



Department of Medicaid

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MEDICAID BEHAVIORAL HEALTH STATE PLAN SERVICES

PROVIDER REQUIREMENTS AND REIMBURSEMENT MANUAL

June 24, 2016

The most recent version may be found at:

Behavioral Health Billing Manual Updates			
Version	Description of Changes	Last Editor	Release Date
Version 1.0	Initial Draft	State Policy Team	6/14/16

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SECTION 1

Introduction

The Ohio Department of Medicaid (ODM) has created a Medicaid behavioral health state plan services provider requirements and reimbursement manual to help providers of behavioral health services understand how to provide and be reimbursed for services provided under the fee for service program. Services covered under the managed care program **ARE NOT** subject to the guidance provided in this manual, but are subject to each individual managed care plan’s respective policies.

Ohio Administrative Code is the basis for the information contained in this manual. Chapter 5160-1 contains regulatory information on the Medicaid program in general. Additional information is available in the following administrative rules:

- [5160-1-02 General reimbursement principles.](#)
- [5160-4-28 Non-covered services](#)
- [5160-1-05.3 Payment for "Medicare Part B" cost sharing.](#)
- [5160-1-08 Coordination of benefits.](#)
- [5160-1-11 Out-of-state coverage \[except as provided through Medicaid contracting managed care plans \(MCPs\)\].](#)
- [5160-1-17 Eligible providers.](#)
- [5160-1-17.2 Provider agreement for providers.](#)
- [5160-1-17.3 Provider disclosure requirements.](#)
- [5160-1-17.4 Conversion to time-limited provider agreements and re-enrollment.](#)
- [5160-1-17.6 Termination and denial of provider agreement.](#)
- [5160-1-17.8 Provider screening and application fee.](#)
- [5160-1-17.9 Ordering or referring providers.](#)
- [5160-1-27 Review of provider records.](#)
- [5160-1-27.1 Hold and review process.](#)
- [5160-1-29 Medicaid fraud, waste, and abuse.](#)
- [5160-1-31 Prior authorization \[except for services provided through Medicaid contracting managed care plans \(MCPs\)\].](#)
- [5160-1-60 Medicaid payment.](#)

The Ohio Department of Mental Health and Addiction Services (OhioMHAS) has additional administrative rules covering the behavioral health program as follows:

Institutions for Mental Disease (IMD)

An IMD is a hospital, nursing facility, or other institution that is primarily engaged in providing diagnosis, treatment, or care for persons with mental or substance use disorders, including medical attention, nursing care, and related services. The IMD exclusion does not apply to inpatient treatment for mental illnesses in facilities that are part of larger medical entities not primarily engaged in the treatment of mental illnesses. Identification of IMDs is fact specific but includes tests to determine if 51 percent or more of the patient population was admitted for treatment of a mental illness, whether the primary mission of the facility is to treat mental illnesses, and whether the staff of the facility is primarily in professions that treat mental illnesses. Some facilities are excluded from the definition of an IMD because they are primarily engaged in treating those with physical illnesses with staff trained in treating physical illnesses.

Assume that a general hospital has a psychiatric unit; if treatment of psychiatric conditions is not the primary business of the general hospital and 51 percent or more of the patient population was

not admitted for treatment of a mental illness, this psychiatric unit can receive Medicaid payments for inpatient behavioral health treatment.

There are four limitations to the IMD exclusion:

1. It does not apply to adults aged 65 years and older residing in a Medicare-certified hospital or nursing facility.
2. It does not apply to individuals younger than age 21 or, in certain circumstances, younger than age 22 receiving services under the inpatient psychiatric services for individuals under age 21 benefit.
3. It does not apply to institutions with 16 or fewer beds.
4. It does not apply to partial hospitalization and day-treatment programs that do not *institutionalize* their patients.

Inpatient Psychiatric Hospitalization

Under federal law, federal reimbursement is prohibited for Medicaid services provided to “individuals under age 65 who are patients in an institution for mental diseases [IMDs] unless they are under age 22 and are receiving inpatient psychiatric services.

The language of the federal regulation clearly makes exceptions for services provided to individuals younger than 22 years who are receiving inpatient psychiatric services. This *psych under 21 benefit* has been interpreted to allow individuals aged 21 years and younger to receive inpatient psychiatric hospital services in three settings: psychiatric hospitals, and psychiatric units in general hospitals.

Inpatient psychiatric services are provided to children and young adults who need intensive treatment for a longer period than acute hospitalization. Although inpatient psychiatric care is a coverage *option* for states, it is *mandatory* when: (1) a child’s condition is diagnosed through an EPSDT screen, and (2) it is determined that the child requires an institutional level of care.

As indicated above, the federal government is prohibited from reimbursing states under the Medicaid program for services rendered to an adult who is a patient in an institution for mental disease (IMD). However, the IMD exclusion does not apply to individuals aged 65 years or older. Federal reimbursement is permitted for individuals in this age range who require inpatient behavioral health services and receive them in a facility that meets the definition of an IMD.

The Ohio Medicaid program covers inpatient psychiatric hospital services through a precertification process which can be found in [OAC 5160-2.07.13](#). The ODM has an interagency agreement with the OhioMHAS that delegates the utilization control for inpatient psychiatric hospital services to OhioMHAS, and in turn, OhioMHAS contracts with a third party to oversee the statewide utilization management program for inpatient psychiatric hospitalizations. Additional information is available on Permedion’s website: <http://hmspermedion.com/oh-medicaid-mental-health-addiction-services/>.

Please pay close attention when accessing the inpatient psychiatric hospitalization information, as Permedion also is responsible for general medical/surgical hospitalization utilization control.

Glossary of Terms

Crisis - An acute circumstance that, in the opinion of a practitioner with knowledge of the member's condition, has overwhelmed the patient's ability to cope, and requires rapid and time-limited care or treatment in order to reduce the likelihood of severe pain or more significant deterioration in functioning.

Family - Family is defined as the primary care-giving unit and is inclusive of the wide diversity of primary caregiving units in our culture. Family is a birth, foster, adoptive or self-created unit of people residing together, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood/caregiving for the child(ren). Persons within this unit share bonds, culture, language, practices and a significant relationship. Birth parents, siblings and others with significant attachment to the individual living outside the home are included in the definition of family. For the purposes of this provider manual, "family" is defined as the persons who live with, or provide care to, a child and may include a parent, spouse, sibling, children, relatives, grandparents, guardians, foster parents or others with significant attachment to the individual.

First Episode Psychosis – First episode psychosis refers to the first time someone experiences psychotic symptoms or a psychotic episode.

Home Setting or Community Setting – is intended to mean the settings in which client primarily resides or spends time, as long as it is not a hospital nursing facility, IDD, ICF, psychiatric nursing facility. Note: this is distinguished from a home and community-based setting, which is a requirement under an HCBS program.

Institution for Mental Disease (IMD) - state or private psychiatric hospital, psychiatric residential treatment facility or crisis stabilization unit with greater than 16 beds. See page 72 for further information.

Medicaid Eligible Child – any child in the state of Ohio that may be eligible for Medicaid to access these State Plan benefits, whether received via deeming, income eligibility, or categorical eligibility (e.g., foster care).

Licensed Practitioner of the Healing Arts – a professional who is licensed as a clinical nurse specialist, certified nurse practitioner, psychiatrist, psychologist, licensed independent social worker (LISW), licensed independent marriage & family therapist (LIMFT), licensed professional clinical counselor (LPCC), licensed independent chemical dependency counselors (LICDC), or physician (per OMH 599 regulations) and practicing within the scope of their state license to recommend rehabilitation services. Clinical nurse specialist, LISWs, LIMFTs, LPCCs, LICDCs, occupational therapists, and physician assistants who are licensed and practicing within the scope of their state license may recommend rehabilitation services, only where noted in the approved State Plan and manual. Note: NLPHAs are licensed by a professional board in the state of Ohio and are authorized to practice under full or partial clinical supervision and have specialty experience and/or training related to persons with behavioral health conditions. This category

includes psychology assistant, psychology intern, psychology trainee, social work trainee, social work assistant, marriage and family therapist trainee, chemical dependency counselor assistant, counselor trainee. These practitioners can only recommend rehabilitation services if specifically listed.

Natural Supports – Natural supports are individuals and informal resources a family/caregiver can access, independent of formal services. These supports are a significant source of culturally relevant emotional support and caring friendships for children and families. Natural supports can be short-term or long-term and are usually sustainable and available to the child and family/caregiver after formal services have ended.

Person-Centered Care – Services should reflect a child and family’s goals and emphasize shared decision-making approaches that empower families, provide choice, and minimize stigma. Services should be designed to optimally treat illness and emphasize wellness and attention to the family’s overall well-being and child’s full community inclusion.

Person-Centered Plan – The person-centered plan is a comprehensive plan that integrates all components and aspects of care that are deemed medically necessary, needs based, are clinically indicated, and are provided in the most appropriate setting to achieve the individual’s goal.

Recovery-Oriented – Services should be provided based on the principle that all individuals have the capacity to recover from mental illness and/or substance use disorders. Specifically, services should support the acquisition of living, vocational, and social skills and be offered in home and community-based settings that promote hope and encourage each person to establish an individual path towards recovery.

School Setting – a setting in which a child attends school. Includes private school meeting the standards under division (D) of section 3301.07 of the Revised Code.

SED – "Person with serious emotional disturbance" means a person less than eighteen years of age who meets criteria that is a combination of duration of impairment, intensity of impairment and diagnosis.

(a) Criteria:

- (i) Under eighteen years of age;
- (ii) Marked to severe emotional/behavioral impairment;
- (iii) Impairment that seriously disrupts family or interpersonal relationships; and
- (iv) May require the services of other youth-serving systems (e.g., education, human services, juvenile court, health, mental health/mental retardation, youth services, and others).

(b) Marked-to-severe behavioral impairment is defined as impairment that is at or greater than the level implied by any of the following criteria in most social areas of functioning:

- (i) Inability or unwillingness to cooperate or participate in self-care activities;
- (ii) Suicidal preoccupation or rumination with or without lethal intent;
- (iii) School refusal and other anxieties or more severe withdrawal and isolation;
- (iv) Obsessive rituals, frequent anxiety attacks, or major conversion symptoms;

- (v) Frequent episodes of aggressive or other antisocial behavior, either mild with some preservation in social relationships or more severe requiring considerable constant supervision; and
 - (vi) Impairment so severe as to preclude observation of social functioning or assessment of symptoms related to anxiety (e.g., severe depression or psychosis).
- (c) An impairment that seriously disrupts family or interpersonal relationships is defined as one:
- (i) Requiring assistance or intervention by police, courts, educational system, mental health system, social service, human services, and/or children's services;
 - (ii) Preventing participation in age-appropriate activities;
 - (iii) In which community (home, school, peers) is unable to tolerate behavior; or
 - (iv) In which behavior is life-threatening (e.g., suicidal, homicidal, or otherwise potentially able to cause serious injury to self or others).

Service Provider – Refers to individuals/organizations that provide and are paid to provide formal services to the youth and family/caregiver

SUD – A diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to use of the substance. The diagnosis of a substance use disorder is based from criteria defined in the current ICD-10 diagnosis codes manual can be applied to all 10 classes of drugs including: alcohol; cannabis; hallucinogens; inhalants; opioids; sedatives, hypnotics, and anxiolytics; stimulants; tobacco; and other (or unknown) substances.

Trauma-informed care (TIC) – TIC takes a trauma-informed approach to the delivery of behavioral health services that includes an understanding of trauma and an awareness of the impact it can have across settings, services, and populations. TIC views trauma through an ecological and cultural lens and recognizes that context plays a significant role in how individuals perceive and process traumatic events, whether acute or chronic. TIC involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to re-traumatize individuals who already have histories of trauma. TIC upholds the importance of consumer participation in the development, delivery, and evaluation of services.

Provider Enrollment

This section of the manual will cover enrollment in the Medicaid Information Technology System (MITS) for organizations/bill-to providers (provider types 84 and 95) and rendering providers (qualified practitioners who can enroll as independent providers). All providers are required to operate in compliance with general Ohio Medicaid program rules found in OAC Chapter 5160-1 (<http://codes.ohio.gov/oac/5160-1>).

MITS provider type 84 – OhioMHAS certified MH providers

Specific Ohio Medicaid rules for the MH fee-for-service (FFS) Medicaid program are found in Ohio Administrative Code (OAC) Chapter 5160-27 (<http://codes.ohio.gov/oac/5160-27>).

Prior to enrollment, a provider must be certified by OhioMHAS as a provider of mental health services. Information on OhioMHAS mental health service certification can be obtained from the Ohio MHAS Bureau of Licensure & Certification by calling 614-752-8880 or by visiting the OhioMHAS licensure and certification webpage here:

<http://mha.ohio.gov/Default.aspx?tabid=123>.

Once certified by OhioMHAS as an MH service provider, an online application for enrollment in the Ohio MH FFS Medicaid program may be submitted using the MITS provider portal. There may be an application fee for applying as provider type 84.

The following link is to the ODM MITS provider enrollment website:

<http://medicaid.ohio.gov/providers/EnrollmentandSupport/ProviderEnrollment.aspx>.

In order to complete the application the following documents are necessary and will need to be uploaded with the application:

- 1) A National Provider Identifier (NPI) number verification from the National Plan and Provider Enumeration System (NPPES, <https://nppes.cms.hhs.gov/NPPES/Welcome.do>). The NPI must be unique for this provider type,
- 2) A signed signature page,
- 3) A signed copy of the MH service provider W-9, and 4) verification of an application fee payment. Once these documents are uploaded and the application is complete, the application will begin routing through the review process.

Once the complete application, including the documents that must be uploaded, has been entered into MITS, please notify OhioMHAS by sending an e-mail to: MH-MedicaidSupport@mha.ohio.gov. Please include in the subject line the Application Tracking Number (ATN) that was assigned to the application and also please include in the body of the e-mail contact information for the person who is responsible for getting the application approved.

MITS provider type 95 – OhioMHAS certified SUD programs

Specific Ohio Medicaid rules for the SUD fee for service (FFS) Medicaid program are found in Ohio Administrative Code (OAC) Chapter 5160-30 (<http://codes.ohio.gov/oac/5160-30>).

Prior to enrollment, a provider must be certified by OhioMHAS as an SUD treatment program. Information on OhioMHAS SUD treatment program certification can be obtained from the OhioMHAS Bureau of Licensure & Certification by calling 614-752-8880 or by visiting the OhioMHAS licensure and certification webpage here: <http://mha.ohio.gov/Default.aspx?tabid=123>.

Once certified by OhioMHAS as an SUD treatment program, then an online application for enrollment in the Ohio SUD FFS Medicaid program may be submitted using the MITS provider portal. There may be an application fee for applying as provider type 95.

The following link is to the ODM MITS provider enrollment website: <http://medicaid.ohio.gov/providers/EnrollmentandSupport/ProviderEnrollment.aspx>.

In order to complete the application the following documents are necessary and will need to be uploaded with the application:

- 1) A National Provider Identifier (NPI) number verification from the National Plan and Provider Enumeration System (NPPES, <https://nppes.cms.hhs.gov/NPPES/Welcome.do>). The NPI must be unique for this provider type,
- 2) A signed signature page,
- 3) A signed copy of the MH service provider W-9, and 4) verification of an application fee payment. Once these documents are uploaded and the application is complete, the application will begin routing through the review process.

Once the complete application, including the documents that must be uploaded, has been entered into MITS, please notify OhioMHAS by sending an e-mail to:

MedicaidSupport@mha.ohio.gov Please include in the subject line the Application Tracking Number (ATN) that was assigned to the application and also please include in the body of the e-mail contact information for the person who is responsible for getting the application approved.

[Multispecialty Providers](#)

-Under Development

[Agency Enrollment of SRS Peer Specialists](#)

-Under Development

[Out of state MH/SUD providers](#)

For reimbursement of MH and/or SUD agencies/programs operating outside of the state of Ohio, the program must be recognized (regulated) in the state in which they operate as a provider of community-based MH and/or SUD services and be enrolled with Ohio Medicaid as a community MH and/or SUD service provider.

Rendering providers (RPs)

ODM will require that the rendering practitioner for all behavioral health services be listed on claims submitted to Ohio Medicaid for payment.

Practitioners listed below will be required to have a National Provider Identifier (NPI) to render services to Medicaid enrollees AND they will be required to enroll in the Ohio Medicaid program. An NPI can be obtained by visiting <https://nppes.cms.hhs.gov/NPPES/Welcome.do>. Once the practitioner has obtained an NPI they must visit the ODM Provider Enrollment page and register as a rendering provider. Each behavioral health agency must then “associate” or link their agency with each of its corresponding rendering practitioners. This step will be performed in the secure section of the Medicaid Information Technology System (MITS) portal by the agency’s MITS Administrator. More details on this process can be found at: <http://mha.ohio.gov/Portals/0/assets/Planning/MACSIorMITS/mits-bits-rendering-providers-part-2-4-19-16.pdf>

RPs include individuals licensed by a professional board in the state of Ohio are listed below with Medicaid provider type code in parentheses.

Physicians (MD/DO) , Psychiatrists (20)	Licensed Independent Social Workers (37)
Certified Nurse Practitioners (72)	Licensed Professional Clinical Counselors (47)
Clinical Nurse Specialists (65)	Licensed Independent Marriage and Family Therapists (52)
Physician Assistants (24)	Licensed Independent Chemical Dependency Counselors (54)
Registered Nurses (38-384)	Licensed Practical Nurses (38-385)
Licensed Psychologists (42)	

For more information on rendering provider see the Rendering Provider MITS BITS at <http://mha.ohio.gov/Portals/0/assets/Planning/MACSIorMITS/mits-bits-rendering-providers-part-2-4-19-16.pdf>

Qualified Provider Overview

General Groupings of Professionals

The following listing represents the current qualified providers (individual clinician types) in Ohio under four broad categories: 1) Medical Behavioral Health Practitioners (M-BHPs), 2) Independent Behavioral Health Professionals (I-BHPs), 3) Behavioral Health Professionals (BHPs), and 4) Behavioral Health Paraprofessionals (BHP-Ps).

Medical Behavioral Health Practitioners (M-BHPs)M-BHPs are professionals who are licensed by a professional board in the state of Ohio and are authorized to practice some level of general medicine and have specialty experience and/or training related to persons with behavioral health conditions. M-BHPs are:

- Physicians as defined in Chapter 4731. of the Ohio Revised Code and who are licensed by the state of Ohio Medical Board.
- Clinical nurse specialist, clinical nurse practitioners, RN/LPN and nurses as defined in Chapter 4723. of the Ohio Revised Code and are who licensed and certified by the state of Ohio Nursing Board.
- Physician assistants as defined in Chapter 4730. of the Ohio Revised Code and who are licensed by the state of Ohio Medical Board.

Independent Behavioral Health Professionals (I-BHPs)

I-BHPs are professionals who are licensed by a professional board in the state of Ohio and are authorized to practice independently (they are not subject to professional supervision) and have specialty experience and/or training related to persons with behavioral health conditions. I-BHPs are:

- Psychologists as defined in Chapter 4732. of the Ohio Revised Code and who are licensed by the state of Ohio Board of Psychology.
- School psychologists as defined in Chapter 4732. of the Ohio Revised Code and who are licensed by the state of Ohio Board of Psychology.
- Licensed professional clinical counselors as defined in Chapter 4757. of the Ohio Revised Code and who are licensed by the state of Ohio Counselor, Social Worker, and Marriage & Family Therapist Board.
- Licensed independent social workers as defined in Chapter 4757. of the Ohio Revised Code and who are licensed by the state of Ohio Counselor, Social Worker, and Marriage & Family Therapist Board.
- Licensed independent marriage and family therapists as defined in Chapter 4757. of the Ohio Revised Code and who are licensed by the state of Ohio Counselor, Social Worker, and Marriage & Family Therapist Board.
- Licensed independent chemical dependency counselors as defined in Chapter 4758. of the Ohio Revised Code and who are licensed by the Ohio Chemical Dependency Professionals Board.

Behavioral Health Professionals (BHPs)

Please Note: In the following descriptions, the term “registered with the state of Ohio” means an individual known to the state professional and/or licensing boards as a practitioner who has met the applicable professional requirements.

BHPs are professionals who are licensed by a professional board in the state of Ohio and are authorized to practice under full or partial clinical supervision and have specialty experience and/or training related to persons with behavioral health conditions. BHPs are:

- A psychology assistant/intern/trainee is a person who is working under the supervision of a psychologist licensed by the state of Ohio Board of Psychology.

- A school psychology assistant/intern/trainee is a person who is working under the supervision of a psychologist or school psychologist licensed by the state of Ohio Board of Psychology.
- School psychologists as defined in Chapter 3301. of the Ohio Revised Code and who are licensed by the state of Ohio Department of Education.
- A licensed professional counselor licensed by the state of state of Ohio Counselor, Social Worker, and Marriage & Family Therapist Board in accordance with Chapter 4757. of the Ohio Revised Code.
- A counselor trainee who is registered with the state of Ohio Counselor, Social Worker, and Marriage & Family Therapist Board in accordance with Chapter 4757. of the Ohio Revised Code. A counselor trainee is seeking licensure as a professional counselor and is enrolled in a practicum or internship in a counselor education program.
- A licensed social worker licensed by the state of Ohio Counselor, Social Worker, and Marriage & Family Therapist Board in accordance with Chapter 4757. of the Ohio Revised Code.
- A social work trainee who is registered with the state of Ohio Counselor, Social Worker, and Marriage & Family Therapist Board in accordance with Chapter 4757. of the Ohio Revised Code. A social work trainee is completing their school approved field placement under a council on social work education accredited master's level program.
- A social work assistant who is registered with the state of Ohio Counselor, Social Worker, and Marriage & Family Therapist Board in accordance with Chapter 4757. of the Ohio Revised Code.
- A licensed marriage and family therapist licensed by the state of Ohio Counselor, Social Worker, and Marriage & Family Therapist Board in accordance with Chapter 4757. of the Ohio Revised Code.
- A marriage and family therapist trainee registered with state of Ohio Counselor, Social Worker, and Marriage & Family Therapist Board in accordance with Chapter 4757. of the Ohio Revised Code. A marriage and family therapist trainee is a student enrolled in a marriage and family therapist practicum or internship in Ohio.
- A licensed chemical dependency counselor III licensed by the Ohio Chemical Dependency Professional Board in accordance with Chapter 4758. of the Ohio Revised Code.
- A licensed chemical dependency counselor II licensed by the Ohio Chemical Dependency Professional Board in accordance with Chapter 4758. of the Ohio Revised Code.
- A chemical dependency counselor assistant certified by the Ohio Chemical Dependency Professionals Board in accordance with Chapter 4758. of the Ohio Revised.

Behavioral Health Paraprofessionals (BHP-Ps)

BHP-Ps are professionals who are **NOT** licensed by a professional board in the state of Ohio but are specially trained to provide a specialty service or services to persons with or in recovery from substance use disorders (SUDs) and/or mental health (MH) conditions. BHP-Ps are:

- Peer recovery supporters (PRSs) are utilized in Specialized Recovery Services (SRS) program and SUD Peer Support (H0038):
 - Are at least 18 years old
 - Have a high school diploma or equivalent.
 - Are registered in the state of Ohio to provide peer services.
 - Self-identify as having lived experience of an SUD, a MH condition or both.
 - Have taken the state-approved standardized peer recovery supporter training that includes academic information as well as practical knowledge and creative activities focused on the principles and concepts of peer support and how it differs from clinical support. The training provides practical tools for promoting wellness and recovery, knowledge about individual rights advocacy, confidentiality, and boundaries as well as approaches to care that incorporate creativity.
 - Achieved a score of at least 70 on the OhioMHAS peer recovery supporter exam.
 - Obtained PRS certification from OhioMHAS.
 - Are supervised by a senior SUD and/or MH peer recovery supporter or supervised by a M-BHP, an I-BHP or a BHP who is knowledgeable about SUD and/or MH peer service delivery.

- SUD specialists

Are people who have received training for or education in alcohol and other drug addiction, abuse, and recovery and who has demonstrated, prior to or within ninety days of hire, competencies in fundamental alcohol and other drug addiction, abuse and recovery. SUD specialists must be supervised by an M-BHP, an I-BHP or a BHP and may only provide referral and assistance as needed for the person to gain access to other needed SUD or mental health services. Fundamental competencies of SUD specialists shall include, at a minimum:

 - Are at least 18 years old
 - Have a high school diploma or equivalent.
 - An understanding of alcohol and other drug treatment and recovery
 - How to engage a person in treatment and recovery and
 - An understanding of other healthcare systems, social service systems and the criminal justice system.

- Qualified Mental Health Specialists (QMHSs)

Are people who have received training or education in mental health competencies and who have demonstrated, prior to or within ninety days of hire, competencies in basic mental health skills along with competencies established by the agency, and who are not otherwise designated as providers or supervisors, and who are not required to perform duties covered under the scope of practice according to Ohio professional licensure. Basic mental health competencies for QMHSs shall include, at a minimum:

 - Are at least 18 years old
 - Have a high school diploma or equivalent

- An understanding of mental illness, psychiatric symptoms, and impact on functioning and behavior
 - How to therapeutically engage a mentally ill person
 - Concepts of recovery/resiliency
 - Crisis response procedures
 - An understanding of the community mental health system
 - De-escalation techniques
 - Understanding how his/her behavior can impact the behavior of individuals with mental illness
- Case Management Specialists (CMS)
 - Under Development

Coordination of Benefits when clients are assigned to Managed Care Plans

-Under Development

Place of Service Considerations

-Under Development

Providers must identify and report on each claim detail lines where a service took place using the CMS

Place of Service Code set in order to receive reimbursement. Each billing chart in this manual will list the allowable place of service codes covered by Medicaid.

Services Delivered in an Inpatient or Outpatient Hospital Setting

If a provider wishes to provide services in an inpatient or outpatient hospital setting, they must contract with the hospital to receive reimbursement for those services, as the payment of these services are included in the payment to the facility.

Services Provided in a School Setting

-Under Development

“Other Place of Service” Setting

Place of service “99-Other Place of Service” will no longer be accepted starting 1/1/17.

If there is a place of service that does not closely describe where a service was provided, CMS has a process for requesting new or modified place of service codes. Their process is outlined below:

To apply for a new or modified place of service code, you should submit a request that responds to the questions listed below. Each request should be limited to one code or modification and should include any additional descriptive material that you think would be helpful in furthering our understanding of the benefit of the code or modification being requested.

After CMS' receive your request, it is placed on the agenda for an upcoming meeting of the CMS Place of Service Workgroup. The Workgroup, comprised of representatives of several components of the Centers for Medicare & Medicaid Services (formerly known as the Health Care Financing Administration), meets to analyze the appropriateness of, and business need for, the requested code; its effect on existing POS codes and descriptions; and the impact of the proposed coding change on health care payers.

If you have questions regarding the process for reviewing place of service code recommendations and associated issues, please feel free to direct them to the POS Coordinator, via e-mail at posrequest@cms.hhs.gov. If you would like to contact CMS regarding an existing code(s) or description(s), please send your question or comment to posinfo@cms.hhs.gov.

Same Day Services Requiring Claims Detail Rollup

-Under Development

Certain services provided to the same patient on the same day are required to be "rolled up" and submitted as one detail line regardless if the time of the services are not provided continuously.

Benefits and Prior Authorization Requests

-Under Development

A Benefits and Services Development workbook has been created to assist providers in determining when prior authorization is necessary for the reimbursement of services.

Modifiers

In order to communicate detailed information in an efficient, standardized way modifiers are two-character suffixes that healthcare providers or coders attach to a CPT code to give additional information about the provider or procedure documented. It is extremely important to accurately report modifiers as they are used to count towards soft limits, price services and adjudicate claims appropriately. Modifiers are always two characters in length. They may consist of two numbers from 21 to 99, two letters, or a mix (alphanumeric).

The following modifiers are required when submitting service to Ohio Medicaid for the following provider types:

Table 1-1: Practitioner Modifiers

Practitioner providing the service:	Modifier
Licensed professional counselor	U2
Licensed chemical dependency counselor II or III	U3
Licensed social worker	U4
Licensed marriage and family therapist	U5
Psychology assistant, intern, trainee	U1
School psychology assistant/trainee (ODE)	U1
Board licensed school psychologist	UB
Chemical dependency counselor assistant	U6
Counselor trainee	U7
Social worker assistant	U8
Social worker trainee	U9
Marriage and family therapist trainee	UA
Pharmacist	UB
QMHS - high school	HM
QMHS - Associate	HM
QMHS - Bachelor	HN
QMHS - Master	HO
QMHS +5 years' experience	HM
CM specialist	HM

The following modifiers are required to describe specific circumstances that may occur during a service:

Table 1-2: Service Modifiers

Service Circumstance	Modifier
Group service	HQ
Secured video-conferencing	GT
Physician, team member (ACT)	AM
Pregnant/parenting women's program	HD
Licensed practitioners providing MH day treatment and TBS per diem	HK
Complex/High Tech Level of Care	TG
Cognitive Impairment	HI
Special Payment Rate	TV
Significant, separately identifiable Evaluation & Management (E&M) service by physician or other qualified health care professional on the same day of the procedure or other service	25
NCCI modifiers 59, XS, XE, XU and XP	See NCCI Section
Crisis used on H2017, H2019, H0004 and H0015	UT
Licensed practitioners providing MH day treatment and TBS per diem	HK

Medical Necessity

When a patient reaches a point in his/her treatment where further improvement does not appear to be indicated and there is no reasonable expectation of improvement, the outpatient psychiatric or substance abuse services are no longer considered reasonable or medically necessary.

Patients with dementia represent a very vulnerable population in which co-morbid psychiatric conditions are common. However, for such a patient to benefit from psychotherapy services requires that their dementia to be mild and that they retain the capacity to recall the therapeutic encounter from one session, individual or group, to another. This capacity to meaningfully benefit from psychotherapy must be documented in the medical record. Psychotherapy services are not covered when documentation indicates that dementia has produced a severe enough cognitive defect to prevent psychotherapy from being effective.

Medical Record Documentation

Clear and concise medical record documentation is critical to providing patients with quality care and is required for the provider to receive accurate and timely payment for furnished services. Medical records chronologically report the care a patient received and record pertinent facts, findings, and observations about the patient's health history. Medical record documentation helps physicians and other health care professionals evaluate and plan the patient's immediate treatment and monitor the patient's health care over time.

Medicaid requires reasonable documentation to ensure that a service is consistent with the patient's insurance coverage and to validate:

- The site of service;
- The medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or
- Services furnished were accurately reported.

The following general principles help ensure that medical record documentation for all services is appropriate:

- The medical record should be complete and legible;
- The documentation of each patient encounter should include:
 - Reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results;
 - Assessment, clinical impression, or diagnosis;
 - Medical plan of care; and
 - Date and legible identity of the observer;
- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred;
- Past and present diagnoses should be accessible to the treating and/or consulting physician;
- Appropriate health risk factors should be identified;
- The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented; and
- The diagnosis and treatment codes reported on the health insurance claim form or billing statement should be supported by documentation in the medical record.

To maintain an accurate medical record, document services during the encounter or as soon as practicable after the encounter. Abbreviations of credentials must be on the signature lines in documentation where credentials are required (i.e. orders for services, progress notes, etc.). For those staff members whose practitioner level is affected by a degree, the degree initials must also be included. For example, if a registered nurse is working with an applicable Bachelor of Arts

degree, he or she would include RN, BA(s) as his or her credentials. Additionally, when working under supervision, the supervisor's initials and credentials must be noted.

Components of the Medical Record:

- Assessment
- Treatment Plan
- Progress Notes
- Treatment Plan Reviews

Assessments: A thorough individualized, person-centered assessment of the individual's presenting issues must be documented in the record. The individual should be an active participant in the assessment process and the participant should include collateral individuals (family, friends) if the individual makes such a request. The assessment includes numerous mandatory elements that are referenced later in this manual. Unless the individual's clinical needs are clearly identified, the treatment may not be determined to be medically necessary and ODM may deny payment. There may be multiple assessments for each individual, especially in situations where they are receiving multi-disciplinary services. There is usually a bio-psychosocial assessment completed by a clinician who is trained to do some or all of this type of assessment. There may also be functional assessments: these are not required but are used by many organizations to provide additional information about the individual, their current level of functioning, and their current service needs. For individuals seeing the psychiatrist for medication management there is usually a psychiatric assessment completed as well.

Mental health service providers may accept mental health assessments from prior evaluations. The clinical record shall reflect that such assessments have been reviewed and updated when appropriate prior to the initiation of any mental health services.

Treatment Plans: The treatment plan is a dated document (there is both a beginning and an ending date for each plan), that is signed by individuals holding the required professional credentials that authorized medically necessary services. The treatment plan should be developed in a person-centered manner with the active participation of the client, family, and providers and be based on the beneficiary's condition and the standards of practice for the provision of rehabilitative services. The treatment plan should include the following information on strengths, culture, goals, objectives, and discussion of service modalities to be used in treatment.

Each agency has its own policies on who must participate in completing the treatment plan and who is ultimately responsible for making sure it is kept current and signed by an appropriate practitioner.

- If an individual's services (MEDICAID only) include medication or nursing services there are 3 options:
 - Have the physician, nurse practitioner, or CNS sign to cover the med services
 - Don't include medical services and have a separate medical management plan signed by MD or nurse practitioner

- Include on the treatment plan a referral for medication evaluation and on-going treatment if necessary and then have the physician/nurse practitioner prescribe their own services and any other medical services directly on each progress note. By doing it this way, the physician does not have to sign the treatment plan.
- If the individual's services (Medicaid only) do NOT include medication or nursing services, the licensed practitioner can sign the treatment plan as long as what is written into the plan is within their scope of practice.
- With Medicare only or dually eligible Medicare/Medicaid clients –a physician (not a nurse practitioner) must sign.

The differences between Medicaid and Medicare sometimes make it very difficult for providers to establish a uniform policy and procedure that satisfies all payer requirements. This means that providers may need to develop payer-specific policies or use a universal conservative approach to treatment plan signatures.

All signatures must be dated and include the practitioner's credentials. **The treatment plan is not active until the last required signature is in place on the plan.** Remember that a late or improperly signed plan will mean that services initiated prior to the finalization cannot be billed to Medicare or Medicaid. Services initiated prior to finalization of the treatment plan may be subject to recovery if billed to Medicaid. For all other payers the provider agencies are responsible for determining payer requirements and for developing internal operational policy to meet those requirements. Check your agency policies for treatment planning and signatures for commercial insurances or other government health programs.

Treatment Plan Reviews/Updates: A minimum review and update of the individual's treatment plan is expected every 180 to 365 days, depending on the type of treatment provided. This review must be documented and placed into the medical record. The documentation of the treatment plan review can be in the form of a progress note, or notes made on the current treatment plan. However the review is documented, it should be signed by the practitioner and the client (family member, when appropriate).

The review and update should record:

- The participants in the treatment plan review.
- The progress the individual has either made or not made towards meeting their goals and objectives. This is best done by separately addressing each goal rather than a summary statement that is more of a general discussion of individual activities and progress towards goals. ODM will expect that if the individual has not progressed that there will be some discussion of why and that there will likely be changes to the plan to attempt to meet the individual's goals in another way. If there has been progress ODM will expect that there will be some discussion of whether or not the treatment plan should change to reflect this progress, for example, should objectives change so that the individual is working on the next steps they need to take to meet their goals.
- Any suggested and agreed upon modifications to the treatment plan as a result of the joint discussions of the individual and the treatment team.

Progress Notes/Progress-to-date: Documentation which is focused on one or more goals or objectives in the treatment plan is required for every service provided to the individual. There is no need to record general check-in conversations or conversations that do not have a specific treatment purpose.

The purpose of the progress note is to:

- Allow communication between members of the treatment team.
- Record for the individual, the purpose and content of each interaction they have with their treatment team.
- Record the individual's progress towards established goals to determine effectiveness of treatment.

When auditing medical records, ODM or their designee will look at the progress notes to determine whether or not:

- The service delivered is a covered service.
- The service has been ordered and signed by the appropriate professionals on a current treatment plan.
- The service was provided in the appropriate location, by the appropriately credentialed worker.
- The bill for the service and the documentation of the service match each other as to date, time, and type of service provided.

ODM expects that all providers will understand the content difference between progress notes and psychotherapy notes (also known as process notes) and the differences in privacy protection as described below. If a provider chooses to write psychotherapy notes, they should maintain them in a separate file to protect the privacy of those notes. Progress notes become part of the clinical record, which may be requested by the client at any time.

Psychotherapy Notes: Defined by CFR 45, Part 164.501 as: "...notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes exclude medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date."

Examples of psychotherapy notes are a description of dream content, specific memories of child abuse, a clinician's thought process about the client's issues, a clinician's personal feelings or counter-transference, etc. Psychotherapy notes differ from regular clinical records and receive special protection under HIPAA (CFR 45, Part 164.524) from other clinical records which may be exchanged between providers and the MHP without specific permission from the client. Physically integrating the excluded information and protected information into one document does not make the excluded information protected.

Psychotherapy notes that are not filed separately from the clinical record, or that contain excluded information, no longer receive special protection under HIPAA. Those notes are subject to review by the MHP and would be seen by the client if he/she so requested. Psychotherapy notes that are maintained separately and do not contain excluded information would only be disclosed via legal action or with the client's release.

Group services: A note must be written for each beneficiary client participating or represented in a therapy or rehabilitation group. These notes must include the minimum requirements above, as well as:

- Summary of the group's behavioral health goals/purpose.
- Primary focus on the client's group interaction & involvement, as relevant to their treatment plan.
- The total number of clients served (regardless of insurance plan/status).
- Total service time: The addition of group time to the time it takes to write progress notes for all clients served (regardless of insurance plan/status).

Medical Record Corrections

Paper Medical Records: When correcting a paper medical record, these principles are generally accomplished by:

1. Using a single line strike through so the original content is still readable, and
2. The author of the alteration must sign and date the revision.

Amendments or delayed entries to paper records must be clearly signed and dated upon entry into the record. Amendments or delayed entries to paper records may be initialed and dated if the medical record contains evidence associating the provider's initials with their name.

Overview of Supervision Requirements

Ohio Medicaid covers services provided by practitioners who, under state licensing, require supervision. The chart below indicates the type of supervision required according to the appropriate licensing board.

General supervision: The supervising practitioner must be available by telephone to provide assistance and direction if needed.

Direct supervision: The supervising practitioner must be "immediately available" and "interruptible" to provide assistance and direction throughout the performance of the procedure; however, he or she does not need to be present in the room when the procedure is performed.

Note-This is a brief overview concerning supervision. It is the practitioner's responsibility to read their respective licensing board's laws and rules for a full understanding of the supervisory requirements.

Ohio Medicaid allows the following practitioners require either direct or general supervision:

Table 1-3: Supervision Requirements

Practitioner Providing the Service:	Must Be Supervised by:
Licensed professional counselor	Under the <u>general</u> supervision of a psychologist, psychiatrist, licensed professional clinical counselor, independent marriage and family therapist, or independent social worker.
Licensed chemical dependency counselor II or III	Under the <u>general</u> supervision of a licensed independent chemical dependency counselor, or chemical dependency counselor III (for CDC-II) licensed under OAC 4758 or an MD/DO, psychologist, LPCC, LISW, LIMFT
Licensed social worker	Under <u>general</u> supervision of a psychologist, psychiatrist, licensed professional clinical counselor, independent marriage and family therapist, independent social worker, or registered nurse who holds a master's degree in psychiatric nursing.
Licensed marriage and family therapist	Under the <u>general</u> supervision of a psychologist, psychiatrist, licensed professional clinical counselor, independent social worker, or independent marriage and family therapist.
Psychology assistant, intern, trainee	<u>Direct</u> supervision by psychologist
School psychology assistant/trainee	<u>Direct</u> supervision by psychologist or board licensed school psychologist
Chemical dependency counselor assistant	Under the <u>direct</u> supervision of an independent chemical dependency counselor-clinical supervisor, independent chemical dependency counselor or chemical dependency counselor III licensed under OAC 4758 or an MD/DO, psychologist, PCC, LISW, LIMFT
Counselor trainee	Counselor trainee must have an active counselor trainee status with the Ohio Counselor, Social Worker and Marriage and Family Therapist Board, and must be <u>directly</u> supervised by a LPC-S (practicum only) or LPCC-S (practicum or internship) when the service is provided in order to receive reimbursement from Ohio Medicaid.
Social worker assistant	Under the <u>direct</u> supervision of a psychologist, psychiatrist, licensed professional clinical counselor, licensed professional counselor, independent marriage and family therapist, independent social

	worker, social worker, or registered nurse who holds a master's degree in psychiatric nursing.
Social worker trainee	Under the <u>direct</u> supervision of an independent social worker, a professional clinical counselor, a psychologist, or a psychiatrist and currently enrolled in a master's level practicum, internship or field work course in social work education program accredited by the "Council on Social Work Education" or an educational institution in candidacy for accreditation by the Ohio Counselor, Social Worker and Marriage and Family Therapist Board.
Marriage and family therapist trainee	Under the <u>direct</u> supervision of a licensed independent marriage and family therapist and has filed a training agreement with the board per rule 4757-25-08 of the Ohio Administrative Code and is currently enrolled in either a practicum or internship in a marriage and family therapy education program as defined in paragraph rule 4757-25-01(A) of the Ohio Administrative Code.

Note: According to the Ohio Counselor, Social Worker and Marriage & Family Therapist Board, "the assessment, diagnosis, treatment plan, revisions to the treatment plan and transfer or termination shall be cosigned by the supervisor".

Incident to Services

The term "incident to" refers to the services or supplies that are a key part of the physician's personal professional services in the course of diagnosis or treatment of an illness or injury. In plain language: under the "incident to" provision of Medicare, services are submitted under the physician's NPI but are actually performed by someone else. There are restrictions on the types of services that ancillary personnel may perform under this provision. To qualify as "incident to," services must be part of the patient's normal course of treatment, during which a physician or independent practitioner personally performed an initial service that day and subsequent services are provided by the physician or independent practitioner at a frequency that reflects the their continuing active participation in and management of the course of treatment. The supervising practitioner does not have to be physically present while these services are provided, but they must provide direct supervision, that is, they must be present in the office suite to render assistance, if necessary.

However, in order to have that same service covered as incident to the services of a physician, it must be performed under the direct supervision of the physician as an integral part of the physician's

personal in-office service. As explained in §60.1, this does not mean that each occasion of an incidental service performed by a non-physician practitioner must always be the occasion of a service actually rendered by the physician. It does mean that there must have been a direct, personal, professional service furnished by the physician to initiate the course of treatment of which the service being performed by the non-physician practitioner is an incidental part, and there must be subsequent services by the physician of a frequency that reflects the physician's continuing active participation in and management of the course of treatment. In addition, the physician must be physically present in the same office suite and be immediately available to render assistance if that becomes necessary.

When a practitioner is permitted to bill for his/her time under the Medicaid State Plan (e.g., OLP or Rehab), it is the state's expectation that unless the physician or higher level practitioner has seen the patient that day, then the practitioner will bill for his/her time under their own authority.

If the service is provided in the patient's home or community, the supervisor must be available by telephone to provide assistance and direction if needed (general supervision is required). The patient record should document the essential requirements for the service. To bill incident-to, there must be a practitioner's service to which the non-physician practitioner's service relates. When billing "incident to" services, the independent practitioner's provider ID is used and a modifier describing the delivering non-physician practitioner's level of education is added to the claim.

Shared/split visit is for services provided in any location when both the physician and a non-physician practitioner (NPP) provide, document, and sign the work they each performed. There must be a face-to-face encounter with both the physician and NPP. The physician can bill the service to Medicare.

It is important to note the difference between incident-to from shared/split visit. Medicare allows 100% of the physician/psychologist fee schedule amount for coverable services submitted by a physician (incident-to). Medicare allows a percentage of the physician fee schedule amount when services are submitted under an NPP provider number (shared/split visit) for an LCSW or other OLP.

When a practitioner is permitted to bill for his/her time for the service under the Medicaid State Plan (e.g., OLP or Rehab), it is the state's expectation that unless the physician or higher level practitioner has seen the patient that day, then the practitioner will bill for his/her time under their own authority.

If a physician or psychologist has a face-to-face encounter, the physician or psychologist would bill the service under their NPI. If another practitioner is able to bill under the State Plan and the physician/psychologist does not have a face-to-face encounter, the practitioner would bill under the billing guidance for their practitioner type under the Medicaid State Plan (e.g., OLP or Rehab). If the physician/psychologist does not have a face-to-face encounter, and the practitioner is not able to bill the service under the Medicaid State Plan, then the practitioner would bill using incident-to guidelines.

For example, if a nurse sees the patient face-to-face but the physician does not and the contact qualifies for billing under TBS, then the agency would bill TBS. If the nurse sees the patient and the physician does not, and the contact does not qualify for TBS, then the agency would bill under incident-to guidelines.

Please note that the requirements for incident-to are different for each payor. For information on Medicare’s guidance on incident-to services, please see the Medicare Claims Processing Manual at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf> .

The following websites contain further guidance on supervision:

State of Ohio Medical Board- <http://med.ohio.gov/>

Ohio Nursing Board- <http://www.nursing.ohio.gov/>

Social Worker, MFT, Counselors- <http://cswmft.ohio.gov/Home.aspx>

Chemical Dependency- <http://ocdp.ohio.gov/>

Psychology- <http://psychology.ohio.gov/>

*This is a brief overview concerning licensure and scope of practice. It is each agency or provider’s responsibility to read the laws and rules for a full understanding of the requirements.

Medicaid Reimbursement Rate

The chart below reflects the Medicaid reimbursement rate for specific provider types:

Table 1-4: Medicaid Reimbursement Rate by Provider Type

Provider Type	Medicaid Reimbursement
Physicians and psychologists	100% of the Medicaid maximum fee
Psychology assistants, psychology interns and psychology trainees (under appropriate supervision)	100% of the Medicaid maximum fee
RNs and LPNs (under appropriate supervision)	Either 100% or 85% depending on service
Clinical nurse specialist Clinical nurse practitioner Physician assistants Licensed professional clinical counselors (LPCCs) Licensed independent social workers (LISW) Licensed independent marriage and family therapists (LIMFT) Licensed independent chemical dependency counselors (LICDCs)	85% of the Medicaid maximum fee

Licensed professional counselors Licensed chemical dependency counselors II & III Licensed social workers Licensed marriage and family therapists	85% of the Medicaid maximum fee
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Non-Covered Services

The following activities **are not covered by Medicaid under the OLP and Rehabilitation sections of the State Plan:**

- Billing not consistent with the American Medical Association (AMA) defined code set (e.g., billing for a 15 minute unit when only 7 minutes of care is delivered).
- Contacts that are not medically necessary.
- Time spent doing, attending, or participating in recreational activities.
- Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor.
- Services provided at facilities where payment for those services are included in a bundled rate, per diem or DRG group (skilled nursing facility, inpatient hospital, dialysis clinics and inpatient psychiatric hospitals).
- Habilitative services for the individual to acquire, retain, and improve the self-help, socialization, and adaptive skills necessary to reside successfully in community settings.
- Child care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- Transportation for the individual or family not provided by a Medicaid transportation provider and billed as such. Services provided in the car are considered transportation and time may not be billed to Medicaid.
- Covered services that have not been rendered.
- Services rendered that are not in accordance with an approved authorization.
- Services not identified on the individual's treatment plan consistent with treatment goals.
- Services provided without prior authorization by ODM or its designee where prior authorization is required.
- Services provided before ODM or its designee (including a managed care plan) has approved authorization when authorization is required.
- Services not in compliance with the provider billing guidance and Medicaid regulations.
- Services provided to children, spouse, parents, or siblings of the eligible individual under treatment or others in the eligible individual's life to address problems not directly related to the eligible individual's issues and not listed on the eligible individual's treatment plan.
- Services provided that are not within the provider's scope of practice.
- Any art, movement, dance, or drama therapies.
- Anything not included in the approved service description or AMA-defined description.
- Changes made to the service that do not follow the requirements outlined in the provider contract, service manual, or regulations.

- Any intervention or contact not documented or consistent with the approved treatment/recovery plan goals, objectives, and approved services will not be reimbursed.
- 12-step programs
- Missed appointments.
- Employment of the individual.
- Time spent with the client in social and leisure activities not performing direct intervention.
- Telephone calls, except as defined in OAC Rule 5122-29-17, 3793:2-1-08 and as defined in Specialized Recovery Services program.
 - Note: This is separate from secure video conferencing which is covered for some services. See Telemedicine.
- Educational, vocational, and job training services.
- OLP or Rehabilitative services provided to incarcerated individuals.
- Services to individuals residing in institutions for mental diseases.
- **CFR 42 § 435.1009 Institutionalized individuals.**
 - (a) FFP is not available in expenditures for services provided to—
 - (1) Individuals who are inmates of public institutions as defined in § 435.1010; or
 - (2) Individuals under age 65 who are patients in an institution for mental diseases unless they are under age 22 and are receiving inpatient psychiatric services under § 440.160 of this subchapter.
 - (b) The exclusion of FFP described in paragraph (a) of this section does not apply during that part of the month in which the individual is not an inmate of a public institution or a patient in an institution for tuberculosis or mental diseases.
 - (c) An individual on conditional release or convalescent leave from an institution for mental diseases is not considered to be a patient in that institution. However, such an individual who is under age 22 and has been receiving inpatient psychiatric services under § 440.160 of this subchapter is considered to be a patient in the institution until he is unconditionally released or, if earlier, the date he reaches age 22.

A Few Words about Fraud, Waste, Abuse and Errors

Medicaid fraud involves making false or misleading statements, or causing such statements to be made, in order to get Medicaid reimbursement. Medicaid fraud may include such acts as billing for, but not providing, services or goods, and providing medically unnecessary services. Medicaid fraud schemes also may involve billing for a more expensive product or service than was actually delivered, billing separately for services that should be billed together, and billing twice for the same product or service. It is also illegal to: dispense generic medications while billing for more expensive brand-name medications; submit false information on Medicaid cost reports; charge co-pays; and provide kickbacks or rebates for goods or services for which Medicaid reimbursement will be sought.

Medicaid fraud is a crime. If the fraud involves sums greater than \$150,000, it is a third-degree felony. Fraud involving sums of more than \$7,500 but less than \$150,000 is a fourth-degree felony. Fraud involving sums of more than \$1,000 but less than \$7,500 is a fifth-degree felony. Penalties may include fines, community control sanctions and, in some cases, prison. Individuals and entities convicted of Medicaid fraud and related crimes are required to be excluded from participation in all federal health care programs.

