

KEPRO Healthcare Utilization Management Guidelines
for West Virginia Medicaid Fee-For-Service
Psychological Services
Version 3.2

CHANGE LOG

Replace	Changes	Date of Change
KEPRO Utilization Management Guidelines For West Virginia Medicaid Psychological Services Version 3.1	Align with updated WV Medicaid Chapter 521 Psychology Manual	April 1, 2015
96101 Psychological Testing, 96111 Developmental Testing: Extended, 96118 Neurobehavioral Testing	2019 CPT Changes effective January 1, 2019	March 6, 2019



**KEPRO Healthcare
Utilization Management Guidelines
For
West Virginia Medicaid Fee-For-Service
Psychological Services**

Version 3.2

Service Utilization Management Guidelines

Psychological Services – CPT Codes

WV Medicaid Fee-For-Service Members

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Service Utilization Management Guidelines
Psychological Services – CPT Codes
KEPRO
West Virginia Medicaid ASO

These Service Utilization Management (UM) Guidelines are organized to provide an overview of the approved CPT code services licensed psychologists may provide Medicaid fee-for-service 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 WVDHHR Bureau for Medical Services Medicaid Manual Chapter 521 - Psychological Services and the American Medical Association Current Procedural Terminology (CPT) Manual. The WV Psychological Medicaid manual can be accessed at the following web link:

http://www.dhhr.wv.gov/bms/Documents/bms_manuals/Chapter_521_psychserv.pdf

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 most frequently 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.

KEPRO strives to assist the provider in gaining authorization for services the member needs. Before a service request not clearly meeting medical necessity is denied, a KEPRO Care Manager will discuss the request with the provider to determine whether a renegotiation for a different intensity, duration, or service can be accomplished. In the event that a member truly does not have a demonstrated behavioral health or I/DD diagnosis and/or need that meets the guidelines for care, the request will be reviewed by a physician reviewer and 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 provide 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 initiation 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 psychologists 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, and stability and availability of the member's support system are evaluated.

The current role of the ASO is to devise clinical rules and review processes that evaluate these characteristics of individuals, ensure that psychological 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 psychologists, 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 psychologist 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 psychologists, 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.

Provider Reviews

Provider 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 Psychological Medicaid 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	Psychological Services
Telehealth	Available
Initial Authorization	Core-Tier 1 required for 2 events per member, per year from start date of initial service Unit = Event
Re-Authorization	<ol style="list-style-type: none"> 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 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	<ol style="list-style-type: none"> 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	<ol style="list-style-type: none"> 1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	<p>Code 90791 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.</p> <p>Psychotherapy, including for crisis, may not be reported on the same day as 90791 or 90792.</p>
Clinical Exclusions	None
Documentation Requirements	<p>Documentation must contain the following and be completed in 15 calendar days from the date of service.</p> <ul style="list-style-type: none"> • Date of Service • Location of Service • Purpose of Evaluation • Signature with credentials

	<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ○ Appearance ○ Behavior ○ Attitude ○ Level of Consciousness ○ Orientation ○ Speech ○ Mood and Affect ○ Thought Process/Form and Thought Content ○ Suicidality and Homicidality ○ Insight and Judgment • Members diagnosis per current DSM or ICD methodology • Medicaid Member's prognosis for Treatment • Rational for Prognosis • Rationale for Diagnosis • Appropriate Recommendations consistent with the findings of the evaluation
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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.

96110 Developmental Screening

Definition: Developmental screening (e.g., developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument.

Note: Limited developmental testing is provided under this code; extensive developmental testing should be provided using 96112 and 96113 Developmental Testing by Professional. Extensive and general psychological testing should be provided utilizing the codes 96130, 96131, 96136, and 96137.

