

Transforming Lives. Building Community Well-Being.

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

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

90791, 90792 Clinical Assessment

96110, 96112, 96113 Developmental Testing

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

90846, 90847 Family Therapy

90849, 90853 <u>Group Therapy</u>

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

96116, 96121, 96136, 96137, 96138, 96139, 96132, <u>Neuropsychological Testing</u>

96133

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

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

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

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

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

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





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

Person-Centered Plan Requirements & Guidance

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

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

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

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

Person-Centered Interview Questions (PCP Guide)

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

Action Plan (PCP Guide)

Revised: 08-16-2024

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

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



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

Enhanced Crisis Intervention Plan (PCP Guide)

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

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

Signature Page (PCP Guide)

Revised: 08-16-2024

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

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

Service & Code	Brief Service Description	Auth Submission Requirements	Authorization Parameters	Source
	Clinical	Pass-Through Period:	Units : The appropriate procedure code(s) determines the	Clinical Coverage
Clinical	Assessment	Up to 24 unmanaged visits each fiscal	billing unit(s). One service code = 1 unit of service.	Policy No. 8C:
Assessment	services are	year of a combination of Individual		Outpatient
	intended to	Therapy, Family Therapy, Group	Age Group: Children/ Adolescents & Adults	Behavioral Health
Code(s):	determine a	Therapy, and Psych Eval.		<u>Services</u>
90791 -	member's		Level of Care: ASAM Level 1 or lower (if applicable). While	
Psychiatric	treatment	Initial Requests (after pass-through):	the LOCUS/ CALOCUS are specifically no longer required,	APSM 45-2
Diagnostic	needs. In	1. TAR: Submission required after the	providers are still expected to use a standardized assessment	<u>Records</u>
Evaluation (No	general,	22nd pass-through visit.	tool when evaluating an individual for treatment services.	Management and
Medical Services;	outpatient	2. CCA: Required		Documentation
GT eligible)	behavioral	3. Tx/ Service Plan: Required.	Service Specifics, Limitations, & Exclusions (not all	<u>Manuals</u>
	health services	Complete PCP is required when the	inclusive):	
90792 -	focus on	member is receiving multiple BH	The provider shall communicate and coordinate care with	PCP Guidance
Psychiatric	reducing	services in addition to the	others providing care. When the member is receiving multiple	Documents &
Diagnostic	psychiatric and	services in Clinical Coverage Policies	BH services in addition to this service, the PCP must be	<u>Templates</u>
Evaluation with	behavioral	8C.	developed, and outpatient behavioral health services are to be	
Medical Services	symptoms in	4. Service Order: Required	incorporated into PCP.	
(GT eligible)	order to	5. Submission of applicable records that	2. Provider must provide, or have a written agreement with	
	improve the	support the member has met the	another entity, for access to 24-hour coverage for BH	
Modifiers:	member's	medical necessity criteria.	emergency services.	
GT: Telehealth	functioning in		3. A CCA that demonstrates medical necessity must be	
	familial, social,	Reauthorization Requests:	completed by a licensed professional prior to provision of	
	educational, or	1. TAR: prior authorization required	outpatient therapy services.	
	occupational	2. Tx/ Service Plan: recently reviewed	4. For services that require a PCP, a CCA must be completed	
	life domains	detailing the member's progress with	prior to service delivery.	
		the service. Updated PCP is required	5. Members w/ both MCD and Medicare, the provider shall bill	
		when this service is provided in	Medicare as primary before submitting a claim to MCD. For	
		conjunction with a service found in the	members having both MCD and any other insurance	
		Clinical Coverage Policies 8A, as well	coverage, the other insurance shall be billed prior to billing	
		as the state-funded enhanced MH/SU	MCD. MCD is the payor of last resort.	
		services.	6. For substance use disorders, ASAM level 1 outpatient	
		3. Submission of applicable records that	services are provided for less than nine hours a week for	
		support the member has met the	adults and less than six (6) hours a week for adolescents.	
		medical necessity criteria.		