CBHCs should be aware and assess vulnerable risk areas for the following fraud and abuse categories; coding and billing, reasonable and necessary services and, documentation and improper inducements, kickbacks and self-referrals.

Fraud includes obtaining a benefit through intentional misrepresentation or concealment of material facts.

Waste includes incurring unnecessary cost as a result of deficient management, practices or controls.

Abuse includes excessively or improperly using government resources.

Fraud, Waste and Abuse Examples:

- Billing for items or services not rendered or not provided as claimed
- Submitting claims for equipment, medical supplies and services that are not reasonable and necessary
- Double billing resulting in duplicate payment (including billing two separate payors without reporting prior payments and billing for a service performed by an external party, and that party also bills for the same service);
- Billing for non-covered services as if covered (using an office visit code when the actual service was non-covered);
- Knowing misuse of provider identification numbers, which results in improper billing;
- Unbundling (billing for each component of the service instead of billing or using an bundled code);
- Failure to properly use coding modifiers;
- Clustering (the practice of coding/charging one or two middle levels of service codes exclusively under the philosophy that charges will average out over time);
- Up-coding the level of service provided; and
- Modifying information in order to receive reimbursement (such as changing a place of service, inappropriately using modifiers, etc.).

Errors happen when a provider inadvertently makes a mistake in the service delivery, documentation, or billing this would constitute an error. Some examples of errors may include but are not limited to; selecting the incorrect service type for the service rendered; not referencing the treatment plan goals or objectives the individual is working on in the session; or selecting the incorrect time for the service. Errors are usually random and do not have a pattern to them. When a provider identifies an error on a paid claim, a claim adjustment must occur and any overpayment refunded. Errors may also be identified by state or federal auditing processes, such as Payment Error Rate Measurement or Surveillance Utilization and Review Section. Any overpayments through these audits may be recovered.

Payment Error Rate Measurement (PERM)-Under development

Medicaid National Correct Coding Initiative

The National Correct Coding Initiative (NCCI) was established by the Centers for Medicare & Medicaid Services (CMS) to promote national correct coding methodologies with the goal to reduce the number of improper coding that result in inappropriate payments for both Medicare and Medicaid. The Affordable Care Act of 2010 (ACA) required state Medicaid programs to incorporate NCCI methodologies in their systems for processing Medicaid claims by October 1, 2010. A complete and up-to-date list of NCCI edits can be found at <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/national-correct-coding-initiative.html>. These edits are updated quarterly.

NCCI essentially requires providers to use the appropriate code for the right service within their current scope of practice. In addition, third party insurers are billed first before either Medicare or Medicaid and pay their appropriate share ensuring the public programs are the payer of last resort.

NCCI edits and medically unlikely edits (MUEs) are only applicable to a single provider to a single beneficiary on the same date of service. NCCI contains two types of edits:

NCCI procedure-to-procedure (PTP) edits

PTP edits define pairs of Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons. The purpose of the PTP edits is to prevent improper payments when incorrect code combinations are reported.

Example 1: The same physician performs a psychotherapy service and E&M service on the same day to the same client (significant and separately identifiable services). NCCI will not allow the psychotherapy code 90834 to be billed with an E&M office visit code 99212, as there are separate add-on codes (+90833, +90836, and +90838) for psychotherapy services provided in conjunction with E&M services.

Example 2: The same physician performs a health and behavioral assessment code 96150 and a psychiatric diagnostic evaluation code 90791 on the same day to the same client. NCCI will not permit these two codes to be billed together as 96150 is too similar a service to 90791. Only the predominant service performed should be billed (90791).

Medicaid PTP (including those that can be overridden by specific modifiers), MUE edits and other relevant information can be found at: <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/national-correct-coding-initiative.html>.

For PTP edits that have a Correct Coding Modifier Indicator (CCMI) of “0,” the codes should never be reported together by the same provider for the same beneficiary on the same date of service. If they are reported on the same date of service, the column one code is eligible for payment and the column two code is denied.

For PTP edits that have a CCMI of “1,” the codes may be reported together only in defined circumstances which are identified on the claim by the use of specific NCCI-associated modifiers. Where services are “separate and distinct,” it may be necessary to override the procedure-to-procedure edit using a specific modifier:

- XE – “Separate encounter, A service that is distinct because it occurred during a separate encounter” This modifier should only be used to describe separate encounters on the same date of service.
- XS – “Separate Structure, A service that is distinct because it was performed on a separate organ/structure”
- XP – “Separate Practitioner, A service that is distinct because it was performed by a different practitioner”
- XU – “Unusual Non-Overlapping Service, The use of a service that is distinct because it does not overlap usual components of the main service”

Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Modifier 59 should only be utilized if no other more specific modifier is appropriate. Note: high usage of all modifiers, especially modifier 59 is subject to retrospective review.

Medically Unlikely Edits (MUEs)

MUEs define for each HCPCS / CPT code the maximum units of service (UOS) that a provider would report under most circumstances for a single beneficiary on a single date of service. MUEs cannot be overridden with the 59, XE, XS, XP, XU modifiers.

Example 1: The same physician performs two diagnostic evaluations (2 units of 90791) to the same client on the same day. NCCI will deny the second evaluation, as it is medically unlikely that one client would need two complete diagnostic evaluations in the same day.

There is extensive guidance regarding Medicaid agencies and national correct coding:

August 2010 (Questions and Answers Section 6507 of the ACA, NCCI Methodologies)

September 1, 2010 (State Medicaid Director Letter [SMD] 10-017)

September 29, 2010 (CMS letter to The National Medicaid EDI Healthcare Workgroup)

April 22, 2011 (SMD 11-003)

CMS website: <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/national-correct-coding-initiative.html>

Secure Video Conferencing

OAC 5122-24-01 (52)-"Interactive videoconferencing" means the use of secure, real-time audiovisual communications of such quality as to permit accurate and meaningful interaction between client and provider. This expressly excludes telephone calls, with the exception of calls made utilizing communication devices which allow visual interaction between the provider and deaf and hard of hearing individuals, images transmitted via facsimile machines, and text messages without visualization of the client, i.e., electronic mail. The client must be present and participating in the session.

OAC 5122-29-04 (C) -The following shall apply with regard to the use of interactive videoconferencing. Interactive videoconferencing is defined in Chapter 5122-24 of the Administrative Code:

- (1) "Client site" means the location of a client at the time at which the service is furnished via interactive videoconferencing technology.
- (2) "Provider site" means the site where the eligible practitioner furnishing the service is located at the time the service is rendered via interactive videoconferencing technology.
- (3) The agency shall obtain from the client/parent/legal guardian, signed, written consent for the use of videoconferencing technology.
- (4) It is the responsibility of the agency to assure contractually that any entity or individuals involved in the transmission of the information guarantee that the confidentiality of the information is protected. When the client chooses to utilize videoconferencing equipment at a client site that is not arranged for by the agency, e.g., at his/her home or that of a family or friend, the agency is not responsible for any breach of confidentiality caused by individuals present at the client site.
- (5) The agency shall provide the client written information on how to access assistance in a crisis, including one caused by equipment malfunction or failure.
- (6) It is the responsibility of the agency to assure that equipment meets standards sufficient to:
 - (a) Assure confidentiality of communication;
 - (b) Provide for interactive videoconferencing communication between the practitioner and the client; and
 - (c) Assure videoconferencing picture and audio are sufficient to assure real-time interaction between the client and the provider and to assure the quality of the service provided.
 - (d) The client site must also have a person available who is familiar with the operation of the videoconferencing equipment in the event of a problem with the operation.
 - (e) If the client chooses to utilize videoconferencing equipment at a client site that is not arranged for by the agency, e.g., at his/her home or that of a family or friend, the agency is only responsible for assuring the equipment standards at the provider site.
- (7) The decision of whether or not to provide initial or occasional in-person sessions shall be based upon client choice, appropriate clinical decision-making, and professional responsibility, including the requirements of professional licensing, registration or credentialing boards.

Medicare coverage of telehealth services

CMS makes additions or deletions to the services defined as Medicare telehealth services effective on a January 1st basis. The annual physician fee schedule proposed rule published in the summer and the final rule (published by November 1) is used as the vehicle to make these

changes. The public has the opportunity to submit requests to add or delete services on an ongoing basis, Providers may verify covered Medicare telehealth services at:

<https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.html>

Time Based CPT Codes

- When billing time-based codes the CPT time rule applies, unless otherwise specified:
- Exact times must be documented in the medical record
 - Psychotherapy should not be reported if less than 16 minutes of therapy is provided.
 - The code reported should be selected based on the time closest to that indicated in the code descriptor. For example; psychotherapy CPT code definitions provide the expected time for the service. When the service time goes over the time indicated in the CPT definition (90832= 30 minutes), but remains below the next time based code (90834 =45 minutes), the length of the service must be more than half of the difference before the higher level code can be billed (15 minutes difference divided by 2= 7.5 minutes. Therefore, the service must be at least 38 minutes before the higher level code can be billed. For the minimum billable service of the lowest code, divide the time by two and add one minute in order to determine if that code can be billed. For example; 90832=30 minutes, therefore the minimum length of service must be 16 minutes in order for the service to be billable.

Conversion Chart 15 Minute CPT Code			Conversion Chart Half Hour Based CPT Reported in Whole Unit			Conversion Chart Hour Based CPT Reported in Whole Unit		
Minimum Minutes	Maximum Minutes	Billing Unit(s)	Minimum Minutes	Maximum Minutes	Billing Increment	Minimum Minutes	Maximum Minutes	Billing Increment
0	7	N/A	1	15	N/A	1	30	N/A
8	22	1	16	45	1	31	90	1
23	37	2	46	75	2	91	150	2
38	52	3	76	105	3	151	210	3
53	67	4	106	135	4	211	270	4

SECTION 2

Medical services (CPT Codes)

For behavioral health billing, medical service codes consist of E&M office visits, psychotherapy, diagnostic evaluation, psychiatric testing and appropriate add-on codes. The AMA publishes annual CPT books, which provide medical codes, description and guidance on appropriate use. Appendix XX has been incorporated in this billing manual to assist with selection of the appropriate E&M office visit codes to submit on claims. Please note, this is only for reference

and the provider is responsible for utilizing the appropriate AMA or CMS guidance for documentation and billing. Therefore, it is recommended that all providers obtain a copy of a current CPT manual, CMS 1995 and 1997 CMS Evaluation and Management documentation guidelines.

Table 2-1: Evaluation & Management

MH / SUD				
Service	Provider Type	Code	Incident to Modifier	Rate
E&M New Patient	MD/DO	99201		\$41.97
		99202		\$71.97
		99203		\$104.49
		99204		\$160.23
		99205		\$201.38
	Certified nurse specialist Certified nurse practitioner Physician assistant	99201	UC	\$35.67
		99202	SA	\$61.17
		99203	UD	\$88.82
		99204		\$136.20
		99205		\$171.17
E&M Established Patient	MD/DO	99211		\$18.96
		99212		\$41.62
		99213		\$70.42
		99214		\$103.93
		99215		\$140.37
	Certified nurse specialist Certified nurse practitioner Physician assistant	99211	UC	\$18.96
		99212	SA	\$35.38
		99213	UD	\$59.86
		99214		\$88.34
		99215		\$119.31
RN/LPN	99211	N/A	\$18.96	
Unit Value	1 encounter (Note: time-in/time-out is required in the documentation)			
Service Definition	The individual must receive appropriate medical interventions as prescribed and provided by members of the medical staff which shall support the individualized goals of recovery as identified by the individual and their parent/guardians and their individualized treatment plan (within the parameters of the individual/family's informed consent).			
Admission Criteria	Applies to Mental Health and SUD agencies: <ul style="list-style-type: none"> Individual is determined to be in need of mental health or substance use disorder services and requires some level of medical oversight; or Individual has been prescribed medications as a part of the treatment/service array. 			

<p>Clinical Operations</p>	<p>In accordance with recovery philosophy, it is expected that individuals will be treated as full partners in the treatment regimen/services planned and received. As such, it is expected that practitioners will fully discuss treatment options with individuals and allow for individual choice when possible. Discussion of treatment/service options should include a full disclosure of the pros and cons of each option (e.g. full disclosure of medication/treatment regimen potential side effects, potential adverse reactions--including potential adverse reaction from not taking medication as prescribed, and expected benefits). If such full discussion/disclosure is not possible or advisable according to the clinical judgment of the practitioner, this should be documented in the individual's chart (including the specific information that was not discussed and a compelling rationale for lack of discussion/disclosure).</p> <ul style="list-style-type: none"> • Assistive tools, technologies, worksheets, etc. can be used by the served individual to facilitate communication about treatment, symptoms, improvements, etc. with the treating practitioner. • This service may be provided with psychotherapy codes 90833, 90836 or 90838, but the two services must be separately identifiable. • For purposes of this definition, a "new patient" is an individual who has not received an E&M code service from that agency within the past three years. If an individual has engaged with the agency, and has seen a non-physician for a behavioral health (BH) assessment, they are still considered a "new patient" until after the first E&M service is completed.
<p>Service Accessibility</p>	<ul style="list-style-type: none"> • This service may not be provided in an IMD, jail, youth development center, or prison system. • This service may not be provided and billed for individuals who are involuntarily detained in youth detention centers awaiting criminal proceedings, penal dispositions, or other involuntary detention proceedings.
<p>Reporting and Billing Requirement</p>	<ul style="list-style-type: none"> • A physician who is covering or on-call for another physician should not classify the patient's encounter as a "new patient" unless the patient's attending physician or member of his/her group has not seen the patient within the past three years. <p>Providers may utilize either CMS 1995 or 1997 E&M documentation guidelines for appropriate CPT code selection. See Appendix C for AMA CPT 2015 E&M Service Determination See Appendix H for Medicare E&M Documentation Guidance</p>

Table 2-2: Evaluation & Management Home Visit

MH / SUD				
Service	Provider Type	Code	Incident to Modifier	Rate
E&M Home Visit New Patient	MD/DO, CNS, CNP	99341		\$54.10
		99342		\$78.03
		99343		\$128.18
		99344		\$179.16
		99345		\$217.23
	Certified Nurse Practitioner (CNP) & Certified Nurse Specialist (CNS)	99341	UC SA	\$45.99
		99342		\$66.33
		99343		\$108.95
		99344		\$152.29
99345		\$184.65		
Physician assistant	99341	UD	\$45.99	
	99342		\$66.33	
	99343		\$108.95	
	99344		\$152.29	
	99345		\$184.65	
E&M Home Visit Established Patient	MD/DO, CNS, CNP	99347		\$54.40
		99348		\$82.77
		99349		\$125.93
		99350		\$174.92
	Certified Nurse Practitioner (CNP) & Certified Nurse Specialist (CNS)	99347		\$46.24
		99348		\$70.35
		99349		\$107.04
		99350		\$148.68
		Physician assistant		99347
99348	\$70.35			
99349	\$107.04			
99350	\$148.68			
Unit Value	1 encounter (Note: time-in/time-out is required in the documentation)			

<p>Service Definition</p>	<p>The CPT codes 99341 through 99350, home services codes, are used to report E&M services furnished to a patient residing in his or her own private residence (e.g., private home, apartment, town home) and not residing in any type of congregate/shared facility living arrangement including assisted living facilities and group homes. The home services codes apply only to the specific 2-digit place of service (POS) code of 12 (Home). Home services codes may not be used for billing E&M services provided in settings other than in the private residence of an individual as described above.</p> <p>A physician who is covering or on-call for another physician should not classify the patient’s encounter as a “new patient” unless the patient’s attending physician or member of his/her group has not seen the patient within the past three years.</p>
<p>Admission Criteria</p>	<p>Applies to Mental Health and SUD agencies:</p> <ul style="list-style-type: none"> • Individual is determined to be in need of mental health or substance use disorder services and requires some level of medical oversight; or • Individual has been prescribed medications as a part of the treatment/service array. <p>The determination of whether home based nurse services are reasonable and necessary is made by the physician based on the condition of the patient when the services were ordered and what is reasonably expected to be appropriate treatment for the illness or injury throughout the treatment period.</p>
<p>Service Exceptions</p>	<ul style="list-style-type: none"> • The service is not personally performed or ordered by the rendering provider. • This service may not be provided in an IMD, jail, youth development center, or prison system. • This service may not be provided and billed for individuals who are involuntarily detained in youth detention centers awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings. • Physician services performed under the 'incident to guidelines are not covered in place of service Home, Domiciliary, Rest Home, Assisted Living and/or Nursing Facility.
<p>Documentation Requirements</p>	<ul style="list-style-type: none"> • The medical record must document the medical necessity of the home visit made in lieu of an office or outpatient visit. The mere presence of inactive or chronic conditions does not constitute medical necessity for any setting (home, rest home, office etc). There must be a chief complaint or a specific reasonable and medically necessary need for each visit. In support of this, the documentation of each beneficiary encounter must include: <ul style="list-style-type: none"> • 1. Reason for the encounter and relevant history • 2. Physical examination findings, and prior diagnostic test results, if applicable • 3. Assessment, clinical impression, or diagnosis • 4. Medical plan of care including how the visit will change/changed the care of the beneficiary. <p>The following conditions do not meet medical necessity for a home visit:</p> <ul style="list-style-type: none"> ○ Lack of Transportation. Transportation can be available through their respective county’s Non-Emergency Medical Transportation service (NEMT). ○ TBD

Table 2-3: Prolonged Physician E&M/Psychotherapy Services

MH / SUD					
Service	Provider Type	Code	Required Modifier	Incident to Modifier	Rate

DRAFT

Prolonged Physician E&M and Psychotherapy Services-First hour	MD/DO (add-on to 99201-99205, 99211-99215)	+99354			\$89.90
	Certified nurse specialist Certified nurse practitioner Physician assistant (add-on to 99201-99205, 99211-99215)	+99354		UC SA UD	\$76.42
	PSY (Add-on to 90837)	+99354			\$89.90
	LISW, LIMFT, LPCC, LICDC, LI School PSY, (Add-on to 90837)	+99354			\$76.42
	LPC LSW LMFT LCDC III, LCDC II	+99354	U2 U4 U5 U3		\$76.42
	PSY Assistant Social Work-Trainee MFT-Trainee CDC-A C-T	+99354		U1 U9 UA U6 U7	Dependent on supervisor
Prolonged Physician E&M and Psychotherapy Services- Each add. 30 minutes	MD/DO (add-on to +99354)	+99355			\$89.24
	Certified nurse specialist Certified nurse practitioner Physician assistant (add-on to +99354)	+99355		UC SA UD	\$75.85
	PSY (Add-on to 90837)	+99354			\$89.24
	LISW, LIMFT, LPCC, LICDC, LI School PSY, (Add-on to 90837)	+99354			\$75.85

	LPC LSW LMFT LCDC III, LCDC II	+99354	U2 U4 U5 U3		\$75.85
	PSY Assistant Social Work-Trainee MFT-Trainee CDC-A C-T	+99354		U1 U9 UA U6 U7	Dependent on supervisor
Unit Value					
Service Definition		Prolonged service codes are used when a physician or other qualified health care professional provides prolonged service involving direct face to face patient contact that is provided beyond the usual E&M service. This code is reported in addition to the designated E&M service provided.			
Reporting and Billing Requirements	Prolonged services codes can only be billed if the total duration of all physician or qualified NPP direct face-to-face services (including the visit) equals or exceeds the threshold time for the evaluation and management service the physician or qualified NPP provided				
	<ul style="list-style-type: none"> • Prolonged service of less than 31 minutes total duration on a given date is not separately reported because the work involved is included in the total work of E&M code. There will be no additional payment in this instance. • In the case of prolonged office services, time spent by office staff with the patient or time the patient remains unaccompanied in the office cannot be billed as a prolonged service. 				
	Code	Typical Time for Code	Threshold Time to Bill Code 99354	Threshold Time to Bill Codes 99354 and 993	Time
	99201	10	41	86	
	99202	20	51	96	
	99203	30	61	106	
	99204	45	76	121	
	99205	60	91	136	
	99212	10	41	86	
	99213	15	46	91	
99214	25	56	101		
99215	40	71	116		

		<ul style="list-style-type: none"> Codes 90832, 90834 and 90837 should not be billed with E&M codes. Instead use 90833, 90836 and 90838, with the appropriate E&M code. <i>Time associated with activities used to meet criteria for the E&M service is not used for reporting the psychotherapy service.</i> If a separately identifiable E&M service and an injection of a physician administered medication (J-codes) is provided by the same provider, both the E&M and 96372 (modified with an NCCI override modifier 59, XS, XU, or XP) can be billed. If the injection is administered during the E&M visit, only the office visit and injectable medication will be reimbursed (administration will not be reimbursed if provided during the E&M service). <u>However, in order to receive reimbursement of the injectable medication, the injection administration and injectable medication codes must be on the claim.</u> If a vaccine is administered during the E&M visit, only the E&M will be reimbursed (administration will not be reimbursed if provided during the E&M service). In order to receive reimbursement of the vaccine, the E&M, vaccine administration and vaccine codes must be on the claim, E&M services in excess of 24 will be paid as the services are billed but will be subject to post-payment review by ODM.
Other Considerations		<p>Prolonged services cannot be billed in the office setting for time spent by office staff with the patient, or time the patient remains unaccompanied in the office. ODM allows prolonged services to be billed in conjunction with E&M base codes only.</p>
Service Exceptions		<ul style="list-style-type: none"> This service may not be provided in an IMD, jail, youth development center, or prison system. This service may not be provided and billed for individuals who are involuntarily detained in youth detention centers awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings.
E&M Dominated by Counseling and or Coordination of Care		<p>Documentation is required to be in the medical record about the duration and content of the medically necessary evaluation and management service and prolonged services billed.</p> <p>There must appropriate and sufficient document in the medical record that the rendering practitioner personally furnished the direct face-to-face time with the patient specified in the CPT code definitions. Make sure that the medical record documents the start and end times of the visit, along with the date of service.</p> <p>Medicaid does not cover prolonged services that are not face to face or prolonged services provided in the home setting.</p> <p>When an E&M service is dominated by counseling and/or coordination of care (the counseling and/or coordination of care represents more than</p>

50% of the total time with the patient) in a face-to-face encounter between the physician or the qualified NPP, and the patient in the office/clinic. The E&M code is selected based on the typical/average time associated with the code levels. The time approximation must meet or exceed the specific CPT code billed (determined by the typical/average time associated with the E&M code) and should not be “rounded” to the next higher level. Further, in E&M services in which the code level is selected based on time, you may only report prolonged services with the highest code level in that family of codes as the companion code.

EXAMPLE 1

A physician performed a visit that met the definition of an office visit code 99213 and the total duration of the direct face-to-face services (including the visit) was 65 minutes. The physician bills code 99213 and one unit of code 99354.

EXAMPLE 2

A physician performed an office visit to an established patient that was predominantly counseling, spending 75 minutes (direct face-to-face) with the patient. The physician should report CPT code 99215 and one unit of code 99354.

EXAMPLE 3

A physician performed a visit that met the definition of visit code 99212 and the total duration of the direct face-to-face contact (including the visit) was 35 minutes. The physician cannot bill prolonged services because the total duration of direct face-to-face service did not meet the threshold time for billing prolonged services.

EXAMPLE 4

A physician performed a visit that met the definition of code 99213 and, while the patient was in the office receiving treatment for 4 hours, the total duration of the direct face-to-face service of the physician was 40 minutes. The physician cannot bill prolonged services because the total duration of direct face-to-face service did not meet the threshold time for billing prolonged services.

EXAMPLE 5

A physician provided a subsequent office visit that was predominantly counseling, spending 60 minutes (face-to-face) with the patient. The physician cannot code 99214, which has a typical time of 25 minutes, and one unit of code 99354. The physician must bill the highest level code in the code family (99215 which has 40 minutes typical/average time units associated with it). The additional time spent beyond this code is 20 minutes and does not meet the threshold time for billing prolonged services.

Table 2-4: Diagnostic Evaluation

MH / SUD					
Service	Provider Type	Code	Req'd Mod	Incident to Modifier (when appropriate)	Rate
Diagnostic Evaluation	MD/DO	90791			\$151.31
	Certified nurse specialist Certified nurse practitioner	90791		UC SA	\$128.61
	Physician assistant	90791		UD	\$128.61
	Licensed independent	90791			\$128.61
	Psychologist	90791			\$151.31
	Board-licensed school psychologist	90791	UB		\$128.61
	Licensed professional counselor	90791	U2		\$128.61
	Licensed social worker	90791	U4		\$128.61
	Licensed marriage and family therapist	90791	U5		\$128.61
	Licensed chemical dependency counselor II or III	90791	U3		\$128.61
	School psychology assistant/trainee (ODE)	90791		U1	Incident to
	Psychology assistant, intern, trainee	90791		U1	Incident to
	Social worker trainee	90791		U9	Incident to
	Marriage and family therapist trainee	90791		UA	Incident to
	Chemical dependency counselor assistant	90791		U6	Incident to
Counselor trainee	90791		U7	Incident to	
Diagnostic Evaluation w/Medical	MD/DO	90792			\$126.50
	Certified nurse specialist Certified nurse practitioner	90792		UC SA	\$107.53
	Physician assistant	90792		UD	\$107.53
Unit Value	1 Encounter	Max Daily Units		Prior Authorization	
Service Definition	Psychiatric diagnostic interview/examination includes a history; mental status exam; evaluation and assessment of physiological phenomena (including co-morbidity between behavioral and physical health care issues); psychiatric diagnostic evaluation (including assessing for co-occurring disorders and the development of a differential diagnosis); screening and/or assessment of any withdrawal symptoms for family with substance related diagnoses; assessment of the appropriateness of initiating or continuing services; and a disposition. These are completed by face-to-face evaluation of the individual (which may include the use of telemedicine) and may include communication with family and other sources, and the ordering and medical interpretation of laboratory or other medical diagnostic studies.				

	<p>Psychotherapy does not include:</p> <ul style="list-style-type: none"> • Teaching grooming skills • Monitoring activities of daily living (ADL) • Recreational therapy (dance, art, play) • Social interaction
Admission Criteria	<ul style="list-style-type: none"> • The individual has a known or suspected mental illness or a substance-related disorder and has recently entered the service system; or • The individual is in need of annual assessment and reassessment of service array; or • The individual has need of an assessment due to a change in clinical/functional status.
Continuing Stay Criteria	The individual's situation/functioning has changed in such a way that re-assessment is necessary.
Discharge Criteria	<p>An adequate treatment plan has been established; and one or more of the following:</p> <ul style="list-style-type: none"> • Individual has withdrawn or been discharged from BH services; or • Individual no longer demonstrates need for continued diagnostic assessment.
Service Accessibility	<ul style="list-style-type: none"> • This service may not be provided in an IMD, jail, youth development center, or prison system. • This service may not be provided and billed for individuals who are involuntarily detained in youth detention centers awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings.
Reporting and Billing Requirements	<ul style="list-style-type: none"> • 90791 is used when an evaluation is provided by a non-physician. • 90792 is used when an evaluation is provided by a physician, PA,CNS or CNP. This 90792 intervention content would include all general behavioral health assessment as well as medical assessment/physical exam beyond mental status as appropriate. <p>Documentation requirements:</p> <ul style="list-style-type: none"> • Elicitation of a complete medical and psychiatric history (including past, family, social history) • Mental status examination • Establishment of an initial diagnosis • Evaluation of the patient's ability and capacity to respond to treatment • Initial plan of treatment • Reported once per day and not on the same day as an E&M service performed by the same individual for the same patient

MH and SUD								
Service	Provider Type	Code	Mod 1	Rate	Provider Type	Code	Mod 1	Rate
Electrocardiogram -at least 12 leads w/interpretation and report								

Electrocardiogram -tracing only w/o interpretation and report								
Electrocardiogram -interpretation and report only								
Unit Value						Utilization Criteria		
Service Definition	<p>Many psychotropic drugs affect the QTc interval of the cardiac muscle: Psychotropic Drugs with high effect (prolong QTc by >20ms) Any intravenous antipsychotic Haloperidol Methadone Thioridazine Pimozide Sertindole Drug or combination of drugs used exceeding recommended maximum dose Psychotropic Drugs with moderate effect (prolong QTc by >10ms) Chlorpromazine Quetiapine Tricyclic antidepressants Carry out ECG prior to starting treatment with: Haloperidol Lithium Clozapine Baseline and change in dose</p>							
Admission Criteria								
Continuing Stay Criteria								
Discharge Criteria								
Service Exclusions								
Clinical Exclusions								
Required Components								
Staffing Requirements								
Clinical Operations								
Service Exclusions	<ul style="list-style-type: none"> • ECGs are not covered when the following indications are present. • Routine screening or baseline ECGs in asymptomatic persons less than 40 years of age with no risk factors. 							

	<ul style="list-style-type: none"> To assess treatment that is known not to produce any cardiovascular effects.
Reporting and Billing Requirements	<ul style="list-style-type: none"> The ordering of the EKG is part of the E&M, as part of the Medical Decision Making (MDM) under the Risk category under Diagnostic Procedures Ordered. The interpretation of the ordered EKG is considered part of the EKG reimbursement, and as such is not part of the Amount and/or Complexity of Data to be Reviewed category under the MDM portion of the E/M service. Counting both a review of the ordered EKG and billing for the interpretation and report of the same EKG is incorrect.
Documentation Requirements	<ul style="list-style-type: none">

Table 2-5: Physician-Administered Medication

MH and SUD								
Service	Medication	Code	Req'd Mod	Rate	Medication	Code	Req'd Mod	Rate
Physician Administered Medication (J-Codes)	Injection, aripiprazole (Abilify), intramuscular, 0.25 mg	J0400	None		Injection, methylnaltrexone (Relistor), 0.1mg	J2212	None	
	Injection, aripiprazole (Abilify), 1 mg	J0401	None		Injection, naloxone (Narcan), 1mg	J2310	None	
	Diphenhydramine hcl (Benadryl), up to 50 mg	J1200	None		Injection, naltrexone (Vivitrol), depot form, 1 mg	J2315	None	
	Haloperidol injection, Up to 5 Mg	J1630	None		Non-OTP Providers are limited to administration of deduction and titration of the following medications;			
	Haloperidol Decanoate injection per 50 Mg	J1631	None		Buprenorphine, oral, 1 mg.	J0571	None	
	Lorazepam injection, 2Mg	J2060	None		Buprenorphine/naloxone, oral, <=to 3 mg.	J0572	None	
	Injection, naloxone (Narcan), 1mg	J2310	None		Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg.	J0573	None	
	Olanzapine long acting injectable 1 Mg	J2358	None		Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg.	J0574	None	

	Fluphenazine Decanoate injection 25 Mg	J2680	None		Buprenorphine/naloxone, oral, greater than 10 mg.	J0575	None	
	Risperidone, long acting, .5 Mg	J2794	None		OTP Providers			
	Paliperidone Palmitate injection (Invega Sustenna or Invega Trinza), 1 Mg	J2426	None		Buprenorphine, oral, 1 mg.	J0571	None	
	Valium injection, Up to 5 Mg	J3360	None		Buprenorphine/naloxone, oral, <=to 3 mg.	J0572	None	
	Cogentin (benztropine mesylate, per 1mg)	J0515	None		Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg.	J0573	None	
	Cogentin (benztropine mesylate, per 1mg)	J0515	None		Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg.	J0574	None	
					Buprenorphine/naloxone, oral, greater than 10 mg.			
Unit Value								
Service Definition	<p>As reimbursed through this service, medication administration includes the act of introducing a medication (any chemical substance that, when absorbed into the body of a living organism, alters normal bodily function) into the body of another person by any number of routes including, but not limited to the following: oral, nasal, inhalant, intramuscular injection, intravenous, topical, suppository or intraocular. Medication administration requires a written order for the medication and the administration of the medication. The order for and administration of medication must be completed by an MD, DO, psychiatrist, CNS, CNP or PA enrolled in Medicaid as an ORP provider and must be administered by licensed or credentialed medical personnel under the supervision of a physician or registered nurse. This service does not cover the supervision of self-administration of medications (See Clinical Exclusions below).</p> <p>The service must include:</p> <ul style="list-style-type: none"> • An assessment, by the licensed or credentialed medical personnel administering the medication, of the individual's physical, psychological and behavioral status in order to make a recommendation regarding whether to continue the medication and/or its means of administration, and whether to refer the individual to the physician for a medication review. • Education to the individual and/or family/responsible caregiver(s), by appropriate licensed medical personnel, on the proper administration and monitoring of prescribed medication in accordance with the individual's treatment plan. 							

Admission Criteria	<ul style="list-style-type: none"> • Individual presents symptoms that are likely to respond to pharmacological interventions; and • Individual has been prescribed medications as a part of the treatment/service array; and • Individual/family/responsible caregiver is unable to self-administer/administer prescribed medication because: <ul style="list-style-type: none"> ○ It is in an injectable form and must be administered by licensed medical personnel; or ○ It is a Schedule II controlled substance which must be stored and dispensed by medical personnel in accordance with federal law; or ○ Administration by licensed/credentialed medical personnel is necessary because an assessment of the individual’s physical, psychological and behavioral status is required in order to make a determination regarding whether to continue the medication and/or its means of administration and/or whether to refer the individual to the physician for a medication review. ○ Due to the family/caregiver’s lack of capacity there is no responsible party to manage/supervise self-administration of medication.
Continuing Stay Criteria	Individual continues to meet admission criteria.
Discharge Criteria	<ul style="list-style-type: none"> • Individual no longer needs medication; or • Individual/family/caregiver is able to self-administer, administer, or supervise self-administration medication; and • Adequate treatment plan has been established.
Service Exclusions	<ul style="list-style-type: none"> • Medication administered as part of ambulatory detoxification is billed as “Ambulatory Detoxification” and is not billed via this set of codes.
Clinical Exclusions	This service does not cover the supervision of self-administered medications. Self-administered medications can be done by anyone physically and mentally capable of taking or administering medications to himself/herself. Individual with mental health issues, or developmental disabilities are very often capable of self-administration of medications even if supervision by others is needed in order to adequately or safely manage self-administration of medication and other activities of daily living.
Documentation Requirements	<ul style="list-style-type: none"> • There must be a documented prescriber order for medication and the administration of the medication. The order must be in the individual’s chart. Telephone orders are acceptable provided they are co-signed by the appropriate members of the medical staff within 24 hours. • Documentation must support that the individual is being trained in the risks and benefits of the medications being administered and that symptoms are being monitored by the staff member administering the medication. • Documentation must support the medical necessity of administration by licensed/credentialed medical personnel rather than by the individual, family or caregiver. • Documentation must support that the individual AND family/caregiver is being trained in the principles of self-administration of medication and supervision of self-administration or that the individual/family/caregiver is physically or mentally unable to self-administer/administer.
Clinical Operations	<ul style="list-style-type: none"> • Medication administration may not be billed for the provision of single or multiple doses of medication that an individual has the ability to self-administer, either independently or with supervision by a caregiver, either in a clinic or a community setting. In a group home setting, for example, medications may be managed by the house parents or residential care staff and kept locked up for safety reasons. Staff may hand out medication to the residents but this does not constitute administration of medication for the purposes of this definition and, like other watchful oversight and monitoring functions, are not reimbursable treatment services.

	<ul style="list-style-type: none"> If individual/family requires training in skills needed in order to learn to manage his/her own medications and their safe self-administration and/or supervision of self-administration, this skills training service can be provided via the community support or family/group training services in accordance with the person’s individualized recovery/resiliency plan.
Service Exceptions	<ul style="list-style-type: none"> This service may not be provided in an IMD, jail, youth development center, or prison system. This service may not be provided and billed for individuals who are involuntarily detained in youth detention centers awaiting criminal proceedings, penal dispositions, or other involuntary detention proceedings.
Reporting and Billing Requirements	<ul style="list-style-type: none"> If a Medicaid claim for this service denies for a procedure-to-procedure edit, a modifier (59) can be added to the claim and resubmitted to the MITS for payment. Note: high usage of modifier 59 will trigger a utilization review. No other modifiers are required. Medicaid does not reimburse for any portion of discarded medication remaining from the administration of the dose. <i>Medication administered during ambulatory detoxification is considered a component of “Ambulatory Detoxification.”</i> <i>When a medication is administered during an E&M visit, only the office visit and the injectable medication will be reimbursed. Administration of the medication, 96372, must be submitted on the claim, however, it will be denied. Only the J-code and E&M will be paid. If the claim is submitted without 96372, the J-code will be denied.</i> <i>If a separately identifiable E&M service and an injection of a physician-administered medication (J-code) are provided, both the E&M (with modifier 25) and 96372 should be billed.</i>

Table 2-6: Medication Administration – Physician Administered

MH / SUD			
Service	Provider	Code	Rate
Injection of Physician Administered Medications	MD, DO	96372	\$21.39
	Certified nurse specialist Certified nurse practitioner Physician assistant RN, LPN	96372	\$18.18
Unit Value			
Service Definition	<p>Medication administration includes the act of introducing a medication (any chemical substance that, when absorbed into the body of a living organism, alters normal bodily function) into the body of another person by any number of routes including, but not limited to the following: oral, nasal, inhalant, intramuscular injection, intravenous, topical, suppository or intraocular. Medication administration requires a written service order for medication administration and a written order for the medication and the administration of the medication. This service does not cover the supervision of self-administration of medications. (See Clinical Exclusions below).</p> <p>The service must include:</p> <ul style="list-style-type: none"> An assessment, by the licensed or credentialed medical personnel administering the medication, of the individual’s physical, psychological and behavioral status in order to make a recommendation regarding whether to continue the medication and/or its means of administration, and whether to refer the individual to the physician for a medication review. 		

	<ul style="list-style-type: none"> ○ Education to the individual and/or family/responsible caregiver(s), by appropriate licensed medical personnel, on the proper administration and monitoring of prescribed medication in accordance with the individual's recovery plan. ○ For individuals who need opioid maintenance, the methadone administration service should be requested. Do not bill this service for administering methadone.
Admission Criteria	<ul style="list-style-type: none"> ○ Individual presents symptoms that are likely to respond to pharmacological interventions; and ○ Individual has been prescribed medications as a part of the treatment/service array; and ○ Individual and family/responsible caregiver is unable to self-administer/administer prescribed medication because: <ul style="list-style-type: none"> ○ It is in an injectable form and must be administered by licensed medical personnel; or ○ It is a Schedule II controlled substance which must be stored and dispensed by medical personnel in accordance with federal law; or ○ Administration by licensed/credentialed medical personnel is necessary because an assessment of the individual's physical, psychological and behavioral status is required in order to make a determination regarding whether to continue the medication and/or its means of administration and/or whether to refer the individual to the physician for a medication review. ○ Due to the family/caregiver's lack of capacity there is no responsible party to manage/supervise self-administration of medication.
Continuing Stay Criteria	Individual continues to meet admission criteria.
Discharge Criteria	<ul style="list-style-type: none"> ○ Individual no longer needs medication; or ○ Individual/family/caregiver is able to self-administer, administer, or supervise self-administration medication; and ○ Adequate treatment plan has been established.
Service Exclusions	<ul style="list-style-type: none"> ○ Medication administered as part of ambulatory detoxification is billed as "Ambulatory Detoxification" and is not billed via this set of codes. ○ Must not be billed in the same day as nursing assessment.
Clinical Exclusions	This service does not cover the supervision of self-administration of medications. Self-administration of medications can be done by anyone physically and mentally capable of taking or administering medications to himself/herself. Individual with mental health issues, or developmental disabilities are very often capable of self-administration of medications even if supervision by others is needed in order to adequately or safely manage self-administration of medication and other activities of daily living.
Documentation Requirements	<ul style="list-style-type: none"> ○ There must be a documented prescriber order for medication and the administration of the medication. The order must be in the individual's chart. Telephone orders are acceptable provided they are co-signed by the appropriate members of the medical staff within 24 hours. ○ Documentation must support that the individual is being trained in the risks and benefits of the medications being administered and that symptoms are being monitored by the staff member administering the medication. ○ Documentation must support the medical necessity of administration by licensed/credentialed medical personnel rather than by the individual, family or caregiver. ○ Documentation must support that the individual AND when appropriate, the family/caregiver, are being trained in the principles of self-administration of medication and supervision of self-administration or that the individual/family/caregiver is physically or mentally unable to self-administer/administer. This documentation will be subject to review. ○ This service does not include the supervision of self-administration of medication.

Clinical Operations	<ul style="list-style-type: none"> ○ Medication administration may not be billed for the provision of single or multiple doses of medication that an individual has the ability to self-administer, either independently or with supervision by a caregiver, either in a clinic or a community setting. In a group home setting, for example, medications may be managed by the house parents or residential care staff and kept locked up for safety reasons. Staff may hand out medication to the residents but this does not constitute administration of medication for the purposes of this definition and, like other watchful oversight and monitoring functions, are not reimbursable treatment services. ○ If individual/family requires training in skills needed in order to learn to manage his/her own medications and their safe self-administration and/or supervision of self-administration, this skills training service can be provided via the TBS or psychosocial rehabilitation (PSR) services in accordance with the person's individualized recovery plan. ○ Agency employees working in residential settings such as group homes, are not eligible to provide TBS or PSR for the supervision of medication self-administration by individual in their care.
Service Accessibility	<p>This service may not be provided in an IMD, jail, youth development center, or prison system.</p> <p>This service may not be provided and billed for individuals who are involuntarily detained in youth detention centers awaiting criminal proceedings, penal dispositions, or other involuntary detention proceedings.</p>
Reporting and Billing Requirements	
Other Considerations	

Lab Services

Table 2-7: Lab Services

Lab Services	See Appendix XX for a list of Pharmacy and Lab Services
Service Definition	This service provides for appropriate lab work, such as medication screens and medication levels, to be performed. This service ensures that necessary medication/lab services are not withheld/delayed based on inability to pay.
Admission Criteria	Individual has been assessed by a prescribing professional to need lab work.
Continuing Stay Criteria	Individual continues to meet the admission criteria as determined by the professional.
Discharge Criteria	Individual requests discharge and individual is not imminently dangerous or under court order for this intervention.
Required Components	
Reporting and Billing Requirements	<p>The CLIA number to be entered in item 23 of the CMS claim form or in the appropriate field for electronic formats for all laboratory services requiring a certificate of registration or a certificate of waiver.</p> <p>When the technical component (TC) and professional component (PC) of pathology services are performed by the same on entity but on different dates of service, they should be reported as separate line items on the same claim.</p>

	<p><u>This includes such actions as reassigning the ordering physician payment to the supplier for the interpretation of the tests. The supplier in turn, bills for both the test and interpretation and pays the ordering physician a fee for the interpretation. This arrangement violates section 1842(b)(6) of the Social Security Act, which prohibits Medicare and Medicaid from paying benefits due the person that furnished the service to any other person.</u></p>
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Vaccines

Ohio Medicaid allows BH providers to administer and receive reimbursement for a limited number of vaccines to their adult clients and to children under the Vaccines for Children program, operated by the Ohio Department of Health (ODH). See Appendix XX for a list of BH approved vaccines.

The Vaccines for Children (VFC) program is a federally-funded program overseen by the Centers for Disease Control and Prevention (CDC) and administered by ODH. The VFC program supplies vaccine at no cost to public and private health care providers who enroll and agree to immunize eligible children in their medical practice or clinic. The VFC program was created by the Omnibus Budget Reconciliation Act of 1993 and began on October 1, 1994. The VFC program was designed to:

- o Reduce the cost of vaccines for a physician or medical practice.
- o Create fewer barriers for parents to immunize their children.
- o Save parents about \$2,200 per child in expenses for vaccines.
- o Keep children in their medical home when they qualify for VFC.

VFC Eligibility Criteria

Children through 18 years of age who meet at least one of the following criteria are eligible to receive VFC vaccine:

- Medicaid eligible: A child who is eligible for the Medicaid program. (For the purposes of the VFC program, the terms "Medicaid-eligible" and "Medicaid-enrolled" are equivalent and refer to children who have health insurance covered by a state Medicaid program)
- Uninsured: A child who has no health insurance coverage
- American Indian or Alaska Native: As defined by the Indian Health Care Improvement Act (25 U.S.C. 1603)
- Underinsured: A child who has health insurance, but the coverage does not include vaccines; a child whose insurance covers only selected vaccines (VFC eligible for non-covered vaccines only). Underinsured children are eligible to receive VFC vaccine only through a Federally

Qualified Health Center (FQHC), or Rural Health Clinic (RHC) or under an approved deputation agreement.

Children whose health insurance covers the cost of vaccinations are not eligible for VFC vaccines, even when a claim for the cost of the vaccine and its administration would be denied for payment by the insurance carrier because the plan's deductible had not been met.

Screening to determine a child's eligibility to receive vaccines through the VFC Program and documentation of the screening results must take place with each immunization visit. The patient eligibility screening record provides a means of recording parent responses to VFC eligibility questions. The parent, guardian or provider may complete this form. Verification of parent/guardian responses is not required. To maximize efficiency, providers may elect to incorporate these screening questions into an existing form; however, any revision must include the core screening information listed on the CDC-developed form and be approved by the state Immunization Program. Patient eligibility screening records should be maintained on file for a minimum of 3 years after service to the patient has been completed unless state law/policy establishes a longer archival period.

Report clinically significant adverse events that follow vaccination through the Federal Vaccine Adverse Event Reporting System (VAERS) or call the 24 hour national toll-free hotline at 800-822-7967.

VAERS is a post-marketing safety surveillance program, collecting information about adverse events (possible side effects) that occur after the administration of vaccines licensed for use in the United States.

VAERS provides a nationwide mechanism by which adverse events following immunization may be reported, analyzed, and made available to the public. VAERS also provides a vehicle for disseminating vaccine safety-related information to parents and guardians, health care providers, vaccine manufacturers, state vaccine programs, and other constituencies.

Remember, please report all suspected cases of vaccine-preventable diseases to your state or local health department.

Further VCF resources, including enrollment with the Ohio Department of Health can be found at:

<http://www.odh.ohio.gov/odhprograms/bid/immunization/VFC%20Manual.aspx>

<http://www.cdc.gov/vaccines/programs/vfc/providers/index.html>

Vaccines for Adults

-Under Development

SECTION 3

PSYCHOTHERAPY SERVICES

Documentation to support psychotherapy services should include, but is not limited to the following:

- Exact time of the psychotherapy service (i.e. 12:30-12:52)
- Modalities and frequency
- Clinical notes for each encounter that summarizes the following:
 - Diagnosis, including all relevant diagnoses pertaining to the medical or physical conditions
 - A description of the patient's symptoms and functional impairment
 - Evidence that the patient has sufficient cognitive capacity to benefit from treatment
 - Test results, if applicable, with interpretation
 - Medications taken or prescribed for the patient
 - Symptoms
 - Functional Status
 - Focused mental status examination
 - Treatment plan, prognosis and progress
 - Summaries of psychotherapy session
 - Name, signature and credentials of the person performing the service. If working under supervision, the initials of the supervising practitioner and date reviewed.

Table 3-1: Psychotherapy for Crisis

MH / SUD				
Service	Provider Type	Code	Req'd Mod	Rate
Psychotherapy for Crisis	MD/DO	90839 +90840		\$137.07 \$65.84
	Certified nurse specialist Certified nurse practitioner	90839 +90840		\$116.51 \$55.96
	Psychologist	90839 +90840		\$137.07 \$65.84
	Licensed independent	90839 +90840		\$116.51 \$55.96
	Board-licensed school psychologist	90839 +90840	UB	\$116.51 \$55.96
	Licensed professional counselor	90839 +90840	U2	\$116.51 \$55.96
	Licensed social worker	90839 +90840	U4	\$116.51 \$55.96
	Licensed marriage and family therapist	90839 +90840	U5	\$116.51 \$55.96
	Licensed chemical dependency counselor II or III	90839 +90840	U3	\$116.51 \$55.96

	Psychology assistant, intern, trainee	90839 +90840	U1	Incident to
	School psychology assistant/trainee (ODE)	90839 +90840	U1	Incident to
	Social worker trainee	90839 +90840	U9	Incident to
	Marriage and family therapist trainee	90839 +90840	UA	Incident to
	Chemical dependency counselor assistant	90839 +90840	U6	Incident to
	Counselor trainee	90839 +90840	U7	Incident to
Unit Value	90839 - 60 min +90840 - add'l 30 min	Max Daily Units		Prior Authorization
Service Definition	<p>Services directed toward the support of an individual who is experiencing an abrupt and substantial change in behavior which is usually associated with a precipitating situation and which is in the direction of severe impairment of functioning or a marked increase in personal distress. Crisis intervention is designed to prevent out of home placement or hospitalization. Often, a crisis exists at such time as an individual/child and/or his or her family/responsible caregiver(s) decide to seek help and/or the individual, family/responsible caregiver(s), or practitioner identifies the situation as a crisis. Crisis services are time-limited and present-focused in order to address the immediate crisis and develop appropriate links to alternate services. Services may involve the individual, caregiver(s) and/or significant other, as well as other service providers.</p> <p>Plans/advanced directives developed during the assessment/individual treatment plan process should be reviewed and updated (or developed if the individual is a new individual) as part of this service to help prevent or manage future crisis situations. Some examples of interventions that may be used to de-escalate a crisis situation could include: a situational assessment; active listening and empathic responses to help relieve emotional distress; effective verbal and behavioral responses to warning signs of crisis related behavior; assistance to, and involvement/participation of the individual (to the extent he or she is capable) in active problem solving planning and interventions; facilitation of access to a myriad of crisis stabilization and other services deemed necessary to effectively manage the crisis; mobilization of natural support systems; and other crisis interventions as appropriate to the individual and issues to be addressed.</p> <p>Licensed practitioners may provide crisis care regardless of:</p> <ul style="list-style-type: none"> • Whether or not the individual is on their case load; • or whether or not the individual is a current patient with the agency (i.e., not requiring a recommendation of care). <p>Unlicensed practitioners providing crisis services as “incident to” may only bill Medicaid if the recipient of the intervention is known to the system, currently carried on the unlicensed practitioner’s caseload and a licensed practitioner has recommended care.</p>			

<p>Admission Criteria</p>	<ul style="list-style-type: none"> • Individual has a known or suspected mental health diagnosis or substance related disorder; and • Individual is at risk of harm to self, others and/or property. Risk may range from mild to imminent; and one or both of the following: <ul style="list-style-type: none"> • Has insufficient or severely limited resources or skills necessary to cope with the immediate crisis; or • Individual demonstrates lack of judgment and/or impulse control and/or cognitive/perceptual abilities.
<p>Continuing Stay Criteria</p>	<p>This service may be utilized at various points in the individual’s course of treatment and recovery, however, each intervention is intended to be a discrete time-limited service that stabilizes the individual and moves him/her to the appropriate level of care.</p>
<p>Discharge Criteria</p>	<p>Crisis situation is resolved and an adequate continuing care plan has been established.</p>
<p>Clinical Exclusions</p>	<p>Severity of clinical issues precludes provision of services at this level of care.</p>
<p>Service Accessibility</p>	<p>This service may not be provided and billed for individuals who are involuntarily detained in youth detention centers awaiting criminal proceedings, penal dispositions, or other involuntary detention proceedings.</p>
<p>Reporting and Billing Requirements</p>	<p>Psychotherapy for Crisis (90839, 90840) may be billed if all the following criteria are met:</p> <ul style="list-style-type: none"> • The nature of the crisis intervention is urgent assessment and history of a crisis situation, assessment of mental status, and disposition and is paired with psychotherapy, mobilization of resources to defuse the crisis and restore safety and the provision of psychotherapeutic interventions to minimize trauma. • The practitioner is working within their scope of practice. • The presenting situation is life-threatening and requires immediate attention to an individual who is experiencing high distress. • Other payors may limit who can provide 90839 and 90840 and therefore a providing agency must adhere to those third party payors’ policies regarding billing practitioners. • All time spent by the same provider, even if time is not continuous, should be added together when selecting a code. • 90839 is utilized when the time of service ranges between 31-60 minutes and may only be utilized once in a single day. <ul style="list-style-type: none"> · Licensed Professionals-Anything less 31minutes can be billed as psychotherapy for licensed professionals. · Unlicensed professionals -Anything less than 45 minutes can be provided through the therapeutic behavioral service code for unlicensed professionals (H2019 with crisis modifier UT). • <i>Add-on time specificity:</i> <ul style="list-style-type: none"> · If additional time above the base 74 minutes is greater than 23 minutes, an additional encounter of 90840 may be billed. • 90839 and 90840 cannot be billed in the same day as any of the codes in the range 90791-90853. • Appropriate add-on codes must be submitted on the same claim as the paired-base code. • Interactive complexity code 90785 cannot be billed with crisis. • Payment predicated on the service definitions in this manual and appropriate documentation.

