

HCY SCREENINGS

Developmental/Mental Health Partial Screens are billable by a provisionally licensed psychologist, psychologist, psychiatrist, psychiatric mental health nurse practitioner (PMHNP), psychiatric clinical nurse specialist (PCNS), LCSW, LMSW, LPC, or PLPC. These screening codes do not use the AH, AJ, UD, or U8 modifiers. Instead the codes must have a 59 modifier and if the child is referred on for further care a UC modifier. The diagnosis code V202 is the only valid diagnosis code for a partial HCY screening.

99429 59 / \$15.00

99429 59 UC / \$15.00

*Modifier "UC" must be used if child was referred for further care as a result of the screening. Modifier "UC" must always appear as the last modifier.

MODIFIERS

Claims must be submitted using the appropriate modifier(s). The specialty modifier is always required.

AH – Psychologist / Provisionally Licensed Psychologist

AJ – Licensed Clinical Social Worker / Licensed Master Social Worker

UD – Licensed Professional Counselor / Provisionally Licensed Professional Counselor

U8 – in home (12) or private school (99)

(The U8 modifier is not appropriate when billing 90853 regardless of POS)

A modifier may be required to track services provided to patients identified as catastrophe/disaster victims in any part of the country. This modifier is used in addition to any other required modifiers. There is no additional reimbursement associated with use of this modifier.

CR – Catastrophe/Disaster Related

With the implementation of National Correct Coding Initiative (NCCI), multiple services rendered on the same date by the same performing provider require an additional modifier. A list of modifiers may be found at the fee schedule link on the MHD Web site.

FREQUENTLY USED PLACE OF SERVICE CODES (POS)

04 – Homeless Shelter	11 – Office	12 – Participant Home	14- Group Home
21 – Inpatient Hospital	22 – Outpatient Hospital	33 – Custodial Care Facility	
50 – FQHC	51 – Inpatient Psychiatric Facility		
56 – Psych Residential Treatment	61 – Comprehensive Inpatient Rehab Facility		
72 – Rural Health Clinic	03 – Public School	99 – Private School	

Refer Psychology Counseling manual, Section 15, for complete list of POS codes and additional description information.

TIME-BASED SERVICE LIMITATIONS

A therapy procedure code representing a measure of time as defined in the CPT is covered for one (1) unit per day. The provider must choose the appropriate time measure to represent the service furnished.

A unit of service, which represents 20-30 minutes, must include at least 20 minutes **face-to-face** with the client. When less than 30 minutes is spent face-to-face with the client, the remainder of the time must be directed towards the benefit of the client including, but not limited to, report writing, note summary, reviewing treatment plan, etc.

A unit of service, which represents 45-50 minutes, must include at least 45 minutes **face-to-face** with the client. When less than 50 minutes is spent face-to-face with the client, the remainder of the time must be directed towards the benefit of the client including, but not limited to, report writing, note summary, reviewing treatment plan, etc.

Currently, the CPT definition for Assessment, Family Therapy with or without the patient present, and Group Therapy is not time limited; and MHD defines a unit of service as a half hour. (These therapies must be provided in full 30-minute units.)

Testing and Crisis Intervention are defined in the CPT as hour services and a full 60 minutes of services must be provided.

Travel time is not reimbursable and must not be included as part of the scheduled appointment time.

Providers may not bill a combination of any psychotherapy codes that have the same description, except for time, on the same date of service. For example a half hour (90804) and 45-50 minutes (90806) is not covered on the same date of service.

Providers may not bill a combination of time measured psychotherapy codes with a code including a medical component. For example 90804 and 90805 are not covered on the same date of service.

Certain services include a medical component and are not billable by a provisionally licensed psychologist, psychologist, LCSW, LMSW, LPC or PLPC. These codes are 90805, 90807, 90811, 90813, 90817, 90819, 90824, 90827, 90862, 90865, and 90870.

Certain services are not covered when provided by an LCSW, LMSW, PLPC or LPC and may not be billed for an adult or child in any setting. These codes are 96101, 96103, 96105, 96111, and 96116.