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 units for one year from start date of initial service/per member/per provider Unit = Event
Re-Authorization	<ol style="list-style-type: none"> 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 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	<ol style="list-style-type: none"> 1. Member has, or is suspected of having a developmental delay and/or behavioral health condition, -or- 2. Member requires developmental testing or evaluation for a specific purpose, -or- 3. Developmental testing/evaluation is required to make specific recommendations regarding additional treatment or services required by the individual.
Continuing Stay Criteria	<ol style="list-style-type: none"> 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	<p>The combination of</p> <ul style="list-style-type: none"> ▪ 96110 Developmental Screening -and- ▪ 96112 Developmental Testing by Professional, first hour ▪ 96113 Developmental Testing by Professional, additional 30 minutes <p>may not exceed 4 units/per member/per year/per provider.</p> <p>This service is not intended for:</p> <ul style="list-style-type: none"> • Psychometrician/Technician Work

	<ul style="list-style-type: none"> • Computer - Scoring • Self-Administered Assessments • Computer – Interpretation • Developmental Testing
Clinical Exclusions	Testing that encompasses more extensive assessment should be performed using 96130 Psychological Testing and associated codes.
Documentation Requirements	<p>Documentation/Report must contain the following and be completed in 15 calendar days from the date of service:</p> <ul style="list-style-type: none"> • 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 • Documentation must contain interpretation, diagnosis, and recommendations. • Mental Status Exam - The Mental Status Exam must include the following elements: <ul style="list-style-type: none"> ○ 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.

96112 Developmental Test Administration, by Professional, first hour

Definition: Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report, 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 4 units for one year from start date of initial service/per member/per provider Unit = Event
Re-Authorization	<ol style="list-style-type: none"> 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 provider/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	<ol style="list-style-type: none"> 1. Member has, or is suspected of having a developmental delay and/or behavioral health condition, -or- 2. Member requires developmental testing or evaluation for a specific purpose, -or- 3. Developmental testing/evaluation is required to make specific recommendations regarding additional treatment or services required by the individual.
Continuing Stay Criteria	<ol style="list-style-type: none"> 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	<p>The combination of</p> <ul style="list-style-type: none"> ▪ 96110 Developmental Screening and ▪ 96112/96113 Developmental Test Administration <p>may not exceed 4 units/per member/per year/per provider.</p> <p>This service is not intended for:</p> <ul style="list-style-type: none"> • Psychometrician/Technician Work • Computer - Scoring • Self-Administered Assessments • Computer – Interpretation

	<ul style="list-style-type: none"> • Developmental Screening
Clinical Exclusions	Testing that encompasses more extensive assessment than developmental assessment should be performed using 96130 Psychological Testing and associated codes.
Documentation Requirements	<p>Documentation/Report must contain the following and be completed in 15 calendar days from the date of service:</p> <ul style="list-style-type: none"> • 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 • Documentation must contain interpretation, diagnosis, and recommendations. • Mental Status Exam - The Mental Status Exam must include the following elements: <ul style="list-style-type: none"> ○ 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.

96113 Developmental Test Administration, by Professional, additional 30 minutes

Definition: Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report, each 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 4 units for one year from start date of initial service/per member/per provider Unit = Event
Re-Authorization	<ol style="list-style-type: none"> 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	<ol style="list-style-type: none"> 1. Member has, or is suspected of having a developmental delay and/or behavioral health condition, -and- 2. Member requires further developmental testing or evaluation for a specific purpose, -or- 3. Additional developmental testing/evaluation is required to make specific recommendations regarding additional treatment or services required by the individual.
Continuing Stay Criteria	<ol style="list-style-type: none"> 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	<p>The combination of</p> <ul style="list-style-type: none"> ▪ 96110 Developmental Screening and ▪ 96112/96113 Developmental Test Administration <p>may not exceed 4 units/per member/per year/per provider.</p> <p>This service is not intended for:</p> <ul style="list-style-type: none"> • Psychometrician/Technician Work • Computer - Scoring • Self-Administered Assessments

	<ul style="list-style-type: none"> • Computer – Interpretation • Developmental Screening
Clinical Exclusions	Testing that encompasses more extensive assessment than developmental assessment should be performed using 96130 Psychological Testing and associated codes.
Documentation Requirements	<p>Documentation/Report must contain the following and be completed in 15 calendar days from the date of service:</p> <ul style="list-style-type: none"> • 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 • Documentation must contain interpretation, diagnosis, and recommendations. • Mental Status Exam - The Mental Status Exam must include the following elements: <ul style="list-style-type: none"> ○ 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.