Other Considerations	
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Table 3-2: Individual Psychotherapy

MH / SUD				
Service	Provider Type	Code	Req'd Mod	Rate
Individual Psychotherapy	MD/DO	90832		\$63.11
		90834		\$82.05
		90837		\$120.36
	Certified nurse specialist Certified nurse practitioner	90832		\$53.64
		90834		\$69.74
		90837		\$102.31
	Psychologist	90832		\$63.11
		90834		\$82.05
		90837		\$120.36
	Licensed independent	90832		\$53.64
		90834		\$69.74
		90837		\$102.31
	Board licensed school psychologist	90832	UB	\$53.64
		90834		\$69.74
		90837		\$102.31
	Licensed professional counselor	90832	U2	\$53.64
		90834		\$69.74
		90837		\$102.31
	Licensed social worker	90832	U4	\$53.64
		90834		\$69.74
		90837		\$102.31
Licensed marriage and family therapist	90832	U5	\$53.64	
	90834		\$69.74	
	90837		\$102.31	
Licensed chemical dependency counselor II or III	90832	U3	\$53.64	
	90834		\$69.74	
	90837		\$102.31	
Psychology assistant, intern, trainee	90832	U1	Incident to	
	90834			
	90837			
Social worker trainee	90832	U9	Incident to	
	90834			
	90837			
Marriage and family therapist trainee	90832	UA	Incident to	
	90834			

		90837		
	Chemical dependency counselor assistant	90832 90834 90837	U6	Incident to
	Counselor trainee	90832 90834 90837	U7	Incident to
Individual Psychotherapy w/E&M Service	MD/DO	90833 90836 90838		\$65.37 \$83.03 \$109.53
	Certified nurse specialist Certified nurse practitioner	90833 90836 90838		\$55.56 \$70.58 \$93.10
Unit Value	1 encounter (Note: time-in/time-out is required in the documentation as it justifies which code above is billed)			
Service Definition	<p>Techniques employed involve the principles, methods and procedures of counseling that assist the family in identifying and resolving personal, social, vocational, intrapersonal and interpersonal concerns. Services are directed toward achievement of specific goals defined by the family and by the parent(s)/responsible caregiver(s) and specified in the individualized treatment plan. These services address goals/issues such as promoting resiliency, and the restoration, development, enhancement or maintenance of:</p> <ul style="list-style-type: none"> • The illness/emotional disturbance and medication self-management knowledge and skills (e.g. symptom management, behavioral management, relapse prevention skills, knowledge of medications and side effects, and motivational/skill development in taking medication as prescribed); • Problem solving and cognitive skills; • Healthy coping mechanisms; • Adaptive behaviors and skills; • Interpersonal skills; • Knowledge regarding the emotional disturbance, substance related disorders and other relevant topics that assist in meeting the individual's needs • Best/evidence based practice modalities may include (as clinically appropriate): motivational interviewing/enhancement therapy, cognitive behavioral therapy, Behavioral modification, behavioral management, rational behavioral therapy, dialectical behavioral therapy, interactive play therapy, and others as appropriate to the individual and clinical issues to be addressed. 			
Admission Criteria	<ul style="list-style-type: none"> • The individual must have a psychiatric or substance-related disorder diagnosis that markedly interferes with the ability to carry out activities of daily living or places others in danger, or causes mental anguish or suffering; and • The individual's level of functioning does not preclude the provision of services in an outpatient setting 			
Continuing Stay Criteria	<ul style="list-style-type: none"> • Individual continues to meet admission criteria; and • Individual demonstrates documented progress relative to goals identified in the individualized treatment plan, but goals have not yet been achieved. 			

Discharge Criteria	<p>Continuing care plan has been established; and one or more of the following:</p> <ul style="list-style-type: none"> • Goals of the individualized treatment plan have been substantially met; or • Individual/family requests discharge and individual is not in imminent danger of harm to self or others; or • Transfer to another service is warranted by change in individual’s condition; or • Individual requires a service approach which supports less or more intensive need. 						
Clinical Exclusions	<ul style="list-style-type: none"> • Severity of needs and lack of support requires a higher level of care. • Severity of cognitive impairment precludes provision of services in this level of care. • There is no outlook for improvement with this particular service. • Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a behavioral health condition overlaying the diagnosis: mental retardation, autism, organic mental disorder and traumatic brain injury. 						
Service Exceptions	<p>This service may not be provided and billed for individuals who are involuntarily detained in youth detention centers awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings. Any exception to this requires supporting documentation from the Department of Youth Services partners. The provider holds the risk for assuring the individual’s eligibility. Any exception must be documented in the medical record by the provider.</p> <p>Any practitioner providing an E&M service not listed in the chart above, may not utilize add-on codes.</p>						
Documentation Requirements	<p>The treatment orientation, modality and goals must be specified and agreed upon by the individual/family/caregiver.</p>						
Clinical Operations	<p>Practitioners and supervisors of those providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based counseling practices.</p>						
Reporting and Billing Requirements	<p>Psychotherapy add on codes may only be paired with 99204, 99205, 99213, 99214 and 99215. When 90833, 90836 and 90838 are provided with an E&M code, these are submitted together on the same claim as the E&M service to MITS.</p> <ul style="list-style-type: none"> • 90833 is used for any intervention which is 16-37 minutes in length. • 90836 is used for any intervention which is 38-52 minutes in length. • 90838 is used for any intervention which is greater than 53 minutes. • Appropriate add-on codes must be submitted on the same claim as the paired base code. • Procedure codes for approximately 75-80 minutes of psychotherapy are reserved for exceptional circumstances and should not be routinely billed. • ODM reserves the right to request medical records prior to payment of services over 90 minutes. The medical record must document the face-to-face time spent with the patient and the medical necessity for the extended time. • If permitted to provide medication management, it is considered a component of psychotherapy and should not be billed separately. <p>Do not bill individual counseling when providing services to family members in order to obtain a higher payment.</p> <p>Treatment in excess of 52 hours or sessions of per episode of illness of any type psychotherapy are subject to prior authorization.</p> <table border="1" data-bbox="386 1738 1390 1877"> <thead> <tr> <th data-bbox="386 1738 841 1843">Length of Psychotherapy Session</th> <th data-bbox="841 1738 1117 1843">Stand Alone Psychotherapy- Code Reported</th> <th data-bbox="1117 1738 1390 1843">In conjunction With an E&M Service</th> </tr> </thead> <tbody> <tr> <td data-bbox="386 1843 841 1877">0-15 minutes</td> <td data-bbox="841 1843 1117 1877">Not Reported</td> <td data-bbox="1117 1843 1390 1877">Report E&M only</td> </tr> </tbody> </table>	Length of Psychotherapy Session	Stand Alone Psychotherapy- Code Reported	In conjunction With an E&M Service	0-15 minutes	Not Reported	Report E&M only
Length of Psychotherapy Session	Stand Alone Psychotherapy- Code Reported	In conjunction With an E&M Service					
0-15 minutes	Not Reported	Report E&M only					

	16-37 minutes	90832-30 minutes	90833-30 minutes
	38-52 minutes	90834-45 minutes	90836-45 minutes
	53-89 minutes	90837-60 minutes	90838-60 minutes

Table 3-3: Group Psychotherapy

MH / SUD					
Service	Provider Type	Code	Req'd Mod	Incident to Mod	Rate
Group Psychotherapy (not multi-family group)	MD/DO	90853			\$28.29
	Certified nurse specialist Certified nurse practitioner	90853			\$24.05
	Psychologist	90853			\$28.29
	Licensed independent	90853			\$24.05
	Board licensed school psychologist	90853	UB		\$24.05
	Licensed professional counselor	90853	U2		\$24.05
	Licensed social worker	90853	U4		\$24.05
	Licensed marriage and family therapist	90853	U5		\$24.05
	Licensed chemical dependency counselor II or III	90853	U3		\$24.05
	School psychology assistant/trainee (ODE)	90853		U1	Incident to
	Psychology assistant, intern, trainee	90853		U1	Incident to
	Social worker trainee	90853		U9	Incident to
	Marriage and family therapist trainee	90853		UA	Incident to
	Chemical dependency counselor assistant	90853		U6	Incident to
	Counselor trainee	90853		U7	Incident to

Family Psychotherapy without patient	MD/DO	90846			\$82.00
	Certified nurse specialist Certified nurse practitioner	90846			\$69.70
	Psychologist	90846			\$82.00
	Licensed independent	90846			\$69.70
	Board licensed school psychologist	90846	UB		\$69.70
	Licensed professional counselor	90846	U2		\$69.70
	Licensed social worker	90846	U4		\$69.70
	Licensed marriage and family therapist	90846	U5		\$69.70
	Licensed chemical dependency counselor II or III	90846	U3		\$69.70
	School psychology assistant/trainee (ODE)	90846		U1	Incident to
	Psychology assistant, intern, trainee	90846		U1	Incident to
	Social worker trainee	90846		U9	Incident to
	Marriage and family therapist trainee	90846		UA	Incident to
	Chemical dependency counselor assistant	90846		U6	Incident to
Counselor trainee	90846		U7	Incident to	
Multi-Family Psychotherapy Group with patient	MD/DO	90847			\$100.72
	Certified nurse specialist Certified nurse practitioner	90847			\$85.61
	Psychologist	90847			\$100.72
	Licensed independent	90847			\$85.61
	Board licensed school psychologist	90847	UB		\$85.61
	Licensed professional counselor	90847	U2		\$85.61
	Licensed social worker	90847	U4		\$85.61

	Licensed marriage and family therapist	90847	U5		\$85.61
	Licensed chemical dependency counselor II or III	90847	U3		\$85.61
	School psychology assistant/trainee (ODE)	90847		U1	Incident to
	Psychology assistant, intern, trainee	90847		U1	Incident to
	Social worker trainee	90847		U9	Incident to
	Marriage and family therapist trainee	90847		UA	Incident to
	Chemical dependency counselor assistant	90847		U6	Incident to
	Counselor trainee	90847		U7	Incident to
Family Psychotherapy (not multi-family group)	MD/DO	90853			\$28.29
	Certified nurse specialist Certified nurse practitioner	90853			\$24.05
	Psychologist	90853			\$28.29
	Licensed independent	90853			\$24.05
	Board licensed school psychologist	90853	UB		\$24.05
	Licensed professional counselor	90853	U2		\$24.05
	Licensed social worker	90853	U4		\$24.05
	Licensed marriage and family therapist	90853	U5		\$24.05
	Licensed chemical dependency counselor II or III	90853	U3		\$24.05
	School psychology assistant/trainee (ODE)	90853		U1	Incident to
	Psychology assistant, intern, trainee	90853		U1	Incident to
	Social worker trainee	90853		U9	Incident to
	Marriage and family therapist trainee	90853		UA	Incident to
	Chemical dependency counselor assistant	90853		U6	Incident to

	Counselor trainee	90853		U7	Incident to
Unit Value	Encounter				
Service Definition	<p>Achievement of specific goals defined by the individual and specified in the individualized treatment plan. Services may address goals/issues such as promoting resiliency, and the restoration, development, enhancement or maintenance of:</p> <ul style="list-style-type: none"> • Cognitive skills; • Healthy coping mechanisms; • Adaptive behaviors and skills; • Interpersonal skills; <p>Identifying and resolving personal, social, intrapersonal and interpersonal concerns family psychotherapy services are covered only where the primary purpose of such psychotherapy is the treatment of the patient's condition. Examples include:</p> <ul style="list-style-type: none"> • When there is a need to observe and correct, through psychotherapeutic techniques, the patient's interaction with family members (90847). • Where there is a need to assess the conflicts or impediments within the family, and assist, through psychotherapy, the family members in the management of the patient (90846 or 90847). 				
Admission Criteria	<ul style="list-style-type: none"> • Individual must have a psychiatric or substance-related disorder diagnosis that is markedly interferes with the ability to carry out activities of daily living or places others in danger causes mental anguish or suffering; and • The individual's level of functioning does not preclude the provision of services in an outpatient milieu; and • The individual's treatment goals that are to be addressed by this service must be conducive to response by a group milieu. 				
Continuing Stay Criteria	<p>Individual continues to meet admission criteria; and</p> <ul style="list-style-type: none"> • Family demonstrates documented progress relative to goals identified in the individualized treatment plan, but goals have not yet been achieved. 				
Discharge Criteria	<p>Continuing treatment plan has been established; and one or more of the following:</p> <ul style="list-style-type: none"> • Goals of the individualized treatment plan have been substantially met; or • Individual requests discharge and the family is not in imminent danger of harm to self or others; or • Transfer to another service/level of care is warranted by change in family's condition; or • Individual requires more intensive services. 				
Clinical Exclusions	<ul style="list-style-type: none"> • Severity of behavioral health issue precludes provision of services. • Severity of cognitive impairment precludes provision of services in this level of care. • There is a lack of social support systems such that a more intensive level of service is needed. 				
Service Accessibility	<p>This service may not be provided in an IMD, jail, youth development center, or prison system.</p> <p>This service may not be provided and billed for individuals who are involuntarily detained in youth detention centers awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings.</p>				
Documentation Requirements	<p>The treatment orientation, modality and goals must be specified and agreed upon by the family/family/caregiver. If there are disparate goals between the patient and family, this is addressed clinically as part of the treatment plan and interventions.</p>				

Staffing Requirements	Face-to-face ratio cannot be less than 2 or more than 12 patients to 1 direct service staff person.
Clinical Operations	<ul style="list-style-type: none"> Practitioners and supervisors of those providing this service are expected to maintain knowledge and skills regarding group practice such as selecting appropriate participants for a particular group, working with the group to establish necessary group norms and goals, and understanding and managing group dynamics and processes.
Reporting and Billing Requirements	<ul style="list-style-type: none"> Medication management is considered a component of psychotherapy and should not be billed separately. These services are typically an hour and can be no less than 45 minutes. Do not bill individual counseling when providing services to family members in order to obtain a higher payment.

Interactive Complexity Overview

Interactive complexity is an add-on code which may be reported in conjunction with Psychiatric Diagnostic Evaluation (90791, 90792), Psychotherapy (90832, 90834, and 90837), Psychotherapy add-ons (90833, 90836, and 90838) and Group Psychotherapy (90853).

Interactive complexity refers to specific communication factors that complicate the delivery of a psychiatric procedure and occur *during* the delivery of the service. Common factors include more difficult communication with discordant or emotional family members and engagement of young and verbally undeveloped or impaired patients. Report 90785 in addition to the primary procedure, when at least one of the following communication factors is present during the visit:

- The need to manage maladaptive communication (related to, e.g., high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicates delivery of care.
- Caregiver emotions or behaviors that interfere with implementation of the treatment plan.
- Evidence or disclosure of a sentinel event and mandated report to a third party (e.g., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.
- Use of play equipment, physical devices, interpreter or translator to overcome barriers to diagnostic or therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language.

These factors are used to communicate with the patient to overcome the barriers to therapeutic or diagnostic interaction between the behavioral health professional and patient who is not fluent in the same language as the professional, or has not developed, or has lost, either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the professional if he/she were to use typical language for communication.

Interactive complexity is often present with patients who:

- Have other individuals legally responsible for their care, such as minors or adults with guardians, or
- Request others to be involved in their care during the visit, such as adults accompanied by one or more participating family members or interpreter or language translator, or
- Require the involvement of other third parties, such as child welfare agencies, parole or probation officers, or schools.

The following examples are NOT interactive complexity:

- Multiple participants in the visit with straightforward communication.
- Patient attends visit individually with no sentinel event or language barriers.
- Treatment plan explained during the visit and understood without significant interference by caretaker emotions or behaviors.

Per the Center for Medicare and Medicaid Services (CMS), “90785 generally should not be billed solely for the purpose of translation or interpretation services” as that may be a violation of federal statute.

Table 3-4: Interactive Complexity

MH / SUD				
Service	Provider Type	Code	Req'd Mod	Rate
Interactive Complexity	MD, DO	+90785		\$13.81
	CNS, CNP	+90785		\$11.74
	Psychologist	+90785		\$13.81
	Licensed independent	+90785		\$11.74
	Board licensed school psychologist	+90785		\$11.74
	Licensed professional counselor	+90785	U2	\$11.74
	Licensed social worker	+90785	U4	\$11.74
	Licensed marriage and family therapist	+90785	U5	\$11.74
	Licensed chemical dependency counselor II or III	+90785	U3	\$11.74
	School psychology assistant/trainee (ODE)	+90785	U1	\$11.74
	Psychology assistant, intern, trainee	+90785	U1	Incident to
	Social worker trainee	+90785	U8	Incident to
	Marriage and family therapist trainee	+90785	UA	Incident to
	Chemical dependency counselor assistant	+90785	U6	Incident to

	Counselor trainee	+90785	U7	Incident to
	Interactive Complexity add-on is only valid in conjunction with the following codes: 90791, 90792, 90832, 90834, 90837, 90833, 90836, 90838 or 90853.			
Unit Value	Encounter			
Service Definition	<p>Interactive Complexity is not a direct service but is done in relation to following base services and reported as a modifier to Psychiatric Diagnostic Evaluation (90791, 90792), Psychotherapy (90832, 90834, and 90837), Psychotherapy add-ons (90833, 90836, and 90838) and Group Psychotherapy (90853). Interactive Complexity is used when:</p> <ul style="list-style-type: none"> • Communication with the individual participant/s is complicated perhaps related to, e.g., high anxiety, high reactivity, repeated questions, or disagreement and therefore delivery of care is challenging. • Caregiver emotions/behaviors complicate the implementation of the individualized treatment plan. • Evidence/disclosure of a sentinel event and mandated report to a third party (e.g., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with the individual and supporters. • Use of play equipment, physical devices, interpreter or translator to overcome significant language barriers (when individual served is not fluent in same language as practitioner, or when the individual has not developed or has lost expressive/receptive communication skills necessary for interactive participation in the intervention). 			
Admission Criteria	Please refer to the base code to which the Interactive Complexity is being added.			
Continuing Stay Criteria				
Discharge Criteria				
Clinical Exclusions				
Documentation Requirements	<p>When this code is submitted, there must be:</p> <ul style="list-style-type: none"> • Record of base service delivery codes AND the qualifications for Interactive Complexity within the patient record; <ul style="list-style-type: none"> ○ The medical record must reflect the elements outlined in the above description and must be rendered by a qualified licensed provider and must indicate that the person being evaluated does not have the ability to interact through normal verbal communicative channels. Additionally, the medical record must include adaptations utilized in the session and the rationale for employing these interactive techniques. If the patient is capable of ordinary verbal communication, this code should not be used. The medical record must include treatment recommendations. • Evidence within the service note which indicates the specific category of complexity (from the list of items 1-4 in the definition above) utilized during the intervention. • The interactive complexity component relates only to the increased work intensity of the base service. • Documentation should support communication factors that complicate deliver of psychiatric care 			

	<ul style="list-style-type: none"> ○ Patients with high anxiety, high reactivity that complicates care ○ Deafness or individuals who do not speak the same language as the healthcare provider ○ Use of play equipment or other devices ○ Evidence of a sentinel event (i.e. abuse)
<p>Reporting and Billing Requirements</p>	<p><i>This service may only be reported/billed in conjunction with one of the following codes: 90791, 90792, 90832, 90834, 90837, 90853, and with the following codes only when paired with 90833 or 90836.</i></p> <p><u>Interactive Complexity must not be billed solely for the purpose of language or interpretation services as this is an ADA requirement.</u></p>

Psychological Testing

Codes 96101 (psychological testing) include the administration, interpretation, and scoring of the tests mentioned in the CPT descriptions and other medically accepted tests for evaluation of intellectual strengths, psychopathology, psychodynamics, mental health risks, insight, motivation, and other factors influencing treatment and prognosis.

Documentation: The medical record must indicate the presence of mental illness or signs of mental illness for:

- Detection of neurologic diseases based on quantitative assessment of neurocognitive abilities (e.g., mild head injury, anoxic injuries, AIDS dementia)
- Detection of neurologic diseases based on quantitative assessment of neurocognitive abilities (e.g., mild head injury, anoxic injuries, AIDS dementia)
- Differential diagnosis between psychogenic and neurogenic syndromes
- Delineation of the neurocognitive effects of central nervous system disorders
- Neurocognitive monitoring of recovery or progression of central nervous system disorders; or
- Assessment of neurocognitive functions for the formulation of rehabilitation and/or management strategies among individuals with neuropsychiatric disorders. Psychological testing is indicated as an aid in the diagnosis and therapeutic planning. The record must show the tests performed, scoring and interpretation, as well as the time involved.

Comments: These codes do not represent psychotherapeutic modalities, but are diagnostic aids. Use of such tests when mental illness is not suspected would be a screening procedure not covered by Medicaid. Each test performed must be medically necessary. Therefore, standardized batteries of tests are not acceptable unless each test in the battery is medically necessary.

Changes in mental illness may require psychological testing to determine new diagnoses or the need for changes in therapeutic measures. Repeat testing not required for diagnosis or continued treatment would be considered medically unnecessary. Nonspecific behaviors that do not indicate the presence of, or change in, a mental illness would not be an acceptable indication for testing. Psychological or psychiatric evaluations that can be accomplished through the clinical interview alone (e.g., response to medication) would not require psychological testing, and such testing might be considered as medically unnecessary.

Adjustment reactions or dysphoria associated with moving to a nursing facility do not constitute medical necessity for psychological testing.

Codes 96111, 96116 and 96118

Codes 96118 is defined by the CPT narrative and describe testing which is intended to diagnose and characterize the neurocognitive effects of medical disorders that impinge directly or indirectly on the brain. Examples of problems that might lead to neuropsychological testing are:

Documentation: The medical record must document that the guidelines outlined in this manual were followed.

The content of neuropsychological testing procedure 96118 differs from that of psychological testing (96101, 96111, 96116) in that neuropsychological testing consists primarily of individually administered ability tests that comprehensively sample cognitive and performance domains that are known to be sensitive to the functional integrity of the brain (e.g., abstraction, memory and learning, attention, language, problem solving, sensorimotor functions, constructional praxis, etc.). These procedures are objective and quantitative in nature and require the patient to directly demonstrate his/her level of competence in a particular cognitive domain. Neuropsychological testing does not rely on self-report questionnaires such as the Minnesota Multiphasic Personality Inventory 2 (MMPI-2), rating scales such as the Hamilton Depression Rating Scale, or projective techniques such as the Rorschach or Thematic Apperception Test (TAT).

Typically, psychological testing will require from four (4) to six (6) hours to perform, including administration, scoring and interpretation. If the testing is done over several days, the testing time should be combined and reported all on the last date of service. If the testing time exceeds eight (8) hours, a report may be requested to indicate the medical necessity for extended testing.

Limitations:

Severe and profound mental retardation (ICD-10 codes F72, F73, F78, or F79) is never covered for psychotherapy services. In such cases, rehabilitative, evaluation and management (E/M) codes, or pharmacological management codes should be reported.

Patients with dementia represent a very vulnerable population in which co-morbid psychiatric conditions are common. However, for such a patient to benefit from psychotherapy services requires that their dementia to be mild and that they retain the capacity to recall the therapeutic encounter from one session, individual or group, to another. This capacity to meaningfully benefit from psychotherapy must be documented in the medical record. Psychotherapy services are not covered when documentation indicates that dementia has produced a severe

Evaluations of the mental status that can be performed within the clinical interview, such as a list of questions concerning symptoms of depression or organic brain syndrome, corresponding to brief questionnaires such as the Folstein Mini Mental Status Examination or the Beck Depression Scale, should not be billed as psychological testing (96101, 96111 and 96118), but is considered included in the clinical interview. Psychological testing to evaluate adjustment reactions or dysphoria associated with placement in a nursing home is not medically necessary. Routine testing of nursing home patients is considered screening and is not covered.

The psychological testing codes should not be reported by the treating physician for reading the testing report or explaining the results to the patient or family. Payment for these services is included in the payment for other services rendered to the patient, such as evaluation and management services.

Table 3-5: Psychological Testing

MH / SUD				
Service	Provider	Code	Req'd Mod	Rate
Psychological Testing	MD/DO	96101		\$59.26
		96111		\$56.11
		96116		\$64.10
		96118		\$78.31
	Certified nurse specialist Certified nurse practitioner	96101		\$59.26
		96111		\$56.11
		96116		\$64.10
		96118		\$78.31
	Psychologist	96101		\$59.26
		96111		\$56.11
		96116		\$64.10
		96118		\$78.31
Board licensed school psychologist	96101	UB	\$59.26	
	96111		\$56.11	
Licensed independent (excluding LICDC)	96101		\$59.26	
	96111		\$56.11	
Licensed professional counselor	96101	U2	\$59.26	
	96111		\$56.11	
Licensed social worker	96101	U4	\$59.26	
	96111		\$56.11	
Licensed marriage and family therapist	96101	U5	\$59.26	
	96111		\$56.11	
School psychology assistant/trainee (ODE)	96101	U1	Incident to	
	96111			

	Psychology assistant, intern, trainee	96101 96111	U1	Incident to
Unit Value				
Service Definition	<p>Psychological testing consists of a face-to-face assessment of emotional functioning, personality, cognitive functioning (e.g. thinking, attention, memory) or intellectual abilities using an objective and standardized tool that has uniform procedures for administration and scoring and utilizes normative data upon which interpretation of results is based.</p> <p>Psychological tests are only administered and interpreted by those who are properly trained in their selection and application. The practitioner administering the test ensures that the testing environment does not interfere with the performance of the examinee and ensures that the environment affords adequate protections of privacy and confidentiality.</p> <p>This service covers both the face-to-face administration of the test instrument(s) by a qualified examiner as well as the time spent by a psychologist or physician (with the proper education and training) interpreting the test results and preparing a written report.</p>			
Admission Criteria	<ol style="list-style-type: none"> 1. A known or suspected mental illness or substance-related disorder; and 2. Initial screening/intake information indicates a need for additional undetermined supports and recovery planning; and 3. Individual meets eligibility for service. 			
Continuing Stay Criteria	The individual's situation or functioning has changed in such a way that previous assessments are outdated.			
Discharge Criteria	Each intervention is intended to be a discrete time-limited service that modifies treatment/support goals or is indicated due to change in illness/disorder.			
Service Accessibility	<p>This service may not be provided in an IMD, jail, youth development center, or prison system.</p> <p>This service may not be provided and billed for individuals who are involuntarily detained in youth detention centers awaiting criminal proceedings, penal dispositions, or other involuntary detention proceedings.</p>			
Clinical Operations	The individual (and caregiver/responsible family members etc. as appropriate) must actively participate in the assessment processes.			
Documentation Requirements	<p>Documentation of clinical assessment findings from this service should also be completed and placed in the individual's chart.</p> <p>When providing psychological testing to individuals with disabilities and/or language/cultural barriers, the practitioner must be able to demonstrate competency when assessing the individual.</p>			
Reporting and Billing Requirements	There may be no more than 8 hours of any combination provided to one individual within a calendar year. Additional units may be prior authorization.			
Other Considerations				

Assertive Community Treatment (ACT) Billing Guidance

Overview:

Medicaid billable ACT will become 1, 2017 for dually certified (mental health and SUD) behavioral health provider organizations who have transitioned to the new Medicaid behavioral health code set. Only agencies who have been reviewed and found to have a minimum level of fidelity to the DACT or the TMACT Models (see more below) may bill Ohio Medicaid for ACT.

Each ACT team may bill a maximum of 4 per diem rates per month. ACT per diems may only be billed for dates of service when one or more members of the ACT team has performed a face to face service with the individual or a family member. Only one per diem may be billed per category of practitioner type, per individual, per day. A maximum of two practitioners - representing different categories of practitioner type - may bill on the same day (i.e. a maximum of two per diems can be billed on a given day.) All other contacts, meetings, travel time, etc., are considered indirect costs and are accounted for in the development of the per diem rate.

Medicaid rates have been set according to the caseload size of each team:

- Small ACT teams serve, on average 47 individuals with no more than 50 individuals.
- Medium ACT teams serve 51-75 individuals (71 on average).
- Large ACT teams serve 76-100 individuals (95 on average).

- For an ACT team per diem to be billable, a 15-minute or longer face to face contact must meet the requirements below. A 15-minute contact is defined as lasting at least 8 minutes. Group contacts alone are not billable and do not qualify as a face-to-face contact for billing an ACT per diem rate. Contacts via secure video-conferencing do not qualify as face-to-face contact.
- Practitioners who bill for activities reimbursed via the ACT per diem shall not bill for those activities outside the ACT per diem for the same enrollee.
- When ACT is billed, no other mental health or SUD services should be billed with the following exception: Specialized Recovery Services Program (SRSP) supported employment as outlined below.
- SUD treatment in addition to ACT is only permitted with prior authorization. SUD targeted case management, psychiatrist services, other licensed practitioner services, and rehabilitation services other than ACT are not permitted.
- The psychiatric prescriber shall be physically located at the home clinic of the ACT team in order to provide office-based services and services in the community when indicated.
- Medically necessary ACT services, such as peer support and transition planning, shall continue during an inpatient stay. However, these services are not separately reimbursable by Ohio Medicaid. They are considered part of the monthly payment made for each ACT enrollee. If a hospital inpatient stay continues beyond [XX time period], the ACT team should consider whether temporary or permanent disenrollment of the client is medically advisable.

ACT Billing Rates, Codes & Modifiers by Team Member

Physician:

H0040 AM

- Small: \$662.60
- Medium: \$615.54
- Large: \$585.22

Master's Level (includes Registered Nurses):

H0040 HO

- Small: \$282.80
- Medium: \$251.91
- Large: \$234.98

Nurse Practitioner:

H0040 HP

- Small: \$383.75
- Medium: \$352.75
- Large: \$333.20

Bachelor's Level:

H0040 HN

- Small: \$221.41
- Medium: \$199.70
- Large: \$186.48

Peer Level:

H0040 HM

- Small: \$178.50
- Medium: \$159.24
- Large: \$147.70

Practitioners on the ACT teams are subject to the following billing limits per category, per month, per individual, not to exceed a total of 4 per diems (as defined above) per individual in total from any combination of practitioners. (Note: the billing must be based on actual services provided to the individual. Medically necessary care consistent with the fidelity model should be delivered even if beyond the minimum number of units permitted to be billed under this reimbursement strategy.)

— Category 1: Physicians and APRNs may not bill more than one (1) per diem per individual, per month in total.

— Category 2: Any combination of masters level clinicians including Psychologist, team leader, LISW, LPCC, LIMFT, LICDC, LPC, LSW, LMFT, master's level behavioral health other. RNs and LPNs are also in Category 2. All of these practitioners may only bill 1 per diem for an individual in a monthly total. Ideally, this visit will not be in a clinic setting.

— Category 3: All other practitioners on the ACT teams may bill up to two (2) per diems for an individual in a monthly total. Ideally, these visits will not be in a clinic setting.

Non-Fidelity ACT Rate Level

A team that does not meet an ACT basic level fidelity rating (see definitions below) may not bill the rates listed above. Instead these teams may only bill individual services listed in either the old or new code set for Ohio Medicaid behavioral health.

Basic ACT Team Fidelity Level

The State of Ohio will be implementing the TMACT fidelity model beginning January 1, 2017.

However, ACT teams operational prior to July 1, 2016 who meet basic fidelity on the DACT scale will be allowed to bill Ohio Medicaid for team based care to ACT enrollees.

“Grandfathered” ACT teams will have a total of 18 months to transition to a BASIC fidelity level using the TMACT model. Within the first 6 months after they begin billing Medicaid, grandfathered teams must undergo a TMACT review and then meet BASIC fidelity ratings within t.

he next 12 months.

Both grandfathered DACT teams and TMACT teams meeting minimum fidelity scores may bill for up to 4 per diems, per month, per individual when all other requirements for a visit are met (i.e., a face to face service with the individual or family member). Consistent with the fidelity model, medically necessary care should be delivered even if it is beyond the minimum number of units billable under this reimbursement strategy.

Teams utilizing the DACT fidelity model must meet an overall average fidelity rating of 3.0. Teams utilizing the TMACT fidelity model must achieve the following minimum fidelity rating scores on the following subscales:

- A minimum score of 3.0 in the following items from the OS subscale must be achieved:
 - OS1 — Low ratio of individuals to staff.
 - OS5 — Program size.
 - OS6 — Priority service population.
 - OS10 — Retention rate.
- A minimum average rating of 3.0 on the CT subscale.
- A minimum rating of 3.0 on CP subscale CP1 — community based services item.

Insert the OAC rule language here....At any time during the 12-month period of basic fidelity level certification, the Ohio Department of Medicaid (ODM) can request additional information to assess any questions that may arise regarding a TMACT fidelity metric. At the time of request, all subsequent billing will be pended subject to verification of the identified TMACT fidelity metric. If the additional review reveals that the fidelity score for any identified metric falls below the standards for OS, CT, and CP1 listed above, the team will have 90 days to demonstrate capacity at a level above the required minimums for each identified metric. If such capacity is not demonstrated to the satisfaction of ODM, billing will revert to the non-fidelity ACT level for all pended and future services until at least basic fidelity level is achieved on those identified metrics.

The following activities may not be billed as part of the ACT per diem rate, and if billed, will be recouped if discovered in an audit:

Contacts that are not medically necessary.

Time spent doing, attending, or participating in recreational activities.

Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor.

- Habilitative services for the individual (adult) to acquire, retain, and improve the self help, socialization, and adaptive skills necessary to reside successfully in community settings.
- Child Care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- Respite care.
- Transportation for the individual or family. Services provided in the car are considered Transportation and time may not be billed for ACT.
- Covered services that have not been rendered.
- Services rendered that are not in accordance with an approved authorization.
- Services not identified on the individual's authorized ACT participant-directed service plan.
- Services provided without prior authorization by the department or its designee (e.g. a 5th per diem if Supported Employment is listed in the individual's treatment plan)
- Services provided before the department or its designee (including a Managed Care Plan) has approved authorization.
- Services not in compliance with the ACT service manual and not in compliance with fidelity standards.
- Services provided to children, spouse, parents, or siblings of the eligible individual under treatment or others in the eligible individual's life to address problems not directly related to the eligible individual's issues and not listed on the eligible individual's ACT participant-directed service plan.
- Services provided that are not within the provider's scope of practice.
- Any art, movement, dance, or drama therapies.
- Anything not included in the approved ACT service description.

Changes made to ACT that do not follow the requirements outlined in the provider contract, service manual, or ACT fidelity standards.

Any intervention or contact not documented or consistent with the approved treatment/recovery plan goals, objectives, and approved services will not be reimbursed.

Employment of the individual. ACT includes non-job specific vocational training, employment assessments, and ongoing support to maintain employment. ACT may also pay for the medical services that enable the individual to function in the workplace, including ACT services such as a psychiatrist's or psychologist's treatment, rehabilitation planning, therapy, and counseling that enable the individual to function in the workplace.

Table 3-6 ACT

IHBT

Under Development

HCPCS Mental Health Services

MH Services provided by NP-BHPs

The Ohio Medicaid FFS program covers individual, family, group outpatient psychotherapy and mental health assessment, evaluation and testing services provided by NP-BHPs.

Limitations for MH Services provided by NP-BHPs

All services in addition to the basic benefit package may be subject to prior authorization or further review for medical necessity. Evidence-Based Practices require prior approval, designations and fidelity reviews on an ongoing basis as determined necessary by the Ohio State EBP Review Team.

Table 3-8: Community Psychiatric Supportive Treatment-Under Development MH						SUD
Service	Provider Type	Code	Req'd Mod	In Group Setting?	Rate	
Community Psychiatric Supportive Treatment	MD/DO	H0036		HQ	\$19.54 \$8.99	Not Covered
	Certified nurse specialist Certified nurse practitioner	H0036		HQ	\$19.54 \$8.99	
	Licensed independent (excluding LICDC)	H0036		HQ	\$19.54 \$8.99	
	Board licensed school psychologist	H0036	UB	HQ	\$19.54 \$8.99	
	Licensed professional counselor	H0036	U2	HQ	\$19.54 \$8.99	
	Licensed social worker	H0036	U4	HQ	\$19.54 \$8.99	
	Licensed marriage and family therapist	H0036	U5	HQ	\$19.54 \$8.99	
	Psychology assistant, intern, trainee	H0036	HM	HQ	\$19.54 \$8.99	
	School psychology assistant/trainee (ODE)	H0036	U1	HQ	\$19.54 \$8.99	
	Social Worker trainee	H0036	U9	HQ	\$19.54 \$8.99	
	MFT trainee	H0036	UA	HQ	\$19.54 \$8.99	
	Counselor trainee	H0036	U7	HQ	\$19.54 \$8.99	
	QMHS - High school	H0036	HM		\$19.54	

				HQ	\$8.99	
	QMHS - Associates	H0036	HM	HQ	\$19.54 \$8.99	
	QMHS - Bachelors	H0036	HN	HQ	\$19.54 \$8.99	
	QMHS - Masters	H0036	HO	HQ	\$19.54 \$8.99	

Unit Value	15 minutes
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Service Definition	<p>Service definition as found in OAC 5122-29-17</p> <p>Community psychiatric supportive treatment (CPST) service provides an array of services delivered by community based, mobile individuals or multidisciplinary teams of professionals and trained others. Services address the individualized mental health needs of the client. They are directed towards adults, children, adolescents and families and will vary with respect to hours, type and intensity of services, depending on the changing needs of each individual. The purpose/intent of CPST services is to provide specific, measurable, and individualized services to each person served. CPST services should be focused on the individual's ability to succeed in the community; to identify and access needed services; and to show improvement in school, work and family and integration and contributions within the community.</p> <p>Activities of the CPST service shall consist of one or more of the following:</p> <ol style="list-style-type: none"> (1) Ongoing assessment of needs; (2) Assistance in achieving personal independence in managing basic needs as identified by the individual and/or parent or guardian; (3) Facilitation of further development of daily living skills, if identified by the individual and/or parent or guardian; (4) Coordination of the ISP, including: <ol style="list-style-type: none"> (a) Services identified in the ISP; (b) Assistance with accessing natural support systems in the community; and (c) Linkages to formal community service/systems; (5) Symptom monitoring; (6) Coordination and/or assistance in crisis management and stabilization as needed; (7) Advocacy and outreach; (8) As appropriate to the care provided to individuals, and when appropriate, to the family, education and training specific to the individual's assessed needs, abilities and readiness to learn; (9) Mental health interventions that address symptoms, behaviors, thought processes, etc., that assist an individual in eliminating barriers to seeking or maintaining education and employment; and (10) Activities that increase the individual's capacity to positively impact his/her own environment. <p>The methods of CPST service delivery shall consist of:</p> <ol style="list-style-type: none"> (1) Service delivery to the person served and/or any other individual who will assist in the person's mental health treatment. <ol style="list-style-type: none"> (a) Service delivery may be face-to-face, by telephone, and/or by video conferencing; and (b) Service delivery may be to individuals or groups.
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	<p>(2) CPST services are not site specific. However, they must be provided in locations that meet the needs of the persons served. When a person served is enrolled in a residential treatment or residential support facility setting, CPST services must be provided by staff that are organized and distinct and separate from the residential service as evidenced by staff job descriptions, time allocation or schedules, and development of service rates.</p>
<p>Admission Criteria</p>	<p>An eligible mental health (MH) diagnosis OR co-occurring substance-related disorder and MH diagnosis,:</p> <p>AND</p> <ul style="list-style-type: none"> • Individual has significant functional impairments that interfere with integration in the community and needs assistance in two (2) or more of the following areas which, despite support from a care giver or behavioral health staff (i.e., case manager SUD support service staff) continues to be an area that the individual cannot complete. Needs significant assistance to: <ul style="list-style-type: none"> ○ Navigate and self-manage necessary services; ○ Maintain personal hygiene; ○ Meet nutritional needs; ○ Care for personal business affairs; ○ Obtain or maintain medical, legal, and housing services; ○ Recognize and avoid common dangers or hazards to self and possessions; ○ Perform daily living tasks ; ○ Obtain or maintain employment at a self-sustaining level or consistently perform homemaker roles (e.g., household meal preparation, washing clothes, budgeting, or childcare tasks and responsibilities); ○ Maintain a safe living situation (e.g. evicted from housing, or recent loss of housing, or imminent risk of loss of housing); <p>AND</p> <ul style="list-style-type: none"> • Individual is engaged in their treatment plan but needs assistance with one (1) or more of the following areas as an indicator of demonstrated ownership and engagement with his/her own illness self-management: <ul style="list-style-type: none"> ○ Taking prescribed medications, or ○ Following a crisis plan, or ○ Maintaining community integration, or ○ Keeping appointments with needed services which have resulted in the exhibition of specific behaviors that have led to two or more of the following within the past 18 months: <ul style="list-style-type: none"> ○ Hospitalization ○ Homelessness, or use of other crisis services
<p>Continuing Stay Criteria</p>	<ul style="list-style-type: none"> ○ Continued difficulty participating in traditional clinic-based services or a community setting at a less intensive level of service/supports; ○ Substandard housing, homeless, or at imminent risk of becoming homeless due to functional impairments associated with behavioral health issues; ○ Needs ongoing support to maintain stable housing; or

	<ul style="list-style-type: none"> ○ Experienced recent life changing event (examples include death of significant other or close family member, change in marital status, Involvement with criminal justice system, serious illness or injury of self or close family member, financial issues including loss of job, disability check, etc.) and needs intensive support to prevent the utilization of crisis level services.
Discharge Criteria	<p>There has been a planned reduction of units of service delivered and related evidence of the individual sustaining functioning through that reduction plan; and</p> <ul style="list-style-type: none"> • Individual has established recovery support networks to assist in maintenance of recovery (such as peer supports, AA, NA, etc.); and • Individual has demonstrated some ownership and engagement with her/his own illness self-management as evidenced by: <ul style="list-style-type: none"> ○ Navigating and self-managing necessary services; ○ Maintaining personal hygiene; ○ Meeting his/her own nutritional needs; ○ Obtaining or maintaining medical and housing services; ○ Recognizing and avoiding common dangers or hazards to self and possessions; ○ Performing daily living tasks; ○ Obtaining or maintaining employment at a self-sustaining level or consistently performing homemaker roles (e.g., household meal preparation, washing clothes, budgeting, or childcare tasks and responsibilities); and ○ Maintaining a safe living situation.
Service Accessibility	<p>This service may not be provided in an IMD, jail, youth development center, or prison system.</p>
Staffing Requirements	<p>There must be one CPST staff who is clearly responsible for case coordination. This staff person must be an employee of an agency that is certified by ODMH to provide CPST services. This person may delegate CPST services to eligible providers internal and/or external to the certified agency as long as the following requirements and/or conditions are met:</p> <ol style="list-style-type: none"> (1) All delegated CPST activities are consistent with this rule in its entirety; (2) The delegated CPST services may be provided by an entity not certified by ODMH to provide CPST services as long as there is written agreement between the certified agency and the non-certified entity that defines the service expectations, qualifications of staff, program and financial accountability, health and safety requirements, and required documentation; and (3) An entity that is not certified by ODMH for CPST service may only seek reimbursement for CPST services through a certified agency and with a written agreement as required in this paragraph. <p>Providers of CPST service shall have a staff development plan based upon identified individual needs of CPST staff. Evidence that the plan is being followed shall be maintained. The plan shall address, at a minimum, the following:</p> <ol style="list-style-type: none"> (1) An understanding of systems of care, such as natural support systems, entitlements and benefits, inter- and intra-agency systems of care, crisis response systems and their purpose, and the intent and activities of CPST; (2) Characteristics of the population to be served, such as psychiatric symptoms, medications, culture, and age/gender development; and (3) Knowledge of CPST purpose, intent and activities. <p>Community psychiatric supportive treatment (CPST) service shall be provided and supervised by staff who are qualified according to rule 5122-29-30 of the Ohio Administrative Code.</p>

Service Exclusions	<ul style="list-style-type: none"> Individuals enrolled with an ACT team or receiving IHBT cannot receive CPST as a separately identified service.
Clinical Exclusions	
Required Components	Maintain face-to-face contact with individuals receiving CPST services, providing a supportive and practical environment that promotes recovery and maintain adherence to the desired performance outcomes that have been established for individuals receiving CPST case management services. It is expected that frequency of face-to-face contact is increased when clinically indicated in order to achieve the performance outcomes, and the intensity of service is reflected in the individual's treatment plan.
Clinical Operations	<ul style="list-style-type: none"> CPST services may include (with consent) coordination with family and significant others and with other systems/supports (e.g., work, religious entities, corrections, aging agencies, etc.) when appropriate for treatment and recovery needs. CPST service providers must have the ability to deliver services in various environments, such as homes, homeless shelters, or street locations.
Reporting and Billing Requirement	CPST services should not be duplicative of TBS or PSR services provided. CPST services are included in ACT and IHBT service rates and therefore, should not be billed when a person is receiving either of these evidence based practices.

Table 3-9: Screening, Brief Intervention and Referral to Treatment

MH				
Service	Provider	Code	Req'd Mod	Rate
Screening, Brief Intervention and Referral to Treatment (SBIRT)	MD/DO	G0396		\$25.05
		G0397		\$47.68
	Certified nurse specialist Certified nurse practitioner	G0396		\$25.05
		G0397		\$47.68
	Physician assistant	G0396		\$25.05
		G0397		\$47.68
	Psychologist	G0396		\$25.05
		G0397		\$47.68
	RN, LPN	G0396		\$25.05
		G0397		\$47.68
	Licensed independent (excluding LICDC)	G0396		\$25.05
		G0397		\$47.68
Board licensed school psychologist	G0396		UB	\$25.05
	G0397			\$47.68
Licensed professional counselor	G0396		U2	\$25.05
	G0397			\$47.68
Licensed social worker	G0396		U4	\$25.05
	G0397			\$47.68
Licensed marriage and family therapist	G0396		U5	\$25.05
	G0397			\$47.68

	Psychology assistant, intern, trainee	G0396 G0397	U1	\$25.05 \$47.68
	School psychology assistant/trainee (ODE)	G0396 G0397	U1	\$25.05 \$47.68
	Social worker trainee	G0396 G0397	U9	\$25.05 \$47.68
	Marriage and family therapist trainee	G0396 G0397	UA	\$25.05 \$47.68
	Counselor trainee	G0396 G0397	U7	\$25.05 \$47.68
Unit Value	Encounter G0396 15 to 30 minutes G0397 over 30 minutes Limitations; 1 code per year per patient per provider			
Service Definition	SBIRT is a comprehensive, integrated, public health approach to identify those who may have a substance abuse disorder or may be at-risk for developing a substance abuse disorder and is composed of a short series of questions that are scored to evaluate the level of risk. Screening tools include the World Health Organization's Alcohol Use Disorders Identification Test (AUDIT) manual and the Drug Abuse Screening Test (DAST). Practitioners engage a client showing risky substance use behaviors in a short conversation, providing feedback and advice.			
Admission Criteria	The client is currently seeking or receiving treatment in a mental health facility			
Continuing Stay Criteria	Those identified at risk of having a substance use disorder should be referred to an SUD agency for further assessment and additional services, if necessary			
Discharge Criteria				
Service Accessibility	This service may not be provided in an IMD, jail or prison system.			
Service Exclusions	Service provide by an SUD facility (provider 95).			
Documentation Requirements	<ul style="list-style-type: none"> SBIRT documentation must include the start and stop time or total face-to-face time with the client, the client's response, appropriate health risk factors, practitioner's initials, the individual's level of risk and any referral source provided. Practitioners must have successfully completed SBIRT training. 			

