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GreenMountainCare
A HEALTHIER STATE OF LIVING

Psychotherapy and Other Psychiatric Services Supplement

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

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Section 1 Introduction

This supplement is designed as an additive and does not replace the Vermont Medicaid General Provider Manual and the Vermont Medicaid General Provider Manual which can be found at Provider Manuals. The information in this supplement was taken from these manuals and consolidated to increase accessibility and clarity for providers. None of this information is new and there are no new requirements. This supplement describes processes to be followed by enrolled Vermont Medicaid providers who are serving Vermont Medicaid members with psychotherapy and other psychiatric services.

For information regarding supervised billing, providers should follow the Vermont Medicaid Supervised Billing Manual for Behavioral Health and all requirements as outlined in HCAR 9.103. All manuals can be found at Provider Manuals and all administrative rules can be found at Health Care Administrative Rules (HCAR).

If you are a Designated Agency or Specialized Services Agency, you should be using the Vermont Department of Mental Health Provider Manual as the primary guide for your practice and billing procedures. Always ensure that you are using the correct manual to prevent errors in service delivery or billing.

Vermont Medicaid only pays for healthcare services that are medically necessary. Per Medicaid Healthcare Administrative Rule 4.101, medically necessary means health care services, including diagnostic testing, preventive services, and aftercare, that are appropriate, in terms of type, amount, frequency, level, setting, and duration, to the beneficiary's diagnosis or health condition, and that: (1) help restore or maintain the beneficiary's health, or (2) prevent deterioration or palliate the beneficiary's condition, and (3) are the least costly, appropriate health service that is available, and (4) are not solely for the convenience of the beneficiary's caregiver or a provider, and (5) are supported by documentation in the beneficiary's medical records.

It is the responsibility of the provider to determine when services are medically necessary by using their knowledge of conditions and treatment within their scope of practice. To ensure that mental health services are provided at an appropriate level of care within the appropriate utilization of resources, the Department of Vermont Health Access (DVHA) utilizes the Change InterQual® criteria. The InterQual® tool provides resource efficient evidence-based clinical decision support across the levels of care. InterQual® Guidelines are available to providers on the Vermont Medicaid website, by navigating to the Transactions Menu and choosing the Login option. After log-in, look for the link to Smart Sheets in Secure Options drop-down menu. InterQual® Guidelines are updated annually.

Section 2 Billing Information and Instructions

2.1 Evaluation and Management Services

When psychotherapy is done during the same session as Evaluation and Management Service (E/M), a psychotherapy code should be used along with the E/M code. The psychiatrist or other qualified health care professional will specify the level of E/M work done and add the psychotherapy component based on the time spent delivering psychotherapy.

- If E/M services are not being provided, use the appropriate psychotherapy code (90832, 90834, 90837)
- Psychotherapy with E/M is reported by selecting the appropriate E/M service code and the appropriate psychotherapy add-on code.
    - When billing an E/M with add-on therapy, you may NOT use time to select the E/M. The E/M **must** be selected based off medical decision making.
    - Time spent providing psychotherapy must be documented separately from the E/M service.
    - The appropriate add-on psychotherapy code should be selected based off time and must be supported by documentation.

2.2 Psychotherapy

The Department of Vermont Health Access (DVHA) covers psychotherapy treatment approaches that are evidence-based. Examples of evidence-based approaches that DVHA recognizes include but are not limited to, Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), Family Therapy, Interpersonal Psychotherapy (IPT) and Eye Movement Desensitization and Reprocessing (EMDR). DVHA supports the use of these approaches when medically necessary and are related to the goals within the treatment plan.

Vermont Medicaid does not cover approaches considered experimental and therefore not evidence based. Current exclusions of approaches include but are not limited to: Pastoral Counseling, Assertiveness Training, Dream Therapy, Equine Therapy, Hypnotherapy, Pet Therapy, Recreational Therapy, Stress Management Training, Adventure Therapy and Bright Light Therapy. These interventions, if used in conjunction with an evidence-based treatment modality are permissible. For example, if the member is engaging with a pet during family therapy and assertiveness training is being utilized, these interventions would be permissible provided family therapy is the primary focus. Documentation should indicate that the primary focus of the session is family therapy. If a provider has any questions about whether or not a treatment modality will be covered by Vermont Medicaid, they should reach out to their Gainwell provider representative.