96130 Psychological Testing Evaluation by Professional, first hour

Definition: Psychological testing evaluation services by physician or other qualified health 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) or 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 1 unit for one year from start date of initial service per member/per provider Unit = One hour
Re-Authorization	<ol style="list-style-type: none"> 1. Core-Tier 1 required for one unit after one year by any provider previously utilizing the benefit for the same member. Unit = One hour 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	<ol style="list-style-type: none"> 1. Member has, or is suspected of having a behavioral health diagnosis, -or- 2. Member requires psychological testing or evaluation for a specific purpose, -or- 3. Psychological testing/evaluation is required to make specific recommendations regarding additional treatment or services required by the individual.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Member has a need for another 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	<p>This service is not intended for:</p> <ul style="list-style-type: none"> • Test Administration and Scoring by Professional (96136,96137) • Psychometrician/Technician Work • Computer - Scoring • Self-Administered Assessments • Computer – Interpretation
Clinical Exclusions	None
Documentation Requirements	<p>Documentation/Report must contain the following and be completed in 15 calendar days from the date of service:</p> <ul style="list-style-type: none"> • Date of Service • Location of Service

	<ul style="list-style-type: none"> • Time Spent (Start/Stop Times) • Signature with Credentials • Purpose of the Evaluation • Documentation that Medicaid Member was present for the evaluation • Report must contain results (score and category) of the administered tests/evaluations • Report must contain interpretation of the administered tests/evaluations • Mental Status Exam - The Mental Status Exam must include the following elements: <ul style="list-style-type: none"> ○ 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 administered test/evaluation
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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.
2. This service includes the provision of results to appropriate parties.

96131 Psychological Testing Evaluation by Professional, additional hour

Definition: Psychological testing evaluation services by physician or other qualified health 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) or caregiver(s), when performed; each additional 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 2 units for one year from start date of initial service per member/per provider Unit = One hour Service must be requested in conjunction or after the code 96130 for initial submission.
Re-Authorization	Core-Tier 1 required for additional units after one year by any provider previously utilizing the benefit for the same member. Unit = One hour 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	<ol style="list-style-type: none"> 1. Member has, or is suspected of having a behavioral health diagnosis, -and- 2. Member requires further psychological testing or evaluation for a specific purpose, -or- 3. Additional psychological testing/evaluation is required to make specific recommendations regarding additional treatment or services required by the individual.
Continuing Stay Criteria	<ol style="list-style-type: none"> 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: <ul style="list-style-type: none"> • Test Administration and Scoring by Professional (96136,96137) • Psychometrician/Technician Work • Computer - Scoring • Self-Administered Assessments • Computer – Interpretation
Clinical Exclusions	None

<p>Documentation Requirements</p>	<p>Documentation/Report must contain the following and be completed in 15 calendar days from the date of service:</p> <ul style="list-style-type: none"> • Date of Service • Location of Service • Time Spent (Start/Stop Times) • Signature with Credentials • Purpose of the Evaluation • Documentation that Medicaid Member was present for the evaluation • Report must contain results (score and category) of the administered tests/evaluations • Report must contain interpretation of the administered tests/evaluations • Mental Status Exam - The Mental Status Exam must include the following elements: <ul style="list-style-type: none"> ○ 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 administered test/evaluation
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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.
2. This service includes the provision of results to appropriate parties.

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: <ul style="list-style-type: none"> • 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 96130/96131 or 96136/36137. 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: <ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Evidence of test administration and scoring must be included in the completed report for 96130/96131 or 96136/36137. 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.

96116 Neurobehavioral Status Exam

Definition: Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to face time with the patient and time interpreting test results and preparing the report.

