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## Psychiatry

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In accordance with Senate Bill X1-1 (Hernandez, Chapter 4, Statutes of 2013), Section 28, and the Patient Protection and Affordable Care Act, effective January 1, 2014, mental health services provided by psychologists and services provided by psychiatrists as indicated below are expanded for all eligible Medi-Cal recipients when medically necessary. For additional information regarding coverage of psychiatry services through the California MMIS Fiscal Intermediary, refer to the *Specialty Mental Health Services* section in this manual.

When medically necessary, eligible Medi-Cal recipients may receive mental health services provided by psychologists, psychiatrists, Licensed Clinical Social Workers (LCSWs) and Marriage and Family Therapists (MFTs) as indicated below.

### **Eligibility**

A recipient obtains eligibility for mental health services if the recipient is diagnosed with a mental health disorder as defined by the *Diagnostic and Statistical Manual of Mental Health Disorders* (DSM) resulting in mild to moderate distress or impairment of mental, emotional or behavioral functioning. Conditions that the DSM identifies as relational problems, that is, couples counseling or family counseling for relational problems are not covered.

### **Pregnancy-Related Services**

Refer to the *Pregnancy: Early Care and Diagnostic Services* section of this manual for additional information.

### **Mental Health Services Delivery Systems**

Eligible Medi-Cal recipients may receive Medi-Cal mental health services through all Medi-Cal delivery systems including, but not limited to, Managed Care and fee-for-service delivery systems. Recipients that meet medical criteria for specialty mental health services will receive mental health services via county-administered specialty mental health services plans.

## **Mental Health Services**

Recipients who are eligible for Medi-Cal mental health services may receive the following:

- Individual and group mental health evaluation and treatment (psychotherapy) rendered by a psychologist, LCSW or MFT
- Psychological testing when clinically indicated to evaluate a mental health condition
- Outpatient services for the purposes of monitoring drug therapy
- Outpatient laboratory, drugs, supplies and supplements
- Psychiatric consultation
- Specialty mental health services provided by County Mental Health Plans

*Treatment Authorization Requests (TARs)* are not required for psychiatric consultation for Medi-Cal recipients that meet eligibility criteria for mental health services.

## **Diagnosis Codes**

Inpatient psychiatric codes 90785, 90791, 90792, 90832 thru 90834, 90836 thru 90840 and 90863 are reimbursable only when billed with ICD-10-CM diagnosis codes F01.50 thru F02.81, F99, H93.25, R37, R45.1, R45.2, R45.5 thru R45.82 or Z87.890 as a primary or secondary diagnosis. Outpatient psychiatric codes 90785, 90791, 90792 and 90863 do not have diagnosis restrictions.

Diagnosis codes are not required when billing for services provided by a psychologist, LCSW or MFT.

## **Psychology Services**

For information about billing psychology services, refer to *Psychological Services* in the appropriate Part 2 manual.

## **Authorization**

Authorization is not required for outpatient psychiatric services. Outpatient psychiatric services are covered services when ordered by a primary care physician.

## **Non-Covered Mental Health Services**

Certain paramedical services are not Medi-Cal benefits through the Medi-Cal FI, whether billed by the individual performing the service or by an employing physician or other outpatient provider. These include mental health services rendered by:

- Psychological assistants
- Learning disability specialists
- Psychiatric technicians

The services of individuals such as psychologists who, although licensed, do not meet the specific licensing requirements of Medi-Cal (outlined in *California Code of Regulations* [CCR], Title 22, Section 51232) also are non-benefits. These services may be covered when provided through a county mental health plan. Refer to the *Specialty Mental Health Services* section in this manual for additional information.

Psychiatry and psychology services billed to Medi-Cal using CPT® codes are covered only when they are personally performed or directly supervised by qualified providers such as MDs, nurse practitioners, physician assistants, psychologists, LCSWs and MFTs.

## **Psychiatric Diagnostic Procedures**

When rendering psychiatric diagnostic procedure services (CPT codes 90785, 90791, 90792 or 90863), providers must retain a record of the type and extent of each service rendered (CCR, Title 22, Section 51476[a]). Claims billing both these services are subject to post-payment review and verification.

## **Home Visit E&M Services: Reimbursement Restrictions**

Home visit Evaluation and Management (E&M) CPT codes (99341 thru 99350) and services for the purposes of monitoring drug therapy (CPT codes 90785, 90791, 90792 and 90863) are not separately reimbursable when billed in combination by the same provider, for the same recipient and date of service. Because the home visit E&M services and psychotherapy services provide similar benefits (patient history, evaluation, drug management, counseling, coordination of care and decision-making), submitting claims for both constitutes duplicate billing.

Medi-Cal will deny reimbursement for the lower-priced service when psychotherapy codes 90785, 90791, 90792 or 90863 are billed in combination with home visit E&M codes 99341 thru 99350 by the same provider, for the same recipient and date of service.