Psychotherapy may involve the use of tools to support the therapeutic process such as art, music, play, and pets. The use of these tools must be therapeutically indicated and not the primary intervention. It should be clearly documented within a session note how the use of a tool (such as art or music) is clinically appropriate and how it assists members in meeting their therapeutic goals, as outlined in their treatment plan, for Vermont Medicaid to cover the session. If non-covered services are provided during therapy, any time spent cannot be included in the total time

billed to Vermont Medicaid. For example, if 15 minutes of an hour session included Hypnotherapy, only 45 minutes could be billed. Time performing non-covered services should be clearly documented within the clinical documentation.

The information below outlines definitions and requirements related to psychotherapy Current Procedural Terminology (CPT) codes.

- Psychotherapy time includes face-to-face time spent with the member and/or family member and/or legal guardian. However, the member must be present for the majority of the encounter. This does not include Family Psychotherapy without the member present (90846).
- Family Psychotherapy, without the member present, (90846) has a limit of 12 sessions per calendar year. Documentation should include specific participation, contributions, and reactions of each family member
- Group therapy (90853) is limited to no more than 3 sessions per week. Reimbursement is limited to one session per day, per group and no more than 10 members in a group. Each member being seen during the session must have an individual session note.
- Professional claims for Individual Psychotherapy (90832, 90834, 90837, 90839 & 90840) will require Prior Authorization when the annual limitation of 260 sessions per calendar year is exceeded. Only 1 session of individual therapy can be billed per day.
- The limit of 260 sessions per calendar year applies to all Vermont Medicaid members regardless of ACO attribution.
- All psychotherapy must be documented. Reference documentation requirements below.

2.3 Crisis Psychotherapy

Crisis Psychotherapy has 3 components: an urgent assessment and history of a crisis state, a mental status exam, and a disposition. The treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma. The presenting problem is typically life threatening or complex and requires immediate attention to a member in high distress. The related codes are timed codes and additional instructions on the appropriate use of codes should be referenced in the current AMA CPT code manual. Start and stop time **must** be documented for the claim to be paid.

- 90839, Psychotherapy for crisis, first 60 minutes (CPT Rule applies: 30-74 minutes)
- +90840 (add-on), Psychotherapy for crisis each additional 30 minutes

2.4 Interactive Complexity

Interactive complexity refers to specific communication factors that complicate the delivery of a psychiatric procedure. Common factors include more difficult communication with discordant or emotional family members and engagement of young and verbally undeveloped or impaired members. Typical members are those who have third parties, such as parents, guardians, other family members, agencies, court officers, or schools involved in their psychiatric care.

Add-on Code 90785 is used to report interactive complexity services when provided in conjunction with psychotherapy codes. See the most current American Medical Association (AMA) CPT code book for further explanation of when and how this code should be used. The guidelines include a list of requirements or factors to consider when determining appropriate use of the interactive complexity code.

- "Interactive Complexity" extends the use to include other factors that complicate the delivery of a service to a member and may be reported when at least one of the following is present:
    - The need to manage maladaptive communication (related to e.g. high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicates delivery of care.
    - Caregiver emotions or behavior that interferes with the caregiver's understanding and ability to assist in the implementation of the treatment plan.
    - Evidence or disclosure of a sentinel event and mandated report to third party (e.g. abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with member and other visit participants.
    - Use of play equipment or other physical devices to communicate with the member to overcome barriers to therapeutic or diagnostic interaction between the physician or other qualified health care professional and a member who has not developed, or has lost, either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the physician or other qualified health care professional if he/she were to use typical language for communication.
- When performed with psychotherapy, the interactive complexity component (+90785) relates only to the increased work intensity of the psychotherapy service but **does not** change the time for the psychotherapy service.

2.5 Psychiatric Diagnostic Evaluation

A psychiatric diagnostic evaluation with medical services is an integrated biopsychosocial and medical assessment, including history (to include past, family, and social), psychiatric history, a complete mental status exam, other physical examination elements as indicated, establishment of a tentative diagnosis, and an evaluation of the member's ability and willingness to participate in the proposed treatment plan. The evaluation may include communication with family members or other sources, prescription of medications, and review and ordering of laboratory or other diagnostic studies.

