as indicated or it will be returned to the provider.

Examples of the CMS 1500 Claim Form with their instructions are available on the KMAP public and secure websites on the Forms Page for the **Claims (Sample Forms and Instructions)** heading.

The fiscal agent does not furnish the CMS-1500 Claim Form to providers. Refer to **Section 1100** of the *General Introduction Fee-for-Service Provider Manual.*

Submission of Claim

Send completed claim and any necessary attachments to:

KMAP
Office of the Fiscal Agent
PO Box 3571
Topeka, KS 66601-3571

7010. SPECIFIC BILLING INSTRUCTIONS Updated 03/24

The T1040 code must be present on all CCBHC claims and the services outlined in the prospective payment policy will be billed on any detail line for reporting purposes to indicate the services performed.

Prospective-Payment-System (PPS) Billing
Regardless of the number of CCBHC services provided to the member, only one PPS claim per member-per calendar day will be reimbursed provided that a qualifying (triggering) service is provided on the same day and is included on the claim. The PPS claim should include all CCBHC services provided for the client on that day. Services provided within this claim will be listed on any detail line in addition to the T1040 Code.

CPT T1040 is billed by the CCBHC provider type/specialty (11/121) only, and the coverage is limited to place of service 11 (office visit). The T1040 in accordance with the 5010 HIPAA Guidelines, if the rendering and billing provider is the same provider, the rendering provider will be left blank. In CCBHC claims this will be the situation.

For the additional services listed, the appropriate rendering provider's National Provider Identifier (NPI) is listed for the service provided. In instances where the service and rendering provider may be the same (11/121), please record as such.

***Note*:** Some services listed as CCBHC services will not trigger a PPS rate if the non-trigger service was the only CCBHC service provided to the individual on the date of service.

Billing
The **Appendix** provides procedure codes for subsequent detailed reporting of service code.

Third-Party Liability (TPL)
KMAP is a **secondary** payor to **all** other insurance programs (including Medicare) and should be billed only after payment or denial has been received from such carriers. For more information see the *General TPL Payment Fee-for-Service Provider Manual.* For codes that do not need to be billed to other insurance including Medicare, refer to the TPL Non-Covered Procedure Code List under the Provider and Interactive Tools section.

Effective with claims processed on and after July 17, 2023, claims billed by a CCBHC that have not been billed to the primary payer will be set to Pay and Chase for TPL purposes.

Spenddown
If the individual's spenddown has not yet been met, both covered and non-covered services should be billed under the CMHC NPI as Fee-for-Service (FFS) reasonable and customary charges. ***The T1040 is not to be billed by the CMHC for any claims including, spenddown claims.***

Currently, CCBHCs are allowed to submit a claim under their CMHC NPI to apply a charge to an unmet spenddown and subsequently NOT bill the customer for the amount that is in the unmet threshold. This allows the correct billed amount to be applied toward the spenddown and moves the client closer to the Medicaid Enhancement Tax (MET) status to become Medicaid eligible. For more information see the *General Benefits Fee-for-Service Provider Manual* found on the KMAP website under Provider Manuals.

7010. SPECIFIC BILLING INSTRUCTIONS Updated 03/24

MediKan
MediKan claims are excluded from the CCBH PPS reimbursement. CCBHCs should not submit MediKan claims under their CCBHC NPI.

Copayment
For CCBHC services a Copayment will not apply. Refer to **Section 8400** of this manual for specific services.

8100. PROVIDER TYPES Updated 05/23

Allowed Providers for CCBHC Services:

Advanced Practice Registered Nurse (APRN)
An Individual licensed by the State of Kansas to provide services within their scope of practices and is employed by a participating CCBHC.

Community Psychiatric Support Treatment (CPST) Specialist
An individual certified in the State of Kansas to provide Psychiatric Support Treatment services meeting the following criteria:

- BA/BS degree or four years of equivalent education and/or experience working in the human services field
- Complete and maintain certifications for the service provided as required by the State of Kansas and the Federal government, which includes criminal, abuse/neglect registry, and professional background checks
- Completion of any required training approved by KDADS

Peer Support Specialist/Peer Mentors/Parent Peer Specialist
An individual certified in the State of Kansas to provide Peer Support services meeting the following criteria:

- Be at least 18 years of age and at least 3 years older than a client under 18 years of age
- Have a high school diploma or equivalent
- Complete and maintain certifications for the service provided as required by the State of Kansas and the Federal government, which includes criminal, abuse/neglect registry, and professional background checks
- Complete any required training approved by KDADS
- Self-identify to have had life experience with a diagnosed mental health or addiction disorder, be in sustained and continued recovery for a minimum of one year, and continued recovery while acting as a Certified Peer Support Specialist
- Parent/Family Peer Support provider must self-identify with life experience in the behavioral health area in which they work

Psychosocial Rehabilitation Specialist (PSR)
An individual certified in the State of Kansas to provide Psychosocial Rehabilitation services meeting the following criteria:

- Be at least 18 years of age and at least 3 years older than a client under 18 years of age
- Have a high school diploma or equivalent
- Complete and maintain certifications for the service provided as required by the State of Kansas and the Federal government, which includes criminal, abuse/neglect registry, and professional background checks
- Complete any required training approved by KDADS

Community Support Specialist
An individual certified in the State of Kansas to provide Community Support services meeting the following criteria:

- Be at least 18 years of age and at least 3 years older than a client under 18 years of age
- Have a high school diploma or equivalent

Community Support Specialist continued

- Complete and maintain certifications for the service provided as required by the State of Kansas and the Federal government, which includes criminal, abuse/neglect registry, and professional background checks
- Complete any required training approved by KDADS

Licensed Addiction Counselor (LAC)

An individual licensed in the State of Kansas to engage in the practice of addiction counseling limited to substance use disorders.

- Be at least 18 years of age and at least 3 years older than a client under 18 years of age
- Have a bachelor's degree or equivalent
- Complete and Maintain certifications for the service provided as required by the State of Kansas and the Federal government, which includes criminal, abuse/neglect registry, and professional background checks
- Complete any required training approved by KDADS

Licensed Mental Health Professional (LMHP)*

An individual who is licensed in the State of Kansas to diagnose and treat mental illness or substance abuse acting within the scope of all applicable state laws and their professional license.