Service & Code	Brief Service Description	Auth Submission Requirements	Authorization Parameters	Source
Developmental Testing Code(s): 96110: Developmental Testing - Limited (GT eligible) 96112: Developmental Testing administrative - first hour 96113: Developmental Testing administrative - each additional 30 minutes. Must be used with 96112. Modifiers: GT: Telehealth	An in-depth look at a member's development, usually done by a trained specialist, such as a developmental pediatrician, psychologist, speechlanguage pathologist, occupational therapist, or other specialist. The specialist may observe the member, give the member a structured test, ask the guardian questions, or ask them to fill out questionnaires.	All Requests: TAR: required if the unmanaged units have been exhausted. Providers may seek prior authorization if they are unsure the member has reached their unmanaged visit limit. To ensure timely prior authorization, requests must be submitted prior to the last unauthorized visit.	 Units: The appropriate procedure code(s) determines the billing unit(s). One service code = 1 unit of service. Up to 9 unmanaged units of 96110: Developmental Testing - Limited. Age Group: Children/ Adolescents & Adults Level of Care: N/A Service Specifics, Limitations, & Exclusions (not all inclusive): The provider shall communicate and coordinate care with others providing care. When the member is receiving multiple BH services in addition to this service, a tx plan must be developed, and outpatient behavioral health services are to be incorporated into the tx plan. Members w/ both MCD and Medicare, the provider shall bill Medicare as primary before submitting a claim to MCD. For members having both MCD and any other insurance coverage, the other insurance shall be billed prior to billing 	Clinical Coverage Policy No. 8C: Outpatient Behavioral Health Services APSM 45-2 Records Management and Documentation Manuals PCP Guidance Documents & Templates



Service & Code	Brief Service Description	Auth Submission Requirements	Authorization Parameters	Source
Evaluation & Management Code(s): 99202 - 99205 99211 - 99215 99305 - 99310 99315 - 99316 99341 - 99350 The GT (Telehealth) modifier can be used with service codes between 99202-99205, 99211-99215, 99347-99350	2.10. 00. 1100	7 10.0.1 0 0.0.0.1	Units: The appropriate procedure code(s) determines the billing unit(s). One service code = 1 unit of service. Age Group: Children/ Adolescents & Adults Level of Care: N/A Service Specifics, Limitations, & Exclusions (not all inclusive): 1. Outpatient BH does not cover: a) sleep therapy for psychiatric disorders; b) medical, cognitive, intellectual or development issue that would not benefit from outpatient treatment services, OR; c) when the focus of treatment does not address the symptoms of the diagnosis. 2. Members w/ both MCD and Medicare, the provider shall bill Medicare as primary before submitting a claim to MCD. For members having both MCD and any other insurance coverage, the other insurance shall be billed prior to billing MCD. MCD is the payor of last resort. 3. Physicians billing E/M codes with psychotherapy add-on codes must have documentation supporting that the E/M	Clinical Coverage Policy No. 8C: Outpatient Behavioral Health Services APSM 45-2 Records Management and Documentation Manuals PCP Guidance Documents & Templates
			service was separate and distinct from the psychotherapy service. 4. The provider will communicate and coordinate care with other professionals providing care to the member.	