- A distinction has been made between diagnostic evaluations without medical services and evaluations with medical services.
- These codes can be used for services provided in any setting.
- These codes may be used more than once a year in instances where the members presentation has significant change or requires re-evaluation. For example, if there has been a gap in care a re-evaluation may be required.
- These codes can be used for reassessments.

- Psychiatrists and other medical providers have the option of using the appropriate E/M code in lieu of the 90792 if documentation supports a medical service was provided.

2.6 Psychological and Neuropsychological Services

Neurobehavioral Status Exam includes clinical assessment of the member, interpretation of results and report writing. The Neurobehavioral Status Exam can only be performed by a Qualified Health Care Professional (QHP) and must be completed prior to the administration of any Neuropsychological Tests.

Neuropsychological or Psychological Testing Evaluation Services includes the evaluation and interpretation of test results, treatment planning, report writing, and interactive feedback. These services can only be performed by a QHP (Physician, Clinical Psychologist, APRN, PA, etc.).

Neuropsychological or Psychological Test Administration & Scoring includes the administration and scoring of two or more tests by any method. These services may be performed by either a QHP or technician by selecting the appropriate time-based code:

- 96136 / 96137 – Must be performed by a QHP.
- 96138 / 96139 – Must be performed by a **qualified technician under the direct supervision of a QHP**. These codes inherently require supervision and fall under their own set of supervision rules. **These codes do not fall under Vermont Medicaid Supervised Billing guidelines and do not require the use of supervised billing modifiers (HO, HN, HM).**
    - Example: if a Licensed Clinical Mental Health Counselor (LCMHC) administered a psychological test, the QHP would bill using the appropriate technician codes as LCMHC are not considered QHP's and require direct supervision. The QHP providing direct supervision would be the attending provider listed on the claim billed to Vermont Medicaid.

It is **not** within the scope of practice of a Masters-Level Psychologist, LCMHC, LCSW, LMFT, etc., to render Neurobehavioral Status Exams or Testing Evaluation Services (even if they are under "supervision"). All services billed to Vermont Medicaid must be within the scope of practice of the individual providing these services.

Section 3 Enrollment

Providers must be enrolled with Vermont Medicaid to participate as a Green Mountain Care healthcare professional and receive reimbursement. To enroll with Vermont Medicaid through the online Provider Management Module and for additional instructions, please visit Provider Enrollment and Revalidation.

Section 4 Provider Types & Modifiers

Vermont Medicaid enrolls the following provider types for Mental Health services. Proper use of the modifiers below is required to assure accurate reimbursement. Failure to use the correct modifier for license type may result in post payment review of your claims

- Vermont Medicaid is continuing to require the use of modifier AJ and AH. Modifier AJ is reimbursed at 76% of allowed amount and modifier AH is reimbursed at 93% of allowed amount
- For clinical services provided by a non-licensed and non-certified provider and billed under Supervised Billing, please reference the Supervised Billing portion document. Designated Agencies, Specialized Service Agencies and Division of Substance Use (DSU) preferred providers are not required to use the modifiers from the table below.

Provider Type	License	Modifier Required
Psychologist – Doctorate Level	Psychologist Doctorate	AH - Clinical Psychologist
Psychologist – Master's Level	Psychologist Master	AJ - Clinical Social Worker
Licensed Mental Health Counselor	LMHC	AJ - Clinical Social Worker
Licensed Clinical Social Worker	LCSW	AJ - Clinical Social Worker
Licensed Marriage & Family Therapist	LMFT	AJ - Clinical Social Worker
Licensed Drug and Alcohol Counselor	LADC	AJ - Clinical Social Worker
Physician – Psychiatric	Physician	No Mental Health Modifier Required
Nurse Practitioner – Psychiatric	Advanced Practice Registered Nurse	No Mental Health Modifier Required
Psychiatrist - MD	Licensed Psychiatrist	No Mental Health Modifier Required

Section 5 Reimbursement

The Fee Schedule contains a complete list of services that are reimbursable by Vermont Medicaid.

The Fee Schedule and other pertinent information including pricing effective dates, whether the codes require a prior authorization, and allowable provider types and specialties can be accessed by visiting Codes/Fee Schedules.

Section 6 Additional Considerations for Billing

Place of Service (POS) codes are 2-digit codes placed on professional health care claims to indicate the setting in which a service was provided. Center for Medicare and Medicaid Services (CMS) maintains the nationwide use of POS codes.