- LMHP providers licensed to practice independently:
  - Licensed psychologist
  - Licensed clinical marriage and family therapist
  - Licensed clinical professional counselor
  - Licensed specialist clinical social worker
  - Licensed clinical psychotherapist

- LMHP providers licensed to practice under supervision or direction:
  - Licensed Masters level marriage and family therapist
  - Licensed Masters level professional counselor
  - Licensed Masters level social worker
  - Licensed Masters level psychologist

*Complete any required training approved by KDADS program

***** These license types can practice addiction counseling if they can provide proof of addiction specific training. This training can be completed through their transcript, Continuing Education Units (CEUs) or on the job training. The BSRB does not have a requirement for number of hours or duration of training. Additionally, these individuals cannot be named "Addiction Counselor" within their job titles.

***Note*:** Additional SUD provider requirements can be referenced in the *Substance Use Disorder Fee-for-Service Provider Manual* found on the KMAP website under Provider Manuals.

Non-Licensed CCBHC Personnel

An individual employed by the CCBHC in the State of Kansas who meets the following criteria:

- Be at least 18 years of age and at least 3 years older than a client under 18 years of age
- Have a high school diploma or equivalent

8100. PROVIDER TYPES Updated 05/23

Non-Licensed CCBHC Personnel continued

- Approved by the State of Kansas to provide the service, having passed any criminal, abuse/neglect registry and professional background checks
- Complete any required training approved by KDADS program

Physician
An individual licensed by the State of Kansas to provide services within their scope of practice.

Physician's Assistant (PA)
An individual licensed by the State of Kansas to provide services within their scope of practice.

Qualified Mental Health Professional (QMHP)
A physician or psychologist who is employed by a participating mental health center or who is providing services as a physician or psychologist under a contract with a participating mental health center, a licensed Master's level psychologist, a Licensed Clinical Psychotherapist, a Licensed Marriage and Family Therapist, a Licensed Clinical Marriage and Family Therapist, a Licensed Professional Counselor, a Licensed Clinical Professional Counselor, a Licensed Specialist Social Worker or a Licensed Master Social worker or an Advanced Practice Registered Nurse (APRN)/Registered Nurse (RN) who has a specialty in psychiatric nursing, who is employed by a participating mental health center and who is acting under the direction of a physician or psychologist who is employed by, or under contract with, a participating mental health center.

Registered Nurse (RN)
An Individual licensed by the State of Kansas to provide services within their scope of practice.

***Note*: When applicable to the service being provided in accordance with the code criteria:**

- Service-specific provider qualifications are noted with the associated service.
- Supervision must be provided by a person eligible to provide Medicaid services and licensed at the clinical level or by a licensed physician. All services must be rendered within the scope of the provider's professional license.

Some Behavioral Health services can only be provided by a CCBHC. Refer to **Section 8410** of this manual for these specific services.

Training approved by the KDADS for non-licensed mental health service providers can be found on the KDADS website here.

8200. MEDICAL ASSESSMENT

DOCUMENTATION
Documentation is not required to be in a standard format. The individual's record must include the following components:

A. **Referral**
   a. Source of referral
   b. Reason for referral

B. **Pertinent Past and Present History**

C. **Treatment Plan**
   a. Psychological tests, procedures, and techniques to be used
   b. Reviewed and updated appropriately

D. **Evaluation**
   a. Interpretation of all completed/attempted psychological tests, procedures, and techniques used with conclusions reached
   b. Recommendations related to meaningful aspects of the individual's everyday existence

Note: It is recommended that if an underlying cause of the maladaptive behavior is suspected of being physical in origin, a medical evaluation should precede a psychological evaluation. Results of the medical evaluation must also be documented in the record.

Note: Per the Centers for Medicare & Medicaid Services (CMS) and Kansas Medicaid, any claim submitted for reimbursement is subject to the applicable national coding guidelines. Payment received for claims not adhering to those standards is subject to recoupment upon review.

Note: Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's medical record.

8300. BENEFIT PLAN Updated 03/24

KMAP service participants are assigned to one or more KMAP benefit plans. These benefit plans entitle the individual to certain services. If there are questions about service coverage for a given benefit plan, refer to **Section 2000** of the *General Benefits Fee-for-Service Provider Manual* on the KMAP website under Provider Manuals for information on eligibility verification.

- If the individual is assigned to an MCO:
  - All mental health services are the responsibility of the appropriate MCO. For more information, contact the specific health plan for managed care assistance.
  - To prevent potential billing and reimbursement errors, services provided when an individual is assigned to an MCO must be billed on a separate CMS-1500 Claim Form than services provided when an individual is not assigned to an MCO.
  - MediKan services are not payable under CCBHC PPS reimbursement.

Telemedicine

Telemedicine is the use of communication equipment to link health care practitioners and individuals in different locations.

Refer to **Section 2720** of the *General Benefits Fee-for-Service Provider Manual* for additional details regarding Telemedicine.

8400. MEDICAID Updated 05/23

EVALUATION AND MANAGEMENT
These codes are used for encounters with health care professionals to evaluate and manage health conditions. National coding guidelines specify the criteria for the appropriate billing code to be utilized. This service requires a professional level provider type.

- **99211**- services may be provided by an RN and billed under the CCBHC provider with the Provider Type (PT) 11 and Provider Specialty (PS) 121. For the CCBHC, the TD modifier is not required.

SERVICE CODES

99211	99212	99213	99214	99215

EVALUATION AND MANAGEMENT TELEPHONE SERVICES
Telephone evaluation and management service provided by a qualified healthcare professional to an established patient, parent, or guardian. National coding guidelines specify the criteria for appropriately billing these three codes.

SERVICE CODES

99441	99442	99443

INDIVIDUAL AND GROUP PSYCHOTHERAPY
Individual and group psychotherapy are covered when a treatment plan contains a psychiatric diagnosis and treatment goals. Psychotherapy is not covered for individuals whose only diagnosis is for intellectual or developmental disabilities. Therapy provided by a non-licensed person is also not covered.

