

WYOMING MEDICAID RULES

CHAPTER 13

MENTAL HEALTH SERVICES

Section 1. Authority.

This Chapter is promulgated by the Department of Health pursuant to the Medical Assistance and Services Act as W.S. § 42-4-101 et. seq. and the Wyoming Administrative Procedures Act as W.S. § 16-3-101 et. seq.

Section 2. Purpose and Applicability.

(a) This rule establishes the scope of mental health services covered by Medicaid when provided in community mental health centers, substance abuse centers, or by independent psychologists, as well as the methods and standards for reimbursing providers of such services. It shall apply to all such services provided on or after its effective date.

(b) The Department may issue Manuals to providers and/or other affected parties to interpret the provisions of this Chapter. Such Manuals shall be consistent with and reflect the policies contained in this Chapter. The provisions contained in Manuals or Bulletins shall be subordinate to the provisions of this Chapter.

Section 3. General Provisions.

(a) Terminology. Except as otherwise specified, the terminology used in this Chapter is the standard terminology and has the standard meaning used in accounting, mental health care, substance abuse care, Medicaid and Medicare.

(b) General methodology. As specified in this Chapter, the Department pays for mental health services pursuant to the Medicaid fee schedule.

(c) Unless otherwise specified, the incorporation by reference of any external standard is intended to be the incorporation of that standard as it is in effect on the effective date of this Chapter, including any applicable amendments, corrections, or revisions, but excluding any subsequent amendments or changes.

Section 4. Definitions.

(a) “Activities of daily living.” Personal care, household management, financial management, and appropriate use of community resources, including obtaining treatment for physical and/or mental health problems.

(b) “Adult.” A recipient other than a recipient under twenty-one years of age.

(c) “Adult day treatment.” Clinical professional or clinical staff contact with an adult to provide a planned and structured group program of community living skills training which addresses functional impairments or behavioral symptoms of the client’s mental disorder in order to slow deterioration, maintain or improve community integration, to ensure personal well being, and to reduce the risk of, or duration of, placement in a more restrictive setting.

(i) Community living skills addressed may include:

(A) Emotional skills;

(B) Behavioral skills;

(C) Daily living and self-care skills; and

(D) Cognitive skills.

(ii) Adult day treatment does not include:

(A) Academic education;

(B) Recreational activities;

(C) Meals and snacks; or

(D) Vocational services and training.

(d) “Adult targeted case management services.” Case management services provided to an adult. Such services shall be provided to a recipient who has been diagnosed by a clinical professional with one of the following mental illnesses:

(i) Schizophrenia or another psychotic disorder;

(ii) Major depressive disorder or bipolar disorder;

(iii) Anxiety disorder;

(iv) Personality disorder; or

(v) A combination of mental disorders sufficiently disabling to make the person functionally disabled; and

(vi) Exhibits impaired role functioning solely from the mental disorder in at least one of the following areas:

(A) The inability to be financially self-supporting;

(B) The inability to independently perform the activities of daily living;

or

(C) The inability to exhibit socially appropriate behavior.

(e) “Advanced Practitioner of Nursing (APN).” A professional registered nurse who is licensed in a specialty area of advanced nursing practice by the Wyoming Board of Nursing.

(f) “Agency.” A Wyoming certified mental health center or certified substance abuse center.

(g) “Audit.” An audit by an independent certified public accountant which includes:

(i) A financial audit performed in accordance with GAAP and which meets the requirements of the Wyoming Department of Audit;

(ii) A statement of internal controls and management letter;

(iii) A contract compliance audit if the provider is currently certified; and

(iv) For new providers, results of testing a sample of insurance billings to determine that billings match clinical record entries describing services provided.

(h) “Case management services.”

(i) Individual, non-clinical services designed to assist a recipient in planning and/or gaining access to needed medical, social, educational and other services as specified by the Department. “Case management services” include:

(A) Linking a recipient to therapeutically necessary services;

(B) Monitoring and/or providing follow-up to ensure that a recipient receives therapeutically necessary services;

(C) Making referrals for therapeutically necessary services;

(D) Advocating for a recipient to ensure that he or she receives therapeutically necessary services; and

(E) Providing crisis intervention services when therapeutically necessary.

(ii) Case Management activities shall be:

(A) A part of a recipient's treatment plan that is reviewed at least every three months; and

(B) Provided by a clinical professional, or clinical staff under the supervision of a clinical professional.

(i) "Certified." The meaning depends on the context:

(i) When used with respect to DFS, "certified" means a home approved by DFS to provide intensive child treatment services, or

(ii) When used with respect to mental health and substance abuse clinical professionals or clinical staff, "certified" means certified by the Mental Health Professions Licensing Board pursuant to the Mental Health Professions Practice Act (Wyo. Stat. §§ 33-38-101 through 113).