- DVHA follows CMS POS instructions when determining the correct facility/non-facility reimbursement. As an entity covered under HIPAA, DVHA must comply with standards and implementation guides adopted by regulations for electronic claim transactions. All electronic and paper CMS-1500 claim forms are required to include a POS code.
- A POS Code reflects the actual place where the member receives the face-to-face service and determines whether the facility or non-facility rate is paid. The correct POS code ensures that reimbursement for the overhead portion of the payment is not paid incorrectly to the physician when the service is performed in a facility setting.

Further information on POS codes is included in these CMS publications:

- **MLN Matters Articles**
- **Place of Service Code Set**

CPT Time Rule(s): A unit of time is attained when the midpoint is passed. When codes are ranked in sequential typical times and the actual time is between two typical times, the code with the typical time closest to the actual time is used.

Example:

- 90832, 90833 is 16-37 minutes
- 90834, 90836 is 38-52 minutes
- 90837, 90838 is 53 minutes and more

Section 7 Documentation Requirements

Each provider must keep written documentation for all services, to include mental health and substance use, actual case record notes for any services performed, or business records that pertain to members for services provided and payments claimed or received. Providers must document all services provided on the same day of the encounter or within a reasonable time. In this section, “a reasonable time” means within one week of providing the service, unless extenuating circumstances prevent the provider from documenting a service within that time. If extenuating circumstances prevent a provider from documenting a service within one week of providing the service, the provider must also document those extenuating circumstances.

All documentation must be legible, contain complete and adequate information and applicable dates. Providers may use any format for documentation, such as SOAP, BIRP, or DAP notes, as long as minimum documentation standards are met. At a minimum, the documentation in a mental health/substance use health record will include the following core components:

1. Identifying data
    a. Name, unique ID, date of birth, and other demographic information as needed.
2. Dates of service
    a. Documentation by the primary treatment provider of all dates and the amount of time clinical services were provided.
3. Comprehensive clinical assessment (e.g., biopsychosocial, medical history, etc.)
    a. Evidence that a comprehensive clinical assessment has been completed, with documentation of a presenting problem.
    b. Evidence of ongoing reassessment as needed.
4. Treatment and continued care planning
    a. Documentation of treatment plan, including the following:
        i. Prioritization of problems and needs.
        ii. Evidence that goals and objectives are related to the assessment.
        iii. Evidence that goals and objectives are individualized, specific, and measurable, with realistic timeframes for achievement.
        iv. Specific follow-up planning, including but not limited to anticipated response to treatment, additional or alternative treatment interventions, and coordination with other treatment providers (e.g., PCP).
        v. Provider printed name, signature or electronic equivalent and date. Under Supervised Billing, the supervising provider must sign off on the treatment plan and demonstrate continuing involvement in supervising patient care.
5. Progress Notes

a. Documentation supporting continued need for services based on medical necessity, including the following:
    i. Dated progress notes that link to initial treatment plan.
    ii. Updates or modifications to treatment plan.
    iii. Interventions provided and client's response.
    iv. Provider printed name, signature or electronic equivalent and date.
    v. Start and stop time must be documented. The time indicated within the procedure code description is not acceptable.

For additional resources visit Clinical Practice Guidelines.

Section 8 Special Investigations Unit

Vermont Medicaid pays only for services that are actually provided and that are medically necessary. In filing a claim for reimbursement, the code(s) should be chosen that most accurately describes the service that was provided. It is a felony under Vermont law 33VSA Sec. 141(d) knowingly to do, attempt, or aid and abet in any of the following when seeking or receiving reimbursement from Vermont Medicaid:

- Billing for services not rendered or more services than actually performed
- Providing and billing for unnecessary services
- Billing for a higher level of services than actually performed
- Charging higher rates for services to Vermont Medicaid than other providers
- Coding billing records to get more reimbursement
- Misrepresenting an unallowable service on bill as another allowable service
- Falsely diagnosing so Vermont Medicaid will pay more for services

For more information on overpayments and potential interest charges, visit the General Provider Manual, section 6.

Suspected fraud, waste or abuse should be reported to the DVHA Special Investigations Unit, telephone 802.241.9210, or the Vermont Medicaid Fraud Control Unit of the Vermont's Attorney General's Office, telephone 802.828.5511.