KEPRO Utilization Management Guidelines for West Virginia Psychiatric Services Version 2.5

CHANGE LOG

Replace	Changes	Date of Change
Version 2.2	Update references to DSM and ICD	October 1, 2015
MR/DD references	Intellectual Disability/Developmental Disability (ID/DD)	October 1, 2015
LICSW's are not required to use codes with an AJ modifier when working in a psychiatric practice	Include LICSW's as able to provide specific services (90791, 90832, 90834, 90837, 90839, 90840, 90846, 90847, 90853)	August 16, 2016
Documentation requirements for some services - removing language of a practice with 5 physicians or less	Corrected documentation requirements – please see each service for specific details	March 2, 2017
96118 and 96120 are deleted CPT codes	Add 96132, 96133, 96136, 96137, and 96146 codes as replacements for 96118 and 96120	March 29, 2019

KEPRO
Utilization Management Guidelines For West Virginia Medicaid Fee-for Service Providers—Psychiatrist

Version 2.5

Service Utilization Management Guidelines
Psychiatric Services – CPT Codes
WV Medicaid Fee-for-Service Providers

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Core-Tier 1

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These Service Utilization Management (UM) Guidelines are organized to provide an overview of the approved CPT code services psychiatrists and eligible staff in their practices may provide Medicaid beneficiaries and invoice the WV Bureau for Medical Services for reimbursement. Notice that each service listing provides:

- a definition,
- level of benefit,
- initial authorization limits,
- increments of re-authorization, and
- service exclusions.

In addition, the service listing provides:

- member-specific criteria, which discusses the conditions for:
  - admission,
  - continuing stay,
  - discharge,
- clinical exclusions, and
- basic documentation requirements.

The elements of these service listings will be the basis for utilization reviews and management by KEPRO. Additional detail regarding service definitions and documentation requirements can be found in the American Medical Association Current Procedural Terminology (CPT) Manual.

Request for Prior Authorization

KEPRO has developed a tiered system for initial and continuing-stay service authorizations. While most services require the provider submit only minimal information for the initial authorization, others require the provision of more clinical information to establish medical necessity. Continued-stay authorizations may require the additional clinical information be submitted. Admission and continued stay criteria for these services were developed based upon the intensity of the service in question, as members are best served when services are tailored to individual needs and are provided in the least restrictive setting.

Status of Request for Prior Authorization

When a prior authorization for service is required, the service provider submits the required information to KEPRO. The provider will be notified if the request is authorized, pended (additional information is needed to make the decision), closed or denied and/or what alternative services may be recommended.

Provider requests for service authorizations failing to meet the medical necessity guidelines are subject to negotiations between the provider and KEPRO. KEPRO strives to assist the provider in developing an appropriate plan of care for each member. Typically, the vast majority of discrepancies between the request for service and final status are resolved through discussion and mutual agreement. In the event that a member truly does not have a demonstrated behavioral health or ID/DD diagnosis and/or need that meet the guidelines for care, the request will be denied. In this event, both the provider and member will receive notification of the denial. Please see the KEPRO Provider Manual for additional information regarding the denial and appeals process.

Multiple Service Providers

Each provider is responsible for obtaining authorization for the service(s) they provide an individual. In cases where one provider has already received prior authorization to perform a service and an additional provider(s) attempts to obtain an authorization that would exceed the client benefit, KEPRO Care Managers will make every effort to determine which provider the member chooses to have render the service. We are hopeful that providers will continue to coordinate services for members to avoid duplication and maximize the therapeutic benefit of interventions.

Note: It is the provider's responsibility to coordinate care and establish internal utilization management processes to ensure members meet all medical necessity/service utilization guidelines and to obtain authorization prior to the onset of service when required. In instances where another provider is performing the service requested or the member benefit is exhausted, requests will not be authorized.

Medical Necessity

Prior authorization does not guarantee payment for services. Prior authorization is an initial determination that medical necessity requirements are met for the requested service. In the Managed Care position paper, published in 1999, the state of West Virginia introduced the following definition of medical necessity: "services and supplies that are (1) appropriate and necessary for the symptoms, diagnosis or treatment of an illness; (2) provided for the diagnosis or direct care of an illness; (3) within the standards of good practice; (4) not primarily for the convenience of the plan member or provider; and (5) the most appropriate level of care that can be safely provided."

The CPT code services rendered by psychiatrists more clearly define the services and criteria utilized to meet parts (1) and (2) of the definition above. In

determining the appropriateness and necessity of services for the treatment of specific individuals, the diagnosis, level of functioning, clinical symptoms, stability, and availability of the member's support system are evaluated. The role of the ASO is to devise clinical rules and review processes that evaluate these characteristics of individuals, ensure that psychiatric services requested are medically necessary, and to enforce the policies of the Bureau for Medical Services.

The Utilization Management Guidelines published by KEPRO serve to outline the requirements for diagnosis, level of functional impairment and clinical symptoms of individuals who require the specific services.

Part (4) of the state's medical necessity definition, in the context of CPT code services rendered by psychiatrists, relates to services requested by the member that may be helpful but are not medically necessary, as well as to alternative and complementary services not provided by the psychiatrist but to which the member may be referred. This portion of the definition prohibits the utilization of treatment codes to provide service that meets a member need but does not meet the medical necessity criteria. Prior authorization review will utilize these guidelines as well as specific clinical requirements for the specific service(s) requested.

Part (5) of the definition which refers to the "most appropriate level of care that can be safely provided", in the context of CPT codes used by psychiatrists, relates to the least restrictive type and intensity of service acceptable to meet the member's needs while ensuring that the member does not represent a direct danger to himself or others in the community.

Prior Authorization Request Tiered System

The information submitted at the ***"Core"*** tier (Tier 1) is brief and is primarily used to track utilization of various services as well as diagnostic groups and focus of treatment.

The information submitted at the second tier (Tier 2) through the Behavioral Health CareConnection® provides a clinically relevant summary of symptomatology and level of functioning, but it alone is not always sufficient documentation of a member's medical necessity. For this reason, KEPRO Care Managers may request additional information to make prior authorization decisions for members who do not clearly meet the UM guidelines for the service or do not clearly meet medical necessity requirements. The assessment, plan of care and proposed discharge criteria all serve to document the appropriateness and medical necessity of services provided to a member.

Retrospective Reviews

Retrospective reviews may determine that services as planned and documented

do not meet the criteria requirements in the Medicaid manual. Through internal utilization management processes, providers need to ensure that medical necessity documentation is complete and consistent throughout the clinical record. Additional information regarding provider reviews can be found in the WV Medicaid Outpatient Services Manual, Chapter 521 at:
http://www.dhhr.wv.gov/bms/Documents/bms_manuals_Chapter_521_psychserv.pdf

90791 Psychiatric Diagnostic Evaluation

Definition: An integrated bio-psychosocial assessment, including history, mental status, and recommendations. The evaluation may include communication with family or other sources and review and ordering of diagnostic studies.

