



KANSAS MEDICAL ASSISTANCE PROGRAM
Fee-for-Service Provider Manual

Mental Health

PART II
MENTAL HEALTH FEE-FOR-SERVICE PROVIDER MANUAL

Introduction

Section	BILLING INSTRUCTIONS	
7000	Billing Instructions.....	7-1
7010	Specific Billing Instructions.....	7-2
	BENEFITS AND LIMITATIONS	
8100	Copayment	8-1
8200	Medical Assessment.....	8-2
8300	Benefit Plan.....	8-4
8400	Medicaid.....	8-5
8410	Services Only Billed by CMHCS.....	8-9
8420	Definitive Criteria	8-20
Appendix	Codes.....	A-1

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 traditional Medicaid fee-for-service 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.

CPT® codes, descriptors, and other data only are copyright 2022 American Medical Association (or such other date of publication of CPT). All rights reserved. Applicable FARS/DFARS apply. Information on the American Medical Association is available at <http://www.ama-assn.org>.

PART II
MENTAL HEALTH FEE-FOR-SERVICE PROVIDER MANUAL

Updated 03/18

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 **Billing Instructions** subsection gives instructions for completing and submitting the billing form mental health providers must use 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.

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

The **Appendix** subsection contains 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 consumers. 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.

BILLING INSTRUCTIONS

7000. BILLING INSTRUCTIONS Created 11/17

Introduction to the CMS 1500 Claim Form and UB-04

Mental health providers must use the CMS 1500 or UB-04 paper 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 and UB-04 along with their instructions are available on the KMAP [public](#) and [secure](#) websites on the [Forms page](#) under the **Claims (Sample Forms and Instructions)** heading.

The fiscal agent does not furnish the CMS 1500 Claim Form or UB-04 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

BILLING INSTRUCTIONS

7010. SPECIFIC BILLING INSTRUCTIONS Created 11/17

Unit Billing

The appendix provides procedure code and time definitions for billing specific procedures (for example, 15 minutes). When billing according to this definition, bill 1 unit in Field 24G.

When billing for less than the amount of time indicated in the definition (less than 1 unit), bill as follows:

- .25 represents one-quarter of the time specified.
- .50 represents one-half of the time specified.
- .75 represents three-fourths of the time specified.

When billing for more than the amount of time indicated in the definition (more than 1 unit), bill as follows:

- 1.25 represents one and one-quarter units of the time specified.
- 1.50 represents one and one-half units of the time specified.
- 1.75 represents one and three-quarters units of the time specified.
- 2.00 represents two units of the time specified, and so forth.

BENEFITS AND LIMITATIONS

8100. COPAYMENT Updated 03/18

Mental health services (including psychotherapies) require a copayment of \$3 per office visit for psychologists and community mental health centers (CMHCs). Psychology services provided by a physician or physician assistant require a copayment of \$2 per office visit.

Do **not** reduce charges or balance due by the copayment amount. This reduction is made automatically during claims processing.

See the *General TPL Payment Fee-for-Service Provider Manual* for a list of individuals who are exempt from copayments.

8200. MEDICAL ASSESSMENT Created 11/17

PROVIDERS*

Allowed providers

- **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
- **Qualified Mental Health Professional (QMHP)** – A Master’s level clinician licensed by the Kansas Behavioral Sciences Regulatory Board and employed by a community mental health center (CMHC), an individual holding a medical degree, or an advanced practice registered nurse (APRN).
- A physician, physician assistant, or an advanced practice Nurse Practitioner working under protocol of a physician
- Nonlicensed mental health service providers
Note: 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.

Training approved by the Kansas Department for Aging and Disability Services (KDADS) for non-licensed mental health service providers can be found on the KDADS website:

- [Training, Registration and Surveys](#) page
- [Medicaid Mental Health Service Provider Training](#) page

Note:* Some Mental Health services can only be provided by a CMHC. Refer to **Section 8410 of this manual for specific services.

8200. MEDICAL ASSESSMENT Updated 03/18

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.

8300. BENEFIT PLAN Updated 03/18

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* 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.
- If the individual resides in a psychiatric residential treatment facility (PRTF), all mental health services are the PRTF's responsibility.
- MediKan coverage is the same as for Medicaid service recipients with the following exceptions:
 - Individual outpatient psychotherapy is limited to 24 hours per calendar year per individual.
 - Group and family therapy in any combination are limited to 24 hours per calendar year per individual.
 - Psychological testing and assessment is limited to four hours every three calendar years, per individual, regardless of provider. Prior authorization will not override this limitation.
 - Targeted Case Management is limited to 80 hours per calendar year per individual.

Note: For specific instructions, reference the ***Targeted Case Management – Mental Health Fee-for-Service Provider Manual*** on the [Provider Manuals](#) page of the KMAP website.

Telemedicine

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

Limitations

Electroshock treatments and psychotherapy may not be performed on the same date of service, regardless of provider.

Mental Health Services Not Covered by Medicaid

- Conference call
- Consultation in an ICF/IID facility
- Crisis Intervention in an institutional setting
- Holding therapy
- Hypnosis, biofeedback, or relaxation therapy
- Occupational therapy
- Perceptual therapy
- Phone call

8400. MEDICAID Created 11/17

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.

Note: Code 99211 (with modifier TD) may be reimbursed when provided by a registered nurse (RN) employed by a CMHC when the guidelines for billing this code are followed.

Psychiatric Evaluation

Assessment of the patient'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).

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 nonlicensed person is also not covered.

These mental health services are covered when provided by a Kansas LMHP as defined previously in **Section 8200**. Reimbursement will not be allowed for LMHPs to supervise a nonlicensed person who is doing therapy. This limitation is monitored postpay and 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

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 during the delivery of service.

Family therapy is covered when a treatment plan contains a psychiatric diagnosis and treatment goals. This limitation is monitored postpay and 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.

Home Based Family Therapy (HBFT) is 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.

KANSAS MEDICAL ASSISTANCE PROGRAM
MENTAL HEALTH FEE-FOR-SERVICE PROVIDER MANUAL
BENEFITS & LIMITATIONS

8400. MEDICAID Updated 09/19

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.

Testing performed by an uncertified assistant and supervised by a PhD psychologist is covered when the psychological assessment conforms to the rules and regulations of the Behavioral Sciences Regulatory Board, 102-1-11.