(j) "Chapter 1." Chapter 1, Rules for Medicaid Administrative Hearings, of the Wyoming Medicaid Rules.

(k) "Chapter 3." Chapter 3, Provider Participation, of the Wyoming Medicaid rules.

(l) "Chapter 4." Chapter 4, Third Party Liability, of the Wyoming Medicaid rules.

(m) "Chapter 8." Chapter 8, Inpatient Hospital Certification, of the Wyoming Medicaid rules.

(n) "Chapter 16." Chapter 16, Medicaid and State Funded Program Integrity, of the Wyoming Medicaid rules.

(o) "Chapter 38." Chapter 38, Safeguarding Information on Applicants and Recipients, of the Wyoming Medicaid rules.

(p) "Chapter 39." Chapter 39, Recovery of Excess Payments, of the Wyoming Medicaid rules.

(q) "Child." A recipient under age twenty-one.

(r) "Childhood disorder."

(i) A mental disorder which primarily affects children, including, but not limited to, ADHD, Oppositional Defiant Disorder, Depression, Anxiety, Disruptive Behavior Disorder and other related children's disorders.

(s) "Children's Day Treatment." Services provided:

(i) To a child with a childhood disorder; and

(ii) Which focus on treating behaviors that improve a child's functioning in the home, school, and community.

(t) "Claim." A request by a provider for Medicaid payment for covered services provided to a recipient.

(u) "Clinical assessment." A written assessment, completed prior to the provision of covered services, which:

(i) Is performed and prepared by a clinical professional or clinical staff member;

(ii) Includes an evaluation of a recipient's mental health and/or substance abuse disorder;

(iii) Is completed before additional covered services are furnished and may include contact with necessary collateral individuals;

(iv) Includes a statement of the presenting problem, including specific symptoms and behaviors of a mental illness or substance abuse disorder;

(v) Includes a summary of the recipient's history relating to current problems and to past history of problems and treatment;

(vi) Contains family and social data relevant to the disorder;

(vii) Includes medical data, including current medications, physical illnesses and substance use or abuse (if not the presenting problem);

(viii) Contains a narrative of significant mental status findings;

(ix) Includes a diagnostic interpretation of case facts;

(x) Specifies a DSM diagnosis;

(xi) Indicates development of the initial treatment plan with the client; and
(xii) Shall contain the full signature and licensure of the clinical professional involved.

(v) “Clinical Professional.” An individual who meets the standards of this subsection.

(i) Licensure. The individual is licensed by the State of Wyoming as a:

(A) Licensed Professional Counselor;

(B) Licensed Addictions Therapist;

(C) Licensed Psychologist;

(D) Licensed Clinical Social Worker;

(E) Licensed Marriage and Family Therapist;

(F) Licensed Physician;

(G) Licensed Psychiatric Nurse (Masters); or

(H) Licensed Advanced Practitioner of Nursing (specialty area of psychiatric/mental health).

(ii) The licensed individual is authorized to refer and to sign for the therapeutic necessity of covered services; and the individual is either:

(A) An employee of the provider agency; or

(B) Has a contractual agreement with the provider by which the clinical professional’s responsibilities under the Medicaid Mental Health Rehabilitative Option, Targeted Case Management Option and EPSDT mental health services are specified.

(iii) Any clinical professional under contract with or employed by a provider shall be required to submit Medicaid claims through the provider and to indicate the provider as payee.

(w) “Clinical records.” Medical records reflecting the treatment and services provided to a recipient, including:

- (i) Documentation of the recipient's consent to treatment. If the recipient is a minor, consent shall be obtained from the minor's parent or guardian;
- (ii) A fee agreement signed by the recipient or, if the recipient is a minor, the recipient's parent or guardian, which contains a medical release for Medicaid billing purposes; and
- (iii) Documentation that the recipient has been informed of his or her patient rights;
- (iv) A completed copy of the State MIS form, in the manner specified by the Department, with the current diagnosis;
- (v) A clinical assessment;
- (vi) A treatment plan;
- (vii) Progress notes;
- (viii) A chronological record of medications taken by the recipient;
- (ix) An appropriate and properly executed release form for each release of information;
- (x) Copies of testing, correspondence and interpretation of psychological testing;
- (xi) Copies of all documents received that relate to the recipient; and
- (xii) Clinical records shall:
 - (A) Identify the covered service provided;
 - (B) Identify the date, length of time, and location of the service;
 - (C) Identify all persons involved;
 - (D) Contain a narrative report of the recipient's condition, the issues addressed, the treatment interventions, and the recipient's progress toward defined goals; and
 - (E) Contain the full name, original signature, and degree or licensure of the therapist involved.

(x) “Clinical staff.” An individual who meets the standards of this subsection.