These mental health services are covered when provided by a Kansas LMHP as defined previously in **Section 8300.** This service requires the provider to document, in legible writing, the amount of time spent in therapy, major issues covered, and changes in medication, diagnosis, condition, treatment plan, or treatment course. The provider must document a review of the treatment plan every three months.

Note: Reimbursement will not be allowed for LMHPs to supervise a non-licensed person who is doing therapy.

FAMILY THERAPY
Family therapy involves treatment of the family as a "system" with the family being the focus of attention and change, specifically including children (may refer to adult children). Therefore, the service shall be billed as a family unit and not by the number of individuals involved in the treatment. The individual who is the primary KMAP recipient of services must be present at the time of the delivery of service.

Family therapy is covered when a treatment plan contains a psychiatric diagnosis and treatment goals. This requires the provider to document, in legible writing, the amount of time spent in therapy, major issues covered, and changes in medication, diagnosis, condition, treatment plan, or treatment course. The provider must document a review of the treatment plan every three months.

FAMILY THERAPY WITHOUT PATIENT PRESENT
Service provided by a licensed clinical practitioner. Treatment sessions must address the problems of and be distinct for the individual. A licensed clinical practitioner will determine that family psychotherapy is

FAMILY THERAPY WITHOUT PATIENT PRESENT continued
necessary to be included in the patient's treatment plan. This service is covered when based on clinical judgement, the member is not present at the time the service is delivered, but the identified member remains the focus of the service. Family therapy services involving the participation of a non-Medicaid eligible individual(s) must be documented in the medical record as having a direct benefit for the member. This documentation must demonstrate that the service is designed to address the identified member's individual needs on the treatment plan and outlining the expected interventions and improvements in behavioral health. When the member is an adult, his/her permission must be obtained in writing.

HOME-BASED FAMILY THERAPY (HBFT)
A theoretical approach of counseling where the family system is the focus of treatment. Therapy is delivered in the family's home rather than in the therapist's office and is provided to a child with Serious Emotional Disturbance (SED) and the child's family by professionals who meet specific requirements.

The service must be billed by the provider using modifier HK. Reference the Home-Based Family Therapy policy on the KDADS website for more information on the requirements for providing these services, guidelines for documentation, and process for billing.

SERVICE CODES

Individual	Group	Family
90785*	90853	90846
90832		90847
90834		90847 HK
90837		
90839		
90840*		

***Must be billed with a primary code**

PSYCHIATRIC EVALUATION
Assessment of the individual's psychosocial history, current mental status, and other physical examination elements and the ordering of diagnostic studies followed by treatment recommendations. Depending on the service delivered and code billed, additional medical services may be provided (such as prescribing medication).

Limitations

- H0032HA can be billed on the same day as 90791 or 90792.
- H0031 Specific to ages 0-8.

Note: Codes 90791 and 90792 can only be billed once per day, and both codes cannot be billed on the same day.

SERVICE CODES

90791	90792

GPRA ASSESSMENT

Government Performance Results and Modernization Act (GPRA) of 2010 - The National Outcome Measures (NOMS) Tool and/or Center for Substance Abuse Treatment (CSAT) Tool is administered, and data collected at baseline.

1. NOMS Tool - NOMS data includes an assessment of a client's demographic data, health status, employment, education, housing, previous mental health history, etc.

2. CSAT Tool - CSAT data includes substance use, criminal activity, mental and physical health, family and living conditions, education/ employment status and social connectedness.

GPRA Measurement Tools: https://www.samhsa.gov/grants/gpra-measurement-tools/cmhs-gpra

Components

Service to be provided by qualified healthcare professional within their scope of practice. The NOMS and CSAT evaluation tools will be evidence of service provision.

Limitations/Exclusions

May be billed only for individuals who are new to the CCBHC and have not been seen previously at the CMHC/CCBHC with in the last three (3) years. The GPRA should be billed within the boundaries of guidelines established for the CPT code.

SERVICE CODES

99202

TOBACCO CESSATION

Tobacco cessation counseling can be provided to any Medicaid member who is a current tobacco user. Tobacco Cessation counseling services will be provided by the following Kansas Medicaid enrolled licensed providers within their scope of practice under state law:

- Physicians
- Physician Assistants
- Licensed Advanced Practice Registered Nurses
- Psychiatrists
- Psychologists
- Licensed Clinical Social Workers
- Licensed Professional Counselors

*Tobacco Treatment Specialist (TTS) certified staff may provide 99406 & 99407 at the CCHBCs only

For service codes and criteria please reference the *Professional Fee-for-Service Provider Manual* on the Provider Manuals page on the KMAP website.

SERVICE CODES

Individual	Group
99406	S9453
99407	

***Note**:* TTS certified staff may provide 99406 & 99407 at the CCHBCs only

8400. MEDICAID Updated 05/23

PSYCHOLOGICAL TESTING/ASSESSMENT
Psychological testing/assessment is defined as the use, in any manner, of established psychological tests, procedures, and techniques with the intent of diagnosing adjustment, functional, mental, vocational, or emotional problems, or establishing treatment methods for individuals having such problems.

Note: For additional/specific criteria and coding, reference the *Mental Health Fee-for-Service Provider Manual* on the Provider Manuals page on the KMAP website.

SERVICE CODES

96130*	96131	96136
96137*	96138	96139*

***Must be billed with a primary code**
***Note*:** These Psychological Testing codes are NOT CCBHC trigger codes.

SCREENING, BRIEF INTERVENTION, AND REFERRAL FOR TREATMENT (SBIRT)
Screening, Brief Intervention and Referral for Treatment (SBIRT) is an evidence-based approach for identifying patients who use alcohol and other drugs at increased levels of risk, with the goal of reducing and preventing related health consequences, diseases, accidents and injuries. Practitioners must follow these requirements set by KDADS for screening patients to bill for SBIRT services provided to Medicaid-eligible patients.

SERVICE CODES

99408	99409

All centers must follow all requirements set by KDADS laid out in the *Substance Use Disorder Provider Manual* on the Provider Manuals page on the KMAP website.