Service Tier	Core-Tier 1
Target Population	Mental Health (MH), Substance Abuse (SA), Intellectual Disability/Developmental Disability(ID/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Core-Tier 1 required for 2 sessions/per member/per year from start date of initial service Unit = Session/Event
Re-Authorization	1. Core-Tier 1 required for additional units after one year by any provider previously utilizing the benefit for the same member. 2 sessions/per member/ per year Unit= Session/Event 2. Tier 2 data submission required to exceed limit of two (2) units per member/per year (member benefit is two (2) sessions per year from any/all providers). This level of data is required to exceed the initial authorization limit and demonstrate medical necessity. Only one unit (session) can be approved and the need for the additional unit should be described in the free-text field.
Admission Criteria	1. Member has, or is suspected of having, a behavioral health condition, **-or-** 2. Member is entering or reentering the service system, **-or-** 3. Member has need of an assessment due to a change in clinical/functional status, **-or-** 4. Evaluation is required to make specific recommendations regarding additional treatment or services required by the individual.
Continuing Stay Criteria	Member has a need for further assessment due to findings of initial evaluation and/or changes in functional status.
Discharge Criteria	1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	1. Codes 90791 and 90792 may be reported once

	per day and not on the same day as an evaluation and management service performed by the same individual for the same patient. 2. Psychotherapy, including for crisis, may not be reported on the same day as 90791 or 90792.
Clinical Exclusions	None

Documentation Requirement	Documentation/Report must contain the following and be completed within 15 calendar days from the date of service.
	
	• Date of Service
	• Location of Service
	• Purpose of Evaluation
	• Time Spent (start/stop times)
	• Physician's signature with credentials
	• Presenting Problem
	• History of Medicaid member's presenting illness
	• Duration and Frequency of Symptoms
	• Current and Past Medication efficacy and compliance
	• Psychiatric History up to Present Day
	• Medical History related to Behavioral Health Condition
	• Mental Status Exam - The Mental Status Exam must include the following elements:
	  ○ Appearance
	  ○ Behavior
	  ○ Attitude
	  ○ Level of Consciousness
	  ○ Orientation
	  ○ Speech
	  ○ Mood and Affect
	  ○ Thought Process/Form and Thought Content
	  ○ Suicidality and Homicidality
	  ○ Insight and Judgment
	• Member's diagnosis per current DSM or ICD methodology
	• Rationale for Diagnosis
	• Medicaid member's prognosis for Treatment
	• Rationale for Prognosis
	• Appropriate Recommendations consistent with the findings of the evaluation

Additional Service Criteria:

1. Physician Extenders or LICSW's may also perform this service. Permissions granted to Physician Assistants can be found in the West Virginia Code 30-3-16 [(b) and (o)] and legislative rule 11 CSR 1B. Program Instruction MA-01-06 issued January 6, 2001 allows the Physician Assistant to be reimbursed for services rendered to Medicaid eligible individuals as outlined in their job description submitted to the West Virginia Board of Medicine.

90792 Psychiatric Diagnostic Evaluation with Medical Services

Definition: Initial or reassessment evaluation by a psychiatrist. Psychiatric Diagnostic Examination includes an integrated biopsychosocial and medical assessment, including history, mental status, other physical examination elements as indicated, and recommendations. This evaluation may include communication with family or other sources, prescription of medications, and review and ordering of laboratory or other diagnostic studies.

Service Tier	Core-Tier 1
Target Population	MH, SA, ID/DD, A&C
Option	Psychiatric Services-CPT codes
Initial Authorization	Core-Tier 1 required for 2 sessions/per member/per year from start date of initial service Unit = Session/Event
Re-Authorization	1. Core-Tier 1 data submission is required for additional units after one year by any provider previously utilizing the benefit for the same member. 2. Tier 2 data submission is required to exceed limit of two (2) sessions/per member/per year. This level of data is required to exceed initial authorization limit and demonstrate medical necessity. Only one unit (session) can be approved and the need for the additional unit should be described in the free-text field.
Admission Criteria	1. Member has a known or suspected behavioral health diagnosis, **-and-** 2. Member is entering or reentering the service system, **-or** 3. Member has need of an assessment due to a change in clinical/functional status.
Continuing Stay Criteria	1. Member has a need for further assessment due to findings of initial evaluation and/or changes in functional status
Discharge Criteria	1. Member has withdrawn or been discharged from service. 2. Goals of member's Individualized Treatment Plan have been substantially met.
Service Exclusions	1. Codes 90791 and 90792 may be reported once per day and not on the same day as an evaluation and management service performed by the same individual for the same patient. 2. Psychotherapy, including for crisis, may not be reported on the same day as 90791 or 90792.
Clinical Exclusions	None

Documentation	Documentation/Report must contain the following and be completed within 15 calendar days from the date of service.
	
	• Date of Service
	• Location of Service
	• Purpose of Evaluation
	• Time Spent (start/stop times)
	• Physician's signature with credentials
	• Presenting Problem
	• History of Medicaid member's presenting illness
	• Duration and Frequency of Symptoms
	• Current and Past Medication efficacy and compliance
	• Psychiatric History up to Present Day
	• Medical History related to Behavioral Health Condition
	• Medical Systems Review
	• Mental Status Exam - The Mental Status Exam must include the following elements:
	  ○ Appearance
	  ○ Behavior
	  ○ Attitude
	  ○ Level of Consciousness
	  ○ Orientation
	  ○ Speech
	  ○ Mood and Affect
	  ○ Thought Process/Form and Thought Content
	  ○ Suicidality and Homicidality
	  ○ Insight and Judgment
	• Member's diagnosis per current DSM or ICD methodology
	• Rationale for Diagnosis
	• Medicaid member's prognosis for Treatment
	• Rationale for Prognosis
	• Appropriate Recommendations consistent with the findings of the evaluation

Additional Service Criteria:

1. Physician Assistant may also perform this service. Permissions granted to Physician Assistants can be found in the West Virginia Code 30-3-16 [(b) and (o)] and legislative rule 11 CSR 1B. Program Instruction MA-01-06 issued January 6, 2001 allows the Physician Assistant to be reimbursed for services rendered to Medicaid eligible individuals as outlined in their job description submitted to the West Virginia Board of Medicine.

H0031 AJ Mental Health assessment by a non-physician

Definition: Initial or reassessment evaluation to determine the needs, strengths, functioning level(s), mental status, and/or social history of an individual. Specialty evaluations such as occupational therapy, nutritional and functional skills assessments are included. The administration and scoring of functional skills assessments are included. This code is to be utilized by Licensed Social Workers (LGSW, LCSW) or Licensed Professional Counselors working in a psychiatric practice.

Level of Service	Core-Tier 1
Target Population	Mental Health (MH), Substance Abuse (SA), Intellectual Disability/Developmental Disability(ID/DD), Child & Adult (C&A)
Medicaid Option	Psychiatric Services-CPT Codes
Initial Authorization	Core-Tier 1 required for 1 session/per member/per year/per provider from start date of initial service Unit= Session/Event
Re-Authorization	1. Core-Tier 1 required for additional units after one year by any provider previously utilizing the benefit for the same member. 1 session/per member/ per year/per provider Unit= Session/Event 2. Tier 2 data submission required to exceeding the limit of four (4) units per member/per year (member benefit is four (4) sessions per year from any/all providers). This level of data is required to exceed the initial authorization limit and demonstrate medical necessity. Only one unit (session) can be approved and the need for the additional unit should be described in the free-text field.
Admission Criteria	1. Member has, or is suspected of having, a behavioral health condition, **-or-** 2. Member is entering or reentering the service system, **-or-** 3. Member has need of an assessment due to a change in clinical/functional status, **-or-** 4. Evaluation is required to make specific recommendations regarding additional treatment or services required by the individual.

