



State of Vermont

**Agency of Human Services
Department of Mental Health
Montpelier, Vermont**

**MEDICAID FEE-FOR-SERVICE
PROVIDER MANUAL**

EFFECTIVE JULY 1, 2014

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Section 1

General Information

1.1 Introduction

Medicaid is Title XIX of the Social Security Act. It is a matching entitlement program that provides medical care to aged, blind, or disabled persons and low-income families with limited resources. It is financed by a combination of both federal and state dollars. The Vermont General Assembly appropriates the state funds.

The Vermont Division of Vermont Health Access (DVHA) has delegated responsibility to the Department of Mental Health (DMH) for the administration of Fee-For-Service Medicaid funds to the Designated Agencies (DA) for the services outlined within this manual.

1.2 Focus & Scope of the Manual

This manual pertains to mental health services offered through the Vermont Department of Mental Health's Medicaid Program for Fee-for-Service for Traditional Medicaid recipients. It is intended to provide guidance to Designated Agencies regarding eligible service activity, procedures for billing, and documentation requirements.

The contents do not represent an inclusive reference directory for all possible questions or clarifications that may be necessary to comply with Medicaid requirements. Providers are responsible for seeking clarification regarding services or activities and eligibility for reimbursement when services or billing is in question. As a general principle, when in doubt about provisions contained in this provider manual, first contact your provider representative at HP Enterprise Services. If you need further clarification, please call 802-828-3824 for questions pertaining to Adult Services and 802-951-1223 for questions pertaining to Children's services.

An electronic copy of the DMH Medicaid FFS Procedure Manual is available on the DMH website at <http://mentalhealth.vermont.gov/publications>.

1.3 Revisions to the Manual

This Medicaid Manual was revised effective July 1, 2014. Ongoing revisions to this manual will be communicated as needed through billing update memorandums. Except for rate changes, this document and the billing update memos will be the only mechanism for reflecting change.

Manual updates and billing update memorandums are available on the DMH website at <http://mentalhealth.vermont.gov/publications>.

1.4 Beneficiary Information

The Department of Children and Family Services (DCF), Economic Services Division (ESD) determines an individual's eligibility for Medicaid. An application for health benefit eligibility and other public benefit determinations may be made online at

<http://dcf.vermont.gov/mybenefits/apply> for benefits, by calling the DCF Benefits Service Center (800) 479-6151 or by visiting a DCF district office. A list of district offices can be found at http://dcf.vermont.gov/fsd/contact_us/district_offices.

The Benefits Service Center's call center interactive voice response (IVR) system serves providers and beneficiaries statewide. It can be reached at 1-800-925-1706. Providers should stay on the line after the -message for a separate queue, and will be serviced directly. Providers may seek member eligibility and claims information by using the Vermont Medicaid Provider Portal at www.vtmedicaid.com.

1.5 Covered Entities

Medicaid payment for covered services is limited to Commissioner Designated Agencies (community mental health centers) and other Commissioner designated entities that are established for the purpose of providing community-based mental health care.

As a Designated Agency (DA), you must re-certify with HPES (HP Enterprise Services) Enrollment every year. HPES will send you a letter at both 60 and 30 days prior to your enrollment recertification due date. Simply complete the Recertification Agreement, available online at:

<http://www.vtmedicaid.com/downloads/forms/Provider%20Recertification%20Agreement%2012-12-12%20Final.pdf>.

If the DA subcontracts services to be performed under the Master Grant agreement it is the responsibility of the DA to ensure that the subcontractor adheres to the requirements set forth in this manual. The subcontractor is then able to perform these services on behalf of the DA.

In order for a Commissioner designated agency or entity to be eligible for participation under the Medicaid State Plan, it must agree to comply with appropriate federal regulations and to perform and bill for services, maintain records, and adhere to the supervision, regulations, standards, procedures, and this manual's requirements of the Commissioner of the Department of Mental Health pursuant to 18 VSA, Chapter 177, Section 7401(2), (4), and (15); and 18 VSA, Chapter 207, Sections 8907 through 8913.

The service must be provided by:

- A Vermont Medicaid enrolled provider consistent with their licensed scope of practice and who is employed by a DA, or
- In accordance with the individual treatment plan by a DA staff member who, based on his/her education, training, or experience, is determined competent to provide the service by the Medical Director of the DA and whose work is directly supervised by a qualifying provider, or
- A qualifying provider above who is sub-contracted by the DA or otherwise authorized by the Commissioner of Mental Health.

1.5.1 Designated Agency/Entity Sub-Contractors

Entities or individuals working under sub-contract for a designated agency/entity acts as an employee of the designated agency/entity for purposes of billing Title XIX services. Sub-contracts must be available for review or Title XIX audit. Sub-contracts require provisions showing:

- With whom the sub-contract is made, stating specific positions and their credentials
- What specific Title XIX services the sub-contractor will provide under the sub-contract
- The staff member responsible for monitoring billing practices of the sub-contractor
- The staff member responsible for providing supervision over the clinical practices of the sub- contractor (with the exception of contract physicians).

1.5.2 Private Non-Medical Institutions (PNMI)

PNMI's are under the auspices of the Department for Children and Families, Family Services Division (DCF).

A PNMI is defined as an agency or facility that is not, as a matter of regular business, a health insuring organization, hospital, nursing home, or a community health care center, that provides medical care to its residents. A PNMI for Child Care Services must be licensed by DCF as a Residential Child Care Facility and have a Medicaid Provider Agreement in effect with the Division of Vermont Health Access.

- Covered services of the PNMI Per-Diem rate (the fee paid, per recipient day, to a PNMI Provider) includes a comprehensive spectrum of mental health care services. Community mental health centers may deliver Service Planning and Coordination or Community Supports for discharge planning/transition/aftercare coordination, not to exceed forty-five (45) hours prior to discharge, provided such billing does not duplicate services of another agency or another agency program. The documentation should include what service and how it reflects discharge planning.
- If a DA/SSA determines the discharge planning process will require additional hours a written request must be submitted to DMH. The request must include a description of the clinical need for additional services, what services are being provided (identify the modality, level of intensity and number of hours) and what services are needed to ensure a smooth discharge plan. Up to an additional 20 hours may be requested. This will be reviewed by the DMH Children's Mental Health Care Manager, the DMH CAFU Operations Chief. A written decision will be issued to the requesting DA/SSA. The written decision should be placed in the clinical file.

1.6 Provider Eligibility

Provider numbers are issued for the provision of specific types of services such as mental health services, developmental services, services in a detoxification facility, neurological services or general medical services.

Only those services specifically allowed under a given provider number will be reimbursed. In cases where multiple provider numbers are issued to a DA, DMH staff will have access to settlement sheets documenting payments under each number. Ongoing Medicaid review activities by DMH will include verification that double payments are not made under multiple provider numbers for the same service.

1.6.1 Staff Qualifications

Specific staff requirements for services will be included in the appropriate section. Staff qualifications also apply to contracted employees, interns, and sub-contracted entities.

1.7 Documentation Standards

Documentation of services provided must be legible, of sufficient clarity, and sufficient clinical content (minimum required content is specified for each service) to ensure eligibility for payment. Auditors must be able to read the service documentation.

All clinical and support notes must include:

- Identification of the individual served
- The date the service was rendered
- The specific title or code of the service rendered
- Location in which the service occurred
- The amount of time it took to deliver the service
- Reference to the treatment goal for the service
- Summary of the service rendered with appropriate clinical content (refer to specific service documentation requirements)
- Specific plan for ongoing treatment
- Name, title and qualification of the service provider(s). If not required by the agency, qualifications, degrees and titles must be on file at the designated agency and provided during audit.
- Signature of the person who rendered the service. If co-therapists are involved in treatment, either may sign the progress note.

Each reimbursed service must be documented in the individual's case record. This documentation may be in another provider's files but must be available to Title XIX auditors and identified with the individual's name and/or record number.

For paper records, the use of white-out in the paper clinical record is prohibited. The use of cross-outs to alter information that has been entered into the clinical record is the only acceptable method of changing information. Information to be altered should have a single line through the information and must be accompanied by the initials of the staff making the alterations, date and time.

For electronic records, all documentation should be locked when complete. If a change is needed after an electronic note has been locked, the agency should assure compliance with its policies regarding this and be able to identify change, time of change, and signature of person making the change.

Checklists by themselves are not acceptable as clinical or support notes. Additional narrative is required to explain the information that has been “checked off”.

1.7.1 Billing matched to Time Record or EMR Equivalent

A time record serves as the source document for Medicaid billing. The information must match billing and the individual’s clinical record data. The time record must include:

- Identification of the individual
- Staff member identification
- Signature of staff member (electronic accepted)
- Program and cost center
- Service (Medicaid modality)
- Duration
- Date
- Number of individuals receiving service present
- Location
- If other staff is present (time records may need to be reviewed during an audit).

1.7.2 Use of Electronic Signatures

Agencies requesting and demonstrating appropriate safeguards for use of computer generated signatures may be authorized to use electronic signature technology if policies and procedures for the agency are submitted and approved by DMH. Policies should be in compliance with Federal law 22CFR Part 11. Credentials must be included with the signature.

1.8 Billing Instructions, Procedures and Claim Processing

1.8.1 Allowable Billing

Billing is allowed only for services provided by:

- Qualified staff that are employed by a designated agency/entity
- Qualified subcontractors that are hired by the agency
- Students/interns, provided that the student/intern is supervised by a qualified staff of the designated agency/entity, is subject to all designated agency/entity policies and procedures, and that the designated agency/entity assumes responsibility for the work performed.

1.8.2 Fee Schedule

The fee schedule is available on the Department of Mental Health website at <http://mentalhealth.vermont.gov/publications>. Notification of updates will be sent to the DAs and other commissioner-authorized entities.

1.8.3 Time/Unit Definitions for Services

The American Psychiatric Association (APA) mandatory Psychiatric and Psychotherapy Current Procedural Terminology (CPT) code changes became effective for all services January 1, 2013. You may consult the APA web page to access detailed guidelines at <http://www.psych.org>.

Where not defined by CPT code, the following description of units of time may be used.

1 minute to 14 minutes	=	1 unit (not billable)
15 minutes to 30 minutes	=	2 units
31 minutes to 45 minutes	=	3 units
46 minutes to 60 minutes	=	4 units
61 minutes to 75 minutes	=	5 units
76 minutes to 90 minutes	=	6 units
91 minutes to 105 minutes	=	7 units
106 minutes to 120 minutes	=	8 units (etc.)

Time spent for Individual Community Supports, Group Community Supports and Service Planning and Coordination will be aggregated and will not exceed the actual time for service provided for an individual on the same day.

Any combination of services may be provided to a client, not to exceed the maximum allowed amount per day. Services cannot be duplicated or provided simultaneously unless otherwise noted in service description.

1.8.4 Billing Codes and Modifiers

1.8.4.1 Evaluation and Management Codes (E/M)

The American Psychiatric Association (APA) mandatory Psychiatric and Psychotherapy Current Procedural Terminology (CPT) code changes became

effective for all services January 1, 2013. You may consult the APA web page to access detailed guidelines at <http://www.psych.org>.

1.8.4.2 Modifiers

MODIFIER	DESCRIPTION
HE	Mental Health Services
76	Repeat procedure by Same physician
77	Repeat procedure by another physician
ET	Emergency services
GY	Item or service statutorily excluded from Medicare
HE/HB	CRT only
HF	Substance Abuse program
HK	Specialized MH programs for High-Risk populations (Success Beyond Six only)
HQ	Group setting
HR	Family/Couple w client present
HS	Family/Couple w/o client present
UD	Nurse practitioner services
GC	Used School Based Clinicians Bundled rate
SE	SFI Program (T2038) Medicaid
HV	SFI Program (T2038) GC Investment
GT	Telemedicine

1.8.5 Instructions for Submission

Claims, either paper or electronic, shall be submitted to the “fiscal agent”, Hewlett Packard Enterprise Services (HPES), according to procedures established by the Department of Mental Health.

There is a maximum reimbursable dollar limit per client per day, regardless of the number of services provided. Please refer to the DMH fee schedule for the current daily limit.

1.8.6 Payments and Conditions of Reimbursement

The following conditions of reimbursement shall apply to all mental health Medicaid services.

- Payment for mental health Medicaid services will be made at the lower of the actual charge or the Medicaid rate on file. The agency must accept, as payment in full, the amounts received from Medicaid.

- According to Federal Law, all clients must be treated similarly in terms of billing for all services. For example, if a non-Medicaid client is being transported with other clients whose services are being reimbursed by Medicaid, the non-Medicaid client must also be billed. (This does not preclude the use of sliding fee scales.)
- The Federal Government (Medicaid – Title XIX) will not reimburse for services to a Medicaid eligible individual if a non-Medicaid individual receives the same service free of charge. This does not preclude the use of sliding fee scales.
- Mental health Fee-for-Service Medicaid services may be provided and reimbursed on the same day prior to the time of admission, or after discharge, to an institution.
- DMH retains sole authority to set payment rates.
- Errors must be refunded or adjustments made immediately upon realization that an error in billing has occurred.