FAMILY THERAPY

Family therapy is defined as the treatment of family members as a family unit, rather than an individual patient. When Family Therapy without the Patient Present (90846) or Family Therapy with the Patient Present (90847) is provided, the session is billed as one service (one family unit), regardless of the number of individuals present at the session. Providers may not bill for Family Therapy for each family member. This will be monitored by the Program Integrity Unit. Treatment of family members (adults) is not covered when provided by an LCSW, LMSW, PLPC, or LPC. Family Therapy furnished by an LCSW, LMSW, PLPC, or LPC must be directed exclusively to the treatment of the child. **Parental issues may not be billed and Family Therapy is only billable when defined in the Treatment Plan as necessary on behalf of the identified patient.**

A psychiatrist, PCNS, PMHNP and provisional licensed psychologist or psychologist may bill for services provided to an adult. When a family consists of a MO HealthNet eligible adult and child(ren) and the therapy is not directed at one specific child, services may be directed to the adult for effective treatment of the family unit to address the adult's issues and impact on the family. If the adult is not eligible and the family therapy is directed to the adult and not the child, the service may not be billed using the child's DCN.

Only one (1) Prior Authorization will be approved and open at a time for Family Therapy. If there is more than one eligible child and no child is exclusively identified as the primary participant of treatment, then the oldest child's DCN must be used for Prior Authorization and billing purposes. When a specific child is identified as the primary participant of treatment, that child's DCN must be used for Prior Authorization and billing purposes. Providers must not request more than one (1) Family Therapy Prior Authorization per family.

A family may be biological, foster, adoptive or other family unit. A family is not a group and **providers may not submit a claim for each eligible person attending the same family therapy session. At least 75% of the session must have both child/children and parent(s) present.**

GROUP THERAPY

Group Therapy must consist of 3 but no more than 10 individuals who are not members of the same family. This applies to inpatient Group Therapy sessions also.

Group Therapy may not be billed on the same date of service as Family Therapy (90846 or 90847) unless the client is inpatient, in a residential treatment facility, or custodial care facility. *Services must be provided at the facility location.* Group Therapy in a group home is billed with POS 14. Group Therapy in a residential/custodial facility is billed with POS 33. Group Therapy in a shelter type setting is billed with POS 04.

PLACE OF SERVICE CODE

The only valid setting for using place of service code 99 is a private school. Place of service 99 cannot be used for therapy provided in a public setting. A public setting includes but is not limited to: a parked or moving vehicle, library, park, shopping center, restaurants, etc. Providers must use the appropriate place of service code for the setting in which services are rendered. If there is no place of service code that matches the setting, services may not be billed to MO HealthNet. Although there is a place of service 15 for mobile unit, MO HealthNet does not cover services provided in this setting.

Place of service 11 (office) is to be used for settings such as a Head Start. Centers for Medicare and Medicaid Services (CMS) has defined an office as a location where the health professional routinely provides services.

Place of service 04 (homeless shelter) should be used when services are provided in a setting such as a crisis center or Salvation Army housing. The CMS definition of a homeless shelter is a facility or location that provides temporary housing.

NURSING HOME

Effective for dates of service February 01, 2009 and after MO HealthNet will allow a Psychiatric Diagnostic Interview, 90801, for participants in a nursing home. The Psychiatric Diagnostic Interview includes a history, mental status, and a disposition. It may include communication with family or other sources and also the ordering and medical interpretation of laboratory or other medical diagnostic studies. The Psychiatric Diagnostic Interview may be done by a psychiatrist, PMHNP, or PCNS.

There are no changes to the established billing guidelines and documentation requirements when a Psychiatric Diagnostic Interview is performed in a nursing home setting.

A psychiatrist, PMHNP, or PCNS may also provide pharmacologic management, 90862, in a nursing home setting.

All other Psychology/Counseling services are not billable by a psychiatrist, PMHNP, PCNS, provisionally licensed psychologist, psychologist, LCSW, LMSW, PLPC, or LPC in the nursing home setting.