## **Pharmacologic Management: Not Separately Reimbursable**

CPT code 90863 (pharmacologic management, including prescription and review of medication, when performed with psychotherapy services) is not separately reimbursable with psychiatric codes 90785, 90791, 90792, 90832 thru 90834, 90836 thru 90838 or with E&M codes <<99202>> thru 99350 when billed by the same provider, for the same recipient and date of service. If code 90863 previously has been paid, reimbursement for any of these psychiatric or E&M codes will be cut back by the amount previously paid for code 90863.

## **Nursing Facility Inpatients**

Psychiatric services for NF Level A or B inpatients with acute psychiatric conditions are payable for the following time periods without prior authorization:

- Two hours per seven-day period during the first two months of treatment
- One hour per seven-day period for the third through seventh month of treatment
- One hour per 14-day period for each month after the seventh month of treatment
- One hour per seven-day period during the month prior to discharge

## **Additional Services**

If a recipient needs additional services to meet “medical necessity” or “to attain or maintain the highest practicable psychosocial functioning,” providers must request prior authorization.

Authorization is required for therapy services rendered to nursing facility patients on an inpatient basis. See “Nursing Facility Resident Authorization Requirements (Valdivia v. Coye)” in this section for authorization procedures.

## **Nursing Facility Resident Authorization Requirements (Valdivia v. Coye)**

Psychiatric therapy, exceeding services outlined under “Psychiatric Services for Hospital and Nursing Facility Inpatients,” rendered to Nursing Facility (NF) Level A or Nursing Facility (NF) Level B recipients require prior authorization. A *Treatment Authorization Request* (TAR) must be submitted for services that are not included in the Medi-Cal inclusive per diem rate for an NF. TAR documentation must justify the additional services.

Psychiatric services may be requested as inpatient or outpatient depending on the condition of the Medi-Cal recipient and whether the service is offered in the NF.

## **Recipient Criteria**

The local Medi-Cal field office or County Mental Health Plan reviews psychiatric therapy TARs for Medi-Cal recipients who meet the following criteria:

- The recipient must reside in an NF Level A or NF Level B.
- The recipient must require therapy services by a psychiatrist.
- The therapy service(s) must be medically necessary and/or necessary to attain or maintain the highest practicable physical, mental and psychosocial functioning.

## TAR Criteria

There are two standards for psychiatric therapy TARs. Medi-Cal recipients must meet one of the following criteria:

(1) *California Code of Regulations (CCR), Section 51303*

“Medical necessity limits health care services to those reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.”

Example: A psychiatrist may complete an assessment and evaluation for a patient diagnosed with major depression (more than six months) and recommends individual visits for a specific period of time.

If the therapy service does not meet the “medical necessity” regulatory standard of criteria, the local Medi-Cal field office or County Mental Health Plan evaluates the TAR under the following criteria:

(2) Valdivia Court Order and Stipulation, paragraph 2(f)(2)(ii)

“Each resident must receive, and the facility must provide, the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial functioning in accordance with the comprehensive assessment and plan of care.”

Example: Patient’s plan of care offers participation in weekly bereavement therapy sessions rendered by a psychiatrist to maintain the resolution of loss and identity issues.

## Inclusive and Exclusive Services

In many cases, therapy services needed to attain and/or maintain the highest practicable level of functioning can and should be performed as part of the NF services rendered to the Medi-Cal resident in the nursing facility.

Below are two examples to help illustrate the relationship between therapy services that are covered in the inclusive services rate and the exclusive services rate.

Inclusive Service Example:

The Medi-Cal patient’s plan of care calls for the monitoring of the patient to determine how the patient is coping with depression.

Exclusive Service Example:

The Medi-Cal recipient’s plan of care calls for weekly individual bereavement therapy sessions provided by psychiatrist to address and resolve grief, loss and identity issues.

## **CCR Requirements, Title 22: Sections 51510 and 51511**

*California Code of Regulations* (CCR), Title 22, Sections 51510 and 51511, state, with the exception of various services separately covered by Medi-Cal, services rendered to NF residents pursuant to Federal Medicaid laws, such as OBRA and State licensing laws, are reimbursed in the Medi-Cal inclusive per diem payment rate.

## **CCR Requirements, Title 22: Sections 72315 and 73315**

CCR, Title 22, Section 72315, lists requirements for nursing services in a nursing facility providing NF Level B care. CCR, Title 22, Section 73315, lists the requirements for nursing services in a nursing facility providing NF Level A care.

**Note:** Psychiatric therapy services are not included in the adult and pediatric subacute care inclusive per diem rate. These services must be authorized on a 50-1 TAR and billed separately.

Two examples of therapy services covered under the Medi-Cal per diem rate are:

- The Medi-Cal recipient's plan of care calls for the depressed patient to receive spiritual counseling from religious professionals.
- The Medi-Cal recipient's plan of care calls for the monitoring of the patient to determine how the patient is coping with his/her grief.