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 2 units/year from start date of initial service/ per member Unit = hour
Re-Authorization	<ol style="list-style-type: none"> 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 two (2) 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	<ol style="list-style-type: none"> 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	<ol style="list-style-type: none"> 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	<p>This service is not intended for:</p> <ul style="list-style-type: none"> • Psychometrician/Technician Work • Computer - Scoring • Self-Administered Assessments • Computer – Interpretation
Clinical Exclusions	None

<p>Documentation Requirements</p>	<p>Documentation/Report must contain the following and be completed in 15 calendar days from the date of service:</p> <ul style="list-style-type: none"> • 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 • Documentation must contain interpretation, diagnosis, and recommendations. • Mental Status Exam - The Mental Status Exam must include the following elements: <ul style="list-style-type: none"> ○ 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
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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.

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	Psychological 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	<ol style="list-style-type: none"> 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	<ol style="list-style-type: none"> 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	<ol style="list-style-type: none"> 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	<p>This service is not intended for:</p> <ul style="list-style-type: none"> • Psychometrician/Technician Work • Computer - Scoring • Self-Administered Assessments • Computer – Interpretation
Clinical Exclusions	None
Documentation Requirements	<p>Documentation/Report must contain the following and be completed in 15 calendar days from the date of service:</p> <ul style="list-style-type: none"> • Date of Service • Location of Service • Purpose of Evaluation • Time Spent (start/stop times) • Signature with credentials

	<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ○ 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
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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	<ol style="list-style-type: none"> 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	<ol style="list-style-type: none"> 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	<ol style="list-style-type: none"> 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	<p>This service is not intended for:</p> <ul style="list-style-type: none"> • Psychometrician/Technician Work • Computer - Scoring • Self-Administered Assessments • Computer – Interpretation
Clinical Exclusions	None
	Documentation/Report must contain the following and be completed

<p>Documentation Requirements</p>	<p>in 15 calendar days from the date of service:</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ○ 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
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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.

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	<ol style="list-style-type: none"> 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	<ol style="list-style-type: none"> 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	<ol style="list-style-type: none"> 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	<p>96136, 96137 should not be billed for the same tests or services performed under neuropsychological test by computer code 96146.</p> <p>This service should not be performed for multiple tests. This is for a single automated test.</p> <p>This service is not intended for:</p> <ul style="list-style-type: none"> • 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 96130/96131 or 96132/96133.

90832 Individual Psychotherapy (16-37 minutes)

Definition: Psychotherapy is the treatment of mental illness and behavioral disturbances in which the psychologist 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 (90832, 90834, 90837 and 90853) 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.

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	Available
Initial Authorization	Core-Tier 1 for 10 units/per year/per member from start date of initial service Unit = 16-37 minutes
Re-Authorization	<p>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 = 16-37 minutes</p> <p>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 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.</p>
Admission Criteria	<p>1. Member has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, -and-</p> <p>2. Member demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, -and-</p> <p>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-</p> <p>4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.</p>
Continuing Stay Criteria	<p>1. The service is necessary and appropriate to meet the member's identified treatment need(s).</p> <p>2. Progress notes document member's progress relative to goals identified for treatment but goals have not yet been achieved.</p>

Discharge Criteria	<ol style="list-style-type: none"> 1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	Psychotherapy for patients in a crisis state is reported with codes 90839 and 90840.
Clinical Exclusions	<ol style="list-style-type: none"> 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 Requirements	<ul style="list-style-type: none"> • 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. <p>Documentation must also include the following:</p> <ul style="list-style-type: none"> • Signature with credentials • Place of service • Date of service • Start-and-Stop times

- 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.

90834 Individual Psychotherapy (38-52 minutes)

Definition: Psychotherapy is the treatment of mental illness and behavioral disturbances in which the psychologist through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse of change maladaptive patterns of behavior, and encourage personality growth and development.

Psychotherapy services (90832, 90834, 90837 and 90853) 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.