SCHOOL BASED SERVICES

When services are provided on public school grounds, the services are billed by the school district using their National Provider Identifier number (NPI) and the individual's NPI as the performing provider. Reimbursement is made back to the school district. The only appropriate place of service for a public school setting is 03 and must be used.

DIAGNOSIS CODES

The diagnosis code on the claim must be a valid ICD-9 diagnosis code and must be mental health related. **This does not include mental retardation.** The only valid code ranges for the psychology/counseling program are 295-316, V11-V118, V154-V1542, V17-V170, V40-V401, V61-V619, V624, V628-V6289, V673, V710-V7102, and V79-V791. An appropriate 4th or 5th digit may be required for the diagnosis code to be valid.

(Psychological services will be covered if they are determined medically necessary when using the DSM IV-TR diagnostic criteria. PA approval is based on the DSM IV-TR diagnosis code. However, the diagnosis code on a submitted claim must be the appropriate ICD-9 code.)

DOCUMENTATION REQUIREMENTS

DIAGNOSTIC ASSESSMENT

A current Diagnostic Assessment as defined in CSR 70-98.015 from a MO HealthNet enrolled provider must be documented in the client's medical record. This assessment will assist in ensuring an appropriate level of care, identifying necessary services, developing a treatment plan and documenting the following:

- Statement of needs, goals, and treatment expectations from the individual requesting services; the family's perceptions when appropriate and available
- Presenting problem and referral source
- History of previous psychiatric and/or substance abuse treatment including number and type of admissions
- Current medications; medication allergies/adverse reactions
- Recent alcohol/drug use for at least the past 30 days; a substance abuse history including duration, patterns, and consequence of use
- Current psychiatric symptoms
- Family, social, legal, and vocational/educational status and functioning. Historical data is also required unless short-term crisis intervention or detoxification are the only services being provided
- Current use of resources and services from other agencies
- Personal and social resources and strengths, including availability of family, peer, and other natural supports
- Multi-axis diagnosis or diagnostic impression according to the current edition of the DSM or International Classification of Diseases, Ninth Revision (ICD-9). The ICD-9 code is required on the treatment plan for billing purposes.

PLAN OF TREATMENT

A current Plan of Treatment as defined in CSR 70-98.015 is required documentation as part of the client's medical record. A treatment plan must be developed based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the client's situation and reflects the need for psychology/counseling services. The Treatment Plan must be individualized to reflect the unique needs and goals of the client. The Treatment Plan must include but is not limited to the following:

- Measurable goals and outcomes
- How each goal/outcome will be accomplished
 - Services, supports, staff member responsible,
 - Actions required of the participant, family, peers, etc.
- Involvement of family, when indicated
- Identification of and plan for coordinating with other agencies
- Referrals to other organizations for other needed services
- Identification of medications
- Projected time frame for completion of each goal/outcome
- Estimated completion/discharge date

TREATMENT UPDATE:

The Treatment Plan must be reviewed on a periodic basis to evaluate progress towards goals/outcomes and to update the plan. Each client will participate in the review of his/her treatment plan. The frequency of plan reviews is based on the level of care or other program rules. Children under the age of 13 should have their treatment plans updated at least every 6 months. Children 13 and older and adults should be done at least every year. A crisis or significant event may require additional review and the treatment plan must be updated and changed as indicated. Each update must include the therapist's assessment of current symptoms and behaviors related to diagnosis, progress towards goals, justification of changed or new diagnosis, and response to other concurrent treatments such as family or group therapy and medications. Plans for continuing treatment and/or termination from therapy and aftercare must be expressed in each Treatment Plan update.