Reimbursement for psychological testing includes the administration of standardized psychological tests, interpretation, and preparation of a written test report.

Psychological testing assessment documentation must:

- Clearly identify the questions and issues to be addressed
- Describe the individual at the time of the assessment
- Illustrate the need for initiating/continuing intervention
- Include the interpretation of findings with impressions and observations
- Give suggestions and recommendations

Note: Positive Behavior Supports (PBS) and Screening, Brief Intervention, and Referral for Treatment (SBIRT) information is available in **Section 8400** of the *Professional Fee-for-Service Provider Manual* on the [Provider Manuals](#) page of the KMAP website.

Services Provided to an Individual in an Inpatient or Residential Setting

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 when provided by psychologists, physicians, or CMHCs in a hospital setting. Inpatient group psychotherapy is content of service of the DRG reimbursement to the hospital.

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 (IMDs), including a PRTF, are considered content of the institutional or residential stay and should not be billed to KMAP.

Behavioral Interventions

Two Behavior Interventions services are available for KBH-EPSDT members.

1. Consultative Clinical and Therapeutic Services

Procedure codes 97151, 97152, 97155, and 97156 can only be billed by provider type 11 and specialty 403. One unit is equal to 15 minutes.

CMHC providers may provide these services. The rendering provider must be enrolled with KMAP with the appropriate provider type and specialties.

8400. MEDICAID Updated 07/21

Behavioral Interventions continued

Note: Coverage of this service requires that a recommendation be made by a physician or other licensed practitioner and is subject to a prior authorization process.

Provider Requirements

- The provider must be a KMAP provider.
- Certificate demonstrating individual is a Board-Certified Behavior Analyst (BCBA) **OR** Board-Certified Behavior Analyst – Doctoral (BCBA-D), **OR** Board-Certified Assistant Behavior Analyst (BCaBA), **OR**
- A letter signed by the Kansas Department for Aging and Disability (KDADS) Home and Community Based Services (HCBS) Autism Waiver Program Manager or HCBS Director. This letter will validate the applicant has met the alternative requirements for this enrollment:
 - An individual with a master's degree, preferably in Human Services or education with documented experience working with a child with an Autism Spectrum Disorder and completion of a State Approved Train Curriculum such as the KCART training.
- The individual must have a clean background, as evidenced through background checks of records maintained by the Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), Nurse Aide Registry, and Motor Vehicle screen.

Individuals who have met the requirements to be enrolled as a CCTS provider are deemed to have met the requirements to enroll as an IIS provider. Provider will need to request this specialty when enrolling.

2. Intensive Individual Supports

Code 97153 can only be billed by provider type 11 and specialty 404. One unit is equal to 15 minutes.

Note: Coverage of this service requires that a recommendation be made by a physician or other licensed practitioner and is subject to a prior authorization process.

- Certificate as Registered Behavior Technician (RBT) **OR**
- A letter signed by the KDADS HCBS Autism Waiver Program Manager or HCBS Director. This letter will validate the individual has met the alternative requirements for this enrollment:
 - An individual of 18 years of age or older
 - High school diploma or equivalent
 - 40 hours of successfully applied behavioral analysis training
 - 8 hours supervised intervention work
 - 3 hours ethics
 - At least one hour of each of:
 - Criterion of reference, social skills training, parent training, and program development

This provider works under the direction of the BCBA or other qualified Consultative Clinical and Therapeutic Services (CCTS) practitioner. The worker will adhere to all state-approved standards, training, and ongoing requirements.

8400. MEDICAID Updated 03/22

Behavioral Interventions continued

The applicant should also demonstrate to KDADS of successful completion of an initial competency assessment. All annual training requirements must be met as specified by certification. Additionally, the Individual must have a clean background, as evidenced through background checks of records maintained by the Kansas Bureau of Investigation (KBI), APS, CPS, nurse aide registry, and motor vehicle screen.

Individuals who have met the requirements to be enrolled as a CCTS provider are deemed to have met the requirements to enroll as an IIS provider will need to request this specialty when enrolling.

Maternal Depression Screenings

Note: For specific instructions, reference the *Professional Fee-for-Service Provider Manual* on the [Provider Manuals](#) page.

Medication Assisted Treatment – Opioid Treatment Programs

Effective October 1, 2020, through September 30, 2025, all Medication Assisted Treatment (MAT) drugs and biological products used for Opioid Use Disorder (OUD) will be covered. All MAT drugs and biologicals billed through the medical benefit require a diagnosis code to be considered for payment.

Medications Covered:

MAT drugs used for OUD are considered Part B drugs, per Medicare guidelines. The following drugs are covered MAT drugs for Opioid Treatment Program (OTP):

- Buprenorphine brand products and their associated generics:
 - Buprenorphine sublingual tablets (Subutex)
 - Buprenorphine/naloxone sublingual films (Suboxone)
 - Buprenorphine/naloxone sublingual tablets (Zubsolv)
 - Buprenorphine/naloxone buccal film (Bunavail)
 - Buprenorphine implants (Probuphine)
 - Buprenorphine extended-release injection (Sublocade)
- Methadone
- Naltrexone brand products and their associated generics:
 - Naltrexone tablets (Depade, Revia)
 - Naltrexone injection (Vivitrol)

Provider Information:

Collaboration and documentation between the OTP and other providers assisting with related OTP services is required to coordinate services included in codes that are a bundled service.

Opioid treatment providers are required to be enrolled in Medicare as an OTP provider. Verification of Medicare enrollment is required. Providers who are enrolled as a Medicare provider for OTP and enroll as a Medicaid provider will be exempt from the Medicaid enrollment fee. Medicaid dual eligible information can be found [here](#).

All licensures must be in accordance with Medicare standards.

8400. MEDICAID Updated 03/22

Medication Assisted Treatment – Opioid Treatment Programs continued

Approved Providers:

Allowed Practitioners will be those individuals employed in a licensed Substance Use Disorder (SUD) program as allowed by State Licensing regulations and/or standards.

Coding for MAT and Add on Codes:

The threshold for billing the codes describing weekly episodes, HCPCS codes G2067-G2075, is the delivery of at least one service in the weekly bundle (either the drug or non-drug component). If no drug was provided to the patient during the episode, the OTP must bill the G-code describing a weekly bundle does not include the drug (G2074) and the threshold to bill would be at least one service in the non-drug component. If a drug was provided with or without additional non-drug component services, the appropriate G-code describing the weekly bundle that includes the drug furnished may be billed.