1.8.7 Exclusions and Prohibitions

The following exclusions and prohibitions are in effect for mental health Medicaid services.

- Any individuals, including physicians, serving as community mental health agency staff members may not concurrently provide private services of a similar nature to their community mental health agency clients and bill for those services under the Medicaid program.
- No reimbursement will be made for services provided in **inpatient** facilities except service planning and coordination for eligible children and adults for discharge planning/transition/aftercare coordination.
- Billing is not to exceed a total of forty-five (45) hours of service prior to discharge provided such billing does not duplicate services of another agency or agency program. Billed service hours must be identified as such in record documentation.
- Activities with the primary purpose of teaching clients the vocational skills needed for a specific job (i.e. vocational trainer/job coach activities) or other vocationally-related services:
 - Vocational Placement
 - Work Adjustment Training
 - Job Placement/Performance evaluation
 - Vocational Workshop
 - Vocational Counseling
 - Vocational Support Group
 - Vocational Program Administration

- Activities with the primary purpose of education, such as academic instruction or tutorial, typically provided in an educational setting by professional educators.
- No other mental health Medicaid reimbursement shall occur for any client receiving:
 - PNMI services, for services that are included in the PNMI rate for that facility
 - Developmental services or mental health and community-based waiver services except as noted below *.

**Children whose services are covered under a Developmental Services Waiver or a Mental Health Waiver may be eligible for additional services if the following conditions are met:*

- For children covered under the Medicaid Waiver program, Success Beyond Six or any school based mental health service, Medicaid may be billed for school supports if:
 - Services must be a specific set of mental health services provided in the school environment.
 - Goals and services must be identified in the Individual Plan of Care.
- For children covered under the Medicaid Waiver programs, additional clinical therapies may be provided by non-DA clinicians if:
 - Services are not duplicative to what is included in the waiver

This exception is available for children up to their 22nd birthday. It is not available for adults over 22.

1.8.7.1 Non-Medicaid FFS Reimbursable Services – Adult Services

Employment Assessment

Employment assessment involves evaluation of the individual’s work skills, identification of the individual’s preferences and interests, and the development of personal work goals.

Employer and Job Development

Employer and job development assists an individual to access employment and establish employer development and support. Activities for employer development include identification, creation or enhancement of job opportunities, education, consulting, and assisting co-workers and managers in supporting and interacting with individuals.

Job Training

Job Training assists an individual to begin work, learn the job, and gain social inclusion at work.

Ongoing Support to Maintain Employment

Ongoing support to maintain employment involves activities needed to sustain paid work by the individual. These supports and services may be provided both on and off the job site, and may involve long-term and/or intermittent follow-up.

Emergency/Crisis Beds

Emergency/Crisis beds are emergency, short-term, 24-hour residential supports in a setting other than a person's home. Crisis stabilization services are reimbursable.

Intensive Residential

- Intensive Residential – Staffed Living are residential living arrangements for one or two people, staffed full-time by providers.
- Intensive Residential – Group Treatment/Living are group living arrangements for three or more people, staffed full-time by providers.

Intermediate Residential

- Intermediate Residential – Supervised/Assisted Living (by the hour) are regularly scheduled or intermittent supports provided to an individual who lives in his/her home or that of a family member.
- Intermediate Residential – Staffed Living are residential living arrangements for one or two people, staffed full-time by providers.
- Intermediate Residential – Group Treatment/Living are group living arrangements for three or more people, staffed full-time by providers.

Consultation, Education and Advocacy

Consultation, Education and Advocacy services are system-based work done with family and community groups to improve circumstances and environments for targeted DMH populations. These services may include community resource development. They are not provided in relation to a specific individual receiving services funded by DMH.

Day Treatment or Day Services

Day Services are group recovery activities in a milieu that promote wellness, empowerment, and a sense of community, personal responsibility, self-esteem and hope. These activities are consumer centered. This service provides socialization, daily skills development, crisis support and promotes self-advocacy.

1.8.7.2 Non-Medicaid FFS Reimbursable Services – Children Services

Employment Assessment

Employment Assessment involves evaluation of the individual's work skills, identification of the individual's preferences and interests, and the

development of personal work goals.

Employer and Job Development

Employer and Job Development assists an individual to access employment and establishes employer development and support. Activities for employer development include identification, creation or enhancement of job opportunities, education, consulting, and assisting co-workers and managers in supporting and interacting with individuals.

Job Training

Job Training assists an individual to begin work, learn the job, and gain social inclusion at work.

Ongoing Support to Maintain Employment

Ongoing support to maintain employment involves activities needed to sustain paid work by the individual. These supports and services may be provided both on and off the job site, and may involve long-term and/or intermittent follow-up.

Emergency/Crisis Beds

Emergency/Crisis beds are emergency, short-term, 24-hour residential supports in a setting other than a person's home. Crisis stabilization services are reimbursable.

Family/Home Provider Supports (Respite)

Family/Home Provider Supports assist family members, significant others (e.g., roommates, friends, partners), home providers and foster families to help support specific individuals with disabilities. It includes:

- Respite (by the hour) services are provided on a short-term basis because of the absence or need for relief of those persons normally providing the care to individuals who cannot be left unsupervised.
- Respite (by the day/overnight) services are provided on a short-term basis because of the absence or need for relief of those persons normally providing the care to individuals who cannot be left unsupervised.

Family Education

Family Education is education, consultation and training services provided to family members, significant others, home providers and foster families with knowledge, skills and basic understanding necessary to promote positive change.

Consultation, Education and Advocacy

Consultation, Education and Advocacy services are system-based work done with family and community groups to improve circumstances and

environments for targeted DMH populations. These services may include community resource development. They are not provided in relation to a specific individual receiving services funded by DMH.

Intensive Residential

- Intensive Residential – Staffed Living are residential living arrangements for one or two people, staffed full-time by providers.
- Intensive Residential – Group Treatment/Living are group living arrangements for three or more people, staffed full-time by providers.
- State approved ISB funded services are allowed.

Intermediate Residential

- Intermediate Residential – Supervised/Assisted Living (by the hour) are regularly scheduled or intermittent supports provided to an individual who lives in his/her home or that of a family member.
- Intermediate Residential – Staffed Living are residential living arrangements for one or two people, staffed full-time by providers.
- Intermediate Residential – Group Treatment/Living are group living arrangements for three or more people, staffed full-time by providers.
- State approved -ISB funded services are allowed.

Day Treatment or Day Services

Day Services are group recovery activities in a milieu that promote wellness, empowerment, and a sense of community, personal responsibility, self-esteem and hope. These activities are consumer centered. This service provides socialization, daily skills development, crisis support and promotes self-advocacy.

Education

Activities with the primary purpose of education, such as academic instruction or tutorial, typically provided in an educational setting by professional educators are not reimbursable.

1.8.8 Timely Filing of Claims and Adjustments

Claims over six months old that have not already been billed to HPES will not be approved for filing except in the following instances:

- The Department of Mental Health has created a situation which made it difficult or impossible to submit the claim and/or adjustment with the allowed time, i.e., rate change
- HPES is at fault (documentation required) for the claim and/or adjustment not being processed in a timely manner
- Retroactive Medicaid eligibility

- Other insurance – no response (attempts to receive denial must be documented in writing) the Department will forward requests for overriding other insurance to the Medicaid Division
- Other insurance – a denial was received after the year filing time and documented attempts were made to receive the denial with the year
- The agency has been over paid and a recoupment is needed
- Re-submissions – all re-submissions should be received by HPES within 6 months, but cannot exceed two years from the service date. Proof of the original submission must be attached to the claim.

Claims and/or adjustments meeting the above criteria, and not more than two years old, will be reviewed on a case-by-case basis. Please be advised that any claims and/or adjustments over two years old cannot be considered for payment in accordance with federal regulation.

1.8.9 Use of Telemedicine

DMH implemented telemedicine, in line with The Department of Vermont Health Access (DVHA), pursuant to Act 107 from the 2011-2012 Legislative Sessions:

- Distance site providers are required to follow correct coding in the application of the GT modifier - CMS and/or Encoder Pro telemedicine codes excluding non-covered services,
- Originating site providers (patient site) are required to document the reason the service is being provided by telemedicine rather than in person and may be reimbursed a facility fee (Q3014).

Telemedicine is defined in Act 107 as “...the delivery of health care services...through the use of live interactive audio and video over a secure connection that complies with the requirements the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. Telemedicine does not include the use of audio-only telephone, e-mail, or facsimile.” Act 107 is available at <http://leg.state.vt.us/docs/2012/Acts/ACT107.pdf> .

Telemedicine may be used for individual psychotherapy and interview/assessment. It is not reimbursable for group or interactive therapies. Telemedicine reimbursement is limited to physicians and nurse practitioners. The correct visit code and the modifier GT must be used in billing telemedicine services. Originating site provider locations are limited to:

- Physician or practitioner's office
- Hospital
- Critical access hospital
- Rural health clinic
- Federally qualified health center
- Community mental health center

- Skilled nursing facility

1.9 Third Party Liability

Medicaid is the payer of last resort, after all third party medical resources have been applied. A third party is defined as one having an obligation to meet all or any portion of the medical expense incurred by the recipient for the time such service was delivered. Such obligation is not discharged by virtue of being undiscovered or undeveloped at the time a Medicaid claim is paid. It then becomes an issue of recovery. Some examples of third party resources are:

- Medicare (agencies must accept assignment)
- Health insurance, including health and accident, but not that portion specifically designated for “income protection” which has been considered in determining recipient and veteran programs, workers’ compensation, etc.
- Liability for medical expenses as agreed or ordered in negligence suits, support settlements, trust funds, etc.

1.10 Waiver of Third Party Billing Sources

The Department of Mental Health (DMH) has approved overriding the third party insurance and Medicare billing for all Service Planning and Coordination services, Community Support services (individual and group), and Transportation. These services can be billed directly to Medicaid.

1.11 “Incident-To” Services

This section is under review by the Department of Mental Health and will be updated when approved.

1.12 Medicaid Audits

Medicaid field audits will be performed at least annually with every Designated Agency. Medicaid field audits consist of two segments: Mental Health Adult and Children’s Services. A random sample of all transactions reimbursed by Medicaid will be drawn for the two segments. The sample size will vary for each Designated Agency based on the entire number of transactions that were billed and paid during the fiscal year under audit. Ten percent (10%) will be the allowable error rate. In addition, a 25% sample of the units of service audited may be selected to be traced to the time records or EMR equivalent documentations. The clinical and fiscal (billing records and documents) findings will be compared to each other to verify agreement. The MCIS match will contribute to the computation of the error rate.

A post-audit reconciliation with the fiscal agency (HP Enterprise Services) must be completed within 30 days unless a formal appeal is in progress. A copy of the reconciliation materials must be sent to DMH within 45 days.

If an error rate exceeds the allowable 10%, the Designated Agency must perform a 100% internal audit on the program(s) that are problematic (DMH will determine the programs to be included in the internal audit). The internal audit must be completed within six months of the original audit. DMH will re-audit at six months or earlier following completion of the internal audit. Should the second audit exceed the allowable 10%, DMH reserves the right to do a complete 100% audit of the Designated Agency. Errors must be refunded or adjustments made immediately upon realization that an error in billing has occurred.

The Designated Agency has a right to appeal the results of an audit. The agency has 15 days from receipt of the audit findings to notify the Commissioner of Mental Health of the agency's intent to appeal. The Commissioner of Mental Health will arrange an informal meeting within 30 days to hear the appeal. The Commissioner of Mental Health will notify the Designated Agency within 15 days of the appeal meeting of his/her findings. If the Designated Agency is not satisfied with the findings, the agency may appeal in writing to the Commissioner of the Department of Mental Health Services within 15 days. The Commissioner of the Department of Mental Health Services will arrange a meeting within 30 days of the subsequent appeal request. The Commissioner of the Department of Mental Health Services will notify the Designated Agency within 30 days of the subsequent appeal meeting of his/her determination. The determination made by the Commissioner of the Department of Mental Health is final.

