



Georgia Department of Behavioral Health & Developmental Disabilities

PROVIDER MANUAL

FOR

COMMUNITY BEHAVIORAL HEALTH PROVIDERS

FOR

THE DEPARTMENT OF BEHAVIORAL HEALTH & DEVELOPMENTAL DISABILITIES

FISCAL YEAR 2015

Effective Date: April 1, 2015

Posted: February 26, 2015

This FY 2015 Provider Manual is designed as an addendum to your contract/agreement with DBHDD to provide you structure for supporting and serving individuals residing in the state of Georgia.

DEPARTMENT OF BEHAVIORAL HEALTH & DEVELOPMENTAL DISABILITIES

FY 2015 COMMUNITY BEHAVIORAL HEALTH PROVIDER MANUAL

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All policies are now posted in DBHDD PolicyStat located at

<http://qadbhdd.policystat.com>

SUMMARY OF CHANGES TABLE

UPDATED FOR APRIL 1, 2015

As a courtesy for Providers, this Summary of Changes is designed to guide the review of new and revised content contained in this updated version of the Provider Manual. The responsibility for thorough review of the Provider Manual content remains with the Provider.

Item#	Topic	Location	Summary of Changes
1	Consumer/Family Assistance	Part I, Section III	This service is being discontinued.
2	Intensive Customized Care Coordination	Part I, Section III	This is a new service published by the DBHDD as a guide to the DCH Georgia Families program. This service is not available to other DBHDD vendors/contractors.
4	Services (WTRS)	Part I, Section III	Old references to Ready for Work (RFW) were replaced with WTRS.
3	Substance Abuse Residential Detoxification	Part I, Section III	ACT is removed as a Service Exclusion.
5	Women's Treatment & Recovery Services (WTRS)	Part I, Section III	Numbering corrected in Clinical Operations section and grammar corrections made.
6	DCH Requirements	Part II, Section I, Item 2.a.i.2.a.	The word "supplementary" is replaced by the word "companion."
7	Corrective Action Plans	Part II, Section I, c. Quality Improvement and Risk Management, page. 206-7.	Adding that Providers are required to implement and complete a corrective action plan (CAP) in response to internal and DBHDD-related quality, compliance, performance management findings (such as, but not limited to, audits, compliance reviews, KPI measurement, QM reviews, etc.). Defines CAP and requires providers to maintain/update CAPs and have available for review.

ALL POLICIES ARE NOW POSTED IN DBHDD **POLICYSTAT LOCATED AT
<http://gadbhdd.policystat.com>**

Details are provided in Policy titled [Access to DBHDD Policies for Community Providers, 04-100](#).

The [DBHDD PolicyStat INDEX](#) helps to identify policies applicable for Community Providers.

The New and Updated policies are listed below. For 90 days after the date of revision, users can see the track changes version of a policy by clicking on [New and Recently Revised Policies](#) at the bottom of PolicyStat Home Page.

Item#	Topic	Location	Summary of Changes
1	Policy 01-117 Transportation Reimbursement for Assertive Community Treatment, Community Support Team and Supported Employment Services	Part III General Policies and Procedures	REVISED: https://gadbhdd.policystat.com/policy/1335667/latest/
2	Policy 01-225 Process for Reporting Compliance with Standards for Tier 1 Comprehensive Community Providers (CCPs)	Part III General Policies and Procedures	REVISED: https://gadbhdd.policystat.com/policy/1231825/latest/ The Attestation Validation (Attachment C) was added to the policy.
3	Policy 16-101 External Entities Audit Standards	Part III General Policies and Procedures	REVISED: https://gadbhdd.policystat.com/policy/1368322/latest/

PART I

Eligibility, Service Definitions and Service Requirements

Provider Manual for
Community Behavioral Health Providers

Fiscal Year 2015



**Georgia Department of Behavioral Health
& Developmental Disabilities**

April 2015

SECTION I

CONSUMER ELIGIBILITY CORE CUSTOMER FOR MENTAL HEALTH AND ADDICTIVE DISEASE SERVICES

A. ACCESS	
CHILD & ADOLESCENT	ADULT
<p>Many adults/youth/families approach the state service delivery system looking for help. Not everyone who seeks assistance is in need of mental health or addictive disease services. In order to efficiently and expeditiously address the needs of those seeking assistance, a quick assessment of the presenting circumstances is warranted. A brief assessment should be initiated by all community-based service providers on all individuals who present for services or who are referred by the Georgia Crisis and Access Line (GCAL) for an evaluation. For the purposes of this definition, a brief assessment refers to a rapid determination of an adult/youth's need for services and whether there are sufficient indications of a mental illness and/or substance related disorder to warrant further evaluation and admission to at least Brief Stabilization services.</p> <ol style="list-style-type: none"> 1. If the adult/youth does not have sufficient indications of a mental illness and/or substance related disorder, or if the individual does not appear to meet Core Customer functional criteria for at least Brief Stabilization services, then an appropriate referral to other services or agencies is provided. 2. If the adult/youth does appear to have a mental illness and/or substance related disorder, and does appear to meet Core Customer functional criteria, then the individual may either begin in Brief Stabilization services or have their status as a Core Customer of Ongoing Support and Recovery services determined as a part of a more comprehensive assessment process (possibly resulting in the individual moving directly into Ongoing Services). <p>For all services, a provider must request a Prior Authorization via a Multipurpose Information Consumer Profile (MICP) form (see MICP User Guide at www.apsero.com).</p>	
B. CORE CUSTOMER CLASSIFICATION AND ELIGIBILITY DETERMINATION	
CHILD & ADOLESCENT	ADULT
<p>There are four variables for consideration to determine whether a youth qualifies as a "core customer" for child and adolescent mental health and addictive disease services.</p> <ol style="list-style-type: none"> 1. Age: A youth must be under the age of 18 years old. Youth aged 18-21 years (children still in high school or when it is otherwise developmentally/clinically indicated) may be served to assist with transitioning to adult services. 2. Diagnostic Evaluation: The state DBHDD system utilizes the Diagnostic and Statistical Manual of Mental Disorders (DSM) classification system to identify, evaluate and classify a youth's type, severity, frequency, duration and recurrence of symptoms. The diagnostic evaluation must yield information that supports an emotional disturbance and/or substance related disorder primary diagnosis (or diagnostic impression) on Axis I in 	<p>There are four variables for consideration to determine whether an individual qualifies as a "Core Customer" for adult mental health and addictive disease services.</p> <ol style="list-style-type: none"> 1. Age: An individual must be over the age of 18 years old. Individuals under age 18 may be served in adult services if they are emancipated minors under Georgia Law, and if adult services are otherwise clinically/developmentally indicated. 2. Diagnostic Evaluation: The state DBHDD system utilizes the Diagnostic and Statistical Manual of Mental Disorders (DSM) classification system to identify, evaluate and classify an individual's type, severity, frequency, duration and recurrence of symptoms. The diagnostic evaluation must yield information that supports a psychiatric disorder and/or substance related disorder primary diagnosis (or diagnostic impression) on Axis I in

accordance with the latest edition of the DSM. The diagnostic evaluation must be documented adequately to support the diagnosis.

3. **Functional/Risk Assessment:** Information gathered to evaluate a child/adolescent's ability to function and cope on a day-to-day basis comprises the functional/risk assessment. This includes youth and family resource utilization and the youth's role performance, social and behavioral skills, cognitive skills, communication skills, personal strengths and adaptive skills, needs and risks as related to an emotional disturbance, substance related disorder or co-occurring disorder. The functional/risk assessment must yield information that supports a behavioral health diagnosis (or diagnostic impression) on Axis I in accordance with the DSM.

4. **Financial Eligibility:** Please see [Payment by Individuals for Community Behavioral Health Services, 01-107](#).

accordance with the latest edition of the DSM. The diagnostic evaluation must be documented adequately to support the diagnostic impression/diagnosis.

3. **Functional/Risk Assessment:** Information gathered to evaluate an individual's ability to function and cope on a day-to-day basis comprises the functional/risk assessment. This includes the individual's resource utilization, role performance, social and behavioral skills, cognitive skills, communication skills, independent living skills, personal strengths and adaptive skills, needs and risks as related to a psychiatric disorder, substance related disorder or co-occurring disorder. The functional/risk assessment must yield information that supports a behavioral health diagnosis (or diagnostic impression) on Axis I in accordance with the DSM.

4. **Financial Eligibility:** Please see [Payment by Individuals for Community Behavioral Health Services, 01-107](#).

C. PRIORITY FOR SERVICES

CHILD & ADOLESCENT

The following youth are priority for services:

1. The first priority group for services is Youth:
 - Who are at risk of out-of home placements; and
 - Who are currently in a psychiatric facility or a community-based crisis residential service including a crisis stabilization unit.
2. The second priority group for services is:
 - Youth with a history of one or more hospital admissions for psychiatric/addictive disease reasons within the past 3 years;
 - Youth with a history of one or more crisis stabilization unit admissions within the past 3 years;
 - Youth with a history of enrollment on an Intensive Family Intervention team within the past 3 years;
 - Youth with court orders to receive services;
 - Youth under the correctional community supervision with mental illness or substance use disorder or dependence;
 - Youth released from secure custody (county/city jails, state YDCs/RVDCs, diversion programs, forensic inpatient units) with mental illness or substance use disorder or dependence;
 - Pregnant youth;
 - Youth who are homeless; or,
 - IV drug Users.