Table 3-10: Psychosocial Rehabilitation

MH								SUD
Service	Provider Type	Code	Req'd Mod	If Group Setting?	If Crisis? (not in group)	Place of Service	Rate	
Psychosocial Rehabilitation (PSR)	LPN	H2017		HQ	UT	11 All others	\$17.50 \$22.39	Not Covered
	Psychology assistant, intern, trainee	H2017	U1	HQ	UT		\$14.42	

	School psychology assistant/trainee (ODE)	H2017	U1	HQ	UT	03	\$14.42
	Social worker assistant	H2017	U8	HQ	UT	11 All others	\$14.42 \$18.55
	Social worker trainee	H2017	U9	HQ	UT	11 All others	\$14.42 \$18.55
	MFT trainee	H2017	UA	HQ	UT	11 All others	\$14.42 \$18.55
	Counselor trainee	H2017	U7	HQ	UT	11 All others	\$14.42 \$18.55
	QMHS - high school	H2017	HM	HQ	UT	11 All others	\$14.42 \$18.55
	QMHS - Associates	H2017	HM	HQ	UT	11 All others	\$14.42 \$18.55
	QMHS - Bachelors	H2017	HN	HQ	UT	11 All others	\$14.42 \$18.55
	QMHS - Masters	H2017	HO	HQ	UT	11 All others	\$14.42 \$18.55
Unit Value	15 minutes						
Service Definition	<p>Psychosocial rehabilitation (PSR) is comprised of individual face-to-face interventions for the purpose of rehabilitative skills building, the personal development of environmental and recovery supports considered essential in improving a person’s functioning, learning skills to promote the person’s self-access to necessary services and in creating environments that promote recovery and support the emotional and functional improvement of the individual. The service activities of PSR include:</p> <ul style="list-style-type: none"> • Providing skills support in the person’s self-articulation of personal goals and objectives; • Assisting the person in the development of skills to self-manage or prevent crisis situations; • Individualized interventions in living, learning, working, other social environments, which shall have as objectives: <ul style="list-style-type: none"> • Identification, with the person, of strengths which may aid him/her in achieving recovery, as well as barriers that impede the development of skills necessary for functioning in work, with peers, and with family/friends; • Supporting skills development to build natural supports (including support/assistance with defining what wellness means to the person in order to assist them with recovery-based goal setting and attainment); • Assistance in the development of interpersonal, community coping and functional skills (which may include adaptation to home, adaptation to work, adaptation to healthy social environments, learning/practicing skills such as personal financial management, medication self-monitoring, symptom self-monitoring, etc.); • Assistance in the acquisition of skills for the person to self-recognize emotional triggers and to self-manage behaviors related to the behavioral health issue; • Assistance with personal development, work performance, and functioning in social and family environments through teaching skills/strategies to ameliorate the effect of behavioral health symptoms; • Assistance in enhancing social and coping skills that improve life stresses resulting from the person’s mental illness/addiction; 						

	<ul style="list-style-type: none"> • Assist the person in his/her skills in gaining access to necessary rehabilitative, medical, social and other services and supports; • Assistance to the person and other supporting natural resources with illness understanding and self-management (including medication self-monitoring); and • Identification, with the individual and named natural supporters, of risk indicators related to substance related disorder relapse, and the development of skills and strategies to prevent relapse. • Assistance to the individual and family/responsible caregivers in the facilitation and coordination of the Individual treatment plan including providing skills support in the individual/family's self-articulation of personal goals and objectives can be billed. <p>This service is provided in order to promote stability and build towards functioning in the person's daily environment. Stability is measured by a decreased number of hospitalizations, by decreased frequency and duration of crisis episodes and by increased and/or stable participation in community/work activities. Supports based on the person's needs are used to promote recovery while understanding the effects of the mental illness and/or substance use/abuse and to promote functioning.</p>
<p>Admission Criteria</p>	<p>Individuals with one of the following: mental health (MH) diagnosis, substance-related disorder, or co-occurring substance-related disorder and MH diagnosis, and one or more of the following:</p> <ul style="list-style-type: none"> • Individual may need assistance with developing, maintaining, or enhancing social supports or other community coping skills; or • Individual may need assistance with daily living skills including coordination to gain access to necessary rehabilitative and medical services.
<p>Continuing Stay Criteria</p>	<ul style="list-style-type: none"> • Individual continues to meet admission criteria; and • Individual demonstrates documented progress or maintenance of community skills relative to goals identified in the individualized treatment plan.
<p>Discharge Criteria</p>	<p>An adequate continuing care plan has been established; and one or more of the following:</p> <ul style="list-style-type: none"> • Goals of the individualized treatment plan have been substantially met; or • Individual requests discharge and the individual is not in imminent danger of harm to self or others; or • Transfer to another service/level of care is warranted by change in individual's condition; or • Individual requires more intensive services.
<p>Service Exclusions</p>	<ul style="list-style-type: none"> • Intensive family intervention may be provided concurrently during transition between these services for support and continuity of care. If services are provided concurrently, PSR should not be duplicative of these services. This service must be adequately justified in the individualized treatment plan. • PSR services do not include, and reimbursement is not available for any of the following, in accordance with section 1905(a)(13) of the Act; <ul style="list-style-type: none"> ○ Transportation ○ Observation/monitoring ○ Diversionary activities (i.e. activities/time for which a therapeutic intervention tied to a goal on the individual's recovery/recovery plan is not occurring) ○ Educational, vocational and job training services; ○ Room and board; ○ Habilitation services; ○ Services to inmates in public institutions as defined in 42 CFR §435.1010; ○ Services to individuals residing in institutions for mental diseases as described in 42 CFR§435.1010;

	<ul style="list-style-type: none"> ○ Recreational and social activities; and ○ Services that must be covered elsewhere in the state Medicaid plan.
Required Components	<ul style="list-style-type: none"> ● PSR must include a variety of interventions in order to assist the individual in developing: <ul style="list-style-type: none"> ○ Symptom self-monitoring and self-management of symptoms. ○ Strategies and supportive interventions for avoiding out-of-community treatment for adults and building stronger knowledge of the adult’s strengths and limitations. ○ Relapse prevention strategies and plans. ● PSR services focus on building and maintaining a therapeutic relationship with the individual and facilitating treatment and recovery goals. ● The frequency and duration of rehabilitation services will be identified in the individual treatment plan and must be supported by an identified need and recovery goal ● The LPN may provide PSR services as outlined in the individual treatment plan, however, they cannot develop the individual treatment plan.
Staffing Requirement	<p>The organization must have a PSR organizational plan that addresses the following:</p> <ul style="list-style-type: none"> ● Description of the particular rehabilitation, recovery and natural support development models utilized, types of intervention practiced, and typical daily schedule for staff; ● Description of the staffing pattern and how staff are deployed to assure that the required staff-to-individual ratios are maintained, including how unplanned staff absences, illnesses, or emergencies are accommodated, case mix, access, etc.; ● Description of the hours of operations as related to access and availability to the individuals served; ● Description of how the plan for services is modified or adjusted to meet the needs specified in every Individualized Treatment Plan and ● If the service is offered through an agency which provides PSR group, then there is a description of agency protocols and accountability procedures to assure that there is no duplication of billing when the person is being supported through the group model. <p>Utilization (frequency and intensity) of PSR should be directly related to the Adult Needs and Strength Assessment (ANSA) and to other functional elements in the assessment. In addition, when clinical/functional needs are great, there should be complementary therapeutic services by licensed/credential professionals paired with the provision of PSR (individual, group, family, etc.).</p>
Documentation Requirements	<ul style="list-style-type: none"> ● The individual medical record must include documentation of services/activities provided to the individual as described in the service definition section. ● Provider is required to complete a progress note for every contact with individual as well as for related collateral contacts ● Progress notes must adhere to documentation requirements set forth in this manual.
Reporting and Billing Requirement	<ul style="list-style-type: none"> ● Unsuccessful attempts to make contact with the individual are not billable.

TBS Day Treatment-Under Development

MH								SUD
Service Code	Provider Type	Code	Req'd Mod	In Group Setting?	For Crisis ?	Place of Service	Rate	
	RN	H2019			UT	11	\$25.62	Not Covered

Therapeutic Behavioral Services (TBS)				HQ		All others 11	\$32.52 \$6.41
	Pharmacist	H2019	UR	N/A	N/A	11 All others 11	\$25.62 \$32.52 \$6.41
	Psychology assistant, intern, trainee	H2019	U1	HQ	UT	Under development	
	School psychology assistant/trainee (ODE)	H2019	U1	HQ	UT		
	Board licensed school psychologist	H2019	UB	HQ	UT		
	LSW	H2019	U4	HQ	UT		
	LMFT	H2019	U5	HQ	UT		
	Social worker trainee	H2019	U9	HQ	UT		
	MFT trainee	H2019	UA	HQ	UT		
	Counselor trainee	H2019	U7	HQ	UT		
	QMHS – Bachelors +2 years' experience	H2019	HN	HQ	UT	11 All others 11	\$18.54 \$23.69 \$4.64
	QMHS – Masters +1 year experience	H2019	HO	HQ	UT	11 All others 11	\$21.05 \$26.82 \$5.26
	Unit Value	15 minutes					
Service Definition	<p>TBS consists of rehabilitative skill, environmental support and resources coordination considered essential to assist an individual/family in gaining access to necessary services and in creating environments that promote resiliency and support the emotional and functional growth and development of the individual. The activities of TBS include:</p> <ul style="list-style-type: none"> • Assistance to the individual and family/responsible caregivers in the facilitation and coordination of the individual treatment plan including providing skills support in the individual/family's self-articulation of personal goals and objectives; • Planning in a proactive manner to assist the individual/family in managing or preventing crisis situations; • Individualized interventions, which shall have as objectives: <ul style="list-style-type: none"> ○ Identification, with the individual, of strengths which may aid him/her in achieving resilience, as well as barriers that impede the development of skills necessary for age-appropriate functioning in school, with peers, and with family; ○ Support to facilitate enhanced natural and age-appropriate supports (including support/assistance with defining what wellness means to the individual in order to assist them with recovery-based goal setting and attainment); ○ Assistance in the development of interpersonal, community coping and functional skills (including adaptation to home, school and healthy social environments); ○ Encouraging the development and eventual succession of natural supports in living, learning, working, other social environments; ○ Assistance in the acquisition of skills for the individual to self-recognize emotional triggers and to self-manage behaviors related to the individual's identified emotional disturbance; 						

	<ul style="list-style-type: none"> ○ Assistance with personal development, school performance, work performance, and functioning in social and family environment through teaching skills/strategies to ameliorate the effect of behavioral health symptoms; ○ Assistance in enhancing social and coping skills that ameliorate life stresses resulting from the individual’s emotional disturbance; ○ Service and resource coordination to assist the individual and family in gaining access to necessary rehabilitative, medical, social and other services and supports; ○ Assistance to individual and other supporting natural resources with illness understanding and self-management ○ Identification, with the individual/family, of risk indicators related to substance related disorder relapse, and strategies to prevent relapse. <p>This service is provided to individual in order to promote stability and build towards age-appropriate functioning in their daily environment. Stability is measured by a decreased number of hospitalizations, by decreased frequency and duration of crisis episodes and by increased and/or stable participation in school and community activities. Supports based on the individual’s needs are used to promote recovery while understanding the effects of the emotional disturbance and/or substance use/abuse and to promote functioning at an age-appropriate level.</p> <p>Some examples of TBS within scope for unlicensed providers:</p> <ul style="list-style-type: none"> ● Development of the treatment plan ● Service planning (Medicaid services only) ● Care coordination (Medicaid services only) ● Collateral contacts ● Identifying triggers ● Individual, group, family and multifamily therapy <p>Para-professionals may implement services with the treatment plan that are within their scope of practice.</p>
Admission Criteria	<p>Individual must meet target population criteria as indicated above; and one or more of the following:</p> <ul style="list-style-type: none"> ● Individual may need assistance with developing, maintaining, or enhancing social supports or other community coping skills; or ● Individual may need assistance with daily living skills including coordination to gain access to necessary rehabilitative and medical services
Continuing Stay Criteria	<ul style="list-style-type: none"> ● Individual continues to meet admission criteria; and ● Individual demonstrates documented progress or maintenance of community skills relative to goals identified in the individualized treatment plan.
Discharge Criteria	<ul style="list-style-type: none"> ● An adequate treatment plan has been previously established; and one or more of the following: <ul style="list-style-type: none"> ○ Goals of individualized treatment plan have been substantially met; or ○ Individual/family requests discharge and the individual is not imminently in danger of harm to self or others; or ○ Transfer to another service is warranted by change in the individual’s condition.
Service Exclusions	<ul style="list-style-type: none"> ● Intensive family intervention may be provided concurrently during transition between these services for support and continuity of care. If services are provided concurrently, TBS should not be duplicative of these services. This service must be adequately justified in the individualized treatment plan. ● Assistance to the individual and family/responsible caregivers in the facilitation and coordination of the individual treatment plan including providing skills support in the individual/family’s self-articulation of personal goals and objectives can be billed.

	<ul style="list-style-type: none"> TBS does not include, and reimbursement is not available for any of the following, in accordance with section 1905(a)(13) of the Act; <ul style="list-style-type: none"> Transportation Observation/monitoring Diversionary activities (i.e. activities/time for which a therapeutic intervention tied to a goal on the individual's recovery/recovery plan is not occurring) Educational, vocational and job training services; Room and board; Habilitation services; Services to inmates in public institutions as defined in 42 CFR §435.1010; Services to individuals residing in institutions for mental diseases as described in 42 CFR§435.1010; Recreational and social activities; and Services that must be covered elsewhere in the state Medicaid plan
Clinical Exclusions	<ul style="list-style-type: none"> There is a significant lack of community coping skills such that a more intensive service is needed. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a co-occurring BH condition: developmental disability, autism, organic mental disorder, traumatic brain injury
Required Components	<ul style="list-style-type: none"> The frequency and duration of TBS services will be identified in the individual treatment plan and must be supported by an identified need and recovery goal. TBS must include a variety of interventions in order to assist the individual in developing: <ul style="list-style-type: none"> Symptom self-monitoring and self-management of symptoms Strategies and supportive interventions for avoiding out-of-home placement for individual and building stronger family support skills and knowledge of the individual or individual's strengths and limitations Medication education TBS focuses on building and maintaining a therapeutic relationship with the individual and facilitating treatment and resiliency goals.
Staffing Requirement	<ul style="list-style-type: none"> The LPN may provide TBS as outlined in the individual treatment plan. A pharmacist may provide medication education services under TBS. See "Other" Section in this chart for pharmacist requirements.
Clinical Operations	<ul style="list-style-type: none"> TBS provided to individual must include coordination with family and significant others and with other systems of care (such as the school system, etc.) juvenile justice system, and child welfare and child protective services when appropriate to treatment and educational needs. Utilization (frequency and intensity) of TBS should be directly related to the Child and Adolescent Needs and Strengths (CANS) or ANSA and to the other functional elements of the individual's assessment. In addition, when clinical/functional needs are great, there should be complementary therapeutic services by licensed/credential professionals paired with the provision of TBS (individual, group, family, etc.).
Service Exclusions	
Reporting and Billing Requirement	Unsuccessful attempts to make contact with the individual are not billable.
Other	Pharmacist Requirements <ul style="list-style-type: none"> The patient must first be seen by the physician, certified nurse practitioner, certified nurse specialist, or physician assistant for an evaluation. The physician, certified nurse practitioner, certified nurse specialist, or physician assistant must have provided authorization for the service, as documented in the medical record.

- The physician, certified nurse practitioner, certified nurse specialist, or physician assistant must continue to see the patient at a frequency that reflects his/her active participation in the management of the course of treatment. A review of the medical record does not qualify.
- Services provided by a pharmacist incident to the physician must be within the Pharmacist's scope of practice as dictated by the state's Pharmacy Practice Act.
- Services and supplies must be furnished in accordance with applicable State law. Any other state laws besides the Pharmacy Practice Act that affect your service must be adhered to.
- The pharmacist providing the incident-to service must be an employee, leased or contracted to the physician or Medicare Part B-approved provider. The practice must have some legal control over the person and his or her services, and the person must represent an expense to the practice. (Expense may include salary, non-salary support such as an exam room, office supplies, staff support etc.)
- Medication consultation is included in the dispensing payment, therefore, this service should not be billed on the same day as medication is dispensed.

SECTION 4

SUD COVERAGE

The Ohio Medicaid programs has selected the American Society of Addiction Medicine (ASAM) placement criteria as the standard of measure for treating individuals with SUD conditions, including individuals with co-occurring MH conditions. The ASAM criteria has been selected to bring a consistent strengths-based evaluation and placement methodology into practice to address individual patient needs, strengths, and supports. While this manual only addresses services provided by qualified providers who are providing OhioMHAS-certified CBHSs, independently practicing licensed practitioners (IPLPs) are also required to use the ASAM criteria for persons identified with SUDs.

The Ohio Medicaid program covers community-based SUD services to Medicaid beneficiaries provided by SUD programs within Ohio that are certified by OhioMHAS and enrolled with ODM as a community SUD service provider.

For reimbursement of SUD programs operating outside of the state of Ohio, the program must be recognized (regulated) in the state in which they operate as a provider of community-based SUD services and be enrolled with ODM as a community SUD service provider.

SUD Services

SUD services include an array of individual-centered outpatient and residential services consistent with the individual's assessed SUD treatment needs, with a rehabilitation and recovery focus designed to promote skills for coping with and managing SUD symptoms and associated behaviors.

Outpatient SUD services include individual-centered activities consistent with the individual's assessed treatment needs with a rehabilitation and recovery focus designed to promote skills for coping with and managing symptoms and behaviors associated with SUDs. These activities are designed to help beneficiaries achieve and maintain recovery from SUDs. Outpatient SUD services include medically necessary care according to assessed needs including: (1) Assessment and clinical treatment plan development; (2) Skill development for coping with and managing symptoms and behaviors associated with SUDs; (3) Counseling to address an individual's major lifestyle, attitudinal, and behavioral problems; and (4) Medication assisted treatment (MAT) when medically necessary. Counseling should address an individual's major lifestyle, attitudinal, and behavioral problems that have the potential to undermine the goals of treatment. Outpatient activities are delivered on an individual or group basis in a wide variety of settings including a provider's office, in the community or in the individual's place of residence. These services may be provided onsite or on a mobile basis in the community. The service setting will be determined by the goal which is identified to be achieved in the individual's treatment plan.

Outpatient services may be indicated as an initial modality of care for a beneficiary whose severity of illness warrants this level of treatment, or when an individual's progress warrants a less intensive modality of service than they are currently receiving. The intensity of the services will be driven by medical necessity. MAT should only be utilized when a beneficiary has an established SUD (e.g., opiate or alcohol dependence condition) that is clinically appropriate for MAT.

Residential services include individual-centered residential services consistent with the individual's assessed treatment needs, with a rehabilitation and recovery focus designed to promote skills for coping with and managing SUD symptoms and behaviors. These services are designed to help beneficiaries achieve changes in their SUD behaviors. Services should address the individual's major lifestyle, attitudinal, and behavioral problems that have the potential to undermine the goals of treatment. Residential SUD services include medically necessary care according to assessed needs including: (1) Assessment and clinical treatment plan development; (2) Skill development for coping with and managing symptoms and behaviors associated with SUD; (3) Counseling to address an individual's major lifestyle, attitudinal, and behavioral problems; (4) MAT when medically necessary. Residential services are delivered on an individual or group basis in a wide variety of settings including treatment in residential settings of sixteen (16) beds or less designed to help beneficiaries achieve changes in their SUD behaviors. The service setting will be determined by the goal which is identified to be achieved in the individual's treatment plan.

SUD Service Limitations

All SUD services are provided as part of a comprehensive specialized program available to all Medicaid beneficiaries with significant functional impairments resulting from a diagnosed SUD(s). Services when subject to prior approval, must be medically necessary and must be recommended by a licensed practitioner or physician, who is acting within the scope of his/her professional licensed and applicable state law (licensed practitioners licensed by a Ohio professional board include physicians, physician assistants, and I-BHPs), to promote the

maximum reduction of symptoms and/or restoration of an individual to his/her best age-appropriate functional level according to an individualized treatment plan.

The activities included in the rehabilitation service shall be intended to achieve the identified Medicaid-eligible client(s)' treatment plan goals or objectives. Components that are not provided to or directed exclusively toward the treatment of the Medicaid eligible individual(s) are not eligible for Medicaid reimbursement.

Medically-managed opioid treatment programs offering buprenorphine-based medications must have at least one physician with a controlled substance waiver of the 1914 Harrison Act. Per federal regulations, the physician may not have a caseload exceeding 30 patients in the first year after receiving this waiver. In subsequent years, caseloads may not exceed 100 patients.

The comprehensive specialized program includes assessment, development of an individualized, person-centered treatment plan and updates, and referral and assistance as needed for the person to gain access to other needed SUD or mental health services. Referral arrangements may include:

- Coordination with other SUD and mental health providers and potential providers of services to ensure seamless service access and delivery.
- Brokering of services to obtain and integrate SUD and mental health services.
- Facilitation and advocacy to resolve issues that impede access to needed SUD or mental health services.
- Appropriate discharge/transfer planning to other SUD or mental health providers or levels of care including coordination with the person's family, friends, and other community members to cultivate the person's natural support network, to the extent that the person has provided permission for such coordination.

Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's medical record.

The activities included in the service must be intended to achieve identified treatment plan goals or objectives. The treatment plan should be developed in a person-centered manner with the active participation of the person, their family members and/or other people they want include, and other Medicaid service providers and be based on the person's condition and the standards of practice for the provision of rehabilitative services. The treatment plan should identify the medical or remedial services intended to reduce the identified condition as well as the anticipated outcomes of the individual. The treatment plan must specify the frequency, amount, and duration of services. The treatment plan must be signed by the licensed practitioner responsible for developing the plan with the person (or authorized representative) also signing to note concurrence with the treatment plan.

The development of the treatment plan should address barriers and issues that have contributed to the need for SUD services. Treatment plans will be updated based upon changes in a person's need for SUD services, changes in level of care, and all treatment plans will be updated at least

annually. All treatment plan updates should involve the person, family, and other Medicaid providers to determine whether SUD services have contributed to meeting the stated goals consistent with all relevant State and federal privacy requirements. A new treatment plan should be developed even if there is no measureable reduction of disability or restoration of functional level. The new plan should identify a different rehabilitation strategy with revised goals and services

Providers must maintain medical records that include a copy of all treatment plans, the name of the person, dates of services provided, nature, content and units of rehabilitation services provided, and progress made toward functional improvement and goals in the treatment plan. Components that are not provided to, or directed exclusively toward the treatment of the person receiving Medicaid, are not eligible for Medicaid reimbursement.

Services provided at a work site must not be job-oriented and must be directly related to treatment of a person's SUD. Any services or components of services, the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of a person receiving covered services (including housekeeping, shopping, child care, and laundry services) are non-covered.

Room and board is excluded from SUD service rates as it is not covered by Medicaid. SUD residential services as determined under the American Society of Addiction Medicine (ASAM) criteria requires prior approval and reviews on an ongoing basis as determined necessary by ODM or its designee to document compliance with the placement standards.

Ohio Medicaid will not reimburse for 12-step programs.

A unit of service is defined according to the HCPCS approved code set per the NCCI unless otherwise specified for licensed practitioners to utilize the CPT code set. No more than one per diem rate may be billed a day for residential SUD programs.

Assessments and testing for individuals not in the custody of the penal system (e.g., not involuntarily residing in prison or jail overnight or detained awaiting trial) are Medicaid covered, including any laboratory and urine tests. Drug court diversion treatment programs are covered by Medicaid. Medicaid eligible individuals who are admitted to medical institutions such as SUD residential treatment programs are eligible for Medicaid funding. Laboratory procedures that the practitioner refers to an outside laboratory or that are performed using an in-house laboratory must be billed by the laboratory to the Medicaid MCO (for Medicaid MCO enrollees) and to Medicaid (for Medicaid FFS enrollees).

For programs offering both outpatient and residential care (setting?), the person's chart must reflect admission to the program which marks the start of the current episode and any reimbursement. If the person is in a service that is paid FFS and changes levels of care within 24 hours to a per diem funded service, it shall be considered part of the per diem service. Both FFS and per diem billing will not be permitted unless the service billed is MAT which is not included in the outpatient or per diem. If the person is in a per diem service and changes levels of care to another per diem level of care, then only one per diem may be billed for the 24-hour period and a new episode will not be allowed (i.e., a single facility cannot bill for discrete services and

multiple per diems in a single 24 hour period). For specific billing guidance on detoxification, see the ASAM 2-WM section.

Outpatient SUD Services

Alcohol and Drug Assessment and Referral

OhioMHAS certified SUD outpatient programs offer alcohol and drug assessments, referrals, and services for individuals presenting with a current or past SUD. The assessment is designed to gather and analyze information regarding an individual's current substance use behavior and social, medical, and treatment history. The purpose of the assessment is to provide sufficient information for problem identification and, if appropriate, SUD treatment or referral.

The services described in this section (e.g., all ASAM Level 1 services) include referral and assistance as needed for the beneficiary to gain access to other needed Medicaid SUD or mental health services. Referral arrangements may include:

- Coordination with other SUD and mental health providers and potential providers of services to ensure seamless service access and delivery.
- Brokering of services to obtain and integrate SUD and mental health services.
- Facilitation and advocacy to resolve issues that impede access to needed SUD or mental health services.
- Appropriate discharge/transfer planning to other SUD or mental health providers or levels of care including coordination with the individual's family, friends, and other community members to cultivate the individual's natural support network, to the extent that the beneficiary has provided permission for such coordination.

Qualified providers shall develop, implement, and comply with policies and procedures that establish processes for referrals for an individual. Qualified providers may conduct an initial screen of an individual's presenting SUD before conducting an assessment of the individual. Qualified providers shall be licensed in accordance with state licensure laws and regulations and will comply with licensing standards in regard to assessment practices. Once an individual receives an assessment, a staff member shall provide the individual with a recommendation for further assessment or treatment and an explanation of that recommendation.

Table 4-1: SUD Assessment

MH		SUD				
Service	Not Covered	Provider	Code	Req'd Mod	Rate	
SUD Assessment		Licensed Practitioners and above (use CPT codes)				
		RN, LPN				\$77.22
		Licensed chemical dependency counselor II, III	H0001		U3	\$77.22
		Social worker trainee	H0001		U9	\$77.22
		MFT-T	H0001		UA	\$77.22
		CDC-A	H0001		U6	\$77.22
		Counselor trainee	H0001		U7	\$77.22
Unit Value						
Service Definition						
Admission Criteria						
Continuing Stay Criteria						
Discharge Criteria						
Service Exclusions						
Clinical Exclusions						
Required Components						
Staffing Requirements	M-BHPs, I-BHPs and BHPs may complete assessments. However, interpretation of the information must be within the assessor's scope of practice. Consultation with the interdisciplinary team is required whenever the assessor is outside of his or her scope of practice and expertise.					
Clinical Operations						
Service Accessibility						

Reporting and Billing Requirements	
Other Considerations	

Table 4-2: SUD Peer Recovery Support

MH		SUD			
Service		Provider Type	Code	Req'd Mod	ate
SUD-Peer Recovery Support - Individual	Non-Covered	Certified peer recovery specialist	H0038	HM	\$15.51
SUD-Peer Recovery Support - Group		Certified peer recovery specialist	H0038	HM	\$1.94 per client
Unit Value					
Service Definition	<p>The Peer Recovery Support (PRS) service provides community-based supports to individuals with or in recovery from a mental illness with individualized and recovery focused activities that promote recovery, self-determination, self-advocacy, well-being and independence through a relationship that supports a person’s ability to promote his or her own recovery. Peer recovery supporters use their own experiences with mental illness, to help individuals reach their recovery goals. Activities included must be intended to achieve the identified goals or objectives as set forth in the individual’s individualized care plan, which delineates specific goals that are flexibly tailored to the individual and attempt to utilize community and natural supports. The structured, scheduled activities provided by this service emphasize the opportunity for individuals to support each other in the restoration and expansion of the skills and strategies necessary to move forward in recovery.</p> <p>PRS services promote self-directed recovery by assisting an individual in:</p> <ul style="list-style-type: none"> ▪ Ongoing exploration of recovery needs ▪ Achieving personal independence as identified by the individual ▪ Encouraging hope ▪ Facilitating further development of daily living skills ▪ Developing and working toward achievement of personal recovery goals ▪ Modeling personal responsibility for recovery ▪ Teaching skills to effectively navigate to the health care delivery system to effectively and efficiently utilize services ▪ Providing group facilitation that addresses symptoms, behaviors, though processes, 				

	<p>etc., that assist an individual in eliminating barriers to seeking or maintaining recovery, employment, education, or housing</p> <ul style="list-style-type: none"> ▪ Assisting with accessing and developing natural support systems in the community ▪ Promoting coordination and linkage among similar providers ▪ Coordinating and/or assistance in crisis interventions and stabilization as needed ▪ Conducting outreach ▪ Attending and participating in treatment teams ▪ Assisting individuals in the development of empowerment skills through self-advocacy and stigma busting activities that encourage hope <p>Peer recovery support services will be provided in the natural environment of the person</p>
Admission Criteria	<ul style="list-style-type: none"> • The frequency and duration of PRS will be identified on the person-centered plan and must be supported by an identified need and recovery goal. PRS will not substitute or supplant natural supports. Emerging evidence indicates peer recovery support can be instrumental in an individual achieving identified recovery goals, and it can be individualized to meet the changing needs of the individual. For instance, an individual who has transitioned to the community from extended tenure in the psychiatric hospital may benefit from multiple hours of daily peer support until they are acclimated to life outside an institution. The frequency and duration of peer recovery support encounters is anticipated to decline as the individual progresses in his or her recovery, builds natural supports and strengths, and is better able to navigate recovery in his or her community of choice.
Continuing Stay Criteria	<ul style="list-style-type: none"> • Determined by the person-centered plan developed by the individual and Recovery Manager.
Discharge Criteria	<ul style="list-style-type: none"> • 6 months to 1 year
Service Exclusions	<p>Peers should not be involved in managing medications and should not generally be expected to perform tasks that other team members are trained to do.</p> <p>Peer recovery supporters do <u>not</u> generally assist with activities of daily living (ADLs).</p>
Clinical Exclusions	<p>Individual must meet all SRS Program criteria including qualifying diagnosis as defined in Appendix XX</p>
Required Component	<p>Developing and working toward achievement of personal recovery goals</p> <ul style="list-style-type: none"> ▪ Modeling personal responsibility for recovery ▪ Teaching skills to effectively navigate to the health care delivery system to effectively and efficiently utilize services ▪ Providing group facilitation that addresses symptoms, behaviors, thought processes, etc., that assist an individual in eliminating barriers to seeking or maintaining recovery, employment, education, or housing ▪ Assisting with accessing and developing natural support systems in the community ▪ Promoting coordination and linkage among similar providers ▪ Coordinating and/or assistance in crisis interventions and stabilization as needed ▪ Conducting outreach ▪ Attending and participating in treatment teams

	<ul style="list-style-type: none"> ▪ Assisting individuals in the development of empowerment skills through self-advocacy and stigma busting activities that encourage hope <p>eer recovery support services will be provided in the natural environment of the person.</p> <ul style="list-style-type: none"> •
<p>Staffing Requirements</p>	<p>Peers should be supervised by other senior peers or non-peer staff that has been certified to supervise peers and receive regularly scheduled clinical supervision from a person meeting the qualifications of a mental health professional with experience regarding this specialized mental health service. Non-peer staff that wishes to supervise peers must complete the 16 hour OhioMHAS E-based Academy pre-course work for peer services. The peer support provider must receive regularly scheduled supervision from a competent behavioral health professional meeting the qualifications of either: a professional meeting the qualifications who meets the criteria for a "qualified behavioral health staff person" or a supervisor who is an individual working as a certified peer support provider for a minimum of five years, in which two years should have been as a credentialed peer advocate or its equivalent including specialized training and/or experience as a supervisor. The individual providing consultation, guidance, mentoring, and on-going training need not be employed by the same agency. Supervision of these activities may be delivered in person or by distance communication methods.</p> <p>It is the expectation that 1 hour of supervision will be delivered for every 40 hours of PRS duties performed. There may be an administrative supervisor who signs the family peer specialist's timesheet and is the primary contact on other related human resource management issues. Supervisors must also be aware of and sensitive to the cultural needs of the population of focus and how to best meet those needs, and be capable of training staff regarding these issues. The team must have training in the general training requirements required by ODM, including cultural competence and trauma informed care. Any practitioner providing behavioral health services must operate within an agency designated as a CMHC. The caseload size must be based on the needs of the clients/families with an emphasis on successful outcomes and individual satisfaction and must meet the needs identified in the individual treatment plan. PRS is available daily, limited to no more than four hours per day for an individual client. Progress notes document the individual's progress relative to goals identified in the person-centered plan PRS services are not a substitute for or adjunct to other HCBS or similar state plan service.</p> <p>Staff to client ratio</p> <ul style="list-style-type: none"> • Supervisor to peer recovery supporter: 1:5 • Peer recovery supporter caseload: 1:20 to 25 • The maximum group size for PRS is no more than 1:12 •
<p>Clinical Operations</p>	<ul style="list-style-type: none"> • The individual medical record must include documentation of services. • Provider is required to complete a progress note for every contact with individual as well as for related collateral contacts. • Progress notes must adhere to documentation requirements set forth in this manual.

Documentation Requirements	<ul style="list-style-type: none"> Providers must adhere to documentation requirements as defined in Administrative Code rules 5160-43-04 and 5160-43-05
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Table 4-3: Individual Counseling by Unlicensed Practitioner

MH		SUD				
Service	Not covered	Provider Type	Code	Req'd Mod	Crisis Mod	ate
Individual Counseling by Unlicensed Practitioner		RN, LPN	H0004		UT	\$19.31
		Licensed chemical dependency counselor II, III	H0004	U3	UT	\$19.31
		Social worker trainee	H0004	U9	UT	\$19.31
		MFT-T	H0004	UA	UT	\$19.31
		Chemical dependency counselor assistant	H0004	U6	UT	\$19.31
		Counselor trainee	H0004	U7	UT	\$19.31
Service Definition	<p>Techniques employed involve the principles, methods and procedures of counseling that assist the individual in identifying and resolving personal, social, vocational, intrapersonal and interpersonal concerns. Services are directed toward achievement of specific goals defined by the individual, family parent(s)/responsible caregiver(s) and specified in the individualized treatment plan. These services address goals/issues such as promoting resiliency, and the restoration, development, enhancement or maintenance of:</p> <ul style="list-style-type: none"> The illness/emotional disturbance and medication self-management knowledge and skills (e.g. symptom management, behavioral management, relapse prevention skills, knowledge of medications and side effects, and motivational/skill development in taking medication as prescribed); Problem solving and cognitive skills; Healthy coping mechanisms; Adaptive behaviors and skills; Interpersonal skills; Knowledge regarding the emotional disturbance, substance related disorders and other relevant topics that assist in meeting the individual's needs Best/evidence based practice modalities may include (as clinically appropriate): motivational interviewing/enhancement therapy, cognitive behavioral therapy, behavioral modification, behavioral management, rational behavioral therapy, dialectical behavioral therapy, interactive play therapy, and others as appropriate to the individual and clinical issues to be addressed 					
Admission Criteria	<ul style="list-style-type: none"> The individual must have a substance use disorder diagnosis. 					
Continuing Stay Criteria	<ul style="list-style-type: none"> Individual continues to meet admission criteria; and Individual demonstrates documented progress relative to goals identified in the treatment plan, but goals have not yet been achieved. 					
Discharge Criteria	<p>Adequate continuing care plan has been established; and one or more of the following:</p> <ul style="list-style-type: none"> Goals of the treatment plan have been substantially met; or Individual/family requests discharge and individual is not in imminent danger of harm to self or others; or Transfer to another service is warranted by change in individual's condition; or Individual requires a service approach which supports less or more intensive need. 					

Clinical Exclusions	<ul style="list-style-type: none"> Severity of behavioral health disturbance precludes provision of services. Severity of cognitive impairment precludes provision of services in this level of care. There is a lack of social support systems such that a more intensive level of service is needed. There is no outlook for improvement with this particular service ASAM criteria indicates a higher level of care is more appropriate.
Required Components	The treatment orientation, modality and goals must be specified and agreed upon by the individual/family/caregiver.
Clinical Operations	<ul style="list-style-type: none"> Practitioners and supervisors of those providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based counseling practices.
Reporting and Billing Requirements	8.9 HOURS PER WEEK FOR ALL 3. FIGURE OUT REFERENCE TO ASAM OUTPATIENT LEVELS

Table 4-4: Group Counseling by Unlicensed Practitioner

MH		SUD			
Service	Non-Covered	Provider Type	Code	Req'd Mod	ate
Group Counseling by Unlicensed Practitioner		Psychology assistant, intern, trainee	H0005	U1	\$6.44 per client
		Social worker trainee	H0005	U9	\$6.44 per client
		Marriage and family therapist trainee	H0005	UA	\$6.44 per client
		Chemical dependency counselor assistant	H0005	U6	\$6.44 per client
		Counselor trainee	H0005	U7	\$6.44 per client
Unit Value					
Service Definition	<p>Achievement of specific goals defined by the individual and specified in the individualized treatment plan. Services may address goals/issues such as promoting resiliency, and the restoration, development, enhancement or maintenance of:</p> <ul style="list-style-type: none"> Cognitive skills; Healthy coping mechanisms; Adaptive behaviors and skills; Interpersonal skills; Identifying and resolving personal, social, intrapersonal and interpersonal concerns 				
Admission Criteria	<ul style="list-style-type: none"> The individual must have a diagnosis of a substance disorder. 				
Continuing Stay Criteria	<ul style="list-style-type: none"> Individual continues to meet admission criteria; and Individual demonstrates documented progress relative to goals identified in the treatment plan, but goals have not yet been achieved. 				
Discharge Criteria	TIE TO ASAM LEVELS OF CARE				

Clinical Exclusions	<p>TIE TO ASAM LEVELS OF CARE</p> <ul style="list-style-type: none"> Severity of behavioral health issue precludes provision of services. Severity of cognitive impairment precludes provision of services in this level of care. There is a lack of social support systems such that a more intensive level of service is needed.
Required Components	The treatment orientation, modality and goals must be specified and agreed upon by the client.
Staffing Requirements	Maximum face-to-face ratio cannot be more than 12 individuals to 1 direct service staff.
Clinical Operations	<ul style="list-style-type: none"> Practitioners and supervisors of those providing this service are expected to maintain knowledge and skills regarding group practice such as selecting appropriate participants for a particular group, working with the group to establish necessary group norms and goals, and understanding and managing group dynamics and processes.
Reporting and Billing Requirements	8.9 HOURS PER WEEK FOR ALL 3. FIGURE OUT REFERENCE TO ASAM OUTPATIENT LEVELS

Table 4-5: SUD Case Management

MH		SUD			
Service		Provider	Code	Req'd Mod	Rate
SUD Targeted Case Management	Not covered	MD,DO			\$19.54
		Certified nurse specialist			\$19.54
		Certified nurse practitioner			\$19.54
		Physician assistant			\$19.54
		LCDC-II	H0006	U3	\$19.54
		LCDC-III	H0006	U3	\$19.54
		Social worker trainee	H0006	U9	\$19.54
		Marriage and family therapist trainee	H0006	UA	\$19.54
		Chemical dependency counselor assistant	H0006	U6	\$19.54
		Counselor trainee	H0006	U7	\$19.54
		Care Management Spec.	H0006	US	\$19.54
		QMHS - high school	H0006	HM	\$19.54
		QMHS - Associates	H0006	HM	\$19.54
		QMHS - Bachelors	H0006	HN	\$19.54
QMHS - Masters	H0006	HO	\$19.54		
Unit Value					

<p>Service Definition</p>	<p>Face-to-Face or telephone calls to assist individuals, eligible under the State plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services. Case management may include contacts with non-eligible individuals that are directly related to the identification of the eligible individual's needs and care, for the purposes of helping the eligible individual access services, identifying needs and supports to assist the eligible individual in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.</p> <p>The assistance that case managers provide in assisting eligible individuals obtain services includes—</p> <p>(1) Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services. These assessment activities include the following:</p> <ul style="list-style-type: none"> (i) Taking client history. (ii) Identifying the needs of the individual, and completing related documentation. (iii) Gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary) to form a complete assessment of the eligible individual. <p>(2) Development (and periodic revision) of a specific care plan based on the information collected through the assessment, that includes the following:</p> <ul style="list-style-type: none"> (i) Specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual. (ii) Includes activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals. (iii) Identifies a course of action to respond to the assessed needs of the eligible individual. <p>(3) Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services, including activities that help link the individual with medical, social, and educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.</p> <p>(4) Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to help determine whether the following conditions are met:</p> <ul style="list-style-type: none"> (i) Services are being furnished in accordance with the individual's care plan. (ii) Services in the care plan are adequate. (iii) There are changes in the needs or status of the eligible individual. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.
<p>Admission Criteria</p>	
<p>Continuing Stay Criteria</p>	
<p>Discharge Criteria</p>	
<p>Service Exclusions</p>	<p>Case management does not include services when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred.</p> <p>Services provided during transportation are not covered. Client transportation can be arranged through county Non-Emergency Medical Transportation (NEMT).</p>
<p>Clinical Exclusions</p>	

Required Components	
Staffing Requirements	
Clinical Operations	
Service Accessibility	
Reporting and Billing Requirements	<p>Providers to maintain case records that document for all individuals receiving case management as follows:</p> <ul style="list-style-type: none"> (i) The name of the individual. (ii) The dates of the case management services. (iii) The name of the provider agency (if relevant) and the person providing the case management service. (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved. (v) Whether the individual has declined services in the care plan. (vi) The need for, and occurrences of, coordination with other case managers. (vii) A timeline for obtaining needed services. (viii) A timeline for reevaluation of the plan
Other Considerations	<p>Case management may not be used to restrict an individual's access to other services. Individuals are not compelled to receive case management services, condition receipt of case management (services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services.</p>

Table 4-6: SUD Drug Testing

MH		SUD			
Service		Provider	Code	Req'd Mod	Rate
SUD Drug Testing- Collection, handling and reading	Not covered	MD,DO	H0048		\$11.48
		Certified nurse specialist Certified nurse practitioner Physician assistant	H0048		\$11.48
		RN, LPN	H0048		\$11.48
		Psychologist	H0048		\$11.48
		Licensed independents	H0048		\$11.48
		Board licensed school psychologist	H0048	UB	\$11.48
		Licensed professional counselor	H0048	U2	\$11.48
		Licensed social worker	H0048	U4	\$11.48
		Licensed marriage and family therapist	H0048	U5	\$11.48
		Licensed chemical dependency counselor II, III	H0048	U3	\$11.48

		Psychology assistant, intern, trainee	H0048	U1	\$11.48
		Social worker trainee	H0048	U8	\$11.48
		Marriage and family therapist trainee	H0048	UA	\$11.48
		Chemical dependency counselor assistant	H0048	U6	\$11.48
		Counselor trainee	H0048	U7	\$11.48
Unit Value					
Service Definition					
Admission Criteria					
Continuing Stay Criteria					
Discharge Criteria					
Service Exclusions					
Clinical Exclusions					
Required Components					
Staffing Requirements					
Clinical Operations					
Service Accessibility					
Reporting and Billing Requirements					
Other Considerations					

ASAM Level 1: Outpatient Services

Outpatient Level 1 services are professionally directed assessment, diagnosis, treatment, and recovery services provided in an organized outpatient treatment setting. Outpatient services are organized activities which may be delivered at an OhioMHAS certified SUD outpatient program or in the natural environment of the person. All outpatient SUD programs are certified under State law.

These services include, but are not limited to individual, group, family counseling including psycho-education on recovery, and wellness. These programs offer comprehensive, coordinated, and defined services that may vary in level of intensity but are fewer than nine contact hours per week for adults (age 18 and older) or fewer than six contact hours per week for adolescents (age 13 - 18). The ASAM criteria are used to determine appropriate medical necessity and level of care (LOC).

Admission Guidelines for ASAM Level 1

1. Acute intoxication and/or withdrawal potential: No signs or symptoms of withdrawal, or individual's withdrawal can be safely managed in an outpatient setting.
2. Biomedical conditions and complications: None or very stable or receiving medical monitoring.
3. Emotional, behavioral, or cognitive conditions and complications: None or stable or receiving concurrent mental health monitoring. May have a co-occurring diagnosis.
4. Readiness to change: Participant should be open to recovery or be willing to explore his/her substance use in order to avoid a negative consequence as in mandated treatment. The individual requires monitoring and motivating strategies to engage in treatment and to progress through the stages of change but not be in need of a structured milieu program.
5. Relapse, continued use, or continued problem potential: Participant is able to achieve abstinence, controlled use and/or addictive behaviors, and related recovery goals with minimal support or willing to explore abstinence and related goals, with support and scheduled therapeutic contact to assist with issues that include, but not limited to ambivalence about preoccupation of alcohol use or other drug use, cravings, peer pressure, and lifestyle, and attitude changes.
6. Recovery environment: Environment is sufficiently supportive that outpatient treatment is feasible, or the individual does not have an adequate, primary, or social support system but has demonstrated motivation and willingness to obtain such a support system.

Screening/Assessment/Treatment Plan Review

1. For individuals new to the program, a comprehensive bio-psychosocial assessment per Ohio Administrative Code (OAC) 3793:2-1-08 (K) completed within 72 hours of admission which substantiates appropriate patient placement. Assessment must be reviewed and signed by the M-BHP, I-BHP or BHP completing or reviewing the assessment. This typically occurs with a diagnostic assessment to confirm the SUD diagnosis and determine the appropriate LOC and a comprehensive bio-psychosocial assessment to inform the treatment plan and on-going care.
2. Physical examination by a M-BHP within 90 days of admission or documentation of good faith effort in referring the client for a physical and/or efforts made to obtain documentation of a physical.
3. An individualized interdisciplinary treatment plan (ITP) per OAC 3793:2-1-06 (L), completed within 7 days of the assessment or at the time of the first face-to-face contact following assessment. This plan shall be developed in collaboration with the person.
4. ITPs shall be reviewed/updated in collaboration with the individual as needed based on changes in functioning.
5. Discharge/transfer planning begins at admission.
6. Referral and assistance as needed for the person to gain access to other needed Medicaid covered SUD or mental health services.

Staffing

1. Level 1 outpatient services may be provided by an array of M-BHPs, I-BHPs, BHPs and/or BHP-Ps operating within their respective scope of practice.
2. Caseload size is based on needs of individuals actively engaged in services to ensure effective, individualized treatment, and rehabilitation. *Active* is defined as being seen for services at least once every 90 days.
3. Counseling groups should not exceed 12 individuals per counselor.
4. Peers may provide group services and/or meet with clients 1:1, but must bill peer support unless also meeting certification criteria to be a M-BHP, an I-BHP or a BHP and providing clinical services.

ASAM Level 1: Opioid Treatment Services: Opioid Treatment Programs (OTPs) and Medically Managed Opioid Treatment (MMOT)

OTPs are federally regulated programs that include direct administration of daily medication (opioid agonists: methadone or buprenorphine based medications) as well as a highly structured psychosocial program that addresses major lifestyle, attitudinal, and behavioral issues that could undermine recovery-oriented goals. The participant does not have a prescription for the methadone or buprenorphine based medication, but receives daily medication from the OTP. OTPs must conform to the federal opioid treatment standards set forth under 42 C.F.R. 8.12 in order to provide Methadone or Buprenorphine based medications for opioid maintenance and detoxification. These regulations require that OTPs provide medical, counseling, drug abuse testing, and other services to patients admitted to treatment. To offer buprenorphine based medications, OTPs need to modify their registration with the DEA to add Schedule III narcotics to their registration certificates.

MMOT takes place at an OhioMHAS certified outpatient or residential treatment program or in the natural environment of a person where the prescribing physician may practice. The physician prescribes buprenorphine based medication(s) (which requires certification and a waiver) and/or injectable naltrexone (an opioid antagonist). Participants fill their prescription at a retail outpatient or specialty pharmacy. Additional psychosocial and behavioral services are provided by the OhioMHAS certified outpatient or residential treatment program the physician is associated with or working for.

OTPs and MMOTs will be able to submit a claim for either a daily administration or a weekly administration for Methadone and Buprenorphine-Under Development

Admission Guidelines for ASAM Level 1 (Opioid Treatment Services)

1. Acute intoxication and/or withdrawal potential: Physically addicted to opioids.
2. Biomedical conditions and complications: Meets biomedical criteria for opioid use disorder and may have concurrent biomedical illness that can be treated on outpatient basis.
3. Emotional, behavioral, or cognitive conditions and complications: None or stable or receiving concurrent mental health monitoring and/or treatment.
4. Readiness to change: Participant requires structured therapeutic and pharmacotherapy program to promote treatment progress and recovery.

5. Relapse, continued use, or continued problem potential: High risk of relapse or continued use without opioid pharmacotherapy, close outpatient monitoring and structured support.
6. Recovery environment: Environment is sufficiently supportive that outpatient treatment is feasible, or the individual does not have an adequate, primary, or social support system but has demonstrated motivation and willingness to obtain such a support system.

Screening/Assessment/Treatment Plan Review

1. For individuals new to the program, a comprehensive bio-psychosocial assessment per OAC 3793:2-1-08 (K) must be completed within 72 hours of admission which substantiates appropriate patient placement. The assessment must be reviewed and signed by the M-BHP, I-BHP or BHP completing the assessment.
2. Physical examination (applies to OTP only; not applicable to MMOT). Per 42 CFR Part 8, a fully documented physical evaluation by a program physician or a primary care physician, or an authorized healthcare professional (e.g., APRN or physician assistant licensed to provide physical exams under their scope of practice as defined under Ohio law) under the supervision of a program physician is completed prior to admission. The full medical examination, including the results of serology and other tests, must be completed within 14 days following admission to an OTP.
3. An individualized, interdisciplinary treatment plan is completed within 7 days of the assessment or at the time of the first face-to-face contact following assessment. The plan must be patient-centered and developed in collaboration with the patient and include an appropriate regimen of methadone or buprenorphine based medication at a dose established by a physician or licensed supervisee. The medication regime must be reviewed and modified as the participant becomes stable and throughout treatment.
4. Treatment plan reviewed/updated in collaboration with the individual as needed based on changes in functioning, or at a minimum of every 90 days.
5. Discharge/transfer planning begins at admission.
6. Referral and assistance as needed for the person to gain access to other needed Medicaid SUD or mental health services.

Staffing

Level 1 (opioid treatment services) outpatient services are provided by an array of M-BHPs, I-BHPs, BHPs and BHP-Ps operating within their scope of practice.