CMS established HCPCS G-codes describing treatment with:

- Methadone (G2067)
- Buprenorphine oral (G2068)
- Buprenorphine injectable (G2069)
- Buprenorphine implants (insertion, removal, and insertion/removal) (G2070, G2071, and G2072)
- Extended-release, injectable naltrexone (G2073)
- Non-drug bundle (G2074) bill for services furnished during an episode of care when a medication is not administered. For example, in the case of a patient receiving injectable buprenorphine, we would expect that OTPs would bill HCPCS code G2069 for the week during which the injection was administered and you would bill HCPCS code G2074, which describes a bundle not including the drug, during any subsequent weeks when you furnish at least one non-drug service until you administer the injection again, at which time, you would bill HCPCS code G2069 again for that week.
- Medication not otherwise specified (G2075) - Use when you give MAT services with a new opioid agonist or antagonist treatment medication approved by the Food and Drug Administration (FDA) under Section 505 of the United States Federal Food, Drug, and Cosmetic Act (FFDCA) for the treatment of OUD.
- Intake activities (G2076)
- Periodic assessments (G2077)
- Take-home supplies of methadone (G2078) and take-home supplies of oral buprenorphine (G2079)
- Additional counseling furnished (G2080)

Frequency of use and other billing guidelines:

- G2067 – G2075 may not be billed more than once per 7 days.
 - G2069 and G2073 may not be billed more than once every 4 weeks.
 - G2070 and G2072 may not be billed more than once every 6 months.
- G2076 (describing intake activities) should only be billed for new patients. (No specific direction for this code currently).

8400. MEDICAID Updated 03/22

Medication Assisted Treatment – Opioid Treatment Programs continued

- G2078 or G2079 may not be billed with more than 3 units (one month take home supply). Substance Abuse and Mental Health Services Administration (SAMHSA) allows a maximum take-home supply of one month of medication; therefore, we do not expect the add-on codes describing take-home doses of methadone and oral buprenorphine to be billed any more than 3 times in one month (in addition to the weekly bundled payment).
- G2078 (take-home supply of methadone) may only be billed with G2067 (methadone weekly episode of care).
- G2079 (take-home supply of buprenorphine) may only be billed with G2068 (buprenorphine weekly episode of care).
- G2080 may be billed when counseling or therapy services are furnished that exceed the amount specified in the patient's individualized treatment plan. OTPs are required to document the medical necessity for these services in the patient's medical record.
- Codes G2067 through G2075 may not be billed within the same 7-day period. When a patient is switching from one drug to another, the OTP should only bill for one code describing a weekly bundled payment for that week and should determine which code to bill based on which drug was furnished for the majority of the week.
- G2067 or 80358 cannot be billed within the same 14 days.
- G2067 or G2078 AND 83840 or H0020 or S0109 cannot be billed in the same week.
- G2080 AND H0004 or H0005 cannot be billed within the same week.
- H0004 AND G2067 or G2068 or G2069 or G2070 or G2071 or G2072 or G2073 or G2074 cannot be billed within the same week.
- H0005 or H0005 U5 AND G2067 or G2068 or G2069 or G2070 or G2071 or G2072 or G2073 or G2074 cannot be billed within the same week.
- H0006 or H0006 U5 AND G2067 or G2068 or G2069 or G2070 or G2071 or G2072 or G2073 or G2074 cannot be billed within the same week.
- H0015 or H0015 U5 AND G2067 or G2068 or G2069 or G2070 or G2071 or G2072 or G2073 or G2074 cannot be billed within the same week.
- G2068 or 80348 cannot be billed within the same 14 days.
- G2068 or G2079 AND J0571 or J0572 or J0573 or J0574 or J0575 cannot be billed within the same week.
- G2073 and J2315 cannot be billed within the same 4 weeks.
- G2069 AND Q9991 or Q9992 cannot be billed within the same 4 weeks.
- G2080 and H0004 should not be billed within the same week.
- G2070, G2071, G2072 and J0570 cannot be billed more than 2 times within 12 months and no more than 2 billings per patient, per current FDA approval of this drug.
- G2070 or G2072 and J0570 cannot be billed within the same 6 months.
- G2071 and G2072 cannot be billed within the same 6 months.
- G2070 and G2071 can only be billed once within the same 12 months as G2072
- H0001 should not be billed by an OTP.
- G2075 requires manual review.

8400. MEDICAID3 Updated 03/22

Medication Assisted Treatment – Opioid Treatment Programs continued

Date of Service:

For the codes that describe a weekly bundle (G2067-G2075), one week is defined as 7 contiguous days. OTPs may choose to apply a standard billing cycle by setting a particular day of the week to begin all episodes of care. In this case, the date of service would be the first day of the OTP's billing cycle. If a member starts treatment at the OTP on a day that is in the middle of the OTP's standard weekly billing cycle, the OTP may still bill the applicable code for that episode of care provided that the threshold to bill for the code has been met.

Alternatively, OTPs may choose to adopt weekly billing cycles that vary across patients. Under this approach, the initial date of service will depend upon the day of the week when the patient was first admitted to the program or when Medicare billing began. Under this approach of adopting weekly billing cycles that vary across patients, when a patient is beginning treatment or re-starting treatment after a break in treatment, the date of service would reflect the first day the patient was seen and the date of service for subsequent consecutive episodes of care would be the first day after the previous 7-day period ends.

For the codes describing add-on services (G2076-G2080), the date of service should reflect the date that service was furnished; however, if the OTP has chosen to apply a standard weekly billing cycle, the date of service for codes describing add-on services may be the same as the first day in the weekly billing cycle.

Covered Place of Service Codes:

- 58 - Non-Residential Opioid Treatment Facility - A location that provides treatment for opioid use disorder on an ambulatory basis. Services include methadone and other forms of MAT.
- 15 - Mobile Unit - OTPs which have a Drug Enforcement Administration (DEA) approved mobile unit, will be reimbursed for delivery of Methadone to patients. A current agreement for approval to provide mobile unit service with the Drug Enforcement Agency is required. All requirements of the agreement and licensure thereof must be adhered to and are auditable.