The timeliness for providing these services is set within the agency's

ADULT

The following individuals are the priority for ongoing support services:

1. The first priority group for services is individuals currently in a state operated psychiatric facility (including forensic individuals), state funded/paid inpatient services, a crisis stabilization unit or crisis residential program.
2. The second priority group for services is:¹
 - Individuals with a history of one or more hospital admissions for psychiatric/addictive disease reasons within the past 3 years;
 - Individuals with a history of one or more crisis stabilization unit admissions within the past 3 years;
 - Individuals with a history of enrollment on an Assertive Community Treatment team within the past 3 years;
 - Individuals with court orders to receive services (especially related to restoring competency);
 - Individuals under the correctional community supervision with mental illness or substance use disorder or dependence;
 - Individuals released from secure custody (county/city jails, state prisons, diversion programs, forensic inpatient units) with mental illness or substance use disorder or dependence;
 - Individuals aging out of out of home placements or who are transitioning from intensive C&A services, for whom adult services are clinically and developmentally appropriate.
 - Pregnant women;
 - Individuals who are homeless; or,

contract/agreement with the DBHDD.	<input type="checkbox"/> IV drug Users. The timeliness for providing these services is set within the agency's contract/agreement with the DBHDD. ¹ Specific to AD Women's Services, Providers shall give preference to admission to services as follows: 1) Pregnant injecting drug users; 2) Pregnant substance abusers; 3) Injecting drug users; and then 4) All others.
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D. BRIEF STABILIZATION- MENTAL HEALTH AND ADDICTIVE DISEASES

CHILD & ADOLESCENT	ADULT
<p>The length of Early Intervention and Stabilization services is 90 days or less. Early Intervention and Stabilization services are subject to the service and unit allowances in the Brief Registration package delineated herein:</p> <p>Early Intervention and Stabilization services must take place within a ninety (90) day timeframe. Youth must be registered/authorized for Early Intervention and Stabilization services (complete Registration-type MICP) prior to service provision (excluding any initial screening by the Agency). Providers have 48 hours from initial contact to submit the MICP Registration. While those registered in Early Intervention and Stabilization services, will not need the more comprehensive prior authorization for services (Ongoing MICP), a service plan must still be completed to guide the provision of services in accordance with the Department's standards, requirements, and the provider's accrediting entity, and the plan must be maintained in the youth's record.</p> <p>For any youth registered with a MICP Registration, a Diagnostic Impression is allowed for 30 days after the initial engagement with the youth. The initial engagement is defined as the Start Date on the MICP Registration. After 30 days, the youth must have a verified diagnosis in order to continue to meet the diagnostic criteria and continue services.</p> <p>Early Intervention: Indicates interventions taking place after a problem (e.g. an emotional disturbance and/or substance related disorder) is already suspected or identified, but that occur early enough to potentially avoid escalation of the problem into a crisis situation or into a chronic/significantly disabling disorder. In order for an youth to qualify for Child and Adolescent Mental Health and Addictive Diseases Early Intervention services, certain diagnostic and functional criteria must be met, including the following:</p>	<p>The length of Brief Stabilization services is 90 days or less. Brief Stabilization services are subject to the service and unit allowances in the Brief Registration package delineated herein:</p> <p>Brief Stabilization services must take place within a ninety (90) day timeframe. Individuals must be registered/authorized for Brief Stabilization services (complete Registration-type MICP) prior to service provision (excluding any initial screening by the Agency). Providers have 48 hours from initial contact to submit the MICP Registration. While those registered in Brief Stabilization services, will not need the more comprehensive prior authorization for services (Ongoing MICP), a service plan must still be completed to guide the provision of services in accordance with the Department's standards, requirements, and the provider's accrediting entity, and the plan must be maintained in the individual's record.</p> <p>For any individual registered with a MICP Registration, a Diagnostic Impression is allowed for 30 days after the initial engagement with the individual. The initial engagement is defined as the Start Date on the MICP Registration. After 30 days, the individual must have a verified diagnosis in order to continue to meet the diagnostic criteria and continue services.</p> <p>Brief Stabilization indicates interventions taking place after a problem has been identified (e.g. a psychiatric disturbance/disorder and/or substance related disorder), which has either already developed into a crisis situation or has become disabling enough to warrant at least short-term, low intensity outpatient stabilization interventions. In order for an individual to qualify for Adult Mental Health and Addictive Diseases Brief Stabilization services, certain diagnostic and functional criteria must be met, including the following:</p>

1. **Diagnostic-** The child or adolescent must have a primary diagnosis or diagnostic impression on Axis I, consisting of an emotional disturbance and/or substance related disorder.
2. **Functional-** The child/adolescent's level of functioning must meet **at least one** of the following criteria:
 - a. is affected by an emotional disturbance or substance related disorder;
 - b. has shown early indications of behaviors that could be disruptive to the community and the family/support system if behaviors intensified,
 - c. has shown early indications behaviors/functional problems that could cause risk of removal from the home if problems intensified;
 - d. has shown early indications of poor school performance (poor grades, disruptive behavior, lack of motivation, suspension);
 - e. has shown early indications of delinquent behaviors that could result in legal system involvement; and/or
 - f. has shown early indications of behavioral/functional problems that could result in multiple agency involvement if problems intensified.

Stabilization: Indicates interventions taking place after a problem has been identified (e.g. an emotional disturbance and/or substance related disorder) and has either developed into a crisis situation or become disabling enough to warrant at least short-term stabilization interventions. In order for a youth to qualify for **Child and Adolescent MENTAL HEALTH AND ADDICTIVE DISEASES STABILIZATION services**, certain diagnostic and functional criteria must be met, including the following:

1. **Diagnostic-** The child or adolescent must have a primary diagnosis or diagnostic impression (allowable for 30 days only) on Axis I, consisting of an emotional disturbance and/or substance related disorder.
2. **Functional -** The child/adolescent's level of functioning must meet **at least one** of the following criteria:
 - a. is significantly affected by a serious emotional disturbance or substance related disorder;
 - b. results in behaviors that demonstrate a risk of harm to self, others, or property;
 - c. causes a risk of removal from the home;
 - d. results in school problems such as poor grades, school failure, disruptive behavior, lack of motivation, drop out, suspension or expulsion;
 - e. results in legal system involvement;
 - f. indicates the need for withdrawal management services; and/or

1. **Diagnostic-** The person must have a verified Axis I diagnosis or diagnostic impression of a mental illness and/or a substance related disorder.
2. **Functional-** Item **"a"** AND at least item **"b"** OR **"c"** must be present:
 - a. The person's level of functioning must be significantly affected by the presenting mental health and/or addictive disease issue; and one or more of the following:
 - b. The person displays behaviors that are significantly disruptive to the community, to the individual's family/support system, or to the individual's ability to maintain his or her current employment/schooling, housing or personal health/safety; **and/or**
 - c. The person displays behaviors that demonstrate a potential risk of harm to self or others.

g. is significantly disruptive to the community or the family/support system.	
E. MENTAL HEALTH ONGOING SUPPORT /TREATMENT/RECOVERY	
CHILD & ADOLESCENT	ADULT
<p>Ongoing Support and Treatment: Indicates interventions taking place after an emotional disturbance of a severe and longer-term nature has been identified and has become disabling enough to warrant ongoing service provision to help support the child and family in order to improve the child's level of functioning and resilience. The length of Ongoing Support and Treatment services is anticipated to be longer than 90 days (though how much longer varies by medical necessity, need/s, resiliency, and biopsychosocial factors affecting functioning). A youth may either start out in Ongoing Support and Treatment services or be transitioned into this category at any point during or following Early Intervention and Stabilization services due to changes in clinical presentation, needs, circumstances or stressors. For a youth/family to qualify for Child and Adolescent MENTAL HEALTH ONGOING SUPPORT AND TREATMENT services, certain diagnostic and functional criteria must be met, including the following:</p> <ol style="list-style-type: none"> 1. Diagnostic- The child/adolescent must have a verified primary diagnosis of a serious emotional disturbance on Axis I, (<i>for example:</i> major depression, an anxiety disorder, or other serious emotional disturbance). The disturbance must have persisted for at least one year or be likely to persist for at least one year without treatment, and must require ongoing, longer-term support and treatment services. Without such services, out of home placement or hospitalization is probable. 2. Functional- The child/adolescent's ability to function has been significantly affected by the serious emotional disturbance to the extent that there is impairment in ability to function at an age appropriate level and difficulty with age appropriate role performance. Functional impairment must be demonstrated by one of the following three indicators: <ol style="list-style-type: none"> a. A total score of 60 or higher on the 8 subscales of the CAFAS, --OR-- b. Either a score of 20 or higher (<i>moderate to severe impairment</i>) on the "Behavior Toward Others", the "Self-Harmful Behavior" or the "Thinking" CAFAS subscale, or a score of 30 (<i>severe impairment</i>) on the "Moods/Emotions" CAFAS subscale, --OR-- 	<p>An individual may either begin in Ongoing Support and Recovery services or be transitioned from Brief services into Ongoing Support and Recovery services either during or following the 90 day Brief services allowable time period due to changes in clinical presentation, needs, circumstances/stressors, clinician's evolving understanding of the individual's clinical issues etc. An agency must complete and submit a MICP "New Episode" or "Ongoing" for approval for individuals for whom Ongoing Support and Recovery services are desired.</p> <p>Ongoing Support and Recovery: Indicates interventions taking place after a psychiatric disorder of a severe and longer-term nature has been identified and has become disabling enough to warrant ongoing service provision to help support the individual in order to improve his or her level of functioning and recovery. The length of Ongoing Support and Recovery services varies based on individual service needs and biopsychosocial factors affecting functioning in accordance with service utilization guidelines. An individual may either start out in the Ongoing services category or be transitioned to this category at any point during or following Brief Stabilization services due to changes in clinical presentation, needs, circumstances or stressors etc. In order for an individual to qualify for Adult Mental Health Ongoing Support and Recovery Services, certain diagnostic and functional criteria must be met, including the following:</p> <ol style="list-style-type: none"> 1. Diagnostic- The individual must have a verified Axis I diagnosis of a severe and persistent mental illness such as schizophrenia, major depression, bipolar disorder or other severely disabling mental disorder that requires ongoing and long-term support, treatment and recovery services. The prognosis indicates a long-term, severe disability. Without supports, hospitalization or other institutionalization (e.g. incarceration) is probable. 2. Functional- The individual's ability to function has been significantly affected by the mental disorder to the degree that there is impairment in activities of daily living with an inability to function independently in the community. This difficulty with activities of daily living and difficulty in functioning independently must be demonstrated EITHER by both "a" and "b" below, OR by "c" alone. <ol style="list-style-type: none"> a. The individual's score on the Level Of Care Utilization System (LOCUS)