Continuing Stay Criteria	1. Member has a need for further assessment due to findings of initial evaluation and/or changes in functional status. 2. Reassessment is needed to update/evaluate the current treatment plan.
Discharge Criteria	1. Member has withdrawn or been discharged from service. 2. Goals for the member's treatment have been substantially met.
Service Exclusions	None
Clinical Exclusions	H0031, 90791 or 90792 are not to be billed at the same initial intake or re-assessment unless the H0031 is performed first and the evaluator recommends more specific assessment by a medical or psychological professional for further evaluation of the need for medical or other specialty treatment. Documentation must justify need for further evaluation using 90791 or 90792.
Documentation	1. Initial/intake (may include use of standardized screening tools): A. Demographic data (name, age, date of birth, etc.); B. Presenting problem(s) (must establish medical necessity for evaluation) including a description of frequency, duration, and intensity of presenting symptomatology that warrants admission; C. Impact of the current level of functioning (self-report and report of others present at interview), which may include as appropriate a description of activities of daily living, social skills, role functioning, concentration, persistence, and pace; for children, current behavioral and academic functioning; D. History of behavioral health and health treatment (recent and remote); E. History of any prior suicide/homicide attempts, high risk behaviors, self-injurious behaviors, etc.; F. Medical problems and medications currently prescribed; G. Social history which may include family history as relevant, description of

	significant childhood events, arrests, educational background, current family structure, vocational history, financial status, marital history, domestic violence (familial and/or personal), substance abuse (familial and/or personal), military history if any; H. Analysis of available social support system at present; I. Mental status examination; J. Recommended treatment (initial); K. Diagnostic Impression, (must be approved/signed and dated by a licensed clinical professional with diagnostic privileges in scope of practice); and L. Place of evaluation, date of evaluation, start/stop times, signature, and credentials of evaluator. M. Efficacy of and compliance with past treatment. (If past treatment is reported) N. Past treatment history and medication compliance (If past treatment is reported) 2. Re-assessment: A. Date of last comprehensive assessment; B. Current demographic data; C. Reason for re-assessment, including description of current presenting problems (must document medical necessity for evaluation. If the re-evaluation is a global annual assessment it must be labeled as such). D. Changes in situation, behavior, functioning since prior evaluation; E. Summary of treatment since prior evaluation including a description of treatment provided over the interval and response to treatment; F. Mental status examination; G. Suggested amendments in treatment/intervention and/or

	recommendations for continued treatment or discharge; H. Specific rationale for any proposed amendment in diagnosis which must be analyzed and approved/signed by licensed clinical professional; and I. Place of evaluation, date of evaluation, start/stop times, signature, and credentials of evaluator.

Additional Service Criteria:

1. The assessments are evaluative services and standardized testing instruments.
2. The assessments are administered by qualified staff and are necessary to make determinations concerning the mental, physical and functional status of the member.

90832 Psychotherapy, 30 minutes with Patient and/or Family Member

Definition: Face-to-face structured intervention by a psychiatrist with the patient and/or family member, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

Psychotherapy services include ongoing assessment and adjustment of psychotherapeutic interventions, and may include involvement of family member(s) or others in the treatment process. The patient must be present for all or some of the service.

This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting.

Service Tier	Core-Tier 1
Target Population	Mental Health (MH), Substance Abuse (SA), Intellectual Disability/Developmental Disability(ID/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Core-Tier 1 for 10 units/per year/per member from start date of initial service Unit = 30 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. 10 additional units/per member/per year Unit = 30 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Member has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Member demonstrates intrapsychic or

	interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the member's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the member's identified treatment need(s). 2. Progress notes document member's progress relative to goals identified for treatment but goals have not yet been achieved.
Discharge Criteria	1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	1. For family psychotherapy without the patient present, use the 90846 service. 2. Psychotherapy provided to a patient in a crisis state is reported with codes 90839 and 90840 and cannot be reported in addition to psychotherapy codes 90832, 90834 and 90837. 3. Some psychiatric patients receive medical evaluation and management (E/M) service on the same day as psychotherapy by the same physician or other health care provider. To report both E/M and psychotherapy, the two services must be significant and separately identifiable. These services are reported by using codes specific for psychotherapy with E/M services (90833 and 90836). 4. Psychotherapy, including for crisis, may not be reported on the same day as the 90791 or 90792.
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation must indicate how often this service is to be provided. There must be a progress note describing each service provided, the relationship of the service to the identified mental health treatment needs, and the member's response to the service. The progress note must include the reason for the service, symptoms and

	functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment. Documentation must also include the following: • Signature with credentials • Place of service • Date of service • Time Spent (start/stop times) • Interventions Utilized

Additional Service Criteria:

1. Physician Extenders and LICSW's may also perform this service.
2. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90832 AJ Psychotherapy 30 minutes with Patient and/or Family Member

Definition: Face-to-face structured intervention by a Licensed Social Worker (LCSW, LGSW) or Licensed Professional Counselor with the patient and/or family member, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

Psychotherapy services include ongoing assessment and adjustment of psychotherapeutic interventions, and may include involvement of family member(s) or others in the treatment process. The patient must be present for all or some of the service.

This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting.

Service Tier	Core-Tier 1
Target Population	Mental Health (MH), Substance Abuse (SA), Intellectual Disability/Developmental Disability(ID/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Core-Tier 1 for 10 units/per year/per member from start date of initial service Unit = 30 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. 10 additional units/per member/per year Unit = 30 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Member has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-**

	2. Member demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the member's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the member's identified treatment need(s). 2. Progress notes document member's progress relative to goals identified for treatment but goals have not yet been achieved.
Discharge Criteria	1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	1. Some psychiatric patients receive medical evaluation and management (E/M) service on the same day as psychotherapy by the same physician or other health care provider. To report both E/M and psychotherapy, the two services must be significant and separately identifiable. These services are reported by using codes specific for psychotherapy with E/M services (90833 and 90836) by the physician. 2. Psychotherapy, including for crisis, may not be reported on the same day as the 90791 or 90792. 3. For family psychotherapy without the patient present, use the 90846 service for the physician.
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation must indicate how often this service is to be provided. There must be a progress note describing each service provided, the relationship of the service to the identified mental health treatment needs, and the member's response to the service. The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable

	theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment. Documentation must also include the following: • Signature with credentials • Place of service • Date of service • Time Spent (start/stop times) • Interventions Utilized

Additional Service Criteria:

1. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90833 Psychotherapy, 30 min. with Patient and/or Family Member with Evaluation and Management Service

Definition: Face-to-face structured intervention by a psychiatrist with the patient and/or family member, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

Psychotherapy services include ongoing assessment and adjustment of psychotherapeutic interventions, and may include involvement of family member(s) or others in the treatment process. The patient must be present for all or some of the service.

This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting.

This service is an add-on code to an Evaluation and Management Service (E/M).

Service Tier	Core-Tier 1
Target Population	Mental Health (MH), Substance Abuse (SA), Intellectual Disability/Developmental Disability(ID/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Core-Tier 1 for 10 units/per year/per member from start date of initial service Unit = 30 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. 10 additional units/per member/per year Unit = 30 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.