Telehealth and transportation codes are covered codes for OTP services. Please refer to the Kansas Medicaid Telehealth and Non-Emergency Medical Transportation (NEMT) policies.

Current rules for other health insurance apply. Providers of this type of service are required to bill claims to primary insurance, if applicable.

Medication Assisted Treatment - Office Based Opioid Treatment (OBOT) Programs

MAT drugs, excluding Methadone, will be covered for Office-based Opioid Treatment (OBOT), according to the inclusions and exceptions listed below. Methadone used for MAT is only covered in an OTP setting. MAT drugs used for OUD are considered Part B drugs, per Medicare guidelines. Covered drugs and biological products approved for OBOT are listed below and providers should follow the laws and guidelines for providing OBOT. More information can be found [here](#).

8400. MEDICAID Updated 03/22

Medication Assisted Treatment - Office Based Opioid Treatment (OBOT) Programs continued

Buprenorphine products indicated for MAT are the following:

- Buprenorphine brand products and their associated generics:
 - Buprenorphine sublingual tablets (Subutex)
 - Buprenorphine/naloxone sublingual films (Suboxone)
 - Buprenorphine/naloxone sublingual tablets (Zubsolv)
 - Buprenorphine/naloxone buccal film (Bunavail)
 - Buprenorphine implants (Probuphine)
 - Buprenorphine extended-release injection (Sublocade)
- Naltrexone brand products and their associated generics:
 - Naltrexone tablets (Depade, Revia)
 - Naltrexone injection (Vivitrol)

Buprenorphine products that are indicated for pain, such as Belbuca, Butrans, and Buprenex, should not be prescribed for MAT.

Physicians, nurse practitioners, physician assistants, and qualified mid-level practitioners approved by Substance Abuse and Mental Health Services Administration (SAMHSA), with a Drug Addiction Treatment Act of 2000 (DATA 2000) waiver may dispense or prescribe any Controlled Substances Act (CSA) scheduled III, IV, V medication approved by the Food and Drug Administration (FDA) for the treatment of Opioid Use Disorder (OUD). More information can be found [here](#).

From October 1, 2018, and ending on October 1, 2023, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives are included in the provider types approved for MAT services, per the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act of 2018. More information can be found [here](#).

Pharmacists will be required to validate that the providers are Drug Addiction Treatment Act (DATA 2000) waived. More information can be found [here](#).

Claims may be audited. Those found to have a Non-DATA 2000 Waiver the provider, may be recouped.

Services covered:

The SUPPORT Act requires counseling and behavioral therapy to be part of a MAT program. Coordination of these services is necessary to ensure services are rendered and proper billing occurs. Compliance with the K.S.A. 39-708c, 65-4016, and 65-4607. “Standards for Licensure/Certification of Alcohol and/or Other Drug Abuse Treatment Programs” R03—711, Section K, regarding counseling requirements is required:

8400. MEDICAID Updated 03/22

Medication Assisted Treatment - Office Based Opioid Treatment (OBOT) Programs continued

80348	H0001	H0004	H0005	H0005 U5
H0006	H0006 U5	H0007	H0015	H0015 U5
J0570	J0571	J0572	J0573	J0574
J0575	J2315	Q9991	Q9991	G2086
G2087	G2088			

*J0592 refers to buprenorphine injections for pain only, not OUD.

For presumptive and definitive urine drug screens, no more than 24 tests cumulative per patient per rolling year will be allowed from the same MAT provider (80348 and 80358). Medication use counseling for OUD medications that is provided by pharmacists are not included as part of OBOT services.

Current rules for other health insurance apply. Providers of this type of service are required to bill claims to primary insurance, if applicable.

All licensures must be in accordance with Medicare standards.

8410. THE FOLLOWING SERVICES CAN CURRENTLY ONLY BE BILLED BY CMHCS**

****Community-Based Services Team Meeting**

This service provides a forum where an individual, family caregivers, providers, and engaged community representatives can meet to discuss recommendations for treatment needs, which may include a recommendation for inpatient treatment.

****Mental Health Services for Nursing Facility for Mental Health Recipients of Services**

The State of Kansas provides the following state-funded services to individuals residing in a nursing facility for mental health (NF/MH):

- **Annual Screen**
 - The annual screen for continued stay for individuals residing in an NF/MH (T2011) 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 CMHC 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. Payment for annual screens require prior authorization by KDADS BHS staff following established guidelines and protocols for this process and are communicated to the fiscal agent. Payment is for one screen per individual per year.

Other services provided to individuals residing in an NF/MH include:

- **Therapy**
 - Up to eight hours of Individual Therapy for individuals in acute trauma and up to four hours per year for Diagnostic Admission Evaluation are allowed.
- **Targeted Case Management**
 - Codes T1017 and H0036HB may be provided during the 120 days prior to discharge.
 - Targeted Case Management is provided by CMHC staff who have completed training approved by KDADS BHS.

Note: For specific instructions, reference the *Targeted Case Management – Mental Health Fee-for-Service Provider Manual* on the [Provider Manuals](#) page.
- **Personal Care Services**
 - Up to 180 hours of code T1019HE may be provided per individual per calendar year for up to 60 days prior to discharge.
 - Personal Care Services (Attendant Care) may be provided when a screen for continued stay in an NF/MH has been completed and approved by KDADS BHS within the last calendar year with a recommendation of "discharge" and under the following additional conditions:
 - A treatment plan has been developed with a goal of "community integration".
 - Personal Care Services are provided in the intended discharge community.
 - Personal Care Services provide one-to-one support or supervision for individuals transitioning from an NF/MH to community living and facilitate identification of needed services and supports an individual will require to live in the community.

8410. THE FOLLOWING SERVICES CAN CURRENTLY ONLY BE BILLED BY CMHCS**

****Mental Health Services for Nursing Facility for Mental Health Recipients of Services continued**

- Personal Care Services are provided by CMHC staff who have completed Attendant Care training approved by KDADS BHS.

****Mental Health Assessment**

This service can be provided by a nonphysician at a professional level and delivered either face-to-face or through Telemedicine. Code H0031HO is reimbursed per session.

Note: Codes 99366, 99367, and 99368 are currently not considered “content of service” when provided by a CMHC.