Section 2

ADULT Medicaid Fee-For-Service Traditional Medicaid Recipients

CLINICAL & SUPPORT SERVICES

2.1 Individual Plan of Care (IPC)

Every Medicaid eligible individual must have an Individual Plan of Care (IPC). The IPC is directly related to assessments and must encompass, at a minimum, the services identified in the plan and provided by the designated agency to the individual. It must contain the following components:

- **Goals:** A statement of the mutually desired overall, long range results of interventions expressed in the individual's words as much as possible. These are often stated in the client's words and tend to be long-term focused.
- **Objectives:** A statement of the specific individual skills and/or community resources that need to be changed or modified to achieve each goal. Objectives are to be stated in observable and measurable terms that are easily understood by the client/family.
- **Interventions:** A description of the interventions to be used to achieve each objective including:
 - The staff position or service component responsible;
 - The intervention activity (service provided);
 - The frequency of the activity (measurable). PRN or "as needed" frequency are reserved for emergent or episodic service delivery. It is acceptable to identify a range of treatment frequency for planned services or interventions. Such treatment or service delivery changes may be substantiated in clinical notes, plan reviews, or plan updates.
- **Outcomes:** The anticipated outcome resulting from the treatment and/or services provided for the identified goal. Outcomes tend to reflect short-term or incremental goals.

At a minimum, the plan must be signed by a licensed master level clinical operating within their scope licensure or an advanced practice psychiatric registered nurse operating within their scope of licensure, and whenever possible, the individual. Any other team member providing treatment should be encouraged to review and sign the individual plan of care.

Plan Necessity

A plan needs to be in place:

- Plans will be required following new admissions (or re-admissions) to the agency and/or programs.
- Plan necessity is determined by a qualifying clinician, operating within the scope of their clinical practice, to deliver necessary and specific treatment services to address the individual's assessed needs and authorized by their signature on an Individual Plan of Care.

- In specific circumstances, initial plan necessity for adults must be authorized by a psychiatrist or an advanced practice registered nurses (APRN) with psychiatric specialization by signature on an Individual Plan of Care. Specific circumstances for Adults include:
- Any adult with an enduring and complex mental illness, receiving psychiatric and/or medication management services
- Any adult returning directly from a psychiatric inpatient setting
- Treatment and service modalities, with the exception of emergent treatment needs and services, must be authorized in the Individual Plan of Care or subsequent revisions for the period in which the treatment and service modalities is provided to be eligible for reimbursement. Emergency treatment needs and services may be delivered PRN or “as needed” and do not need to be identified as planned services. IPCs should identify services that you intend to deliver (not every possible option).
- For mental health services, an individual plan of care must be completed within 30 days of opening an individual for services.

Plan Review and Revision:

- A review and updated treatment plan will be required when there is a significant change in life circumstances for the consumer that the clinician or consumer feels requires a sustained intervention or a revised plan as defined in the October 29, 2010 memorandum entitled “Negotiated Changes in Paperwork and Administrative Burden”. (Under review) The consumer and their team working together govern treatment-planning decisions. Examples of the types of circumstances that may trigger the need for a review include, but are not limited to:
 - New, complicating or worsening symptoms (mental health or physical health changes); relapse (or use of) a mind altering substance; hospitalization
 - Development of new goals or support services or revisions to current service/support agreements
 - Failure to progress in skill building or mental health treatment over a period of six months;
 - Social Support changes that are upsetting/deregulating to the person (major losses, changes in job, residence, caregiver or other relationships, deaths) or reflect milestones (major gains, successes, job, marriage, pregnancy, birth)
 - Changes in legal status of the consumer, family member or significant other; newly reported concerns of abuse or neglect/being perpetrator or victim of crime.
- Significant changes in life circumstances that the clinician or consumer feels requires a sustained intervention or a revised plan require review by the team or supervising professional and the consumer. Mental Health treatment plan

reviews and updates will be signed by at least a licensed master's level clinician operating within their scope of licensure or an advanced practice psychiatric registered nurse operating within their scope of practice.

Client Involvement

It is expected that the treatment plan is completed with the collaboration of the consumer, guardian and/or family and any significant person(s) that the consumer, guardian and/or family designates. The consumer, guardian and/or family must be integral to development of goals and objectives regardless of whether or not a written treatment plan is required. This is best evidenced by the client or guardian signature. It is not required that the individual be present when the IPC is updated.

If an individual has not had services for six months or the individual plan of care recommends the IPC be closed, then the case must be considered closed. Individual's requesting services after six months from the date of their last service should be considered new to services and must have a new plan of care prescribed. A new Diagnostic Assessment should be considered following a period of non-service or significant change in clinical presentation. In such cases, an addendum or update to information is acceptable if a comprehensive assessment was completed within the previous six months.

Staff Qualifications

The service must be provided by:

- a Vermont Medicaid enrolled provider consistent with their licensed scope of practice and who is employed by a designated agency, or
- by a DA staff member who, based on his/her education, training, or experience, is determined competent to provide the service by the Medical Director of the DA and whose work is directly supervised by a qualifying provider, or
- a qualifying provider above who is sub-contracted by the DA or otherwise authorized by the Commissioner of Mental Health

2.2 Clinical Assessment (Diagnostic and Evaluation Services)

Definition

Clinical Assessment services evaluate across environments individual and family strengths, needs, existence and severity of disability and functioning. A clinical assessment is a service related to identifying the extent of an individual's condition. It may take the form of a psychiatric and/or psychological and/or developmental and/or social assessment, including the administration and interpretation of psychometric tests. It may include: an evaluation of the individual's attitudes, behavior, emotional state, personality characteristics, developmental history, motivation, intellectual functioning, memory, and orientation; an evaluation of the individual's social situation relating to family background, family interaction and current living

situation; an evaluation of the individual's social performance, community living skills, self-care skills and prevocational skills; an evaluation of the support system's and community's strengths and availability to the individual and family; and/or an evaluation of strategies, goals and objectives included in the development of a service plan.

Clinical Assessment or reassessment must be a face-to-face contact. A clinical assessment or reassessment that extends over several services should be entered into the individual's record as one cumulative assessment with the dates and lengths of service outlined at the beginning of the assessment.

Attributes

The administration and interpretation of a diagnostic instrument is reimbursable, as long as the nine elements of clinical assessment are present and referenced. Testing reports should have a narrative as well as test results (scores).

Assessment "write-up time" is not service time that is reimbursable. This time is indirect service time and already allocated in administrative costs.

A single clinician need not necessarily be the collector of all the data, but documentation should reference and assimilate all pertinent data of other qualified clinicians. If referenced data (i.e. psychosocial history, medical history etc.) is used, there must be an update from the date of the most recent referenced material (if older than six months).

Only time spent by a qualified clinician collecting assessment information may be reimbursed as clinical assessment. Information obtained by non-qualified staff in face-to-face contact for a clinical assessment or re-assessment and signed off by a qualified clinician may not be reimbursed as clinical assessment service. Assessment information obtained in this manner may be reimbursed separately as community support service.

Qualified clinicians obtaining information for purposes of clinical assessment or clinical intake may not be reimbursed as any other service (e.g. billing community support services rather than Diagnosis and Evaluation).

Administratively required assessments (e.g. assessment ordered by a judge or social agency) that do not meet clinical assessment and service prescription requirements are not reimbursable. DMH does provide reimbursement for guardianship evaluation requested by the courts through DMH.

Staff Qualifications

- A psychiatrist licensed in Vermont.
- A psychologist licensed in Vermont.
- A professional nurse holding a M.S. in Psychiatric/Mental Health Nursing from a university with an accredited nursing program, licensed in Vermont.
- A social worker holding a clinical license in Vermont.
- A mental health counselor licensed in Vermont.

- Persons with a minimum of a Master's level degree in a human services field approved by the clinical or medical and executive director as qualified to provide clinical assessment services. A current list of all individuals so approved, signed by the clinical director and the executive director, must be kept on file at the center.

Staff qualifications for clinical assessment also apply to contracted employees.

Documentation Requirements

In addition to the standard documentation requirements listed on page 9 of this manual, documentation in the case record must contain the following ten current (done within the past six months), discreet, and labeled elements:

- History of the presenting complaint or issue;
- Psychosocial history, including developmental history;
- Medical history;
- Mental status;
- Individual strengths that will be contributory to treatment outcomes;
- Individual needs or deficits voiced or identified as a result of assessment;
- Diagnosis or impression;
- Clinical formulation or interpretive summary; and
- Treatment recommendations
- Source of information

2.3 Individual Therapy (Psychotherapy)

Definition

Individual Therapy is specialized, formal interaction between a mental health professional and a client in which a therapeutic relationship is established to help resolve symptoms, increase function, and facilitate emotional and psychological amelioration of a mental disorder, psychosocial stress, relationship problem/s, and difficulties in coping in the social environment.

Individual therapy is face-to-face. Individual therapy provided in any other medium is not reimbursable.

Attributes

Only one charge may be made for any service regardless of the number of therapists present.

Medicaid cannot reimburse individual therapy with a spouse of a Medicaid eligible individual, who is ineligible for Title XIX.

Staff Qualifications

The service must be provided either directly by a Vermont enrolled physician directly affiliated with the Designated Agency, or prescribed by a physician or authorized APRN directly affiliated with the Designated Agency and provided by staff of the Designated Agency who, with a minimum of a Master's degree, is authorized by the prescribing physician or Medical Director as competent to provide the service.

Documentation Requirements

Each session requires a discreet note; for instance, documentation of two ½ hour sessions on the same day, but at different times requires two progress notes. The notes may be included on the same page if practical.

The clinical content of a progress note for individual therapy must include the relationship of the services in the treatment regimen with the goal outlined in the Individual Plan of Care and in summary form document:

- Clinical intervention used;
- Current issues discussed or addressed;
- Observations made of the individual (the individual's response to the treatment session) or any significant factors affecting treatment;
- If indicated, the involvement of family and/or significant others in treatment;
- The clinician's assessment of the issues;
- Movement or progress toward the treatment goal (with any description of change in approach, if necessary); and
- Specific plan for ongoing treatment or follow-up

2.4 Family Therapy (Psychotherapy)

Definition

Family Therapy is an intervention by a therapist with an individual and/or his/her family members considered to be a single unit of attention. Typically, the approach focuses on the whole family system of individuals and their interpersonal relationships and communication patterns. This method of treatment seeks to clarify roles and reciprocal obligations and to facilitate more adaptive emotional, psychological and behavioral changes among the family members.

A family therapy session is face-to-face. Family therapy provided in any other medium is not reimbursable.

Attributes

Couples therapy sessions will be reimbursed as family therapy. You may bill for only one family member.

Staff Qualifications

The service must be provided either directly by a Vermont enrolled physician directly affiliated with the Designated Agency, or prescribed by a physician or authorized APRN directly affiliated with the Designated Agency and provided by staff of the Designated Agency who, with a minimum of a Master's degree, is authorized by the prescribing physician or Medical Director as competent to provide the service.

Documentation Requirements

Each session needs a discreet note; for instance, documentation of two ½ hour sessions on the same day, but at different times requires two progress notes. The notes may be included on the same page if practical.

The clinical content of a progress note for family therapy must include the relationship of the services in the treatment regimen with the goal outlined in the Individual Plan of Care and in summary form document:

- Clinical intervention used;
- Current issues discussed or addressed;
- Observations made of the individual and family (the individual or family system response to the treatment session) or any significant factors affecting treatment;
- The clinician's assessment of the issues;
- Movement or progress toward the treatment goal (with any description of change in approach, if necessary); and
- Plan for ongoing treatment or follow-up.

2.5 Group Therapy (Psychotherapy)

Definition

Group Therapy is an intervention strategy that treats individuals simultaneously for social maladjustment issues or emotional and behavioral disorders by emphasizing interactions and mutuality within a group dynamic. Group therapy may focus on the individual's adaptive skills involving social interaction to facilitate emotional or psychological change and improved function to alleviate distress.

Group therapy also includes multiple families or multiple couple's therapy.

Attributes

- Group Therapy sessions may not exceed a 1-to-10 clinician ratio or exceed maximum of (15) individuals.
- Group Therapy for less than one hour (60 minutes) is not reimbursable.
- If two or more clinicians lead a group, only one can bill.

Staff Qualifications

The service must be provided either directly by a Vermont enrolled physician directly affiliated with the Designated Agency, or prescribed by a physician or authorized APRN directly affiliated with the Designated Agency and provided by staff of the Designated Agency who, with a minimum of a Master's degree, is authorized by the prescribing physician or Medical Director as competent to provide the service.

Documentation Requirements

The clinical content of a progress note for group therapy must include the relationship of the services in the treatment regimen with the goal outlined in the Individual Plan of Care and in summary form document:

- Clinical intervention used
- Current issues discussed or addressed;
- Observations made of the individual (the individual response to the group dynamic in the treatment session) or any significant factors affecting treatment;
- The clinician's assessment of the issues;
- Movement or progress toward the treatment goal (with any description of change in approach, if necessary); and
- Plan for ongoing treatment or follow-up.