	Brief Service	Auth Submission		
Service & Code	Description	Requirements	Authorization Parameters	Source
	Service is	Pass-Through Period:	Units: The appropriate procedure code(s) determines the billing	Clinical
Family Therapy	focused on	Up to 24 unmanaged visits each	unit(s). One service code = 1 unit of service.	Coverage
i anni ino apy	reducing	fiscal year of a combination of		Policy No.
Code(s):	psychiatric and	Individual Therapy, Family Therapy,	Age Group: Children/ Adolescents & Adults	8C:
90846 : Family	behavioral	Group Therapy, and Psych Eval.	- igo or out	Outpatient
Therapy w/o	symptoms to		Level of Care: ASAM Level 1 or lower (if applicable). While the	Behavioral
member.	improve the	Initial Requests (after pass-	LOCUS/ CALOCUS are specifically no longer required, providers	Health
	member's	through):	are still expected to use a standardized assessment tool when	Services
90847 : Family	functioning in	1. TAR: Submission required after	evaluating an individual for treatment services	
Therapy with	familial, social,	the 22nd pass-through visit.	, and the second	APSM 45-2
member. May not	educational, or	2. CCA: Required	Service Specifics, Limitations, & Exclusions (not all inclusive):	Records
be used with	occupational life	3. Tx/ Service Plan: Required.	1. Outpatient BH does not cover: a) sleep therapy for psychiatric	Management
90785.	domains. The	Complete PCP is required when the	disorders; b) medical, cognitive, intellectual or development issue	<u>and</u>
	member's needs	member is receiving multiple BH	that would not benefit from outpatient treatment services, OR; c)	<u>Documentati</u>
The GT	and preferences	services in addition to the	when the focus of treatment does not address the symptoms of the	on Manuals
(Telehealth) and	determine the	services in Clinical Coverage	diagnosis.	
KX (Telephonic)	treatment goals,	Policies 8C.	2. Individual, Group, or Family Outpatient services cannot be billed	<u>PCP</u>
modifiers can be	frequency, and	4. Service Order: Required	while a member is auth'd for: ACT, IIH, MST, Day Treatment,	<u>Guidance</u>
used with these	duration of	5. Submission of applicable records	SAIOP, SACOT. Outpatient Med Management and Outpatient	Documents &
service codes.	services, as well	that support the member has met the	Psychiatric Services cannot be billed while a member is auth'd to	<u>Templates</u>
	as measurable	medical necessity criteria.	receive ACT.	
Telephonic	and desirable		3. For substance use disorders, ASAM level 1 outpatient services	
Services (KX) are	outcomes.	Reauthorization Requests:	are provided for less than nine hours a week for adults and less than	
reserved for when		1. TAR: prior authorization required	six (6) hours a week for adolescents.	
physical or BH		2. Tx/ Service Plan: recently	4. Members w/ both MCD and Medicare, the provider shall bill	
status or access		reviewed detailing the member's progress with the service. Updated	Medicare as primary before submitting a claim to MCD. For	
issues (transportation,		PCP is required when this service is	members having both MCD and any other insurance coverage, the other insurance shall be billed prior to billing MCD. MCD is the	
telehealth		provided in conjunction with a	payor of last resort.	
technology) prevent		service found in the Clinical	5. The provider shall communicate and coordinate care with others	
the member from		Coverage Policies 8A, as well as the	providing care. When the member is receiving multiple BH services	
participating in-		state-funded enhanced MH/SA.	in addition to this service, the PCP must be developed, and	
person or		3. Submission of applicable records	outpatient behavioral health services are to be incorporated into	
telehealth services.		that support the member has met the	PCP.	
10.0.100111 001 11000.		medical necessity criteria.	6. Provider must provide, or have a written agreement with another	
		The second secon	entity, for access to 24-hour coverage for BH emergency services.	
		I .	Torrity, for accept to 2 i flour coverage for bit officing city convicted.	<u> </u>