(i) “Provisional licensees.” Are provisionally licensed by the Mental Health Professions Licensing Board pursuant to the Mental Health Professions Practice Act (Wyo. Stat. §§ 33-38-101 through 113) to practice under the supervision of a qualified clinical supervisor licensed in the state of Wyoming and student interns who meet the definition of a mental health counselor in the Standards for the Operation of Community Mental Health and Substance Abuse Programs.

(ii) Is a Certified Social Worker (CSW) or a Certified Mental Health Worker (CMHW), certified by the Mental Health Professions Licensing Board pursuant to the Mental Health Professions Practice Act (Wyo. Stat. §§ 33-38-101 through 113) to practice under the supervision of a qualified clinical supervisor licensed in the state of Wyoming.

(iii) Is a certified addictions practitioner (CAP), certified by the Mental Health Professions Licensing Board pursuant to the Mental Health Professions Practice Act (Wyo. Stat. §§ 33-38-101 through 113) to practice under the supervision of a qualified clinical supervisor licensed in the state of Wyoming and student interns who meet the definition of a substance abuse counselor in the Standards for the Operation of Community Mental Health and Substance Abuse Programs.

(iv) Is a Registered Nurse (RN) who is performing nursing duties within the scope of practice as defined by the Wyoming Board of Nursing Rules, Chapter III-Standards of Nursing Practice.

(y) “CMS.” The Centers for Medicaid and Medicare Services of the United States Department of Health and Human Services, its agent, designee or successor.

(z) “Community-based individual/family therapy.” A therapeutic contact with a recipient and/or collaterals that occurs outside an agency, or that is furnished by an independent psychologist outside of the office setting, for the purpose of developing and implementing a treatment plan for an individual or family. The therapy shall be directed at treating a specific, identified mental health disorder. “Community-based individual/family therapy” shall:

(i) Be furnished only by a clinical professional or clinical staff member; or

(ii) An independent psychologist;

(iii) Be documented in clinical records; and

(aa) “Covered services.” Mental health and substance abuse services which are Medicaid reimbursable pursuant to this Chapter.

(bb) “Critical incident review.” A review of any incident that involves injury to a recipient, staff member, or a third person. The review shall be undertaken using the standards and procedures specified by the Department and disseminated to providers by Provider Bulletins or Manuals.

(cc) “Day treatment.” Adult or children’s day treatment.

(dd) “Department.” The Wyoming Department of Health, its agent, designee or successor.

(ee) “Department of Audit.” The Wyoming Department of Audit, its agent, designee, or successor.

(ff) “Developmental disability.” A person who has a confirmed diagnosis of Mental Retardation or a related condition as defined in 42 CFR 435.1009, which definition is incorporated by this reference.

(gg) “DFS.” The Wyoming Department of Family Services, its agent, designee, or successor.

(hh) “DSM.” The most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, which is incorporated by this reference. The DSM is published by the American Psychiatric Association, Washington, D.C., and is available from the publisher.

(ii) “EPSDT mental health services.” The following services furnished to a child:

(i) Intensive child treatment services;

(ii) On-going case management; and

(iii) Transitional case management.

(iv) EPSDT mental health services shall be:

(A) A part of the child’s treatment plan, which plan is reviewed at least every three months; and

(B) Provided by the appropriate clinical professional or clinical staff indicated for that particular service.

(jj) “Enrolled.” “Enrolled” as defined in Chapter 3, which definition is incorporated by this reference.

(kk) “Excess payments.” “Excess payments” as defined in Chapter 39, which definition is incorporated by this reference.

(ll) “Generally Accepted Auditing Standards (GAAS).” Auditing standards, practices and procedures established by the American Institute of Certified Public Accountants.

(mm) “Group therapy.” A therapeutic contact with two or more unrelated persons for the purpose of implementing each person’s treatment plan for the purpose of treating a specific, diagnosed mental illness, substance abuse disorder, or both. “Group therapy” shall be:

(i) Furnished by a clinical professional, clinical staff member, or independent psychologist, as appropriate;

(ii) Documented in clinical records;

(nn) “Home.” A home approved by DFS as a foster home.

(oo) “Independent psychologist.” A psychologist who is a Medicaid provider, enrolled, and practices independently of an agency, institution, or physician’s office.

(pp) “Intensive child treatment services.” Foster family-based services provided to a severely emotionally disturbed child or adolescent as an alternative to services provided in an institutional residential agency, including but not limited to:

(i) Placement in a therapeutic foster home;

(ii) Respite care for the foster parents;

(iii) Eligibility requirements. Eligibility for intensive child treatment services is limited to children who cannot or could not be maintained in the individual’s own home. The Department may, from time to time, specify criteria to be used in determining a child’s eligibility for such services. Such criteria shall be disseminated to affected providers through Provider Manuals or Provider Bulletins. Services furnished to a child over age 18 must receive prior authorization.