2.6 Service Planning and Coordination, Non-Categorical Case Management

Definition

Service planning and coordination assists individuals and their families in planning, developing, choosing, gaining access to, coordinating and monitoring the provision of needed services and supports for a specific individual. Services and supports that are planned and coordinated may be formal (provided by the human services system) or informal (available through the strengths and resources of the family or community). Services and supports include discharge planning, advocacy and monitoring the well-being of individuals (and their families), and supporting them to make and assess their own decisions.

Service planning and coordination does not include vocational activities.

Service Planning

Staff Conferences, with or without the individual's presence, for treatment-related case discussions, for developing or modifying individual plans of care, for monitoring the appropriateness of on-going treatment, or for the review and determination of current case assignment or reassignment, constitute service planning. Multiple staff members, agencies, and others may be involved in treatment planning activities. Contact with family, guardian, or primary support relationships specific to treatment planning or determining the appropriateness

of current services and supports may be service planning and coordination (e.g. phone contact to discuss or inform the child/family of IPC updates or other changes in treatment is a service planning activity) and may be billed.

The designated case manager should be the staff member responsible for setting overall goals and providing service planning activities. If a case manager is away, his or her case should be reassigned to an “acting” case manager. Only the designated or acting case managers may be reimbursed for service planning and coordination services. Notes should be signed by the designated case manager or “acting” case manager.

Service Coordination

Service coordination involves authorized contact with other providers from agencies or services or school personnel other than one’s own for the purpose of case review or consultation regarding the provision and coordination of services to a specific individual. Other service professionals may include: physicians, hospitals, corrections, law enforcement, state agencies, and community organization representatives. Service Coordination may also occur with family, guardian, landlord, or primary support relationships as indicated to build and promote continuity of services. Service coordination includes both face-to-face and telephone consultation with other providers.

For adults who are hospitalized, discharge planning/transition/aftercare coordination is part of service coordination for up to forty-five (45) hours during the course of treatment and prior to discharge when there is no duplication of service between the institution and the designated agency. If more than forty-five (45) hours are required, **prior written authorization** must be obtained. The designated case manager should be the staff member responsible for providing coordination.

Attributes

Service planning and coordination may be provided simultaneously with other clinic services, but only one service can be billed. When multiple clinicians provide service planning and coordination to an individual, only one clinician can bill for service planning and coordination.

Staff Qualifications

The service must be provided either directly by a Vermont enrolled physician directly affiliated with the Designated Agency, or prescribed by a physician or authorized APRN directly affiliated with the Designated Agency and provided by staff of the Designated Agency who, based on his/her education, training, or experience, is authorized by the prescribing physician or Medical Director as competent to provide the service.

Documentation Requirements

Service planning and coordination may be documented by each billable service contact or in a separate monthly summary note. Each program or sub-component must designate which method

of documentation it will use.

Per service documentation for service planning and coordination should:

- Summarize each contact by describing the discussion and its purpose. Identifying treatment modality (e.g. service planning and coordination is inadequate to describe the activity);
- Describe any indications/observations/assessment impacting treatment and describe individual's response if applicable;
- Describe overall outcome or follow-up activity in relation to the individual service plan.

Or

Weekly or monthly summary documentation (in addition to billed services print-out) should identify:

- Summary of primary service planning and/or coordinating activities consistent with treatment goals;
- Summarized observations of case management contacts that may impact treatment;
- Assessed effects of service planning and coordination activities and any progress toward treatment goals;
- Ongoing needs and plan for case management services.

It is acceptable to document service planning and coordination in a log-type format. Clinicians providing multiple interventions in a day (e.g. a school environment) where it may be impractical to provide per intervention documentation in the treatment setting, the clinician may summarize service planning and coordination activity in a daily log. These logs can be separate, but must be available for purposes of audit. The log should identify date of service, service modality, briefly describe the activity/intervention, and be accompanied by the staff member initials. If the same person provides the service planning and coordination entries on a log sheet, they would only need to sign the page once. However, if other staff members log service planning and coordination services on the log sheet, they must sign their individual notes.

2.7 Medication Evaluation, Management and Consultation Services (Chemotherapy, Med-Check)

Definition

Medication Management and Consultation Services include evaluating the need for, prescribing and monitoring medication, and providing medical oversight, support and consultation for an individual's health care.

Medication evaluation, management, and consultation services are face-to-face services.

Medication evaluation, management, and consultation services may be done in a group setting with client agreement to participate in this treatment forum. Separate notes must be written for each individual.

Staff Qualifications

Medication evaluation, management and consultation services may only be provided by a physician, advanced practice nurse, or physician's assistant licensed in Vermont and operating within the scope of their respective professions. Services provided by resident physicians placed in the Designated Agency are not billable.

Documentation Requirements

Any change in medication (addition, deletion, change in dosage) should be documented on the medication list and, if proper authorization is in place, shared with the individual's primary care provider.

The administration of medication per se is not reimbursable as medication evaluation, management, and consultation services. There must be a face-to-face interaction with the individual that includes evaluation of the individual in terms of symptoms, diagnosis, and pharmacologic history; efficacy and management of the medication being prescribed or continued, and/or the monitoring of the individual's reaction (favorable or unfavorable) to the medication. Furthermore, the reaction of the individual to the medication is not only in terms of the physical reaction (side effects) but most importantly the mental status change at which the medication is aimed and requires both pharmacological and mental health psychiatric skills. It should also include any discussion with the individual of other physician or laboratory reports as they pertain to his/her medical/mental health.

2.8 Medication/Psychotherapy Services

Definition

Medication/Psychotherapy Services is a planned treatment intervention maximizing two service modalities: individual psychotherapy and medication management. The service combines the formal individual mental health relationship and its therapeutic interactions to alleviate distress with the qualified healthcare professional's capacity to evaluate and manage medications as part of the course of overall treatment.

Medication evaluation, management, and consultation services are face-to-face services.

Medical personnel may bill emergency medication/psychotherapy services only in those emergency situations where a pre-existing treatment relationship already exists between that clinician and the client.

Attributes

This is an evaluation and management code with modifier.

Staff Qualifications

A physician or an authorized APRN licensed in Vermont may provide medication/psychotherapy services if the individual plan of care specifies this service plan.

Documentation Requirements

There must be a face-to-face interaction with the individual that in addition to the requirements of Individual Psychotherapy documentation includes evaluation of ongoing psychiatric symptoms, efficacy and management of medication being prescribed or continued, and/or the monitoring of the individual's response to the medication. Individual response should be assessed for physical reaction (side effects) and mental status change. Documentation may include any discussion with the individual of other physician or laboratory reports as they pertain to his/her medical/mental health.

2.9 Emergency Care and Assessment Services/Mobile Crisis Services (Emergency Care, Crisis Intervention)

Definition

Emergency Care and Assessment Services are acute, time-limited, intensive supports provided to individuals, their families, or their immediate support system that are currently experiencing a psychological, behavioral, or emotional crisis. Services are initiated on behalf of a person or provided to a person/s experiencing an acute mental health crisis as evidenced by: (1) a sudden change in behavior with negative consequences for well-being; (2) a loss of effective coping mechanisms; or, (3) presenting danger to self or others. Services include triage, early intervention, information gathering, consultation, and planning for crisis stabilization.

Assessment includes acute outreach, crisis evaluation, treatment and direct clinical interventions, and integration/discharge planning back to the person's home or alternative setting. Assessment may also include screening for inpatient psychiatric admission. These services are available 24 hours a day, 7 days a week.

Emergency Care and Assessment Services may be face-to-face or provided by telephone.

Attributes

A face-to-face or telephone emergency care and assessment service lasting less than 15 minutes cannot be reimbursed.

During an emergency care and assessment service, it would be legitimate to include time spent transporting an individual. However, a clinician's travel time to or from the emergency scene is not reimbursable.

Emergency care and assessment services provided under the supervision of a Medicaid enrolled physician affiliated with a designated agency may be reimbursed without a prescription in the individual treatment plan.

No matter how many clinicians are involved at the same time with an individual or significant others during a crisis, only one clinician's time will be reimbursed. If two separate services are provided that require unique qualifications (e.g. medication management that can only be provided by medical personnel and emergency care services that is provided by a different qualifying clinician), each clinician may bill only for the time spent in their specific service.

Staff Qualifications

The service must be provided either directly by a Vermont enrolled physician directly affiliated with the Designated Agency, or prescribed by a physician or authorized APRN directly affiliated with the Designated Agency and provided by staff of the Designated Agency who, based on his/her education, training, or experience, is authorized by the prescribing physician or Medical Director as competent to provide the service.

Documentation Requirements

A. Telephone Intervention guidelines:

One progress note per day or per event is required that documents the emergency care and assessment services provided to an individual by phone. It should include, in summary form:

- Identified issue or precipitant to crisis contact;
- Issues addressed or discussed;
- The clinician's impressions/assessment of the issues/situation;
- Disposition or plan resulting from the crisis intervention

If telephone Emergency Care and Assessment Services are documented in a log and are provided by the same individual, that crisis staff member would need to sign the page only once. However, if other crisis staff members enter notes periodically in the log, their signatures must accompany their individual notes.

B. Face-to-Face Intervention guidelines:

One progress note per face-to-face contact is required to document the emergency care and assessment services provided to an individual. It should include, in summary form:

- Identified issue or precipitant to crisis contact;
- Issues addressed or discussed;
- Collateral contact information as solicited or available;
- Observations made by the clinician;

- The clinician's assessment of the issues/situation including mental status and lethality/risk potential;
- Disposition or plan resulting from the crisis intervention;
- Psychiatric consultation, as clinically indicated.

It is acceptable to document telephone and face-to-face Emergency Care and Assessment Services in a logbook only if all documentation requirements are present.

2.10 Crisis Stabilization and Support Services (Emergency Community Support)

Definition

Facility based Crisis Stabilization, Support, and Referral Services are focused and ongoing support services provided to individuals, their families, or their immediate support system that may be time-limited, but necessary to maintain stability or avert destabilization of an expected psychological, behavioral, or emotional crisis. Services are provided to persons experiencing mental health crisis as evidenced by: (1) a progressing change in behavior with negative consequences for well-being; (2) declining or loss of usual coping mechanisms; or, (3) increasing risk of danger to self or others. Crisis stabilization services are face-to-face services in an environment other than a person's home. Support and referral includes triaging aftercare needs, supportive counseling, skills training, symptom management, medication monitoring, crisis planning, and assistance with referrals from crisis stabilization in a person's home or by phone. These services are available 24 hours a day, 7 days a week.

Attributes

Mental health services cannot be billed during the time period billed to crisis stabilization services.

Crisis stabilization and support services provided under the supervision of a Medicaid enrolled physician affiliated with a designated agency may be reimbursed without a prescription in the individual treatment plan.

Staff Qualifications

The service must be provided either directly by a Vermont enrolled physician directly affiliated with the Designated Agency, or prescribed by a physician or authorized APRN directly affiliated with the Designated Agency and provided by staff of the Designated Agency who, based on his/her education, training, or experience, is authorized by the prescribing physician or Medical Director as competent to provide the service.

Documentation Requirements

Crisis stabilization and support service needs must be documented upon admission, per shift

and/or per 8-hour period of crisis stabilization, and upon discharge for all emergency community support services. Other Medicaid services provided during the crisis stabilization period must follow the documentation requirements for that service.

Crisis stabilization services documentation should reflect early on that a review with a physician has occurred and a determination made that crisis stabilization services are required.

If crisis stabilization and support service admission and discharge occur within the course of an 8-hour period, documentation may abbreviate admission, shift, and discharge information into a summary overview note to reflect the brief course of care.

Crisis stabilization and support services should include, in summary form:

Admission Documentation

- Precipitant crisis or behavioral/psychiatric decompensation (e.g. observation of behavior supporting crisis stabilization);
- Assessment of treatment needs or anticipated benefits of proactive clinical intervention;
- Plan for treatment (e.g. issues to be addressed or discussed);
- Physician consultation and agreement with treatment plan.

Per shift and/or 8-hour period of ongoing crisis stabilization

- Observations made of the individual (e.g. behavioral or psychiatric indicators for ongoing crisis stabilization);
- Interventions and client response;
- The clinician's assessment of the issues/situation/risks;
- Ongoing plan for crisis stabilization

Discharge Summary

- Observations of individual's current behavior and presentation;
- Issues addressed or discussed or skills developed in the course of service;
- The clinician's assessment of the client response to crisis stabilization;
- Follow-up plan (e.g. appointments, supports, medication change, etc.)

It is acceptable to document crisis stabilization and support services in a log. If the crisis stabilization and support services are documented in a log and are provided by the same individual, that staff member would need to sign the page only once. However, if other staff members enter notes periodically in the log, they would need to sign their own individual notes. The log sheet should be placed in the clinical record for purposes of audit.