<p>c. The child or adolescent has been in services for an extended period of time (six months or longer) with a qualifying Axis I diagnosis, but does not currently meet the functional criteria. Without the supports/services provided, the child/adolescent would <i>likely</i> be unable to maintain his or her current level of functioning to the extent that functioning would revert back to meeting the functional criteria.</p>	<p>indicates that the individual would be appropriate for a Level 1 level of care.</p> <p style="text-align: center;">--AND--</p> <p>b. The individual has been in services for an extended period of time (six months or longer) with a qualifying Axis I diagnosis, and functioning does not currently meet the criteria for a LOCUS Level 2 or higher level of care. Without the supports/services provided, the individual would likely be unable to maintain his or her current level of recovery to the extent that his or her functioning would revert back to meeting the criteria for a LOCUS Level 2 or higher level of care.</p> <p style="text-align: center;">--OR--</p> <p>c. The individual's LOCUS score indicates that the individual would be appropriate for a Level 2 or above level of care.</p>
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F. ADDICTIVE DISEASES ONGOING SUPPORT AND RECOVERY

CHILD & ADOLESCENT	ADULT
<p>Ongoing Support and Recovery: Indicates interventions taking place after a substance-related disorder has been identified and has become disabling enough to warrant ongoing service provision to assist in stabilizing/supporting the child and family, and to facilitate the child's recovery. The length of service is anticipated to be longer than 90 days (though how much longer varies by medical necessity, need/s, resiliency, and biopsychosocial factors affecting functioning/recovery). An youth may either start out in Ongoing Support and Recovery services or be transitioned into this category at any point during or following Early Intervention and Stabilization services due to changes in clinical presentation, needs, circumstances or stressors. For a person to qualify for Child and Adolescent ADDICTIVE DISEASES ONGOING SUPPORT AND RECOVERY services, certain diagnostic and functional criteria must be met, including the following:</p> <ol style="list-style-type: none"> 1. Diagnostic- The child/adolescent must have a primary diagnosis on Axis I of a substance related disorder (excluding substance intoxication). Substances can refer to a drug of abuse, a medication or a toxin (Caffeine and nicotine are excluded). <i>This must be a verified diagnosis, not just a diagnostic impression.</i> 2. Functional- The child/adolescent's ability to function has been significantly affected by the substance related disorder to the extent that there is impairment in ability to function at an age appropriate level and difficulty with age appropriate role performance. This functional difficulty must be demonstrated by <i>one of the following indicators</i>: 	<p>An individual may either begin in Ongoing Support and Recovery services or be transitioned from Brief services into Ongoing services either during or following the 90 day Brief services allowable time period due to changes in clinical presentation, needs, circumstances/stressors, clinician's evolving understanding of the individual's clinical issues etc. An agency must complete and submit a MICP "New Episode" or "Ongoing" form for approval for individuals for whom Ongoing Support and Recovery services are desired.</p> <p>Ongoing Support and Recovery: Indicates interventions taking place after a substance-related disorder has been identified, and has become disabling enough to warrant ongoing service provision to help support the individual to improve his or her level of functioning and recovery. The length of Ongoing Support and Recovery services varies considering support and recovery needs and by other bio-psycho-social factors affecting functioning against criteria set forth in service utilization guidelines. In order for a person to qualify for Adult ADDICTIVE DISEASE ONGOING SUPPORT AND RECOVERY services, certain diagnostic and functional criteria must be met, including the following:</p> <ol style="list-style-type: none"> 1. Diagnostic- The person has a verified Axis I diagnosis (note: not just a diagnostic impression) of a substance related disorder (excluding substance intoxication). Substances can refer to a drug of abuse, a medication or a toxin. 2. Functional - The individual's level of functioning has been significantly affected by the substance related disorder to the degree that there is a

<p>a. A score of 20 or higher (moderate to severe impairment) on the 'Substance Abuse' subscale of the CAFAS. --OR--</p> <p>b. The child or adolescent has been in services for an extended period of time (six months or longer) with a qualifying Axis I diagnosis, but does not currently meet the functional criteria. Without the supports/services provided, the child/adolescent would <i>likely</i> be unable to maintain his or her current level of functioning to the extent that functioning would revert back to meeting the functional criteria.</p>	<p>marked decrease in health and in ability to function. This decrease in health or in functioning must be demonstrated EITHER by <i>both "a" and "b"</i> below, OR by "c" alone.</p> <p>a. The individual's LOCUS score indicates that the individual would be appropriate for a Level 1 level of care. --AND--</p> <p>b. The individual has been in services for an extended period of time (six months or longer) with a qualifying Axis I diagnosis, and functioning does not currently meet the criteria for a LOCUS Level 2 or higher level of care. Without the supports/services provided, the individual would likely be unable to maintain his or her current level of recovery to the extent that his or her functioning would revert back to meeting the criteria for a LOCUS Level 2 or higher level of care. --OR--</p> <p>c. The individual's LOCUS score indicates that the individual would be appropriate for a Level 2 or above level of care.</p>
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G. APPROVED DIAGNOSTIC CATEGORIES

CHILD & ADOLESCENT	ADULT
<p>1. Child and Adolescent Mental Health:</p> <p>a. Axis I disorders classified in the most recent version of the DSM.</p> <p>b. By definition, an Adjustment Disorder must resolve within 6 months of the termination of the stressor <i>or</i> its consequences.</p> <p>c. Exclusions: The following disorders are excluded unless co-occurring with a qualifying primary Axis I emotional disturbance or substance related disorder that is the focus of treatment:</p> <ol style="list-style-type: none"> 1. Tic disorders; 2. Mental Retardation; 3. Learning Disorders; 4. Motor Skills Disorders; 5. Communication Disorders; 6. Organic Mental Disorders; 7. Pervasive Developmental Disorders; and, 8. V Codes <p>2. Child and Adolescent Addictive Diseases:</p> <p>a. Substance Related Disorders including but not limited to substance abuse, substance dependence, and substance withdrawal as classified in the most recent version of the DSM.</p> <p>b. The severity and duration of substance related disorders are not considered in regard to the Core Customer criteria (except as they are</p>	<p>1. Adult Mental Health:</p> <ol style="list-style-type: none"> a. Schizophrenia and Other Psychotic Disorders b. Mood Disorders c. Anxiety Disorders d. Adjustment Disorders (By definition, an Adjustment Disorder must resolve within 6 months of the termination of the stressor or its consequences) e. Mental Disorders Due to a General Medical Condition Not Elsewhere Classified f. Exclusions: The following disorders are excluded unless co-occurring with a qualifying primary Axis I mental or substance related disorder that is the focus of treatment: <ol style="list-style-type: none"> 1. Tic disorders; 2. Mental Retardation; 3. Learning Disorders; 4. Motor Skills Disorders; 5. Communication Disorders; 6. Organic Mental Disorders; 7. Pervasive Developmental Disorders 8. Personality Change Due to a General Medical Condition 9. Mental Disorder NOS Due to a General Medical Condition 10. V Codes

<p>inherent to the definition of a disorder).</p> <p>c. Exclusions: The following disorders are excluded:</p> <ol style="list-style-type: none"> 1. Caffeine-Induced Disorders; 2. Nicotine-Related Disorders; and, 3. Substance Intoxication- only excluded for Ongoing Services. 	<p>2. Adult Addictive Diseases</p> <ol style="list-style-type: none"> a. Substance-Related Disorders including but not limited to substance abuse, substance dependence, and substance withdrawal. b. Severity and duration of substance related disorders are not considered in regard to the Core Customer criteria (except as they are inherent to definition of disorder). c. Exclusions: <ol style="list-style-type: none"> 1. Caffeine-Induced Disorders 2. Nicotine-Related Disorders 3. Substance Intoxication- only excluded for Ongoing Services.
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***NOTE:** The presence of co-occurring mental illnesses/emotional disturbances, substance related disorders and/or developmental disabilities is not uncommon and typically results in a more complicated clinical presentation. Individuals diagnosed with the excluded Axis I mental disorders listed above and/or with Axis II disorders may receive services **ONLY** when these disorders co-occur with a qualifying primary Axis I mental illness or substance related disorder. The qualifying Axis I mental illness or substance related disorder must be the presenting problem and the primary diagnosis/focus of treatment, and the individual must meet the functional criteria listed above.*

H. CONTINUED REVIEW OF ELIGIBILITY

CHILD & ADOLESCENT	ADULT
Eligibility will be reviewed as individuals' MICP reauthorizations become due.	