PROGRESS NOTES

Progress Notes as defined in CSR 70-98.015 must be written in narrative form, fully describe each session, and be kept in the patient's medical record for each date of service for which a claim is filed. A check-off list or pre-established form is not acceptable as sole documentation. Progress notes for Psychology/Counseling services must specify:

- First and last name of client
- Specific service rendered
- Date (month/day/year)
- Actual clock begin and end times (1:00 p.m. to 2:00 p.m.)
- Name of person who provided the service
- Setting
- Patient's report of recent symptoms and behaviors related to diagnosis and treatment plan goals
- Therapist's intervention for the visit and participant's response
- The pertinence of the service to the treatment plan
- Patient's progress towards goals in treatment plan
- Family Therapy - must identify each member of the family, first and last name, included in the session and
 - Description of immediate issue addressed
 - Identification of underlying roles, conflicts or patterns
 - Description of therapist intervention, patient response, and progress toward specific goal
- Group Therapy - must identify the number of group members present and
 - Description of immediate issue addressed
 - Identification of underlying roles, conflicts or patterns
 - Description of therapist intervention, patient's response, and progress towards goals

(FYI – These are generalized points of CSR 70-98.015. Providers should refer to this rule for a complete description of the documentation requirements.

Note: If **Individual Interactive Therapy** is provided, the documentation must include the need for this service and the type of equipment, devices, or other mechanism of equipment used. (This is specifically required per CSR 70-98.015).

If the service is for a child in the legal custody of the Children's Division (CD), a copy of the Treatment Plan must be provided to the CD.

These documentation requirements do not replace or negate documentation/reports required by CD for individuals in their care and custody. Providers are expected to comply with policies and procedures established by CD.

AFTERCARE PLAN

When care is completed, the aftercare plan must include, but is not limited to, the following:

- Dates (care) begin and end
- Frequency and duration of visits
- Target symptoms/behaviors addressed
- Interventions
- Progress achieved towards goals
- Final diagnosis
- Final recommendations including further services, providers, and activities to promote further recovery

For all medically necessary covered services, the stipulated documentation is an essential and integral part of the service. No service will be considered performed if documentation requirements are not met, and no reimbursement will be made.

Only the enrolled MO HealthNet provider can provide psychology/counseling services and be reimbursed. MO HealthNet does not cover services provided by someone other than the enrolled provider.

Services provided by an individual under the direction or supervision of the enrolled provider are not covered.

MO HealthNet providers must retain for six (6) years from the date of service, fiscal and medical records that coincide with and fully document services billed to MO HealthNet and must furnish or make records available for inspection or audit by the Department of Social Services or its representative upon request.

PHARMACOLOGICAL MANAGEMENT – CPT 90862

Pharmacological management is intended for use for patients who are being managed primarily by psychotropic medications or electroconvulsive therapy (ECT, procedure code 90870). Pharmacological management must be provided during a face-to-face visit with the patient and any psychotherapy must be less than 20 minutes.

The focus of a pharmacological management visit is the use of medication for relief of the patient's signs and symptoms of mental illness. When the patient continues to experience signs and symptoms of mental illness necessitating discussion beyond minimal psychotherapy in a given day, the focus of the service is broader and is considered psychotherapy rather than pharmacological management.

Documentation Requirements – Pharmacological Management

The treating provider must document the medical necessity of the chosen treatment and list the diagnosis code that most accurately describes the condition of the patient that necessitated the need for the pharmacological management. All documentation must support that the service was reasonable and medically necessary for the billed diagnosis. A check-off list is not accepted as sole documentation.

Documentation of medical necessity for pharmacological management must address all of the following information in the patient's medical record in legible format:

- Date and time
- Diagnosis – update at least annually
- Interim Medication history
- Current symptoms and problems that include any physical symptoms
- Problems, reactions, and side effects, if any, to medications and/or ECT
- Current Mental Status Exam
- Any medication modifications
- The reasons for medication adjustments/changes or continuation
- Desired therapeutic drug levels, if applicable
- Current laboratory values, if applicable
- Anticipated physical and behavioral outcome(s)

PROCEDURE CODES FOR LCSW AND LPC

The procedure codes listed below are the only counseling codes billable by an LCSW, LMSW, LPC, or PLPC. The appropriate AJ or UD modifier must be used for **all** codes.