2.11 Community Supports/Rehabilitation Services (Psycho-social Rehabilitation)

Definition

Specialized Community Supports are individualized and goal oriented services to assist individuals and their families, but who have psychosocial needs and diminished function. Services assist the individual to access community supports and develop social skills necessary to improve overall function and promote community connectedness and promote positive growth. These supports may include support in accessing and effectively utilizing community services and activities, advocacy and collateral contacts to build and sustain healthy personal and family relationships, supportive counseling, and assistance in managing and coping with daily living issues.

Accessing and utilizing community services and activities may include the development of those skills that enable an individual to seek out, clarify, and maintain resources, services, and supports for independent living in the community, including communication and socialization skills and techniques.

Supportive counseling includes services directed toward the elimination of psychological barriers that impede the development or modification of skills necessary for independent functioning in the community. The emphasis is upon advice, opinion or instruction given to an individual to influence his/her judgment and/or conduct in everyday situations. This activity can be provided either face-to-face or by phone.

Managing and coping with daily living issues may include support in acquiring functional living skills resources and guidance in areas such as budgeting, meal planning, household maintenance, and community mobility skills.

Group community support may be an appropriate treatment modality. This intervention strategy should clearly align with individual treatment goals, emphasizing interactions and mutuality of issues between two or more individuals, for anticipated benefits of a group intervention.

Attributes

For specialized group community support, there must be no less than a one staff member to four (4) individuals present. Reimbursement for specialized group community support is limited a minimum of 15 minutes up to a maximum of two (2) hours per day (8 units) and no more than ten (10) hours per week per individual.

- Specialized community supports can be billed for supportive counseling and advocacy.
- Specialized community supports may also be billed for collateral services within a nursing facility. It does not include daily living and social skills interventions that are provided through the nursing facility Medicaid per diem.

Vocational and educational service activities cannot be billed as specialized community supports.

Transportation costs are included in the specialized community support service rate and cannot be billed additionally.

Staff Qualifications

The service must be provided either directly by a Vermont enrolled physician directly affiliated with the Designated Agency, or prescribed by a physician or authorized APRN directly affiliated with the Designated Agency and provided by staff of the Designated Agency who, based on his/her education, training, or experience, is authorized by the prescribing physician or Medical Director as competent to provide the service.

Documentation Requirements

Specialized community supports may be documented for each service provided; or with one monthly summary note. Each program or sub-component must designate which method of documentation it will use.

Per service documentation for individual or group treatment modality should identify:

- Clinical intervention used
- Service modality (individual community support or group community support)
- Summarize each service by describing the discussion/training/skill building provided and its purpose.
- Identifying treatment modality (e.g. specialized community support is inadequate to describe the activity)
- Describe individual's response or clinician's observations.
- Describe overall outcome/results/progress in relation to the individual service plan.

For monthly summary documentation (in addition to billed services print-out) should identify:

- Clinical intervention used
- Summary of major content or intervention themes consistent with treatment goals;
- Observations made of the individual or responses to interventions;
- Assessment of progress toward treatment goal;
- Ongoing needs for continued intervention and plan.

2.12 Transportation

Definition

Transportation services are only available to individuals covered by Vermont Medicaid who have no means of transportation available to them. The trips must be to an enrolled Medicaid provider, and the services received must be eligible for Medicaid reimbursement.

Staff Qualifications

Any individual or agency hired or contracted with to provide transportation services may do so with the approval of the executive director.

2.13 SFI Programming

Definition

Serious Functional Impairment (SFI) is a designation created by the General Assembly to confer specialized services upon inmates who experience a mental, functional, or similar challenge that impairs their ability to function solely in a correctional setting. The SFI designation originates from the Department of Corrections and represents a population based on clinical diagnosis, severity of diagnosis, criminogenic risk, functional impairment and need.

Attributes

The SFI designation is to be used to define services for individuals who have approved budgets associated with their care. It is reimbursed as a bundled rate that is negotiated with the DA for each specific individual.

The SFI modifier must be used.

Staff Qualifications

The service must be provided either directly by a Vermont enrolled physician directly affiliated with the Designated Agency, or prescribed by a physician or authorized APRN directly affiliated with the Designated Agency and provided by staff of the Designated Agency who, based on his/her education, training, or experience, is authorized by the prescribing physician or Medical Director as competent to provide the service.

Section 3

CHILDREN Medicaid Fee-For-Service Traditional Medicaid Recipients

**For Designated Agencies participating in IFS,
the IFS Manual is in process and the link will be
added when it is available.**

CLINICAL & SUPPORT SERVICES

3.1 Individual Plan of Care (IPC)

Every Medicaid eligible individual must have an Individual Plan of Care (IPC). The IPC is directly related to assessments and must encompass, at a minimum, the services identified in the plan and provided by the designated agency to the individual. It must contain the following components:

- **Goals:** A statement of the mutually desired overall, long range results of interventions expressed in the individual's words as much as possible. These are often stated in the client's words and tend to be long-term focused.
- **Objectives:** A statement of the specific individual skills and/or community resources that need to be changed or modified to achieve each goal. Objectives are to be stated in observable and measurable terms that are easily understood by the client/family.
- **Interventions:** A description of the interventions to be used to achieve each objective including:
 - The staff position or service component responsible;
 - The intervention activity (service provided);
 - The frequency of the activity (measurable). PRN or "as needed" frequency are reserved for emergent or episodic service delivery. It is acceptable to identify a range of treatment frequency for planned services or interventions. Such treatment or service delivery changes may be substantiated in clinical notes, plan reviews, or plan updates.
- **Outcomes:** The anticipated outcome resulting from the treatment and/or services provided for the identified goal. Outcomes tend to reflect short-term or incremental goals.

At a minimum, the plan must be signed by a licensed master level clinical operating within their scope licensure or an advanced practice psychiatric registered nurse operating within their scope of licensure, and whenever possible, the individual. Any other team member providing treatment should be encouraged to review and sign the individual plan of care.

Plan Necessity

- Plans will be required following new admissions (or re-admissions) to the agency and/or programs.
- Plan necessity is determined by a qualifying clinician, operating within the scope of their clinical practice, to deliver necessary and specific treatment services to address the individual's assessed needs and authorized by their signature on an Individual Plan of Care.

In specific circumstances, initial plan necessity for children must be authorized by a psychiatrist or an advanced practice registered nurse (APRN) with psychiatric specialization by signature on an Individual Plan of Care. Specific circumstances for Children include:

- Any child with an enduring and complex mental illness, receiving psychiatric and/or medication management services
- Any child returning directly from a psychiatric inpatient setting
- Children who have co-occurring physical health and emotional/behavioral conditions that the supervising clinician feels needs a review and consult
- Treatment and service modalities, with the exception of urgent treatment needs and services, must be authorized in the Individual Plan of Care or subsequent addendums for the period in which the treatment and service modalities is provided to be eligible for reimbursement. Emergency treatment needs and services may be delivered PRN or “as needed” and do not need to be identified as planned services. IPCs should identify services that you intend to deliver (not every possible option).
- For mental health services, an individual plan of care must be completed prior within 30 days of opening an individual for services.
- If a child is receiving Intensive Family Based Services (IFBS DCF/FSD contract) concurrent to other DA mental health services, there should be separate and unique goals for each program and the services need to be coordinated.

Plan Review and Revision

- A review and updated treatment plan will be required when there is a significant change in life circumstances for the consumer that the clinician or consumer feels requires a sustained intervention or a revised plan as defined in the October 29, 2010 memorandum entitled “Negotiated Changes in Paperwork and Administrative Burden”. The consumer and their team working together govern treatment-planning decisions. Examples of the types of circumstances that may trigger the need for a review include, but are not limited to:
 - New, complicating or worsening symptoms (mental health or physical health changes); relapse (or use of) a mind altering substance; hospitalization
 - Development of new goals or support services or revisions to current service/support agreements
 - Failure to progress in skill building or mental health treatment over a period of six months;
 - Social Support changes that are upsetting/deregulating to the person (major losses, changes in job, residence, caregiver or other relationships, deaths) or reflect milestones (major gains, successes, job, marriage, pregnancy, birth)
 - Changes in legal status of the consumer, family member or significant other; newly reported concerns of abuse or neglect/being perpetrator or victim of crime.
 - For children youth and families, changes in educational arrangements

- Significant changes in life circumstances that the clinician or consumer feels requires a sustained intervention or a revised plan require review by the team or supervising professional and the consumer. Mental Health treatment plan reviews and updates will be signed by at least a licensed master's level clinician operating within their scope of licensure or an advanced practice psychiatric registered nurse operating within their scope of practice.

Client Involvement

It is expected that the treatment plan is completed with the collaboration of the consumer and guardian and/or family and any significant person(s) that the consumer, guardian and/or family designates. The consumer, guardian and/or family must be integral to development of goals and objectives regardless of whether or not a written treatment plan is required. This is best evidenced by the client or guardian signature. It is not required that the individual be present when the IPC is updated.

If an individual has not had services for six months or the individual plan of care recommends the IPC be closed, then the case must be considered closed. Individual's requesting services after six months from the date of their last service should be considered new to services and must have a new plan of care prescribed. A new Diagnostic Assessment should be considered following a period of non-service or significant change in clinical presentation. In such cases, an addendum or update to information is acceptable if a comprehensive assessment was completed within the previous six months.

Staff Qualifications

The service must be provided by:

- a Vermont Medicaid enrolled provider consistent with their licensed scope of practice and who is employed by a designated agency, or
- by a DA staff member who, based on his/her education, training, or experience, is determined competent to provide the service by the Medical Director of the DA and whose work is directly supervised by a qualifying provider, or
- a qualifying provider above who is sub-contracted by the DA or otherwise authorized by the Commissioner of Mental Health

3.2 Clinical Assessment/Psychiatric Diagnostic Evaluation (Diagnosis and Evaluation Services)

Definition

Clinical Assessment services evaluate across environments individual and family strengths, needs, existence and severity of disability and functioning. A clinical assessment is a service related to identifying the extent of an individual's condition. It may take the form of a psychiatric and/or psychological and/or developmental and/or social assessment, including the

administration and interpretation of psychometric tests. It may include: an evaluation of the individual's attitudes, behavior, emotional state, personality characteristics, developmental history, motivation, intellectual functioning, memory, and orientation; an evaluation of the individual's social situation relating to family background, family interaction and current living situation; an evaluation of the individual's social performance, community living skills, self-care skills and prevocational skills; an evaluation of the support system's and community's strengths and availability to the individual and family; and/or an evaluation of strategies, goals and objectives included in the development of a service plan.

Clinical Assessment or reassessment must be a face-to-face contact. A clinical assessment or reassessment that extends over several services should be entered into the individual's record as one cumulative assessment with the dates and lengths of service outlined at the beginning of the assessment.

Attributes

The administration and interpretation of a diagnostic instrument is reimbursable, as long as the nine elements of clinical assessment are present and referenced. Testing reports should have a narrative as well as test results (scores).

Assessment "write-up time" is not service time that is reimbursable. This time is indirect service time and already allocated in administrative costs.

A single clinician need not necessarily be the collector of all the data, but documentation should reference and assimilate all pertinent data of other qualified clinicians. If referenced data (i.e. psychosocial history, medical history etc.) is used, there must be an update from the date of the most recent referenced material (if older than six months).

Only time spent by a qualified clinician collecting assessment information may be reimbursed as clinical assessment. Information obtained by non-qualified staff in face-to-face contact for a clinical assessment or re-assessment and signed off by a qualified clinician may not be reimbursed as clinical assessment service. Assessment information obtained in this manner may be reimbursed separately as community support service.

Qualified clinicians obtaining information for purposes of clinical assessment or clinical intake may not be reimbursed as any other service (e.g. billing community support services rather than Diagnosis and Evaluation).

Administratively required assessments (e.g. assessment ordered by a judge or social agency) that do not meet clinical assessment and service prescription requirements are not reimbursable. DMH does provide reimbursement for guardianship evaluation requested by the courts through DMH.

Staff Qualifications

- A psychiatrist licensed in Vermont.

- A psychologist licensed in Vermont.
- A professional nurse holding a M.S. in Psychiatric/Mental Health Nursing from a university with an accredited nursing program, licensed in Vermont.
- A social worker holding a clinical license in Vermont.
- A mental health counselor licensed in Vermont.
- Persons with a minimum of a Master's level degree in a human services field approved by the clinical or medical and executive director as qualified to provide clinical assessment services. A current list of all individuals so approved, signed by the clinical director and the executive director, must be kept on file at the center.

Staff qualifications for clinical assessment also apply to contracted employees.