(qq) “Medicaid.” Medical assistance and services provided pursuant to Title XIX of the Social Security Act and/or the Wyoming Medical Assistance and Services Act. “Medicaid” includes any successor or replacement program enacted by Congress or the Wyoming Legislature.

(rr) “Medicaid fee schedule.” The “Medicaid fee schedule” as established pursuant to Chapter 3.

(ss) “Medical records.” All documents, in whatever form, including clinical records, in the possession of, or subject to the control of the provider which describes the recipient’s diagnosis, treatment or condition. “Medical records” include clinical records.

(tt) “Mental disorder.” A condition defined in the DSM, excluding a sole diagnosis of mental retardation or a specific developmental disorder.

(uu) “Medicare.” The health insurance program for the aged and disabled established pursuant to Title XVIII of the Social Security Act.

(vv) “Mental health center.” An agency located in Wyoming which is certified by the Mental Health Division as a “mental health center.”

(ww) “Mental health center/substance abuse center services.” The following services:

- (i) Mental health rehabilitative option services;
- (ii) Adult targeted case management; and
- (iii) EPSDT mental health services.

(xx) “Mental Health Division.” The “Mental Health Division” of the Department, its agent, designee, or successor.

(yy) “Mental health rehabilitative option services.” Rehabilitative option services which are:

- (i) A part of the recipient’s treatment plan, which plan is reviewed at least every three months; and
- (ii) Provided by, or under the supervision of, a clinical professional .

(zz) “Mental health or substance abuse disorder.” A primary diagnosis of a “mental health or substance abuse disorder” on Axis I and/or Axis II of the DSM, other than the following DSM diagnoses:

- (i) Diagnosis of any V code;
- (ii) Axis I or II diagnosis of 799.90;
- (iii) Any Axis III diagnosis;
- (iv) Mental retardation; or

(v) Developmental disorder.

(aaa) “Mental health services.” Mental health center/substance abuse center services and qualified psychological services.

(bbb) “Mental retardation.” “Mental retardation” as defined in the DSM, which definition is incorporated by this reference.

(ccc) “Nursing facility.” “Nursing facility” as defined by 42 U.S.C. § 1396r(a). “Nursing facility” may include a distinct part of a hospital or institution which is designated to provide skilled nursing facility services.

(ddd) “Office-based individual/family therapy services.” An office-based therapeutic contact with a recipient and/or collaterals for the purpose of developing and implementing a treatment plan for an individual or family, including medication management by licensed medical personnel as indicated. The service shall be targeted at reducing or eliminating specific symptoms or behaviors which are identified in the treatment plan. “Office-based individual/family therapy” shall be:

(i) Furnished by a clinical professional, clinical staff member, or independent psychologist as appropriate;

(ii) Documented in clinical records which:

(A) Identify the covered service provided;

(B) Identify the date, length of time, and location of the service;

(C) Identify all persons involved;

(D) Contain a narrative report of the recipient’s condition, the issues addressed, the treatment interventions, and the recipient’s progress toward defined goals; and

(E) Contain the full signature and degree or licensure of the therapist involved.

(eee) “Ongoing case management.” Individual, non-clinical services furnished to a recipient under age twenty-one to assist that individual in planning and gaining access to necessary medical, social, educational and other services. “Ongoing case management activities” shall be:

(i) Developed by the recipient's primary therapist as part of the recipient's treatment plan, and may include any or all of the following activities:

- (A) Advocacy on behalf of the child;
- (B) Crisis intervention and stabilization;
- (C) Liaison with service providers;
- (D) Monitoring of services; and
- (E) Referrals to appropriate service providers.

(fff) "Physician." A person licensed to practice medicine or osteopathy by the Wyoming State Board of Medical Examiners or a similar agency in another state.

(ggg) "Prior authorization." Approved pursuant to Section 11 before the services are provided.

(hhh) "Provider." An agency or independent psychologist that meets the requirements of Section 5.

(iii) "Provider agreement." "Provider agreement" as defined in Chapter 3, which definition is incorporated by this reference.

(jjj) "Psychologist." A person licensed to practice psychology by the Wyoming State Board of Psychology or, when services are provided in another state, by a person licensed to practice psychology by the Board of Psychology in that state.

(kkk) "Quality assurance plan." A provider's plan for reviewing medical records to determine the effectiveness and cost-efficiency of covered services. The "quality assurance plan" must meet the requirements of Section 12.

(lll) "Qualified clinical supervisor." A "qualified clinical supervisor": shall be a licensed professional counselor, licensed clinical social worker, licensed marriage and family therapist, licensed addictions therapist, licensed psychologist, licensed psychiatrist, licensed advanced practitioner of nursing with psychiatric specialty or a licensed physician with specialty in addictionology as specified by the Mental Health Professions Licensing Board pursuant to the Mental Health Professions Practice Act (Wyo. Stat. §§ 33-38-101 through 113).

(mmm) “Qualified psychological services.” Covered services provided by an independent psychologist as set forth in subsection 8(b).