SECTION II

ORIENTATION TO SERVICE AUTHORIZATION OPTIONS

Overview of Service Packages

In order to make it easier for providers to request groups of services that are frequently provided concurrently, there are service packages which can be requested to support an individual. These packages work in a manner similar to the Brief Registration package. When a request for a package is approved, the response includes authorization for all of the services in the package without the need for the provider to individually select each of the component services. In addition, when compared to services selected individually from the À la carte menu, packages may have different authorization periods and may authorize different quantities of units within the package to reflect the particular needs of the target group of individuals (in which case the specific “package” parameters supersede those limits established in the **Service Guidelines**). In order to utilize a package, it is not necessary that the individual receive all of the services and/or units in the package (unless otherwise noted in a specific guideline for that service).

Orders and Treatment Plans

Orders for services and treatment plans must still indicate which specific services from the package are being requested for an individual. The treatment plan must reference the individual services and the frequency with which they will be provided. The order and treatment plan must conform to requirements set forth in this manual.

Adding Additional Services to Packages

If additional services are needed once a package is authorized, providers may add services by using an MICP Update request type. Providers should be aware that, if the number of days remaining on the package is greater than the length of the authorization period for the additional a’ la carte service selected, the end date of the package’s authorization period will be rolled back to reflect the shorter authorization period of the additional service. For example, if there are 200 days remaining on a Medication Maintenance package and Individual Counseling (180-day authorization period) is added, the end of the Medication Maintenance package will be rolled back to 180 days from the date Individual Counseling is added. If there had been 150 days remaining on the Medication Maintenance package at the time Individual Counseling was added, the length of authorization for both the Medication Maintenance package and the added Individual Counseling service would remain at 150 days. The only exception to this is the Crisis Stabilization Program service, which has an authorization period of 20 days and which will continue to “float” over any other services authorized and will not cause the authorization periods for other services to be rolled back.

The available packages are detailed below:

A. Brief Registration	Package Code	Service Groups Included	Service Group Name	Auth Period in Days	Max Auth Units	Max Daily Units
The Brief Registration Package is designed to provide a comprehensive package of services that can be provided to new individuals for up to 90 days. It may be requested only through submission of a MICP Registration. This package includes the services determined to be essential to completing the initial		When accessing the Registration Package for an Adult:				
	P0001	10101	Beh Health Assmt & Serv Plan Devel.	90	32	24
		10102	Psychological Testing	90	5	5
		10103	Diagnostic Assessment	90	2	2
		10104	Interactive Complexity	90	24	4

<p>assessments and individualized resiliency/recovery plan, crisis intervention services, and a brief period of therapy and skills training services. Services, maximum daily unit limits, and maximum units currently available during the 90-day authorization period are to the right. This package may only be requested for new individuals. It cannot be requested for existing individuals, cannot follow any existing MICP authorization, and must either be followed by a MICP Discharge or a MICP Ongoing request.</p>		10110	Crisis Intervention	90	20	16	
		10120	Psychiatric Treatment	90	12	2	
		10130	Nursing Assessment & Care	90	12	12	
		10140	Medication Administration	90	6	1	
		10151	Psychosocial Rehabilitation-Individual	90	52	32	
		21302	Case Management	90	68	24	
		10152	Addictive Disease Support Services	90	100	48	
		10160	Individual Outpatient Services	90	8	1	
		10170	Group Outpatient Services	90	480	16	
		10180	Family Outpatient Services	90	32	16	
		21203	Legal Skills/Competency Restoration	90	200	8	
		When accessing the Registration Package for an Youth:					
		10101	Beh Health Assmt & Serv Plan Devel.	90	32	24	
		10102	Psychological Testing	90	5	5	
		10103	Diagnostic Assessment	90	2	2	
		10104	Interactive Complexity	90	24	4	
		10110	Crisis Intervention	90	20	16	
		10120	Psychiatric Treatment	90	12	2	
		10130	Nursing Assessment & Care	90	12	12	
		10140	Medication Administration	90	6	1	
		10150	Community Support- Individual	90	100	48	
		10160	Individual Outpatient Services	90	8	1	
		10170	Group Outpatient Services	90	480	16	
		10180	Family Outpatient Services	90	32	16	
	21203	Legal Skills/Competency Restoration	90	200	8		
B. Medication Maintenance	Package Code	Service Groups Included	Service Group Name	Auth Period in Days	Max Auth Units	Max Daily Units	
<p>This package is designed for the provider to request the units of service necessary to support an individual whose mental health or substance abuse problems are essentially stable and whose needs include ongoing medication management and relatively fewer supports. The authorization period for this package is 365 days and it may be requested by submission of a <i>MICP New Episode</i> or <i>MICP Ongoing</i> request with the Medication Maintenance package selected. Services, maximum daily unit</p>	P0002	When accessing the Registration Package for Youths:					
		10101	Beh Health Assmt & Serv Plan Development	365	6	6	
		10103	Diagnostic Assessment	365	2	2	
		10120	Psychiatric Treatment	365	12	2	
		10130	Nursing Assessment & Care	365	8	8	
		10140	Medication Administration	365	30	1	
		10151	Psychosocial Rehabilitation-Individual	365	12	12	

limits, and maximum units currently available during the 365-day authorization period are listed to the right.		21302	Case Management	365	36	24
		10152	Addictive Disease Support Services	365	12	12
		10104	Interactive Complexity	365	8	4
	When accessing the Registration Package for an Youth:					
		10101	Beh Health Assmt & Serv Plan Devel.	365	6	6
		10103	Diagnostic Assessment	365	2	2
		10120	Psychiatric Treatment	365	12	2
		10130	Nursing Assessment & Care	365	8	8
		10140	Medication Administration	365	30	1
		10104	Interactive Complexity	365	8	4
		10150	Community Support Individual	365	48	12
C. Crisis Stabilization Package	Package Code	Service Groups Included	Service Group Name	Auth Period in Days	Max Auth Units	Max Daily Units
<p>This package is designed for use by providers that operate Crisis Stabilization Units of 16 beds or less off the grounds of a state hospital and bill Medicaid. Programs of greater than 16 beds or those on the grounds of a state hospital may not bill claims to Medicaid and should submit a MICP request for the individual Crisis Stabilization Unit service and submit encounters as instructed in the CSU service definition.</p> <p>Providers that are eligible to bill Medicaid for services provided in a CSU may bill for the unbundled services listed in the package, up to the daily maximum for each service, and should also submit encounters for the CSU service as instructed in the service definition. Providers of C&A CSU services may not bill unbundled service encounters through the C&A fee-for-service system for services provided within any Crisis Stabilization Unit due to the fact that this is a state-contracted service. Only CSU service encounters may be submitted for non-Medicaid eligible children in CSUs. Services, maximum daily unit limits, and maximum units currently available during the 20-day authorization period are listed to the right.</p>	P0003	20101	Crisis Stabilization Program	20	20	1
		20102	Community-Based Inpatient Psychiatric/Detox	20	20	1
		20103	Crisis Service Center	20	7	1
		20104	Crisis Respite Services	20	20	1
		20105	Temporary Observation	20	7	1
		10101	Beh Health Assmt & Serv Plan Devel.	20	32	24
		10103	Diagnostic Assessment	20	2	2
		10110	Crisis Intervention	20	32	8
		10120	Psychiatric Treatment	20	40	2
		10130	Nursing Assessment & Care	20	80	5
		10140	Medication Administration	20	20	1
		10151	Psychosocial Rehabilitation-Individual	20	32	8
		10152	Addictive Disease Support Services	20	24	16
		10170	Group Outpatient Services	20	80	4
10104	Interactive Complexity	20	22	4		
D. MH Intensive Outpatient (C&A)	Package Code	Service Groups Included	Service Group Name	Auth Period in Days	Max Auth Units	Max Daily Units