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	Available
Initial Authorization	Core-Tier 1 for 10 units/per year/per member from start date of initial service Unit = 30-52 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 = 30-52 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	<ol style="list-style-type: none"> 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 Requirements	<ul style="list-style-type: none"> • 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. <p>Documentation must also include the following:</p> <ul style="list-style-type: none"> • Signature with credentials • Place of service • Date of service • Start-and-Stop times

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.

90837 Psychotherapy (53 or more minutes)

Definition: Psychotherapy is the treatment of mental illness and behavioral disturbances in which the psychologist through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse of change maladaptive patterns of behavior, and encourage personality growth and development.

Psychotherapy services (90832, 90834, 90837 and 90853) 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.

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	Available
Initial Authorization	Core-Tier 1 for 10 units/per year/per member from start date of initial service Unit = 53 or more 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 = 53 or more 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	<ol style="list-style-type: none"> 1. Member has a behavioral health diagnosis which qualifies for Medicaid behavioral health services <p style="text-align: center;">-and-</p> <ol style="list-style-type: none"> 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	<ol style="list-style-type: none"> 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	<ol style="list-style-type: none"> 1. Member has withdrawn or been discharged from service.

	2. Goals for member's treatment have been substantially met.
Service Exclusions	None
Clinical Exclusions	<ol style="list-style-type: none"> 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 Requirements	<ul style="list-style-type: none"> • 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. <p>Documentation must also include the following:</p> <ul style="list-style-type: none"> • Signature with credentials • Place of service • Date of service • Start-and-Stop times

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.

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 psychologist providing psychotherapy for crisis, even if the time spent on that date is not continuous. For any given time spent providing this service, the psychologist 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 psychologist is not continuous. If the crisis episode has continued for more than 74 minutes, the 90840 code should be requested to address the additional time.

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 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. 2 additional units/per member/30 calendar days Unit = 60 minutes
Admission Criteria	<ol style="list-style-type: none"> 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 psychologist 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.

<p>Service Exclusions</p>	<p>Not to be used as an emergency response to a member running out of medications or housing problems.</p> <p>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).</p> <p>Psychotherapy for crisis should not be used in conjunction with 90791 or 90792.</p> <p>No other psychological service may be provided and billed during this service.</p> <p>This service should not be used for:</p> <ul style="list-style-type: none"> • 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.
<p>Clinical Exclusions</p>	<p>None.</p>
<p>Documentation Requirements</p>	<p>Documentation must contain the following:</p> <p>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.</p> <p>The documentation must also include the following:</p> <ul style="list-style-type: none"> • Signature with credentials • Safety Plan • Place of service • Date of service • Start-and-Stop times • Mental Status Exam - The Mental Status Exam must include the following elements: <ul style="list-style-type: none"> ○ 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:

- 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.

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 psychologist providing psychotherapy for crisis, even if the time spent on that date is not continuous. For any given time spent providing this service, the psychologist 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	Psychological Services
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	<ol style="list-style-type: none"> 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 psychologist 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	<p>Not to be used as an emergency response to a member running out of medications or housing problems.</p> <p>Psychotherapy for a crisis of less than 74 minutes total duration on a given date should be reported with the 90839 service.</p> <p>Psychotherapy for crisis should not be used in conjunction with 90791 or 90792.</p> <p>No other psychiatric service may be provided and billed during this service.</p> <p>This service should not be used for:</p> <ul style="list-style-type: none"> • 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 Requirements	<p>Documentation must contain the following:</p> <p>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</p> <p>The documentation must also include the following:</p> <ul style="list-style-type: none"> • Signature with credentials • Safety Plan • Place of service • Date of service • Start-and-Stop times • Mental Status Exam - The Mental Status Exam must include the following elements: <ul style="list-style-type: none"> ○ Appearance ○ Behavior ○ Attitude ○ Level of Consciousness ○ Orientation

	<ul style="list-style-type: none">○ Speech○ Mood and Affect○ Thought Process/Form and Thought Content○ Suicidality and Homicidality○ Insight and Judgment
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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.