****Specialized Community-Based Rehabilitation Services**

Community-Based Psychiatric Rehabilitation Services are only provided by CMHCs. 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.

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. Services, other than those described in the **Mental Health Services for Nursing Facilities for Mental Health Recipients of Services** section above, may not be provided in an IMD.

1. **Community Psychiatric Support and Treatment (CPST)** is goal-directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the service recipient’s individualized treatment plan. CPST is a face-to-face intervention with the service recipient present; however, family or other collaterals may also be involved. The majority of CPST contacts must occur in community locations where the individual lives, works, attends school, and/or socializes.

CPST may include the following components:

- Assist the individual and family members or other collaterals to identify strategies or treatment options associated with the individual’s mental illness, with the goal of minimizing the negative effects of mental illness symptoms or emotional disturbances or associated environmental stressors which interfere with the individual’s daily living; financial management; housing; academic

KANSAS MEDICAL ASSISTANCE PROGRAM
MENTAL HEALTH FEE-FOR-SERVICE PROVIDER MANUAL
BENEFITS & LIMITATIONS

8410. THE FOLLOWING SERVICES CAN CURRENTLY ONLY BE BILLED BY CMHCS**

****Specialized Community-Based Rehabilitation Services continued**

and/or employment progress; personal recovery or resilience; family and/or interpersonal relationships; and community integration.

- Provide individual supportive counseling, solution-focused interventions, emotional and behavioral management, and problem behavior analysis with the individual, with the goal of assisting the individual to develop and implement social, interpersonal, self-care, daily living, and independent living skills to restore stability, support functional gains, and adapt to community living.
- Participate in and use strengths-based planning and treatments, which include assisting the individual and family members or other collaterals to identify strengths and needs, resources, and natural supports; to develop goals and objectives; and to use personal strengths, resources, and natural supports to address functional deficits associated with the individual’s mental illness.
- Assist the individual with effectively responding to or avoiding identified precursors or triggers that would risk the individual remaining in a natural community location, including assisting the individual and family members or other collaterals to identify a potential psychiatric or personal crisis, develop a crisis management plan, and/or (as appropriate) seek other supports to restore stability and functioning.

Provider qualifications:

- BA/BS degree or four years of equivalent education and/or experience working in the human services field
- Certification in the State of Kansas to provide the service, which includes criminal, abuse/neglect registry, and professional background checks
- Completion of a training program approved by KDADS

To bill CPST, submit the following procedure codes and modifiers*:

H0036HA	Child (21 years or under)	H0036HB	Adult (16 years or over)
---------	---------------------------	---------	--------------------------

***Note:** If clinical reasons are present that support an individual under the age of 4 or over the age of 18 would benefit from services provided as an individual or in a group setting utilizing “child/youth” services, billing justification for this clinical decision should be documented in the medical record. If an individual 18 years of age or under would benefit from services provided as an individual or in a group setting utilizing “adult” services, this clinical decision should likewise be documented in the medical record.

Existing modifiers currently attached to code H0036 are intended to be allowed via Telemedicine until that allowance is specifically rescinded.

Service limitations ratio: Caseload size must be based on the needs of the clients and families with an emphasis on successful outcomes and client satisfaction and must meet the needs identified in the individual treatment plan. The following general ratio should serve as a guide:

- 1 full-time equivalent (FTE) to 15 youth clients
- 1 FTE to 25 adult clients

KANSAS MEDICAL ASSISTANCE PROGRAM
MENTAL HEALTH FEE-FOR-SERVICE PROVIDER MANUAL
BENEFITS & LIMITATIONS

8410. THE FOLLOWING SERVICES CAN CURRENTLY ONLY BE BILLED BY CMHCS**

****Specialized Community-Based Rehabilitation Services continued**

2. **Psychosocial Rehabilitation (PSR)** services are designed to assist the individual with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with the individual’s mental illness. Activities included must be intended to achieve the identified goals or objectives as set forth in the individual’s individualized 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. Services may be provided individually or in a group setting. The majority of PSR contacts must occur in community locations where the individual lives, works, attends school, and/or socializes.

PSR may include the following components:

- Restore and support with the development of social and interpersonal skills to increase community tenure, enhance personal relationships, establish support networks, increase community awareness, and develop coping strategies and effective functioning in the individual’s social environment including home, work, and school.
- Restore and support with the development of daily living skills to improve self-management of the negative effects of psychiatric or emotional symptoms that interfere with an individual’s daily living.
- Support the individual with development and implementation of daily living skills and daily routines critical to remaining in home, school, work, and community.
- Implement learned skills so the individual may remain in a natural community location.
- Assist the individual to effectively respond to or avoid identified precursors or triggers that result in functional impairments.

Provider qualifications

- Must be at least 18 years of age and at least 3 years older than a client under 18 years of age
- Must have a high school diploma or equivalent
- Must be certified in the State of Kansas to provide the service, which includes criminal, abuse/neglect registry, and professional background checks
- Must complete a training program approved by KDADS

To bill PSR, submit the following procedure codes and modifiers:

H2017	Individual	H2017TJ	Child Group (21 years or under)	H2017HQ	Adult Group (16 years or over)
-------	------------	---------	---------------------------------------	---------	--------------------------------------

***Note:** If clinical reasons are present that support an individual under the age of 4 or over the age of 18 would benefit from services provided as an individual or in a group setting utilizing “child/youth” services, billing justification for this clinical decision should be

8410. THE FOLLOWING SERVICES CAN CURRENTLY ONLY BE BILLED BY CMHCS**

****Specialized Community-Based Rehabilitation Services continued**

documented in the medical record. If an individual 18 years of age or under would benefit from services provided as an individual or in a group setting utilizing “adult” services, this clinical decision should likewise be documented in the medical record.

Service limitations:

- 1 FTE to 8 individuals is the maximum group size for adults.
- 1 FTE to 4 individuals is the maximum group size for youth.

Peer Support (PS) services are individual-centered services with a rehabilitation and recovery focus. These services are designed to promote skills to cope with and manage 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 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. The majority of PS contacts must occur in community locations where the individual lives, works, attends school, and/or socializes.