<p>This Intensive Outpatient package was designed to support agencies that provide services at an intensity that would be consistent with a C&A Mental Health day treatment model. Since the DBHDD was required by CMS to discontinue reimbursement for bundled day treatment services, providers have had to bill for the individual services provided within their programs.</p> <p>Services, maximum daily unit limits, and maximum units currently available during the 180-day authorization period are listed to the right.</p>	P0004	10101	Beh Health Assmt & Serv Plan Devel.	180	32	24
		10102	Psychological Testing	180	10	5
		10103	Diagnostic Assessment	180	4	2
		10110	Crisis Intervention	180	24	16
		10120	Psychiatric Treatment	180	48	2
		10130	Nursing Assessment & Care	180	24	16
		10140	Medication Administration	180	40	1
		10150	Community Support	180	104	48
		10160	Individual Outpatient Services	180	26	1
		10170	Group Outpatient Services	180	1170	16
		10180	Family Outpatient Services	180	78	16
		10104	Interactive Complexity	180	48	4
E. MH Intensive Outpatient (Adult)	Package Code	Service Groups Included	Service Group Name	Auth Period in Days	Max Auth Units	Max Daily Units
<p>The Intensive Outpatient package was designed to support agencies that provide services at an intensity that would be consistent with a day treatment model. Since the DBHDD was required by CMS to discontinue reimbursement for bundled day treatment services, providers have had to bill for the individual services provided within their programs.</p> <p>Services, maximum daily unit limits, and maximum units currently available during the 180-day authorization period are listed to the right.</p>	P0005	10101	Beh Health Assmt & Serv Plan Devel.	180	32	24
		10102	Psychological Testing	180	10	5
		10103	Diagnostic Assessment	180	4	2
		10110	Crisis Intervention	180	24	16
		10120	Psychiatric Treatment	180	48	2
		10130	Nursing Assessment & Care	180	24	16
		10140	Medication Administration	180	40	1
		10151	Psychosocial Rehabilitation-Individual	180	104	32
		21302	Case Management	180	104	24
		10160	Individual Outpatient Services	180	26	1
		10170	Group Outpatient Services	180	1170	16
		10180	Family Outpatient Services	180	100	8
10104	Interactive Complexity	180	48	4		
F. SA Intensive Outpatient (Adolescent)	Package Code	Service Groups Included	Service Group Name	Auth Period in Days	Max Auth Units	Max Daily Units
<p>This Intensive Outpatient package was designed to support agencies that provide services at an intensity that would be consistent with a SA Adolescent day treatment model. Since the DBHDD was required by CMS to discontinue reimbursement for bundled day treatment services, providers have had to bill for the individual services provided within their programs.</p>	P0006	10101	Beh Health Assmt & Serv Plan Devel.	180	32	24
		10103	Diagnostic Assessment	180	4	2
		10120	Psychiatric Treatment	180	12	2
		10130	Nursing Assessment & Care	180	48	16
		10150	Community Support	180	200	48
		10160	Individual Outpatient Services	180	36	1

Services, maximum daily unit limits, and maximum units currently available during the 180-day authorization period are listed to the right.		10170	Group Outpatient Services	180	1170	20	
		10180	Family Outpatient Services	180	100	16	
		10104	Interactive Complexity	180	48	4	
G. SA Intensive Outpatient (Adult)	Package Code	Service Groups Included	Service Group Name	Auth Period in Days	Max Auth Units	Max Daily Units	
<p>The SA Intensive Outpatient package is designed to support agencies that provide services at an intensity that would be consistent with a day treatment model. Since the DBHDD was required by CMS to discontinue reimbursement for bundled day treatment services, providers have had to bill for the individual services provided within their programs.</p> <p>Services, maximum daily unit limits, and maximum units currently available during the 180-day authorization period are listed to the right.</p>	P0007	10101	Beh Health Assmt & Serv Plan Devel.	180	32	24	
		10103	Diagnostic Assessment	180	4	2	
		10120	Psychiatric Treatment	180	12	2	
		10130	Nursing Assessment & Care	180	48	16	
		10152	Addictive Disease Support Services	180	200	48	
		10160	Individual Outpatient Services	180	36	1	
		10170	Group Outpatient Services	180	1170	20	
		10180	Family Outpatient Services	180	100	8	
		10104	Interactive Complexity	180	48	4	
H. Women's Treatment and Recovery Supports (WTRS)	Package Code	Service Groups Included	Service Group Name	Auth Period in Days	Max Auth Units	Max Daily Units	
<p>The WTRS packages are designed to allow agencies to select a group of services specified in their contracts to support a very specific population (See Part I, Section V). The package format allows the DBHDD to track and monitor services for this specific set of services in an unbundled environment. (NOTE: Package coding will remain labeled RFW until a later date.)</p>	RFW Intensive Outpatient	P0008	10101	Beh Health Assmt & Serv Plan Devel.	180	32	24
			10103	Diagnostic Assessment	180	4	2
			10120	Psychiatric Treatment	180	12	2
			10130	Nursing Assessment & Care	180	48	16
			10152	Addictive Disease Support Services	180	200	48
			10160	Individual Outpatient Services	180	36	1
			10170	Group Outpatient Services	180	1170	20
			10180	Family Outpatient Services	180	100	8
			10104	Interactive Complexity	180	48	4
	RFW Intensive Residential	P0009	20510	Structured Residential- RFW/TANF ¹	180	180	1
			10101	Beh Health Assmt & Serv Plan Devel	180	32	24
			10103	Diagnostic Assessment	180	4	2
			10120	Psychiatric Treatment	180	24	2
			10130	Nursing Assessment & Care	180	48	16
			10140	Medication Administration	180	40	1
		10104	Interactive Complexity	180	48	4	
I. Mobile Crisis	Package Code	Service Groups	Service Group Name	Auth Period	Max Auth	Max Daily	

		Included		in Days	Units	Units
Package is intended for short-term (2 day) Mobile Crisis contact/MICP forms. This service package is only utilized by those providers under contract with the DBHDD to deliver mobile crisis services.	P0010	10110	Crisis Intervention	2	48	24
J. Psychosocial Rehabilitation	Package Code	Service Groups Included	Service Group Name	Auth Period in Days	Max Auth Units	Max Daily Units
Package is intended to promote administrative ease for provider who may provide Psychosocial Rehabilitation through both of these described modalities.	P0016	10151	Psychosocial Rehabilitation- Individual	180	104	48
		20903	Psychosocial Rehabilitation- Group	180	300	20

¹ These services cannot be billed to Medicaid and should be billed as State Contracted Services or Fee for Service

Overview of Modifiers:

Certain services in the Service Guidelines contain specific modifiers. The following is a list of the modifiers included herein and their specific description:

GT =Via Interactive audio/video telecommunication systems	HS =Family/Couple without client present	U3 = Practitioner Level 3	U7 = Out-of-Clinic*
HA =Child/Adolescent Program	HT =Multidisciplinary team	U4 = Practitioner Level 4	UK = Collateral Contact
HQ =Group Setting	U1 =Practitioner Level 1	U5 = Practitioner Level 5	TG=Complex Level of Care
HR =Family/Couple with client present	U2 =Practitioner Level 2	U6 = In-Clinic	

The following modifiers are State created and used on state services only:

H9 = Court-ordered	TB = Transitional Bed (State Code)	ZJ = From Jail / YDC / RYDC (State Code)
R1 = Residential Level 1 (State Code)	U2 = CSU High Intensity (State Code)	ZO = From Other Institutional Setting (State Code)
R2 = Residential Level 2 (State Code)	ZC = From CSU (State Code)	ZP = From PRTF (State Code)
R3 = Residential Level 3 (State Code)	ZH = From State Hospital (State Code)	

* If a service is provided out-of-clinic and has an established U7 modifier, then that U7 modifier is utilized on the associated claim/encounter submission. "Out-of-Clinic" may only be billed when: 1) Travel by the practitioner is to a non-contiguous location; and/or 2) Travel by the practitioner is to a facility not owned, leased, controlled or named as a service site by the agency who is billing the service(excepting visits to Shelter Plus sites); and/or 3) Travel is to a facility owned, leased or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; and/or 4) Travel is to a facility owned, leased, controlled or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day. If the service does not qualify to be billed as "out of clinic," then the "in-clinic" rate may still be billed.

SECTION III

SERVICE DEFINITIONS

C&A Core Services

Behavioral Health Assessment														
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
MH Assessment by a non-Physician	Practitioner Level 2, In-Clinic	H0031	U2	U6			\$38.97	Practitioner Level 2, Out-of-Clinic	H0031	U2	U7			\$46.76
	Practitioner Level 3, In-Clinic	H0031	U3	U6			\$30.01	Practitioner Level 3, Out-of-Clinic	H0031	U3	U7			\$36.68
	Practitioner Level 4, In-Clinic	H0031	U4	U6			\$20.30	Practitioner Level 4, Out-of-Clinic	H0031	U4	U7			\$24.36
	Practitioner Level 5, In-Clinic	H0031	U5	U6			\$15.13	Practitioner Level 5, Out-of-Clinic	H0031	U5	U7			\$18.15
Unit Value	15 minutes							Maximum Daily Units	24 units (Combined with H0032)					
Initial Authorization	32 units (Combined with H0032)							Re-Authorization	32 units (Combined with H0032)					
Authorization Period	180 days							Utilization Criteria	CAFAS scores: 10-240					
Service Definition	<p>The Behavioral Health Assessment process consists of a face-to-face comprehensive clinical assessment with the individual, which must include the youth's perspective as a full partner and should include family/responsible caregiver(s) and others significant in the youth's life as well as collateral agencies/treatment providers.</p> <p>The purpose of the Behavioral Health Assessment process is to gather all information needed in to determine the youth's problems, symptoms, strengths, needs, abilities, resources and preferences, to develop a social (extent of natural supports and community integration) and medical history, to determine functional level and degree of ability versus disability, if necessary, to assess trauma history and status, and to engage with collateral contacts for other assessment information. An age-sensitive suicide risk assessment shall also be completed. The information gathered should support the determination of a differential diagnosis and assist in screening for/ruling-out potential co-occurring disorders.</p> <p>As indicated, information from medical, nursing, school, nutritional, etc. staff should serve as the basis for the comprehensive assessment and the resulting IRP.</p>													
Admission Criteria	<ol style="list-style-type: none"> 1. A known or suspected mental illness or substance-related disorder; and 2. Initial screening/intake information indicates a need for further assessment. 													
Continuing Stay Criteria	The youth's situation/functioning has changed in such a way that previous assessments are outdated.													
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Individual has withdrawn or been discharged from service; or 3. Individual no longer demonstrates need for additional assessment. 													
Required Components	<ol style="list-style-type: none"> 1. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed clinical social worker, licensed psychologist, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol. 2. As indicated, medical, nursing, peer, school, nutritional, etc. staff can provide information from records, and various multi-disciplinary resources to complete the comprehensive nature of the assessment and time spent gathering this information may be billed as long as the detailed documentation justifies the time and need for capturing said information. 3. An initial Behavioral Health Assessment is required within the first 30 days of service with ongoing assessments completed as demanded by changes with an individual. 													