	Brief Service Auth Submission			
Service & Code	Description	Requirements	Authorization Parameters	Source
	Service is	Pass-Through Period:	Units : The appropriate procedure code(s) determines the billing	Clinical
Group Therapy	focused on	Up to 24 unmanaged visits each	unit(s). One service code = 1 unit of service.	Coverage
	reducing	fiscal year of a combination of		Policy No.
Code(s):	psychiatric and	Individual Therapy, Family Therapy,	Age Group: Children/ Adolescents & Adults	<u>8C:</u>
90849 : Group	behavioral	Group Therapy, and Psych Eval.		Outpatient
Therapy (multi-	symptoms to		Level of Care: ASAM Level 1 or lower (if applicable). While the	Behavioral
family).	improve the	Initial Requests (after pass-	LOCUS/ CALOCUS are specifically no longer required, providers are	<u>Health</u>
	member's	through):	still expected to use a standardized assessment tool when evaluating	<u>Services</u>
90853 : Group	functioning in	1. TAR: Submission required after	an individual for treatment services	
Therapy	familial, social,	the 22nd pass-through visit.		APSM 45-2
	educational, or	2. CCA: Required	Service Specifics, Limitations, & Exclusions (not all inclusive):	Records
The GT	occupational life	3. Tx/ Service Plan: Required.	1. Outpatient BH does not cover: a) sleep therapy for psychiatric	<u>Management</u>
(Telehealth) and	domains. The	Complete PCP is required when the	disorders; b) medical, cognitive, intellectual or development issue that	<u>and</u>
KX (Telephonic)	member's needs	member is receiving multiple BH	would not benefit from outpatient treatment services, OR; c) when the	<u>Documentati</u>
modifiers can be	and preferences	services in addition to the	focus of treatment does not address the symptoms of the diagnosis.	on Manuals
used with these	determine the	services in Clinical Coverage	2. Individual, Group, or Family Outpatient services cannot be billed	
service codes.	treatment goals,	Policies 8C.	while a member is auth'd for: ACT, IIH, MST, Day Treatment, SAIOP,	<u>PCP</u>
	frequency, and	4. Service Order: Required	SACOT. Outpatient Med Management and Outpatient Psychiatric	<u>Guidance</u>
Telephonic	duration of	5. Submission of applicable records	Services cannot be billed while a member is auth'd to receive ACT.	Documents &
Services (KX) are	services, as well	that support the member has met	3. The provider shall communicate and coordinate care with others	<u>Templates</u>
reserved for when	as measurable	the medical necessity criteria.	providing care. When the member is receiving multiple BH services in	
physical or BH	and desirable		addition to this service, the PCP must be developed, and outpatient	
status or access	outcomes.	Reauthorization Requests:	behavioral health services are to be incorporated into PCP.	
issues		1. TAR: prior authorization required	4. Provider must provide, or have a written agreement with another	
(transportation,		2. Tx/ Service Plan: recently	entity, for access to 24-hour coverage for BH emergency services.	
telehealth		reviewed detailing the member's	5. Members w/ both MCD and Medicare, the provider shall bill	
technology) prevent		progress with the service. Updated	Medicare as primary before submitting a claim to MCD. For members	
the member from		PCP is required when this service is	having both MCD and any other insurance coverage, the other	
participating in-		provided in conjunction with a	insurance shall be billed prior to billing MCD. MCD is the payor of	
person or		service found in the Clinical	last resort.	
telehealth services.		Coverage Policies 8A, as well as	6. For substance use disorders, ASAM level 1 outpatient services are	
		the state-funded enhanced MH/SA.	provided for less than nine hours a week for adults and less than six	
		3. Submission of applicable records	(6) hours a week for adolescents.	
		that support the member has met		
		the medical necessity criteria.		



	Brief Service	Auth Submission		
Service & Code	Description	Requirements	Authorization Parameters	Source
	Service is	Pass-Through Period:	Units : The appropriate procedure code(s) determines the billing	Clinical
Individual Therapy	focused on	Up to 24 unmanaged visits each	$\frac{1}{\text{unit}(s)}$. One service code = 1 unit of service.	Coverage
.,	reducing	fiscal year of a combination of		Policy No. 8C:
Code(s):	psychiatric and	Individual Therapy, Family	Age Group: Children/ Adolescents & Adults	Outpatient
90832: 30 Minutes (GT	behavioral	Therapy, Group Therapy, and		Behavioral
& KX eligible)	symptoms to	Psych Eval.	Level of Care: ASAM Level 1 or lower (if applicable). While the	Health Services
90833 : 30 Minute add	improve the	Initial Requests (after pass-	LOCUS/ CALOCUS are specifically no longer required, providers	
on to E&M (GT eligible)	member's	through):	are still expected to use a standardized assessment tool when	APSM 45-2
90834 : 45 Minutes (GT	functioning in	1. TAR: Submission required	evaluating an individual for treatment services	Records
& KX eligible)	familial, social,	after the 22nd pass-through visit.		Management
90836: 45 Minute add	educational, or	2. CCA: Required	Service Specifics, Limitations, & Exclusions (not all inclusive):	and
on to E&M (GT eligible)	occupational	3. Tx/ Service Plan: Required.	1. Outpatient BH does not cover: a) sleep therapy for psychiatric	Documentation
90837: 60 Minutes (GT	life domains.	Complete PCP is required when	disorders; b) medical, cognitive, intellectual or development issue	Manuals
& KX eligible)	The member's	the member is receiving multiple	that would not benefit from outpatient treatment services, OR; c)	
90838: 60 Minute add	needs and	BH services in addition to the	when the focus of treatment does not address the symptoms of the	PCP Guidance
on to E&M (GT eligible)	preferences	services in Clinical Coverage	diagnosis.	Documents &
, , ,	determine the	Policies 8C.	2. Individual, Group, or Family Outpatient services cannot be billed	Templates
Modifiers:	treatment	4. Service Order: Required	while a member is auth'd for: ACT, IIH, MST, Day Treatment,	
GT: Telehealth	goals,	5. Submission of applicable	SAIOP, SACOT. Outpatient Med Management and Outpatient	
KX: Telephonic	frequency, and	records that support the member	Psychiatric Services cannot be billed while a member is auth'd to	
	duration of	has met the medical necessity	receive ACT.	
Telephonic Services	services, as	criteria.	3. For substance use disorders, ASAM level 1 outpatient services	
(KX) are reserved for	well as	Reauthorization Requests:	are provided for less than nine hours a week for adults and less	
when physical or BH	measurable	1. TAR: prior authorization	than six (6) hours a week for adolescents.	
status or access issues	and desirable	required	4. The provider shall communicate and coordinate care with others	
(transportation,	outcomes.	2. Tx/ Service Plan: recently	providing care. When the member is receiving multiple BH services	
telehealth technology)		reviewed detailing the member's	in addition to this service, the PCP must be developed, and	
prevent the member		progress with the service.	outpatient behavioral health services are to be incorporated into	
from participating in-		Updated PCP is required when	PCP.	
person or telehealth		this service is provided in	5. Provider must provide, or have a written agreement with another	
services.		conjunction with a service found	entity, for access to 24-hour coverage for BH emergency services.	
		in the Clinical Coverage Policies	6. Members w/ both MCD and Medicare, the provider shall bill	
		8A, as well as the state-funded	Medicare as primary before submitting a claim to MCD. For	
		enhanced MH/SA.	members having both MCD and any other insurance coverage, the	
		3. Submission of applicable	other insurance shall be billed prior to billing MCD. MCD is the	
		records that support the member	payor of last resort.	
		has met the medical necessity		
		criteria.		