Admission Criteria	1. Member has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Member demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the member's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change, **-and-** 5. Medical evaluation and/or management services are required.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the member's identified treatment need 2. Progress notes document member's progress relative to goals identified for treatment but goals have not yet been achieved.
Discharge Criteria	1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	Services 90791 and 90792 Psychiatric Diagnostic Evaluation and Psychiatric Diagnostic Evaluation with Medical Evaluation and 90836 Psychotherapy with Patient and/or Family Member with Evaluation and Management Service 45 minutes may not be billed *on the same day as* 90833 Psychotherapy with Patient and/or Family Member with Evaluation and Management Service 30 minutes.
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation must indicate how often this service is to be provided. There must be a progress note describing each service provided, the relationship of the service to the identified mental health treatment needs, and the member's response to the service. The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for

	assessing change, and the member's response to the intervention and/or treatment. The documentation must also include the following: • Signature with credentials • Place of service • Date of service • Time Spent (start/stop times) • Interventions Utilized

Additional Service Criteria:

1. Physician Assistant may also perform this service.
2. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90834 Psychotherapy, 45 minutes with Patient and/or Family Member

Definition: Face-to-face structured intervention by a psychiatrist with the patient and/or family member, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

Psychotherapy services include ongoing assessment and adjustment of psychotherapeutic interventions, and may include involvement of family member(s) or others in the treatment process. The patient must be present for all or some of the service.

This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting.

Service Tier	Core-Tier 1
Target Population	Mental Health (MH), Substance Abuse (SA), Intellectual Disability/Developmental Disability(ID/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Core-Tier 1 for 10 units/per year/per member from start date of initial service Unit = 45 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. 10 additional units/per member/per year Unit = 45 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten (10) additional units/ per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g. 15, 20 etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Member has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Member demonstrates intrapsychic or

	interpersonal conflicts and/or need to change behavior patterns, **-and-** 1. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the member's problem, **-and-** 2. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the member's identified treatment needs. 2. Progress notes document member's progress relative to goals identified for treatment, but goals have not yet been achieved.
Discharge Criteria	1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	1. For family psychotherapy without the patient present, use the 90846 service. 2. Psychotherapy provided to a patient in a crisis state is reported with codes 90839 and 90840 and cannot be reported in addition to psychotherapy codes 90832, 90834 and 90837. 3. Some psychiatric patients receive medical evaluation and management (E/M) service on the same day as psychotherapy by the same physician or other health care provider. To report both E/M and psychotherapy, the two services must be significant and separately identifiable. These services are reported by using codes specific for psychotherapy with E/M services (90833 and 90836). 4. Psychotherapy, including for crisis, may not be reported on the same day as the 90791 or 90792.
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation must indicate how often this service is to be provided. There must be a progress note describing each service provided, the relationship of the service to the identified mental health treatment needs, and the member's response to the service. The progress note must include the reason for the service, symptoms and

	functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment. The documentation must also include the following: • Signature with credentials • Place of service • Date of service • Time Spent (start/stop times) • Interventions Utilized

Additional Service Criteria:

1. Physician Extenders or LICSW's may also perform this service.
2. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90834 AJ Psychotherapy 45 minutes with Patient and/or Family Member

Definition: Face-to-face structured intervention by a Licensed Social Worker (LCSW, LGSW) or Licensed Professional Counselor with the patient and/or family member, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

Psychotherapy services include ongoing assessment and adjustment of psychotherapeutic interventions, and may include involvement of family member(s) or others in the treatment process. The patient must be present for all or some of the service.

This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting.

Service Tier	Core-Tier 1
Target Population	Mental Health (MH), Substance Abuse (SA), Intellectual Disability/Developmental Disability(ID/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Core-Tier 1 for 10 units/per year/per member from start date of initial service Unit = 45 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. 10 additional units/per member/per year Unit = 45 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Member has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Member demonstrates intrapsychic or

	interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the member's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the member's identified treatment need(s). 2. Progress notes document member's progress relative to goals identified for treatment but goals have not yet been achieved.
Discharge Criteria	1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	1. Some psychiatric patients receive medical evaluation and management (E/M) service on the same day as psychotherapy by the same physician or other health care provider. To report both E/M and psychotherapy, the two services must be significant and separately identifiable. These services are reported by using codes specific for psychotherapy with E/M services (90833 and 90836) by the physician. 2. Psychotherapy, including for crisis, may not be reported on the same day as the 90791 or 90792. 3. For family psychotherapy without the patient present, use the 90846 service for the physician.
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation must indicate how often this service is to be provided. There must be a progress note describing each service provided, the relationship of the service to the identified mental health treatment needs, and the member's response to the service. The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment.

	The documentation must also include the following: • Signature with credentials • Place of service • Date of service • Time Spent (start/stop times) • Interventions Utilized

Additional Service Criteria:

1. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not “stand-alone” interventions.

90836 Psychotherapy, 45 min. with Evaluation and Management Services

Definition: Face-to-face structured intervention by a psychiatrist to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting. This service includes medical evaluation and management services and may include more intensive medical psychotherapy than is allowable under the Pharmacologic Management service.

Service Tier	Core-Tier 1
Target Population	Mental Health (MH), Substance Abuse (SA), Intellectual Disability/Developmental Disability(ID/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Core-Tier 1 for 10 units/per year/per member from start date of initial service Unit = 45-50 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. 10 additional units/per member/per year Unit = 45-50 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Member has a behavioral health diagnosis (other than a V-code) which qualifies for Medicaid behavioral health services, **-and-** 2. Member demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for

	purposes of focusing on the dynamics of the member's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change, **-and-** 5. Medical evaluation and/or management services are required.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the member's identified treatment need(s). 2. Progress notes document member's progress relative to goals identified for treatment, but goals have not yet been achieved.
Discharge Criteria	1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	Services 90801 Psychiatric Diagnostic Interview Examination, 90862 Pharmacologic Management, and 90805 Individual Psychotherapy with Medical Evaluation and Management Services 20-30 minutes, may not be billed *on the same day as* 90807 Individual Psychotherapy with Medical Evaluation and Management Services 45-50 minutes. This is an outpatient service. If the member is admitted to an inpatient hospital, partial hospital or residential care facility, codes 90816, 90817, 90818 and 90819 should be utilized depending on the type and duration of psychotherapy required.
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation must indicate how often this service is to be provided. There must be a progress note describing each service provided, the relationship of the service to the identified mental health treatment needs, and the member's response to the service. The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment.

	The documentation must also include the following: • Signature with credentials • Place of service • Date of service • Time Spent (start/stop times) • Interventions Utilized

Additional Service Criteria:

1. Physician Assistant may also perform this service.
2. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not “stand-alone” interventions.

90837 Psychotherapy, 60 minutes with Patient and/or Family Member

Definition: Face-to-face structured intervention by a psychiatrist with the patient and/or family member, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

Psychotherapy services include ongoing assessment and adjustment of psychotherapeutic interventions, and may include involvement of family member(s) or others in the treatment process. The patient must be present for all or some of the service.

This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting.