Community Support														
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod4	Rate
Community Support	Practitioner Level 4, In-Clinic	H2015	U4	U6			\$20.30	Practitioner Level 4, In-Clinic, Collateral Contact	H2015	UK	U4	U6		\$20.30
	Practitioner Level 5, In-Clinic	H2015	U5	U6			\$15.13	Practitioner Level 5, In-Clinic, Collateral Contact	H2015	UK	U5	U6		\$15.13
	Practitioner Level 4, Out-of-Clinic	H2015	U4	U7			\$24.36	Practitioner Level 4, Out-of-Clinic, Collateral Contact	H2015	UK	U4	U7		\$24.36
	Practitioner Level 5, Out-of-Clinic	H2015	U5	U7			\$18.15	Practitioner Level 5, Out-of-Clinic, Collateral Contact	H2015	UK	U5	U7		\$18.15
Unit Value	15 minutes							Maximum Daily Units	48 units					
Initial Authorization	80 units							Re-Authorization	80 units					
Authorization Period	180 days							Utilization Criteria	<u>CAFAS scores: 10-240</u>					
Service Definition	<p>Community Support services consist of rehabilitative, environmental support and resources coordination considered essential to assist a youth/family in gaining access to necessary services and in creating environments that promote resiliency and support the emotional and functional growth and development of the youth. The service activities of Community Support include:</p> <ul style="list-style-type: none"> • Assistance to the youth and family/responsible caregivers in the facilitation and coordination of the Individual Resiliency Plan (IRP) including providing skills support in the youth/family's self-articulation of personal goals and objectives; • Planning in a proactive manner to assist the youth/family in managing or preventing crisis situations; • Individualized interventions, which shall have as objectives: <ol style="list-style-type: none"> 1) Identification, with the youth, of strengths which may aid him/her in achieving resilience, as well as barriers that impede the development of skills necessary for age-appropriate functioning in school, with peers, and with family; 2) Support to facilitate enhanced natural and age-appropriate supports (including support/assistance with defining what wellness means to the youth in order to assist them with resiliency-based goal setting and attainment); 3) Assistance in the development of interpersonal, community coping and functional skills (including adaptation to home, school and healthy social environments); 4) Encouraging the development and eventual succession of natural supports in living, learning, working, other social environments; 5) Assistance in the acquisition of skills for the youth to self-recognize emotional triggers and to self-manage behaviors related to the youth's identified emotional disturbance; 6) Assistance with personal development, school performance, work performance, and functioning in social and family environment through teaching skills/strategies to ameliorate the effect of behavioral health symptoms; 7) Assistance in enhancing social and coping skills that ameliorate life stresses resulting from the youth's emotional disturbance; 8) Service and resource coordination to assist the youth and family in gaining access to necessary rehabilitative, medical, social and other services and supports; 9) Assistance to youth and other supporting natural resources with illness understanding and self-management; 10) Any necessary monitoring and follow-up to determine if the services accessed have adequately met the youth's needs; 11) Identification, with the youth/family, of risk indicators related to substance related disorder relapse, and strategies to prevent relapse. 													

Community Support

	<p>This service is provided to youth in order to promote stability and build towards age-appropriate functioning in their daily environment. Stability is measured by a decreased number of hospitalizations, by decreased frequency and duration of crisis episodes and by increased and/or stable participation in school and community activities. Supports based on the youth's needs are used to promote resiliency while understanding the effects of the emotional disturbance and/or substance use/abuse and to promote functioning at an age-appropriate level. The Community Support staff will serve as the primary coordinator of behavioral health services and will provide linkage to community; general entitlements; and psychiatric, substance use/abuse, medical services, crisis prevention and intervention services.</p>
Admission Criteria	<ol style="list-style-type: none"> 1. Individual must meet target population criteria as indicated above; and one or more of the following: 2. Individual may need assistance with developing, maintaining, or enhancing social supports or other community coping skills; or 3. Individual may need assistance with daily living skills including coordination to gain access to necessary rehabilitative and medical services
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual continues to meet admission criteria; and 2. Individual demonstrates documented progress or maintenance of community skills relative to goals identified in the Individualized Resiliency Plan.
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Goals of Individualized Resiliency Plan have been substantially met; or 3. Individual/family requests discharge and the individual is not imminently in danger of harm to self or others; or 4. Transfer to another service is warranted by change in the individual's condition.
Service Exclusions	<ol style="list-style-type: none"> 1. Intensive Family Intervention may be provided concurrently during transition between these services for support and continuity of care for a maximum of four units of CSI per month. If services are provided concurrently, CSI should not be duplication of IFI services. This service must be adequately justified in the Individualized Resiliency Plan. 2. Assistance to the youth and family/responsible caregivers in the facilitation and coordination of the Individual Resiliency Plan (IRP) including providing skills support in the youth/family's self-articulation of personal goals and objectives can be billed as CSI; however, the actual plan development must be billed and provided in accordance with the service guideline for Service Plan Development. 3. The billable activities of Community Support do not include: <ul style="list-style-type: none"> • Transportation • Observation/Monitoring • Tutoring/Homework Completion • Diversionary Activities (i.e. activities/time for which a therapeutic intervention tied to a goal on the individual's treatment plan is not occurring)
Clinical Exclusions	<ol style="list-style-type: none"> 1. There is a significant lack of community coping skills such that a more intensive service is needed. 2. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a co-occurring Behavioral Health condition: Developmental Disability, Autism, Organic Mental Disorder, Traumatic Brain Injury
Required Components	<ol style="list-style-type: none"> 1. Community Support services must include a variety of interventions in order to assist the individual in developing: <ul style="list-style-type: none"> • Symptom self-monitoring and self-management of symptoms • Strategies and supportive interventions for avoiding out-of-home placement for youth and building stronger family support skills and knowledge of the youth or youth's strengths and limitations • Relapse prevention strategies and plans 2. Community Support services focus on building and maintaining a therapeutic relationship with the youth and facilitating treatment and resiliency goals. 3. Contact must be made with youth receiving Community Support services a minimum of twice each month. At least one of these contacts must be face-to-face and the second may be either face-to-face or telephone contact (denoted by the UK modifier) depending on the youth's support needs and documented preferences of the family. 4. At least 50% of CSI service units must be delivered face-to-face with the identified youth receiving the service and at least 80% of all face-to-face service units must be delivered in non-clinic settings over the authorization period (these units are specific to single individual records and are not aggregate across an agency/program or multiple payers). 5. In the absence of the required monthly face-to-face contact and if at least two unsuccessful attempts to make face-to-face contact have been tried and

Community Support

	<p>documented, the provider may bill for a maximum of two telephone contacts in that specified month (denoted by the UK modifier).</p> <ol style="list-style-type: none"> 6. Unsuccessful attempts to make contact with the individual are not billable. 7. When the primary focus of Community Support services for youth is medication maintenance, the following allowances apply: <ol style="list-style-type: none"> a. These youth are not counted in the offsite service requirement or the individual-to-staff ratio; and b. These youth are not counted in the monthly face-to-face contact requirement; however, face-to-face contact is required every 3 months and monthly calls are an allowed billable service.
Staffing Requirements	<ol style="list-style-type: none"> 1. Community Support practitioners may have the recommended individual-to-staff ratio of 30 individuals per staff member and must maintain a maximum ratio of 50 individuals per staff member. Youth who receive only medication maintenance are not counted in the staff ratio calculation.
Clinical Operations	<ol style="list-style-type: none"> 1. Community Support services provided to youth must include coordination with family and significant others and with other systems of care (such as the school system, etc.) juvenile justice system, and child welfare and child protective services when appropriate to treatment and educational needs. This coordination with other child-serving entities is an essential component of Community Support and can be billed for up to 70 percent of the contacts when directly related to the support and enhancement of the youth's resilience. When this type of intervention is delivered, it shall be designated with a UK modifier. 2. The organization must have a Community Support Organizational Plan that addresses the following: <ol style="list-style-type: none"> a. Description of the particular rehabilitation, resiliency and natural support development models utilized, types of intervention practiced, and typical daily schedule for staff b. Description of the staffing pattern and how staff are deployed to assure that the required staff-to-individual ratios are maintained, including how unplanned staff absences, illnesses, or emergencies are accommodated, how case mix is managed, access, etc. c. Description of the hours of operations as related to access and availability to the youth served; and d. Description of how the plan for services is modified or adjusted to meet the needs specified in every Individualized Resiliency Plan. 3. Utilization (frequency and intensity) of CSI should be directly related to the CAFAS and to the other functional elements of the youth's assessment. In addition, when clinical/functional needs are great, there should be complementary therapeutic services by licensed/credential professionals paired with the provision of CSI (individual, group, family, etc.).
Service Accessibility	<ol style="list-style-type: none"> 1. Specific to the "Medication Maintenance Track," individuals who require more than 4 contacts per quarter for two consecutive quarters (as based upon clinical need) are expected to be re-evaluated with the CAFAS for enhanced access to CSI and/or other services. The designation of the CSI "medication maintenance track" should be lifted and exceptions stated above in A.10. are no longer applied.
Reporting and Billing Requirements	<p>When a billable collateral contact is provided, the H2015UK reporting mechanism shall be utilized. A collateral contact is classified as any contact that is not face-to-face with the individual.</p>