OTP

1. OTPs must conform to the federal opioid treatment standards set forth under 42 C.F.R. 8.12. OTPs are allowed to develop staffing models with these regulations in mind and must have an adequate number of physicians, nurses, counselors, and other staff for the level of care provided and the number of patients enrolled in the program. Programs should determine staffing patterns by taking into account the characteristics and needs of particular patient populations. Likewise, patient-to-staff ratios should be sufficient to ensure that patients have reasonable and prompt access to counselors and receive counseling services at the required levels of frequency and intensity.
2. OTPs must have a designated medical director available on site or for consultation at all times the facility is open.

Table 4-17: Methadone

MH		SUD			
Service		Provider	Code	Req'd. Mod	Rate
Methadone	Not Covered	OHMAS certified methadone clinic	H0020		\$16.38
Unit Value	Per diem				
Service Definition	<p>An organized, usually ambulatory, addiction treatment service for opiate-addicted individuals. The nature of the services provided (such as dosage, level of care, length of service or frequency of visits) is determined by the individual's clinical needs, but such services always includes scheduled psychosocial treatment sessions and medication visits (often occurring on a daily basis) within a structured program. Services function under a defined set of policies and procedures, including admission, discharge and continued service criteria stipulated by state law and regulation and the federal regulations at FDA 21 CFR Part 291. Length of service varies with the severity of the individual's illness, as well as his or her response to and desire to continue treatment. Treatment with methadone is designed to address the individual's goal to achieve changes in his or her level of functioning, including elimination of illicit opiate and other alcohol or drug use. To accomplish such change, the individualized treatment plan must address major lifestyle, attitudinal and behavioral issues that have the potential to undermine the goals of recovery. The individualized treatment plan should also include individualized treatment, resource coordination, and personal health education specific to addiction recovery (including education about human immunodeficiency virus, tuberculosis and sexually transmitted diseases).</p>				
Admission Criteria	<ul style="list-style-type: none"> ○ Must be approved by the Ohio Medical Board to prescribe and dispense methadone and be an OhioMHAS certified methadone administration clinic. ○ By physician prescription only. ○ Must meet criteria established by the Ohio Pharmacy Board for dispensing and the Food and Drug Administration's guidelines for this service. 				
Continuing Stay Criteria					
Discharge Criteria					
Required Components	<p>Must meet and follow criteria established by the Ohio regulatory body for opioid administration programs (Department of Community Health, Healthcare Facilities Regulation Division) and the Food and Drug Administration's guidelines for this service.</p>				
Reporting and Billing Requirements					
Other Considerations					

MMOT

MMOT programs must have a registered controlled substances prescriber with a waiver of the 1914 Harrison Act. Per federal regulations, the physician may not have a caseload exceeding 30 patients at any given point in time in the first year after receiving a waiver. In subsequent years, caseloads may not exceed 100 patients at any given point in time.

ASAM Level 2.1 Intensive Outpatient Treatment

Patients at the IOP level of care are eligible for all outpatient services. For group counseling, use H0015 in place of H0005. For all other outpatient services associated with the IOP level of care, please see the Outpatient section for coverage and billing guidance.

1. Intensive outpatient treatment is professionally directed assessment, diagnosis, treatment, and recovery services provided in an organized, non-residential treatment setting. Intensive outpatient services are organized activities which may be delivered in any appropriate community setting that meets state licensure. All outpatient SUD programs are regulated by OhioMHAS.
2. Services include, but are not limited to individual, group, and family counseling including psycho-education on recovery. Intensive outpatient program services should include evidence-informed practices, such as cognitive behavioral therapy (CBT), motivational interviewing, and multidimensional family therapy. Services also include monitoring of medication use and orientation and referral to community-based support groups. Timely access to additional support systems and services, including medical, psychological, and toxicology services, are available through consultation or referral.
3. These programs offer comprehensive, coordinated, and defined services that may vary in level of intensity but must be nine or more contact hours per week for adults, age 18 years and older, with a minimum of contact three days per week (not to exceed 20 hours per week) or must be six or more contact hours per week for adolescents age 13 - 18 years, with a minimum of contact three days per week (not to exceed 20 hours per week). This level consists of a scheduled series of face-to-face sessions appropriate to the individual's treatment plan. These programs may be provided for persons at risk of being admitted to more intensive LOCs, such as residential, inpatient, or withdrawal management, or for continuing care for those who require a step-down following a more intensive LOC and require support to avoid relapse. ASAM criteria are used to determine LOC.

Admission Guidelines ASAM Level 2.1

1. Acute intoxication and/or withdrawal potential: No signs or symptoms of withdrawal, or individual's withdrawal can be safely managed in an intensive outpatient setting.
2. Biomedical conditions and complications: None, or sufficiently stable to permit participation in outpatient treatment.
3. Emotional, behavioral, or cognitive conditions and complications: None to moderate. If present, client must be admitted to either a co-occurring disorder capable or co-occurring disorder enhanced program, depending on the client's level of function, stability, and degree of impairment. **Note:** As noted in the ASAM admission criteria, a Level 2.1 facility may be considered as co-occurring capable or enhanced when the facility has dual certification from OhioMHAS.

4. Readiness to change: Participant requires structured therapy and a programmatic milieu to promote treatment progress and recovery because motivational interventions at another LOC have failed. Alternatively, the participant's perspective and lack of impulse control inhibit his or her ability to make behavioral changes without repeated, structured, and clinically directed motivational interventions. Such interventions are not feasible or are not likely to succeed in a Level 1 program. However, the client's willingness to participate in treatment and to explore his or her level of awareness and readiness to change suggest the treatment at Level 2.1 can be effective.
5. Relapse, continued use, or continued problem potential: Participant is experiencing an intensification of symptoms related to substance use, and their level of functioning is deteriorating despite modification of the treatment plan. Alternatively, there is a high likelihood of relapse or continued use or continued problems without close monitoring and support several times a week, as indicated by his or her lack of awareness of relapse triggers, difficulty in coping, or in postponing immediate gratification, or ambivalence toward treatment.
6. Recovery environment: Insufficiently supportive environment and participant lacks the resources or skills necessary to maintain an adequate level of functioning without services in intensive outpatient treatment. Alternatively, the client lacks social contacts, has unsupportive social contacts that jeopardize recovery, or has few friends or peers who do not use alcohol or other drugs.

Screening/Assessment/Treatment Plan Review

1. For individuals new to the program, a comprehensive bio-psychosocial assessment per Ohio Administrative Code (OAC) 3793:2-1-08 (K) completed within 72 hours of admission which substantiates appropriate patient placement. Assessment must be reviewed and signed by the M-BHP, I-BHP or BHP completing or reviewing the assessment. This typically occurs with a diagnostic assessment to confirm the SUD diagnosis and determine the appropriate LOC and a comprehensive bio-psychosocial assessment to inform the treatment plan and on-going care.
2. Physical examination by a qualified medical professional within a reasonable time, as determined by the client's medical condition not to exceed within 90 days prior to admission or documentation of good faith effort in referring the client for a physical and/or efforts made to obtain documentation of a physical.
3. An ITP is completed within 7 days of the assessment or at the time of the first face-to-face contact following assessment. The plan must be patient-centered and developed in collaboration with the patient.
4. ITPs are reviewed/updated in collaboration with the individual as needed based on changes in functioning, or at a minimum of every 30 days.
5. Discharge/transfer planning begins at admission.
6. Referral and assistance as needed for the person to gain access to other needed Medicaid SUD or mental health services.

Staffing

1. Level 2.1 IOP services may be provided by an array of M-BHPs, I-BHPs, BHPs and/or BHP-Ps operating within their respective scope of practice.

2. Caseload size is based on needs of individuals actively engaged in services to ensure effective, individualized treatment, and rehabilitation. *Active* is defined as being seen for services at least once every 90 days.
3. Counseling groups should not exceed 12 individuals per counselor.
4. Peers may provide group services and/or meet with clients 1:1, but must bill peer support unless also meeting certification criteria to be an M-BHP, an I-BHP or a BHP and providing clinical service

Table 4-7: Intensive Outpatient Group Counseling

MH		SUD			
Service		Provider Type	Code	Req'd Mod	Rate
Intensive Outpatient Group Counseling	Not covered	Psychologist	H0015	HK	\$149.88
		Licensed independents	H0015	HK	\$149.88
		Psychologist	H0015	HK	\$149.88
		Board licensed school psychologist	H0015	HK	\$149.88
		Licensed professional counselor	H0015	HK	\$149.88
		Licensed social worker	H0015	HK	\$149.88
		Licensed marriage and family therapist	H0015	HK	\$149.88
		Licensed chemical dependency counselor II, III	H0015	HK	\$149.88
		Psychology assistant, intern, trainee	H0015	U1	\$103.04
		Social worker trainee	H0015	U9	\$103.04
		Marriage and family therapist trainee	H0015	UA	\$103.04
		Chemical dependency counselor assistant	H0015	U6	\$103.04
		Counselor trainee	H0015	U7	\$103.04
Unit Value	Per Diem – Service must be a Minimum length of 2 hours and 1 minute				

ASAM Level 2.5 Partial Hospitalization Services (PH)

Patients at the IOP level of care are eligible for all outpatient services. For group counselling, use H0015 in place of H0005. For all other outpatient services associated with the IOP level of care, please see the Outpatient section for coverage and billing guidance.

PHP generally provides 20 or more hours of clinically intensive programming per week based on individual treatment plans. Programs have ready access to psychiatric, medical, and laboratory services. Intensive services at this LOC provide comprehensive bio-psychosocial assessments and individualized treatment, and allow for a valid assessment of dependency. This LOC also provides for frequent monitoring/management of the client's medical and emotional concerns in order to avoid hospitalization. These conditions will lead to generalization of what was learned in treatment in the client's natural environment. **Note:** The only distinction between IOP and PHP programs are the service intensity required by the client.

These services include, but are not limited to individual, group, family counseling, and psycho-education on recovery, as well as monitoring of medication use, medication management, medical, and psychiatric examinations, crisis intervention, and orientation to community-based support groups. Partial hospitalization services should include evidence-informed practices, such as CBT, motivational interviewing, and multidimensional family therapy.

These programs offer comprehensive, coordinated and defined services that may vary in level of intensity but must be a minimum of 20 contact hours per week for adults and adolescents, at a minimum of three days per week. This level consists of a scheduled series of face-to-face sessions appropriate to the individual's treatment plan. These programs may be provided for persons at risk of being admitted to more intensive LOCs, such as residential, inpatient or withdrawal management, or for continuing care for those who require a step-down following a more intensive LOC and require support to avoid relapse. ASAM criteria are used to determine LOC.

Admission Guidelines ASAM Level 2.5

1. Acute intoxication and/or withdrawal potential: No signs or symptoms of withdrawal, or individual's withdrawal can be safely managed in a partial hospital setting.
2. Biomedical conditions and complications: None, or not sufficient to interfere with treatment, but are severe enough to distract from recovery efforts and require medical monitoring and/or medical management.
3. Emotional, behavioral, or cognitive conditions and complications: None to moderate. If present, client must be admitted to either a co-occurring disorder capable or co-occurring disorder enhanced program, depending on the client's level of function, stability, and degree of impairment.
4. Readiness to change: Participant requires structured therapy and a programmatic milieu to promote treatment progress and recovery at an intensive level. Such interventions are not feasible or are not likely to succeed in a Level 2.1 program. Alternatively, the client's perspective and lack of impulse control inhibit his or her ability to make behavioral changes without repeated, structured, and clinically directed motivational interventions. Such interventions are not feasible or are not likely to succeed in a Level 1 or Level 2.1 program. However, the client's willingness to participate in treatment and to explore his or her level of awareness and readiness to change suggest the treatment at Level 2.5 can be effective.
5. Relapse, continued use, or continued problem potential: Participant is experiencing an intensification of symptoms related to substance use, and their level of functioning is deteriorating despite

modification of the treatment plan and active participation in a Level 1 or Level 2.1 program. Alternatively, there is a high likelihood of relapse or continued use or continued problems without near-daily support and monitoring, as indicated by his or her lack of awareness of relapse triggers, difficulty in coping, or in postponing immediate gratification or ambivalence toward treatment.

6. Recovery environment: Insufficiently supportive environment and participant lacks the resources or skills necessary to maintain an adequate level of functioning without services in a partial hospitalization program. Alternatively, family members and/or significant others who live with the client are not supportive of his or her recovery goals, or are passively opposed to his or her treatment. The client requires the intermittent structure of Level 2.5 treatment services and relief from the home environment in order to remain focused on recovery, but may live at home because there is not active opposition to, or sabotaging of, his or her recovery efforts.

Screening/Assessment/Treatment Plan Review

1. For individuals new to the program, a comprehensive bio-psychosocial assessment per Ohio Administrative Code (OAC) 3793:2-1-08 (K) completed within 72 hours of admission which substantiates appropriate patient placement. Assessment must be reviewed and signed by the M-BHP, I-BHP or BHP completing or reviewing the assessment. This typically occurs with a diagnostic assessment to confirm the SUD diagnosis and determine the appropriate LOC and a comprehensive bio-psychosocial assessment to inform the treatment plan and on-going care.
2. A physical exam should occur in a 90 day window surrounding an admission to treatment. This may be achieved through an onsite physical or the provider ensures transportation for the member to a M-BMP or personal PCP to complete the physical, or the inclusion of documentation that the physical occurred prior to admission, but within the 90 day window. The physical should be updated if the member has experienced a change in health status since the last physical.
3. An individualized interdisciplinary treatment plan (ITP) per OAC 3793:2-1-06 (L), completed within 7 days of the assessment or at the time of the first face-to-face contact following assessment. This plan shall be developed in collaboration with the person.
4. ITPs shall be reviewed/updated in collaboration with the individual as needed based on changes in functioning.
5. Discharge/transfer planning begins at admission.
6. Referral and assistance as needed for the person to gain access to other needed Medicaid SUD or mental health services.

Staffing

Refer to section <x.x>

1. Level 2.5 PHP services may be provided by an array of M-BHPs, I-BHPs, BHPs and/or BHP-Ps operating within their respective scope of practice.
2. Caseload size is based on needs of individuals actively engaged in services to ensure effective, individualized treatment, and rehabilitation. *Active* is defined as being seen for services at least once every 90 days.
3. Counseling groups should not exceed 12 individuals per counselor.

- Peers may provide group services and/or meet with clients 1:1, but must bill peer support unless also meeting certification criteria to be a M-BHP, an I-BHP or a BHP and providing clinical services.

Table 4-8: Partial Hospitalization Group Counseling

MH		SUD				
Service		Provider Type	Code	ASAM 2,1 Req'd Mod	ASAM 2.5 Req'd Mod(s)	Rate
Partial Hospitalization Group Counseling	Not covered	Psychologist	H0015	HK	HK, TG	\$224.82
		Licensed independents	H0015	HK	HK, TG	\$224.82
		Psychologist	H0015	HK	HK, TG	\$224.82
		Board licensed school psychologist	H0015	HK	HK, TG	\$224.82
		Licensed professional counselor	H0015	HK	HK, TG	\$224.82
		Licensed social worker	H0015	HK	HK, TG	\$224.82
		Licensed marriage and family therapist	H0015	HK	HK, TG	\$224.82
		Licensed chemical dependency counselor II, III	H0015	HK	HK, TG	\$224.82
		Psychology assistant, intern, trainee	H0015	U1	U1, TG	\$154.56
		Social worker trainee	H0015	U\$	U4, TG	\$154.56
		Marriage and family therapist trainee	H0015	U5	U5, TG	\$154.56
		Chemical dependency counselor assistant	H0015	U6	U6, TG	\$154.56
		Counselor trainee	H0015	U7	U7, TG	\$154.56
Unit Value		Per Diem – Minimum of 3 hours and 1 minute				

ASAM Level 2-WM Ambulatory Withdrawal Management with Extended Onsite Monitoring

Level 2-WM is an organized outpatient service, which may be delivered at an OhioMHAS

certified outpatient or residential treatment program by trained clinicians, who provide medically supervised evaluation, withdrawal management, and referral services. Appointments for services are regularly scheduled. These services are designed to treat the individual's level of clinical severity to achieve safe and comfortable withdrawal from mood-altering chemicals and to effectively facilitate the individual's entry into ongoing treatment and recovery. Withdrawal management is conducted on an outpatient basis. It is important for medical and nursing personnel to be readily available to evaluate and confirm that withdrawal management in the less supervised setting is relatively safe. Counseling services may be available through the withdrawal management program or may be accessed through affiliation with entities providing outpatient services.

Additionally, this LOC can include up to 23 hours of continuous observation, monitoring, and support in a supervised environment for an individual to achieve initial recovery from the effects of alcohol and/or other drugs and to be appropriately transitioned to the most appropriate LOC to continue the recovery process. These 23-hour programs are referred to as Level 2-WM (23 hour) in this manual. Because these programs operate 24/7 and the client must be discharged within 23 hours of admission, program expectations differ from other ambulatory withdrawal management with extended onsite monitoring programs (i.e., Level 2-WM (23 hour) has different requirements than Level 2-WM). For individuals in need of greater than 23 hours, Level 3.2-WM, Clinically Managed Residential Withdrawal Management or Level 3.7-WM, Medically Monitored Inpatient Withdrawal Management should be used depending on the severity of the individual's withdrawal syndrome.

If the individual is admitted to detoxification and remains for less than 4 hours, the provider would solely bill Level 2-WM codes. The service would not be considered Level 2-WM (23 hour) and the provider would use H0014 code for services rendered. Level 2-WM indicates up to "several hours of monitoring, medication, and treatment".

Ohio will consider detoxification services up to 4 hours to be Level 2-WM and activities performed "upon admission" to a Level 2-WM setting are required to be consistent with this Manual and should be completed within this 4 hour timeframe. This would include:

1. Urine drug screens are required upon admission and as directed by the treatment plan and are considered covered under the rates paid to the provider.
2. Nursing assessment and behavioral health assessment at time of admission that is reviewed by a physician to determine need for withdrawal management, eligibility, and appropriateness (proper patient placement) for admission and referral.
3. Discharge/transfer planning begins at admission. An initial discharge plan is developed at time of admission, while a comprehensive discharge plan is complete at discharge.
4. If the individual is discharged to the typical IOP LOC for induction/detoxification (Level 2-WM) within 4 hours, the H0014 code would be billed for the assessment and discharge planning activities noted in numbers 1 through 3 above.

The program would then proceed with assessment/treatment planning/billing process/etc. per this manual when the member begins services in the IOP. If the member remains at the Level 2-WM (23 hour) setting MORE THAN 4 HOURS BUT LESS THAN 24 HOURS, the per diem code

(H0012) is used instead of the H0014 code. H0012 is a program per diem payment, therefore no other service is paid on the same day. The Level 2-WM (23 hour) program would ensure that all required assessment/treatment planning/billing process/etc. occurs per this Manual.

If the individual remains in the facility greater than 24 hours, then it is a residential detoxification bed and the H0014 and H0012 codes would not be billed at all. Instead, the residential per diem would be billed. It would be expected that the individual would meet medical necessity for this level of care and is anticipated to remain in the residential detoxification setting for longer than 36 hours even if the individual does not remain that long.

1. The residential detoxification program would begin billing the per diem code upon admission to the facility. No outpatient H0014 or H0012 codes would be permitted.
2. The facility may not bill using the H0014 or H0012 codes within 24 hours of admission to a residential detoxification level of care.
3. The residential detoxification program would begin billing the per diem upon admission; it cannot begin billing the per diem on the same day the H0012 code was billed (i.e., only 1 per diem in a 24-hour period).

Admission Guidelines

Level 2-WM (up to 4 hours)

Participant is experiencing signs and symptoms of withdrawal, or there is evidence (based on history of substance intake; age; gender; previous withdrawal history; present symptoms; physical condition; and/or emotional, behavioral, or cognitive condition) that withdrawal is imminent. The participant is assessed as being at moderate risk of severe withdrawal syndrome outside the program setting; is free of severe physical and psychiatric complications; and would safely respond to several hours of monitoring, medication, and treatment.

Level 2-WM (more than 4 but less than 24 hours)

Participant is experiencing signs and symptoms of withdrawal, or there is evidence (based on history of substance intake; age; gender; previous withdrawal history; present symptoms; physical condition; and/or emotional, behavioral, or cognitive condition) that withdrawal is imminent, but the severity of the withdrawal is unknown and the participant would benefit from extended observation and monitoring by clinical and medical staff in order to determine the most appropriate LOC (e.g., the presence of co-occurring physical and/or psychiatric conditions or combinations of classes of substances that increase risk of severe withdrawal and physical symptoms).

Screening/Assessment/Treatment Plan Review

Level 2-WM (up to 4 hours)

1. Urine drug screens are required upon admission and as directed by the treatment plan and are considered covered under the rates paid to the provider.
2. Nursing assessment and behavioral health assessment at time of admission that is reviewed by a physician to determine need for withdrawal management, eligibility, and appropriateness (proper patient placement) for admission and referral.
3. A medical care plan within 24 hours of admission based on the findings of a physical examination (completed prior to admission or on site by medical/nursing staff), including a

brief screening to identify motivation for treatment, relapse potential, and recovery environment at discharge. The medical plan shall be reviewed by a physician and shall be filed in the individual's record and updated as needed.

4. Initial treatment plan within 24 hours of admission and comprehensive treatment plan within seven days of admission.
5. Updates to treatment plan every seven days.
6. Ambulatory withdrawal management should follow the Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Improvement Protocol (TIP) Series, No. 45. (TIP-45).
7. Buprenorphine/naloxone must be available for use with opiate withdrawal as preferred medications.
8. Discharge/transfer planning begins at admission. An initial discharge plan is developed at time of admission, while a comprehensive discharge plan is complete at discharge.
9. Referral and assistance as needed for the person to gain access to other needed Medicaid SUD or mental health services.
10. The program shall implement the withdrawal management/treatment plan and document the individual's response to and/or participation in scheduled activities. Notes shall include:
 - a. The individual's physical condition, including vital signs.
 - b. The individual's mood and behavior.
 - c. Statements about the individual's condition and needs.
 - d. Information about the individual's progress or lack of progress in relation to withdrawal management/treatment goals.
 - e. Additional notes shall be documented, as needed.
11. Physician orders *are* required for medical and psychiatric management.

Level 2-WM (more than 4 but less than 24 hours)

1. Urine drug screens are required upon admission and as directed by the treatment plan and are considered covered under the rates paid to the provider.
2. Nursing assessment and behavioral health assessment at time of admission that is reviewed by a physician to determine need for withdrawal management, eligibility, and appropriateness (proper patient placement) for admission and referral.
3. Initial treatment plan at admission.
4. Ambulatory withdrawal management should follow the Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Improvement Protocol (TIP) Series, No. 45. (TIP-45).
5. Buprenorphine/naloxone must be available for use with opiate withdrawal as preferred medications.
6. Discharge/transfer planning begins at admission. An initial discharge plan is developed at time of admission, while a comprehensive discharge plan is complete at discharge.
7. If the individual steps down to Level 2-WM, then all screening/assessment/treatment plan review for that ASAM level must be completed consistent with that LOC.
8. Referral and assistance as needed for the person to gain access to other needed Medicaid SUD or mental health services.

9. The program shall implement the withdrawal management/treatment plan and document the individual's response to and/or participation in scheduled activities. Notes shall include:
 - a. The individual's physical condition, including vital signs.
 - b. The individual's mood and behavior.
 - c. Statements about the individual's condition and needs.
 - d. Information about the individual's progress or lack of progress in relation to withdrawal management/treatment goals.
 - e. Additional notes shall be documented, as needed.
10. Physician orders *are* required for medical and psychiatric management.

Staffing

1. Level 2-WM (up to 4 hours) and Level 2-WM (more than 4 but less than 24 hours) facilities shall have qualified professional medical, nursing, counseling, and other support staff necessary to provide services appropriate to the bio-psychosocial needs of individuals being admitted to the program.
2. One FTE during clinic hours dedicated to performing referral arrangements for all individuals served by the facility. This FTE may be a I-BHP, a BHP or a BHP-P.

Level 2-WM (up to 4 hours)

1. An addiction-credentialed physician designated as medical director available on call at all times as allowed under law.
2. A designated prescriber available on site or for consultation at least 10 hours per week; a physician's assistant (PA), NP, or APRN, licensed as physician extenders, may perform duties designated by a physician within their scope of practice.
3. At least one nurse (NP, RN, or licensed practical nurse [LPN]) available on site at least 10 hours per week but at no time serve more than 15 patients.
4. M-BHPs, I-BHPs, or BHPs with direct supervision on site as professionally required; one clinician per 12 individuals.
5. One full-time certified peer.

Level 2-WM (more than 4 but less than 24 hours) Staffing

1. An addiction-credentialed physician designated as medical director available on call at all times as allowed under law. Programs unable to comply with this requirement for an addiction-credentialed physician may obtain, at the discretion of OhioMHAS, a time-limited waiver following the submission of a plan to ameliorate this deficiency.
2. A designated prescriber with on call availability 24/7 for consultation and in order to discharge participant to higher LOC if necessary. A PA, NP, or APRN, licensed as physician extenders, may perform duties designated by a physician within their scope of practice.
3. At least one nurse (NP, RN, or LPN) per 12 individuals on site at all times.
4. One BHP-P per 12 individuals on site during days and evenings.
5. One I-BHP or BHP per 12 individuals on site at all times.

Table 4-9: SUD-Ambulatory Detox – Program Rate

MH		SUD			
Service	Not covered	Provider Type	Code	Req'd Mod	Rate
SUD-Ambulatory Detox-Program Rate (ASAM 2WM)		RN	H0014		\$102.57
		LPN	H0014		\$74.81
		Agency	H0012		\$360.36
Unit Value	H0012 per diem H0014 hour				

ASAM Level 3.1 Clinically Managed Low-Intensity Residential Treatment (Halfway House)

Residential programs offer at least 10 hours per week of a combination of low-intensity clinical and recovery-focused services. These programs provide at least five hours a week of individual, group, family therapy, medication management, and psycho-education. All programs are regulated by OhioMHAS.

Treatment is directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility, and reintegrating the individual into the worlds of work, education, and family life. Services provided may include individual, group and family therapy, medication management, and medication education. Mutual/self-help meetings usually are available on site. Residential SUD programs are not recovery residences, sober houses, boarding houses, or group homes where treatment services are not provided on site to the residents as a condition of residence. ASAM criteria are used to determine this LOC.

Admission Guidelines

1. Acute intoxication and/or withdrawal potential: None, or minimal/stable withdrawal risk and can be safely managed in a Level 3.1 setting.
2. Biomedical conditions and complications: None or stable. If present, the participant must be receiving medical monitoring.
3. Emotional, behavioral, or cognitive conditions and complications: None or minimal. If present, conditions must be stable and not too distracting to the participant's recovery and must be concurrently addressed through appropriate psychiatric services.
4. Readiness to change: Participant should be open to recovery but in need of a structured, therapeutic environment to promote treatment progress and recovery due to impaired ability to make behavior changes without the support of a structured environment.
5. Relapse, continued use, or continued problem potential: Participant understands the risk of relapse but lacks relapse prevention skills or requires a structured environment to continue to apply recovery and coping skills.
6. Recovery environment. Participant is able to cope, for limited periods of time, outside of the 24-hour structure but the participant's environment jeopardizes recovery.

Screening/Assessment/Treatment Plan Review

1. A urine drug screen and a tuberculosis test are required within 72 hours of admission and as directed by the treatment plan and are considered covered under the rates paid to the provider.
2. A comprehensive bio-psychosocial assessment per Ohio Administrative Code (OAC) 3793:2-1-08 (K) completed within 72 hours of admission which substantiates appropriate patient placement. Assessment must be reviewed and signed by the M-BHP, I-BHP or BHP completing or reviewing the assessment. This typically occurs with a diagnostic assessment to confirm the SUD diagnosis and determine the appropriate LOC and a comprehensive bio-psychosocial assessment to inform the treatment plan and on-going care.
3. Physical examination performed within a reasonable time, as determined by the client's medical condition(s). **Note:** This may be performed by community medical providers not involved with direct services in ASAM 3.1 or by program staff qualified to perform general medicine.
4. Individualized, interdisciplinary treatment/treatment plan, consistent with Title 16 Ohio Administrative Code 3793:2-1-06 (L) and (N), which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. This plan should be developed in collaboration with the individual within 7 days of completion of the comprehensive bio-psychosocial assessment or at the time of the first face-to face contact following the assessment.

The treatment/treatment plan is reviewed in collaboration with the individual at least every 60 days and updated accordingly.

5. Discharge/transfer planning begins at admission.
6. Referral and assistance as needed for the person to gain access to other needed Medicaid SUD or mental health services.

Staffing

Staffing Requirements- ASAM 3.1	Staffing
Physician	0.06 Full Time Equivalent (FTE) (2.5 hours/week)
One independent Behavioral Health Practitioner or one Behavioral Health Practitioner (not an independent) with direct supervision per 16 residents onsite during the day	1 FTE
One independent Behavioral Health Practitioner or one Behavioral Health Practitioner on call when the professional is not onsite	0.13 FTE
One Behavioral Health Paraprofessional per 16 residents while residents are awake	2 FTE (1 day, 1 evening)
One FTE for referral arrangements per 35 residents	1 FTE
House Manager (1 FTE per shift)	3 FTE (1 day, 1 evening, 1 overnight)
Total FTEs per 16 beds where available	7.19 FTEs

Table 4-11: Clinically Managed Low-Intensity Residential Treatment

MH	SUD
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Service		Provider Type	Code	Req'd Mod	Rate
Clinically Managed Low-Intensity Residential Treatment (Halfway House) ASAM 3.1	Not covered	Agency	H2034		\$213.70
Unit Value	Per diem				

ASAM Level 3.2-WM Clinically Managed Residential Withdrawal Management

Residential programs provided in an organized, residential, non-medical setting delivered by an appropriately trained staff that provides safe, 24-hour medication monitoring observation and support in a supervised environment for a person served to achieve initial recovery from the effects of alcohol and/or other drugs. The program emphasis is on SUD services and supports, not medical and nursing care. All facilities are regulated by Ohio MHAS.

Withdrawal management is appropriate for individuals who are able to participate in the daily residential activities and is often used as a less intensive, non-medical alternative to inpatient withdrawal management. ASAM criteria are used to determine this LOC.

Admission Guidelines

Participant has been assessed as not requiring medication, but does require 24-hour monitoring to complete withdrawal and continue treatment and/or self-help recovery. Withdrawal signs and symptoms are not severe and do not require the full resources of an acute care general hospital or a medically supported program. Participant does require 24-hour monitoring because the participant's recovery environment cannot support withdrawal and recovery, or a recent history of withdrawal management at a lower LOC was unsuccessful due to environmental factors and/or lack of skill, including the continued use of substances.

Screening/Assessment/Treatment Plan Review

1. Urine drug screens are required upon admission and as directed by the treatment plan and are considered covered under the rates paid to the provider.
2. A comprehensive nursing assessment at admission, including an addiction-focused history, is provided to obtain a clear understanding of the individual's present health (physical and behavioral) status. If self-administered withdrawal management medications are to be used, a physical examination by a physician, physician assistant, or nurse practitioner should be made at time of admission. Assessment of addiction-focused history must be reviewed with a physician during the admission process.
3. For individuals new to the program, a comprehensive bio-psychosocial assessment per Ohio Administrative Code (OAC) 3793:2-1-08 (K) completed within 24 hours of admission which substantiates appropriate patient placement. Assessment must be reviewed and signed by the M-BHP, I-BHP or BHP completing or reviewing the assessment. This typically occurs with a diagnostic assessment to confirm the SUD diagnosis and determine the

appropriate LOC and a comprehensive bio-psychosocial assessment to inform the treatment plan and on-going care.

4. Full physical exam within 24 hours.
5. An individualized interdisciplinary treatment plan (ITP) per OAC 3793:2-1-06 (L), completed within 24 hours of admission and includes problem formulation and articulation of short term measurable treatment goals and activities designed to achieve those goals. This plan shall be developed in collaboration with the person.
6. A comprehensive treatment plan is developed within three days of admission if the patient is still in the service and additional updates to the treatment plan as indicated.
7. Initial discharge plan within 24 hours of admission, and comprehensive discharge plan at discharge.
8. Referral and assistance as needed for the person to gain access to other needed Medicaid SUD or mental health services.
9. The program shall implement the withdrawal management/treatment plan and document the individual's response to and/or participation in scheduled activities. Notes shall include:
 - a. The individual's physical condition, including vital signs.
 - b. The individual's mood and behavior.
 - c. Statements about the individual's condition and needs.
 - d. Information about the individual's progress or lack of progress in relation to withdrawal management/treatment goals.
 - e. Additional notes shall be documented, as needed.
10. Physician orders are required for medical and psychiatric management.

Staffing

An interdisciplinary team of appropriately trained M-BHPs, I-BHPs, BHPs and BHP-Ps are available to assess and treat the individual and to obtain and interpret information regarding the patient's needs. The number and disciplines of team members are appropriate to the range and severity of the individual's problems.

Staffing Requirements	Staffing
Medical Director	0.13 FTE (5 hours/week)
Psychiatrist, Psychiatric Nurse Practitioner (NP) or Advanced Practice Registered Nurse (APRN) onsite at least 5 hours per week per 16 residents	0.13 FTE (5 hours/week)
Primary Care Physician or Physician Extender onsite at least 5 hours per week for every 16 residents	0.13 FTE (5 hours/week)
Registered Nurse (RN) or Licensed Practical Nurse onsite per 16 residents at all times	3 FTE (1 day, 1 evening, 1 overnight)
RN supervisor or NP on call	0.13 FTE (5 hours/week)
One independent Behavioral Health Practitioner or one Behavioral Health Practitioner (not an independent) with direct supervision per 16 residents onsite during the day and evenings	2 FTE (1 day, 1 evening)
One Behavioral Health Paraprofessional per 16 residents during days and evenings	2 FTE (1 day, 1 evening)

Staffing Requirements	Staffing
One FTE for referral arrangements during normal business hours for all residents	1 FTE
Total FTEs per 16 beds where available	8.50 FTEs

Table 4-12: SUD Residential Inpatient Sub-acute Detoxification

MH		SUD			
Service	Not covered	Provider Type	Code	Req'd Mod	Rate
SUD Residential Inpatient Sub-acute Detoxification (ASAM 3.2 WM)			Agency	H0010	
Unit Value	Per diem				

ASAM Level 3.3 Clinically Managed Population-Specific High Intensity Residential Treatment

Residential programs offer 24-hour treatment staff with at least 30 hours per week of a combination of clinical and recovery-focused services specifically focused on individuals where the effects of the substance use or a co-occurring disorder has resulted in cognitive impairment. At least 10 of the 30 hours is to include individual, group, and/or family counseling. The level of impairment is so great that outpatient motivational and/or relapse prevention strategies are not feasible or effective. Similarly, the patient's cognitive limitations make it unlikely that he or she could benefit from other levels of residential care.

The functional limitations seen in individuals who are appropriately placed at Level 3.3 are primarily cognitive and can be either temporary or permanent. They may result in problems in interpersonal relationships, emotional coping skills, or comprehension. For example, temporary limitations may be seen in the individual who suffers from an organic brain syndrome as a result of his or her substance use and who requires treatment that is slower paced, more concrete, and more repetitive until his or her cognitive impairment subsides. Treatment goals are to stabilize a person who is in imminent danger if not in a 24-hour treatment setting. All facilities are regulated by OhioMHAS.

Level 3.3 programs provide a structured recovery environment in combination with high intensity, population-specific clinical services to support recovery. ASAM criteria are used to determine LOC.

Admission Guidelines

1. Acute intoxication and/or withdrawal potential: None, or minimal risk of withdrawal or withdrawal needs can be managed at this level.
2. Biomedical conditions and complications: None or stable. If present, the participant must be receiving medical monitoring.
3. Emotional, behavioral, or cognitive conditions and complications: Moderate to high severity; need structure to focus on recovery; if stable, a co-occurring disorder capable program is appropriate. If not, a co-occurring disorder enhanced program is required. Treatment should be designed to respond to the individual's cognitive deficits.
4. Readiness to change: Because of intensity and chronicity of addictive disorder participant has little awareness of need for change or of the relationship between addiction and impaired level of functioning. Participant requires structured and repeated intervention within a 24-hour milieu to consider and/or make behavior changes or engage in and stay in recovery and treatment.
5. Relapse, continued use, or continued problem potential: Participant has little awareness of relapse triggers and is in imminent danger of relapse or continued substance use. Participant requires relapse prevention activities that are delivered at a slower pace, more concretely and more repetitively within a 24-hour structured environment.
6. Recovery environment: Environment interferes with recovery and is characterized by moderately high risk of victimization and or abuse or the participant is unable to cope outside of a 24-hour structure, but recovery is achievable within a 24-hour structure.

Screening/Assessment/Treatment Plan Review

1. A urine drug screen and a tuberculosis test are required within 72 hours of admission and as directed by the treatment plan and are considered covered under the rates paid to the provider.
2. Nursing assessment within 24 hours of admission that is reviewed by a physician to determine need for eligibility and appropriateness (proper patient placement) for admission and referral.
3. For individuals new to the program, a comprehensive bio-psychosocial assessment per Ohio Administrative Code (OAC) 3793:2-1-08 (K) completed within 48 hours of admission which substantiates appropriate patient placement. Assessment must be reviewed and signed by a qualified professional. This typically occurs with a diagnostic assessment to confirm the SUD diagnosis and determine the appropriate LOC and a comprehensive bio-psychosocial assessment to inform the treatment plan and on-going care.
4. A physical examination performed within a reasonable time, as determined by the client's medical condition.
5. Individualized interdisciplinary treatment plan, per OAC 3793:2-1-06 (L), which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. This plan should be developed within 72 hours of admission and in collaboration with the individual.
6. The treatment/treatment plan is reviewed in collaboration with the individual every 30 days

- and updates/changes documented accordingly.
7. Discharge/transfer planning begins at admission.
 8. Referral and assistance as needed for the person to gain access to other needed Medicaid SUD or mental health services.

Staffing

Staffing Requirements	Proposed Staffing Model
Medical Director	0.13 FTE (5 hours/week)
RN onsite per 16 residents during day shift	1 FTE
Psychiatrist or Psychiatric NP onsite at least 5 hours per week for every 16 residents	0.13 FTE (5 hours/week)
Primary Care Physician or Physician Extender onsite at least 2.5 hours per week for every 16 residents	0.06 FTE (2.5 hours/week)
One independent Behavioral Health Practitioner or one Behavioral Health Practitioner (not an independent) with direct supervision per 16 residents onsite during the day	2.13 FTE (1 day, 1 evening, and on call)
One Behavioral Health Paraprofessional per 16 residents at all times	3 FTE (1 day, 1 evening, 1 overnight)
One FTE for referral arrangements during clinic hours for all residents	1 FTE
Total FTEs per 16 beds where available	7.45 FTEs

Table 4-13: Clinically Managed Population-Specific High Intensity Residential Treatment

	MH	SUD			
Service	Not covered	Provider Type	Code	Req'd Mod	Rate
Clinically Managed Population-Specific High Intensity Residential Treatment ASAM 3.3			Agency	H2036	HI
Unit Value					

ASAM Level 3.5 Clinically Managed High Intensity Residential Treatment

SUD residential programs offer 24-hour treatment staff with at least 30 hours per week of a combination of clinical and recovery-focused services specifically focused on individuals who

have significant social and psychological problems. At least 10 of the 30 hours are to include individual, group, and/or family counseling. All facilities are regulated by OhioMHAS.

SUD residential programs are characterized by their utilization of the treatment community as a therapeutic agent. Treatment goals are to stabilize a person who is in imminent danger if not in a 24-hour treatment setting. It is also to promote abstinence from substance use and antisocial behavior and to effect a global change in participants' lifestyles, attitudes, and values. Individuals typically have multiple deficits, which include SUDs and may include criminal activity, psychological problems, impaired functioning, and disaffiliation from mainstream values. ASAM criteria are used to determine LOC.

Admission Guidelines

1. Acute intoxication and/or withdrawal potential: None, or withdrawal symptoms can be safely managed at this level.
2. Biomedical conditions and complications: None or stable and participant can self-administer any prescribed medication, or, if condition is severe enough to distract from treatment and recovery participant can receive medical monitoring within the program or through another provider.
3. Emotional, behavioral, or cognitive conditions and complications: Demonstrates repeated inability to control impulses, or a personality disorder requires structure to shape behavior. Other functional deficits require a 24-hour setting to teach coping skills. A co-occurring disorder enhanced setting is required for seriously and persistently mentally ill patients.
4. Readiness to change: Has marked difficulty with or opposition to treatment, with dangerous consequences. If there is high severity in this dimension but not in other dimensions, the individual; therefore, needs ASAM Level 1 placement with inclusion of motivational enhancement therapy (MET). MET is a therapeutic intervention and a component part of the program.
5. Relapse, continued use, or continued problem potential: Participant is unable to recognize relapse triggers and has no recognition of the skills needed to prevent continued use, with limited ability to initiate or sustain ongoing recovery and sobriety in a less structured environment.
6. Recovery environment: Participant lives in an environment with moderately high risk or abuse or is a culture highly invested in substance use. Participant lacks skills to cope with challenges to recovery outside of a highly structured 24-hour setting.

Screening/Assessment/Treatment Plan Review

1. A urine drug screen and a tuberculosis test are required within 72 hours of admission and as directed by the treatment plan and are considered covered under the rates paid to the provider.
2. Nursing assessment within 24 hours of admission that is reviewed by a physician to determine need for eligibility and appropriateness (proper patient placement) for admission and referral.
3. For individuals new to the program, a comprehensive bio-psychosocial assessment per Ohio Administrative Code (OAC) 3793:2-1-08 (K) completed within 48 hours of admission which substantiates appropriate patient placement. Assessment must be reviewed and signed by a qualified professional. This typically occurs with a diagnostic assessment to confirm

- the SUD diagnosis and determine the appropriate LOC and a comprehensive bio-
psychosocial assessment to inform the treatment plan and on-going care.
4. A physical examination performed within a reasonable time, as determined by the client’s medical condition.
 5. Individualized interdisciplinary treatment plan, per OAC 3793:2-1-06 (L), which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. This plan should be developed within 72 hours of admission and in collaboration with the individual.
 6. The treatment/treatment plan is reviewed in collaboration with the individual every 30 days and updates/changes documented accordingly.
 7. Discharge/transfer planning begins at admission.
 8. Referral and assistance as needed for the person to gain access to other needed Medicaid SUD or mental health services.

Staffing

Staffing Requirements	Proposed Staffing Model
Physician — Medical Director	0.13 FTE (5 hours/week)
RN onsite per 16 residents during day shift	1 FTE
Psychiatrist or Psychiatric NP onsite at least 5 hours per week for every 16 residents	0.13 FTE (5 hours/week)
Primary Care Physician or Physician Extender onsite at least 2.5 hours per week for every 16 residents	0.06 FTE (2.5 hours/week)
One independent Behavioral Health Practitioner or one Behavioral Health Practitioner (not an independent) with direct supervision per 16 residents onsite during days and evenings	2 FTE (1 day, 1 evening)
One independent Behavioral Health Practitioner or one Behavioral Health Practitioner on call when the professional above is not onsite	0.13 FTE (5 hours/week)
One Behavioral Health Paraprofessional per 16 residents at all times	3 FTE (1 day, 1 evening, 1 overnight)
One FTE for referral arrangements for all residents during clinic hours	1 FTE
Total FTEs per 16 beds where available	7.45 FTEs

Table 4-14: Clinically Managed High Intensity Residential Treatment

MH		SUD			
Service	Not covered	Provider Type	Code	Req'd Mod	Rate

Clinically Managed High Intensity Residential Treatment (ASAM 3.5 WM)		Agency	H2036		\$213.70
Unit Value	Per diem				

ASAM Level 3.7 Medically Monitored Intensive Inpatient Treatment (Adults) and Medically Monitored High-Intensity Inpatient Services (Adolescent)

This SUD treatment LOC provides 30 hours of structured treatment activities per week including, but not limited to comprehensive bio-psycho social assessments, diagnosis treatment, and rehabilitation services. At least 10 of the 30 hours is to include individual, group, and/or family counseling target population for this LOC are participants with high risk of withdrawal symptoms, moderate co-occurring psychiatric and/or medical problems that are of sufficient severity to require a 24-hour treatment LOC. Whereas individuals whose most severe problems are in readiness to change, relapse potential, and living environment are best served in clinically managed residential programs or PHP with supportive housing. All facilities are regulated by OhioMHAS Treatment goals are to stabilize a person who is in imminent danger if not in a 24-hour medically monitored treatment setting.

This level of service also provides a planned regimen of 24-hour professionally directed evaluation, observation, and medical monitoring of SUD treatment in an inpatient setting. They feature permanent facilities, including inpatient beds, and function under a defined set of policies, procedures, and clinical protocols. Appropriate for patients whose sub-acute biomedical and emotional, behavior, or cognitive problems are so severe that they require enhanced residential treatment, but who do not need the full resources of an acute care general hospital. ASAM criteria are used to determine LOC.

Admission Guidelines

Individuals in this LOC have SUD disorders and may have co-occurring mental health disorders that need to be stabilized and meet the eligibility criteria for placement in a co-occurring disorder-capable program or have difficulties with mood, behavior, or cognition related to a substance use, mental disorder, emotional behavioral, or cognitive symptoms that are troublesome, but may not meet the diagnostic criteria for a mental disorder.

1. Acute intoxication and/or withdrawal potential: High risk of withdrawal symptoms that can be managed in a Level 3.7 program.
2. Biomedical conditions and complications: Moderate to severe conditions which require 24-hour nursing and medical monitoring or active treatment but not the full resources of an acute care hospital.
3. Emotional, behavioral, or cognitive conditions and complications: Moderate to severe conditions and complications (such as diagnosable co-morbid mental disorders or symptoms). These symptoms may not be severe enough to meet diagnostic criteria but

interfere or distract from recovery efforts (for example, anxiety/hypomanic or depression and/or cognitive symptoms) and may include compulsive behaviors, suicidal or homicidal ideation with a recent history of attempts but no specific plan, or hallucinations and delusions without acute risk to self or others. Psychiatric symptoms are interfering with abstinence, recovery and stability to such a degree that the individual needs a structured 24-hour, medically monitored (but not medically managed) environment to address recovery efforts.

4. Readiness to change: Participant unable to acknowledge the relationship between the addictive disorder and mental health and/or medical issues, or participant is in need of intensive motivating strategies, activities, and processes available only in a 24-hour structured medically monitored setting (but not medically managed).
5. Relapse, continued use, or continued problem potential: Participant is experiencing an escalation of relapse behaviors and/or acute psychiatric crisis and/or re-emergence of acute symptoms and is in need of 24-hour monitoring and structured support.
6. Recovery environment: Environment or current living arrangement is characterized by a high risk of initiation or repetition of physical, sexual, or emotional abuse or substance use so endemic that the patient is assessed as unable to achieve or maintain recovery at a less intensive LOC.

Screening/Assessment/Treatment Plan Review

1. A urine drug screen and a tuberculosis test are required within 72 hours of admission and as directed by the treatment plan and are considered covered under the rates paid to the provider.
2. A comprehensive nursing assessment at admission.
3. For individuals new to the program, a comprehensive bio-psychosocial assessment per Ohio Administrative Code (OAC) 3793:2-1-08 (K) completed within 24 hours of admission which substantiates appropriate patient placement. Assessment must be reviewed and signed by a qualified professional. This typically occurs with a diagnostic assessment to confirm the SUD diagnosis and determine the appropriate LOC and a comprehensive bio-psychosocial assessment to inform the treatment plan and on-going care.
4. A physical examination performed by a physician within 24 hours of admission, or a review and update by the facility physician of the record of a prior physical exam no more than seven days old.
5. Individualized, interdisciplinary treatment plan (ITP), consistent with Ohio Administrative Code (OAC) 3793:2-1-06 (L), completed within 72 hours of admission which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. This plan should be developed in collaboration with the individual.
6. The treatment/treatment plan is reviewed and updated in collaboration with the individual every 30 days and documented accordingly.
7. Discharge/transfer planning begins at admission.
8. Referral and assistance as needed for the person to gain access to other needed Medicaid SUD or mental health services.

Staffing

Staffing Requirements	Proposed Staffing Model
Physician — Medical Director	0.13 FTE (5 hours/week)
Psychiatrist, Psychiatric NP or APRN onsite at least 10 hours per week for every 16 residents	0.25 FTE (10 hours/week)
Primary Care Physician or Physician Extender onsite at least 5 hours per week for every 16 residents	0.13 FTE (5 hours/week)
RN onsite per 16 residents during day shift	1 FTE
LPN on site per 16 residents at all times	3 FTE (1 day, 1 evening, 1 over-night)
One independent Behavioral Health Practitioner or one Behavioral Health Practitioner (not an independent) with direct supervision per 16 residents onsite during days and evenings	2 FTE (1 day, 1 evening)
One Behavioral Health Paraprofessional per 16 residents onsite at all times	3 FTE (1 day, 1 evening, 1 overnight)
One FTE for referral arrangements for all residents	1 FTE
Total FTEs per 16 beds where available	10.5 FTEs

Table 4-15: Medically Monitored Intensive Inpatient Treatment (Adults) and Medically Monitored High-Intensity Inpatient Services (Adolescent)

Service	MH	SUD			
		Provider Type	Code	Req'd Mod	Rate
Medically Monitored Intensive Inpatient Treatment (Adults) and Medically Monitored High-Intensity Inpatient Services (Adolescent) ASAM 3.7	Not covered	Agency	H2036	TG	\$303.49
Unit Value	Per diem				

ASAM Level 3.7-WM Medically Monitored Inpatient Withdrawal Management

Medically monitored inpatient withdrawal management within an SUD residential program is an organized service delivered by medical and nursing professionals, which provide for 24-hour medically-supervised evaluation under a defined set of physician-approved policies and

physician-monitored procedures or clinical protocols. All facilities are regulated by OhioMHAS SUD residential programs utilizing buprenorphine based medications for LOC 3.7-WM must have a M-BHP who is boarded in addiction medicine and has a waiver to prescribe and dispense.

Admission Guidelines

Provides care to individuals whose withdrawal signs and symptoms are sufficiently severe to require 24-hour residential care. It sometimes is provided as a “step-down” service from a specialty unit of an acute care general or psychiatric hospital. Twenty-four hour observation, monitoring and treatment are available. However, the full resources of an acute care general hospital or a medically managed intensive inpatient treatment program are not necessary. Intakes are accepted 24 hours per day. ASAM criteria are used to determine LOC.