SERVICES PROVIDED TO AN INDIVIDUAL IN AN INPATIENT OR RESIDENTIAL SETTING
Services provided to a resident of an intermediate care facility for individuals with an intellectual disability (ICF/IID) or an individual receiving treatment in an Institution for Mental Diseases (IMD), including a Psychiatric Residential Treatment Facility (PRTF), are considered content of the institutional or residential stay and should not be billed to KMAP.

Non-IMD inpatient hospital visits are limited to those ordered by the individual's physician. Daily individual or group psychotherapy is required for inpatient hospital stays for psychiatric illness; however, group psychotherapy is not covered. Inpatient group psychotherapy is content of service of the DRG reimbursement to the hospital.

COMMUNITY BASED SERVICES TEAM (CBST) MEETING
CBST meetings provide a forum where an individual, family caregivers, providers, and engaged community representatives can meet to review current services, identify, and address barriers to treatment and make recommendations for additional services to meet the treatment needs of the youth. The CBST meeting is normally part of the requested evaluations for any youth being considered or evaluated for PRTF admission.

COMMUNITY BASED SERVICES TEAM (CBST) MEETING continued

A request for a higher level of care at a PRTF must be evaluated as a medical necessity. This request will use both the CBST meeting, as well as the Psychiatric Diagnostic Evaluation codes. The Psychiatric Diagnostic Evaluation will be conducted face-to-face with the child/youth using the approved methods.

Limitations

- H0032HA can be billed on the same day as 90791 or 90792.
- H0031 Specific to ages 0-8.

Note: Codes 90791 and 90792 can only be billed once per day, and both codes cannot be billed on the same day.

SERVICE CODES

H0031	H0032	H0032 HA

PSYCHIATRIC DIAGNOSTIC EVALUATION CODES:

90791	90792

ANNUAL SCREEN FOR CONTINUED STAY FOR INDIVIDUALS RESIDING IN A NURSING FACILITY FOR MENTAL HEALTH (NF/MH)

The annual screen for continued stay for individuals residing in an NF/MH is completed to determine the individual's continued need for this level of care. The annual screen is a scheduled face-to-face interview with the individual by a trained CCBHC screener and a screening facilitator who are registered with KDADS Behavioral Health Services (BHS) Commission.

Additional information should be gathered from other sources including the guardian/family member, treatment staff, and other informants. A review of the facility chart should be made, and pertinent information included on the screening tool.

SERVICE CODE

T2011

TARGETED CASE MANAGEMENT (TCM)

TCM is to assist adults and children who qualify for this service in maintaining access to needed medical, social, educational, and other services.

Note: **TCM is not payable to CCBHCs for Title XXI recipients**

Note*:* TCM services should not be billed by CCBHCs for individuals also assigned as OneCare Kansas members.

Note: For specific service criteria reference the *Targeted Case Management – Mental Health Fee-for-Service Provider Manual* on the Provider Manuals page on the KMAP website.

SERVICE CODES

T1017

8400. MEDICAID Updated 05/23

SPECIALIZED COMMUNITY-BASED PSYCHIATRIC REHABILITATION SERVICES

Community-Based Psychiatric Rehabilitation Services provided by CCBHCs. These services are part of a comprehensive specialized psychiatric program available to all KMAP service recipients with significant functional impairments resulting from an identified mental health diagnosis or substance abuse diagnosis.

- The medical necessity for these rehabilitative services must be determined by an LMHP or physician who is acting within the scope of his or her professional license and applicable state law.
- The services must be furnished by or under the direction of a physician to promote the maximum reduction of symptoms or restoration of an individual to his or her best possible functional level.
- Services must be medically necessary, must be recommended by an LMHP or physician according to an individualized treatment plan, and must be furnished under the direction of a physician. The activities included in the service must be intended to achieve identified treatment plan goals or objectives.
- Unless otherwise stated, services that require ongoing and regular clinical supervision by a person meeting the qualifications of a QMHP or LMHP, such consultation support, shall be available.
- Services provided at a work site must not be job-task oriented. Services provided in an educational setting must not be educational in purpose. Any services or components of services of which the basic nature is to supplant housekeeping, homemaking, or basic services for the convenience of a person receiving covered services (including housekeeping, shopping, childcare, and laundry services) are noncovered. This service may not be provided in an IMD.

  Note: For additional/specific instructions, reference the *Mental Health Fee-for-Service Provider Manual* on the Provider Manuals page on the KMAP website.

1. **COMMUNITY PSYCHIATRIC SUPPORT AND TREATMENT (CPST)**

   CPST is goal-directed supports and solution-focused interventions intended to improve functioning and restore capabilities to help the individual achieve the identified goals or objectives as set forth in his or her individualized treatment plan. CPST is a face-to-face intervention with the individual present; however, family, or other collaterals may also be involved. The majority of CPST contacts must occur in community locations where the person lives, works, attends school, and/or socializes.

   Note: For additional/specific criteria and coding, reference the *Mental Health Fee-for-Service Provider Manual* on the Provider Manuals page on the KMAP website.

   SERVICE CODES

H0036 HA CPST Child	H0036 HB CPST Adult	H0036 HH Dual Diagnosis
H0036 HJ Supported Employment	H0036 HK Strengths Based	

2. **PSYCHOSOCIAL REHABILITATION (PSR)**

   PSR services are designed to assist the individual with compensating for or eliminating functional deficits, promoting stability/ongoing stability in their daily lives, and interpersonal and/or environmental barriers associated with their mental illness. Activities must be intended to achieve the identified goals or objectives as set forth in the individual's treatment plan.

   The intent of PSR is to restore the fullest possible integration of the individual as an active and productive member of his or her family, community, and/or culture with the least amount of ongoing professional intervention. PSR is a face-to-face intervention with the individual present.

SPECIALIZED COMMUNITY-BASED PSYCHIATRIC REHABILITATION SERVICES continued

Services may be provided individually or in a group setting. The majority of PSR contacts must occur in community locations where the person spends time, lives, works, attends school, and/or socializes.

Note: For additional/specific criteria and coding, reference the *Mental Health Fee-for-Service Provider Manual* on the Provider Manuals page on the KMAP website.