(nnn) “Recipient.” A person who has been determined eligible for Medicaid.

(ooo) “Recipient under age twenty-one.” A recipient is under age twenty-one before or during the month in which he or she turns twenty-one years of age.

(ppp) “Registered Nurse (RN).” A person licensed to practice nursing by the Wyoming Board of Nursing.

(qqq) “Rehabilitative option services.”

(i) A comprehensive set of services, including some or all of the following:

- (A) Clinical assessment;
- (B) Office-based individual/family therapy services;
- (C) Community-based individual/family therapy;
- (D) Day treatment;
- (E) Group therapy; and
- (F) Individual and intensive individual rehabilitative services.

(rrr) “Serious and persistent mental illness.”

(i) One of the conditions specified in (ii) if:

- (A) Diagnosed by a licensed mental health professional;
- (B) The condition impairs the individual’s ability to perform the activities of daily living; and
- (C) The condition has existed continuously or episodically for at least one year.

(ii) Serious and persistent mental illness includes:

- (A) Schizophrenia and other psychotic disorders;

(B) Major depressive disorders and bipolar disorders; and

(C) Substance dependence disorders.

(iii) Serious and persistent mental illness does not include:

(A) A sole diagnosis of mental retardation or other developmental disability;

(B) A sole diagnosis of substance abuse disorder; or

(C) Mental disorders caused by a medical condition for which supervision and medication are the individual's primary treatment needs.

(sss) "School psychologist." An individual who is licensed to practice school psychology by the Wyoming State Board of Psychology, or a similar governmental entity in another state.

(ttt) "Services." Goods or "services" authorized for Medicaid payments under W.S. § 42-4-103 and the rules of the Department.

(uuu) "Serious Emotional Disorder (SED)." A child who:

(i) Has a DSM diagnosis other than V codes, adjustment disorders, mental retardation, or learning disabilities unless such diagnosis is concurrent with a psychiatric diagnosis;

(ii) Has a functional disability which results solely from the child's mental disorder and which impairs at least two of the following activities of daily life:

(A) Age appropriate self-care;

(B) Age appropriate education;

(C) Family life;

(D) Community living; and

(E) Personal hygiene.

(F) For children under age six, the child also must exhibit emotional or behavioral problems, including, but not limited to, severe withdrawal, attachment disorder, autism, and/or aggressive behavior, which occur in more than one setting.

(iii) Has had a condition which meets the criteria of paragraphs (i) and (ii) for one year or more, either continuously or episodically, or the condition is expected to last for one year or more and the child enters treatment because of such condition; and

(iv) Whose condition places him or her at significant risk for out-of-home, out-of-school, or out-of-community placement.

(vvv) “Substance abuse center.” An agency located in Wyoming which is certified by the Substance Abuse Division as a “substance abuse center.”

(www) “Substance Abuse Division.” The “Substance Abuse Division” of the Department, its agent, designee, or successor.

(xxx) “Substance Abuse Intensive Outpatient Program.” Clinical professional or clinical staff contact with two or more enrolled clients (and collaterals as necessary) for the purpose of providing a pre-planned and structured program of group treatment which may include education about role functioning, illness and medications; group therapy and problem solving, and similar treatment to implement each enrolled client’s treatment plan.

(yyy) “Therapeutic foster home.” A home in which the parent or parents have successfully completed the pre-placement training required by DFS for approval as a “therapeutic foster home,” as well as required continuing training as required by DFS.

(zzz) ”Therapeutic necessity” or “therapeutically necessary.” A covered services that is required to diagnose, treat, or cure a mental health disorder, substance abuse disorder, or both. The covered service must be:

(i) Consistent with the recipient’s diagnosis and level of functional impairment in critical activities of daily living, such as those involving school, family, job, or community;

(ii) Required to meet the treatment needs of the recipient and undertaken for reasons other than the convenience of the recipient and/or the recipient’s therapist;

(iii) Provided in the least costly setting that is consistent with the severity of the recipient’s functional impairment; and

(iv) Provided in accordance with the professional standards established by licensing boards for the mental health professional and/or substance abuse professional who is authorized to certify the “therapeutic necessity” of the services in the recipient’s treatment plan.

(aaaa) “Transitional case management services.”

(bbbb) “Treatment plan.” A written description of expected services outcome developed by a clinical professional and approved and signed within five working days of the third face-to-face therapeutic contact. The “treatment plan” must:

- (i) Be signed by a clinical professional;
- (ii) Contain a description of the methods and activities and their frequency that will be employed by specific persons to implement the treatment;
- (iii) Specify the changes in the recipient’s symptoms and behavior that are expected during the course of the “treatment plan”;
- (iv) Contain the statement: “I certify that services in this “treatment plan” are therapeutically necessary and that the client’s treatment goals are appropriate.”; and
- (v) The “treatment plan” must be developed at a minimum of every three months that the recipient remains in treatment as required by the recipient’s needs. Updated “treatment plans” must meet the requirements in paragraphs (i) through (iv).