Service Tier	Core-Tier 1
Target Population	Mental Health (MH), Substance Abuse (SA), Intellectual Disability/Developmental Disability(ID/DD), Child and Adult (C&A)
Program Option	Psychological Services-CPT codes
Initial Authorization	Core-Tier 1 for 10 units/per year/per member from start date of initial service Unit = 60 minutes
Re-Authorization	4. Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. 10 additional units/per member/per year Unit = 60 minutes NOTE: Tier 2 data submission required for a provider to exceed the limit of ten (10) additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Member has a behavioral health diagnosis which qualifies for Medicaid behavioral health services

	-and- 2. Member demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the member's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the member's identified treatment need(s). 2. Progress notes document member's progress relative to goals identified for treatment but goals have not yet been achieved.
Discharge Criteria	1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	None
Clinical Exclusions	1. For family psychotherapy without the patient present, use the 90846 service. 2. Psychotherapy provided to a patient in a crisis state is reported with codes 90839 and 90840 and cannot be reported in addition to psychotherapy codes 90832, 90834 and 90837. 3. Some psychiatric patients receive medical evaluation and management (E/M) service on the same day as psychotherapy by the same physician or other health care provider. To report both E/M and psychotherapy, the two services must be significant and separately identifiable. These services are reported by using codes specific for psychotherapy with E/M services (90833 and 90836). 4. Psychotherapy, including for crisis, may not be reported on the same day as the 90791 or 90792.
Documentation Requirement	Documentation must indicate how often this service is to be provided. There must be a progress note describing each service provided, the relationship of the service to the identified mental health treatment needs, and the member's response to the service. The progress note must include the reason for the service, symptoms and

	functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment. The documentation must also include the following: • Signature with credentials • Place of service • Date of service • Time Spent (start/stop times) • Interventions Utilized

Additional Service Criteria:

1. Physician Extenders or LICSW's may also perform this service.
2. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90839 Psychotherapy for Crisis; First 60 Minutes

Definition: Psychotherapy for crisis is an urgent assessment and history of a crisis state, a mental status exam and a disposition. The treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma. The presenting problem is typically life threatening or complex and requires immediate attention to a patient in high distress.

This code is used to report the total duration of time face-to-face with the patient and/or family spent by the physician providing psychotherapy for crisis, even if the time spent on that date is not continuous. For any given time spent providing this service, the physician must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during the same time period. The patient must be present for all or some of the service.

Code 90839 should be used to report the first 30-74 minutes of psychotherapy for crisis on a given date. It should be used only once per date even if the time spent by the physician is not continuous.

Service Tier	Core-Tier 1
Target Population	Mental Health (MH), Substance Abuse (SA), Intellectual Disability/Developmental Disability(ID/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Core-Tier 1 for 2 units/per 30 calendar days/per member from start date of initial service Unit = 60 minutes
Re-Authorization	Another request for prior authorization is required for any provider to exceed the limit of 2 units/per member/ per 30 calendar days for utilization review purposes – or- if this is a new crisis episode. If the crisis episode has continued for more than 74 minutes, the 90840 code should be requested to address the additional time. 2 additional units/per member/30 calendar days Unit = 60 minutes
Admission Criteria	1. Member has a behavioral health diagnosis **-** and- 2. The member presents the need for an urgent assessment of their crisis state – and- 3. Member demonstrates severe to acute psychiatric symptoms, impaired functional

	abilities due to the crisis – and – 4. Requires the immediate, direct attention of the physician to address the presenting problem which is typically life threatening or complex and requires immediate attention to a patient in high distress.
Continuing Stay Criteria	This service may be required at different points in the member's course of treatment. Each intervention is designed to be a time-limited service which stabilizes the member and evaluates their level of care.
Discharge Criteria	Crisis episode which triggered the need for this service has been sufficiently managed to promote the well-being of the member.
Service Exclusions	• Not to be used as an emergency response to a member running out of medications or housing problems. • Psychotherapy for a crisis of less than 30 minutes total duration on a given date should be reported with the 90832 or 90833 (when provided with an E/M service). • Psychotherapy for crisis should not be used in conjunction with 90791 or 90792. • No other psychiatric service may be provided and billed during this service. • Response to a Domestic Violence Situation • Admission to a Hospital • Admission to a Crisis Stabilization Unit • Time awaiting for Transportation or the transportation itself • Removal of a minor or an incapacitated adult from an abusive or neglectful household. • Completion of certification for involuntary commitment.
Clinical Exclusions	None.
Documentation Requirement	There must be a progress note for this service. The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment for the crisis The documentation must also include the following:

	• Signature with credentials
	• Safety Plan
	• Place of service
	• Date of service
	• Time Spent (start/stop times)
	• Mental Status Exam - The Mental Status Exam must include the following elements:
	  ○ Appearance
	  ○ Behavior
	  ○ Attitude
	  ○ Level of Consciousness
	  ○ Orientation
	  ○ Speech
	  ○ Mood and Affect
	  ○ Thought Process/Form and Thought Content
	  ○ Suicidality and Homicidality
	  ○ Insight and Judgment

Additional Service Criteria:

1. Physician Extenders or LICSW's may also perform this service.

90840 Psychotherapy for Crisis; Additional 30 Minutes

Definition: Psychotherapy for crisis is an urgent assessment and history of a crisis state, a mental status exam and a disposition. The treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma. The presenting problem is typically life threatening or complex and requires immediate attention to a patient in high distress.

This code is used to report the total duration of time face-to-face with the patient and/or family spent by the physician providing psychotherapy for crisis, even if the time spent on that date is not continuous. For any given time spent providing this service, the physician must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during the same time period. The patient must be present for all or some of the service.

Code 90840 is an add-on service to 90839 and should be used to report the additional 30 minutes following the first 74 minutes of psychotherapy for crisis on a given date.

Service Tier	Core-Tier 1
Target Population	Mental Health (MH), Substance Abuse (SA), Intellectual Disability/Developmental Disability(ID/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Core-Tier 1 for 2 units/per 30 calendar days/per member from start date of initial service Unit = 30 minutes An authorization must exist for the 90839 service by the same provider for the same member for the same date of service.
Re-Authorization	2 units/per member/ per 30 calendar days for utilization review purposes Unit = 30 minutes Another request for prior authorization is required for any provider to exceed the limit of 74 minutes for a crisis response on a specific date. An authorization must exist for the 90839 service by the same provider for the same member for the same date of service.
Admission Criteria	1. Member has a behavioral health diagnosis **-** and- 2. The member presents the need for an urgent assessment of their crisis state – and-

	3. Member demonstrates severe to acute psychiatric symptoms, impaired functional abilities due to the crisis – and – 4. Requires the immediate, direct attention of the physician to address the presenting problem which is typically life threatening or complex and requires immediate attention to a patient in high distress.—and- 5. The 74 minutes of 90839 have been exhausted for this date of service.
Continuing Stay Criteria	This service may be required at different points in the member's course of treatment. Each intervention is designed to be a time-limited service which stabilizes the member and evaluates their level of care.
Discharge Criteria	Crisis episode which triggered the need for this service has been sufficiently managed to promote the well-being of the member.
Service Exclusions	• Not to be used as an emergency response to a member running out of medications or housing problems. • Psychotherapy for a crisis of less than 74 minutes total duration on a given date should be reported with the 90839 service. • Psychotherapy for crisis should not be used in conjunction with 90791 or 90792. • No other psychiatric service may be provided and billed during this service. • Response to a Domestic Violence Situation • Admission to a Hospital • Admission to a Crisis Stabilization Unit • Time awaiting for Transportation or the transportation itself • Removal of a minor or an incapacitated adult from an abusive or neglectful household. • Completion of certification for involuntary commitment.
Clinical Exclusions	None
Documentation Requirement	There must be a progress note for this service. The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment for the crisis.