PS services may include the following components:

- Help the individual to develop a network for information and support from others who have been through similar experiences
- Assist the individual with regaining the ability to make independent choices and to take a proactive role in treatment including discussing questions or concerns about medications, diagnoses, or treatment with his or her clinician
- Assist the individual to identify and effectively respond to or avoid identified precursors or triggers that result in functional impairments

Provider qualifications:

- Must be at least 18 years of age and at least 3 years older than a client under 18 years of age
- Must have a high school diploma or equivalent
- Must be certified in the State of Kansas to provide the service, which includes criminal, abuse/neglect registry, and professional background checks
- Must complete a training approved by KDADS
- Must self-identify as a present or former recipient of mental health services

To bill for PS, submit the following procedure codes and modifiers:

H0038PS	Individual	H0038HQ	Group
---------	------------	---------	-------

Service limitations:

- 1 FTE to 8 individuals is the maximum group size.

8410. THE FOLLOWING SERVICES CAN CURRENTLY ONLY BE BILLED BY CMHCS**

**Specialized Community-Based Rehabilitation Services continued

Approved training:

- [Training, Registration and Surveys](#) page
- [Medicaid Mental Health Service Provider Training](#) page

3. **Crisis Intervention (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, including an emergency room, clinic setting, or other community location where the individual lives, works, attends school, and/or socializes.

There are three tiers of CI that are provided to individuals who are experiencing a psychiatric crisis and require the assistance of another person to regulate their behavior:

- Basic Crisis Intervention
- Intermediate Crisis Intervention
- Advanced Crisis Intervention

CI is provided based on the assessed needs of the individual in crisis. The individual needs are assessed by a CMHC and identified in the individual's chart.

A QMHP from a CMHC shall re-evaluate the need for crisis services for an individual every 72 hours or more frequently as needed.

Eligibility criteria

- All individuals experiencing a serious psychological/emotional change that results in a marked increase in personal distress and exceeds the abilities and resources of those involved to effectively resolve it are eligible for CI services. The intent of CI services is to give the level of intervention necessary to help stabilize the individual, so a higher level of care is not necessary.
- An individual in crisis may be represented by a family member or other collateral contact who has knowledge of the individual's capabilities and functioning.
- Individuals in crisis who require this service may be using or abusing substances, such as illegal substances or prescription medications. Substance use or abuse should be recognized and addressed in an integrated fashion since it may be contributing to the personal distress that exceeds the abilities and resources of the individual.

Additional service criteria

- Services provided to children and youth must include coordination with family and significant others and, when feasible and appropriate, other systems of care

8410. THE FOLLOWING SERVICES CAN CURRENTLY ONLY BE BILLED BY CMHCS**

**Specialized Community-Based Rehabilitation Services continued

such as education, juvenile justice, and child welfare. Coordination with other systems of care occurs mainly as a part of referral and follow-up after the crisis has been resolved. This coordination must be documented in the individual's chart.

- When the individual is unknown or new to the CMHC, the initial preliminary diagnostic and face-to-face assessment of risk, mental status, and medical stability must be completed by a QMHP or contractor-designated LMHP with experience regarding this specialized mental health service.
- The crisis plan developed from the assessment and all the services delivered to the individual by anyone other than a QMHP or contractor-designated LMHP must be provided under the supervision of a QMHP or contractor-designated LMHP. In addition, a QMHP or LMHP must be available at all times to provide back up, support, and/or consultation to the supporting staff member who is not a QMHP or LMHP and is providing CI services.

Limitations/exclusions

- The appropriate MCO(s) shall be notified for any of their assigned individuals after 72 hours of crisis stabilization services have been provided and it has been determined additional crisis services are required in order to resolve the current crisis. CI services include residential stabilization services as well as placement in facilities offering short-term crisis stabilization beds. For services provided to individuals not assigned to an MCO, KDADS shall be notified as indicated.
- Basic Crisis Intervention (H2011) does not have a daily limit.
Note: Re-evaluation for the need for crisis services is to be completed by a QMHP every 72 hours or more frequently as needed. Documentation of the re-evaluation shall be maintained in the medical record and made available to the assigned MCO and KDADS upon request.
- Intermediate Crisis Intervention (H2011HK) requires detailed documentation when it is provided more than 7 hours a day.
Note: Re-evaluation for the need for crisis services is to be completed by a QMHP every 72 hours or more frequently as needed. Documentation of the re-evaluation shall be maintained in the medical record.
- Advanced Crisis Intervention (H2011HO) requires detailed documentation when it is provided more than 3 hours a day.
Note: Re-evaluation for the need for crisis services is to be completed by a QMHP every 72 hours or more frequently as needed. Documentation of the re-evaluation shall be maintained in the medical record.
- H2011 and H2011HK are limited to a combined 72 continuous hours unless, through re-evaluation, a QMHP determines this level of care is further indicated. For individuals assigned to an MCO, after 72 continuous hours of crisis intervention services, if the current crisis is not anticipated to be resolved within 14 days, the MCO shall be notified and may require additional documentation to determine if additional services and continued services are justified. For services provided to individuals not assigned to an MCO, KDADS shall be notified.

8410. THE FOLLOWING SERVICES CAN CURRENTLY ONLY BE BILLED BY CMHCS**

****Specialized Community-Based Rehabilitation Services continued**

- H2011 and H2011HO are limited to a combined 72 hours, unless, through re-evaluation, a QMHP determines this level of care is further indicated. For individuals assigned to an MCO, after 72 continuous hours of crisis intervention services, if the current crisis is not anticipated to be resolved within 14 days, the MCO shall be notified and may require additional documentation to determine if additional services and continued services are justified. For services provided to individuals not assigned to an MCO, KDADS shall be notified.
- For the safety of the individual and staff, H2011 may be billed concurrently with H2011HK or H2011HO, not to exceed three hours (for a total of six hours), when the need is identified. The need for this level of support must be documented in the individual's chart and be re-evaluated by a QMHP every 72 hours.
- The individual's chart must document the cause for termination of the crisis services to either a restored level of functioning or a higher level of care.

Basic Crisis Intervention: H2011

Basic Crisis Intervention (Basic CI) is a face-to-face intervention provided to an individual in crisis who requires the assistance of another person for stabilization and support. Intervention activities include assistance with immediate crisis resolution and de-escalation; individual support; and assistance with referral and linkage to appropriate community services to avoid more restrictive levels of treatment. All activities must occur within the context of a potential or actual psychiatric crisis. The goals of Basic CI are symptom reduction, stabilization, and restoration to a previous level of functioning.