	5.1.6			
Service & Code	Brief Service Description	Auth Submission Requirements	Authorization Parameters	Source
	Neuropsychological	Pass-Through Period:	Units: The appropriate procedure code(s) determines	Clinical Coverage
Neuropsychological	Testing is intended	Up to 9 unmanaged hours	the billing unit(s). One service code = 1 unit of service.	Policy No. 8C:
Testing	to assess cognition	of testing administration		Outpatient Behavioral
_	and behavior,	per fiscal year.	Age Group: Children/ Adolescents & Adults	Health Services
Code(s):	examining the			
96116: Neurobehavioral	effects of any brain	Initial & Reauthorization	Level of Care: N/A. For substance use disorders,	APSM 45-2 Records
Exam (First Hour)	injury or	Requests (after pass-	clinical across the six ASAM criteria assessment	Management and
	neuropathological	through):	dimensions is required.	<u>Documentation</u>
96121: Neurobehavioral	process that a	1. TAR: required if the		<u>Manuals</u>
Exam (Each Add'l Hour)	person may have	unmanaged units have	Service Specifics, Limitations, & Exclusions (not all	
	experienced.	been exhausted.	inclusive):	PCP Guidance
96136 : Testing		Providers may seek prior	Psychological Testing does not cover testing: for the	Documents &
Administration (First 30		authorization if they are	purpose of educational testing; if requested by the	Templates
minutes)		unsure the member has	school or legal system, unless MN exists for the	
		reached their unmanaged	psychological testing; if the proposed psychological	
96137 : Testing		visit limit. To ensure	testing measures have no standardized norms or	
Administration (Each add'l 30		timely prior authorization,	documented validity, or; if the focus of assessment is not	
minutes)		requests must be	the symptoms of the current diagnosis.	
		submitted prior to the last	2. Limit of eight hours of Psychological Testing allowed	
96138 : Testing		unauthorized visit.	to be billed per date of service.	
Administration by Technician		2. Submission of all	3. Members w/ both MCD and Medicare, the provider	
(First 30 minutes)		records that support the	shall bill Medicare as primary before submitting a claim	
		member has met the	to MCD. For members having both MCD and any other	
96139 : Testing		medical necessity criteria.	insurance coverage, the other insurance shall be billed	
Administration by Technician			prior to billing MCD. MCD is the payor of last resort.	
(Each add'l 30 minutes)			4. Testing must include all elements detailed in the CCP.	
			5. The provider shall communicate and coordinate care	
96132: Evaluation of Testing			with others providing care. When the member is	
(First hour, GT eligible)			receiving multiple BH services in addition to this service,	
			a tx plan must be developed, and outpatient behavioral	
96133: Evaluation of Testing			health services are to be incorporated into the tx plan.	
(Each add'l hour, GT eligible)				
Modifier(s):				
GT: Telehealth				