SERVICE CODES

Child Group (21 years or under)	Adult Group (16 years or over)
H2017 TJ	H2017 HQ

3. **PEER SUPPORT (PS)**

PS services are individual-centered services with a rehabilitation and recovery focus. These services are designed to promote skills to cope with, build recovery capacity and manage addictions, substance abuse and/or psychiatric symptoms while facilitating the use of natural resources and the enhancement of community living skills. Activities included must be intended to achieve the identified goals or objectives as set forth in the recipient's individualized treatment plan. The structured, scheduled activities provided by this service emphasize assisting in reduction of barriers to fully engaging in recovery, the opportunity for individuals to support each other in the restoration and expansion of the skills and strategies necessary to move forward in recovery. PS is a face-to-face intervention with the service recipient present. Services may be provided individually or in a group setting. Most PS contacts must occur in community locations where the individual lives, works, attends school, and/or socializes.

Note: For additional/specific criteria and coding, including Parent Peer Support, reference the *Mental Health Fee-for-Service Provider Manual* on the Provider Manuals page on the KMAP website.

SERVICE CODES

Individual	Group
H0038	H0038 HQ

4. **OPERATION COMMUNITY INTEGRATION (OIC) – SUPPORTED HOUSING**

Intensive Community Residential Placement (ICRP) H0037 HK

Designed to assist high risk behavioral health consumers with intensive support services necessary to improve independent living skills and reduce symptoms that will interfere with a consumer's ability to sustain safe and stable permanent community housing.

Intensive Community Integration (ICI) Support Services H0037

The ICI Medicaid billing support code is targeted towards consumers who are unable to tolerate congregate living arrangements in which the presence of other consumers in their immediate living area tends to precipitate psychiatric and substance abuse relapse, aggression, or other behaviors associated with risk of re-hospitalization or incarceration. Administered in individual apartment settings (one person per apartment) in either a clustered location or the consumers current

independent living/apartment setting (this will include emergency shelters and crisis diversion units) that are in the community.

Note: For additional/specific criteria and coding, reference the *Mental Health Fee-for-Service Provider Manual* on the Provider Manuals page on the KMAP website.

SERVICE CODE

H0037	H0037 HK

5. **INDIVIDUAL PLACEMENT & SUPPORT (IPS) – SUPPORTED EMPLOYMENT**

Supported Employment helps people with mental health and SUDs find and keep meaningful jobs in the community of their choosing. The State's preferred model is IPS. KDADS will provide training, technical assistance and fidelity reviews to support CCBHCs that are engaged in IPS. IPS-Y is a youth model for IPS and is supported as a subset of the IPS & Supported Employment model.

Component services can include intensive support services such as: learning appropriate work habits, identifying behaviors that interfere with work performance, personal hygiene, time management, capacity to follow directions, managing symptoms/cravings, planning transportation. All support services and interventions must be medically necessary and driven by consumer choice.

***Note*:** Any services associated with providing IPS services are included in the daily per-diem code and **should not be billed** in addition to the IPS per-diem code.

***Note*:** Any services provided by the IPS staff need to be documented in patient records as support for billing the IPS per-diem code.

SERVICE CODE:

H2024

6. **CRISIS INTERVENTION (CI)**

CI services are provided to an individual who is experiencing a psychiatric crisis. CI is designed to interrupt and/or ameliorate a crisis experience, including a preliminary assessment; immediate crisis resolution and de-escalation; and referral and linkage to appropriate community services to avoid more restrictive levels of treatment. The goals of CI are symptom reduction, stabilization, and restoration to a previous level of functioning. All activities must occur within the context of a potential or actual psychiatric crisis. CI is a face-to-face intervention and may occur in a variety of locations, including an emergency room or clinic setting in addition to other community locations where the individual lives, works, attends school, and/or socializes.

Note: For additional/specific criteria and coding, reference the *Mental Health Fee-for-Service Provider Manual* on the Provider Manuals page on the KMAP website.

SERVICE CODES

Basic	Intermediate	Advanced	Mobile Crisis Response
H2011	H2011 HK	H2011 HO	H2011 U1

7. MOBILE CRISIS INTERVENTION

Mobile Crisis Intervention (MCI) services are available for individuals across the life span to access trained professionals who help de-escalate behavioral health crises via a crisis helpline accessible to all individuals in Kansas. "Crisis" is to be self-determined by the caller. If a self-determined crisis by a caller cannot be resolved or de-escalated during the call or the request is made for a face-to-face response, MCI services can be dispatched to participating CMHCs/CCBHCs. MCIs can also be deployed if the situation is likely to turn into a behavioral health crisis if supportive services are not provided.

Note: For additional/specific criteria and coding, reference the *Mental Health Fee-for-Service Provider Manual* on the on the Provider Manuals page on the KMAP website.

SERVICE CODES

H2011 U1

CHRONIC CARE MANAGEMENT

Chronic Care Management (CCM) refers to the continuity of treatment received for patients with numerous chronic conditions outside of the daily office visit. **National coding guidelines specify** the criteria for the appropriate billing code to be utilized. Service Requirements Services should be directed by a physician or other qualified health care professionals and within their scope of practice.

Limitations/Exclusions

- A practitioner must obtain consent before furnishing or billing CCM.
- Only one practitioner can furnish and be paid for these services during a calendar month.
- Consumer has the right to stop the CCM services at any time (effective at the end of the calendar month).

Provider Qualifications

Physician, PA, APRN

SERVICE CODES

99490	99439*

Note: 99439 is an add-on only code and **NOT** a trigger code.

MATERNAL DEPRESSION SCREENING

For service codes and criteria please reference the *Professional Manual Fee-for-Service Manual* on the Provider Manuals page on the KMAP website.

SERVICE CODES

96161

8400. MEDICAID Updated 03/24

MEDICAL TEAM CONFERENCES

Medical Team Conferences are a process in which a physician or another qualified health care professional is responsible for direct care of an individual and, additionally, for coordinating, managing access to, initiating, and/or supervising other health care services needed by the patient. Medical team conferences include face-to-face participation by a minimum of three qualified health care professionals from different specialties or disciplines (each of whom provide direct care to the individual outside of the team conference), with or without the presence of the individual, family member(s), community agencies, legal guardian(s), and/or caregiver(s). The participating professionals must be actively involved in the development, revision, coordination, and implementation of services needed by the individual.