Screening/Assessments/Treatment Plan Review

1. Urine drug screens are required upon admission and as directed by the treatment plan and are considered covered under the rates paid to the provider.
2. A comprehensive nursing assessment at admission, including an addiction-focused history, about the individual to provide a clear understanding of the individual's present status. If self-administered withdrawal management medications are to be used, a physical examination by a physician, physician assistant, or NP should be made at time of admission. Assessment of addiction-focused history to be reviewed with a physician during the admission process.
3. For individuals new to the program, a comprehensive bio-psychosocial assessment per Ohio Administrative Code (OAC) 3793:2-1-08 (K) completed within 24 hours of admission which substantiates appropriate patient placement. Assessment must be reviewed and signed by a qualified professional. This typically occurs with a diagnostic assessment to confirm the SUD diagnosis and determine the appropriate LOC and a comprehensive bio-psychosocial assessment to inform the treatment plan and on-going care.
4. Full physical exam within 24 hours of admission.
5. Initial individualized, interdisciplinary treatment/treatment plan, consistent with Ohio Administrative Code (OAC) 3793:2-1-06 (L), completed within 24 hours of admission which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. This plan should be developed in collaboration with the individual.
6. A comprehensive treatment plan within three days of admission if participant is still in the service and additional updates to the treatment plan as indicated.
7. Initial discharge plan within 24 hours of admission, and comprehensive discharge plan at discharge.
8. Referral and assistance as needed for the person to gain access to other needed Medicaid SUD or mental health services.
9. The program shall implement the withdrawal management/treatment plan and document the individual's response to and/or participation in scheduled activities. Notes shall include:
 - a. The individual's physical condition, including vital signs.
 - b. The individual's mood and behavior.
 - c. Statements about the individual's condition and needs.
 - d. Information about the individual's progress or lack of progress in relation to withdrawal management/treatment goals.

- e. Additional notes shall be documented, as needed.
- 10. Physician orders are required for medical and psychiatric management.

Staffing

An interdisciplinary team of appropriately trained clinicians, M-BHPs, I-BHPs, BHPs and BHP-Ps, is available to assess and treat patients and to obtain and interpret information regarding their needs. The number and disciplines of team members are appropriate to the range and severity of the individual’s problems. These facilities must have medical personnel including physicians or physician extenders knowledgeable about addiction treatment and allied health professional staff. The number and disciplines of team members are appropriate to the range and severity of the individual’s problems.

Staffing Requirements	Proposed Staffing Model
Physician — Medical Director	0.13 FTE (5 hours/week)
Psychiatrist, Psychiatric NP or APRN onsite at least 15 hours per week for every 16 residents	0.38 FTE (15 hours/week)
Primary Care Physician or Physician Extender onsite at least 15 hours per week for every 16 residents	0.38 FTE (15 hours/week)
RN or LPN onsite per 16 residents at all times	3 FTE (1 day, 1 evening, 1 overnight)
RN supervisor or NP on call	0.13 FTE (5 hours/week)
One independent Behavioral Health Practitioner or one Behavioral Health Practitioner (not an independent) with direct supervision per 16 residents onsite during days and evenings	5 FTE (2 day, 2 evening, 1 overnight)
One independent Behavioral Health Practitioner or one Behavioral Health Practitioner (not an independent), or one Behavioral Health Paraprofessional per 16 residents onsite at all times	2 FTE (1 day, 1 evening)
One FTE for referral arrangements for all residents	1 FTE
Total FTEs per 16 beds where available	12.0 FTEs

Table 4-16: Medically Monitored Inpatient Withdrawal Management

MH		SUD			
Service	Not covered	Provider Type	Code	Req'd Mod	Rate

Medically Monitored Inpatient Withdrawal Management ASAM 3.7WM		Agency	H0011		\$392.86
Unit Value					

SECTION 5

Specialized Recovery Services (SRS) Program [1915(i)]

How providers enroll-under development

Peer Recovery Support

PRS service provides community-based supports to individuals with or in recovery from a mental illness with individualized and recovery focused activities that promote recovery, self-determination, self-advocacy, well-being and independence through a relationship that supports a person's ability to promote his or her own recovery. Peer Recovery Supporters use their own experiences with mental illness, to help individuals reach their recovery goals. Activities included must be intended to achieve the identified goals or objectives as set forth in the individual's individualized care plan, which delineates specific goals that are flexibly tailored to the individual and attempt to utilize community and natural supports.

Table 5-1: SRS Peer Recovery

MH					SUD
Service	Provider Type	Code	Group Mod	Rate	
SRS Peer Recovery	Peer Recovery supporter	H0038		\$15.51	Not Covered
	Peer Recovery supporter	H0038	HQ	\$1.94	
Unit Value	15 minutes				
Service Definition	The Peer Recovery Support (PRS) service provides community-based supports to individuals with or in recovery from a mental illness with individualized and recovery focused activities that promote recovery, self-determination, self-advocacy, well-being and independence through a relationship that supports a person's ability to promote his or her own recovery. Peer recovery supporters use their own experiences with mental illness, to help individuals reach their recovery goals. Activities included must be				

	<p>intended to achieve the identified goals or objectives as set forth in the individual’s individualized care plan, which delineates specific goals that are flexibly tailored to the individual and attempt to utilize community and natural supports. The structured, scheduled activities provided by this service emphasize the opportunity for individuals to support each other in the restoration and expansion of the skills and strategies necessary to move forward in recovery.</p> <p>PRS services promote self-directed recovery by assisting an individual in:</p> <ul style="list-style-type: none"> ▪ Ongoing exploration of recovery needs ▪ Achieving personal independence as identified by the individual ▪ Encouraging hope ▪ Facilitating further development of daily living skills ▪ Developing and working toward achievement of personal recovery goals ▪ Modeling personal responsibility for recovery ▪ Teaching skills to effectively navigate to the health care delivery system to effectively and efficiently utilize services ▪ Providing group facilitation that addresses symptoms, behaviors, though processes, etc., that assist an individual in eliminating barriers to seeking or maintaining recovery, employment, education, or housing ▪ Assisting with accessing and developing natural support systems in the community ▪ Promoting coordination and linkage among similar providers ▪ Coordinating and/or assistance in crisis interventions and stabilization as needed ▪ Conducting outreach ▪ Attending and participating in treatment teams ▪ Assisting individuals in the development of empowerment skills through self-advocacy and stigma busting activities that encourage hope <p>Peer recovery support services will be provided in the natural environment of the person.</p>
<p>Admission Criteria</p>	<ul style="list-style-type: none"> • The frequency and duration of PRS will be identified on the person-centered plan and must be supported by an identified need and recovery goal. PRS will not substitute or supplant natural supports. Emerging evidence indicates peer recovery support can be instrumental in an individual achieving identified recovery goals, and it can be individualized to meet the changing needs of the individual. For instance, an individual who has transitioned to the community from extended tenure in the psychiatric hospital may benefit from multiple hours of daily peer support until they are acclimated to life outside an institution. The frequency and duration of peer recovery support encounters is anticipated to decline as the individual progresses in his or her recovery, builds natural supports and strengths, and is better able to navigate recovery in his or her community of choice.
<p>Continuing Stay Criteria</p>	<p>Determined by the person-centered plan developed by the individual and Recovery Manager.</p>
<p>Target Length of Stay</p>	<p>6 months to 1 year</p>

<p>Service Exclusions</p>	<p>Peers should not be involved in managing medications and should not generally be expected to perform tasks that other team members are trained to do.</p> <p>Peer recovery supporters do <u>not</u> generally assist with activities of daily living (ADLs).</p>
<p>Clinical Exclusions</p>	<p>Individual must meet all SRS Program criteria including qualifying diagnosis as defined in Appendix XX</p>
<p>Required Components</p>	<p>Developing and working toward achievement of personal recovery goals</p> <ul style="list-style-type: none"> ▪ Modeling personal responsibility for recovery ▪ Teaching skills to effectively navigate to the health care delivery system to effectively and efficiently utilize services ▪ Providing group facilitation that addresses symptoms, behaviors, though processes, etc., that assist an individual in eliminating barriers to seeking or maintaining recovery, employment, education, or housing ▪ Assisting with accessing and developing natural support systems in the community ▪ Promoting coordination and linkage among similar providers ▪ Coordinating and/or assistance in crisis interventions and stabilization as needed ▪ Conducting outreach ▪ Attending and participating in treatment teams ▪ Assisting individuals in the development of empowerment skills through self-advocacy and stigma busting activities that encourage hope <p>Peer recovery support services will be provided in the natural environment of the person.</p>
<p>Staffing Requirements</p>	<p>Peers should be supervised by other senior peers or non-peer staff that has been certified to supervise peers and receive regularly scheduled clinical supervision from a person meeting the qualifications of a mental health professional with experience regarding this specialized mental health service. Non-peer staff that wishes to supervise peers must complete the 16 hour OhioMHAS E-based Academy pre-course work for peer services. The peer support provider must receive regularly scheduled supervision from a competent behavioral health professional meeting the qualifications of either: a professional meeting the qualifications who meets the criteria for a "qualified behavioral health staff person" or a supervisor who is an individual working as a certified peer support provider for a minimum of five years, in which two years should have been as a credentialed peer advocate or its equivalent including specialized training and/or experience as a supervisor. The individual providing consultation, guidance, mentoring, and on-going training need not be employed by the same agency. Supervision of these activities may be delivered in person or by distance communication methods.</p> <p>It is the expectation that 1 hour of supervision will be delivered for every 40 hours of PRS duties performed. There may be an administrative supervisor who signs the family peer specialist's timesheet and is the primary contact on other related human resource management issues. Supervisors must also be aware of and sensitive to the cultural needs of the population of focus and how to best meet those needs, and be capable of training staff regarding these issues. The team must have training in the general training</p>

	<p>requirements required by ODM, including cultural competence and trauma informed care. Any practitioner providing behavioral health services must operate within an agency designated as a CMHC. The caseload size must be based on the needs of the clients/families with an emphasis on successful outcomes and individual satisfaction and must meet the needs identified in the individual treatment plan.</p> <p>PRS is available daily, limited to no more than four hours per day for an individual client. Progress notes document the individual’s progress relative to goals identified in the person-centered plan PRS services are not a substitute for or adjunct to other HCBS or similar state plan service.</p> <p>Staff to client ratio</p> <ul style="list-style-type: none"> • Supervisor to peer recovery supporter: 1:5 • Peer recovery supporter caseload: 1:20 to 25 • The maximum group size for PRS is no more than 1:12
Reporting and Billing Requirements	<ul style="list-style-type: none"> • The individual medical record must include documentation of services. • Provider is required to complete a progress note for every contact with individual as well as for related collateral contacts. • Progress notes must adhere to documentation requirements set forth in this manual.
Documentation Requirements	<ul style="list-style-type: none"> • Providers must adhere to documentation requirements as defined in Administrative Code rules 5160-43-04 and 5160-43-05
Other Considerations	

Table 5-2: SRS–IPS – Supported Employment

MH					SUD
Service	Provider Type	Code	Req'd Mod	Rate	
SRS-IPS - Supported Employment -Initial Visit	MD, DO	H2023		\$19.53	Not Covered
	Certified nurse specialist	H2023		\$19.53	
	Certified nurse practitioner	H2023		\$19.53	
	Physician assistant	H2023		\$19.53	
	RN, LPN	H2023		\$19.53	
	Psychologist	H2023		\$19.53	
	Board licensed school psychologist	H2023		\$19.53	
	Licensed independents	H2023		\$19.53	
	Psychology assistant, intern, trainee	H2023	U1	\$19.53	
	School psychology assistant/trainee (ODE)	H2023	U1	\$19.53	
	Board licensed school psychologist	H2023	HB	\$19.53	
	LSW	H2023	U4	\$19.53	
	LMFT	H2023	U5	\$19.53	
Social worker trainee	H2023	U9	\$19.53		

	Social Worker Asst.	H2023	U8	\$19.53	
	MFT trainee	H2023	UA	\$19.53	
	Counselor trainee	H2023	U7	\$19.53	
	QMHS - high school	H2023	HM	\$19.53	
	QMHS - Associate	H2023	HM	\$19.53	
	QMHS - Bachelors	H2023	HN	\$19.53	
	QMHS - Masters	H2023	HO	\$19.53	
SRS-IPS - Supported Employment Ongoing Support	MD, DO	H2025		\$19.53	
	Certified nurse specialist Certified nurse practitioner Physician assistant	H2025		\$19.53	
	RN, LPN	H2025		\$19.53	
	Psychologist	H2025		\$19.53	
	Board licensed school psychologist	H2025		\$19.53	
	Licensed independents	H2025		\$19.53	
	Psychology assistant, intern, trainee	H2025	U1	\$19.53	
	School psychology assistant/trainee (ODE)	H2025	U1	\$19.53	
	Board licensed school psychologist	H2025	HB	\$19.53	
	LSW	H2025	U4	\$19.53	
	LMFT	H2025	U5	\$19.53	
	Social worker trainee	H2025	U9	\$19.53	
	Social Worker Asst.	H2025	U8	\$19.53	
	MFT trainee	H2025	UA	\$19.53	
	Counselor trainee	H2025	U7	\$19.53	
	QMHS - High School	H2025	HM	\$19.53	
	QMHS - Associates	H2025	HM	\$19.53	
	QMHS - Bachelors	H2025	HN	\$19.53	
QMHS - Masters	H2025	HO	\$19.53		
Unit Value	H2023 per 15 minutes H2025 per 15 minutes				
Service Definition	<p>Individualized Placement and Support-Supported Employment (IPS-SE) promotes recovery through the implementation of evidence based and best practices which allow individuals to obtain and maintain integrated competitive meaningful employment by providing training, ongoing individualized support, and skill development that honor client choice. The outcome of an employment service is that individuals will obtain and maintain a job of their choosing through rapid job placement which will increase their self-sufficiency and further their recovery. Employment services should be coordinated with mental health services and substance use treatment and services.</p> <p>Consistent with the purpose and intent of this service definition, IPS-SE shall include at least one of the following evidence based and best practice employment activities, as provided by the qualified IPS-SE provider and as listed below:</p> <ul style="list-style-type: none"> • Vocational assessment • Development of a vocational plan ; 				

	<ul style="list-style-type: none"> • On-the-job training and skill development; • Job seeking skills training (JSST); • Job development and placement; • Job coaching; • Individualized job supports, which may include regular contact with the employers, family members, guardians, advocates, treatment providers, and other community supports; • Benefits planning; • General consultation, advocacy, building and maintaining relationships with employers; • Rehabilitation guidance and counseling; or, • Time unlimited vocational support. <p>Any of the following employment supports may be provided in conjunction with at least one (1) of the above eleven (11) employment activities or which has received prior approval from the OhioMHAS, including:</p> <ol style="list-style-type: none"> 1. Facilitation of natural supports; 2. Transportation; or, 3. Peer services.
Admission Criteria	Determined by the person-centered plan developed by the individual and recovery manager.
Continuing Stay Criteria	Determined by the person-centered plan developed by the individual and recovery manager.
Discharge Criteria	<ul style="list-style-type: none"> • Goals of the person-centered plan related to employment have been substantially met; or • Individual requests a discharge from this service; or • Individual does not currently desire competitive employment. • Duration of services is for up to one year, but six month review with person-centered plan to review progress is recommended. The recovery manager can recommend extended follow along after twelve months.
Service Exclusions	<ul style="list-style-type: none"> • Services do not include payment for the supervisory activities rendered as a normal part of the business setting. • Services do not include payment for supervision, training, support, and adaptations typically available to other non-disabled workers filling similar positions in the business. • Transportation to and from the work site will be a component of - and the cost of this transportation will be included in - the rate paid to providers, unless the individual can access public transportation or has other means of transportation available to them. If public transportation is available, then it should be utilized by the individual, if at all possible. • Employment services may be used for an individual to gain work-related experience considered crucial for job placement (e.g., unpaid internship), only if such experience is vital to the person to achieve his or her vocational goal. • Documentation must be maintained for each individual receiving this service that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973, relating to vocational rehabilitation services, or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.), relating to special education. • Services may not be for job placements paying below minimum wage.

	<ul style="list-style-type: none"> • Services must be delivered in a manner that supports and respects the individual’s communication needs including translation services, assistance with, and use of communication devices. • Services may not be provided on the same day and at the same time as services that contain elements integral to the delivery of employment services (e.g., rehabilitation). • Services must be provided in regular integrated settings and do not include sheltered work or other types of vocational services in specialized facilities, or incentive payments, subsidies, or unrelated vocational training expenses such as the following: Incentive payments made to an employer to encourage hiring the individual; • Payments that are passed through to the individual; <ul style="list-style-type: none"> ○ Payments for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business; or ○ Payments used to defray the expenses associated with starting up or operating a business. <p>Services do not include adaptations, assistance, and training used to meet an employer’s responsibility to fulfill requirements for reasonable accommodations under the Americans with Disabilities Act.</p>
Clinical Exclusions	Individual must meet all SRS Program criteria including qualifying diagnosis as defined in Appendix XX
Required Components	<ul style="list-style-type: none"> • Vocational Assessment • Development of a Vocational Plan ; • On-the-job Training and skill development; • Job seeking skills training (JSST); • Job development and placement; • Job coaching; • Individualized job supports, which may include regular contact with the employers, family members, guardians, advocates, treatment providers, and other community supports; • Benefits planning; • General consultation, advocacy, building and maintaining relationships with employers; • Rehabilitation guidance and counseling; or, • Time unlimited vocational support.
Staffing Requirements	<p>Providers who chose to offer IPS-SE employment service shall meet the following requirements to be OhioMHAS qualified providers:</p> <ol style="list-style-type: none"> 1. IPS-SE is an evidence based practice which is integrated and coordinated with mental health treatment and rehabilitation designed to provide individualized placement and support to assist individuals with a severe and persistent mental illness obtain, maintain, and advance within competitive community integrated employment positions. 2. In order to be an IPS-SE qualified provider, the provider must: <ol style="list-style-type: none"> (a) Provide the evidence-based practice of IPS-SE after completion of training/certification on the model; (b) Have current fidelity reviews completed by an OhioMHAS approved fidelity reviewer as required by the developer of the practice; and,

	<p>(c) Achieve the minimum fidelity score necessary to maintain fidelity, as defined by the developer of the practice.</p> <p>Staff to client ratio</p> <ul style="list-style-type: none"> • Team lead: 1:8 • Employment specialist: 1:15 to 20
Clinical Operations	
Reporting and Billing Requirements	<ul style="list-style-type: none"> • The individual medical record must include documentation of services. • Provider is required to complete a progress note for every contact with individual as well as for related collateral contacts. • Progress notes must adhere to documentation requirements set forth in this manual.
Documentation Requirements	<ul style="list-style-type: none"> •
Other Considerations	

SECTION 6 - Appendices

Appendix A- Specialized Recovery Services Program

Peer Recovery Support – Criminal Records Checks - Offenses and Exclusions

<i>ORC/Offense</i>	Permanent Exclusion MHAS Certification	Permanent Exclusion SRSP	10 Year Exclusion SRSP	7 Year Exclusion SRSP	5 Year Exclusion SRSP	3 Year Exclusion MHAS Certification
2903.01 Aggravated murder	X	X				
2903.15 Permitting child abuse	X	X				
2903.16 Failing to provide for a functionally impaired person	X	X				
2903.34 Patient abuse or neglect	X	X				
2903.341 Patent endangerment	X	X				
2905.32 human trafficking	X	X				
2905.33 unlawful conduct with respect to documents	X	X				
2907.02 Rape	X	X				
2907.03 Sexual battery	X	X				
2907.04 Unlawful sexual conduct with a minor, formerly corruption of a minor	X	X				
2907.05 Gross sexual imposition	X	X				
2907.06 Sexual imposition	X	X				

<i>ORC/Offense</i>	Permanent Exclusion MHAS Certification	Permanent Exclusion SRSP	10 Year Exclusion SRSP	7 Year Exclusion SRSP	5 Year Exclusion SRSP	3 Year Exclusion MHAS Certification
2907.07 Importuning	X	X				
2907.08 Voyeurism	X	X				
2907.12 Felonious sexual penetration, as it existed prior to 9/3/96	X	X				
2907.31 Disseminating matter harmful to juveniles	X	X				
2907.32 Pandering obscenity	X	X				
2907.321 Pandering obscenity involving a minor	X	X				
2907.322 Pandering sexually oriented matter involving a minor	X	X				
2907.323 Illegal use of a minor in nudity oriented material or performance	X	X				
2909.22 Soliciting or providing support for act of terrorism	X	X				
2909.23 Making terroristic threats	X	X				
2909.24 Terrorism	X	X				
2913.40 Medicaid fraud	X	X				
2905.04 Child Stealing	X	X				
2905.05 Child Enticement	X	X				
2907.21 Compelling prostitution	X	X				
2907.22 Promoting prostitution	X	X				
2925.02 Corrupting another with drugs	X	X				
3716.11 Placing harmful or hazardous objects in food or confection	X	X				
2903.21 Aggravated menacing	X	X				
2919.22 Endangering children	X	X				
2925.24 Tampering with drugs	X	X				
2907.33 Deception to obtain matter harmful to juveniles	X	X				
2925.23 Illegal processing of drug documents	X	X				
2925.36 Illegal dispensing of drug samples	X	X				
2903.02 Murder		X				X
2903.03 Voluntary manslaughter		X				X
2903.11 Felonious assault		X				X
2905.01 Kidnapping		X				X
2905.02 Abduction		X				X
2903.04 Involuntary manslaughter			X			X
2903.041 Reckless homicide			X			X
2905.11 Extortion			X			X

<i>ORC/Offense</i>	Permanent Exclusion MHAS Certification	Permanent Exclusion SRSP	10 Year Exclusion SRSP	7 Year Exclusion SRSP	5 Year Exclusion SRSP	3 Year Exclusion MHAS Certification
2907.23 Enticement or solicitation to patronize a prostitute; procurement of a prostitute for another			X			X
2909.03 Arson			X			X
2911.01 Aggravated robbery			X			X
2911.11 Aggravated burglary			X			X
2913.46 illegal use of food stamps or WIC program benefits			X			X
2913.48 Workers' Compensation fraud			X			X
2913.49 Identity fraud			X			X
2917.02 Aggravated riot			X			X
2923.12 Carrying concealed weapons			X			X
2923.122 Illegal conveyance or possession of deadly weapon or danger ordnance in a school safety zone, illegal possession of an object indistinguishable from a firearm in a school safety zone			X			X
2923.123 Illegal conveyance, possession, or control of deadly weapon or ordnance into courthouse			X			X
2923.13 Having weapons while under a disability			X			X
2923.161 Improperly discharging a firearm at or into a habitation or school			X			X
2923.162 Discharge of firearm on or near prohibited premises			X			X
2923.21 Improperly furnishing firearms to a minor			X			X
2923.32 Engaging in a pattern of corrupt activity			X			X
2923.42 Participating in a criminal gang			X			X
2925.03 Trafficking in drugs			X			X
2925.04 illegal manufacture of drugs or cultivation of marijuana			X			X
2925.041 Illegal assembly or possession of chemicals for the manufacture of drugs			X			X
959.13 Cruelty to animals				X		X
959.131 Prohibitions concerning companion animals				X		X
2903.12 Aggravated assault				X		X
2903.211 Menacing by stalking				X		X
2905.12 Coercion				X		X

<i>ORC/Offense</i>	Permanent Exclusion MHAS Certification	Permanent Exclusion SRSP	10 Year Exclusion SRSP	7 Year Exclusion SRSP	5 Year Exclusion SRSP	3 Year Exclusion MHAS Certification
2909.04 <i>Disrupting public services</i>				X		X
2911.02 <i>Robbery</i>				X		X
2911.12 <i>Burglary</i>				X		X
2913.47 <i>Insurance fraud</i>				X		X
2917.01 <i>Inciting to violence</i>				X		X
2917.03 <i>Riot</i>				X		X
2917.31 <i>Inducing panic</i>				X		X
2919.25 <i>Domestic violence</i>				X		X
2921.03 <i>Intimidation</i>				X		X
2921.11 <i>Perjury</i>				X		X
2921.13 <i>Falsification, falsification in a theft offense, falsification to purchase a firearm, or falsification to obtain a concealed handgun license</i>				X		X
2921.34 <i>Escape</i>				X		X
2921.35 <i>Aiding escape or resistance to lawful authority</i>				X		X
2921.36 <i>Illegal conveyance of weapons, drugs or other prohibited items onto the grounds of a detention facility or institution</i>				X		X
2925.05 <i>Funding drug trafficking</i>				X		X
2925.06 <i>Illegal administration or distribution of anabolic steroids</i>				X		X
2927.12 <i>Ethnic intimidation</i>				X		X
2903.13 <i>Assault</i>					X	X
2903.22 <i>Menacing</i>					X	X
2907.09 <i>Public indecency</i>					X	X
2907.24 <i>Soliciting</i>					X	X
2907.25 <i>Prostitution</i>					X	X
2911.13 <i>Breaking and entering</i>					X	X
2913.02 <i>Theft</i>					X	X
2913.03 <i>Unauthorized use of a vehicle</i>					X	X
2913.04 <i>Unauthorized use of computer, cable or telecommunication property</i>					X	X
2913.05 <i>Telecommunications fraud</i>					X	X
2913.11 <i>Passing bad checks</i>					X	X
2913.21 <i>Misuse of credit cards</i>					X	X
2913.31 <i>Forgery, forging identification cards or selling or distributing forged identification cards</i>					X	X
2913.32 <i>Criminal simulation</i>					X	X

<i>ORC/Offense</i>	Permanent Exclusion MHAS Certification	Permanent Exclusion SRSP	10 Year Exclusion SRSP	7 Year Exclusion SRSP	5 Year Exclusion SRSP	3 Year Exclusion MHAS Certification
2913.41 Defrauding a rental agency or hostelry					X	X
2913.42 Tampering with records					X	X
2913.43 Securing writings by deception					X	X
2913.44 Personating an officer					X	X
2913.441 Unlawful display of law enforcement emblem					X	X
2913.45 Defrauding creditors					X	X
2913.51 Receiving stolen property					X	X
2919.12 Unlawful abortion					X	X
2919.121 Unlawful abortion upon a minor					X	X
2919.123 Unlawful distribution of an abortion-inducing drug					X	X
2919.23 Interference with custody					X	X
2919.24 Contributing to the unruliness or delinquency of a child					X	X
2921.21 Compounding a crime					X	X
2921.24 Disclosure of confidential information					X	X
2921.32 Obstructing justice					X	X
2921.321 Assaulting or harassing a police dog, horse or service animal					X	X
2921.51 Impersonation of a peace officer					X	X
2925.09 Illegal administration, dispensing, distribution, manufacture, possession, selling, or using of any dangerous veterinary drug					X	X
2925.11 Drug possession, other than a minor drug possession offense					X	X
2925.13 Permitting drug abuse					X	X
2925.22 Deception to obtain a dangerous drug					X	X
2925.55 Unlawful purchase of pseudoephedrine product					X	X
2925.56 Unlawful sale of pseudoephedrine product					X	X

Appendix B- SRS Program Allowed Diagnoses

ODM Rule 5160-43-02

Qualifying Diagnoses for Specialized Recovery Services Program eligibility on and after July 1, 2016.

ICD-10 CODES DIAGNOSIS CATEGORY DESCRIPTION

F06.0 Psychotic disorders with hallucinations or delusions

F06.2 Psychotic disorder with delusions

F06.30-F06.34 Mood disorders

F06.4 Anxiety disorder

F07.0 Personality change

F20.0-F25.9 Schizophrenia

F29 Unspecified psychosis

F30.10-F30.9 Manic episodes

F31.0-F31.9 Bipolar disorder

F32.0-F39 Major depressive and mood disorders

F40.00-F40.11 Phobic and other anxiety disorders

F40.8 Other phobic anxiety disorders

F41.0 Panic disorder without agoraphobia

F41.1 Generalized anxiety disorder

F42 Obsessive-compulsive disorder

F43.10-F43.12 Post-traumatic stress disorder

F43.20-F43.25 Adjustment disorders

F44.0 Dissociative amnesia

F44.1 Dissociative fugue

F44.4-F44.9 Dissociative and conversion disorders

F45.0-F45.9 Somatoform disorders

F48.1 Depersonalization-derealization syndrome

F48.8-F48.9 Other nonpsychotic mental disorders

F50.00-F50.9 Eating disorders

F53 Postpartum depression

F60.3 Borderline personality disorder

F63.3-F63.9 Impulse disorders

F64.1 Gender identity disorder in adolescence and adulthood

F64.8-F64.9 Other gender identity disorders

F68.10-F68.8 Disorders of adult personality and behavior

F94.0 Selective mutism

[Appendix C- AMA CPT 2015 Evaluation and Medical Service Determination](#)

Evaluation and management services are used to report a wide range of medical treatments provided to patients. The descriptors for E&M services recognize seven components, six of which are used in defining the levels of E&M services. These components are:

- History*

- Examination*
- Medical decision making*
- Counseling**
- Coordination of care**
- Nature of presenting problems
- Time

*Key components in selecting the appropriate code.

**When counseling and/or coordination of care represent more than 50% of the face to face time, then time, then time shall be considered the controlling factor in selecting an E&M code. Face to face time for office services associated with any E&M service is a valid proxy for the total work done before, during and after the visit, as this time is included in calculating the total work and is included in the rate. However, only time spent face to face with the patient is taken into consideration for determining the time component of the E&M code (Please see above for key components in determining the appropriate E&M code).

Evaluation and Management (E&M) Billing and Coding Considerations

Selecting the Code That Best Represents the Service Furnished

Billing for an E&M service requires the selection of a Current Procedural Terminology (CPT) code that best represents:

- Patient type;
- Setting of service; and
- Level of E&M service performed.

Patient Type

For purposes of billing for E&M services, patients are identified as either new or established, depending on previous encounters with the provider.

A **new patient** is defined as an individual who has not received any professional services from the physician/non-physician practitioner (NPP) or another physician of the same specialty who belongs to the same group practice within the previous 3 years.

An **established patient** is an individual who has received professional services from the physician/NPP or another physician of the same specialty who belongs to the same group practice within the previous 3 years

Setting of Service

E&M services are categorized into different settings depending on where the service is furnished. Examples of settings include:

- Office or other outpatient setting;
- Hospital inpatient;
- Emergency department (ED); and

- Nursing facility (NF).

Level of E&M Service Performed

The code sets to bill for E&M services are organized into various categories and levels. In general, the more complex the visit, the higher the level of code you may bill within the appropriate category. To bill any code, the services furnished must meet the definition of the code. You must ensure that the codes selected reflect the services furnished.

The three key components when selecting the appropriate level of E&M services provided are history, examination, and medical decision making. Visits that consist predominately of counseling and/or coordination of care are an exception to this rule. For these visits, time is the key or controlling factor to qualify for a particular level of E&M services. *If more than 50% of the encounter is counseling and/or coordinating care, then time is considered the key factor to determine the appropriate E&M code and the extent of counseling and/or coordination of care must be documented in the medical record.*

History

The chart below depicts the elements required for each type of history. More information on the activities comprising each of these elements is provided on pages 5–10. To qualify for a given type of history, all four elements indicated in the row must be met. Note that as the type of history becomes more intensive, the elements required to perform that type of history also increase in intensity.

For example, a problem focused history requires documentation of the chief complaint (CC) and a brief history of present illness (HPI), while a detailed history requires the documentation of a CC, an extended HPI, plus an extended review of systems (ROS), and pertinent past, family, and/or social history (PFSH).

Elements Required for Each Type of History

Type of History	CC	HPI	ROS	PFSH
Problem Focused	Required	Brief	N/A	N/A
Expanded Problem Focused	Required	Brief	Problem Pertinent	N/A
Detailed	Required	Extended	Extended	Pertinent
Comprehensive	Required	Extended	Complete	Complete

While documentation of the CC is required for all levels, the extent of information gathered for the remaining elements related to a patient’s history depends on clinical judgment and the nature of the presenting problem.

Chief Complaint

A CC is a concise statement that describes the symptom, problem, condition, diagnosis, or reason for the patient encounter. The CC is usually stated in the patient’s own words. For example,

patient complains of upset stomach, aching joints, and fatigue. The medical record should clearly reflect the CC.

History of Present Illness

HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. HPI elements are:

- Location (example: left leg);
- Quality (example: aching, burning, radiating pain);
- Severity (example: 10 on a scale of 1 to 10);
- Duration (example: started 3 days ago);
- Timing (example: constant or comes and goes);
- Context (example: lifted large object at work);
- Modifying factors (example: better when heat is applied); and
- Associated signs and symptoms (example: numbness in toes).

The two types of HPIs are brief and extended.

A *brief* HPI includes documentation of one to three HPI elements.

In the following example, three HPI elements – location, quality, and duration – are documented:

Example 1:

CC: Patient complains of earache.

Brief HPI: Dull ache in left ear over the past 24 hours.

An *extended* HPI:

1995 documentation guidelines – Should describe four or more elements of the present HPI or associated comorbidities.

1997 documentation guidelines – Should describe at least four elements of the present HPI or the status of at least three chronic or inactive conditions.

In the following example, five HPI elements – location, quality, duration, context, and modifying factors – are documented:

Example 2:

CC: Patient complains of earache.

Extended HPI: Patient complains of dull ache in left ear over the past 24 hours. Patient states he went swimming two days ago. Symptoms somewhat relieved by warm compress and ibuprofen.

Review of Systems

ROS is an inventory of body systems obtained by asking a series of questions to identify signs and/or symptoms that the patient may be experiencing or has experienced. The following systems are recognized for ROS purposes:

- Constitutional Symptoms (for example, fever, weight loss);
- Eyes;
- Ears, Nose, Mouth, Throat;

- Cardiovascular;
- Respiratory;
- Gastrointestinal;
- Genitourinary;
- Musculoskeletal;
- Integumentary (skin and/or breast);
- Neurological;
- Psychiatric;
- Endocrine;
- Hematologic/Lymphatic; and
- Allergic/Immunologic.

The three types of ROS are problem pertinent, extended, and complete:

A *problem pertinent* ROS inquires about the system directly related to the problem identified in the HPI.

In the following example, one system – the ear – is reviewed:

CC: Earache.

ROS: Positive for left ear pain. Denies dizziness, tinnitus, fullness, or headache.

An *extended ROS* inquires about the system directly related to the problem(s) identified in the HPI and a limited number (two to nine) of additional systems.

In the following example, two systems – cardiovascular and respiratory – are reviewed:

CC: Follow-up visit in office after cardiac catheterization. Patient states “I feel great.”

ROS: Patient states he feels great and denies chest pain, syncope, palpitations, and shortness of breath. Relates occasional unilateral, asymptomatic edema of left leg.

A *complete ROS* inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional (minimum of ten) organ systems. You must individually document those systems with positive or pertinent negative responses. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, you must individually document at least ten systems.

In the following example, ten signs and symptoms are reviewed:

CC: Patient complains of “fainting spell.”

ROS:

- Constitutional: Weight stable, + fatigue.
- Eyes: + loss of peripheral vision.
- Ear, Nose, Mouth, Throat: No complaints.
- Cardiovascular: + palpitations; denies chest pain; denies calf pain, pressure, or edema.
- Respiratory: + shortness of breath on exertion.
- Gastrointestinal: Appetite good, denies heartburn and indigestion. + episodes of nausea. Bowel movement daily; denies constipation or loose stools.

- Urinary: Denies incontinence, frequency, urgency, nocturia, pain, or discomfort.
- Skin: + clammy, moist skin.
- Neurological: + fainting; denies numbness, tingling, and tremors.
- Psychiatric: Denies memory loss or depression. Mood pleasant.

Past, Family, and/or Social History (PFSH)

PFSH consists of a review of three areas:

- Past history includes experiences with illnesses, operations, injuries, and treatments;
- Family history includes a review of medical events, diseases, and hereditary conditions that may place the patient at risk; and
- Social history includes an age appropriate review of past and current activities.

The two types of PFSH are pertinent and complete.

A pertinent PFSH is a review of the history areas directly related to the problem(s) identified in the HPI. The pertinent PFSH must document at least one item from any of the three history areas.

In the following example, two systems – cardiovascular and respiratory – are reviewed:

CC: Follow-up visit in office after cardiac catheterization. Patient states “I feel great.”

ROS: Patient states he feels great and denies chest pain, syncope, palpitations, and shortness of breath. Relates occasional unilateral, asymptomatic edema of left leg.

A complete ROS inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional (minimum of ten) organ systems. You must individually document those systems with positive or pertinent negative responses. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, you must individually document at least ten systems.

In the following example, ten signs and symptoms are reviewed:

CC: Patient complains of “fainting spell.”

ROS:

- Constitutional: Weight stable, + fatigue.
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- Ear, Nose, Mouth, Throat: No complaints.
- Cardiovascular: + palpitations; denies chest pain; denies calf pain, pressure, or edema.
- Respiratory: + shortness of breath on exertion.
- Gastrointestinal: Appetite good, denies heartburn and indigestion. + episodes of nausea. Bowel movement daily; denies constipation or loose stools.
- Urinary: Denies incontinence, frequency, urgency, pain, or discomfort.
- Skin: + clammy, moist skin.
- Neurological: + fainting; denies numbness, tingling, and tremors.
- Psychiatric: Denies memory loss or depression. Mood pleasant.

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- Family history includes a review of medical events, diseases, and hereditary conditions that may place the patient at risk; and
- Social history includes an age appropriate review of past and current activities.

The two types of PFSH are pertinent and complete.

- A pertinent PFSH is a review of the history areas directly related to the problem(s) identified in the HPI. The pertinent PFSH must document at least one item from any of the three history areas.
- Notes on the Documentation of History

You may list the CC, ROS, and PFSH as separate elements of history or you may include them in the description of the HPI;

You do not need to re-record a ROS and/or a PFSH obtained during an earlier encounter if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his or her own record or in an institutional setting or group practice where many physicians use a common record. You may document the review and update by:

- Describing any new ROS and/or PFSH information or noting there is no change in the information; and
- Noting the date and location of the earlier ROS and/or PFSH;
- Ancillary staff may record the ROS and/or PFSH. Alternatively, the patient may complete a form to provide the ROS and/or PFSH. You must provide a notation supplementing or confirming the information recorded by others to document that the physician reviewed the information; and
- If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance which precludes obtaining a history.

Examination

There are two versions of documentation guidelines – the 1995 version and the 1997 version. The most substantial differences between the two versions occur in the examination documentation section. For billing Medicaid, you may use either version of the documentation guidelines, not a combination of the two, to document a patient encounter.

The levels of E&M services are based on four types of examination:

- Problem Focused – A limited examination of the affected body area or organ system;
- Expanded Problem Focused – A limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s);
- Detailed – An extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s); and
- Comprehensive – A general multi-system examination or complete examination of a single organ system (and other symptomatic or related body area(s) or organ system(s) – 1997 documentation guidelines).

Below are some important points to keep in mind when documenting general multi-system and single organ system examinations (in both the 1995 and the 1997 documentation guidelines):

- Document specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s). A notation of “abnormal” without elaboration is not sufficient;
- Describe abnormal or unexpected findings of the examination of any asymptomatic body area(s) or organ system(s); and
- It is sufficient to provide a brief statement or notation indicating “negative” or “normal” to document normal findings related to unaffected area(s) or asymptomatic organ system(s).

Medical Decision Making

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option, which is determined by considering the following factors:

- The number of possible diagnoses and/or the number of management options that must be considered;
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and
- The risk of significant complications, morbidity, and/or mortality as well as comorbidities associated with the patient’s presenting problem(s), the diagnostic procedure(s), and/or the possible management options.

The chart below depicts the elements for each level of medical decision making. Note that to qualify for a given type of medical decision making, two of the three elements must either be met or exceeded.

Elements for Each Level of Medical Decision Making

Type of Decision Making	Number of Diagnoses or Management Options	Amount and/or Complexity of Data to be Reviewed	Risk of Significant Complications, Morbidity, and/or Mortality
Straightforward	Minimal	Minimal or None	Minimal
Low Complexity	Limited	Limited	Low
Moderate Complexity	Multiple	Moderate	Moderate
High Complexity	Extensive	Extensive	High

Number of Diagnoses and/or Management Options

The number of possible diagnoses and/or the number of management options to consider is based on:

- The number and types of problems addressed during the encounter;
- The complexity of establishing a diagnosis; and

- The management decisions made by the physician.

In general, decision making for a diagnosed problem is easier than decision making for an identified but undiagnosed problem. The number and type of diagnosed tests performed may be an indicator of the number of possible diagnoses. Problems that are improving or resolving are less complex than those problems that are worsening or failing to change as expected. Another indicator of the complexity of diagnostic or management problems is the need to seek advice from other health care professionals.

Below are some important points to keep in mind when documenting the number of diagnoses or management options. You should document:

An assessment, clinical impression, or diagnosis for each encounter, which may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation:

For a presenting problem with an established diagnosis, the record should reflect whether the problem is:

- Improved, well controlled, resolving, or resolved; or
- Inadequately controlled, worsening, or failing to change as expected; or
- For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of differential diagnoses or as a “possible,” “probable,” or “rule out” diagnosis;
- The initiation of, or changes in, treatment, which includes a wide range of management options such as patient instructions, nursing instructions, therapies, and medications; and
- If referrals are made, consultations requested, or advice sought, to whom or where the referral or consultation is made or from whom advice is requested.

Amount and/or Complexity of Data to be Reviewed

The amount and/or complexity of data to be reviewed is based on the types of diagnostic testing ordered or reviewed. Indications of the amount and/or complexity of data being reviewed include:

- A decision to obtain and review old medical records and/or obtain history from sources other than the patient (increases the amount and complexity of data to be reviewed);
- Discussion of contradictory or unexpected test results with the physician who performed or interpreted the test (indicates the complexity of data to be reviewed); and
- The physician who ordered a test personally reviews the image, tracing, or specimen to supplement information from the physician who prepared the test report or interpretation (indicates the complexity of data to be reviewed).
- Below are some important points to keep in mind when documenting amount and/or complexity of data to be reviewed. You should document:
 - The type of service, if a diagnostic service is ordered, planned, scheduled, or performed at the time of the E&M encounter;
 - The review of laboratory, radiology, and/or other diagnostic tests. A simple notation such as “WBC elevated” or “Chest x-ray unremarkable” is acceptable. Alternatively, document the review by initialing and dating the report that contains the test results;

- A decision to obtain old records or obtain additional history from the family, caretaker, or other source to supplement information obtained from the patient;
- Relevant findings from the review of old records and/or the receipt of additional history from the family, caretaker, or other source to supplement information obtained from the patient. You should document that there is no relevant information beyond that already obtained, as appropriate. A notation of “Old records reviewed” or “Additional history obtained from family” without elaboration is not sufficient;
- Discussion about results of laboratory, radiology, or other diagnostic tests with the physician who performed or interpreted the study; and
- The direct visualization and independent interpretation of an image, tracing, or specimen previously or subsequently interpreted by another physician.

Risk of Significant Complications, Morbidity, and/or Mortality

The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the following categories:

- Presenting problem(s);
- Diagnostic procedure(s); and
- Possible management options.
- The assessment of risk of the presenting problem(s) is based on the risk related to the disease process anticipated between the present encounter and the next encounter.
- The assessment of risk of selecting diagnostic procedures and management options is based on the risk during and immediately following any procedures or treatment. The highest level of risk in any one category determines the overall risk.

The level of risk of significant complications, morbidity, and/or mortality can be:

- Minimal;
- Low;
- Moderate; or
- High.

Below are some important points to keep in mind when documenting level of risk. You should document:

- Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality;
- The type of procedure, if a surgical or invasive diagnostic procedure is ordered, planned, or scheduled at the time of the E&M encounter;
- The specific procedure, if a surgical or invasive diagnostic procedure is performed at the time of the E&M encounter; and
- The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis. This point may be implied.

Determination of risk is complex and not readily quantifiable. The table below provides examples in an effort to assist whether the level of risk of significant complications, morbidity, and/or mortality is minimal, low, moderate, or high.

Table of Risk

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
<i>Minimal</i>	<ul style="list-style-type: none"> One self-limited or minor problem 	<ul style="list-style-type: none"> Laboratory tests requiring venipuncture Chest x-rays EKG/EEG Urinalysis Ultrasound 	<ul style="list-style-type: none"> Rest Gargles Elastic bandages Superficial dressings
<i>Low</i>	<ul style="list-style-type: none"> Two or more self-limited or minor problems One stable chronic illness (for example, well controlled hypertension, non-insulin dependent diabetes) Acute uncomplicated illness or injury 	<ul style="list-style-type: none"> Physiologic tests not under stress Non-cardiovascular imaging studies with Superficial needle biopsies Clinical laboratory tests requiring arterial puncture Skin biopsies 	<ul style="list-style-type: none"> Over-the-counter medications Minor surgery with no identified risk factors Physical therapy Occupational therapy IV fluids without additives
<i>Moderate</i>	<ul style="list-style-type: none"> One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment Two or more stable chronic illnesses Undiagnosed new problem with uncertain prognosis Acute illness with systemic symptoms Acute complicated injury 	<ul style="list-style-type: none"> Physiologic tests under stress Diagnostic endoscopies with no identified risk factors Deep needle or incisional biopsy Cardiovascular imaging studies with contrast and no identified risk factors Obtain fluid from body cavity 	<ul style="list-style-type: none"> Minor surgery with identified risk factors Elective major surgery with no identified risk factors Prescription medication management Closed treatment of fracture or dislocation without manipulation
<i>High</i>	<ul style="list-style-type: none"> One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment Acute or chronic injuries that pose a threat to life or bodily function (for example, multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or 	<ul style="list-style-type: none"> Cardiovascular imaging studies with identified risk factors Cardiac physiological tests Cardiac electrophysiological tests Diagnostic endoscopies with identified risk factors Discography 	<ul style="list-style-type: none"> Elective major surgery with identified risk factors Emergency (open, percutaneous or endoscopic) major surgery with identified risk factors Parenteral controlled substances Medication therapy requiring intensive monitoring for toxicity Emergency major surgery (open, percutaneous or endoscopic) Parenteral controlled substances Medication therapy requiring intensive monitoring for toxicity Decision not to resuscitate or to de-

	others, peritonitis, acute renal failure) An abrupt change in neurologic status (for example, seizure, TIA, weakness, sensory loss)		escalate care because of poor prognosis
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Documentation of an Encounter Dominated by Counseling and/or Coordination of Care

When counseling and/or coordination of care dominates (more than 50 percent of) the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting, floor/unit time in the hospital, or NF), time is considered the key or controlling factor to qualify for a particular level of E&M services. *If the level of service is reported based on counseling and/or coordination of care, you should document the total length of time of the encounter and the record should describe the counseling and/or activities to coordinate care.*

The Level I and Level II CPT® books, available from the American Medical Association, list average time guidelines for a variety of E&M services. These times include work done before, during, and after the encounter. The specific times expressed in the code descriptors are averages and, therefore, represent a range of times that may be higher or lower depending on actual clinical circumstances.

