MEDICAID MENTAL HEALTH REFORM
FREQUENTLY ASKED QUESTIONS - SEPTEMBER – DECEMBER 2009

Rules applicable to Medicaid-reimbursed mental health clinics and psychosocial rehabilitation agencies can be viewed on the Department of Administration's Web site.
This document will be updated as we receive additional questions. To submit questions, please contact: Carolyn Burt at (208) 364-1844 or send an email to: burtc@dhw.idaho.gov.

Question	Answer
1. Is Healthy Connections referral considered documentation that a history and physical has occurred? **(updated November 2009)**	No. A Healthy Connections referral from the participant's primary care physician serves as documentation that the physician agrees that a referral to the service is medically necessary. History and physical (H&P) documentation is the document itself or some notation of the communication that has occurred between the H&P provider and the mental health services provider that a H&P visit has occurred. The intent of the physician's visit is to ensure that there are no medical reasons for a participant's symptoms. Ideally, this visit would also acknowledge that a referral to mental health services was appropriate and medically necessary. Mental health provider agencies are not responsible for the quality of the H&P but are responsible to ensure they do not provide services until an H&P has been completed (unless it is a crisis situation). Some mental health providers have reported that they've received various documents from the PCP but not an actual report of a physical exam. In such cases Medicaid considers the mental health agency as having fulfilled their due diligence to obtain the appropriate medical records. The mental health agency should file the documents in the participant's record and proceed with services if they've also obtained a referral number from the PCP office.

Question	Answer
2. Is it true that a history and physical must be completed by the participant's Healthy Connections primary care provider only? **(updated November 2009)**	No. Any primary care provider (PCP) can deliver this service which includes nurse practitioners and physician assistants. Additionally, physicians, licensed practitioners of the healing arts, and physician specialists may have performed a physical examination in the course of delivering another medical service. Such a physical examination fulfills the H&P requirement for mental health services. The H&P may be in many forms; the document may be called a "well child check", a "well adult check", or an H&P or other type of examination. Also, the PCP or other medical specialist may just write a progress note or may just relay the information over the phone.
3. Our agency is completing the functional assessment and amending a participant's treatment plan. If the participant receives clinical services at another agency and we obtain the diagnostic assessment from that agency, is there a need for us to complete a separate diagnostic assessment? **(updated November 2009)**	Generally, no. If the comprehensive diagnostic assessment was completed accurately and includes all the components for such an assessment as outlined in rule, then your agency should utilize that document to complete your update. It would be appropriate to bill for comprehensive diagnostic assessment work if your agency had to complete missing content of the diagnostic assessment that you obtained from another agency. If the obtained document is significantly lacking in the required information, your agency should report this to Medicaid in order for us to follow up with a quality review.

Question	Answer
4. Can the Primary Care Provider (PCP) complete and score the CAFAS? **(updated November 2009)**	No. The primary care provider does not administer the CAFAS in any scenario for Medicaid re
5. My agency has been looking at the different training programs regarding the use of restraints. Can you provide any guidance toward the types of trainings that would be most appropriate? **(updated November 2009)**	The intent of this rule is an important consideration when deciding what type of training your agency will use. Although the Department does not endorse any one specific training, it is the industry standard to use trainings that are developed for working in behavioral health settings, **not corrections**.
6. Did the code for Group Skill Training change from what was previously used for Group PSR? Does this code require the group modifier? **(updated November 2009)**	Group Skill Training should be billed with code H2014 and the HQ group modifier. This code is set up this way in the Medicaid claim system. See the *corrected* Table 2 at the end of this document.