Service & Code	Brief Service	Auth Submission	Authorization Parameters	Source
	Description	Requirements		55355
	Psychological services for	Initial & Reauthorization	<u>Units</u> :	Clinical Coverage
Psychological Services	children and adolescents	Requests:	1. The appropriate procedure code(s)	Policy 8-I:
Provided by Health	are goal-directed	Outpatient behavioral	determines the billing	Psychological Services
Departments and School-	interventions designed to	health services must be	unit(s).	Provided by Health
Based Health Centers to the	enable children,	provided in accordance with		Departments and
Under 21 Population	adolescents, and their	the requirements and	Age Group: Children/ Adolescents & Adults	School-Based Health
	families to cope more	procedures documented in		Centers to the Under
Code(s):	effectively with complex	Clinical Coverage Policy	Level of Care: Outpatient behavioral health	21 Population
90791: Psychiatric Diagnostic	problems. Services may	8C: Outpatient Behavioral	services must be provided in accordance	
Evaluation (No Medical Services)	include comprehensive	Health Services Provided	with the requirements and procedures	Clinical Coverage
	psychosocial	by Direct-Enrolled	documented in Clinical Coverage Policy 8C:	Policy No. 8C:
90832: Individual Therapy, 30	assessments and	Providers and the	Outpatient Behavioral Health Services	Outpatient Behavioral
Minutes	treatment planning, goal-	applicable Trillium Benefit	Provided by Direct-Enrolled Providers and	Health Services
	directed psychotherapy	Plan.	the applicable Trillium Benefit Plan.	
90834: Individual Therapy, 45	(individual, group, or			APSM 45-2 Records
Minutes	family), and referral to	Note: No medical referral	Service Specifics, Limitations, &	Management and
	other mental health	is needed to access this	Exclusions (not all inclusive):	<u>Documentation</u>
90837: Individual Therapy, 60	resources as needed.	service.	The provider shall communicate and	<u>Manuals</u>
Minutes	These services involve		coordinate care with others providing care.	
	the identification of and		When the member is receiving multiple BH	PCP Guidance
90839: Psychotherapy for Crisis,	intervention with children		services in addition to this service, a tx plan	Documents &
first 60 Minutes	and adolescents who		must be developed, and outpatient	Templates
	may be at risk for		behavioral health services are to be	
90840: Psychotherapy for Crisis,	developing more serious		incorporated into the tx plan.	
for each additional 30 minutes	emotional or behavioral			
	problems as well as those			
90846: Family Therapy w/o	who are already			
member. May not be used with	experiencing these			
90785.	problems.			
90847: Family Therapy with				
member. May not be used with				
90785.				
90853: Group Therapy				