	The documentation must also include the following:
	
	• Signature with credentials
	• Safety Plan
	• Place of service
	• Date of service
	• Time Spent (start/stop times)
	• Mental Status Exam - The Mental Status Exam must include the following elements:
	  ○ Appearance
	  ○ Behavior
	  ○ Attitude
	  ○ Level of Consciousness
	  ○ Orientation
	  ○ Speech
	  ○ Mood and Affect
	  ○ Thought Process/Form and Thought Content
	  ○ Suicidality and Homicidality
	  ○ Insight and Judgment

Additional Service Criteria:

1. Physician Extenders or LICSW's may also perform this service.

90846 Family Psychotherapy (without patient present)

Definition: Face-to-face structured family intervention by a psychiatrist to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting.

Service Tier	Core-Tier 1
Target Population	Mental Health (MH), Substance Abuse (SA), Intellectual Disability/Developmental Disability(ID/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Core-Tier 1 for 10 units/per year/per member from start date of initial service Unit = 45-50 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. 10 additional units/per member/per year Unit = 45-50 minutes **NOTE:** Tier 2 data submission required for a provider to exceed limit of ten additional units/per member/per year. This level of data is required to exceed authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Member has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Member demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the member's problem, **-and-**

	4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the member's identified treatment need(s). 2. Progress notes document member's progress relative to goals identified for treatment, but goals have not yet been achieved.
Discharge Criteria	1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	90846 Family Psychotherapy (without patient present) has a combined service limit with 90847 Family Psychotherapy (with patient present) of 10 units/per member/per year.
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation must indicate how often this service is to be provided. There must be a progress note describing each service provided, the relationship of the service to the identified mental health treatment needs, and the member's response to the service. The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment. The documentation must also include the following: • Signature with credentials • Place of service • Date of service • Time Spent (start/stop times) • Interventions Utilized

Additional Service Criteria:

1. Physician Extenders or LICSW's may also perform this service.
2. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.
3. This service may not be used solely to communicate evaluation and test results.

90847 Family Psychotherapy (with patient present)

Definition: Face-to-face structured family intervention by a psychiatrist to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting. The identified patient must be present to utilize this code.

Service Tier	Core-Tier 1
Target Population	Mental Health (MH), Substance Abuse (SA), Intellectual Disability/Developmental Disability(ID/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Core-Tier 1 for 10 units/per year/per member from start date of initial service Unit = 45-50 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. 10 additional units/per member/per year Unit = 45-50 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Member has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Member demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the member's problem, **-and-**

	4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the member's identified treatment need(s). 2. Progress notes document member's progress relative to goals identified for treatment but goals have not yet been achieved.
Discharge Criteria	1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	90847 Family Psychotherapy (with patient present) has a combined service limit with 90846 Family Psychotherapy (without patient present) of 10 units/per member/per year.
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation must indicate how often this service is to be provided. There must be a progress note describing each service provided, the relationship of the service to the identified mental health treatment needs, and the member's response to the service. The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment. The documentation must also include the following: • Signature with credentials • Place of service • Date of service • Time Spent (start/stop times) • Interventions Utilized

Additional Service Criteria:

1. Physician Extenders or LICSW's may also perform this service.
2. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.
3. This service may not be used solely to communicate evaluation and test results.

90847 AJ Family Psychotherapy (with patient present)

Definition: Face-to-face structured family intervention by a Licensed Social Worker (LCSW, LGSW) or Licensed Professional Counselor to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting. The identified patient must be present to utilize this code.

Service Tier	Core-Tier 1
Target Population	Mental Health (MH), Substance Abuse (SA), Intellectual Disability/Developmental Disability(ID/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Core-Tier 1 for 10 units/per year/per member from start date of initial service Unit = 45-50 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. 10 additional units/per member/per year Unit = 45-50 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Member has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Member demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the member's problem, **-and-**

	4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the member's identified treatment need(s). 2. Progress notes document member's progress relative to goals identified for treatment, but goals have not yet been achieved.
Discharge Criteria	1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	None.
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation must indicate how often this service is to be provided. There must be a progress note describing each service provided, the relationship of the service to the identified mental health treatment needs, and the member's response to the service. The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment. The documentation must also include the following: • Signature with credentials • Place of service • Date of service • Time Spent (start/stop times) • Interventions Utilized

Additional Service Criteria:

1. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand alone" interventions.
2. This service may not be used solely to communicate evaluation and test results.

90853 Group Psychotherapy

Definition: Face-to-face structured intervention by a psychiatrist to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting. These activities are carried out within a group context where the therapist engages the group dynamics in terms of relationships, common problems focus, and mutual support to promote progress for individual members. This code may not be utilized for multiple family group therapy.

Service Tier	Core-Tier 1
Target Population	Mental Health (MH), Substance Abuse (SA), Intellectual Disability/Developmental Disability(ID/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Core-Tier 1 for 10 units/per year/per member from start date of initial service Unit = 75-80 minutes
Re-Authorization	1. Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. 10 additional units/per member/ per year Unit = 75-80 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity and the total number of units requested over ten (10) (e.g., 15, 20, etc.) should be specified in the free-text field, otherwise ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Member has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Member demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of

	focusing on the dynamics of the member's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the member's identified treatment need(s). 2. Progress notes document member's progress relative to goals identified for treatment, but goals have not yet been achieved.
Discharge Criteria	1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	None
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation must indicate how often this service is to be provided. There must be a progress note describing each service provided, the relationship of the service to the identified mental health treatment needs, and the member's response to the service. The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment. The documentation must also include the following: • Signature with credentials • Group Topic • Place of service • Date of service • Time Spent (start/stop times) • Interventions Utilized

Additional Service Criteria:

1. Physician Extenders or LICSW's may also perform this service.
2. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90853 AJ Group Psychotherapy

Definition: Face-to-face structured intervention by a Licensed Social Worker (LCSW, LGSW) or Licensed Professional Counselor to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting. These activities are carried out within a group context where the therapist engages the group dynamics in terms of relationships, common problems focus, and mutual support to promote progress for individual members. This code may not be utilized for multiple family group therapy.