Documentation Requirements

In addition to the standard documentation requirements listed on page 8 of this manual, documentation in the case record must contain the following ten current (done within the past six months), discreet, and labeled elements:

- History of the presenting complaint or issue;
- Psychosocial history, including developmental history;
- Medical history;
- Mental status;
- Individual strengths that will be contributory to treatment outcomes;
- Individual needs or deficits voiced or identified as a result of assessment;
- Diagnosis or impression;
- Clinical formulation or interpretive summary; and
- Treatment recommendations
- Source of information

For children, a multi informant approach will be used.

3.3 Individual Therapy (Psychotherapy)

Definition

Individual Therapy is specialized, formal interaction between a mental health professional and a client in which a therapeutic relationship is established to help resolve symptoms, increase function, and facilitate emotional and psychological amelioration of a mental disorder, psychosocial stress, relationship problem/s, and difficulties in coping in the social environment.

Individual therapy is face-to-face. Individual therapy provided in any other medium is not reimbursable.

Attributes

Only one charge may be made for any service regardless of the number of therapists present.

Medicaid cannot reimburse individual therapy with a spouse of a Medicaid eligible individual, who is ineligible for Title XIX.

Staff Qualifications

The service must be provided either directly by a Vermont enrolled physician directly affiliated with the Designated Agency, or prescribed by a physician or authorized APRN directly affiliated with the Designated Agency and provided by staff of the Designated Agency who, with a minimum of a Master's degree, is authorized by the prescribing physician or Medical Director as competent to provide the service.

Documentation Requirements

Each session requires a discreet note; for instance, documentation of two ½ hour sessions on the same day, but at different times requires two progress notes. The notes may be included on the same page if practical.

The clinical content of a progress note for individual therapy must include the relationship of the services in the treatment regimen with the goal outlined in the Individual Plan of Care and in summary form document:

- Clinical intervention used;
- Current issues discussed or addressed;
- Observations made of the individual (the individual's response to the treatment session) or any significant factors affecting treatment;
- If indicated, the involvement of family and/or significant others in treatment;
- The clinician's assessment of the issues;
- Movement or progress toward the treatment goal (with any description of change in approach, if necessary).

3.4 Family Therapy (Psychotherapy)

Definition

Family Therapy is an intervention by a therapist with an individual and his/her family members considered to be a single unit of attention. Typically, the approach focuses on the whole family system of individuals and their interpersonal relationships and communication patterns. This method of treatment seeks to clarify roles and reciprocal obligations and to facilitate more adaptive emotional, psychological and behavioral changes among the family members.

A family therapy session is face-to-face. Family therapy provided in any other medium is not reimbursable.

Attributes

Couples therapy sessions will be reimbursed as family therapy. You may bill for only one family member. Couples therapy may be billed under the covered child only for services related to the benefit of the child.

Staff Qualifications

The service must be provided either directly by a Vermont enrolled physician directly affiliated with the Designated Agency, or prescribed by a physician or authorized APRN directly affiliated with the Designated Agency and provided by staff of the Designated Agency who, with a minimum of a Master's degree, is authorized by the prescribing physician or Medical Director as competent to provide the service.

Documentation Requirements

Each session needs a discreet note; for instance, documentation of two ½ hour sessions on the same day, but at different times requires two progress notes. The notes may be included on the same page if practical.

The clinical content of a progress note for family therapy must include the relationship of the services in the treatment regimen with the goal outlined in the Individual Plan of Care and in summary form document:

- Clinical intervention used;
- Current issues discussed or addressed;
- Observations made of the individual and family (the individual or family system response to the treatment session) or any significant factors affecting treatment;
- The clinician's assessment of the issues;
- Movement or progress toward the treatment goal (with any description of change in approach, if necessary); and
- Plan for ongoing treatment or follow-up.

3.5 Group Therapy (Psychotherapy)

Definition

Group Therapy is an intervention strategy that treats individuals simultaneously for social maladjustment issues or emotional and behavioral disorders by emphasizing interactions and mutuality within a group dynamic. Group therapy may focus on the individual's adaptive skills involving social interaction to facilitate emotional or psychological change and improved function to alleviate distress.

Group therapy also includes multiple families or multiple couple's therapy.

Attributes

Group Therapy sessions may not exceed a 1-to-10 clinician ratio or exceed a maximum of (15) individuals.

Group Therapy for less than one hour (60 minutes) is not reimbursable.

If two or more clinicians lead a group, only one can bill.

Staff Qualifications

The service must be provided either directly by a Vermont enrolled physician directly affiliated with the Designated Agency, or prescribed by a physician or authorized APRN directly affiliated with the Designated Agency and provided by staff of the Designated Agency who, with a minimum of a Master's degree, is authorized by the prescribing physician or Medical Director as competent to provide the service.

Documentation Requirements

The clinical content of a progress note for group therapy must include the relationship of the services in the treatment regimen with the goal outlined in the Individual Plan of Care and in summary form document:

- Clinical intervention used
- Current issues discussed or addressed;
- Observations made of the individual (the individual response to the group dynamic in the treatment session) or any significant factors affecting treatment;
- The clinician's assessment of the issues;
- Movement or progress toward the treatment goal (with any description of change in approach, if necessary); and
- Plan for ongoing treatment or follow-up.

3.6 Service Planning and Coordination (Specialized Rehabilitation Services)

Definition

Service planning and coordination assists individuals and their families in planning, developing, choosing, gaining access to, coordinating and monitoring the provision of needed services and supports for a specific individual. Services and supports that are planned and coordinated may be formal (provided by the human services system) or informal (available through the strengths and resources of the family or community). Services and supports include discharge planning, advocacy and monitoring the well-being of individuals (and their families), and supporting them to make and assess their own decisions.

Children who receive services through the Home and Community-based Waiver are not eligible for FFS service planning and coordination, with the noted exception of Success Beyond Six school-based services.

Service planning and coordination does not include vocational activities.

Service Planning

Staff Conferences, with or without the individual's presence, for treatment-related case discussions, for developing or modifying individual plans of care, for monitoring the appropriateness of on-going treatment, or for the review and determination of current case assignment or reassignment, constitute service planning. Multiple staff members, agencies, and others may be involved in treatment planning activities. Contact with family, guardian, or primary support relationships specific to treatment planning or determining the appropriateness of current services and supports may be service planning and coordination (e.g. phone contact to discuss or inform the child/family of IPC updates or other changes in treatment is a service planning activity) and may be billed.

The designated case manager should be the staff member responsible for setting overall goals and providing service planning activities. If a case manager is away, his or her case should be reassigned to an "acting" case manager. Only the designated or acting case managers may be reimbursed for service planning and coordination services. Notes should be signed by the designated case manager or "acting" case manager.

Service Coordination

Service coordination involves authorized contact with other providers from agencies or services or school personnel other than one's own for the purpose of case review or consultation regarding the provision and coordination of services to a specific individual. Other service professionals may include: physicians, hospitals, corrections, law enforcement, state agencies, and community organization representatives. Service Coordination may also occur with family, guardian, landlord, or primary support relationships as indicated to build and promote continuity of services. Service coordination includes both face-to-face and telephone consultation with other providers.

For children who are in residential treatment or children who are hospitalized, discharge planning/transition/aftercare coordination is part of the service. Please refer to the PNMI description in this manual.

Target Population: Children must meet the definition of severe emotional disturbance.

Attributes

Service planning and coordination may be provided simultaneously with other clinic services, but only one service can be billed. When multiple clinicians provide service planning and coordination to an individual, only one clinician can bill for service planning and coordination.

For children in **PNMI** settings, if service planning and aftercare coordination services are combined with community support for the purpose of discharge planning/transition/aftercare coordination, the collective total of the two service modalities may not exceed 45 hours or duplicate the service between the institution and the designated agency. Billed service hours must be identified as such in record documentation. Service planning and coordination is the only service that may be provided for the purpose of discharge planning from an **inpatient** setting.

Staff Qualifications

The service must be provided either directly by a Vermont enrolled physician directly affiliated with the Designated Agency, or prescribed by a physician or authorized APRN directly affiliated with the Designated Agency and provided by staff of the Designated Agency who, based on his/her education, training, or experience, is authorized by the prescribing physician or Medical Director as competent to provide the service.

Documentation Requirements

Service planning and coordination may be documented by each billable service contact or in a separate monthly summary note. Each program or sub-component must designate which method of documentation it will use.

Per service documentation for service planning and coordination should:

- Summarize each contact by describing the discussion and its purpose. Identifying treatment modality (e.g. service planning and coordination is inadequate to describe the activity);
- Describe any indications/observations/assessment impacting treatment and describe individual's response if applicable;
- Describe overall outcome or follow-up activity in relation to the individual service plan.

Or

Weekly or monthly summary documentation (in addition to billed services print-out) should identify:

- Summary of primary service planning and/or coordinating activities consistent with treatment goals;
- Summarized observations of case management contacts that may impact treatment;
- Assessed effects of service planning and coordination activities and any progress toward treatment goals;
- Ongoing needs and plan for case management services.

It is acceptable to document service planning and coordination in a log-type format. Clinicians providing multiple interventions in a day (e.g. a school environment) where it may be impractical

to provide per intervention documentation in the treatment setting, the clinician may summarize service planning and coordination activity in a daily log. These logs can be separate, but must be available for purposes of audit. The log should identify date of service, service modality, briefly describe the activity/intervention, and be accompanied by the staff member initials. If the same person provides the service planning and coordination entries on a log sheet, they would only need to sign the page once. However, if other staff members log service planning and coordination services on the log sheet, they must sign their individual notes.

For Children: The content of the record should reflect behaviors described in the definition of Severe Emotional Disturbance. The information can be documented via clinical assessments, progress notes and Individual Plans of Care. It is not necessary to state in the record that a child has been determined severely emotionally disturbed. It should be evident by the behaviors related in the child's record.

If the family is the focus of treatment and all or some family members are Medicaid eligible, then individual and family treatment may be provided and documented appropriately. If a child is the only member of the family who is Medicaid eligible, but the family is clearly the focus of treatment in plan and/or notes (as is often the case with very young children), then a family IPC must be written to reflect the treatment plan, goals, objectives and outcomes as they relate to the client within the family.

3.7 Community Supports/Rehabilitation Services (Specialized Rehabilitation Services)

Definition

Specialized Community Supports are individualized and goal oriented services to assist individuals and their families, but who have psychosocial needs and diminished function. Services assist the individual to access community supports and develop social skills necessary to improve overall function and promote community connectedness and promote positive growth. These supports may include support in accessing and effectively utilizing community services and activities, advocacy and collateral contacts to build and sustain healthy personal and family relationships, supportive counseling, and assistance in managing and coping with daily living issues.

Accessing and utilizing community services and activities may include the development of those skills that enable an individual to seek out, clarify, and maintain resources, services, and supports for independent living in the community, including communication and socialization skills and techniques.

Supportive counseling includes services directed toward the elimination of psychological barriers that impede the development or modification of skills necessary for independent functioning in the community. The emphasis is upon advice, opinion or instruction given to an individual to influence his/her judgment and/or conduct in everyday situations. This activity can be provided either face-to-face or by phone.

Managing and coping with daily living issues may include support in acquiring functional living skills resources and guidance in areas such as budgeting, meal planning, household maintenance, and community mobility skills.

Group community support may be an appropriate treatment modality. This intervention strategy should clearly align with individual treatment goals, emphasizing interactions and mutuality of issues between two or more individuals, for anticipated benefits of a group intervention.

Attributes

For specialized group community support, there must be no less than a one staff member to four (4) individuals present. Reimbursement for specialized group community support is limited a minimum of 15 minutes up to a maximum of two (2) hours per day (8 units) and no more than ten (10) hours per week per individual.

- Specialized community supports can be billed for supportive counseling and advocacy.
- Specialized community supports may also be billed for collateral services within a nursing facility. It does not include daily living and social skills interventions that are provided through the nursing facility's Medicaid per diem.

Vocational and educational service activities cannot be billed as specialized community supports.

Transportation costs are included in the specialized community support service rate and cannot be billed additionally.

For children in **PNMI** settings, if service planning and aftercare coordination services are combined with community support for the purpose of discharge planning/transition/aftercare coordination, the collective total of the two service modalities may not exceed 45 hours or duplicate the service between the institution and the designated agency. Billed service hours must be identified as such in record documentation. Service planning and coordination is the only service that may be provided for the purpose of discharge planning from an **inpatient** setting.

Staff Qualifications

The service must be provided either directly by a Vermont enrolled physician directly affiliated with the Designated Agency, or prescribed by a physician or authorized APRN directly affiliated with the Designated Agency and provided by staff of the Designated Agency who, based on his/her education, training, or experience, is authorized by the prescribing physician or Medical Director as competent to provide the service.

Documentation Requirements

Specialized community supports may be documented for each service provided; or with one monthly summary note. Each program or sub-component must designate which method of documentation it will use.