90846 Family Psychotherapy (without patient present)

Definition: Psychotherapy is the treatment of mental illness and behavioral disturbances in which the psychologist through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. This code is specific to family psychotherapy without the patient present in the therapeutic session.

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	Available
Initial Authorization	Core-Tier 1 for 10 units/per year/per member from start date of initial service Unit = 45-50 minutes
Re-Authorization	<p>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 = 45-50 minutes</p> <p>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.</p>
Admission Criteria	<p>1. Member has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, -and-</p> <p>2. Member demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, -and-</p> <p>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-</p> <p>4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.</p>
Continuing Stay Criteria	<p>1. The service is necessary and appropriate to meet the member's identified treatment need(s).</p> <p>2. Progress notes document member's progress relative to goals identified for treatment, but goals have not yet been achieved.</p>
Discharge Criteria	<p>1. Member has withdrawn or been discharged from service.</p> <p>2. Goals for member's treatment have been substantially met.</p>
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 Requirements	<ul style="list-style-type: none"> • 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. <p>Documentation must also include the following:</p> <ul style="list-style-type: none"> • Signature with credentials • Place of service • Date of service • Start-and-Stop times

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.
- This service may not be used solely to communicate the results of testing and evaluation.

90847 Family Psychotherapy (with patient present)

Definition: Psychotherapy is the treatment of mental illness and behavioral disturbances in which the psychologist through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse of change maladaptive patterns of behavior, and encourage personality growth and development. This code is specific to family psychotherapy with the patient present in the therapeutic session.

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	Available
Initial Authorization	Core-Tier 1 for 10 units/per year/per member from start date of initial service Unit = 45-50 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 = 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	<ol style="list-style-type: none"> 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 Requirements	<ul style="list-style-type: none"> • 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. <p>Documentation must also include the following:</p> <ul style="list-style-type: none"> • Signature with credentials • Place of service • Date of service • Start-and-Stop times

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.
- This service may not be used solely to communicate the results of testing and evaluation.

90853 Group Psychotherapy

Definition: Group psychotherapy is the treatment of mental illness and behavioral disturbances in which the psychologist through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. The psychotherapy codes 90832, 90834, 90837, and 90853 include ongoing assessment and adjustment of psychotherapeutic interventions and may include involvement of family member(s) or others in the treatment process.

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. A maximum of 12 individuals may participate in a group setting. 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	Psychological Services
Telehealth	Available
Initial Authorization	Core-Tier 1 for 10 units/per year/per member from start date of initial service Unit= 75-80 minutes
Re-Authorization	<p>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</p> <p>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.</p>
Admission Criteria	<p>1. Member has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, -and-</p> <p>2. Member demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, -and-</p> <p>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-</p> <p>4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.</p>

Continuing Stay Criteria	<ol style="list-style-type: none"> 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	<ol style="list-style-type: none"> 1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	None
Clinical Exclusions	<ol style="list-style-type: none"> 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	<ul style="list-style-type: none"> • 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. <p>Documentation must also include the following:</p> <ul style="list-style-type: none"> • Signature with credentials • Place of service • Date of service • Start-and-Stop times

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.

Appendix A

WV Medicaid Medication Assisted Treatment Guidelines

WV Medicaid Medication Assisted Treatment Policy

West Virginia Medicaid covers Medication Assisted Treatment Services under the following circumstances:

Physicians or physician extenders wanting to provide Suboxone®/Subutex® services must be approved by the Bureau for Medical Services. Please see section 521.13.4 of the WV Medicaid Manual, Chapter 521 – Behavioral Health Outpatient Services for further information.

Individuals seeking opioid addiction treatment for Suboxone®/Subutex® or Vivitrol® for the treatment of opioid/alcohol dependence must be evaluated by an enrolled physician, Advance Practice Registered Nurse (APRN), or physician extender as specified below, before beginning medication assisted treatment.