Procedure Code	Modifier	Maximum Allowed	Maximum Quantity	Description
90801		\$24.00	6	Assessment
90801	U8	\$29.00	6	Assessment-home/private school (PS)
90802		\$24.00	2	Assessment-interactive (intac)
90802	U8	\$29.00	2	Assessment-interactive-home/PS
90804		\$24.00	1	Individual 20-30 mins
90804	U8	\$29.00	1	Individual 20-30 mins- home/PS
90806		\$48.00	1	Individual 45-50 mins
90806	U8	\$58.00	1	Individual 45-50 mins- home/PS
90810		\$24.00	1	Intac Indiv 20-30 mins
90810	U8	\$29.00	1	Intac Indiv 20-30 mins- home/PS
90812		\$48.00	1	Intac Indiv 45-50 mins
90812	U8	\$58.00	1	Intac Indiv 45-50 mins-home/PS
90816		\$24.00	1	Indiv hosp 20-30 mins
90818		\$48.00	1	Indiv hosp 45-50 mins
90823		\$24.00	1	Intac Indiv Hosp 20-30 mins
90826		\$48.00	1	Intac Indiv Hosp 45-50 mins
90846		\$24.00	2	Family w/o Patient
90846	U8	\$29.00	2	Family w/o Patient-home/PS
90847		\$24.00	2	Family w/ Patient
90847	U8	\$29.00	2	Family w/ Patient-home/PS
90853		\$10.00	3	Group Therapy
S9484		\$48.00	6	Crisis Intervention, hour
S9484	U8	\$53.00	6	Crisis Intervention, hour-home/PS

PROCEDURE CODES FOR PSYCHOLOGISTS

The procedure codes listed below are the only counseling codes billable by a provisional licensed psychologist, or psychologist. The AH modifier must be used on **all** codes.

Procedure Code	Modifier	Maximum Allowed	Maximum Quantity	Description
90801		\$30.00	6	Assessment
90801	U8	\$35.00	6	Assessment-home/private school PS
90802		\$30.00	2	Assessment-interactive (intac)
90802	U8	\$35.00	2	Assessment-interactive-home/PS
90804		\$30.00	1	Individual 20-30 mins
90804	U8	\$35.00	1	Individual 20-30 mins- home/PS
90806		\$60.00	1	Individual 45-50 mins
90806	U8	\$70.00	1	Individual 45-50 mins- home/PS
90810		\$30.00	1	Intac Indiv 20-30 mins
90810	U8	\$35.00	1	Intac Indiv 20-30 mins- home/PS
90812		\$60.00	1	Intac Indiv 45-50 mins
90812	U8	\$70.00	1	Intac Indiv 45-50 mins-home/PS
90816		\$30.00	1	Indiv hosp 20-30 mins
90818		\$60.00	1	Indiv hosp 45-50 mins
90823		\$30.00	1	Intac Indiv Hosp 20-30 mins
90826		\$60.00	1	Intac Indiv Hosp 45-50 mins
90846		\$30.00	2	Family w/o Patient
90846	U8	\$35.00	2	Family w/o Patient-home/PS
90847		\$30.00	2	Family w/ Patient
90847	U8	\$35.00	2	Family w/ Patient-home/PS
90853		\$12.50	3	Group Therapy
90880		\$8.00	1	Hypnotherapy
90885		\$24.00	1	Psych eval of hospital records
96101		\$60.00	4	Testing – admin by psychologist
96101	U8	\$60.00	4	Testing – psychologist - home/PS
96103		\$20.00	4	Testing – admin by computer
96103	U8	\$20.00	4	Testing – admin by comp – home/PS
96105		\$35.00	1	Assess of aphasia
96111		\$35.00	1	Developmental testing, extended
96116		\$35.00	1	Neurobehavior status exam
S9484		\$60.00	6	Crisis Intervention, hour
S9484	U8	\$65.00	6	Crisis Intervention, hour- home/PS