Per service documentation for individual or group treatment modality should identify:

- Clinical intervention used
- Service modality (individual community support or group community support)
- Summarize each service by describing the discussion/training/skill building provided and its purpose.
- Identifying treatment modality (e.g. specialized community support is inadequate to describe the activity)
- Describe individual's response or clinician's observations.
- Describe overall outcome/results/progress in relation to the individual service plan.

For weekly or monthly summary documentation (in addition to billed services print-out) should identify:

- Clinical intervention used
- Summary of major content or intervention themes consistent with treatment goals;
- Observations made of the individual or responses to interventions;
- Assessment of progress toward treatment goal;
- Ongoing needs for continued intervention and plan.

3.8 Medication Evaluation, Management and Consulting Services (Chemotherapy, Med-Check)

Definition

Medication Management and Consultation Services include evaluating the need for, prescribing and monitoring medication, and providing medical oversight, support and consultation for an individual's health care.

Medication evaluation, management, and consultation services are face-to-face services.

Medication evaluation, management, and consultation services may be done in a group setting with client agreement to participate in this treatment forum. Separate notes must be written for each individual.

Staff Qualifications

Medication evaluation, management and consultation services may only be provided by a physician, advanced practice nurse, or physician's assistant licensed in Vermont and operating within the scope of their respective professions. Services provided by resident physicians placed in the Designated Agency are not billable.

Documentation Requirements

Any change in medication (addition, deletion, change in dosage) should be documented on the medication list and, if proper authorization is in place, shared with the individual's primary care provider.

The administration of medication per se is not reimbursable as medication evaluation, management, and consultation services. There must be a face-to-face interaction with the individual that includes evaluation of the individual in terms of symptoms, diagnosis, and pharmacologic history; efficacy and management of the medication being prescribed or continued, and/or the monitoring of the individual's reaction (favorable or unfavorable) to the medication. Furthermore, the reaction of the individual to the medication is not only in terms of the physical reaction (side effects) but most importantly the mental status change at which the medication is aimed and requires both pharmacological and mental health psychiatric skills. It should also include any discussion with the individual of other physician or laboratory reports as they pertain to his/her medical/mental health.

3.9 Medication/Psychotherapy Service

Definition

Medication/Psychotherapy Services is a planned treatment intervention maximizing two service modalities: individual psychotherapy and medication management. The service combines the formal individual mental health relationship and its therapeutic interactions to alleviate distress with the qualified healthcare professional's capacity to evaluate and manage medications as part of the course of overall treatment.

Medication evaluation, management, and consultation services are face-to-face services.

Medical personnel may bill emergency medication/psychotherapy services only in those emergency situations where a pre-existing treatment relationship already exists between that clinician and the client.

Attributes

This is an evaluation and management code with a modifier.

Staff Qualifications

A physician or an authorized APRN licensed in Vermont may provide medication/psychotherapy services if the individual plan of care specifies this service plan.

Documentation Requirements

There must be a face-to-face interaction with the individual that in addition to the requirements of Individual Psychotherapy documentation includes evaluation of ongoing psychiatric symptoms, efficacy and management of medication being prescribed or continued, and/or the monitoring of the individual's response to the medication. Individual response should be assessed for physical reaction (side effects) and mental status change. Documentation may include any discussion with the individual of other physician or laboratory reports as they pertain to his/her medical/mental health.

3.10 Emergency Care and Assessment Services/Mobile Crisis Services (Emergency Care)

Definition

Emergency Care and Assessment Services are acute, time-limited, intensive supports provided to individuals, their families, or their immediate support system that are currently experiencing a psychological, behavioral, or emotional crisis. Services are initiated on behalf of a person or provided to a person/s experiencing an acute mental health crisis as evidenced by: (1) a sudden change in behavior with negative consequences for well-being; (2) a loss of effective coping mechanisms; or, (3) presenting danger to self or others. Services include triage, early intervention, information gathering, consultation, and planning for crisis stabilization. Assessment includes acute outreach, crisis evaluation, treatment and direct clinical interventions, and integration/discharge planning back to the person's home or alternative setting. Assessment may also include screening for inpatient psychiatric admission. These services are available 24 hours a day, 7 days a week.

Emergency Care and Assessment Services may be face-to-face or provided by telephone.

Attributes

A face-to-face or telephone emergency care and assessment service lasting less than 15 minutes cannot be reimbursed.

During an emergency care and assessment service, it would be legitimate to include time spent transporting an individual. However, a clinician's travel time to or from the emergency scene is not reimbursable.

Emergency care and assessment services provided under the supervision of a Medicaid enrolled physician affiliated with a designated agency may be reimbursed without a prescription in the individual treatment plan.

No matter how many clinicians are involved at the same time with an individual or significant others during a crisis, only one clinician's time will be reimbursed. If two separate services are provided that require unique qualifications (e.g. medication management that can only be provided by medical personnel and emergency care services that is provided by a different qualifying clinician), each clinician may bill only for the time spent in their specific service.

Staff Qualifications

The service must be provided either directly by a Vermont enrolled physician directly affiliated with the Designated Agency, or prescribed by a physician or authorized APRN directly affiliated with the Designated Agency and provided by staff of the Designated Agency who, based on his/her education, training, or experience, is authorized by the prescribing physician or Medical Director as competent to provide the service.

Documentation Requirements

A. Telephone Intervention guidelines:

One progress note per day is required that documents the emergency care and assessment services provided to an individual by phone. It should include, in summary form:

- Identified issue or precipitant to crisis contact;
- Issues addressed or discussed;
- The clinician's impressions/assessment of the issues/situation;
- Disposition or plan resulting from the crisis intervention

If telephone Emergency Care and Assessment Services are documented in a log and are provided by the same individual, that crisis staff member would need to sign the page only once. However, if other crisis staff members enter notes periodically in the log, their signatures must accompany their individual notes.

B. Face-to-Face Intervention guidelines:

One progress note per face-to-face contact is required to document the emergency care and assessment services provided to an individual. It should include, in summary form:

- Identified issue or precipitant to crisis contact;
- Issues addressed or discussed;
- Collateral contact information as solicited or available;
- Observations made by the clinician;
- The clinician's assessment of the issues/situation including mental status and lethality/risk potential;

- Disposition or plan resulting from the crisis intervention;
- Psychiatric consultation, as clinically indicated.

It is acceptable to document telephone and face-to-face Emergency Care and Assessment Services in a logbook only if all documentation requirements are present.

3.11 Transportation

Definition

Transportation services are only available to individuals covered by Vermont Medicaid who have no means of transportation available to them. The trips must be to an enrolled Medicaid provider, and the services received must be eligible for Medicaid reimbursement.

Staff Qualifications

Any individual or agency hired or contracted with to provide transportation services may do so with the approval of the executive director.

3.12 Success Beyond Six Services

Success Beyond Six (SB6) is a funding mechanism that allows schools to provide Medicaid billable, school-based mental health services through direct contracts with their local mental health designated agencies.

3.12.1 School Based Clinicians

Definition

The State of Vermont uses a case rate reimbursement methodology for school-based clinician services within the Success Beyond Six (SB6) program. The Global Commitment Demonstration provides the flexibility to develop alternative approaches intended to promote access and public health/early intervention strategies to improve care delivery and reduce program costs. The case rate model is designed to achieve the following objectives:

- Promote flexibility in service delivery to meet the needs of program participants and promotion of early intervention/prevention initiatives, including Vermont's Positive Behavior Interventions and Supports (PBIS) program
- Reduce paperwork demands strictly related to Medicaid fee-for-service billing that do not promote meaningful use of information
- Facilitate documentation requirements based on best clinical practice and quality oversight

- Shift focus of program reviews from volume and adequacy of billing documentation to clinical appropriateness and efficacy
- Establish a predictable funding mechanism
- Preserve existing funding streams and local arrangements between schools and designated agencies
- Eliminate payment fluctuations resulting from changes in the Medicaid fee schedule
- Enable schools and providers to collaborate and identify the best use of clinical resources

Attributes

The DA is on record with DMH as providing SB6 School Based Clinician services as either a monthly case rate or fee-for-service.

- Children who receive services through the Integrated Family Services capitated payment system are eligible for case rate or fee-for-service school based clinician services provided that the services delivered in the educational setting are separate and delivered distinct from the treatment services provided through the integrated family plan.
- Children may receive services provided by a school based clinician under the bundled case rate as well as services provided fee-for-service by a different provider in a Behavioral Interventionist program on the same day.
- School based clinician services do not include vocational activities or education services.

Case Rate

The monthly case rate methodology provides reimbursement for the full array of covered services provided by school-based clinicians and provides the flexibility for schools and Designated Agencies to collaborate in order to develop innovative service delivery options. Services include, but are not limited to, the following:

- Service planning and assessment
- Collateral contacts
- Daily living skills training
- Psychotherapy
- Counseling
- Individual and group therapy
- Social and coping skills development
- Crisis response
- Family support
- Health and wellness

There is a minimum service threshold of 2 hours (8 units) of service per month in order to bill the monthly case rate.

A higher case rate limit has been established for clinicians working in Vermont's Positive Behavior Interventions and Supports (PBIS)-participating schools.

Designated Agencies will continue to submit claims for individuals receiving at least two hours of service within each month, even if the maximum billing amount has been reached. Case rate claims may be submitted at any point in time, subject to timely filing requirements.

The State will establish two procedure codes for billing the monthly case rate: PBIS and Non-PBIS. Designated Agencies may elect to submit claims with a "Billed Amount" below the payment rate on file and payment will be processed at the lesser of the billed amount or rate on file. In the alternative, Designated Agencies may bill at the rate on file, subject to their ability to make local match dollar payments in accordance with State policies.

- School based clinicians cannot bill a case rate and Fee for Service.
- When multiple clinicians provide school based services, only one claim per child may be submitted.

Services Provided

Services provided by a school-based clinician may include Clinical Assessment (3.2), Individual Therapy (3.3), Family Therapy (3.4), Group Therapy (3.5), Service Planning & Coordination (3.6), and Community Supports (3.7).

Staff Qualifications

The service must be provided either directly by a Vermont enrolled physician directly affiliated with the Designated Agency, or prescribed by a physician or authorized APRN directly affiliated with the Designated Agency and provided by staff of the Designated Agency who, with a minimum of a Master's degree, is authorized by the prescribing physician or Medical Director as competent to provide the service.

Documentation

Documentation should include specific outcome measures. These measures will closely align with outcomes established for PBIS.

3.12.2 C.E.R.T. Concurrent with Education, Mental Health Rehabilitation and Treatment (Alternative Day Schools)

Definition

Therapeutic behavior services concurrent to education (community support in a school setting) assists individuals, their families, and educators in planning, developing, choosing, coordinating and monitoring the provision of needed mental health services and supports for a specific individual in conjunction with a structured educational setting. Services and supports include planning, advocacy and monitoring the well-being of individuals in the educational environment, and supporting individuals and their families to make, sustain, and follow-through with decisions relevant to their mental health needs in an educational setting. Concurrent to the educational services provided by educational staff are specific, individualized and goal oriented services provided by mental health staff either one-to-one or in a group setting and assist individuals in developing skills and social supports necessary to promote positive growth. These supports may include assistance in daily routine, peer engagement and communication skills, supportive counseling, support to participate in curricular activities, behavioral self-control, collateral contacts, and building and sustaining healthy personal, family and community relationships.

School-based mental health services programs must be approved by DMH prior to billing C.E.R.T. services.

Children who receive services through the Home and Community-based Waiver may be eligible for a daily C.E.R.T. service rate. Mental health services provided in the educational setting must be an identifiable set of services from the treatment services provided through the home and community-based mental health waiver treatment plans.

C.E.R.T. services for a student do not include vocational activities or education services.

Service Planning

Service planning includes educational team conferences and case discussions or contact with family, guardian, or primary support relationships, with or without the child's presence, to design or redesign individual plans of care, to monitor and determine the appropriateness of on-going treatment and/or to review and determine the appropriateness of current services and supports. Contact with multiple disciplines and/or agencies may be involved in service planning.

Service Coordination

Service coordination includes both face-to-face and telephone consultation with other professionals. Service coordination involves contact with school personnel and other

service professionals from agencies other than one's own for the purpose of case review or consultation regarding the provision and coordination of services to a specific child. Other service professionals may include: physicians, juvenile justice, law enforcement, child protection services workers, and youth organization community representatives. Service Coordination may also occur with family, guardian, or primary support relationships as indicated to build and promote continuity of services between the living and educational environments.

Therapeutic Behavioral Services (Rehabilitation and Treatment)

Rehabilitation and treatment services are specific, individualized and goal oriented services provided either one-to-one or in a group setting which assist individuals in developing skills and social supports necessary to promote positive growth. These supports may include assistance in daily routine, peer engagement and communication skills, supportive counseling, support to participate in curricular activities, behavioral self-control, collateral contacts, and building and sustaining healthy personal, family and community relationships.