- An initial evaluation may be completed by a staff member other than the physician however no medication may be prescribed until the physician has completed their evaluation.
- Members seeking treatment must have an appropriate diagnosis for the medication utilized.
- All physicians and/or physician extenders agree to adhere to the Coordination of Care Agreement (Please see Appendix B) which will be signed by the member, the treating physician/physician extender, and the treating therapist.
- Each member receiving medication assisted treatment must also be involved in individual therapy and/or group therapy as specified in the Coordination of Care Agreement.
- If a change of physician, physician extender, or therapist takes place, a new agreement must be signed. This agreement must be placed in the member's record and updated annually.
- The agreement is not required if the member is receiving services at an agency where both the physician, physician extender, and therapist are employed.

Program Guidelines:

Note: These are the minimum requirements that are set forth in this manual. Providers may have more stringent guidelines set forth in their internal policy.

Phase 1: Members in phase 1 (less than 12 months of compliance with treatment) will attend a **minimum** of four (4) hours of psychotherapy services per month. The four hours must contain a **minimum** of one (1) hour individual psychotherapy session per month. Frequency of therapeutic services may increase based upon medical necessity.

Phase 2: Members in phase 2 (12 months or more of compliance with treatment) will attend a minimum of (1) hour of psychotherapy services per month with individual, family, or group modalities. Frequency of therapeutic services may increase based upon medical necessity.

Staff Credentials: The following are the minimum supervision requirements per degree/credential type:

• **Bachelor's Degree in Human Services without Alcohol and Drug Counselor Credential*:** Indirect supervision required by Clinical Supervisor, Advanced Alcohol and Drug Counselor, Certified Clinical Counselor, Master Addiction Counselor, Licensed Psychologist, Licensed Professional Counselor, or Licensed Independent Clinical Social Worker.

• **Master’s Degree Only, includes Licensed Clinical Social Worker and Licensed Graduate Social Worker*:** Indirect supervision required by Clinical Supervisor, Advanced Alcohol and Drug Counselor, Certified Clinical Counselor, Master Addiction Counselor, Licensed Psychologist, Licensed Professional Counselor, or Licensed Independent Clinical Social Worker.

• **Doctoral Level, Non-Licensed*:** Indirect supervision required by Clinical Supervisor, Advanced Alcohol and Drug Counselor, Certified Clinical Counselor, Master Addiction Counselor, Licensed Psychologist, Licensed Professional Counselor, or Licensed Independent Clinical Social Worker.

The following providers do not require supervision*:

- Licensed Independent Clinical Social Worker
- Licensed Psychologist
- Board Supervised Psychologist
- Licensed Professional Counselor
- National Certified Addiction Counselor II
- Master Addiction Counselor
- Bachelor’s Degree in Human Services with Alcohol and Drug Counselor Credential

*Certification requirements for West Virginia Association of Alcoholism and Drug Abuse Counselors, Inc. (WVAADC) may be different from those included above. This policy is not meant to circumvent any requirements as set forth by this organization.

Drug Screens: A minimum of two (2) random urine drug screens per month are required for members in phase 1. A minimum of one (1) random urine drug screen per month is required for members in phase 2. A record of the results of these screens may be requested from the physician or physician extender. The drug screen must test for, at a minimum, the following substances:

- Opiates
- Oxycodone
- Methadone
- Buprenorphine
- Benzodiazepines
- Cocaine
- Amphetamine
- Methamphetamine

Instructions for non-compliance with treatment: Non-compliance is defined as failure of a drug screen or failure to meet the monthly requirement of therapeutic services.

Members in phase 1 must demonstrate increased treatment frequency after two instances of non-compliance such as two failed drug screens, two months of not meeting therapeutic requirements, or a combination of one failed drug screen and one month of failed therapeutic requirements. If increase in treatment frequency is not demonstrated consistently within seven days, the patient may be terminated from the program at the physician or physician extender’s discretion.

The physician, physician extender, and/or treatment program has the option to allow the patient to reapply to the program after 30 days with proven participation in professional therapies. With three violations within six months, the physician or physician extender will terminate the individual from the program. The program has the option to allow the patient to reapply after 30 days during which time

the patient must demonstrate compliance with professional therapies. An exception is made for pregnant women at physician or physician extender's discretion.