Appendix D Vaccines Administration

Procedure Code	Description	Current Maximum Fee (Medicaid)	Medicare Fee (For dually eligible beneficiaries)	Other Conditions/Rate source	Covered through Vaccines for Children (VFC) program
90460	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other health care professional; first or only component of each vaccine or toxoid administered	\$15.00 (as of 1/1/16)	\$26.16		N/A

90471	Immunization administration (includes percutaneous, intradermal, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)	\$19.35 (as of 1/1/16)	\$23.95		N/A
+90472 (add-on to 90471)	Immunization administration; each additional vaccine. List separately in addition to code for primary procedure	\$9.50 (as of 1/1/16)	\$12.34	Add-on code to 90471	N/A
90473	Administration of 1 nasal or oral vaccine	\$19.35	\$23.86		N/A

Appendix E -Vaccines

90633	Hepatitis A vaccine (HepA), pediatric/adolescent dosage-2 dose schedule, for intramuscular use	\$61.64 (covered under VFC program, not billed to Medicaid)	N/A	ODM Provider-Administered Pharmaceutical fee schedule	Yes. Bill Medicaid for administration only (90460, 90471, +90472)
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90634	Hepatitis A vaccine (HepA), pediatric/adolescent dosage-3 dose schedule, for intramuscular use	\$61.64 (covered under VFC program, not billed to Medicaid)	N/A	ODM Provider-Administered Pharmaceutical fee schedule	Yes. Bill Medicaid for administration only (90460, 90471, or 90472)
90632	Hepatitis A vaccine (HepA), adult dosage, for intramuscular use	\$51.23	\$49.40	Part B ASP Fee schedule	No
90371	Hepatitis B immune globulin (HBIG), human, for intramuscular use	\$113.22	\$110.39	Part B ASP Fee schedule	No
90650	Human Papillomavirus vaccine, types 16, 18, bivalent (2vHPV), 3 dose schedule, for intramuscular use	\$136.96	N/A	ODM Provider-Administered Pharmaceutical fee schedule	Yes. Bill Medicaid for administration only (90460, 90471, or 90472)
90649	Human Papillomavirus vaccine, types 6, 11, 16, 18, quadrivalent (4vHPV), 3 dose schedule, for intramuscular use	\$144.43	N/A	ODM Provider-Administered Pharmaceutical fee schedule	Yes. Bill Medicaid for administration only (90460, 90471, or 90472)

90644	Meningococcal conjugate vaccine, serogroups C & Y and Haemophilus influenza type b vaccine (Hib-MenCY), 4 dose schedule, when administered to children 6 weeks-18 months of age, for intramuscular use	Covered under VFC program, not billed to Medicaid	N/A	ODM Provider-Administered Pharmaceutical fee schedule	Yes. Bill Medicaid for administration only (90460, 90471, or 90472)
90698	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Haemophilus influenza type b, and inactivated poliovirus vaccine (DTaP-IPV/Hib), for intramuscular use	\$85.33 (adult)	\$85.33	ODM Provider-Administered Pharmaceutical fee schedule	Yes. Bill Medicaid for administration only (90460, 90471, or 90472)
90654	Influenza virus vaccine, trivalent (IIV3), split virus, preservative-free, for intradermal use	\$18.92	Payment allowance pending for 2015-2016 Flu season (\$18.92 for 2014-2015 season)	95% of AWP (Average Wholesale Price)	No
90658	Influenza virus vaccine, trivalent (IIV3), split virus, when administered to individuals 3 years of age and older, for intramuscular use	Covered under VFC program, not billed to Medicaid	N/A	ODM Provider-Administered Pharmaceutical fee schedule	Yes. Bill Medicaid for administration only (90460, 90471, or 90472)

90660	Influenza virus vaccine, trivalent, live (LAIV3), for intranasal use	23.46 (adult)	\$23.46 (8/1/12-7/31/13)	Covered by Part B.	Yes. Bill Medicaid for administration only (90460-VFC, 90473-Adult)
90670	Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use	\$173.15	\$173.15	Part B ASP Fee schedule	Yes (0-5, 12+)
90680	Rotavirus vaccine, pentavalent (RV5), 3 dose schedule, live, for oral use	Covered under VFC program, not billed to Medicaid	N/A	ODM Provider-Administered Pharmaceutical fee schedule	Yes. Bill Medicaid for administration only (90460, or 90473)
90681	Rotavirus vaccine, human, attenuated (RV1), 2 dose schedule, live, for oral use	Covered under VFC program, not billed to Medicaid	N/A	ODM Provider-Administered Pharmaceutical fee schedule	Yes. Bill Medicaid for administration only (90460 or 90473)
90696	Diphtheria, tetanus toxoids, acellular pertussis vaccine and inactivated poliovirus vaccine (DTaP-IPV), when administered to children 4 through 6 years of age, for intramuscular use	Covered under VFC program, not billed to Medicaid	N/A	ODM Provider-Administered Pharmaceutical fee schedule	Yes. Bill Medicaid for administration only (90460, 90471, or 90472)

90713	Poliovirus vaccine, inactivated (IPV), for subcutaneous or intramuscular use	Covered under VFC program, not billed to Medicaid	N/A	ODM Provider-Administered Pharmaceutical fee schedule	Yes. Bill Medicaid for administration only (90460, 90471, or 90472)
90707	Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use	\$57.66	N/A	ODM Provider-Administered Pharmaceutical fee schedule	Yes. Bill Medicaid for administration only (90460, 90471, or 90472)
90710	Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use	\$157.59	N/A	ODM Provider-Administered Pharmaceutical fee schedule	Yes. Bill Medicaid for administration only (90460, 90471, or 90472)
90714	Tetanus and diphtheria toxoids adsorbed (Td), preservative free, when administered to individuals 7 years or older, for intramuscular use	\$22.75	\$21.06	Part B ASP Fee schedule	Yes. Bill Medicaid for administration only (90460, 90471, or 90472)
90715	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use	\$31.21	\$31.58	Part B ASP Fee schedule	Yes. Bill Medicaid for administration only (90460, 90471, or 90472)

90716	Varicella virus vaccine (VAR), live, for subcutaneous use	\$104.85 (adults)	\$104.85	ODM Provider-Administered Pharmaceutical fee schedule	Yes. Bill Medicaid for administration only (90460, 90471, or 90472)
90736	Shingles vaccine (HZV), live, for subcutaneous injection (individuals 60+ years old)	\$210.93	\$210.93	ODM Provider-Administered Pharmaceutical fee schedule	No
90732	Pneumococcal polysaccharide vaccine, 23-valent (PPSV23), adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use	\$82.52	\$82.51	Part B ASP Fee schedule	Yes. Bill Medicaid for administration only (90460, 90471, or 90472)
90733	Meningococcal polysaccharide vaccine, serogroups A, C, Y, W-135, quadrivalent (MPSV4), for subcutaneous use	\$126.39	N/A	ODM Provider-Administered Pharmaceutical fee schedule	Yes. Bill Medicaid for administration only (90460, 90471, or 90472)
90734	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135, quadrivalent (MenACWY), for intramuscular use	\$115.88	N/A	ODM Provider-Administered Pharmaceutical fee schedule	Yes. Bill Medicaid for administration (90460, 90471, or 90472)

90740	Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, 3 dose schedule, for intramuscular use	\$119.42	\$119.42	Part B ASP Fee schedule	No
90746	Hepatitis B vaccine (HepB), adult dosage, 3 dose schedule, for intramuscular use	\$59.71	\$59.71	Part B ASP Fee schedule	No
90747	Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, 4 dose schedule, for intramuscular use	\$119.42	\$119.42	Part B ASP Fee schedule	No

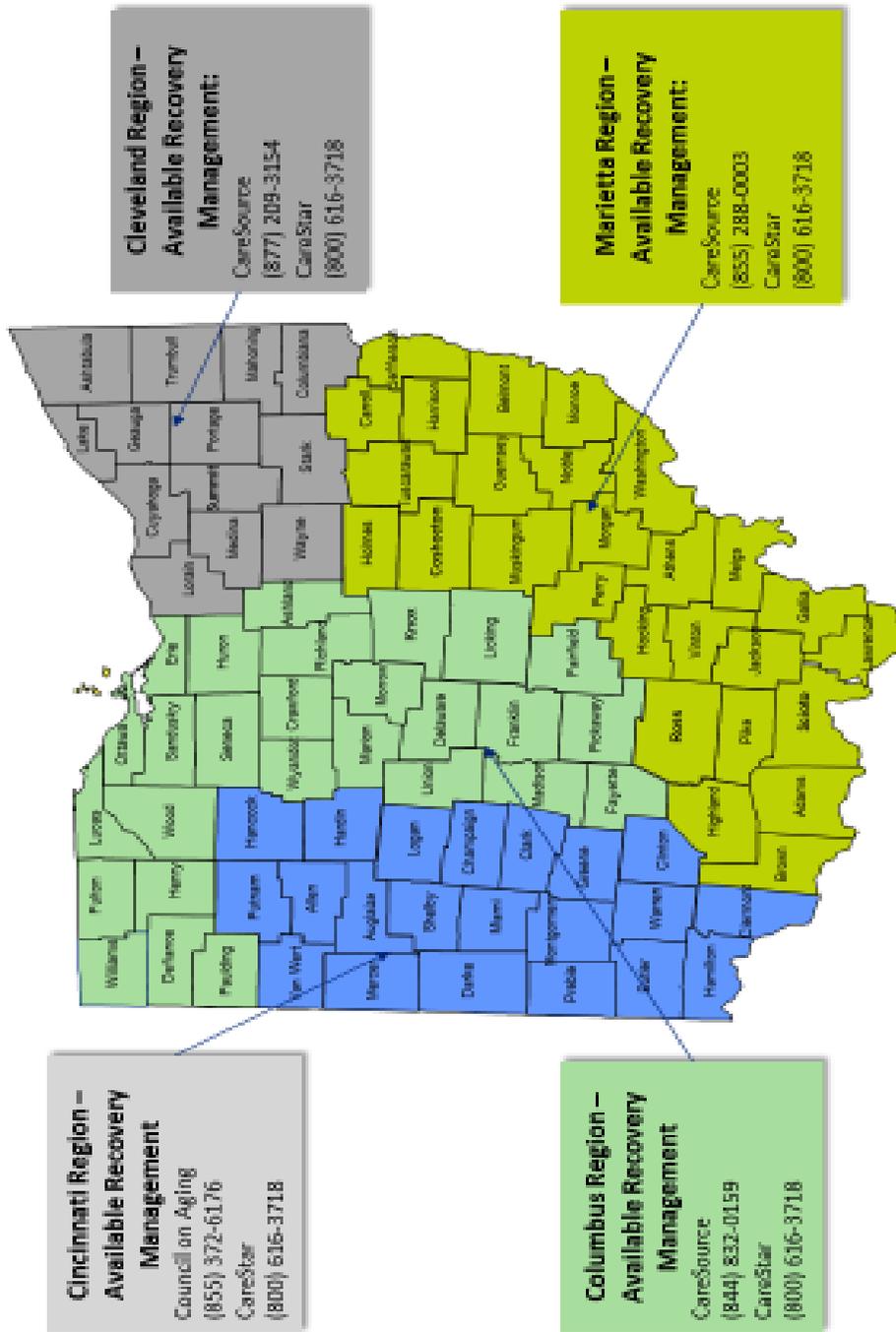
Appendix E-Labs

Procedure Code	Description	Current Maximum Fee (Medicaid)	Medicare Fee (For dually eligible beneficiaries)	CLIA* Waived
Labs				
83037	Hemoglobin; glycosylated (A1C) by device cleared by FDA for home use	\$12.58	\$13.21	QW Modifier (certificate of waiver)
85014	Blood count; hematocrit (Hct)	\$3.17	\$3.23	QW Modifier (certificate of waiver)

82962	Blood glucose by monitoring device cleared by the FDA specifically for home use	\$3.17	\$3.19	Yes
86803	Hepatitis C antibody	\$17.66	\$17.93	QW Modifier (certificate of waiver)
86701	Antibody; HIV-1	\$11.91	\$12.09	QW Modifier (certificate of waiver)
87806	Infectious agent antigen detection by immunoassay with direct optical observation; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies	\$26.22	\$32.80	QW Modifier (certificate of waiver)
83718	Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)	\$10.97	\$11.14	QW Modifier (certificate of waiver)
82465	Cholesterol, serum or whole blood, total	\$5.84	\$5.92	QW Modifier (certificate of waiver)
80061	Lipid panel	\$17.04	\$17.31	QW Modifier (certificate of waiver)
81002	Urinalysis, by dip stick or tablet reagent; non-automated, without microscopy	\$3.16	\$3.21	Yes
81003	Urinalysis, by dip stick or tablet reagent; automated, without microscopy	\$3.01	\$3.06	QW Modifier (certificate of waiver)
81025	Urine Pregnancy test, visual color comparison	\$8.48	\$8.61	Yes
80178	Lithium	\$8.86	\$9.00	QW Modifier (certificate of waiver)

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Specialized Recovery Services Program – Recovery Management Contractors



Appendix G-Early Periodic Screening, Diagnosis, and Treatment (EPSDT)

The EPSDT benefit for children and youth is designed to “ascertain their physical or mental defects and such health care, treatment and other measures to correct or ameliorate defects and chronic conditions.” It provides an overarching mandate specific to children and youth, including a comprehensive package of services for individuals younger than 21 years.

Under EPSDT, “States are required to provide comprehensive services and furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, based on certain federal guidelines. The principles of EPSDT can be summarized as follows:

- **Early**—assess and identify problems early in the child’s life;
- **Periodic**—check the child’s health at periodic, age-appropriate intervals;
- **Screening**—provide physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems;
- **Diagnosis**—perform diagnostic tests to follow up when a risk is identified; and
- **Treatment**—control, correct, or reduce health problems found.

Federal Medicaid law does not define medical necessity directly; instead, it gives states the ability and flexibility to do so. However, federal law reflects the delicate balance between providing clinically appropriate services that are cost effective. Federal law also requires that states do “not arbitrarily deny or reduce the amount, duration, or scope of a required service...solely because of the diagnosis, type of illness, or condition.” Yet, the state “may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.”

The Bright Futures website (<http://www.brightfutures.org/wellchildcare/toolkit/states.html#>) provides information about each state’s EPSDT program, including manuals, forms, rules and regulations, and other detailed policy and operational guidance.

APPENDIX H-E&M Documentation



EVALUATION AND MANAGEMENT SERVICES

ICN 006764 August 2015

Preface

This guide is offered as a reference tool and does not replace content found in the “1995

Documentation Guidelines for Evaluation and Management Services” and the “1997 Documentation Guidelines for Evaluation and Management Services.” These publications are available in the Reference Section of this guide and at https://www.cms.gov/Outreachand-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Doc_guidelines.pdf and <https://www.cms.gov/Outreach-and-Education/Medicare-LearningNetwork->

[MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf](#) on the Centers for Medicare & Medicaid Services website.

Note: You may use either version of the documentation guidelines, not a combination of the two, for a patient encounter. For reporting services furnished on and after September 10, 2013, to Medicare, you may use the 1997 documentation guidelines for an extended history of present illness along with other elements from the 1995 documentation guidelines to document an evaluation and management service.

Medical Record Documentation

This chapter provides information on the general principles of evaluation and management (E/M) documentation, common sets of codes used to bill for E/M services, and E/M services providers.

General Principles of E/M Documentation

“If it isn’t documented, it hasn’t been done” is an adage frequently heard in the health care setting.

Clear and concise medical record documentation is critical to providing patients with quality care and is required for you to receive accurate and timely payment for furnished services. Medical records chronologically report the care a patient received and record pertinent facts, findings, and observations about the patient’s health history. Medical record documentation helps physicians and other health care professionals evaluate and plan the patient’s immediate treatment and monitor the patient’s health care over time.

Health care payers may require reasonable documentation to ensure that a service is consistent with the patient’s insurance coverage and to validate:

The site of service;

The medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or

That services furnished were accurately reported.

General principles of medical record documentation apply to all types of medical and surgical services in all settings. While E/M services vary in several ways, such as the nature and amount of physician work required, the following general principles help ensure that medical record documentation for all E/M services is appropriate:

The medical record should be complete and legible;

The documentation of each patient encounter should include:

Reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results;

Assessment, clinical impression, or diagnosis;

Medical plan of care; and

Date and legible identity of the observer;

If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred;

Past and present diagnoses should be accessible to the treating and/or consulting physician;

Appropriate health risk factors should be identified;

The patient’s progress, response to and changes in treatment, and revision of diagnosis should be documented; and

The diagnosis and treatment codes reported on the health insurance claim form or billing statement should be supported by documentation in the medical record. To maintain an accurate medical record, document services during the encounter or as soon as practicable after the encounter.

Common Sets of Codes Used to Bill for E/M Services

When billing for a patient's visit, select codes that best represent the services furnished during the visit. A billing specialist or alternate source may review the provider's documented services before submitting the claim to a payer. These reviewers may help select codes that best reflect the provider's furnished services. However, the provider must ensure that the submitted claim accurately reflects the services provided.

The provider must ensure that medical record documentation supports the level of service reported to a payer. You should not use the volume of documentation to determine which specific level of service to bill.

Services must meet specific medical necessity requirements in the statute, regulations, and manuals and specific medical necessity criteria defined by National Coverage Determinations and Local Coverage Determinations (if any exist for the service reported on the claim). For every service billed, you must indicate the specific sign, symptom, or patient complaint that makes the service reasonable and necessary.

Healthcare Common Procedure Coding System (HCPCS)

The HCPCS is the Health Insurance Portability and Accountability Act-compliant code set for providers to report procedures, services, drugs, and devices furnished by physicians and other non-physician practitioners, hospital outpatient facilities, ambulatory surgical centers, and other outpatient facilities. This system includes Current Procedural Terminology Codes, which the American Medical Association developed and maintains.

International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS)

ICD-10-CM codes – All providers, including physicians, use this code set to report medical diagnoses on all types of claims for services furnished in the United States (U.S.).

ICD-10-PCS codes – Facilities use this code set to report inpatient procedures and services furnished in U.S. hospital inpatient health care settings. Use HCPCS codes to report ambulatory services and physician services, including those physician services furnished during an inpatient hospitalization.

E/M Services Providers

To receive payment from Medicare for E/M services, the Medicare benefit for the relevant type of provider must permit him or her to bill for E/M services. The services must also be within the scope of practice for the relevant type of provider in the State in which they are furnished.

Evaluation and Management (E/M) Billing and Coding

Considerations

This chapter provides information on selecting the code that best represents the service furnished and other considerations.

Selecting the Code That Best Represents the Service Furnished

Billing Medicare for an E/M service requires the selection of a Current Procedural Terminology (CPT) code that best represents:

Patient type;
 Setting of service; and
 Level of E/M service performed.

Patient Type

For purposes of billing for E/M services, patients are identified as either new or established, depending on previous encounters with the provider.

A **new patient** is defined as an individual who has not received any professional services from the physician/non-physician practitioner (NPP) or another physician of the same specialty who belongs to the same group practice within the previous 3 years.

An **established patient** is an individual who has received professional services from the physician/NPP or another physician of the same specialty who belongs to the same group practice within the previous 3 years.

Setting of Service

E/M services are categorized into different settings depending on where the service is furnished. Examples of settings include:

- Office or other outpatient setting;
- Hospital inpatient;
- Emergency department (ED); and
- Nursing facility (NF).

Level of E/M Service Performed

The code sets to bill for E/M services are organized into various categories and levels. In general, the more complex the visit, the higher the level of code you may bill within the appropriate category. To bill any code, the services furnished must meet the definition of the code. You must ensure that the codes selected reflect the services furnished.

The three key components when selecting the appropriate level of E/M services provided are history, examination, and medical decision making. Visits that consist predominately of counseling and/or coordination of care are an exception to this rule. For these visits, time is the key or controlling factor to qualify for a particular level of E/M services.

The three key components are discussed in more detail on pages 5–17.

History

The chart below depicts the elements required for each type of history. More information on the activities comprising each of these elements is provided on pages 5–10. To qualify for a given type of history, all four elements indicated in the row must be met. Note that as the type of history becomes more intensive, the elements required to perform that type of history also increase in intensity.

For example, a problem focused history requires documentation of the chief complaint (CC) and a brief history of present illness (HPI), while a detailed history requires the documentation of a CC, an extended HPI, plus an extended review of systems (ROS), and pertinent past, family, and/or social history (PFSH).

Elements Required for Each Type of History

Type of History	CC	HPI	ROS	PFSH
Problem Focused	Required	Brief	N/A	N/A

Expanded Problem Focused	Required	Brief	Problem Pertinent	N/A
Detailed	Required	Extended	Extended	Pertinent
Comprehensive	Required	Extended	Complete	Complete

While documentation of the CC is required for all levels, the extent of information gathered for the remaining elements related to a patient's history depends on clinical judgment and the nature of the presenting problem.

Chief Complaint

A CC is a concise statement that describes the symptom, problem, condition, diagnosis, or reason for the patient encounter. The CC is usually stated in the patient's own words. For example, patient complains of upset stomach, aching joints, and fatigue. The medical record should clearly reflect the CC.

History of Present Illness

HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. HPI elements are:

Location (example: left leg);

Quality (example: aching, burning, radiating pain);

Severity (example: 10 on a scale of 1 to 10);

Duration (example: started 3 days ago);

Timing (example: constant or comes and goes);

Context (example: lifted large object at work);

Modifying factors (example: better when heat is applied); and

Associated signs and symptoms (example: numbness in toes).

The two types of HPIs are brief and extended.

A **brief HPI** includes documentation of one to three HPI elements.

In the following example, three HPI elements – location, quality, and duration – are documented:

CC: Patient complains of earache.

Brief HPI: Dull ache in left ear over the past 24 hours.

An **extended HPI**:

1995 documentation guidelines – Should describe four or more elements of the present HPI or associated comorbidities.

1997 documentation guidelines – Should describe at least four elements of the present HPI or the status of at least three chronic or inactive conditions.

For reporting services furnished on and after September 10, 2013, to Medicare, you may use the 1997 documentation guidelines for an extended HPI along with other elements from the 1995 documentation guidelines to document an E/M service.

In the following example, five HPI elements – location, quality, duration, context, and modifying factors – are documented:

CC: Patient complains of earache.

Extended HPI: Patient complains of dull ache in left ear over the past 24 hours. Patient states he went swimming two days ago. Symptoms somewhat relieved by warm compress and ibuprofen.

Review of Systems

ROS is an inventory of body systems obtained by asking a series of questions to identify signs and/or symptoms that the patient may be experiencing or has experienced. The following systems are recognized for ROS purposes:

Constitutional Symptoms (for example, fever, weight loss);

Eyes;

Ears, Nose, Mouth, Throat;

Cardiovascular;

Respiratory;

Gastrointestinal;

Genitourinary;

Musculoskeletal;

Integumentary (skin and/or breast);

Neurological;

Psychiatric;

Endocrine;

Hematologic/Lymphatic; and ∞ Allergic/Immunologic.

The three types of ROS are problem pertinent, extended, and complete.

A **problem pertinent ROS** inquires about the system directly related to the problem identified in the HPI.

In the following example, one system – the ear – is reviewed:

CC: Earache.

ROS: Positive for left ear pain. Denies dizziness, tinnitus, fullness, or headache.

An **extended ROS** inquires about the system directly related to the problem(s) identified in the HPI and a limited number (two to nine) of additional systems.

In the following example, two systems – cardiovascular and respiratory – are reviewed:

CC: Follow-up visit in office after cardiac catheterization. Patient states “I feel great.”

ROS: Patient states he feels great and denies chest pain, syncope, palpitations, and shortness of breath. Relates occasional unilateral, asymptomatic edema of left leg.

A **complete ROS** inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional (minimum of ten) organ systems. You must individually document those systems with positive or pertinent negative responses. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, you must individually document at least ten systems.

In the following example, ten signs and symptoms are reviewed:

CC: Patient complains of “fainting spell.”

ROS:

Constitutional: Weight stable, + fatigue.

Eyes: + loss of peripheral vision.

Ear, Nose, Mouth, Throat: No complaints.

Cardiovascular: + palpitations; denies chest pain; denies calf pain, pressure, or edema.

Respiratory: + shortness of breath on exertion.

Gastrointestinal: Appetite good, denies heartburn and indigestion. + episodes of nausea. Bowel movement daily; denies constipation or loose stools.

Urinary: Denies incontinence, frequency, urgency, nocturia, pain, or discomfort.

Skin: + clammy, moist skin.

Neurological: + fainting; denies numbness, tingling, and tremors.

Psychiatric: Denies memory loss or depression. Mood pleasant.

Past, Family, and/or Social History

PFSH consists of a review of three areas:

Past history includes experiences with illnesses, operations, injuries, and treatments;

Family history includes a review of medical events, diseases, and hereditary conditions that may place the patient at risk; and

Social history includes an age appropriate review of past and current activities. The two types of PFSH are pertinent and complete.

A **pertinent PFSH** is a review of the history areas directly related to the problem(s) identified in the HPI. The pertinent PFSH must document at least **one** item from any of the three history areas.

In the following example, the patient's past surgical history is reviewed as it relates to the identified HPI:

HPI: Coronary artery disease.

PFSH: Patient returns to office for follow-up of coronary artery bypass graft in 1992.

Recent cardiac catheterization demonstrates 50 percent occlusion of vein graft to obtuse marginal artery.

A **complete PFSH** is a review of two or all three of the areas, depending on the category of E/M service. A complete PFSH requires a review of all three history areas for services that, by their nature, include a comprehensive assessment or reassessment of the patient. A review of two history areas is sufficient for other services.

You must document at least one specific item from **two** of the three history areas for a complete PFSH for the following categories of E/M services:

Office or other outpatient services, established patient;

ED;

Domiciliary care, established patient;

Subsequent NF care (if following the 1995 documentation guidelines); and ☞ Home care, established patient.

You must document at least one specific item from **each** of the history areas for the following categories of E/M services:

Office or other outpatient services, new patient;

Hospital observation services;

Hospital inpatient services, initial care;

Comprehensive NF assessments; ☞ Domiciliary care, new patient; and ☞ Home care, new patient.

In the following example, the patient's genetic history is reviewed as it relates to the current HPI:

HPI: Coronary artery disease.

PFSH: Family history reveals the following:

Maternal grandparents – Both + for coronary artery disease; grandfather: deceased at age 69; grandmother: still living.

Paternal grandparents – Grandmother: + diabetes, hypertension; grandfather: + heart attack at age 55.

Parents – Mother: + obesity, diabetes; father: + heart attack at age 51, deceased at age 57 of heart attack.

Siblings – Sister: + diabetes, obesity, hypertension, age 39; brother: + heart attack at age 45, living.

Notes on the Documentation of History

You may list the CC, ROS, and PFSH as separate elements of history or you may include them in the description of the HPI;

You do not need to re-record a ROS and/or a PFSH obtained during an earlier encounter if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his or her own record or in an institutional setting or group practice where many physicians use a common record. You may document the review and update by:

Describing any new ROS and/or PFSH information or noting there is no change in the information; and

Noting the date and location of the earlier ROS and/or PFSH;

Ancillary staff may record the ROS and/or PFSH. Alternatively, the patient may complete a form to provide the ROS and/or PFSH. You must provide a notation supplementing or confirming the information recorded by others to document that the physician reviewed the information; and

If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance which precludes obtaining a history.

Examination

As stated previously, there are two versions of the documentation guidelines – the 1995 version and the 1997 version. The most substantial differences between the two versions occur in the examination documentation section. For billing Medicare, you may use either version of the documentation guidelines, not a combination of the two, to document a patient encounter.

The levels of E/M services are based on four types of examination:

Problem Focused – A limited examination of the affected body area or organ system;

Expanded Problem Focused – A limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s);

Detailed – An extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s); and

Comprehensive – A general multi-system examination or complete examination of a single organ system (and other symptomatic or related body area(s) or organ system(s) – 1997 documentation guidelines).

An examination may involve several organ systems or a single organ system. The type and extent of the examination performed is based on clinical judgment, the patient's history, and nature of the presenting problem(s).

The 1997 documentation guidelines describe two types of comprehensive examinations that can be performed during a patient's visit: general multi-system examination and single organ examination.

A **general multi-system examination** involves the examination of one or more organ systems or body areas, as depicted in the chart below.

General Multi-System Examination

Type of Examination	Description
Problem Focused	Include performance and documentation of one to five elements identified by a bullet in one or more organ system(s) or body area(s).
Expanded Problem Focused	Include performance and documentation of at least six elements identified by a bullet in one or more organ system(s) or body area(s).
Detailed	Include at least six organ systems or body areas. For each system/area selected, performance and documentation of at least two elements identified by a bullet is expected. Alternatively, may include performance and documentation of at least twelve elements identified by a bullet in two or more organ systems or body areas.
Comprehensive	Include at least nine organ systems or body areas. For each system/area selected, all elements of the examination identified by a bullet should be performed, unless specific directions limit the content of the examination. For each area/system, documentation of at least two elements identified by bullet is expected.*

* The 1995 documentation guidelines state that the medical record for a general multi-system examination should include findings about eight or more organ systems.

A **single organ system examination** involves a more extensive examination of a specific organ system, as depicted in the chart below.

Single Organ System Examination

Type of Examination	Description
Problem Focused	Include performance and documentation of one to five elements identified by a bullet, whether in a box with a shaded or unshaded border.
Expanded Problem Focused	Include performance and documentation of at least six elements identified by a bullet, whether in a box with a shaded or unshaded border.

Detailed	Examinations other than the eye and psychiatric examinations should include performance and documentation of at least twelve elements identified by a bullet, whether in a box with a shaded or unshaded border. Eye and psychiatric examinations include the performance and documentation of at least nine elements identified by a bullet, whether in a box with a shaded or unshaded border.
Comprehensive	Include performance of all elements identified by a bullet, whether in a shaded or unshaded box. Documentation of every element in each box with a shaded border and at least one element in a box with an unshaded border is expected.

Both types of examinations may be performed by any physician, regardless of specialty. Below are some important points to keep in mind when documenting general multi-system and single organ system examinations (in both the 1995 and the 1997 documentation guidelines):

Document specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s). A notation of “abnormal” without elaboration is not sufficient;

Describe abnormal or unexpected findings of the examination of any asymptomatic body area(s) or organ system(s); and

It is sufficient to provide a brief statement or notation indicating “negative” or “normal” to document normal findings related to unaffected area(s) or asymptomatic organ system(s).

Medical Decision Making

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option, which is determined by considering the following factors:

The number of possible diagnoses and/or the number of management options that must be considered;

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and

The risk of significant complications, morbidity, and/or mortality as well as comorbidities associated with the patient’s presenting problem(s), the diagnostic procedure(s), and/or the possible management options.

The chart below depicts the elements for each level of medical decision making. Note that to qualify for a given type of medical decision making, two of the three elements must either be met or exceeded.

Elements for Each Level of Medical Decision Making

Type of Decision Making	Number of Diagnoses or Management Options	Amount and/or Complexity of Data to be Reviewed	Risk of Significant Complications, Morbidity, and/or Mortality
Straightforward	Minimal	Minimal or None	Minimal
Low Complexity	Limited	Limited	Low
Moderate Complexity	Multiple	Moderate	Moderate
High Complexity	Extensive	Extensive	High

Number of Diagnoses and/or Management Options

The number of possible diagnoses and/or the number of management options to consider is based on:

The number and types of problems addressed during the encounter;

The complexity of establishing a diagnosis; and

The management decisions made by the physician.

In general, decision making for a diagnosed problem is easier than decision making for an identified but undiagnosed problem. The number and type of diagnosed tests performed may be an indicator of the number of possible diagnoses. Problems that are improving or resolving are less complex than those problems that are worsening or failing to change as expected. Another indicator of the complexity of diagnostic or management problems is the need to seek advice from other health care professionals.

Below are some important points to keep in mind when documenting the number of diagnoses or management options. You should document:

An assessment, clinical impression, or diagnosis for each encounter, which may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation:

For a presenting problem with an established diagnosis, the record should reflect whether the problem is:

Improved, well controlled, resolving, or resolved; or

Inadequately controlled, worsening, or failing to change as expected; or

For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of differential diagnoses or as a “possible,” “probable,” or “rule out” diagnosis;

The initiation of, or changes in, treatment, which includes a wide range of management options such as patient instructions, nursing instructions, therapies, and medications; and

If referrals are made, consultations requested, or advice sought, to whom or where the referral or consultation is made or from whom advice is requested.

Amount and/or Complexity of Data to be Reviewed

The amount and/or complexity of data to be reviewed is based on the types of diagnostic testing ordered or reviewed. Indications of the amount and/or complexity of data being reviewed include:

A decision to obtain and review old medical records and/or obtain history from sources other than the patient (increases the amount and complexity of data to be reviewed); Discussion of contradictory or unexpected test results with the physician who performed or interpreted the test (indicates the complexity of data to be reviewed); and The physician who ordered a test personally reviews the image, tracing, or specimen to supplement information from the physician who prepared the test report or interpretation (indicates the complexity of data to be reviewed).

Below are some important points to keep in mind when documenting amount and/or complexity of data to be reviewed. You should document:

The type of service, if a diagnostic service is ordered, planned, scheduled, or performed at the time of the E/M encounter;

The review of laboratory, radiology, and/or other diagnostic tests. A simple notation such as “WBC elevated” or “Chest x-ray unremarkable” is acceptable. Alternatively, document the review by initialing and dating the report that contains the test results; A decision to obtain old records or obtain additional history from the family, caretaker, or other source to supplement information obtained from the patient;

Relevant findings from the review of old records and/or the receipt of additional history from the family, caretaker, or other source to supplement information obtained from the patient. You should document that there is no relevant information beyond that already obtained, as appropriate. A notation of “Old records reviewed” or “Additional history obtained from family” without elaboration is not sufficient;

Discussion about results of laboratory, radiology, or other diagnostic tests with the physician who performed or interpreted the study; and

The direct visualization and independent interpretation of an image, tracing, or specimen previously or subsequently interpreted by another physician.

Risk of Significant Complications, Morbidity, and/or Mortality

The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the following categories:

Presenting problem(s); ☞ Diagnostic procedure(s); and Possible management options.

The assessment of risk of the presenting problem(s) is based on the risk related to the disease process anticipated between the present encounter and the next encounter.

The assessment of risk of selecting diagnostic procedures and management options is based on the risk during and immediately following any procedures or treatment. The highest level of risk in any one category determines the overall risk.

The level of risk of significant complications, morbidity, and/or mortality can be:

Minimal;

Low;

Moderate; or ☞ High.

Below are some important points to keep in mind when documenting level of risk. You should document:

Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality;

The type of procedure, if a surgical or invasive diagnostic procedure is ordered, planned, or scheduled at the time of the E/M encounter;

The specific procedure, if a surgical or invasive diagnostic procedure is performed at the time of the E/M encounter; and

The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis. This point may be implied.

The table below can help determine whether the level of risk of significant complications, morbidity, and/or mortality is minimal, low, moderate, or high. Because determination of risk is complex and not readily quantifiable, the table includes common clinical examples rather than absolute measures of risk.

Table of Risk

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	<ul style="list-style-type: none"> One self-limited or minor problem (for example, cold, insect bite, tinea corporis) 	Laboratory tests requiring venipuncture Chest x-rays EKG/EEG Urinalysis Ultrasound (for example, echocardiography) KOH prep	<ul style="list-style-type: none"> Rest Gargles Elastic bandages Superficial dressings
Low	<ul style="list-style-type: none"> Two or more self-limited or minor problems One stable chronic illness (for example, well controlled hypertension, non-insulin dependent diabetes, cataract, BPH) Acute uncomplicated illness or injury (for example, cystitis, allergic rhinitis, simple sprain) 	Physiologic tests not under stress (for example, pulmonary function tests) Non-cardiovascular imaging studies with contrast (for example, barium enema) Superficial needle biopsies Clinical laboratory tests requiring arterial puncture Skin biopsies	<ul style="list-style-type: none"> Over-the-counter drugs Minor surgery with no identified risk factors Physical therapy Occupational therapy IV fluids without additives

Moderate	<ul style="list-style-type: none"> • One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses <p>Undiagnosed new problem with uncertain prognosis (for example, lump in breast)</p> <p>Acute illness with systemic symptoms (for example, pyelonephritis, pneumonitis, colitis)</p> <p>Acute complicated injury (for example, head injury with brief loss of consciousness)</p>	<p>Physiologic tests under stress (for example, cardiac stress test, fetal contraction stress test)</p> <p>Diagnostic endoscopies with no identified risk factors</p> <p>Deep needle or incisional biopsy</p> <p>Cardiovascular imaging studies with contrast and no identified risk factors (for example, arteriogram, cardiac catheterization)</p> <p>Obtain fluid from body cavity (for example, lumbar puncture, thoracentesis, culdocentesis)</p>	<ul style="list-style-type: none"> • Minor surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation
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Table of Risk (cont.)

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
High	<ul style="list-style-type: none"> • One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment <p>Acute or chronic illnesses or injuries that pose a threat to life or bodily function (for example, multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure)</p> <p>An abrupt change in neurologic status (for example, seizure, TIA, weakness, sensory loss)</p>	<p>Cardiovascular imaging studies with contrast with identified risk factors</p> <p>Cardiac electrophysiological tests</p> <p>Diagnostic endoscopies with identified risk factors</p> <p>Discography</p>	<ul style="list-style-type: none"> • Elective major surgery (open, percutaneous or endoscopic) with identified risk factors • Emergency major surgery (open, percutaneous or endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis

Documentation of an Encounter Dominated by Counseling and/or Coordination of Care

When counseling and/or coordination of care dominates (more than 50 percent of) the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting, floor/unit time in the hospital, or NF), time is considered the key or controlling factor to qualify for a particular level of E/M services. If the level of service is reported based on counseling and/or coordination of care, you should document the

total length of time of the encounter and the record should describe the counseling and/or activities to coordinate care.

The Level I and Level II CPT® books, available from the American Medical Association, list average time guidelines for a variety of E/M services. These times include work done before, during, and after the encounter. The specific times expressed in the code descriptors are averages and, therefore, represent a range of times that may be higher or lower depending on actual clinical circumstances.

Other Considerations

Split/Shared Services

A split/shared service is an encounter where a physician and a NPP each personally perform a portion of an E/M visit. Below are the rules for reporting split/shared E/M services between physicians and NPPs:

In the office or clinic setting:

For encounters with established patients who meet incident to requirements, use either practitioner's National Provider Identifier (NPI); and

For encounters that do not meet incident to requirements, use the NPP's NPI.

Hospital inpatient, outpatient, and ED setting encounters shared between a physician and a NPP from the same group practice:

When the physician provides any face-to-face portion of the encounter, use either provider's NPI; and

When the physician does not provide a face-to-face encounter, use the NPP's NPI.

Consultation Services

Effective for services furnished on or after January 1, 2010, Medicare no longer recognizes inpatient consultation codes (CPT codes 99251–99255) and office and other outpatient consultation codes (CPT codes 99241–99245) for Part B payment purposes.

However, telehealth consultation codes (Healthcare Common Procedure Coding System G0406–G0408 and G0425–G0427) are recognized for Medicare payment.

Physicians and NPPs who furnish services that, prior to January 1, 2010, would have been reported as CPT consultation codes, should report the appropriate E/M visit code to bill for these services beginning January 1, 2010.

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Reference Section

Resources

The chart below provides evaluation and management (E/M) services resource information.

E/M Services Resources

For More Information About...	Resource
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Evaluation and Management Services	<p>The “Medicare Benefit Policy Manual” (Publication 100-02) and the “Medicare Claims Processing Manual” (Publication 100-04) located at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the Centers for Medicare & Medicaid Services (CMS) website</p> <p>“1995 Documentation Guidelines for Evaluation and Management Services” located at https://www.cms.gov/Outreachand-Education/Medicare-LearningNetwork-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf on the CMS website</p> <p>“1997 Documentation Guidelines for Evaluation and Management Services” located at https://www.cms.gov/Outreachand-Education/Medicare-LearningNetwork-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf on the CMS website</p>
ICD-10-CM/PCS	<p>https://www.cms.gov/Medicare/Coding/ICD10 on the CMS website</p>
CPT® Books	<p>American Medical Association (AMA) located at https://commerce.ama-assn.org/store on the AMA website</p>

E/M Services Resources (cont.)

For More Information About...	Resource
All Available MLN Products	<p>“MLN Catalog” located at https://www.cms.gov/Outreach-and-Education/Medicare-LearningNetwork-MLN/MLNProducts/Downloads/MLNCatalog.pdf on the CMS website or scan the Quick Response (QR) code</p> 

Provider-Specific Medicare Information	MLN publication titled “MLN Guided Pathways: Provider Specific Medicare Resources” located at https://www.cms.gov/Outreach-and-Education/MedicareLearning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf on the CMS website
Medicare Information for Patients	https://www.medicare.gov on the CMS website

DRAFT

I. INTRODUCTION

WHAT IS DOCUMENTATION AND WHY IS IT IMPORTANT?

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care. The medical record facilitates:

- the ability of the physician and other healthcare professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her healthcare over time;
- communication and continuity of care among physicians and other healthcare professionals involved in the patient's care;
- accurate and timely claims review and payment;
- appropriate utilization review and quality of care evaluations; and
- collection of data that may be useful for research and education.

An appropriately documented medical record can reduce many of the "hassles" associated with claims processing and may serve as a legal document to verify the care provided, if necessary.

WHAT DO PAYERS WANT AND WHY?

Because payers have a contractual obligation to enrollees, they may require reasonable documentation that services are consistent with the insurance coverage provided. They may request information to validate:

- the site of service;
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- the medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or
- that services provided have been accurately reported.

II. GENERAL PRINCIPLES OF MEDICAL RECORD DOCUMENTATION

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For Evaluation and Management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient's status. The general principles listed below may be modified to account for these variable circumstances in providing E/M services.

The medical record should be complete and legible.

The documentation of each patient encounter should include:

- reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results;
- assessment, clinical impression, or diagnosis;
- plan for care; and
- date and legible identity of the observer.

If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.

Past and present diagnoses should be accessible to the treating and/or consulting physician.

Appropriate health risk factors should be identified.

The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.

The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

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II. DOCUMENTATION OF E/M SERVICES

This publication provides definitions and documentation guidelines for the three **key** components of E/M services and for visits which consist predominately of counseling or coordination of care. The three key components--history, examination, and medical decision making--appear in the descriptors for office and other outpatient services, hospital observation services, hospital inpatient services, consultations, emergency department services, nursing facility services, domiciliary care services, and home services. While some of the text of CPT has been repeated in this publication, the reader should refer to CPT for the complete descriptors for E/M services and instructions for selecting a level of service. **Documentation guidelines are identified by the symbol • DG.**

The descriptors for the levels of E/M services recognize seven components which are used in defining the levels of E/M services. These components are:

- history;
- examination;
- medical decision making;
- counseling;
- coordination of care;
- nature of presenting problem; and
- time.

The first three of these components (i.e., history, examination and medical decision making) are the **key** components in selecting the level of E/M services. An exception to this rule is the case of visits which consist predominantly of counseling or coordination of care; for these services time is the key or controlling factor to qualify for a particular level of E/M service.

For certain groups of patients, the recorded information may vary slightly from that described here. Specifically, the medical records of infants, children, adolescents and pregnant women may have additional or modified information recorded in each history and examination area.

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As an example, newborn records may include under history of the present illness (HPI) the details of mother's pregnancy and the infant's status at birth; social history will focus on family structure; family history will focus on congenital anomalies and hereditary disorders in the family. In addition, information on growth and development and/or nutrition will be recorded. Although not specifically defined in these documentation guidelines, these patient group variations on history and examination are appropriate.

A. DOCUMENTATION OF HISTORY

The levels of E/M services are based on four types of history (Problem Focused, Expanded Problem Focused, Detailed, and Comprehensive). Each type of history includes some or all of the following elements:

- Chief complaint (CC);
- History of present illness (HPI);
- Review of systems (ROS); and
- Past, family and/or social history (PFSH).

The extent of history of present illness, review of systems, and past, family and/or social history that is obtained and documented is dependent upon clinical judgment and the nature of the presenting problem(s).

The chart below shows the progression of the elements required for each type of history. To qualify for a given type of history, **all three elements in the table must be met.** (A chief complaint is indicated at all levels.)

History of Present Illness (HPI)	Review of Systems (ROS)	Past, Family, and/or Social History (PFSH)	Type of History
Brief	N/A	N/A	<i>Problem Focused</i>
Brief	Problem Pertinent	N/A	<i>Expanded Problem Focused</i>
Extended	Extended	Pertinent	<i>Detailed</i>
Extended	Complete	Complete	<i>Comprehensive</i>

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- *DG: The CC, ROS and PFSH may be listed as separate elements of history, or they may be included in the description of the history of the present illness.*
- *DG: A ROS and/or a PFSH obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his/her own record or in an institutional setting or group practice where many physicians use a common record. The review and update may be documented by:*
 - *describing any new ROS and/or PFSH information or noting there has been no change in the information; and*
 - *noting the date and location of the earlier ROS and/or PFSH.*
- *DG: The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.*
- *DG: If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance which precludes obtaining a history.*

Definitions and specific documentation guidelines for each of the elements of history are listed below.

CHIEF COMPLAINT (CC)

The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter.

- *DG: The medical record should clearly reflect the chief complaint.*

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HISTORY OF PRESENT ILLNESS (HPI)

The HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. It includes the following elements:

- location;
 - quality;
 - severity;
 - duration;
 - timing;
 - context;
 - modifying factors;
- and
- associated signs and symptoms.

Brief and **extended** HPIs are distinguished by the amount of detail needed to accurately characterize the clinical problem(s).

A **brief** HPI consists of one to three elements of the HPI.

- *DG: The medical record should describe one to three elements of the present illness (HPI).*

An **extended** HPI consists of four or more elements of the HPI.

- *DG: The medical record should describe four or more elements of the present illness (HPI) or associated comorbidities.*

REVIEW OF SYSTEMS (ROS)

A ROS is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced.

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For purposes of ROS, the following systems are recognized:

- Constitutional symptoms (e.g., fever, weight loss)
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

A **problem pertinent** ROS inquires about the system directly related to the problem(s) identified in the HPI.

- *DG: The patient's positive responses and pertinent negatives for the system related to the problem should be documented.*

An **extended** ROS inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems.

- *DG: The patient's positive responses and pertinent negatives for two to nine systems should be documented.*

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A **complete** ROS inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional body systems.

- *DG: At least ten organ systems must be reviewed. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least ten systems must be individually documented.*

PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)

The PFSH consists of a review of three areas:

- past history (the patient's past experiences with illnesses, operations, injuries and treatments);
- family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk); and
- social history (an age appropriate review of past and current activities).

For the categories of subsequent hospital care, follow-up inpatient consultations and subsequent nursing facility care, CPT requires only an "interval" history. It is not necessary to record information about the PFSH.

A **pertinent** PFSH is a review of the history area(s) directly related to the problem(s) identified in the HPI.

- *DG: At least one specific item from any of the three history areas must be documented for a pertinent PFSH.*

A **complete** PFSH is of a review of two or all three of the PFSH history areas, depending on the category of the E/M service. A review of all three history areas is required for services that by their nature include a comprehensive assessment or reassessment of the patient. A review of two of the three history areas is sufficient for other services.

- *DG: At least one specific item from two of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services, established patient; emergency department; subsequent nursing facility care; domiciliary care, established patient; and home care, established patient.*

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- *DG: At least one specific item from each of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services, new patient; hospital observation services; hospital inpatient services, initial care; consultations; comprehensive nursing facility assessments; domiciliary care, new patient; and homecare, new patient.*

B. DOCUMENTATION OF EXAMINATION

The levels of E/M services are based on four types of examination that are defined as follows:

- **Problem Focused** -- a limited examination of the affected body area or organ system.
- **Expanded Problem Focused** -- a limited examination of the affected body area or organ system and other symptomatic or related organ system(s).
- **Detailed** -- an extended examination of the affected body area(s) and other symptomatic or related organ system(s).

- **Comprehensive** -- a general multi-system examination or complete examination of a single organ system.

For purposes of examination, the following **body areas** are recognized:

- Head, including the face
- Neck
- Chest, including breasts and axillae
- Abdomen
- Genitalia, groin, buttocks
- Back, including spine
- Each extremity

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For purposes of examination, the following **organ systems** are recognized:

- Constitutional (e.g., vital signs, general appearance)
- Eyes
- Ears, nose, mouth, and throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic/immunologic

The extent of examinations performed and documented is dependent upon clinical judgment and the nature of the presenting problem(s). They range from limited examinations of single body areas to general multi-system or complete single organ system examinations.

- *DG: Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of "abnormal" without elaboration is insufficient.*
- *DG: Abnormal or unexpected findings of the examination of the unaffected or asymptomatic body area(s) or organ system(s) should be described.*
- *DG: A brief statement or notation indicating "negative" or "normal" is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).*
- *DG: The medical record for a general multi-system examination should include findings about 8 or more of the 12 organ systems.*

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C. DOCUMENTATION OF THE COMPLEXITY OF MEDICAL DECISION MAKING

The levels of E/M services recognize four types of medical decision making (straightforward, low complexity, moderate complexity, and high complexity). Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- the number of possible diagnoses and/or the number of management options that must be considered;
- the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and
- the risk of significant complications, morbidity, and/or mortality, as well as comorbidities associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

The chart below shows the progression of the elements required for each level of medical decision making. To qualify for a given type of decision making, **two of the three elements in the table must be either met or exceeded.**

Number of diagnoses or management options	Amount and/or complexity of data to be reviewed	Risk of complications and/or morbidity or mortality	Type of decision making
Minimal	Minimal or None	Minimal	<i>Straightforward</i>
Limited	Limited	Low	<i>Low Complexity</i>
Multiple	Moderate	Moderate	<i>Moderate Complexity</i>
Extensive	Extensive	High	<i>High Complexity</i>

Each of the elements of medical decision making is described on the following page.

NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS

The number of possible diagnoses and/or the number of management options that must be considered is based on the number and types of problems addressed during the encounter, the complexity of establishing a diagnosis and the management decisions that are made by the physician.

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Generally, decision making with respect to a diagnosed problem is easier than that for an identified but undiagnosed problem. The number and type of diagnostic tests employed may be an indicator of the number of possible diagnoses. Problems which are improving or resolving are less complex than those which are worsening or failing to change as expected. The need to seek advice from others is another indicator of complexity of diagnostic or management problems.

- *DG: For each encounter, an assessment, clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.*
- *For a presenting problem with an established diagnosis the record should reflect whether the problem is: a) improved, well controlled, resolving or resolved; or, b) inadequately controlled, worsening, or failing to change as expected.*

- For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of a differential diagnoses or as "possible," "probable," or "rule out" (R/O) diagnoses.
- DG: The initiation of, or changes in, treatment should be documented. Treatment includes a wide range of management options including patient instructions, nursing instructions, therapies, and medications.
- DG: If referrals are made, consultations requested or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom the advice is requested.

AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED

The amount and complexity of data to be reviewed is based on the types of diagnostic testing ordered or reviewed. A decision to obtain and review old medical records and/or obtain history from sources other than the patient increases the amount and complexity of data to be reviewed.

Discussion of contradictory or unexpected test results with the physician who performed or interpreted the test is an indication of the complexity of data being reviewed. On

12 occasion the physician who ordered a test may personally review the image, tracing or specimen to supplement information from the physician who prepared the test report or interpretation; this is another indication of the complexity of data being reviewed.

- DG: If a diagnostic service (test or procedure) is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service, eg, lab or x-ray, should be documented.
- DG: The review of lab, radiology and/or other diagnostic tests should be documented. An entry in a progress note such as "WBC elevated" or "chest xray unremarkable" is acceptable. Alternatively, the review may be documented by initialing and dating the report containing the test results.
- DG: A decision to obtain old records or decision to obtain additional history from the family, caretaker or other source to supplement that obtained from the patient should be documented.
- DG: Relevant finding from the review of old records, and/or the receipt of additional history from the family, caretaker or other source should be documented. If there is no relevant information beyond that already obtained, that fact should be documented. A notation of "Old records reviewed" or "additional history obtained from family" without elaboration is insufficient.
- DG: The results of discussion of laboratory, radiology or other diagnostic tests with the physician who performed or interpreted the study should be documented.
- DG: The direct visualization and independent interpretation of an image, tracing, or specimen previously or subsequently interpreted by another physician should be documented.

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RISK OF SIGNIFICANT COMPLICATIONS, MORBIDITY, AND/OR MORTALITY

The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the presenting problem(s), the diagnostic procedure(s), and the possible management options.

- *DG: Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.*
- *DG: If a surgical or invasive diagnostic procedure is ordered, planned, or scheduled at the time of the E/M encounter, the type of procedure eg, laparoscopy, should be documented.*
- *DG: If a surgical or invasive diagnostic procedure is performed at the time of the E/M encounter, the specific procedure should be documented.*
- *DG: The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied.*

The following table may be used to help determine whether the risk of significant complications, morbidity, and/or mortality is **minimal**, **low**, **moderate**, or **high**. Because the determination of risk is complex and not readily quantifiable, the table includes common clinical examples rather than absolute measures of risk. The assessment of risk of the presenting problem(s) is based on the risk related to the disease process anticipated between the present encounter and the next one. The assessment of risk of selecting diagnostic procedures and management options is based on the risk during and immediately following any procedures or treatment. The highest level of risk in any one category (presenting problem(s), diagnostic procedure(s), or management options) determines the overall risk.