Service Tier	Core-Tier 1
Target Population	Mental Health (MH), Substance Abuse (SA), Intellectual Disability/Developmental Disability(ID/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Core-Tier 1 for 10 units/per year/per member from start date of initial service Unit = session/75-80 minutes
Re-Authorization	1. Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. 10 additional units/per member/ per year Unit = session/75-80 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity and the total number of units requested over ten (10) (e.g., 15, 20, etc.) should be specified in the free-text field, otherwise ten (10) additional units will be granted. Additionally, the need for additional units must be described in the free-text field.
Admission Criteria	1. Member has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Member demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can

	be delineated and/or the intervention is for purposes of focusing on the dynamics of the member's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the member's identified treatment need(s). 2. Progress notes document member's progress relative to goals identified for treatment, but goals have not yet been achieved.
Discharge Criteria	1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	None
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation must indicate how often this service is to be provided. There must be a progress note describing each service provided, the relationship of the service to the identified mental health treatment needs, and the member's response to the service. The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment. The documentation must also include the following: • Signature with credentials • Group Topic • Place of service • Date of service • Time Spent (start/stop times) • Interventions Utilized

Additional Service Criteria:

1. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90875 Individual Psychotherapy Biofeedback 30 minutes

Definition: Face-to-face structured intervention by a psychiatrist to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes individual psychophysiological therapy incorporating biofeedback training by any modality with psychotherapy to provide therapeutic change in an outpatient setting.

Service Tier	Core-Tier 1
Target Population	Mental Health (MH), Substance Abuse (SA), Intellectual Disability/Developmental Disability(ID/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Core-Tier 1 for 10 units/per year/per member from start date of initial service Unit = 30 minutes
Re-Authorization	1. Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. 10 additional units/per member/per year Unit = 30 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Member has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Member demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the member's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a

	framework for assessing change, **-and-** 5. Service includes biofeedback training by any modality.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the member's identified treatment need(s). 2. Progress notes document member's progress relative to goals identified for treatment, but goals have not yet been achieved.
Discharge Criteria	1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	None
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation must indicate how often this service is to be provided. There must be a progress note describing each service provided, the relationship of the service to the identified mental health treatment needs, and the member's response to the service. The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment. The documentation must also include the following: • Signature with credentials • Place of service • Date of service • Time Spent (start/stop times) • Interventions Utilized

Additional Service Criteria:

1. Psychiatrist, Physician Assistant, Nurse Practitioner or other qualified professional billing this code must have specific training in biofeedback techniques.
2. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90876 Individual Psychotherapy Biofeedback 45 minutes

Definition: Face-to-face structured intervention by a psychiatrist to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes individual psychophysiological therapy incorporating biofeedback training by any modality with psychotherapy to provide therapeutic change in an outpatient setting.

Service Tier	Core-Tier 1
Target Population	Mental Health (MH), Substance Abuse (SA), Intellectual Disability/Developmental Disability(ID/DD), Child and Adult (C&A)
Program Option	Psychiatric Services-CPT codes
Initial Authorization	Core-Tier 1 for 10 units/per year/per member from start date of initial service Unit = 45 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. 10 additional units/per member/per year Unit = 45 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Member has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, **-and-** 2. Member demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the member's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a

	framework for assessing change, **-and-** 5. Service includes biofeedback training by any modality.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the member's identified treatment need(s). 2. Progress notes document member's progress relative to goals identified for treatment, but goals have not yet been achieved.
Discharge Criteria	1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	None
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	Documentation must indicate how often this service is to be provided. There must be a progress note describing each service provided, the relationship of the service to the identified mental health treatment needs, and the member's response to the service. The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment. The documentation must also include the following: • Signature with credentials • Place of service • Date of service • Time Spent (start/stop times) • Interventions Utilized

Additional Service Criteria:

1. Psychiatrist, Physician Assistant, Nurse Practitioner or other qualified professional billing this code must have specific training in biofeedback techniques.
2. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

96132 Neuropsychological Testing Evaluation by Professional, first hour

Definition: Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s), caregiver(s), when performed; first hour.

Service Tier	Core-Tier 1
Target Population	Mental Health (MH), Substance Abuse (SA), Intellectual Disability/Developmental Disability (ID/DD), Child and Adult (C&A)
Program Option	Psychiatric Services
Telehealth	Not Available
Initial Authorization	Core-Tier 1 required for 1 unit/per member/per year from start date of initial service Unit = One hour
Re-Authorization	1. Core-Tier 1 required for additional units after one year by any provider previously utilizing the benefit for the same member. 2. Tier 2 data submission required any provider when requesting another testing episode per member/per year. This level of data is required to exceed the initial authorization limit and demonstrate medical necessity. The need for these additional units should be described in the free-text field. The total number of additional units being requested must be specified in the free-text field, otherwise a maximum of one (1) additional unit will be granted.
Admission Criteria	1. Member has, or is suspected of having, a behavioral health condition with an organic component or etiology, **-or-** 2. Member requires testing or evaluation for a specific purpose, **-or-** 3. Neurobehavioral testing/evaluation is required to make specific recommendations regarding additional treatment or services required by the individual.
Continuing Stay Criteria	1. Member has a need for further assessment due to findings of initial evaluation and/or changes in functional status. 2. Reassessment is needed to update/evaluate the current treatment plan.
Discharge Criteria	Member has withdrawn or been discharged from service.
Service Exclusions	This service is not intended for: • Psychometrician/Technician Work • Computer - Scoring • Self-Administered Assessments • Computer – Interpretation

Clinical Exclusions	None

Documentation Requirements	Documentation/Report must contain the following and be completed in 15 calendar days from the date of service:
	• Date of Service
	• Location of Service
	• Purpose of Evaluation
	• Time Spent (start/stop times)
	• Signature with credentials
	• Documentation that the member was present for the evaluation
	• Documentation must contain the results (scores and category) of the administered tests/evaluations
	• Mental Status Exam - The Mental Status Exam must include the following elements:
	  ○ Appearance
	  ○ Behavior
	  ○ Attitude
	  ○ Level of Consciousness
	  ○ Orientation
	  ○ Speech
	  ○ Mood and Affect
	  ○ Thought Process/Form and Thought Content
	  ○ Suicidality and Homicidality
	  ○ Insight and Judgment
	• Rendering of the Medicaid Member's diagnosis within the current DSM or ICD Methodology
	• Recommendations consistent with the findings of the administered tests/evaluations

Additional Service Criteria:

- Must be performed by a West Virginia Licensed Psychologist in good standing with WV Board of Examiners of Psychology, a Supervised Psychologist who is supervised by a Board approved Supervisor, a Physician or a Physician Extender.

96133 Neuropsychological Testing Evaluation by Professional, additional hour

Definition: Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s), caregiver(s), when performed; first hour.

Service Tier	Core-Tier 1
Target Population	Mental Health (MH), Substance Abuse (SA), Intellectual Disability/Developmental Disability (ID/DD), Child and Adult (C&A)
Program Option	Psychological Services
Telehealth	Not Available
Initial Authorization	Core-Tier 1 required for 9 units/per member/per year from start date of initial service Unit = One hour This code must be requested in combination or following the 96132 code.
Re-Authorization	1. Core-Tier 1 required for additional units after one year by any provider previously utilizing the benefit for the same member. 2. Tier 2 data submission required any provider when requesting another testing episode per member/per year. This level of data is required to exceed the initial authorization limit and demonstrate medical necessity. The need for these additional units should be described in the free-text field. The total number of additional units being requested must be specified in the free-text field, otherwise a maximum of one (1) additional unit will be granted.
Admission Criteria	1. Member has received one hour of 96136 and requires additional time and, 2. Member has, or is suspected of having, a behavioral health condition with an organic component or etiology, **-or-** 3. Member requires testing or evaluation for a specific purpose, **-or-** 4. Neurobehavioral testing/evaluation is required to make specific recommendations regarding additional treatment or services required by the individual.
Continuing Stay Criteria	1. Member has a need for further assessment due to findings of initial evaluation and/or changes in functional status. 2. Reassessment is needed to update/evaluate the current treatment plan.
Discharge Criteria	Member has withdrawn or been discharged from

	service.
Service Exclusions	This service is not intended for: • Psychometrician/Technician Work • Computer - Scoring • Self-Administered Assessments • Computer – Interpretation
Clinical Exclusions	None