Limitations/Exclusions

- Participating professionals must have performed face-to-face evaluations or treatments with the individual within 60 days prior to the medical team conference.
- No more than one individual from the same specialty may bill 99366 - 99368 for the same encounter.
- 99366 - 99368 cannot be billed when the participating professional is part of a facility or organizational service contractually obligated to provide the service.
- This code should be billed only within the boundaries and guidelines established for the CPT Code.

Provider Qualifications

Physician, PA, QMHP, LMHP, RN, LAC

SERVICE CODES

99366	99367	99368

GAMBLING/ALCOHOL/DRUG ASSESSMENT

Involves face-to-face interview with the individual. The assessment should be complete before treatment is initiated, to determine need and appropriate level of treatment. Includes a Biopsychosocial clinical assessment containing DSM-5 diagnostic criteria and a recommendation regarding the need for treatment, level of risk of harm to self or others and any necessary referrals to be provided.

Provider Qualifications

LAC

Limitations/Exclusions

- This code should be billed only within the boundaries and guidelines established for the CPT Code.

SERVICE CODE

H0001

8400. MEDICAID Updated 05/23

ADDICTIONS/SUD-INDIVIDUAL/GROUP THERAPY

Individual/Group Therapy refers to the therapeutic interaction between a patient or patients and a counselor intended to improve, eliminate, or manage one or more of a patient's Substance Use/Opioid use behavior. Help to establish treatment goals and plans for achieving those goals and provide interventions to assist persons in accordance with the plan. Outpatient services may be appropriate at the start of treatment, throughout treatment, or after an episode of residential or inpatient treatment, depending on the person's acuity, severity, comorbidity, needs, or preferences.

Eligibility Criteria

- All Medicaid eligible individuals who meet medical necessity criteria.
- Individuals with less severe disorders.
- Individuals who are in the early stage, ongoing, partial or full remission needing continuing help to maintain progress.

Limitations/Exclusions

- All services must be rendered within the scope of the provider's professional license.
- If the primary diagnosis is SUD, the CCBHC must be a licensed SUD provider.

LEVEL I: OUTPATIENT

Outpatient is nonresidential treatment consisting of group, individual, and/or family counseling.

- Individual who is age 18 years or older, minimum of 8 hours or less of scheduled counseling services per week.
- Individual under age 18 years, 5 hours or less of scheduled counseling service per week.

LEVEL II: INTENSIVE OUTPATIENT TREATMENT

Intensive Outpatient is nonresidential treatment consisting of group, individual, and/or family counseling.

- Individual who is age 18 years or older, minimum of 9 hours or less of scheduled counseling services in a 7-day period.
- Individual who is 17 years of age or younger, 6 hours or less of scheduled counseling service per 7-day period.

Provider Qualifications

LAC, *LMHP

*These license types can practice addiction counseling if they can provide proof of addiction specific training. This training can be completed through their transcript, CEU's or on the job training. The BSRB does not have a requirement for number of hours or duration of training. Additionally, these individuals cannot be named "Addiction Counselor's" within their job titles.

SERVICE CODES

H0004	H0005	H0005 U5

SUBSTANCE USE DISORDER (SUD) CASE MANAGEMENT

SUD Case Management Services assist individuals to become more self-sufficient through an array of services which assess, plan, implement, coordinate, monitor and evaluate the options and services to meet an individual's needs, using communication and available resources to promote quality, cost effective outcomes. A one-on-one goal-directed service for individuals with an SUD through which the

SUBSTANCE USE DISORDER (SUD) CASE MANAGEMENT continued
individual is assisted in obtaining access to needed family, legal, medical, employment, educational, psychiatric, and other services.

Eligibility Criteria
- All Medicaid eligible individuals who meet medical necessity criteria.
- As a service indicated in the individualized treatment plan.

Limitations/Exclusions
- For individuals served by an MCO, this service must be a part of the treatment plan developed and determined medically necessary by the MCO.
- The case manager providing the service must complete the certification requirements to become a Person-Centered Case Manager. Certification requirements can be found on the KDADS website.
- Case management services are provided in Outpatient levels of care.
- Case load size as determined by center policy, based on the type of services provided by the agency.

Provider Qualifications
LAC

SERVICE CODE

H0006 U5

SUD RELAPSE & PREVENTION
Behavioral health prevention dissemination service (one-way direct or non-direct contact with service audiences to affect knowledge and attitude) targeting specific, at-risk individuals in a given population who are in need of assistance with substance use issues. This may include mobile teams that contact at-risk individuals in the home, centers in which individuals can drop-in and obtain information regarding substance use treatment or social services, or other various methods of contact.

Limitations/Exclusions
A licensee shall be licensed or certified by KDADS in one or more of the following modalities:
1. Early Intervention/Interim treatment
2. Outpatient treatment
3. Intensive outpatient treatment
4. Intermediate treatment
5. Therapeutic community treatment
6. Reintegration treatment
7. Social detoxification
8. Opioid maintenance outpatient treatment
9. Alcohol and Drug Safety Action Program (ADSAP)
10. Alcohol and drug assessment and referral

*All licensees of the above-mentioned modalities 1 through 9 must be additionally licensed or certified in the modality of alcohol and drug assessment and referral.

SUD RELAPSE & PREVENTION continued

Provider Qualifications
LAC, LMHP, Non-licensed CCBHC Personnel

SERVICE CODE

H0024

AMBULATORY DETOX
Medication, in combination with counseling and care coordination services, provide effective support for recovery from addictive substances. Medications may be provided in the short-term as Ambulatory Detox. American Society of Addiction Medicine (ASAM) criteria Levels 1-WM through 3.7-WM apply to CCBHCs. Centers are required to evaluate patient need as it relates to ASAM criteria.