Components

- Short-term crisis interventions including crisis resolution and debriefing with and in support of the individual.
- Follow-up with the individual, and as necessary, with the individual's caregiver and/or family members.

Provider qualifications

- Must be at least 18 years of age and at least 3 years older than an individual under 18 years of age
- Must have the appropriate certification in the State of Kansas to provide the service, which includes criminal, abuse/neglect registry, and professional background checks
- Must complete a state-approved standardized basic training on the Kansas Train site - **KDADS: Crisis Intervention (1065738)**

Intermediate Crisis Intervention: H2011HK

Intermediate Crisis Intervention (Intermediate CI) is a face-to-face intervention provided to an individual in crisis who requires the assistance of another person to regulate behavior and/or for stabilization. Intervention activities include a preliminary visual assessment to determine risk and ability to engage; immediate crisis resolution and de-escalation; and referral and linkage to appropriate community services to avoid more restrictive or higher levels of care. All activities must occur within the context of a potential or actual psychiatric crisis. Intermediate CI may occur without the

KANSAS MEDICAL ASSISTANCE PROGRAM
MENTAL HEALTH FEE-FOR-SERVICE PROVIDER MANUAL
BENEFITS & LIMITATIONS

8410. THE FOLLOWING SERVICES CAN CURRENTLY ONLY BE BILLED BY CMHCS**

****Specialized Community-Based Rehabilitation Services continued**

presence of a QMHP if the individual in crisis is engaged in services at a CMHC and has a crisis plan or if the individual is a frequent user of crisis services and methods for intervening have been identified in a crisis plan. The goals of Intermediate CI are symptom reduction, stabilization, and restoration to a previous level of functioning.

Components

- A preliminary nondiagnostic assessment of risk, mental status, and medical stability, along with the need for further evaluation or other mental health services
Note: This shall include contact with the individual, family members, or other collateral contacts (e.g. caregiver, school personnel) with pertinent information for the purpose of determining the best possible interventions including effective supports.
- Short-term crisis goal interventions including crisis resolution and debriefing with the individual
- Follow-up with the individual and, as necessary, with the individual's caregiver and/or family members
- Consultation with a physician or other providers to assist with the individual's specific crisis
Note: This level of CI may be billed either face-to-face or via Telemedicine.

Provider qualifications

- Must be a QMHP as defined by the state plan or the contractor(s) designated LMHP with experience regarding this specialized mental health service
- Must be certified in the State of Kansas to provide the service, which includes criminal, abuse/neglect registry, and professional background checks
- Must complete a state-approved standardized basic training program

Documentation

- The chart shall document the individual's medical necessity for crisis intervention, crisis plan, treatment plan, re-evaluation for continued crisis intervention, and coordination of services with the family and other system of care (i.e. education, juvenile justice, substance use provider, child welfare).
- Re-evaluation to justify continued need for crisis services shall document the specific needs to be addressed during a continuation of services and the specific services to be provided.

Quality assurance

- For individuals assigned to an MCO, the assigned MCO shall be responsible for ensuring quality assurance for crisis intervention. This may include reviewing charts, requesting additional information, and monitoring services. The MCOs shall notify any CMHC of concerns related to crisis intervention and address any noncompliance issues as needed. KDADS shall be responsible for quality assurance for those receiving CI services who are not assigned to an MCO.

8410. THE FOLLOWING SERVICES CAN CURRENTLY ONLY BE BILLED BY CMHCS**

**Specialized Community-Based Rehabilitation Services continued

Definition

- **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.

Note: Per national guidance, a new patient visit is not covered when it is within three years of any professional services rendered by qualified health care professionals of the exact same specialty and subspecialty who belong to the same group practice. CMHC-employed professionals are considered to be practicing under the same specialty even though their licensure may vary.

Mobile Crisis Intervention: H2011 U1

Beacon provides access to trained professionals who help deescalate behavioral health crises via a crisis helpline accessible to all children in Kansas. This code can only be reimbursed for individuals aged 0-20. If a self-determined crisis by a caller cannot be deescalated during the call or the request is made for a face-to-face response, Mobile Crisis Intervention (MCI) services will be deployed by Beacon. Preference is for MCI to be provided in person, at the preferred location of the individual or family (home, school, or another community-based setting) by a Qualified Mental Health Professional (QMHP). In situations where a face-to-face service is not available, the medical record should reflect the reason that a QMHP was unable to respond to the crisis. In those cases, utilization of the telemedicine delivery mode is allowed.

During the mobile response, the licensed QMHP would be required to provide de-escalation, crisis intervention, safety planning, and a referral to community-based services. The QMHP would also be required to complete a State-approved assessment tool and a crisis plan with the individual and family with documentation kept in the Center's medical record. If acute hospitalization is needed, this would also be arranged at this time.

MCI is available 24 hours a day, 365 days a year.

MCI services cannot be delivered when an individual has inpatient status (as in a Hospital, PRTF, or other institutional settings).

If the caller describes life-threatening risk, emergency services will be contacted by Beacon if deemed unsafe or immediate active rescue is required.

Mobile Crisis Dispatch Levels:

Emergent Psychiatric Response- acute screen needed, 60-minute response time, youth is actively suicidal or homicidal

- Individual/caller indicates that failure to obtain immediate care would place the individual's life, another's life or property in jeopardy, or cause serious impairment of bodily functions.

8410. THE FOLLOWING SERVICES CAN CURRENTLY ONLY BE BILLED BY CMHCS**

****Specialized Community-Based Rehabilitation Services continued**

Emergent Crisis- Non-life-threatening emergency, 60-minute response time if family deems necessary. Only one of the following needs to be present:

- Potential danger to self or others exists as indicated by behavior, plan, or ideation.
- Individual is labile or unstable and demonstrates significant impairment in judgement, impulse control and/or functioning.
- Existence of several medical complications concurrent with, or as, a consequence of psychiatric or substance use illness and treatment.
- Caller indicates a need to be seen on an emergency basis.

Urgent- Crisis response within 24-hours or less if family deems necessary. Only one of the following needs to be present:

- Individual is upset and distressed but not in immediate danger of harm to self or others, there is evidence of adequate pre-morbid functioning, but social/family supports have significantly changed or diminished.
- Individual is displaying moderate impairment in judgement, impulse control, and/or functioning which is expected to further diminish.
- Individual indicates intoxication and risk of withdrawal.
- Individual indicates an urgent clinical need to be seen.