Community Transition Planning

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Community Transition Planning	Community Transition Planning (State Hospital)	T2038	ZH				\$20.92	Community Transition Planning (Jail / Youth Detention Center)	T2038	ZJ				\$20.92
	Community Transition Planning (Crisis Stabilization Unit)	T2038	ZC				\$20.92	Community Transition Planning(Other)	T2038	ZO				\$20.92
	Community Transition Planning (PRTF)	T2038	ZP				\$20.92							
Unit Value	15 minutes													

Community Transition Planning

Initial Authorization	50 units	Re-Authorization	50 units
Authorization Period	90 days (Registration) 180 days (New Episode)	Utilization Criteria	Available to those currently in qualifying facilities who meet Core Customer Eligibility Definition
Service Definition	<p>Community Transition Planning (CTP) is a service provided by Core and IFI providers to address the care, service, and support needs of youth to ensure a coordinated plan of transition from a qualifying facility to the community. Each episode of CTP must include contact with the individual, family, or caregiver with a minimum of one (1) face-to-face contact with the individual prior to release from a facility. Additional Transition Planning activities include: educating the individual, family, and/or caregiver on service options offered by the chosen primary service agency; participating in facility treatment team meetings to develop a transition plan.</p> <p>In partnership between other community service providers and the hospital/f facility staff, the community service agency maintains responsibility for carrying out transitional activities either by the individual's chosen primary service coordinator or by the service coordinator's designated Community Transition Liaison. CTP may also be used for Community Support staff, ACT team members and Certified Peer Specialists who work with the individual in the community or will work with the individual in the future to maintain or establish contact with the individual.</p> <p>CTP consists of the following interventions to ensure the youth, family, and/or caregiver transitions successfully from the facility to their local community:</p> <ul style="list-style-type: none"> • Establishing a connection or reconnection with the youth/parent/caregiver through supportive contacts while in the qualifying facility. By engaging with the youth, this helps to develop and strengthen a relationship • Educating the youth/parent/caregiver about local community resources and service options available to meet their needs upon transition into the community. This allows the youth/parent/caregiver to make self-directed, informed choices on service options to best meet their needs; • Participating in qualifying facility team meetings especially in person centered planning for those in an out-of-home treatment facility for longer than 60 days, to share hospital and community information related to estimated length of stay, present problems related to admission, discharge/release criteria, progress toward treatment goals, personal strengths, available supports and assets, medical condition, medication issues, and community treatment needs; • Linking the youth with community services including visits between the youth and the Community Support staff, or IFI team members who will be working with the youth/parent/caregiver in the community to improve the likelihood of the youth accepting services and working toward change 		
Admission Criteria	<p>Individual who meet Core Customer Eligibility while in one of the following qualifying facilities:</p> <ol style="list-style-type: none"> 1. State Operated Hospital 2. Crisis Stabilization Unit (CSU) 3. Psychiatric Residential Treatment Facility (PRTF) 4. Jail/Youth Development Center (YDC) 5. Other (ex: Community Psychiatric Hospital) 		
Continuing Stay Criteria	Same as above.		
Discharge Criteria	<ol style="list-style-type: none"> 1. Individual/family requests discharge; or 2. Individual no longer meets Core Customer Eligibility; or 3. Individual is discharged from a qualifying facility. 		
Clinical Exclusions	Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a co-occurring Behavioral Health condition: Developmental Disability, Autism, Organic Mental Disorder, Traumatic Brain Injury		
Required Components	<p><u>Prior to Release from a Qualifying Facility:</u> When the youth has had (a) a length of stay of 60 days or longer in a facility or (b) youth is readmitted to a facility within 30 days of discharge, a community transition plan in partnership with the facility is required. Evidence of planning shall be recorded and a copy of the Plan shall be included in both the youth's hospital and community record.</p>		
Clinical	<ol style="list-style-type: none"> 1. If you are an IFI provider, you may provide this service to those youth who are working towards transition into the community (as defined in the CTP guideline) 		

Community Transition Planning

Operations	and are expected to receive services from the IFI team. Please refer to the Core Guidelines for the detail. 2. Community Transition Planning activities shall include: a) Telephone and Face-to-face contacts with youth/family/caregiver; b) Participating in youth's clinical staffing(s) prior to their discharge from the facility; c) Applications for youth resources and services prior to discharge from the facility including i. Healthcare ii. Entitlements for which they are eligible iii. Education iv. Consumer Support Services v. Applicable waivers, i.e., PRTF, and/or MRDD
Service Accessibility	1. This service must be available 7 days a week (if the qualifying facility discharges or releases 7 days a week). 2. This service may be delivered via telemedicine technology or via telephone conferencing.
Reporting & Billing Requirements	1. The modifier on Procedure Code indicates setting from which the individual is transitioning. 2. There must be a minimum of one face-to-face with the youth prior to release from hospital or qualifying facility in order to bill for any telephone contacts.
Documentation Requirements	1. A documented Community Transition Plan for: a. Individuals with a length of stay greater than 60 days; or b. Individuals readmitted within 30 days of discharge. 2. Documentation of all face-to-face and telephone contacts and a description of progress with Community Transition Plan implementation and outcomes.

Crisis Intervention

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Crisis Intervention	Practitioner Level 1, In-Clinic	H2011	U1	U6			\$58.21	Practitioner Level 1, Out-of-Clinic	H2011	U1	U7			\$74.09
	Practitioner Level 2, In-Clinic	H2011	U2	U6			\$38.97	Practitioner Level 2, Out-of-Clinic	H2011	U2	U7			\$46.76
	Practitioner Level 3, In-Clinic	H2011	U3	U6			\$30.01	Practitioner Level 3, Out-of-Clinic	H2011	U3	U7			\$36.68
	Practitioner Level 4, In-Clinic	H2011	U4	U6			\$20.30	Practitioner Level 4, Out-of-Clinic	H2011	U4	U7			\$24.36
	Practitioner Level 5, In-Clinic	H2011	U5	U6			\$ 15.13	Practitioner Level 5, Out-of-Clinic	H2011	U5	U7			\$ 18.15
Psychotherapy for Crisis	Practitioner Level 1, In-Clinic, first 60 minutes (base code)	90839	U1	U6			\$232.84	Practitioner Level 1, Out-of-Clinic	90840	U1	U6			\$116.42
	Practitioner Level 2, In-Clinic, first 60 minutes (base code)	90839	U2	U6			\$155.88	Practitioner Level 2, Out-of-Clinic, add-on each additional 30 mins.	90840	U2	U6			\$77.94
	Practitioner Level 3, In-Clinic, first 60 minutes (base code)	90839	U3	U6			\$120.04	Practitioner Level 3, Out-of-Clinic, add-on each additional 30 mins.	90840	U3	U6			\$60.02
	Practitioner Level 1, In-Clinic, first 60 minutes (base code)	90839	U1	U7			\$296.36	Practitioner Level 1, Out-of-Clinic, add-on each additional 30 mins.	90840	U1	U7			\$148.18
	Practitioner Level 2, In-Clinic, first 60 minutes (base code)	90839	U2	U7			\$187.04	Practitioner Level 2, Out-of-Clinic, add-on each additional 30 mins.	90840	U2	U7			\$93.52
	Practitioner Level 3, In-Clinic, first 60 minutes (base code)	90839	U3	U7			\$146.72	Practitioner Level 3, Out-of-Clinic, add-on each additional 30 mins.	90840	U3	U7			\$73.36