Provider Qualifications
LAC

SERVICE CODE

H0014

MEDICATION ASSISTED TREATMENT
Medication-Assisted Treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of SUD. Research shows that a combination of medication and therapy can successfully treat these disorders, and for some people struggling with addiction, MAT can help sustain recovery. MAT allows individuals to physically tolerate their withdrawal and ongoing symptoms while engaging in treatment and care coordination services as they build long term support to increase their chances of success.

All centers must follow all MAT requirements set by KDADS laid out in the *Substance Use Disorder Fee-for-Service Provider Manual* on the Provider Manuals page on the KMAP website.

1. **MAT – Facilitation**
   MAT patients receiving treatment in Office Based Opioid Treatment (OBOT) must receive counseling, which may include different forms of behavioral therapy. These services are required along with medical, vocational, educational, and other assessment and treatment services to assist a person in abstaining. Outpatient services may be appropriate at the start of treatment, throughout treatment, or after an episode of residential or inpatient treatment, depending on the person's acuity, severity, comorbidity, needs, or preferences.

   SERVICE CODE

H0022

2. **MAT – Injection**
   For MAT injectable drugs administered by a practitioner, the allowed frequency of administration is based upon the FDA approved dosing intervals and Medicare billing.

MEDICATION ASSISTED TREATMENT continued

Limitations/Exclusions:
Injectable drugs limited to Buprenorphine and Naltrexone. Reference the *Substance Use Disorder Fee-for-Service Provider Manual* on the Provider Manuals page on the KMAP website.

SERVICE CODE

96372 U8

URINE DRUG SCREENING
Urine Drug Screening services may be used in the CCBHC to monitor compliance of maintenance, abuse, or other drug dependence by individuals receiving SUD services that may require a level of monitoring.

Limitations/Exclusions

- Each code is only reported once per date of service regardless of the number of drugs tested
- Current rules for Other Health Insurance apply
- CLIA Waiver Certification is required for 80305 QW
- A Certificate of Registration, Compliance or Accreditation is required to bill 80306 and 80307

SERVICE CODES

80305 QW	80306	80307

ADDICTIONS CRISIS INTERVENTION
Services can be provided to individuals being served in outpatient and intensive outpatient services in their clinic. Timely response is essential in providing crisis intervention services. Services must be client accessible on a 24/7 basis.

Services will follow the established principles of crisis management:

- Providing reassurance and support
- Evaluating the nature of the problem and determining the patient's mental, psychiatric, suicidal or homicidal, and medical statuses
- Ensuring the safety of the patient and others
- Assisting the patient in developing an action plan that minimizes distress, and obtaining patient commitment to the plan; and
- Following up with the patient and other relevant persons to ensure follow-through, assess progress, and provide additional assistance and support. Medication or referral for psychiatric or psychological counseling and/or hospitalization may be necessary for patients with continuing or severe problems. (American Family Physician 2006;74:1159-64, 1165-66. Copyright © 2006 American Academy of Family Physicians).

Eligibility Criteria
All individuals with established or self-defined SUD diagnosis experiencing a serious addiction/psychological/emotional change that results in a marked increase in personal distress and

ADDICTIONS CRISIS INTERVENTION continued

exceeds the abilities and resources of those involved to effectively resolve it are eligible for CI services.

Provider Qualifications
LAC, LMHP, Peer Support provider

SERVICE CODE

H0007

ASSERTIVE COMMUNITY TREATMENT PROGRAM

An evidence-based practice to improve outcomes in individuals with diagnosed severe mental illness or co-occurring SMI/SUD. Provided pursuant to an individual treatment plan incorporating a flexible array of community behavioral health services provided by a team of providers, based on assertive outreach and designed to promote recovery for individuals with the most challenging and persistent problems.

Eligibility Criteria

- Eligibility is based on diagnostic, functional and other relevant assessment as documented in the case record. ACT-F/ACT teams must ensure the coordination and provision of all services necessary to meet an individual's needs as identified in the individual's treatment plan.
- ACT Services must be available 24 hours a day, 7 days a week.
- ACT Youth serves individuals aged 8 to 24 years old; ACT Adult is for individuals 18 years old and above.
- All ACT-F/ACT services which result in billing must be documented in the individuals case record.

Limitations/Exclusions

- The procedure may only be billed once per day per individual; if an individual receives multiple direct contacts in a day from non-medical team members, the procedure is only billed once.
- The CCBHC has and uses measurable and operationally defined criteria to screen out inappropriate referrals.
- Individuals' functional impairment is solely a result of a SUD, autism spectrum disorder, developmental disability, personality disorder or traumatic brain injury without a co-occurring psychiatric disorder.

***Note*:** Any services associated with providing ACT services are included in the daily per-diem code and **should not be billed** in addition to the ACT per-diem code.

***Note*:** Any services provided by the ACT Team need to be documented in patient records as support for billing the ACT per-diem code

Provider Qualifications
Physician, PA, APRN, RN, LMHP, LAC, and non-licensed CCBHC Personnel

ASSERTIVE COMMUNITY TREATMENT PROGRAM continued

SERVICE CODE
H0040

NON-EMERGENCY MEDICAL TRANSPORTATION

Non-Emergency Medical Transportation (NEMT) is provided for people receiving services to the extent possible with relevant funding or programs to facilitate access to services in alignment with the person-centered and family-centered treatment plan.

Note: Transportation provided must meet the CMS requirements for individual client transportation services

SERVICE CODE
A0425

8410. DEFINITIVE CRITERIA Updated 05/23

Providers must keep and maintain, in accordance with K.A.R. 30-5-59, medical records for Medicaid service recipients to consist of, at least, the following:

- Individual's identification number.
- Date of admission to treatment service.
- Treatment plan that has been completed within 14 days of admission to treatment services, not necessarily intake, which includes recommendations for treatment and has been reviewed and updated within the last 90 days.
  Note: This treatment plan must meet the following objectives:
  - Treatment regimen to achieve those objectives
  - Projected schedule for service delivery
  - Type of personnel required to deliver the services
  - Projected schedule for review of the individual's condition and updating of the treatment plan
- Current diagnosis that has been reviewed and updated within the last 90 days.
  Note: This update must also describe the individual's progress.
- Prognosis that has been reviewed and updated within the last 90 days.