(cccc) “Usual and customary charges.” A provider’s charges for comparable services provided to non-Medicaid recipients other than persons eligible for payment on a reduced or sliding fee schedule.

(dddd) “Utilization review.” A review of the cost-effectiveness of the utilization of covered services. The review shall be undertaken in accordance with the standards and procedures specified by the Department and disseminated to providers by Provider Manuals or Bulletins.

Section 5. Provider participation.

(a) “Payments only to providers.” No agency or independent psychologist that furnishes covered services to a recipient shall receive Medicaid funds unless the agency or independent psychologist has signed a provider agreement.

(b) “Compliance with Chapter 3.” An agency or independent psychologist that wishes to receive Medicaid reimbursement for covered services furnished to recipients must meet the provider participation requirements of Chapter 3, which are incorporated by this reference.

(c) “Enrolled.” An agency or an independent psychologist that wishes to receive Medicaid reimbursement for covered services furnished to recipients must be “enrolled.”

(d) “Eligible providers.”

- (i) Mental health centers and substance abuse centers; and
- (ii) Independent psychologists.

(e) “Special requirements for mental health centers and substance abuse centers.”

An agency which wishes to receive Medicaid reimbursement for furnishing covered services to recipients must:

(i) Be certified by the Mental Health Division, the Substance Abuse Division, or both, as appropriate;

(ii) Have a quality assurance plan;

(iii) Meet the following audit requirements.

(A) For new providers. An agency which is not certified and enrolled must submit an audit of its most recently completed fiscal period to the Department and the Department of Audit.

(B) For on-going providers. A provider which wishes to continue as a Medicaid provider shall submit a copy of a financial audit to the Department and the Department of Audit within one-hundred and eighty (180) days after the end of each fiscal year for which the agency is a provider.

(C) Audit standards. Audits performed pursuant to this Section shall:

(I) Be conducted by an independent certified public account;

(II) Meet the requirements of the Department of Audit;

(III) For new providers, include a sample of insurance billings which match clinical records with billed services; and

(IV) For on-going providers, include a contract compliance audit which verifies compliance with the purchase of service(s) contract between the provider and the Mental Health Division or the substance Abuse Division.

(D) Correction of audit deficiencies.

(I) For new providers. An agency shall not become a provider until the Department deems the audit to be sufficient or that any deficiencies noted by the Department of Audit have been corrected;

(II) For on-going providers. The Department shall require an on-going provider to correct any deficiencies.

(iv) Special requirements. Providers who wish to receive Medicaid funds for providing the services specified in this paragraph must meet the criteria of this paragraph:

(A) Case management services. All members of the agency's staff who provide case management services must:

(I) Be employed by, or under contract with, a "certified mental health or substance abuse center";

(II) Be a clinical professional, clinical staff or non-licensed/non-certified staff who has a degree in a human relations discipline.

(B) Individual rehabilitative services (IRS). All members of the agency's staff who provide individual rehabilitative option services must:

(I) Be eighteen years of age or older;

(II) Be employed by, or under contract with, a certified mental health center;

(III) Complete a basic training program which includes non-violent behavior management; and

(IV) Have a GED, high school degree or higher in non-clinical discipline.

(V) IRS services must be supervised by a clinical professional or clinical staff member.

(C) Intensive child treatment services. The following may provide intensive child treatment services.

(I) An agency which is certified by DFS as a child placing agency;

- (II) An agency which is able to furnish:
 - (a) Case management services;
 - (b) Clinical assessment;
 - (c) Individual/family therapy; and
 - (d) Group therapy.

- (D) Therapeutic foster parents who:
 - (I) Are approved as such by DFS;
 - (II) Have no more than two SED children in the therapeutic foster home, unless otherwise approved by DFS; and
 - (III) Are provided access to respite care.

- (E) Mental health center services. All members of the agency's staff who provide mental health center services must:
 - (I) Be employed by, or under contract with, a certified mental health center;
 - (II) Be a clinical professional, clinical staff, qualified as a case manager, or Individual Rehabilitative Services worker per the requirements of the service provided.

- (F) Substance abuse center services. All members of the agency's staff must:
 - (I) Be employed by, or under contract with, a certified substance abuse center;
 - (II) Be a clinical professional, clinical staff, qualified as a case manager, or Individual Rehabilitative Services worker per the requirements of the service provided.

Section 6. Provider records. A provider must comply with the record keeping requirements of Chapter 3, which are incorporated by this reference.

Section 7. Verification of recipient data. A provider must comply with the verification

of recipient data requirements of Chapter 3, which are incorporated by this reference.

Section 8. Covered services.

(a) “Services furnished by a mental health center or a substance abuse center.”