**PSYCHIATRISTS, PSYCHIATRIC CLINICAL NURSES, FQHC,
PSYCHIATRIC MENTAL HEALTH NURSE PRACTITIONERS
AND RHC**

Procedure Code	Modifier	MO HealthNet Maximum Allowed	Maximum Quantity	Description
90801		\$90.08	6	Psy dx interview Psy dx interview, home/private school
90801	U8	\$95.08	6	PS
90802		\$95.50	2	Intac psy dx interview
90802	U8	\$100.50	2	Intac psy dx interview, home/PS
90804		\$37.86	1	Psy tx, office, 20-30 min
90804	U8	\$43.86	1	Psy tx, 20-30 min, home/PS
90805		\$41.86	1	Psy tx, off, 20-30 min w/e&m
90805	U8	\$46.86	1	Psy tx, 20-30 min w/e&m, home/PS
90806		\$66.00	1	Psy tx, off, 45-50 min
90806	U8	\$86.00	1	Psy tx, 45-50 min, home/PS
90807		\$71.50	1	Psy tx, off, 45-50 min w/e&m
90807	U8	\$81.50	1	Psy tx, 45-50 min w/e&m home/PS
90810		\$40.24	1	Intac psy tx, off, 20-30 min
90810	U8	\$45.24	1	Intac psy tx, 20-30 min, home/PS
90811		\$46.26	1	Intac psy tx, 20-30 w/e&m
90811	U8	\$50.76	1	Intac psy tx, 20-30, w/e&m, home/PS
90812		\$66.00	1	Intac psy tx, off, 45-50 min
90812	U8	\$76.00	1	Intac psy tx, 45-50 min home/PS
90813		\$71.50	1	Intac psy tx, 45-50 min w/e&m Intac psy tx, 45-50 min w/e&m,
90813	U8	\$81.50	1	home/PS
90816		\$35.66	1	Psy tx, hosp, 20-30 min
90817		\$39.21	1	Psy tx, hosp, 20-30 min w/e&m
90818		\$66.00	1	Psy tx, hosp, 45-50 min
90819		\$71.50	1	Psy tx, hosp, 45-50 min w/e&m
90823		\$38.48	1	Intac psy tx, hosp, 20-30 min
90824		\$42.51	1	Intac psy tx, hosp 20-30 w/e&m
90826		\$66.00	1	Intac psy tx, hosp, 45-50 min
90827		\$71.50	1	Intac psy tx, hosp, 45-50 w/e&m
90846		\$52.30	2	Family psy tx w/o patient
90846	U8	\$57.30	2	Family psy tx w/o patient, home/PS
90847		\$65.12	2	Family psy tx w/patient
90847	U8	\$70.12	2	Family psy tx w/patient, home/PS
90853		\$18.45	3	Group psychotherapy
90862		\$31.92	1	Medication management
90865		\$90.66	1	Narcosynthesis

Procedure Code	Modifier	MO HealthNet Maximum Allowed	Maximum Quantity	Description
90870		\$83.79	1	Electroconvulsive therapy
90880		\$65.32	1	Hypnotherapy
90885		\$24.00	1	Psy evaluation of records
96101		\$66.00	4	Testing – admin by physician
96101	U8	\$66.00	4	Testing – admin by phys – home/PS
96103		\$23.76	4	Testing – admin by computer
96103	U8	\$23.76	4	Testing – admin by computer – home/PS
96105		\$42.68	1	Assessment of aphasia
96111		\$78.33	1	Developmental test, extend
96116		\$58.59	1	Neurobehavior status exam
S9484		\$60.00	6	Crisis intervention, per hour
S9484	U8	\$65.00	6	Crisis intervention, per hour home/PS

The U8 Modifier is the only appropriate modifier and must be used when submitting claims for place of service 12 (home) or 99 (private school – PS) as indicated.

When multiple services are rendered on the same day by the same performing provider an NCCI modifier is required on the second service. The NCCI modifier is in addition to the specialty modifier and, when appropriate, the U8 modifier. Providers should reference the Fee Schedule link on the MHD Web site for a list of NCCI modifiers and use the appropriate modifier for billing.

Procedure Codes

Providers must use the appropriate procedure code when billing for testing, 96101 or 96103.

Psychological Testing may NOT be performed by an LCSW, LMSW, PLPC or LPC.

Psychological Testing administered by a technician (96102) is NOT a covered service.

Neuropsychological Testing (96118, 96119, and 96120) are NOT covered services.