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Table of Risk

<i>Level of Risk</i>	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
<i>Minimal</i>	One self-limited or minor problem, eg, cold, insect bite, tinea corporis	Laboratory tests requiring venipuncture Chest x-rays EKG/EEG Urinalysis Ultrasound, eg, echocardiography KOH prep	Rest Gargles Elastic bandages Superficial dressings
<i>Low</i>	Two or more self-limited or minor problems One stable chronic illness, eg, well controlled hypertension, non-insulin dependent diabetes, cataract, BPH Acute uncomplicated illness or injury, eg, cystitis, allergic rhinitis, simple sprain	Physiologic tests not under stress, eg, pulmonary function tests Non-cardiovascular imaging studies with contrast, eg, barium enema Superficial needle biopsies Clinical laboratory tests requiring arterial puncture Skin biopsies	Over-the-counter drugs Minor surgery with no identified risk factors Physical therapy Occupational therapy IV fluids without additives

Moderate	<p>One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment</p> <p>Two or more stable chronic illnesses</p> <p>Undiagnosed new problem with uncertain prognosis, eg, lump in breast</p> <p>Acute illness with systemic symptoms, eg, pyelonephritis, pneumonitis, colitis</p> <p>Acute complicated injury, eg, head injury with brief loss of consciousness</p>	<p>Physiologic tests under stress, eg, cardiac stress test, fetal contraction stress test</p> <p>Diagnostic endoscopies with no identified risk factors</p> <p>Deep needle or incisional biopsy</p> <p>Cardiovascular imaging studies with contrast and no identified risk factors, eg, arteriogram, cardiac catheterization</p> <p>Obtain fluid from body cavity, eg lumbar puncture, thoracentesis, culdocentesis</p>	<p>Minor surgery with identified risk factors</p> <p>Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors</p> <p>Prescription drug management</p> <p>Therapeutic nuclear medicine</p> <p>IV fluids with additives</p> <p>Closed treatment of fracture or dislocation without manipulation</p>
High	<p>One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment</p> <p>Acute or chronic illnesses or injuries that pose a threat to life or bodily function, eg, multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure</p> <p>An abrupt change in neurologic status, eg, seizure, TIA, weakness, sensory loss</p>	<p>Cardiovascular imaging studies with contrast with identified risk factors</p> <p>Cardiac electrophysiological tests</p> <p>Diagnostic Endoscopies with identified risk factors</p> <p>Discography</p>	<p>Elective major surgery (open, percutaneous or endoscopic) with identified risk factors</p> <p>Emergency major surgery (open, percutaneous or endoscopic)</p> <p>Parenteral controlled substances</p> <p>Drug therapy requiring intensive monitoring for toxicity</p> <p>Decision not to resuscitate or to de-escalate care because of poor prognosis</p>

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D. DOCUMENTATION OF AN ENCOUNTER DOMINATED BY COUNSELING OR COORDINATION OF CARE

In the case where counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E/M services.

- *DG: If the physician elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter (face-to-face or floor time, as appropriate) should be documented and the record should describe the counseling and/or activities to coordinate care.*

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1997 Documentation Guidelines for Evaluation and Management Services

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I. INTRODUCTION

WHAT IS DOCUMENTATION AND WHY IS IT IMPORTANT?

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care. The medical record facilitates:

- the ability of the physician and other healthcare professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her healthcare over time.
- communication and continuity of care among physicians and other healthcare professionals involved in the patient's care;
- accurate and timely claims review and payment;
- appropriate utilization review and quality of care evaluations;
- and • collection of data that may be useful for research and education.

An appropriately documented medical record can reduce many of the hassles associated with claims processing and may serve as a legal document to verify the care provided, if necessary.

WHAT DO PAYERS WANT AND WHY?

Because payers have a contractual obligation to enrollees, they may require reasonable documentation that services are consistent with the insurance coverage provided. They may request information to validate:

- the site of service;
- the medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or
- that services provided have been accurately reported.

GENERAL PRINCIPLES OF MEDICAL RECORD DOCUMENTATION

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For Evaluation and Management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient's status. The general principles listed below may be modified to account for these variable circumstances in providing E/M services.

The medical record should be complete and legible.

The documentation of each patient encounter should include:

- reason for encounter and relevant history, physical examination findings, and prior diagnostic test results;
- assessment, clinical impression, or diagnosis;
- plan for care; and
- date and legible identity of the observer.

If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.

Past and present diagnoses should be accessible to the treating and/or consulting physician.

Appropriate health risk factors should be identified.

The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.

The CPT and ICD-9-CM codes reported on the health insurance claim form should be supported by the documentation in the medical record.

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DOCUMENTATION OF E/M SERVICES

This publication provides definitions and documentation guidelines for the three key components of E/M services and for visits which consist predominately of counseling or coordination of care. The three *key* components--history, examination, and medical decision making--appear in the descriptors for office and other outpatient services, hospital observation services, hospital inpatient services, consultations, emergency department services, nursing facility services, domiciliary care services, and home services. While some of the text of CPT has been repeated in this publication, the reader should refer to CPT for the complete descriptors for E/M services and instructions for selecting a level of service. Documentation guidelines are identified by the symbol • DG.

The descriptors for the levels of E/M services recognize seven components which are used in defining the levels of E/M services. These components are:

- history; examination; medical decision making; counseling;
- coordination of care; nature of presenting problem; and time.
- The first three of these components (i.e., history, examination and medical decision making) are the key components in selecting the level of E/M services. In the case of visits which consist predominantly of counseling or coordination of care, time is the key or controlling factor to qualify for a particular level of E/M service.

Because the level of E/M service is dependent on two or three key components, performance and documentation of one component (eg, examination) at the highest level does not necessarily mean that the encounter in its entirety qualifies for the highest level of E/M service.

These Documentation Guidelines for E/M services reflect the needs of the typical adult population. For certain groups of patients, the recorded information may vary slightly from that described here. Specifically, the medical records of infants, children, adolescents and pregnant women may have additional or modified information recorded in each history and examination area.

As an example, newborn records may include under history of the present illness (HPI) the details of mother's pregnancy and the infant's status at birth; social history will focus on family structure; family history will focus on congenital anomalies and hereditary disorders in the family. In addition, the content of a pediatric examination will vary with the age and development of the child.

Although not specifically defined in these documentation guidelines, these patient group variations on history and examination are appropriate.

A. DOCUMENTATION OF HISTORY

The levels of E/M services are based on four levels of history (Problem Focused, Expanded Problem Focused, Detailed, and Comprehensive). Each type of history includes some or all of the following elements:

- Chief complaint (CC)

- History of present illness (HPI)
- Review of systems (ROS) and
- Past, family, and/or social history (PFSH).

The extent of the history of present illness, review of systems, and past, family and/or social history that is obtained and documented is dependent upon clinical judgment and the nature of the presenting problem(s).

The chart below shows the progression of the elements required for each type of history. To qualify for a given type of history all three elements in the table must be met. (A chief complaint is indicated at all levels.)

History of Present Illness (HPI)	Review of Systems (ROS)	Past, Family, and/or Social History (PFSH)	Type of History
Brief	N/A	N/A	<i>Problem Focused</i>
Brief Problem	Problem Pertinent	N/A	<i>Focused Expanded Problem</i>
Extended	Extended	Pertinent	<i>Detailed</i>
Extended	Complete	Complete	<i>Comprehensive</i>

- **DG:** *The CC, ROS and PFSH may be listed as separate elements of history, or they may be included in the description of the history of the present illness.*
- **DG:** *A ROS and/or a PFSH obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his/her own record or in an institutional setting or group practice where many physicians use a common record. The review and update may be documented by:*
 - *describing any new ROS and/or PFSH information or noting there has been no change in the information; and*
 - *noting the date and location of the earlier ROS and/or PFSH.*
- **DG:** *The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.*
- **DG:** *If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance that precludes obtaining a history.*

Definitions and specific documentation guidelines for each of the elements of history are listed below.

CHIEF COMPLAINT (CC)

The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter, usually stated in the patient's own words.

- **DG:** *The medical record should clearly reflect the chief complaint.*

HISTORY OF PRESENT ILLNESS (HPI)

The HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. It includes the following elements:

- location , quality , severity, duration, timing, context , modifying factors, and associated signs and symptoms.
- *Brief and extended HPIs are distinguished by the amount of detail needed to accurately characterize the clinical problem(s).*
- *A brief HPI consists of one to three elements of the HPI.*
- • *DG: The medical record should describe one to three elements of the present illness (HPI).*
- *An extended HPI consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions.*
- *DG: The medical record should describe at least four elements of the present illness (HPI), or the status of at least three chronic or inactive conditions.*

REVIEW OF SYSTEMS (ROS)

A ROS is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced.

For purposes of ROS, the following systems are recognized: Constitutional

- Symptoms (eg, fever, weight loss)
- Eyes
- Ears, Nose, Mouth, and Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic
- *A problem pertinent ROS inquires about the system directly related to the problem(s) identified in the HPI.*

- *DG: The patient's positive responses and pertinent negatives for the system related to the problem should be documented.*

An extended ROS inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems.

- *DG: The patient's positive responses and pertinent negatives for two to nine systems should be documented.*

A complete ROS inquires about the system(s) directly related to the problem(s) identified in the HPI, plus all additional body systems.

- ***DG: At least ten organ systems must be reviewed. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least ten systems must be individually documented.***

PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)

The PFSH consists of a review of three areas:

- **past history** (the patient's past experiences with illnesses, operations, injuries and treatments);
- **family history** (a review of medical events in the patient's family, including diseases which maybe hereditary or place the patient at risk); and
- **social history** (an age appropriate review of past and current activities).

For certain categories of E/M services that include only an interval history, it is not necessary to record information about the PFSH. Those categories are subsequent hospital care, follow-up inpatient consultations and subsequent nursing facility care.

A ***pertinent*** PFSH is a review of the history area(s) directly related to the problem(s) identified in the HPI.

- ***DG: At least one specific item from any of the three history areas must be documented for a pertinent PFSH.***

A ***complete*** PFSH is a review of two or all three of the PFSH history areas, depending on the category of the E/M service. A review of all three history areas is required for services that by their nature include a comprehensive assessment or reassessment of the patient. A review of two of the three history areas is sufficient for other services.

- ***DG: At least one specific item from two of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services, established patient; emergency department; domiciliary care, established patient; and home care, established patient.***

- ***DG: At least one specific item from each of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services, new patient; hospital observation services; hospital inpatient services, initial care; consultations; comprehensive nursing facility assessments; domiciliary care, new patient; home care, new patient.***

B. DOCUMENTATION OF EXAMINATION

The levels of E/M services are based on four types of examination:

- ***Problem Focused*** – a limited examination of the affected body area or organ system.
- ***Expanded Problem Focused*** – a limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s).

- **Detailed** – an extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s).
- **Comprehensive** – a general multi-system examination, or complete examination of a single organ system and other symptomatic or related body area(s) or organ system(s).

These types of examinations have been defined for general multi-system and the following single organ systems:

- Cardiovascular
- Ears, Nose, Mouth, and Throat
- Eyes
- Genitourinary (Female)
- Genitourinary (Male)
- Hematologic/Lymphatic/Immunologic
- Musculoskeletal
- Neurological
- Psychiatric
- Respiratory
- Skin

A general multi-system examination or a single organ system examination may be performed by any physician, regardless of specialty. The type (general multisystem or single organ system) and content of examination are selected by the examining physician and are based upon clinical judgment, the patient's history, and the nature of the presenting problem(s).

The content and documentation requirements for each type and level of examination are summarized below and described in detail in tables beginning on page 13. In the tables, organ systems and body areas recognized by CPT for purposes of describing examinations are shown in the left column. The content, or individual elements, of the examination pertaining to that body area or organ system are identified by bullets (•) in the right column.

Parenthetical examples “(eg,...)”, have been used for clarification and to provide guidance regarding documentation. Documentation for each element must satisfy any numeric requirements (such as “Measurement of *any three of the following seven...*”) included in the description of the element. Elements with multiple components but with no specific numeric requirement (such as “Examination of *liver and spleen*”) require documentation of at least one component. It is possible for a given examination to be expanded beyond what is defined here. When that occurs, findings related to the additional systems and/or areas should be documented.

- **DG: Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of “abnormal” without elaboration is insufficient.**
- **DG: Abnormal or unexpected findings of the examination of any asymptomatic body area(s) or organ system(s) should be described.**

- **DG: A brief statement or notation indicating “negative” or “normal” is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).**

GENERAL MULTI-SYSTEM EXAMINATIONS

General multi-system examinations are described in detail beginning on page 13. To qualify for a given level of multi-system examination, the following content and documentation requirements should be met:

- **Problem Focused Examination** – should include performance and documentation of one to five elements identified by a bullet (•) in one or more organ system(s) or body area(s).
- **Expanded Problem Focused Examination** – should include performance and documentation of at least six elements identified by a bullet (•) in one or more organ system(s) or body area(s).
- **Detailed Examination** – should include at least six organ systems or body areas. For each system/area selected, performance and documentation of at least two elements identified by a bullet (•) is expected. Alternatively, a detailed examination may include performance and documentation of at least twelve elements identified by a bullet (•) in two or more organ systems or body areas.
- **Comprehensive Examination** – should include at least nine organ systems or body areas. For each system/area selected, all elements of the examination identified by a bullet (•) should be performed, unless specific directions limit the content of the examination. For each area/system, documentation of at least two elements identified by a bullet is expected.

SINGLE ORGAN SYSTEM EXAMINATIONS

The single organ system examinations recognized by CPT are described in detail beginning on page 18. Variations among these examinations in the organ systems and body areas identified in the left columns and in the elements of the examinations described in the right columns reflect differing emphases among specialties. To qualify for a given level of single organ system examination, the following content and documentation requirements should be met: • **Problem Focused Examination** – should include performance and documentation of one to five elements identified by a bullet (•), whether in a box with a shaded or unshaded border.

- **Expanded Problem Focused Examination** – should include performance and documentation of at least six elements identified by a bullet (•), whether in a box with a shaded or unshaded border.
- **Detailed Examination** – examinations other than the eye and psychiatric examinations should include performance and documentation of at least twelve elements identified by a bullet (•), whether in a box with a shaded or unshaded border.

Eye and psychiatric examinations should include the performance and documentation of at least nine elements identified by a bullet (•), whether in a box with a shaded or unshaded border.

- **Comprehensive Examination** – should include performance of all elements identified by a bullet (•), whether in a shaded or unshaded box. Documentation of every element in each box with a shaded border and at least one element in a box with an unshaded border is expected.

CONTENT AND DOCUMENTATION REQUIREMENTS

General Multi-System Examination

System/Body Area	Elements of Examination
Constitutional	<ul style="list-style-type: none"> • Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Eyes	<ul style="list-style-type: none"> • Inspection of conjunctivae and lids • Examination of pupils and irises (eg, reaction to light and accommodation, size and symmetry) • Ophthalmoscopic examination of optic discs (eg, size, C/D ratio, appearance) and posterior segments (eg, vessel changes, exudates, hemorrhages)
Ears, Nose, Mouth and Throat	<ul style="list-style-type: none"> • External inspection of ears and nose (eg, overall appearance, scars, lesions, masses) • Otoscopic examination of external auditory canals and tympanic membranes • Assessment of hearing (eg, whispered voice, finger rub, tuning fork) • Inspection of nasal mucosa, septum and turbinates • Inspection of lips, teeth and gums • Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils and posterior pharynx
Neck	<ul style="list-style-type: none"> • Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus) • Examination of thyroid (eg, enlargement, tenderness, mass)

System/Body Area	Elements of Examination

Respiratory	<ul style="list-style-type: none"> • Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement) • Percussion of chest (eg, dullness, flatness, hyperresonance) • Palpation of chest (eg, tactile fremitus) • Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)
Cardiovascular	<ul style="list-style-type: none"> • Palpation of heart (eg, location, size, thrills) • Auscultation of heart with notation of abnormal sounds and murmurs <p>Examination of:</p> <ul style="list-style-type: none"> • carotid arteries (eg, pulse amplitude, bruits) • abdominal aorta (eg, size, bruits) • femoral arteries (eg, pulse amplitude, bruits) • pedal pulses (eg, pulse amplitude) • extremities for edema and/or varicosities
Chest (Breasts)	<ul style="list-style-type: none"> • Inspection of breasts (eg, symmetry, nipple discharge) • Palpation of breasts and axillae (eg, masses or lumps, tenderness)
Gastrointestinal (Abdomen)	<ul style="list-style-type: none"> • Examination of abdomen with notation of presence of masses or tenderness • Examination of liver and spleen • Examination for presence or absence of hernia • Examination (when indicated) of anus, perineum and rectum, including sphincter tone, presence of hemorrhoids, rectal masses • Obtain stool sample for occult blood test when indicated
System/Body Area	Elements of Examination

Genitourinary	<p>MALE:</p> <ul style="list-style-type: none"> • Examination of the scrotal contents (eg, hydrocele, spermatocele, tenderness of cord, testicular mass) • Examination of the penis • Digital rectal examination of prostate gland (eg, size, symmetry, nodularity, tenderness) <p>FEMALE:</p> <p>Pelvic examination (with or without specimen collection for smears and cultures), including</p> <ul style="list-style-type: none"> • Examination of external genitalia (eg, general appearance, hair distribution, lesions) and vagina (eg, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele) • Examination of urethra (eg, masses, tenderness, scarring) • Examination of bladder (eg, fullness, masses, tenderness) • Cervix (eg, general appearance, lesions, discharge) • Uterus (eg, size, contour, position, mobility, tenderness, consistency, descent or support) • Adnexa/parametria (eg, masses, tenderness, organomegaly, nodularity)
Lymphatic	<p>Palpation of lymph nodes in two or more areas:</p> <ul style="list-style-type: none"> • Neck • Axillae • Groin • Other
System/Body Area	Elements of Examination

Musculoskeletal	<ul style="list-style-type: none"> • Examination of gait and station • Inspection and/or palpation of digits and nails (eg, clubbing, cyanosis, inflammatory conditions, petechiae, ischemia, infections, nodes) <p>Examination of joints, bones and muscles of one or more of the following six areas: 1) head and neck; 2) spine, ribs and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity. The examination of a given area includes:</p> <ul style="list-style-type: none"> • Inspection and/or palpation with notation of presence of any misalignment, asymmetry, crepitation, defects, tenderness, masses, effusions • Assessment of range of motion with notation of any pain, crepitation or contracture • Assessment of stability with notation of any dislocation (luxation), subluxation or laxity • Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements
Skin	<ul style="list-style-type: none"> • Inspection of skin and subcutaneous tissue (eg, rashes, lesions, ulcers) • Palpation of skin and subcutaneous tissue (eg, induration, subcutaneous nodules, tightening)
Neurologic	<ul style="list-style-type: none"> • Test cranial nerves with notation of any deficits • Examination of deep tendon reflexes with notation of pathological reflexes (eg, Babinski) • Examination of sensation (eg, by touch, pin, vibration, proprioception)
Psychiatric	<ul style="list-style-type: none"> • Description of patient's judgment and insight <p>Brief assessment of mental status including:</p> <ul style="list-style-type: none"> • orientation to time, place and person • recent and remote memory • mood and affect (eg, depression, anxiety, agitation)

Content and Documentation Requirements

Level of Exam

Perform and Document:

Problem Focused

One to five elements identified by a bullet.

Expanded Problem Focused

At least six elements identified by a bullet.

Detailed

At least two elements identified by a bullet **from each of six areas/systems**
OR at least twelve elements identified by a bullet **in two or more areas/systems.**

Comprehensive

Perform **all elements** identified by a bullet in **at least nine** organ systems or body areas and document **at least two** elements identified by a bullet **from each of nine areas/systems.**

Cardiovascular Examination

System/Body Area	Elements of Examination
Constitutional	<ul style="list-style-type: none"> • Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	
Eyes	<ul style="list-style-type: none"> • Inspection of conjunctivae and lids (eg, xanthelasma)
Ears, Nose, Mouth and Throat	<ul style="list-style-type: none"> • Inspection of teeth, gums and palate • Inspection of oral mucosa with notation of presence of pallor or cyanosis
Neck	<ul style="list-style-type: none"> • Examination of jugular veins (eg, distension; a, v or cannon a waves) • Examination of thyroid (eg, enlargement, tenderness, mass)
Respiratory	<ul style="list-style-type: none"> • Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement) • Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)
Cardiovascular	<ul style="list-style-type: none"> • Palpation of heart (eg, location, size and forcefulness of the point of maximal impact; thrills; lifts; palpable S3 or S4) • Auscultation of heart including sounds, abnormal sounds and murmurs • Measurement of blood pressure in two or more extremities when indicated (eg, aortic dissection, coarctation) Examination of: <ul style="list-style-type: none"> • Carotid arteries (eg, waveform, pulse amplitude, bruits, apical-carotid delay) • Abdominal aorta (eg, size, bruits) • Femoral arteries (eg, pulse amplitude, bruits) • Pedal pulses (eg, pulse amplitude) • Extremities for peripheral edema and/or varicosities
System/Body Area	Elements of Examination

Chest (Breasts)	
Gastrointestinal (Abdomen)	<ul style="list-style-type: none"> • Examination of abdomen with notation of presence of masses or tenderness • Examination of liver and spleen • Obtain stool sample for occult blood from patients who are being considered for thrombolytic or anticoagulant therapy
Genitourinary (Abdomen)	
Lymphatic	
Musculoskeletal	<ul style="list-style-type: none"> • Examination of the back with notation of kyphosis or scoliosis • Examination of gait with notation of ability to undergo exercise testing and/or participation in exercise programs • Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements
Extremities	<ul style="list-style-type: none"> • Inspection and palpation of digits and nails (eg, clubbing, cyanosis, inflammation, petechiae, ischemia, infections, Osler's nodes)
Skin	<ul style="list-style-type: none"> • Inspection and/or palpation of skin and subcutaneous tissue (eg, stasis dermatitis, ulcers, scars, xanthomas)
Neurological/ Psychiatric	<ul style="list-style-type: none"> • Brief assessment of mental status including Orientation to time, place and person, • Mood and affect (eg, depression, anxiety, agitation)

Content and Documentation Requirements

Level of Exam

Perform and Document:

Problem Focused

One to five elements identified by a bullet.

At least six elements identified by a bullet.

Expanded Problem Focused

Detailed

Comprehensive

At least twelve elements identified by a bullet.

Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

Ear, Nose and Throat Examination

System/Body Area	Elements of Examination

Constitutional	<ul style="list-style-type: none"> • Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming) • Assessment of ability to communicate (eg, use of sign language or other communication aids) and quality of voice
Head and Face	<ul style="list-style-type: none"> • Inspection of head and face (eg, overall appearance, scars, lesions and masses) • Palpation and/or percussion of face with notation of presence or absence of sinus tenderness • Examination of salivary glands • Assessment of facial strength
Eyes	<ul style="list-style-type: none"> • Test ocular motility including primary gaze alignment
Ears, Nose, Mouth and Throat	<ul style="list-style-type: none"> • Otoscopic examination of external auditory canals and tympanic membranes including pneumo-otoscopy with notation of mobility of membranes • Assessment of hearing with tuning forks and clinical speech reception thresholds (eg, whispered voice, finger rub) • External inspection of ears and nose (eg, overall appearance, scars, lesions and masses) <ul style="list-style-type: none"> • Inspection of nasal mucosa, septum and turbinates • Inspection of lips, teeth and gums • Examination of oropharynx: oral mucosa, hard and soft palates, tongue, tonsils and posterior pharynx (eg, asymmetry, lesions, hydration of mucosal surfaces) • Inspection of pharyngeal walls and pyriform sinuses (eg, pooling of saliva, asymmetry, lesions) • Examination by mirror of larynx including the condition of the epiglottis, false vocal cords, true vocal cords and mobility of larynx (Use of mirror not required in children) • Examination by mirror of nasopharynx including appearance of the mucosa, adenoids, posterior choanae and eustachian tubes (Use of mirror not required in children)
System/Body Area	Elements of Examination

Neck	<ul style="list-style-type: none"> Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus) Examination of thyroid (eg, enlargement, tenderness, mass)
Respiratory	<ul style="list-style-type: none"> Inspection of chest including symmetry, expansion and/or assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement) Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)
Cardiovascular	<ul style="list-style-type: none"> Auscultation of heart with notation of abnormal sounds and murmurs Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness)
Chest (Breasts)	
Gastrointestinal (Abdomen)	
Genitourinary	
Lymphatic	<ul style="list-style-type: none"> Palpation of lymph nodes in neck, axillae, groin and/or other location
Musculoskeletal	
Extremities	
Skin	
Neurological/ Psychiatric	<ul style="list-style-type: none"> Test cranial nerves with notation of any deficits <p>Brief assessment of mental status including</p> <ul style="list-style-type: none"> Orientation to time, place and person, Mood and affect (eg, depression, anxiety, agitation)

Content and Documentation Requirements

Level of Exam

Perform and Document:

Problem Focused

One to five elements identified by a bullet.

At least six elements identified by a bullet.

Expanded Problem Focused

Detailed

At least twelve elements identified by a bullet.

Comprehensive

Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

Eye Examination

System/Body Area	Elements of Examination
Constitutional	
Head and Face	
Eyes	<p>Test</p> <ul style="list-style-type: none"> • visual acuity (Does not include determination of refractive error) • Gross visual field testing by confrontation <p>Test</p> <ul style="list-style-type: none"> • ocular motility including primary gaze alignment • Inspection of bulbar and palpebral conjunctivae • Examination of ocular adnexae including lids (eg, ptosis or lagophthalmos), lacrimal glands, lacrimal drainage, orbits and preauricular lymph nodes • Examination of pupils and irises including shape, direct and consensual reaction (afferent pupil), size (eg, anisocoria) and morphology <p>Slit</p> <ul style="list-style-type: none"> • lamp examination of the corneas including epithelium, stroma, endothelium, and tear film <p>Slit flare</p> <ul style="list-style-type: none"> • lamp examination of the anterior chambers including depth, cells, and <p>Slit</p> <ul style="list-style-type: none"> • lamp examination of the lenses including clarity, anterior and posterior capsule, cortex, and nucleus • Measurement of intraocular pressures (except in children and patients with trauma or infectious disease) <p>Ophthalmoscopic examination through dilated pupils (unless contraindicated) of</p> <ul style="list-style-type: none"> • Optic discs including size, C/D ratio, appearance (eg, atrophy, cupping, tumor elevation) and nerve fiber layer • Posterior segments including retina and vessels (eg, exudates and hemorrhages)
Ears, Nose, Mouth and Throat	
Neck	
Respiratory	

System/Body Area	Elements of Examination

Cardiovascular	
Chest (Breasts)	
Gastrointestinal (Abdomen)	
Genitourinary	
Lymphatic	
Musculoskeletal	
Extremities	
Skin	
Neurological/ Psychiatric	<p>Brief assessment of mental status including</p> <ul style="list-style-type: none"> • Orientation to time, place and person • Mood and affect (eg, depression, anxiety, agitation)

Content and Documentation Requirements

Level of Exam

Perform and Document:

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Comprehensive

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Genitourinary Examination

System/Body Area	Elements of Examination
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Constitutional	<ul style="list-style-type: none"> • Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	
Eyes	
Ears, Nose, Mouth and Throat	
Neck	<ul style="list-style-type: none"> • Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus) <ul style="list-style-type: none"> • Examination of thyroid (eg, enlargement, tenderness, mass)
Respiratory	<ul style="list-style-type: none"> • Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement) • Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)
Cardiovascular	<ul style="list-style-type: none"> • Auscultation of heart with notation of abnormal sounds and murmurs • Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (e.g. pulses, temperature, edema, tenderness)
Chest (Breasts)	[See genitourinary (female)]
Gastrointestinal (Abdomen)	<ul style="list-style-type: none"> • Examination of abdomen with notation of presence of masses or tenderness • Examination for presence or absence of hernia • Examination of liver and spleen • Obtain stool sample for occult blood when indicated
System/Body Area	Elements of Examination

Genitourinary	<p>MALE:</p> <ul style="list-style-type: none"> • Inspection of anus and perineum <p>Examination (with or without specimen collection for smears and cultures) of genitalia including:</p> <ul style="list-style-type: none"> • Scrotum (eg, lesions, cysts, rashes) • Epididymides (eg, size, symmetry, masses) • Testes (eg, size, symmetry, masses) • Urethral meatus (eg, size, location, lesions, discharge) <ul style="list-style-type: none"> • Penis (eg, lesions, presence or absence of foreskin, foreskin retractability, plaque, masses, scarring, deformities) <p>Digital rectal examination including:</p> <ul style="list-style-type: none"> • Prostate gland (eg, size, symmetry, nodularity, tenderness) • Seminal vesicles (eg, symmetry, tenderness, masses, enlargement) • Sphincter tone, presence of hemorrhoids, rectal masses
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System/Body Area	Elements of Examination
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Genitourinary (Cont'd)	<p>FEMALE: Includes at least seven of the following eleven elements identified by bullets: • Inspection and palpation of breasts (eg, masses or lumps, tenderness, symmetry, nipple discharge)</p> <ul style="list-style-type: none"> • Digital rectal examination including sphincter tone, presence of hemorrhoids, rectal masses <p>Pelvic examination (with or without specimen collection for smears and cultures) including:</p> <ul style="list-style-type: none"> • External genitalia (eg, general appearance, hair distribution, lesions) • Urethral meatus (eg, size, location, lesions, prolapse) • Urethra (eg, masses, tenderness, scarring) • Bladder (eg, fullness, masses, tenderness) • Vagina (eg, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele) <ul style="list-style-type: none"> • Cervix (eg, general appearance, lesions, discharge) • Uterus (eg, size, contour, position, mobility, tenderness, consistency, descent or support) <ul style="list-style-type: none"> • Adnexa/parametria (eg, masses, tenderness, organomegaly, nodularity) • Anus and perineum
Lymphatic	<ul style="list-style-type: none"> • Palpation of lymph nodes in neck, axillae, groin and/or other location
Musculoskeletal	
Extremities	
Skin	<ul style="list-style-type: none"> • Inspection and/or palpation of skin and subcutaneous tissue (eg, rashes, lesions, ulcers)
Neurological/ Psychiatric	<p>Brief assessment of mental status including</p> <ul style="list-style-type: none"> • Orientation (eg, time, place and person) and • Mood and affect (eg, depression, anxiety, agitation)

Content and Documentation Requirements

Level of Exam

Perform and Document:

Problem Focused

One to five elements identified by a bullet.

At least six elements identified by a bullet.

Expanded Problem Focused
Detailed

At least twelve elements identified by a bullet.

Comprehensive

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Hematologic/Lymphatic/Immunologic Examination

System/Body Area	Elements of Examination
Constitutional	<ul style="list-style-type: none"> • Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	<ul style="list-style-type: none"> • Palpation and/or percussion of face with notation of presence or absence of sinus tenderness
Eyes	<ul style="list-style-type: none"> • Inspection of conjunctivae and lids
Ears, Nose, Mouth and Throat	<ul style="list-style-type: none"> • Otoscopic examination of external auditory canals and tympanic membranes • Inspection of nasal mucosa, septum and turbinates • Inspection of teeth and gums • Examination of oropharynx (eg, oral mucosa, hard and soft palates, tongue, tonsils and posterior pharynx)
Neck	<ul style="list-style-type: none"> • Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus) • Examination of thyroid (eg, enlargement, tenderness, mass)
Respiratory	<ul style="list-style-type: none"> • Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement) • Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)
Cardiovascular	<ul style="list-style-type: none"> • Auscultation of heart with notation of abnormal sounds and murmurs • Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (pulses, temperature, edema, tenderness)
Chest (Breasts)	

Gastrointestinal (Abdomen)	<ul style="list-style-type: none"> • Examination of abdomen with notation of presence of masses or tenderness • Examination of liver and spleen
Genitourinary	

System/Body Area	Elements of Examination
Lymphatic	<ul style="list-style-type: none"> • Palpation of lymph nodes in neck, axillae, groin, and/or other location
Musculoskeletal	
Extremities	<ul style="list-style-type: none"> • Inspection and palpation of digits and nails (eg, clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)
Skin	<ul style="list-style-type: none"> • Inspection and/or palpation of skin and subcutaneous tissue (eg, rashes, lesions, ulcers, ecchymoses, bruises)
Neurological/ Psychiatric	<p>Brief assessment of mental status including</p> <ul style="list-style-type: none"> • Orientation to time, place and person • Mood and affect (eg, depression, anxiety, agitation)

Content and Documentation Requirements

Level of Exam

Perform and Document:

Problem Focused

One to five elements identified by a bullet.

Expanded Problem Focused

At least six elements identified by a bullet.

Detailed

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Comprehensive

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Musculoskeletal Examination

System/Body Area	Elements of Examination

Constitutional	<ul style="list-style-type: none"> • Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	
Eyes	
Ears, Nose, Mouth and Throat	
Neck	
Respiratory	
Cardiovascular	<ul style="list-style-type: none"> • Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness)
Chest (Breasts)	
Gastrointestinal (Abdomen)	
Genitourinary	
Lymphatic	<ul style="list-style-type: none"> • Palpation of lymph nodes in neck, axillae, groin and/or other location
System/Body Area	Elements of Examination

Musculoskeletal	<ul style="list-style-type: none"> • Examination of gait and station <p>Examination of joint(s), bone(s) and muscle(s)/ tendon(s) of four of the following six areas: 1) head and neck; 2) spine, ribs and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity. The examination of a given area includes:</p> <ul style="list-style-type: none"> • Inspection, percussion and/or palpation with notation of any misalignment, asymmetry, crepitation, defects, tenderness, masses or effusions • Assessment of range of motion with notation of any pain (eg, straight leg raising), crepitation or contracture • Assessment of stability with notation of any dislocation (luxation), subluxation or laxity • Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements <p>NOTE: For the comprehensive level of examination, all four of the elements identified by a bullet must be performed and documented for each of four anatomic areas. For the three lower levels of examination, each element is counted separately for each body area. For example, assessing range of motion in two extremities constitutes two elements.</p>
Extremities	[See musculoskeletal and skin]
Skin	<ul style="list-style-type: none"> • Inspection and/or palpation of skin and subcutaneous tissue (eg, scars, rashes, lesions, cafe-au-lait spots, ulcers) in four of the following six areas: 1) head and neck; 2) trunk; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity. <p>NOTE: For the comprehensive level, the examination of all four anatomic areas must be performed and documented. For the three lower levels of examination, each body area is counted separately. For example, inspection and/or palpation of the skin and subcutaneous tissue of two extremities constitutes two elements.</p>
Neurological/ Psychiatric	<ul style="list-style-type: none"> • Test coordination (eg, finger/nose, heel/ knee/shin, rapid alternating movements in the upper and lower extremities, evaluation of fine motor coordination in young children) • Examination of deep tendon reflexes and/or nerve stretch test with notation of pathological reflexes (eg, Babinski) <ul style="list-style-type: none"> • Examination of sensation (eg, by touch, pin, vibration, proprioception) <p>Brief assessment of mental status including</p> <ul style="list-style-type: none"> • Orientation to time, place and person • Mood and affect (eg, depression, anxiety, agitation)

Content and Documentation Requirements

Level of Exam

Perform and Document:

Problem Focused

One to five elements identified by a bullet.

Expanded Problem Focused

At least six elements identified by a bullet.

Detailed

At least twelve elements identified by a bullet.

Comprehensive

Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

Neurological Examination

System/Body Area	Elements of Examination
Constitutional	<ul style="list-style-type: none"> Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	
Eyes	<ul style="list-style-type: none"> Ophthalmoscopic examination of optic discs (eg, size, C/D ratio, appearance) and posterior segments (eg, vessel changes, exudates, hemorrhages)
Ears, Nose, Mouth and Throat	
Neck	
Respiratory	
Cardiovascular	<ul style="list-style-type: none"> Examination of carotid arteries (eg, pulse amplitude, bruits) Auscultation of heart with notation of abnormal sounds and murmurs Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness)
Chest (Breasts)	
Gastrointestinal (Abdomen)	
Genitourinary	
Lymphatic	

System/Body Area	Elements of Examination
Musculoskeletal	<ul style="list-style-type: none"> Examination of gait and station Assessment of motor function including: <ul style="list-style-type: none"> Muscle • strength in upper and lower extremities Muscle • tone in upper and lower extremities (eg, flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements (eg, fasciculation, tardive dyskinesia)
Extremities	[See musculoskeletal]
Skin	
Neurological	<ul style="list-style-type: none"> Evaluation of higher integrative functions including: <ul style="list-style-type: none"> Recent • Orientation to time, place and person • and remote memory • Attention span and concentration • Language (eg, naming objects, repeating phrases, spontaneous speech) Fund • of knowledge (eg, awareness of current events, past history, vocabulary) Test the following cranial nerves: <ul style="list-style-type: none"> 2nd • cranial nerve (eg, visual acuity, visual fields, fundi) 3rd, 4th • and 6th cranial nerves (eg, pupils, eye movements) 5th • cranial nerve (eg, facial sensation, corneal reflexes) 7th • cranial nerve (eg, facial symmetry, strength) 8th • cranial nerve (eg, hearing with tuning fork, whispered voice and/or finger rub) 9th • cranial nerve (eg, spontaneous or reflex palate movement) 11th • cranial nerve (eg, shoulder shrug strength) 12th cranial nerve (eg, tongue protrusion) • Examination of sensation (eg, by touch, pin, vibration, proprioception) • Examination of deep tendon reflexes in upper and lower extremities with notation of pathological reflexes (eg, Babinski) • Test coordination (eg, finger/nose, heel/knee/shin, rapid alternating movements in the upper and lower extremities, evaluation of fine motor coordination in young children)
Psychiatric	

Content and Documentation Requirements

Level of Exam

Perform and Document:

Problem Focused

One to five elements identified by a bullet.

At least six elements identified by a bullet.

Expanded Problem Focused

Detailed

At least twelve elements identified by a bullet.

Comprehensive

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Psychiatric Examination

System/Body Area	Elements of Examination
Constitutional	<ul style="list-style-type: none"> • Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	
Eyes	
Ears, Nose, Mouth and Throat	
Neck	
Respiratory	
Cardiovascular	
Chest (Breasts)	
Gastrointestinal (Abdomen)	
Genitourinary	
Lymphatic	

Musculoskeletal	<ul style="list-style-type: none"> Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements Examination of gait and station
Extremities	
Skin	
Neurological	

System/Body Area	Elements of Examination
Psychiatric	<ul style="list-style-type: none"> Description of speech including: rate; volume; articulation; coherence; and spontaneity with notation of abnormalities (eg, perseveration, paucity of language) Description of thought processes including: rate of thoughts; content of thoughts (eg, logical vs. illogical, tangential); abstract reasoning; and <ul style="list-style-type: none"> computation Description of associations (eg, loose, tangential, circumstantial, intact) Description of abnormal or psychotic thoughts including: hallucinations; delusions; preoccupation with violence; homicidal or suicidal ideation; and obsessions Description of the patient's judgment (eg, concerning everyday activities and social situations) and insight (eg, concerning psychiatric condition) <ul style="list-style-type: none"> Complete mental status examination including Orientation to time, place and person Recent and remote memory Attention span and concentration Language (eg, naming objects, repeating phrases) Fund of knowledge (eg, awareness of current events, past history, vocabulary) Mood and affect (eg, depression, anxiety, agitation, hypomania, lability)

Content and Documentation Requirements

Level of Exam

Perform and Document:

Problem Focused	One to five elements identified by a bullet.
Expanded Problem Focused	At least six elements identified by a bullet.
Detailed	At least nine elements identified by a bullet.

Comprehensive

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Respiratory Examination

System/Body Area	Elements of Examination
Constitutional	<ul style="list-style-type: none"> • Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) <ul style="list-style-type: none"> • General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	
Eyes	
Ears, Nose, Mouth and Throat	<ul style="list-style-type: none"> • Inspection of nasal mucosa, septum and turbinates • Inspection of teeth and gums • Examination of oropharynx (eg, oral mucosa, hard and soft palate, tongue, tonsils and posterior pharynx)
Neck	<ul style="list-style-type: none"> • Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus) • Examination of thyroid (eg, enlargement, tenderness, mass) • Examination of jugular veins (eg, distention, a, v or cannon a waves)
Respiratory	<ul style="list-style-type: none"> • Inspection of chest with notation of symmetry and expansion • Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement) • Percussion of chest (eg, dullness, flatness, hyperresonance) • Palpation of chest (eg, tactile fremitus) • Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)
Cardiovascular	<ul style="list-style-type: none"> • Auscultation of heart with notation of abnormal sounds and murmurs • Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (pulses, temperature, edema, tenderness)
Chest (Breasts)	

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System/Body Area	Elements of Examination

Gastrointestinal (Abdomen)	<ul style="list-style-type: none"> Examination of abdomen with notation of presence of masses or tenderness Examination of liver and spleen
Genitourinary	
Lymphatic	<ul style="list-style-type: none"> Palpation of lymph nodes in neck, axillae, groin and/or other location
Musculoskeletal	<ul style="list-style-type: none"> Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements Examination of gait and station
Extremities	<ul style="list-style-type: none"> Inspection and palpation of digits and nails (eg, clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)
Skin	<ul style="list-style-type: none"> Inspection and/or palpation of skin and subcutaneous tissue (eg, rashes, lesions, ulcers)
Neurological/ Psychiatric	<p>Brief assessment of mental status including</p> <ul style="list-style-type: none"> Orientation to time, place and person Mood and affect (eg, depression, anxiety, agitation)

Content and Documentation Requirements

Level of Exam

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Detailed

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Comprehensive

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Skin Examination

System/Body Area	Elements of Examination
Constitutional	<ul style="list-style-type: none"> Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) <ul style="list-style-type: none"> General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	

Eyes	<ul style="list-style-type: none"> • Inspection of conjunctivae and lids
Ears, Nose, Mouth and Throat	<ul style="list-style-type: none"> • Inspection of teeth and gums • Examination of oropharynx (eg, oral mucosa, hard and soft palates, tongue, tonsils, posterior pharynx)
Neck	<ul style="list-style-type: none"> • Examination of thyroid (eg, enlargement, tenderness, mass)
Respiratory	
Cardiovascular	<ul style="list-style-type: none"> • Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness)
Chest (Breasts)	
Gastrointestinal (Abdomen)	<ul style="list-style-type: none"> • Examination of liver and spleen • Examination of anus for condyloma and other lesions
Genitourinary	
Lymphatic	<ul style="list-style-type: none"> • Palpation of lymph nodes in neck, axillae, groin and/or other location
Musculoskeletal	
Extremities	<ul style="list-style-type: none"> • Inspection and palpation of digits and nails (eg, clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)
System/Body Area	Elements of Examination

Skin	<ul style="list-style-type: none"> • Palpation of scalp and inspection of hair of scalp, eyebrows, face, chest, pubic area (when indicated) and extremities • Inspection and/or palpation of skin and subcutaneous tissue (eg, rashes, lesions, ulcers, susceptibility to and presence of photo damage) in eight of the following ten areas: • Head, including the face and • Neck • Chest, including breasts and axillae • Abdomen • Genitalia, groin, buttocks • Back • Right upper extremity • Left upper extremity • Right lower extremity • Left lower extremity <p>NOTE: For the comprehensive level, the examination of at least eight anatomic areas must be performed and documented. For the three lower levels of examination, each body area is counted separately. For example, inspection and/or palpation of the skin and subcutaneous tissue of the right upper extremity and the left upper extremity constitutes two elements.</p> <ul style="list-style-type: none"> • Inspection of eccrine and apocrine glands of skin and subcutaneous tissue with identification and location of any hyperhidrosis, chromhidroses or bromhidrosis
Neurological/ Psychiatric	<p>Brief assessment of mental status including</p> <ul style="list-style-type: none"> • Orientation to time, place and person • Mood and affect (eg, depression, anxiety, agitation)

Content and Documentation Requirements

Level of Exam

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C. DOCUMENTATION OF THE COMPLEXITY OF MEDICAL DECISION MAKING

The levels of E/M services recognize four types of medical decision making (straightforward, low complexity, moderate complexity and high complexity). Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

the number of possible diagnoses and/or the number of management options that must be considered;

the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and

the risk of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

The chart below shows the progression of the elements required for each level of medical decision making. To qualify for a given type of decision making, **two of the three elements in the table must be either met or exceeded.**

Number of diagnoses or management options	Amount and/or complexity of data to be reviewed	Risk of complications and/or morbidity or mortality	Type of decision making
Minimal	Minimal or None	Minimal	<i>Straightforward</i>
Limited	Limited	Low	<i>Low Complexity</i>
Multiple	Moderate	Moderate	<i>Moderate Complexity</i>
Extensive	Extensive	High	<i>High Complexity</i>

Each of the elements of medical decision making is described below.

NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS

The number of possible diagnoses and/or the number of management options that must be considered is based on the number and types of problems addressed during the encounter, the complexity of establishing a diagnosis and the management decisions that are made by the physician.

Generally, decision making with respect to a diagnosed problem is easier than that for an identified but undiagnosed problem. The number and type of diagnostic tests employed may be an indicator of the number of possible diagnoses. Problems which are improving or resolving are less complex than those which are worsening or failing to change as expected. The need to seek advice from others is another indicator of complexity of diagnostic or management problems.

DG: *For each encounter, an assessment, clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.*

For a presenting problem with an established diagnosis the record should reflect whether the problem is: a) improved, well controlled, resolving or resolved; or, b) inadequately controlled, worsening, or failing to change as expected.

For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of differential diagnoses or as a "possible", "probable", or "rule out" (R/O) diagnosis.

DG: *The initiation of, or changes in, treatment should be documented. Treatment includes a wide range of management options including patient instructions, nursing instructions, therapies, and medications.*

DG: *If referrals are made, consultations requested or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom the advice is requested.*

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AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED

The amount and complexity of data to be reviewed is based on the types of diagnostic testing ordered or reviewed. A decision to obtain and review old medical records and/or obtain history from sources other than the patient increases the amount and complexity of data to be reviewed.

Discussion of contradictory or unexpected test results with the physician who performed or interpreted the test is an indication of the complexity of data being reviewed. On occasion the physician who ordered a test may personally review the image, tracing or specimen to supplement information from the physician who prepared the test report or interpretation; this is another indication of the complexity of data being reviewed.

DG: *If a diagnostic service (test or procedure) is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service, eg, lab or x-ray, should be documented.*

DG: *The review of lab, radiology and/or other diagnostic tests should be documented. A simple notation such as "WBC elevated" or "chest x-ray unremarkable" is acceptable. Alternatively, the review may be documented by initialing and dating the report containing the test results.*

DG: *A decision to obtain old records or decision to obtain additional history from the family, caretaker or other source to supplement that obtained from the patient should be documented.*

DG: *Relevant findings from the review of old records, and/or the receipt of additional history from the family, caretaker or other source to supplement that obtained from the patient should be documented. If there is no relevant information beyond that already obtained, that fact should be documented. A notation of "Old records reviewed" or "additional history obtained from family" without elaboration is insufficient.*

DG: *The results of discussion of laboratory, radiology or other diagnostic tests with the physician who performed or interpreted the study should be documented.*

DG: *The direct visualization and independent interpretation of an image, tracing or specimen previously or subsequently interpreted by another physician should be documented.*

RISK OF SIGNIFICANT COMPLICATIONS, MORBIDITY, AND/OR MORTALITY

The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the presenting problem(s), the diagnostic procedure(s), and the possible management options.

DG: *Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.*

DG: If a surgical or invasive diagnostic procedure is ordered, planned or scheduled at the time of the E/M encounter, the type of procedure, eg, laparoscopy, should be documented.

DG: If a surgical or invasive diagnostic procedure is performed at the time of the E/M encounter, the specific procedure should be documented.

DG: The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied.

The following table may be used to help determine whether the risk of significant complications, morbidity, and/or mortality is *minimal, low, moderate, or high*. Because the determination of risk is complex and not readily quantifiable, the table includes common clinical examples rather than absolute measures of risk. The assessment of risk of the presenting problem(s) is based on the risk related to the disease process anticipated between the present encounter and the next one. The assessment of risk of selecting diagnostic procedures and management options is based on the risk during and immediately following any procedures or treatment. **The highest level of risk in any one category (presenting problem(s), diagnostic procedure(s), or management options) determines the overall risk.**

TABLE OF RISK

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	One self-limited or minor problem, eg, cold, insect bite, tinea corporis	Laboratory tests requiring venipuncture Chest x-rays EKG/EEG Urinalysis Ultrasound, eg, echocardiography KOH prep	Rest Gargles Elastic bandages Superficial dressings
Low	Two or more self-limited or minor problems One stable chronic illness, eg, well controlled hypertension, non-insulin dependent diabetes, cataract, BPH Acute uncomplicated illness or injury, eg, cystitis, allergic rhinitis, simple sprain	Physiologic tests not under stress, eg, pulmonary function tests Non-cardiovascular imaging studies with contrast, eg, barium enema Superficial needle biopsies Clinical laboratory tests requiring arterial puncture Skin biopsies	Over-the-counter drugs Minor surgery with no identified risk factors Physical therapy Occupational therapy IV fluids without additives

<p>Moderate</p>	<p>One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment Two or more stable chronic illnesses Undiagnosed new problem with uncertain prognosis, eg, lump in breast Acute illness with systemic symptoms, eg, pyelonephritis, pneumonitis, colitis Acute complicated injury, eg, head injury with brief loss of consciousness</p>	<p>Physiologic tests under stress, eg, cardiac stress test, fetal contraction stress test Diagnostic endoscopies with no identified risk factors Deep needle or incisional biopsy Cardiovascular imaging studies with contrast and no identified risk factors, eg, arteriogram, cardiac catheterization Obtain fluid from body cavity, eg lumbar puncture, thoracentesis, culdocentesis</p>	<p>Minor surgery with identified risk factors Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors Prescription drug management Therapeutic nuclear medicine IV fluids with additives Closed treatment of fracture or dislocation without manipulation</p>
<p>High</p>	<p>One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment Acute or chronic illnesses or injuries that pose a threat to life or bodily function, eg, multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure An abrupt change in neurologic status, eg, seizure, TIA, weakness, sensory loss</p>	<p>Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiological tests Diagnostic Endoscopies with identified risk factors Discography</p>	<p>Elective major surgery (open, percutaneous or endoscopic) with identified risk factors Emergency major surgery (open, percutaneous or endoscopic) Parenteral controlled substances Drug therapy requiring intensive monitoring for toxicity Decision not to resuscitate or to de-escalate care because of poor prognosis</p>

D. DOCUMENTATION OF AN ENCOUNTER DOMINATED BY COUNSELING OR COORDINATION OF CARE

In the case where counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (face-to-face time in the office or other or outpatient setting, floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E/M services.

DG: *If the physician elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter (face to-face or floor time, as appropriate) should be documented and the record should describe the counseling and/or activities to coordinate care.*