Service & Code	Brief Service Description	Auth Submission Requirements	Authorization Parameters	Source
Psychological	Psychological testing	Pass-Through Period:	<u>Units</u> : The appropriate procedure code(s)	Clinical Coverage
Testing (Hourly)	involves the culturally and	Up to 9 unmanaged hours of	determines the billing unit(s). One service code = 1	Policy No. 8C:
	linguistically appropriate	testing administration per fiscal.	unit of service.	<u>Outpatient</u>
Code(s):	administration of			Behavioral Health
96136 : Testing	standardized tests to	Initial & Reauthorization	Age Group: Children/ Adolescents & Adults	<u>Services</u>
Administration	assess a member's	Requests (after pass-through):		
(First 30 minutes)	psychological or cognitive	1. TAR: required if the unmanaged	Level of Care: N/A. For substance use disorders,	APSM 45-2 Records
	functioning. Testing results	units have been exhausted.	clinical across the six ASAM criteria assessment	Management and
96137 : Testing	must inform treatment	Providers may seek prior	dimensions is required.	<u>Documentation</u>
Administration	selection and treatment	authorization if they are unsure the		<u>Manuals</u>
(Each add'l 30	planning.	member has reached their	Service Specifics, Limitations, & Exclusions (not	
minutes)		unmanaged visit limit. To ensure	all inclusive):	PCP Guidance
		timely prior authorization, requests	Psychological Testing does not cover testing: for	Documents &
96138 : Testing		must be submitted prior to the last	the purpose of educational testing; if requested by	<u>Templates</u>
Administration by		unauthorized visit.	the school or legal system, unless MN exists for the	
Technician (First		2. Submission of all records that	psychological testing; if the proposed psychological	
30 minutes)		support the member has met the	testing measures have no standardized norms or	
		medical necessity criteria.	documented validity, or; if the focus of assessment is	
96139 : Testing			not the symptoms of the current diagnosis.	
Administration by			2. Limit of eight hours of Psychological Testing	
Technician (Each			allowed to be billed per date of service.	
add'l 30 minutes)			3. Members w/ both MCD and Medicare, the provider	
00400 F '			shall bill Medicare as primary before submitting a	
96130: Evaluation			claim to MCD. For members having both MCD and	
of Testing (First			any other insurance coverage, the other insurance	
hour, GT eligible)			shall be billed prior to billing MCD. MCD is the payor	
00404. Falat'			of last resort.	
96131: Evaluation			4. Testing must include all elements detailed in the	
of Testing (Each			CCP.	
add'l hour, GT			5. The provider shall communicate and coordinate	
eligible)			care with others providing care. When the member is	
Modifier(s):			receiving multiple BH services in addition to this	
Modifier(s): GT: Telehealth			service, a tx plan must be developed, and outpatient	
Gr. relenealth			behavioral health services are to be incorporated into	
			the tx plan.	

Service & Code	Brief Service Description	Auth Submission Requirements	Authorization Parameters	Source
Psychotherapy for Crisis Code(s): 90839: First 60 Minutes	On rare occasions, licensed outpatient service providers are presented with individuals in crisis situations which may require unplanned	Prior authorization is not required for this service.	 <u>Units</u>: The appropriate procedure code(s) determines the billing unit(s). One service code = 1 unit of service. <u>Age Group</u>: Children/ Adolescents & Adults <u>Level of Care</u>: N/A 	Clinical Coverage Policy No. 8C: Outpatient Behavioral Health Services APSM 45-2 Records Management and
90840: For each additional 30 minutes. Must be used with 90839. The GT (Telehealth) and KX (Telephonic) modifiers can be used with these service codes. Modifiers: GT: Telehealth KX: Telephonic	extended services to manage the crisis in the office with the goal of averting more restrictive levels of care. This service is used only in those extreme situations in which an unforeseen crisis situation arises, and additional time is required to manage the crisis event. Services are restricted to outpatient crisis assessment, stabilization, and disposition for acute, lifethreatening situations.		Service Specifics, Limitations, & Exclusions (not all inclusive): 1. Psychotherapy for Crisis is not covered: a) if the focus of tx does not address the symptoms of the DSM-5 dx or related symptoms; b) in emergency departments, inpatient settings, or facility-based crisis settings, OR; c) if the member presents with a medical, cognitive, intellectual or development issue that would not benefit from outpatient tx services. If Psychotherapy for Crisis is billed, no other outpatient therapy services can be billed on that same day for that member. 2. For members having both Medicaid and Medicare, the provider shall bill Medicare as primary before submitting a claim to Medicaid. For beneficiaries having both Medicaid and any other insurance coverage, the other insurance shall be billed prior to billing Medicaid, as Medicaid is considered the payor of last resort. 3. The provider will complete an assessment prior to the delivery of any subsequent services following the provision of this service. 4. When receiving multiple BH services in addition to outpatient, a PCP must be developed. 5. The provider will complete an assessment prior to the delivery of any subsequent services following the provision of this service. 6. The provider shall communicate and coordinate care with others providing care. When the member is receiving multiple BH services in addition to this service, a tx plan must be developed, and outpatient behavioral health services are to be incorporated into the tx plan. 5. Provider must provide, or have a written agreement with another entity, for access to 24-hour coverage for BH emergency services.	Documentation Manuals PCP Guidance Documents & Templates