(i) Services listed in paragraph (a)(ii) are covered services when furnished in an agency or in the community if:

(A) Furnished to a recipient;

(B) Therapeutically necessary;

(C) Furnished by a provider;

(D) Provided as treatment for a recipient with a primary diagnosis of a mental disorder or a substance abuse disorder; and

(E) Furnished pursuant to a treatment plan, updated and signed by a clinical professional at least every three months.

(ii) Covered services.

(A) Mental health center services;

(B) Substance abuse services.

(iii) Community-based services furnished to children. The following services are covered services if furnished by an agency to a child:

(A) Intensive child treatment services;

(B) Ongoing case management activities; and

(C) Transitional case management.

(b) “Services furnished by an independent psychologist.”

(i) Services listed in paragraph (b)(ii) are covered services when furnished by an independent psychologist if:

(A) Furnished to a recipient by an independent psychologist; and

(B) Therapeutically necessary;

(ii) Covered services.

(A) Diagnostic and therapeutic services provided to recipients in an independent psychologist's office or a community setting;

(B) The following rehabilitative option services:

(I) Clinical assessment;

(II) Office-based individual/family therapy services;

(III) Group therapy; and

(IV) Community-based individual/family therapy.

(c) "Provider's right to exercise professional judgement." Nothing in this Chapter is intended to interfere with the professional judgement of a mental health professional or substance abuse professional to prescribe or provide services which the professional believes to be therapeutically necessary. This Chapter simply establishes limits on Medicaid reimbursement.

Section 9. Excluded services.

(a) "For services furnished by a mental health center or substance abuse center."

(i) Clinical services not provided face-to-face other than collateral contacts necessary to develop or implement a treatment plan;

(ii) Consultation on behalf of a patient, except:

(A) Face-to-face contact to implement the treatment plan of a patient receiving rehabilitative option services;

(B) Face-to-face contact to implement the treatment plan of a patient receiving EPSDT mental health services; or

(C) Face-to-face or telephone contact to implement the treatment plan of a patient receiving case management services.

(iii) Education, public education, public relations, and speaking

engagements;

- (iv) Day care;
- (v) Driving while under the influence (DUI) classes;
- (vi) Missed appointment;
- (vii) Psychological testing done for the sole purpose of education diagnosis, school or institution admission or placement;
- (viii) Record-keeping time;
- (ix) Recreation and socialization services;
- (x) Remedial or other formal education;
- (xi) Residential room, board, or care;
- (xii) Substance abuse or mental health disorder prevention services;
- (xiii) Support groups such as AA or NA;
- (xiv) Time spent preparing records or reports; except
 - (A) Up to three hours for a licensed psychologist to prepare a formal report of test findings;
 - (B) Time spent completing reports, forms, and correspondence regarding case management services;
 - (C) Consulting with non-recipients on behalf of a recipient unless the consultation is part of a face-to-face contact with a recipient or a face-to-face contact with a collateral on behalf of a client receiving mental health rehabilitative services;
 - (I) In telephone conversations; and
 - (II) Travel time.
- (xv) Vocational services.
- (xvi) Services provided to a recipient with:

(A) DSM diagnosis on Axis III;

(B) DSM diagnosis of mental retardation;

(C) DSM diagnosis of factitious disorder;

(D) DSM Axis I diagnosis of any V code unless the recipient's medical record contains a written statement signed by the affiliated physician explaining why the treatment of a condition that is not a mental disorder is medically necessary;

(I) DSM diagnosis of 799.90 on Axis I or Axis II;

(II) DSM diagnosis of specific developmental disorders.

(xvii) "Services provided by an independent psychologist in an agency";

(xviii) "Services provided by a school psychologist."

Section 10. Limited services.

(a) "Nursing home residents." Medicaid reimbursement for services provided to a recipient in a nursing facility is limited to:

(i) Clinical assessment;

(ii) Community-based individual or family therapy; and

(iii) Group therapy.

(b) "Patients in certified freestanding substance abuse centers." Medicaid reimbursement for services provided to a recipient who is a "patient in a certified freestanding substance abuse center" is limited to:

(i) Clinical assessment;

(ii) Individual/family therapy;

(iii) Group therapy;

(iv) Case management; and

- (v) Substance abuse intensive outpatient programs.
- (c) “Independent psychologists.”
 - (i) The interpretation or explanation of results of psychological services to a patient’s family members or other responsible persons is included in the fee for psychotherapy; and
 - (ii) Psychological testing is reimbursed on a per hour basis.

Section 11. Prior authorization.

(a) “Incorporation of Chapter 3.” Prior authorization of mental health services or substance abuse services shall be governed by the prior authorization requirements of Chapter 3, which are incorporated by this reference.

(b) “Services that require prior authorization.”

(i) The Department may, from time to time, designate covered services that require prior authorization.