  Note: The 90-day review is not required if the services are provided solely by a medical professional such as a physician or registered nurse for medical conditions such as medication check or other medical treatment and are documented by clinical notes.

  Note: For outpatient treatment, a chronological record includes all treatment provided to the individual, all activities performed on the individual's behalf, the type or mode of treatment, and the amount of time per session of treatment. These entries must include the signature and credentials of the person responsible for the entry and the date the service was rendered. The record must reflect the relationship of the services to the treatment plan.

  Note: If services not shown in the treatment plan or services differing from the treatment plan in scheduling frequency, duration, or designated staff are delivered to the individual, a detailed explanation of how these services relate to the treatment plan must be included in the record.

Updated 03/24

APPENDIX I: CODES

The following codes represent a list of mental health services billable to KMAP for individuals **not assigned** to an MCO.

Use the following resources to determine coverage and pricing information. For accuracy, use your provider type and specialty as well as the participant ID number or benefit plan. Information is available:

- On the public website
- On the secure website under Pricing and Limitations

Charts have been developed to assist providers in understanding how KMAP will handle specific modifiers. The Coding Modifiers Table and Ambulance Coding Modifiers Table are available on both the public and secure websites. They can be accessed from the Reference Codes link under the Interactive Tools heading on the Provider page and Pricing and Limitations on the secure portion. Information is also available on the American Medical Association (AMA) website.

Note: The AMA holds the copyright on the code descriptions.

Please refer to the *General Benefits Fee-for-Service Provider Manual* on the Provider Manuals page on the KMAP website for information regarding providing telemedicine services.

The originating site, with the member present, may bill code Q3014 with the appropriate POS code. No payment will be made for Q3014 if the originating telemedicine site is place of service "home" (POS code 12) without the physical presence of a provider.

THERAPY HCPCS CODES

Individual	Family	Group
90785	90832	90853
90832	90834	
90834	90837	
90837	90839	
90839	90840	
90840	90846	
	90847	
	90847 HK	

TOBACCO CESSATION

S9453	99406	99407

SCREENING (SBIRT)

99408	99409	

CASE CONFERENCE

99366	99367	99368

Updated 03/24

EVALUATION AND MANAGEMENT

99202	99213
99211	99214
99212	99215

EVALUATION AND MANAGEMENT-TELEPHONE

99441	99443
99442	

ADMISSION ASSESSMENT, EVALUATION, AND TESTING

Admission Evaluation (Diagnostic)	
90791	96156
90792	96160
96127	96161

PSYCHOLOGICAL TESTING/ASSESSMENT

Psychological Testing	
96130	96137*
96131*	96138
96136	96139*

* - add-on codes only

SUD/ADDICTION SERVICES

80305 QW	H0005 U5
80306	H0006 U5
80307	H0007
H0001	H0014
H0004	H0022
A0160	H0024
H0005	

CBST MEETING

H0032 HA	

MENTAL HEALTH SERVICES FOR NURSING FACILITY FOR MENTAL HEALTH RECIPIENTS OF SERVICE

H0036HB	CPST – Adult
T1017	Targeted Case Management (TCM)
T2011	Annual Screen

TARGETED CASE MANAGEMENT

T1017	

INDIVIDUAL PLACEMENT & SUPPORT (IPS) - SUPPORTED EMPLOYMENT

H2024	

Updated 03/24

Community Psychiatric Support and Treatment (CPST)	
H0036 HA	Child
H0036 HB	Adult
H0036 HH	EBP Dual Diagnosis
H0036 HJ	EBP Employment Support
H0036 HK	EBP Strength Based
Peer Support	
H0038	Individual
H0038 HQ	Group
Crisis Intervention	
H2011	Basic
H2011 HK	Intermediate
H2011 HO	Advanced
H2011 U1	Mobile Crisis Response
Psychosocial Rehabilitation	
H2017 HQ	Adult Group
H2017 TJ	Child Group

INDIVIDUAL THERAPY WITH MEDICAL EVALUATION AND MANAGEMENT, MEDICATION MANAGEMENT, AND MEDICATION ADMINISTRATION

90785	99490
90792	99439
96372 U8	H0022

TELEVIDEO-ORIGINATING SITE FACILITY FEE

Q3014	

ASSERTIVE COMMUNITY TREATMENT

H0040	

NON-TRIGGER CODES

90785	96138
96127	96139
96130	99439
96131	A0425
96136	Q3014
96137	T2011

APPENDIX II: ADDITIONAL MANUALS

Additional fee-for-service manuals commonly used for billing and treatment services.

Early Childhood Intervention Manual

General Benefits Manual

General Billing Manual

General Introduction Manual

General Special Requirements Manual

General TPL Payment Manual

HCBS Autism Manual

HCBS FE Manual

HCBS FMS Manual

HCBS IDD Manual

HCBS PD Manual

HCBS TBI Manual

HCBS Technology Assisted Waiver Manual

KAN Be Healthy - Early and Periodic Screening, Diagnostic, and Treatment Manual

Nursing/Intermediate Care Facility Manual

Psychiatric Residential Treatment Facility

Rehabilitative Therapy Services Manual

Substance Use Disorder Manual

Targeted Case Management – Mental Health

APPENDIX III: GLOSSARY OF TERMS

Clinical Supervision
Having provided services overseen and regularly evaluated by a licensed LMHP and/or QMHP either in-person or via regular review of individual case files and documentation.

Collateral contact
A source of information knowledgeable about the individual's situation. The collateral contact typically either corroborates or supports information provided by household members. Collateral contacts provide a third-party validation of the individual's circumstances and help ensure correct eligibility determinations are made.

Continuous
Any un-interrupted period of time.

Documentation
Term referencing the noting, charting, and written history of treatments, plans, individual histories, and all relevant information to diagnosis and treatment of a mental health issue.

Individual
Term referring to the person receiving services – this term is synonymous with patient, client, consumer, etc.

Notification
The process of informing through verifiable means another entity of information regarding any individual receiving any type of services.

Resolution
Term referring to the conclusion of services needed to resolve an individual's mental health concern sufficiently for the individual to not be a danger to him/herself or the general public.