Routine- Mild/moderate risk, problem solving, referral to CMHC for intake or crisis session within 72-hours. Only one of the following needs to be present:

- Individual demonstrates some distress, but the associated stressors can be easily identified.
- Individual manifests and adequate to good premorbid level of functioning with continuing adequate social/family supports and resources.
- Individual demonstrated mild impairment in judgement, functioning or impulse control.

Claims will not be submitted to the MCOs for members in an unmet spenddown status. These costs are not member responsibility and should not apply to spenddown. The CMHCs will submit claims for non-Medicaid eligible individuals and those who are Medicaid eligible but not assigned to an MCO directly to Beacon for payment (including those members who are in an unmet spenddown status). These costs will be paid for through DCF funds.

8420. DEFINITIVE CRITERIA Updated 11/19

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.

SUPPORTIVE HOUSING SERVICES

The State of Kansas has opened the following HCPCS Level II Per Diem codes H0037 and H0037HK to enhance community supportive services. These per diem program codes were 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. All support services and interventions must be medically necessary and driven by consumer choice. The intensive support service code is known as Operation Community Integration (OCI) programming and will be billed on a per diem basis. The level of care will be determined by the target population, consumers medical need, and the completion of the DLA 20 screen by a certified screener.

8420. DEFINITIVE CRITERIA Added 11/19

OPERATION COMMUNITY INTEGRATION (OCI)

Reimbursement will be provided for services targeting individuals at high risk of being unable to sustain independently in the community without intensive level supportive services offered through a **Community Mental Health Center (CMHC)** and/or a State of Kansas Licensed Substance Use Disorder (SUD) Provider.

- All residential and community OCI sites must be determined safe and habitable prior to being used as an OCI setting. Agencies participating in OCI must submit a completed OCI Habitability Check List on all consumers participating in OCI programming.
- All providers must be approved and in good contractual standing with KDADS, and the Managed Care Organizations contracted under the State Medicaid Authority of Kansas Department of Health and Environment, prior to any billing of the designated OCI codes.
- All provider agencies must submit an implementation and service delivery plan to KDADS Behavioral Health Commission for review and approval.
- Each CMHC provider will be given 24 months to have a base-line fidelity review for Evidence Based Practices, and it will be an expectation that all CMHC providers are using billing codes H0037 and H0037HK be within good fidelity standing by July 1, 2021.

Intensive Community Residential Placement (ICRP) Support Services (HCPCS code H0037HK)

The ICRP service level of need is targeted towards consumers whose screening indicates a need for medically necessary intensive on-site residential services, because of a history of unsuccessful integration in multiple community settings and/or the presence of an ongoing risk of harm to self or others which would otherwise require long-term psychiatric or incarceration. Payment for this level of service will be reimbursed through the Medicaid Billing Code H0037HK on a per diem rate and will involve admission to a congregate living environment with 5-16 beds.

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. Payment for this level of service will be reimbursed through the Medicaid Billing Code H0037 at a per diem rate and will be 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

BILLING AND DOCUMENTATION REQUIREMENTS

Codes H0037 and H0037HK are intended for direct face-to-face intensive services and supports delivered in both residential and community settings, will be subject to the prior authorization process, and the CMHC can bill Medicaid code H0037 for the completion of the admission screening process. These supportive services are intended to be intensive, directed supports that will be of a short-term nature and therefore, the initial prior authorization period will be for no more than 45 units for each level of service payment. If an individual should transition from a

8410. DEFINITIVE CRITERIA Added 11/19

BILLING AND DOCUMENTATION REQUIREMENTS continued

higher intensity of service billing the H0037HK to a lower intensity level of care service billing the H0037, the individual would have a total of 90 service units. These are to be considered soft limits and if criteria are met for a continuance, an extension can be considered and approved by the individual's MCO and KDADS BHS staff on a case-by-case basis. OCI services are billed at a daily per diem unit rate based on service delivery of a face-to-face intervention.

The following service codes and modifiers are allowed to be billed in addition to H0037 and H0037HK: 90832, 90834, 90837, 90847, 99211, 99212, 99213, 99214, and 99215.

Interventions and supports reimbursed through OCI Programs shall not be duplicated and shall NOT be part of the service menu offered through the OCI programs

On each day that an OCI code is billed the client chart must reflect documentation of intensive services and supports delivered that day. Examples of appropriate documentation may include, but is not limited to the following; daily summary progress notes, weekly summary progress notes, shift notes, progress notes documenting individual interventions with consumers including but not limited to individual assistance (i.e. Crisis assistance/support, conflict management, behavior re-direction, prompting and reminders, providing education on goal directed activities, assistance with completions of HUD documentation for access to HUD housing and programming supports, vocational rehabilitation referrals, and/or food stamp applications, communication with SOAR Eligibility Specialist for SSA up-dates and Medicaid application and reviews.

REQUIRED DOCUMENTATION

Consumer charts must include and/or demonstrate the following approved services and supports;

- Copy of the initial screen, eligibility and recommendations made by the (Certified DLA 20 admissions screener)
- Treatment plans must be completed within 72 hours of admission to the program
- Treatment plans must be modified and updated as necessary and reviewed with treatment team monthly. Proof of treatment plan review shall be placed in consumer's chart
- Admission Note that supports which target population and level of service need the admitting consumer qualified under
- Face-to-face interventions
- Discharge documentation should include the outcome of the local HUD COC Coordinated Entry assessment, and the name/location of the Coordinated Entry Access Point that the consumer participated in, and a copy of the Homeless Certification Worksheet
- Individuals in Residential Programming ICRP level of care must also have entries in a safety log as well as progress notes that reflect safety monitoring, and evidence of periodic safety checks overnight
- Individuals in the ICI level of care must have a critical intervention plan for all consumers participating in this level of care in the consumer's individual file

Providers must follow applicable KDADS to provide these services. Policies can be found on the KDADS website. Tools and forms can be downloaded on <https://www.kdads.ks.gov/provider-home/providers/policies-and-regulations>

CODES Updated 11/19

THERAPY – INDIVIDUAL

90832	90834	90837	90839	90840				
-------	-------	-------	-------	-------	--	--	--	--