(ii) In designating services that require prior authorization, the Department shall consider the:

- (A) Cost of the service;
- (B) Potential for over-utilization of the service; and
- (C) Availability of lower cost alternatives.

(iii) The Department shall disseminate a list of mental health services that require prior authorization to providers through Provider Manuals or Provider Bulletins.

(iv) The failure to obtain prior authorization shall result in denial of Medicaid payment for the service.

Section 12. Quality assurance for agencies.

(a) Each agency must have a quality assurance plan that meets the standards specified by the Department and has been approved by the Department. The plan must meet the provisions of this Section, and shall include:

- (i) Utilization and quality review criteria to review and evaluate the

appropriateness of the services provided;

(ii) Standards for completeness review and clinical record keeping; and

(iii) Definitions of critical incidents which require professional review and review procedures.

(b) The Department shall develop standards for quality assurance programs to supplement those contained in this Chapter.

(i) In developing quality assurance standards, the Department shall consider;

(A) Types of services provided in mental health and substance abuse centers;

(B) Potential for over-utilization of the services; and

(C) Availability of alternative treatments which can meet the therapeutic needs of recipients.

(ii) The Department shall disseminate its quality assurance standards, as well as any modifications to those standards, to providers through Provider Manuals or Provider Bulletins.

(c) “Quality assurance committee.” The quality assurance plan must include a “quality assurance committee” that:

(i) Consists of clinical staff, including non-supervisory clinical staff;

(ii) Conducts utilization review and critical incident review, unless another body is designated for critical incident reviews. The committee shall:

(A) Review annually at least ten percent of all Medicaid cases, including one case that involves each member of the clinical staff and a proportionate number of mental health and substance abuse cases;

(B) Document the results of all reviews and all committee activities;

(C) Document in each clinical record reviewed the type of review, the date of the review and the person(s) involved in the review;

(D) Exclude from any review an individual that is the primary or co-therapist;

(E) Prepare an annual report of all reviews, including recommendations for appropriate corrective activities. Submit a copy of the annual report to the Mental Health Division or the Substance Abuse Division, as appropriate; within thirty days after its completion;

(F) Make available to the agency staff and governing body a summary of the annual report; and

(G) Such other activities as specified by the Department.

(d) A provider may satisfy the requirements of this Section by entering into a formal agreement with another provider that has a quality assurance plan.

Section 13. Medicaid allowable payment.

(a) Providers shall receive the lower of the provider's usual and customary fee or the fee specified in the Medicaid fee schedule for the service or services furnished to a recipient.

Section 14. Submission and Payment of claims.

(a) Payment and submission of claims shall be pursuant to the payment and submission claims provisions of Chapter 3, which are incorporated by this reference.

(b) Before a provider submits a claim for mental health Rehabilitative Option, Targeted Case Management Option or EPSDT mental health services, a licensed practitioner shall sign and date the client's clinical assessment and written treatment plan, including the following statement, "I certify that the services in this treatment plan are therapeutically essential for the reduction of mental health/substance abuse disability." Only an original signature is valid.

(c) Licensed practitioners who sign for services that are not therapeutically essential are subject to sanctions pursuant to Chapter 16, referral to the relevant professional licensing board, or both.

Section 15. Third-party liability.

(a) "Submission of claims." Claims for which third-party liability exists shall be submitted in accordance with Chapter 4, which is incorporated by this reference.

(b) "Medicaid payment." The "Medicaid payment" for a claim for which third party liability exists shall be the difference between the Medicaid allowable payment and the third party payment. In no case shall the "Medicaid payment" exceed the payment otherwise allowable pursuant to this Chapter.

Section 16. Recovery of excess payments or overpayments.

(a) The Department may recover excess payments pursuant to Chapter 39, which is incorporated by this reference.

(b) The Department may recover overpayments pursuant to Chapter 16, which is incorporated by this reference.

Section 17. Reconsideration.

(a) A provider may request that the Department reconsider a decision to recover excess payments or overpayments. The request for reconsideration, the reconsideration, and any administrative hearing shall be pursuant to the reconsideration provisions of Chapter 3, which are incorporated by this reference.

Section 18. Disposition of recovered funds.

(a) The Department shall dispose of recovered funds pursuant to the provisions of Chapter 16, which provisions are incorporated by this reference.

Section 19. Interpretation of Chapter.

(a) The order in which the provisions of this Chapter appear is not to be construed to mean any one provision is more or less important than any other provision.

(b) The text of this Chapter shall control the titles of its various provisions.

Section 20. Superseding effect.

(a) When promulgated, this Chapter supersedes all prior rules or policy statements issued by the Department, including Provider Manuals and Provider Bulletins, which are inconsistent with this Chapter.

Section 21. Severability.

(a) If any portion of this Chapter is found to be invalid or unenforceable, the remainder shall continue in full force and effect.