Question	Answer
7. Can you explain what is meant by the requirement for discharge criteria and an aftercare plan on treatment plans? **(updated November 2009)**	This rule is related to the standard of care that requires a disposition be identified from the initiation of treatment. The disposition is not just a recommendation that a person needs a certain service but includes a recommendation about duration and intensity of treatment. The discharge planning at the beginning of treatment can be a general statement that describes the plan and provides a sense of conclusion of treatment. For participants who have enduring illnesses, the discharge plan may not refer to a conclusion of treatment but more of a description of the expectations around what the current year of treatment should result in. What is written on the treatment plan for discharge/aftercare should focus on the general answer to the following question: After I accomplish all these objectives on my plan, then what? Discharge/aftercare planning at the time of discharge is expected to be much more detailed and specific.
8. Some of the degrees listed in rule regarding the PSR Specialist qualifications are not available from Idaho schools. Is the Department planning to make adjustments to the rules to include the Idaho degrees? **(updated November 2009)**	One of the Mental Health Reform workgroups has completed research on the comparable degrees that are offered in Idaho that meet the intent of the rule. The following list of Idaho degrees are considered equivalent to those listed in rule. **Primary Education** = Education (though not just a Teaching Certificate) **Early Childhood Development** = Childhood Development Family Relations **Family Science =** Family and Consumer Science Education OR Human Development and Family Studies **Human Services** = Sociology If an applicant holds a Masters Degree in any of the degrees listed, they are also considered in compliance with meeting the qualifications in rule for a PSR Specialist.

Question	Answer
9. My agency has been receiving denials on claims for services that have been provided as baseline services with the renewal of a participant's plan. Don't the participant's benefits start over with their new plan year? **(updated November 2009)**	No. If a participant's benefit is identified as a yearly, annual, or calendar year benefit, then the participant's benefit runs from January 1 to December 31. For example, if a plan contains additional prior authorized services and expires on November 15th, and the annual review clinically indicates the need for the continuation of such services, then the service agency should do the following: 1) Complete the participant's annual review exactly as described in the statewide provider training that was recently presented to providers, including all the necessary components as identified in *IDADA* 16.03.09.710.03-05 and 16.03.10.116.03 and 129.06-07 Develop new annual treatment plan and determine participant service needs. If baseline limits have already been used up in the previous treatment plan year, services from the renewal date through the end of December only will require prior authorization. (Remember, the benefit year starts over January 1 for the participant).

Additional Information

Table 1. Professional Mental Health Staff and Scope Units, Of Assessments

	Intake Assessment	Comprehensive Diagnostic Assessment	Functional Assessment
PSR Specialist working for a PSR Agency	•		•
LSW	•		•
LMSW, LPC, LAMFT or Psychologist Extender, with required licensing supervision	•	•	•
LCSW, LCPC, LMFT, Psychologist	•	•	•
Certified Nurse Practitioner, RN	•	•	•
Practitioner of the Healing Arts	•	•	•
Physician, Psychiatrist	•	•	•

Table 2. Codes, Service Descriptions, Billing and Explanatory Comments (partial code list)

Code	Services	Billing	Comments
T1028	Intake Assessment (formerly Social History Evaluation)	1 unit = 15 minutes	No change in rate.
90801	Comprehensive Diagnostic Assessment (formerly Psychiatric Diagnostic Interview Exam)	1 unit = 15 minutes	No change in rate.
H0031	Functional Assessment (formerly Mental Health Assessment or Rehabilitative Evaluation)	1 unit = 15 minutes	Focus entirely on participant's functional skills; Exclusively for participants seeking skill training-type interventions in Partial Care or Rehab Services
H2017	Individual Skill Training (formerly Individual PSR)	1 unit = 15 minutes	No change in rate.
H0036	Community Reintegration *(NEW CODE)*	1 unit = 15 minutes	Pays same rate as H2017. Individual service only.
H2014 *HQ*	Group Skill Training (formerly Group PSR)	1 unit = 15 minutes	Modified required. No change in rate.

Table 3. Prior Authorization (PA) Alternatives for Same Services and Changing Services.

PA Alternatives	Same Services	Change Services
PA'd over 10 hrs/week	Ensure new service limits not exceeded; proceed with service delivery	Amend plan; ensure service limits not exceeded; submit for new authorization if adding H0036
PA'd greater than 5 but not greater than 10 hrs/week	Proceed with service delivery	Amend plan; ensure service limits not exceeded; submit for new authorization if adding H0036
PA'd for 5 or less hrs/week	Proceed with service delivery	Amend plan; proceed with service delivery
Transfers	Submit for authorization if services on plan exceed baselines described in rule	Submit for authorization if services on plan exceed baselines described in rule or if adding H0036
New and subsequent treatment plans with service(s) at or below baselines	All new and recurring treatment plans containing services at or below baselines described in rule do not need to be submitted for authorization; provider should create plan and proceed with service delivery.	
New and subsequent treatment plans with service(s) above baselines	All new and recurring treatment plans containing services in excess of baselines described in rule must be submitted for authorization.	