## **Exclusive Services: TAR Required**

Psychiatric services may be performed as part of the exclusive services and are payable separately if a recipient needs licensed psychiatric therapy intervention to meet his/her specific medically necessary needs and/or to attain the highest practicable level of functioning.

In these cases, providers must obtain an approved TAR for therapy services with the expressed purpose of assessing the needs of the recipient more thoroughly, providing direct therapy service(s), or evaluating effectiveness of the planned treatment delivered by the NF staff.

Example: Individual therapy is ordered once a week for 12 weeks by a psychiatrist.

For a listing of subacute care inclusive and exclusive items, refer to the *Subacute Care Programs* section in the appropriate Part 2 manual. Also see "TAR Criteria" on a previous page in this section.

## TAR Documentation

Providers must submit specific documentation when requesting prior authorization for recipients requiring either “medical necessity” or “attaining and maintaining” services.

### Medical Necessity TAR

If the TAR requesting therapy services meets the Medi-Cal definition of “medical necessity,” the following minimum documentation is needed:

- Minimum Data Set (MDS)
- Therapist’s plan of care
- Signed physician’s orders if the psychiatrist is not the attending physician
- PASRR level II determination that includes documentation that the second level screen of the PASRR was completed, the facility where the Medi-Cal recipient resides is the appropriate placement for the Medi-Cal recipient, and the documentation of the need for mental health services
- Claim showing the prior non-TAR authorized psychiatric visits and/or hours billed to the Medi-Cal program
- The *Patient Status* box on the *Treatment Authorization Request (50-1)* must include an “X” in the *SNF/ICF* box if the patient is a resident of a nursing facility.

**Note:** The TAR must clearly identify the Medi-Cal recipient for whom services are requested as a “nursing facility resident” to assure that requests for prior authorization of the therapy services are evaluated consistently with the Federal and State regulatory requirements for certified nursing facilities.

- The *Medical Justification* area on the *Treatment Authorization Request (50-1)* must indicate: “Request is for a resident of (*Nursing Facility Name*) nursing facility.”

Be sure to attach all documentation and supporting medical information, the pertinent parts of the Minimum Data Set (MDS), and the recipient’s comprehensive care plan (including frequency of services and probable length of treatment necessary to achieve measurable goals) to the TAR.

## Attain and Maintain TAR

If the TAR requesting therapy services does not meet the current Medi-Cal definition of “medical necessity” and the Valdivia Court Order and Stipulation is applied, the following documentation and supporting medical justification must include at a minimum:

- All documentation and supporting medical information that would normally accompany a TAR, including pertinent parts of the Medi-Cal recipient’s MDS

Medi-Cal recipient’s Resident Assessment Protocol (RAP) summary sheet is part of federal Resident Assessment Instrument (RAI) development that identifies the record location of various information (including nature of the condition, complications and risk factors, need for referrals to appropriate health professionals, or reasons for decisions to proceed or not proceed).

- Medi-Cal recipient’s comprehensive plan of care
- Statement describing the Medi-Cal recipient’s progress toward achieving the therapeutic goals included in the Medi-Cal recipient’s treatment plan
- Signed physician’s prescription/orders
- Documentation to substantiate the therapy need
- Therapist’s evaluation
- PASRR level II determination that includes documentation that the second level screen of the PASRR was completed, the facility where the Medi-Cal recipient resides is the appropriate placement for the Medi-Cal recipient, and the documentation of the need for mental health services
- A claim showing the prior non-TAR-authorized psychiatric visits and/or hours billed to the Medi-Cal program
- The *Patient Status* box on the *Treatment Authorization Request* (50-1) must include an “X” in the *SNF/ICF* box if the patient is a resident of a nursing facility.

**Note:** The TAR must clearly identify the Medi-Cal recipient for whom services are requested as a “nursing facility resident” to assure that requests for prior authorization of the therapy services are evaluated consistently with the Federal and State regulatory requirements for certified nursing facilities.

- The *Medical Justification* area on the *Treatment Authorization Request* (50-1) must indicate: “Request is for a resident of (*Nursing Facility Name*) nursing facility.”

**Note:** If all of the “medical necessity” documentation and Valdivia standard documentation previously listed are submitted with the TAR, there will be less risk of TAR deferrals and denials.

## **Reauthorization Requests**

To request reauthorization of inpatient psychiatric therapy services, the psychiatrist must substantiate the need and include a statement describing the recipient's progress toward achieving the therapeutic goals included in the treatment plan. Reauthorization requests must be received prior to the expiration of the previously authorized TAR.

## **Transportation**

In most cases, the TAR-authorized psychiatric therapy services can be provided within the NF. However, where services are rendered outside the nursing facility, a TAR requesting non-emergency medical transportation along with a copy of the TAR requesting psychiatric services must be submitted to the TAR Processing Center. The non-emergency medical transportation TAR must include documentation that psychiatric therapy services have been requested.

**<<Legend>>**

<<Symbols used in the document above are explained in the following table.>>

<b>Symbol</b>	<b>Description</b>
<<	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
>>	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.