Documentation Requirements	Documentation/Report must contain the following and be completed in 15 calendar days from the date of service:
	• Date of Service
	• Location of Service
	• Purpose of Evaluation
	• Time Spent (start/stop times)
	• Signature with credentials
	• Documentation that the member was present for the evaluation
	• Documentation must contain the results (scores and category) of the administered tests/evaluations
	• Mental Status Exam - The Mental Status Exam must include the following elements:
	  ○ Appearance
	  ○ Behavior
	  ○ Attitude
	  ○ Level of Consciousness
	  ○ Orientation
	  ○ Speech
	  ○ Mood and Affect
	  ○ Thought Process/Form and Thought Content
	  ○ Suicidality and Homicidality
	  ○ Insight and Judgment
	• Rendering of the Medicaid Member's diagnosis within the current DSM or ICD Methodology
	• Recommendations consistent with the findings of the administered tests/evaluations

Additional Service Criteria:

- Must be performed by a West Virginia Licensed Psychologist in good standing with WV Board of Examiners of Psychology, a Supervised Psychologist who is supervised by a Board approved Supervisor, a Physician or a Physician Extender.

96136 Psychological or Neuropsychological Test Administration and Scoring by Physician or Other Health Professional, first 30 minutes

Definition: Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes.

Service Tier	Core-Tier 1
Target Population	Mental Health (MH), Substance Abuse (SA), Intellectual Disability/Developmental Disability (ID/DD), Child and Adult (C&A)
Program Option	Psychological Services
Telehealth	Not Available
Initial Authorization	Core-Tier 1 required for 1 unit for one year from start date of initial service per member/per provider Unit = 30 minutes
Re-Authorization	1. Core-Tier 1 required for one unit after one year by any provider previously utilizing the benefit for the same member. Unit = 30 minutes 2. Tier 2 data submission required any provider when requesting another testing episode per member/per year. This level of data is required to exceed the initial authorization limit and demonstrate medical necessity. The need for these additional units should be described in the free-text field. Authorization of one (1) unit will be granted if another episode is medically necessary.
Admission Criteria	Member has, or is seeking psychological or neuropsychological testing and evaluation that includes test administration and scoring by professional.
Continuing Stay Criteria	Continued test administration and scoring must be requested under the 96137 code.
Discharge Criteria	Member has withdrawn or been discharged from service
Service Exclusions	This service is not intended for: • Time for evaluation services (e.g., integration of patient data or interpretation of test results • Psychometrician/Technician Work • Computer - Scoring • Self-Administered Assessments • Computer – Interpretation • Administration of single test
Clinical Exclusions	None
Documentation Requirements	Evidence of test administration and scoring must be included in the completed report for 96132/96133. Please see those codes for documentation requirements.

Additional Service Criteria:

1. Must be performed by a West Virginia Licensed Psychologist in good standing with WV Board of Examiners of Psychology, a Supervised Psychologist who is supervised by a Board approved Supervisor, a physician or physician extender.

96137 Psychological or Neuropsychological Test Administration and Scoring by Physician or Other Health Professional, additional 30 minutes

Definition: Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; additional 30 minutes.

Service Tier	Core-Tier 1
Target Population	Mental Health (MH), Substance Abuse (SA), Intellectual Disability/Developmental Disability (ID/DD), Child and Adult (C&A)
Program Option	Psychological Services
Telehealth	Not Available
Initial Authorization	Core-Tier 1 required for 3 units for one year from start date of initial service per member/per provider Unit = 30 minutes Service must be requested in conjunction or after the code 96136 for initial submission.
Re-Authorization	1. Core-Tier 1 required for 3 units after one year by any provider previously utilizing the benefit for the same member. Unit = 30 minutes 2. Tier 2 data submission required any provider when requesting another testing episode per member/per year. This level of data is required to exceed the initial authorization limit and demonstrate medical necessity. The need for these additional units should be described in the free-text field. Authorization of one (1) unit will be granted if another episode is medically necessary.
Admission Criteria	Member has, or is seeking psychological or neuropsychological testing and evaluation that includes test administration and scoring by professional for greater than 30 minutes in duration.
Continuing Stay Criteria	Additional test administration and scoring is required to complete psychological or neuropsychological testing evaluation by professional.
Discharge Criteria	Member has withdrawn or been discharged from service
Service Exclusions	This service is not intended for: • Time for evaluation services (e.g., integration of patient data or interpretation of test results • Psychometrician/Technician Work • Computer - Scoring • Self-Administered Assessments • Computer – Interpretation • Administration of Single Test
Clinical Exclusions	None

Documentation Requirement	• Evidence of test administration and scoring must be included in the completed report for 96132/96133. Please see those codes for report requirements.

Additional Service Criteria:

1. Must be performed by a West Virginia Licensed Psychologist in good standing with WV Board of Examiners of Psychology, a Supervised Psychologist who is supervised by a Board approved Supervisor, a physician or physician extender.

96146 Psychological or Neuropsychological Automated Testing and Results

Definition: Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated results only.

Service Tier	Core-Tier 1
Target Population	Mental Health (MH), Substance Abuse (SA), Intellectual Disability/Developmental Disability (ID/DD), Child and Adult (C&A)
Program Option	Psychological Services
Telehealth	Not Available
Initial Authorization	Core-Tier 1 required for 4 events/per member/per year from start date of initial service Unit = Event
Re-Authorization	1. Core-Tier 1 required for additional units after one year by any provider previously utilizing the benefit for the same member. 2. Tier 2 data submission is required to exceed the limit of four (4) units per member/per year. This level of data is required to exceed the initial authorization limit and demonstrate medical necessity. The need for these additional units should be described in the free-text field. The total number of additional units being requested must be specified in the free-text field, otherwise a maximum of one (1) additional unit will be granted.
Admission Criteria	1. Member has, or is suspected of having, a behavioral health condition with an organic component or etiology, **-or-** 2. Member requires testing or evaluation for a specific purpose, **-or-** 3. Neurobehavioral testing/evaluation is required to make specific recommendations regarding additional treatment or services required by the individual.
Continuing Stay Criteria	1. Member has a need for further assessment due to findings of initial evaluation and/or changes in functional status. 2. Reassessment is needed to update/evaluate the current treatment plan.
Discharge Criteria	Member has withdrawn or been discharged from service.
Service Exclusions	96136, 96137 should not be billed for the same tests or services performed under neuropsychological test by computer code 96146. This service should not be performed for multiple tests.

	This is for a single automated test. This service is not intended for: • Psychometrician/Technician Work • Psychologist test administration and scoring • Self-Administered Assessments
Clinical Exclusions	None
Documentation Requirements	Automated results should be incorporated into documentation requirements found under codes 96130, 96131.

Additional Service Criteria:
When testing is administered by the computer, interpretation and report is included in the 96132/96133.