Members in phase 2 will be returned to phase 1 of treatment after one instance of non-compliance (see Phase 1 required timelines).

Individuals discharged for non-compliance and ineligible for re-start must receive information describing alternative methods of treatment and listing contact information for alternative treatment providers as appropriate.

Titration Policy: Titration due to non-compliance is per Physician or Physician extender order when the Medicaid Member is found to be non-compliant during treatment. Titration must be completed within four (4) weeks of the physicians order to stop medication assisted treatment. Vivitrol will be discontinued immediately due to non-compliance.

Any physician that prescribes medication under the Medication Assistance Treatment must have a plan in place for when they are unavailable to address any medical issues or medication situations that should arise.

Appendix B

Information shared from WV Medicaid:
Chapter 521, Psychological Services, Appendix 521A

Coordination of Care and Release of Information Form
Suboxone®/Subutex® or Vivitrol® Providers

Coordination of Care and Release of Information between Suboxone®/Subutex®/Vivitrol® Provider and BH Provider

Communication between behavioral providers and your Suboxone®/Subutex®/Vivitrol® Prescribing Physician other Behavioral health providers and/or facilities is important to ensure that you receive comprehensive and quality health care. This form will allow your behavioral health provider to share protected health information (PHI) with your other provider. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication, if necessary.

Patient Rights

- You may end this authorization (permission to use or disclose information) any time by contacting the practitioner's office.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.
- You have a right to a copy of this signed authorization.

Patient Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified patient. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. **This consent expires in one year (12 months) from the date of my signature below unless otherwise stated herein.**

_____ (BH Provider) is authorized to release protected health information related to the evaluation and treatment of _____ (Member) to _____ (Suboxone®/Subutex®/Vivitrol® Prescribing Physician).

(Member Name) _____

(Medicaid ID#) _____

**Coordination of Care and Release of Information between
Suboxone®/Subutex®/Vivitrol® Provider and BH Provider**

(Date of Birth – MM/DD/YYYY) ____/____/____

Suboxone® or Vitriol® Prescribing Physician: _____

Physician Phone: (____) _____ - _____

Physician Address: _____

BH Provider Name: _____

BH Provider Phone: (____) _____ - _____

BH Provider Address: _____

Disclosure may include the following verbal or written information: (check all that apply)

Demographic Information History & Physical Laboratory/diagnostic testing results

Discharge Summary Medication records Psychological Eva/Testing Results

Psychiatric evaluation ER record Service Plan

Behavioral health/psychological consults Psychosocial Assessment report

Summary of Treatment records, progress Substance abuse treatment record

Other (specify below)

**Coordination of Care and Release of Information between
Suboxone®/Subutex®/Vivitrol® Provider and BH Provider**

(Print Provider Name) _____

(Signature) _____

(Date) ____ / ____ / _____

**I want to inform you that _____ was seen by me for the
treatment of:** (Member Name)

DSM/ICD, and/or medical diagnosis:

Date of appointment: ____ / ____ / _____

Summary:

The treatment plan consists of the following modalities:

- € Individual Psychotherapy € Group Psychotherapy € Family Psychotherapy
- € Psychological Testing € Medication Management (see next page)
- € Other (please specify)

**Coordination of Care and Release of Information between
Suboxone®/Subutex®/Vivitrol® Provider and BH Provider**

Current Medication(s) (Dosage, Frequency and Delivery)

The following medication was or will be started (indicate medication and dosage):

Estimated length of treatment:

Notice to Recipient: This information has been disclosed to you from records protected by Federal confidentiality regulations 42 CFR Part 2 and state law requirements. Under such law, the information received pursuant to this document is confidential and prohibits the recipient from making further re-disclosure of this information to any other person or entity, or to use it for a purpose other than as authorized herein, without the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict the use of the information to criminally investigate or prosecute any alcohol or drug patients. WV Department of Health and Human Resources Bureau for Medical Services.