Daily routine skills can include scheduling, planning, and organizing activities in a manner that promotes success in the educational environment. Active skill building opportunities during the course of the school day may relate to communication, social interactions, adaptive behavior, healthy choices, and coping skills.

Supportive counseling includes services directed toward the elimination of psychological barriers that impede the development or modification of skills necessary for more independent function. The emphasis is upon advice, opinion or instruction given to an individual to influence his/her judgment and/or conduct in everyday situations.

Support is provided to develop those skills necessary for the student to identify, engage in, and maintain more independent function in community-based activities. This includes social behaviors, accessing and utilizing community social, leisure and essential public services, and community mobility skills.

Collateral contacts reflect the day-to-day service delivery discussions with educators and or other school-based clinicians regarding implementation, direct interventions, skill building, counseling or consultation with family, legal guardian, or primary living support relationships to insure effective treatment of the individual. The Medicaid individual must be central to such services. Collateral contacts can be provided either face-to-face or on the phone.

Target Population

Children must meet the definition of severe emotional disturbance.

Attributes

School-based mental health services programs must be approved by DMH prior to billing concurrent to education rehabilitation and treatment services. Children who receive services through the Integrated Family Services capitated payment system may be eligible for the daily CERT service rate. Mental health services provided in the educational setting must be an identifiable set of services from the treatment services provided through the integrated family plan.

Reimbursement is limited to school-based mental health programs approved by DMH. Reimbursement is limited to the daily service rate, and not to exceed five services per week. Service must be at least two hours (8 units) in duration to bill the daily rate. All other services may be reimbursed on the same day. There is currently a daily limit for all services per client that can be found on the DMH fee schedule.

If service is provided in a group, no more than 10 students can be present.

Service planning and coordination and community support cannot be billed by school-based providers at the same time (during the school day or pertaining to school issues/activity) that a C.E.R.T. service rate is provided. Service planning and coordination and community supports may be provided at the same time as C.E.R.T. services as long the rehabilitative service are not driven by the C.E.R.T. school-based treatment plan, but to goals pertaining to community or home based plan of care and the service provider is unrelated to the C.E.R.T. services.

When multiple clinicians provide C.E.R.T. services, only one clinician can bill the daily service rate.

Transportation costs are included in the cost of C.E.R.T. services. For example, if a school-based clinician or other mental health agency worker provides transportation to or from school, community support or transportation cannot be billed in addition to the daily rate.

Staff Qualifications

The service must be provided either directly by a Vermont enrolled physician directly affiliated with the Designated Agency, or prescribed by a physician or authorized APRN directly affiliated with the Designated Agency and provided by staff of the Designated Agency who, based on his/her education, training, or experience, is authorized by the prescribing physician or Medical Director as competent to provide the service.

Documentation Requirements

C.E.R.T. services must be documented each day of service and progress reported in a weekly or monthly summary note.

The clinical note or log content by day must include a cumulative description of each service (e.g. service planning and coordination, individual supports, and group support) provided. The daily documentation must be included in the clinical record. If the same staff person provides the entries on the daily documentation, that staff member would need to sign the page only once. However, if other staffs enter notes periodically on the daily documentation sheet, they must sign their individual entries.

The monthly summary for C.E.R.T. services must be completed, evaluating progress, outcomes, and changes in service plan accompanied by the daily documentation. The monthly progress note does not need to provide an accounting of the service encounters given the detail of the daily documentation. The note should reflect an analysis of the client response and progress toward the treatment goals and future planning needs.

3.12.3 Behavioral Interventionist Services

Description

The Behavioral Intervention Program (BI Services) is collaboration between the local Designated Agency (DA) Children's Mental Health Program and local educational program to provide mental health services and behavioral intervention with targeted students in a school setting. The BI services are individualized to the student's mental health and behavioral needs to help the student access his/her academics. The BI Services include clinical training and supervision of the BI, initial and ongoing assessment by clinical professionals, and behavior interventions that are grounded in the assessment and behavior support plan as described in the BI Minimum Standards.

Attributes

- Goal of BI Program services is to support student participation in regular classroom learning by providing emotional and behavioral support in coordination with school personnel; does not provide curriculum content support or direct instruction.
- BI provides pro-social and coping skill development.
- Clinical decision-making including matching of BI to student, admission, discharge, changes in ratio, and treatment is led by qualified mental health staff of the BI Program in conjunction with the school team responsible for the education of the student.
- Team meetings occur regularly and are facilitated by BI program staff.
- Coordination between mental health services, school, family and other community partners as needed.
- Plan is established for BI absences as agreed upon by school, family and mental health agency (e.g. BI substitute available, school provides coverage or alternative school plan).
- BI services are provided during school hours.
- Ongoing assessment protocol

- Seclusion and restraint are minimized and only utilized after less intrusive crisis interventions are attempted and only in cases of imminent risk of harm. This is conducted only by staff trained in crisis intervention (see training requirements in the BI Program Minimum Standards). The values of the program focus on efforts to significantly reduce the use of seclusion and restraint, and prioritize early and alternative interventions. The BI Program will review use of seclusion and restraint in the context of the student's individual support plan and make adjustments as indicated. The BI Program will also review trends in the use of seclusion and restraint and, in conjunction with education, develop strategies to reduce or eliminate such practices.
- Crisis response services, consultation and mental health assessment are available during contracted time and a crisis prevention/response plan is developed if needed during non-school hours.
- Transition plan to lower level of supports
- Plan incorporates work with the family system

Eligibility Criteria for Behavior Interventionist Services

The BI Program, in collaboration with education, will determine if student is eligible for the BI Program services based on the following criteria:

- Student has a mental health diagnosis; AND
- The student is enrolled in Special Education and has an (IEP); or has a 504 plan; or an Educational Support Team plan or a Behavior Support Plan that identifies support needs that might be addressed using a Behavior Interventionist; AND
- A history of any lower level interventions/services provided including private/public mental health and school based services have been tried and have not been successful. These interventions/services have not had sufficient impact on student's mental health or behavioral issues in order to increase student's ability to access academics; AND
- An individualized mental health and behavioral supports approach is indicated (by a CBCL, clinical documentation, FBA or other evaluations); AND
- Student is at risk of a more restrictive educational alternative placement in an out of school program or residential school program, OR
- The student is transitioning back into public school from an alternative school or residential school placement.

The eligibility of a student for a Behavior Interventionist Program should be determined at the minimum of each school year.

Services Provided

Services provided through the BI program include Service Planning & Coordination (3.6), Community Supports (3.7), and Clinical Assessment (3.2).

Staff Qualifications

The service must be provided either directly by a Vermont enrolled physician directly affiliated with the Designated Agency, or prescribed by a physician or authorized APRN directly affiliated with the Designated Agency and provided by staff of the Designated Agency who, based on his/her education, training, or experience, is authorized by the prescribing physician or Medical Director as competent to provide the service.

Documentation Requirements

Documentation requirements follow the requirements set forth in each section for the specific service (3.2, 3.6 and 3.7)

3.13 JOBS Program

Definition

The JOBS Program serves youth who are often covered by Medicaid insurance. The Medicaid is obtained via a case rate/performance based system providing increased flexibility regarding services to these Medicaid eligible youth. Allowed services include service planning and coordination, community supports, employment assessment, employer and job development, job training, and ongoing support to maintain employment.

Attributes

Persons served by JOBS must have an SED diagnosis, are 16-21 (under 22) years of age, and meet all of the Program eligibility criteria. Each participant must have a completed assessment and performance goals/outcomes must be defined.

A participant who has had at least one direct, face to face, Medicaid billable service within 90 days may be counted as part of the caseload.

Agencies may bill for additional services provided to the youth via other staff or programs provided these services are not included in the case rate and are reported through the different cost center. There must be adequate evidence that the other services are addressing some other treatment need and not substituting for services covered under the case rate.

If a person has private insurance, services that are billable to the private insurance should be billed to the insurer.

Documentation Requirements:

Monthly progress note documentation is required and will identify:

- Summary of major content or intervention themes consistent with treatment goals
 - This may include both Medicaid as well as non-Medicaid services
- Observations made of the individual or responses to interventions
- Assessment of progress toward treatment goals
- Ongoing needs for continued intervention and next steps

Quality Audit Requirements

The statewide JOBS coordinator meets with JOBS programs twice a year to assess progress towards outcomes. The quality audit requirements include the following.

The percent of individuals who:

- Were enrolled in a health insurance program
- Accessed primary care while in the program
- Received a mental health assessment or already had an up-to-date assessment on file at intake
- Received a substance abuse screening or assessment at intake

Staff Qualifications

The service must be provided either directly by a Vermont enrolled physician directly affiliated with the Designated Agency, or prescribed by a physician or authorized APRN directly affiliated with the Designated Agency and provided by staff of the Designated Agency who, based on his/her education, training, or experience, is authorized by the prescribing physician or Medical Director as competent to provide the service.

3.14 ARCh Program (Howard Center only)

Definition

The ARCh Program provides an integrated approach to expand response to children with mental health and/or developmental disabilities. Services include:

- Targeted case management as defined in the state plan for children with Developmental Disabilities as defined in the DAIL System of Care.
- Psycho-social Rehabilitation/Specialized Rehabilitation as defined in the state plan and DMH Fee-For-Service Medicaid Manual. This includes service coordination, community skills work, collateral contact/family outreach, supportive counseling and behavioral consultation (individual or group) to all children who are identified as having a mental health and/or developmental disability and it is determined medically necessary.

Attributes

Any child up to age 22 who has a disability (behavioral, developmental, or mental health), has needs that meet the definition of medical necessary and this array of services would most appropriately meet their needs. If necessary, additional Medicaid and support services identified as approved for concurrent billing may be provided as well.

Approved Medicaid services that may be provided concurrently:

- Success Beyond Six school based services
- Individual Therapy
- Group Therapy
- Family Therapy
- Crisis Services
- Psychiatry
- Respite through the respite grant or family managed

The following services may NOT be billed concurrently for individuals being provided services through the ARCh program:

- Former home and community based waiver (DS and MH)
- Fee-for-service Psycho-Social Rehabilitation/Specialized Rehabilitation unless Success Beyond Six funded including community supports and service planning and coordination
- PNMI
- Psychiatric Inpatient
- Hospital Diversion
- Children's Integrated Services

Staff Qualifications

The service must be provided either directly by a Vermont enrolled physician directly affiliated with the Designated Agency, or prescribed by a physician or authorized APRN directly affiliated with the Designated Agency and provided by staff of the Designated Agency who, based on his/her education, training, or experience, is authorized by the prescribing physician or Medical Director as competent to provide the service.

Documentation

Services will be reported monthly. Service providers and documentation must be in accordance with the DMH Medicaid FFS rules. At least one standardized assessment tool on each client will be completed, used to develop an Individualized Plan of Care, and entered into the clinical record.

Quality oversight is described in the Master Grant document.

3.15 DMH Co-occurring Mental Health and Substance Abuse Service Planning and Coordination (Adolescents Only)

Adolescents eligible for DMH Co-occurring Mental Health and Substance Abuse Service Planning and Coordination must meet all of the following requirements:

- Have a primary mental health diagnosis
- Have a secondary diagnosis of substance abuse, substance dependence or substance use disorder
- Be receiving substance abuse treatment at a level of care of 0.5 or greater by ASAM placement criteria
- Under the age of 19 unless still attending high school

Definition

This program provides funding for adolescents currently receiving Children's Mental Health services and involved in substance abuse treatment.

Attributes

Reimbursement is limited to a minimum of 15 minutes (2 units) per day and a maximum of 10 hours (40 units) per client per week for all Service Planning and Coordination and Community Support services combined.

Services must be billed using a separate provider number and indicating the secondary diagnosis of substance abuse.

Staff Qualifications

The service must be provided either directly by a Vermont enrolled physician directly affiliated with the Designated Agency, or prescribed by a physician or authorized APRN directly affiliated with the Designated Agency and provided by staff of the Designated Agency who, based on his/her education, training, or experience, is authorized by the prescribing physician or Medical Director as competent to provide the service.

Documentation Requirements

Combined services may be documented by each service provided; or with one monthly summary note. Each program or sub-component must designate which method of documentation it will use.

Per service documentation should identify:

- Clinical intervention used;
- Modality of service provided;
- Summarize each service by describing the discussion/training/skill building

- provided and its purpose;
- Describe individual's response or clinician's observations;
- Describe overall outcome/results/progress in relation to the individual service plan.

Monthly summary documentation should identify for each treatment modality:

- Clinical intervention used;
- Summary of major content or intervention themes consistent with treatment goals;
- Observations made of the individual or responses to interventions;
- Assessment of progress toward treatment goal;
- Ongoing needs for continued intervention and plan.