Unit Value	Crisis Intervention	15 minutes	Maximum Daily Units*	Crisis Intervention	16 units
	Psychotherapy for Crisis	1 encounter		Psychotherapy for Crisis, base code	2 encounters
				Psychotherapy for Crisis, add-ons	4 encounters
Initial Authorization*	48 units		Re-Authorization*	48 units	
Authorization Period*	180 days		Utilization Criteria	CAFAS scores:10-240	
Service Definition	<p>Services directed toward the support of a child who is experiencing an abrupt and substantial change in behavior which is usually associated with a precipitating situation and which is in the direction of severe impairment of functioning or a marked increase in personal distress. Crisis Intervention is designed to prevent out of home placement or hospitalization. Often, a crisis exists at such time as a child and/or his or her family/responsible caregiver(s) decide to seek help and/or the individual, family/responsible caregiver(s), or practitioner identifies the situation as a crisis. Crisis services are time-limited and present-focused in order to address the immediate crisis and develop appropriate links to alternate services. Services may involve the youth and his/her family/responsible caregiver(s) and/or significant other, as well as other service providers.</p> <p>The current family-owned safety plan, if existing, should be utilized to help manage the crisis. Interventions provided should honor and be respectful of the child and family's wishes/choices by following the plan as closely as possible in line with appropriate clinical judgment. Plans/advanced directives developed during the Assessment/IRP process should be reviewed and updated (or developed if the individual is a new individual) as part of this service to help prevent or manage future crisis situations.</p> <p>Some examples of interventions that may be used to de-escalate a crisis situation could include: a situational assessment; active listening and empathic responses to help relieve emotional distress; effective verbal and behavioral responses to warning signs of crisis related behavior; assistance to, and involvement/participation of the individual (to the extent he or she is capable) in active problem solving planning and interventions; facilitation of access to a myriad of crisis stabilization and other services deemed necessary to effectively manage the crisis; mobilization of natural support systems; and other crisis interventions as appropriate to the individual and issues to be addressed.</p>				
Admission Criteria	<ol style="list-style-type: none"> 1. Treatment at a lower intensity has been attempted or given serious consideration; and #2 and/or #3 are met: 2. Youth has a known or suspected mental health diagnosis or substance related disorder; or 3. Youth is at risk of harm to self, others and/or property. Risk may range from mild to imminent; and one or both of the following: <ol style="list-style-type: none"> a. Youth has insufficient or severely limited resources or skills necessary to cope with the immediate crisis; or b. Youth demonstrates lack of judgment and/or impulse control and/or cognitive/perceptual abilities. 				
Continuing Stay Criteria	This service may be utilized at various points in the youth's course of treatment and recovery, however, each intervention is intended to be a discrete time-limited service that stabilizes the individual and moves him/her to the appropriate level of care.				
Discharge Criteria	<ol style="list-style-type: none"> 1. Youth no longer meets continued stay guidelines; and 2. Crisis situation is resolved and an adequate continuing care plan has been established. 				
Clinical Exclusions	Severity of clinical issues precludes provision of services at this level of care.				
Clinical Operations	In any review of clinical appropriateness of this service, the mix of services offered to the individual is important. The use of crisis units will be looked at by the External Review Organization in combination with other supporting services. For example, if an individual presents in crisis and the crisis is alleviated within an hour but ongoing support continues, it is expected that 4 units of crisis will be billed and then some supporting service such as individual counseling will be utilized to support the individual during that interval of service.				

Staffing Requirements	<ol style="list-style-type: none"> 90839 and 90840 are only utilized when the content of the service delivered is Crisis Psychotherapy. Therefore, the only practitioners who can do this are those who are recognized as practitioners for Individual Counseling in the Service X Practitioner Table A. included herein. The practitioner who will bill 90839 (and 90840 if time is necessary) must devote full attention to the individual served and cannot provide services to other individuals during the time identified in the medical record and in the related claim/encounter/submission.
Service Accessibility	<ol style="list-style-type: none"> All crisis service response times for this service must be within 2 hours of the individual or other constituent contact to the provider agency. Services are available 24-hours/ day, 7 days per week, and may be offered by telephone and/or face-to-face in most settings (e.g. home, school, community, clinic etc.).
Additional Medicaid Requirements	The daily maximum within a CSU for Crisis Intervention is 8 units/day.
Reporting and Billing Requirements	<ol style="list-style-type: none"> Any use of a telephonic intervention must be coded/reported with a U6 modifier as the person providing the telephonic intervention is not expending the additional agency resources in order to be in the community where the person is located during the crisis. Any use beyond 16 units will not be denied but will trigger an immediate retrospective review. Psychotherapy for Crisis (90839, 90840) may be billed if the following criteria are met: <ul style="list-style-type: none"> The nature of the crisis intervention is urgent assessment and history of a crisis situation, assessment of mental status, and disposition and is paired with psychotherapy, mobilization of resources to defuse the crisis and restore safety and the provision of psychotherapeutic interventions to minimize trauma, AND the practitioner meets the definition to provide therapy in the Georgia Practice Acts, AND the presenting situation is life-threatening and requires immediate attention to an individual who is experiencing high distress. Other payers may limit who can provide 90839 and 90840 and therefore a providing agency must adhere to those third party payers' policies regarding billing practitioners. The 90839 code is utilized when the time of service ranges between 45-74 minutes and may only be utilized once in a single day. Anything less than 45 minutes can be provided either through an Individual Counseling code or through the H2011 code above (whichever best reflects the content of the intervention). Add-on Time Specificity: <ul style="list-style-type: none"> If additional time above the base 74 minutes is provided and the additional time spent is greater than 23 minutes, an additional encounter of 90840 may be billed. If the additional time spent (above base code) is 45 minutes or greater, a second unit of 90840 may be billed. If the additional time spent (above base code) is 83 minutes or greater, a third unit of 90840 may be billed. If the additional time spent (above base code) is 113 minutes or greater, a fourth unit of 90840 may be billed. 90839 and 90840 cannot be submitted by the same practitioner in the same day as H2011 above. 90839 and 90840 cannot be provided/submitted for billing in the same day as 90791, 90792, 90833, or 90836.

Diagnostic Assessment

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Psychiatric Diagnostic Evaluation (no medical service)	Practitioner Level 2, In-Clinic	90791	U2	U6			\$116.90	Practitioner Level 3, In-Clinic	90791	U3	U6			\$90.03
	Practitioner Level 2, Out-of-Clinic	90791	U2	U7			\$140.28	Practitioner Level 3, Out-of-Clinic	90791	U3	U7			\$110.04
	Practitioner Level 2, Via interactive audio and video telecommunication systems	90791	GT	U2			\$116.90	Practitioner Level 3, Via interactive audio and video telecommunication systems*	90791	GT	U3			\$90.03
Psychiatric	Practitioner Level 1, In-Clinic	90792	U1	U6			\$174.63	Practitioner Level 2, Via interactive	90792	GT	U2			\$116.90

Diagnostic Evaluation with medical services)							audio and video telecommunication systems						
	Practitioner Level 1, Out-of-Clinic	90792	U1	U7		\$222.26	Practitioner Level 2, In-Clinic	90792	U2	U6			\$116.90
	Practitioner Level 1, Via interactive audio and video telecommunication systems	90792	GT	U1		\$174.63	Practitioner Level 2, Out-of-Clinic	90792	U2	U7			\$140.28
Unit Value	1 encounter						Maximum Daily Units*	1 unit per procedure code					
Initial Authorization*	2 units						Re-Authorization*	2 units					
Authorization Period*	180 days						Utilization Criteria	CAFAS scores:10-240					
Service Definition	Psychiatric diagnostic interview examination includes a history; mental status exam; evaluation and assessment of physiological phenomena (including co-morbidity between behavioral and physical health care issues); psychiatric diagnostic evaluation (including assessing for co-occurring disorders and the development of a differential diagnosis); screening and/or assessment of any withdrawal symptoms for youth with substance related diagnoses; assessment of the appropriateness of initiating or continuing services; and a disposition. These are completed by face-to-face evaluation of the youth (which may include the use of telemedicine) and may include communication with family and other sources and the ordering and medical interpretation of laboratory or other medical diagnostic studies.												
Admission Criteria	1. Youth has a known or suspected mental illness or a substance-related disorder and has recently entered the service system; or 2. Youth is in need of annual assessment and re-authorization of service array; or 3. Youth has need of an assessment due to a change in clinical/functional status.												
Continuing Stay Criteria	Youth's situation/functioning has changed in such a way that previous assessments are outdated.												
Discharge Criteria	1. An adequate continuing care plan has been established; and one or more of the following: 2. Individual has withdrawn or been discharged from service; or 3. Individual no longer demonstrates need for continued diagnostic assessment.												
Required Components	Telemedicine may be utilized for an initial Psychiatric Diagnostic Examination as well as for ongoing Psychiatric Diagnostic Examination via the use of appropriate procedure codes with the GT modifier.												
Staffing Requirements	The only U3 practitioner who can provide Diagnostic Assessment is an LCSW.												
Billing and Reporting Requirements	1. 90791 is used when an initial evaluation is provided by a non-physician 2. 90792 is used when an initial evaluation is provided by a physician, PA, or APRN. This 90792 intervention content would include all general behavioral health assessment as well as Medical assessment/Physical exam beyond mental status as appropriate. 3. If a Medicaid claim for this service denies for a Procedure-to-Procedure edit, a modifier (59) can be added to the claim and resubmitted to the MMIS for payment.												
Additional Medicaid Requirements	The daily maximum within a CSU for Diagnostic Assessment (Psychiatric Diagnostic Interview) for a youth is 2 units. Two units should be utilized only if it is necessary in a complex diagnostic case for the physician extender (PA or APRN) to call in the physician for an assessment to corroborate or verify the correct diagnosis.												

Family Outpatient Services: Family Counseling

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Family – BH counseling/	Practitioner Level 2, In-Clinic	H0004	HS	U2	U6		\$38.97	Practitioner Level 2, Out-of-Clinic	H0004	HS	U2	U7		\$46.76
	Practitioner Level 3, In-Clinic	H0004	HS	U3	U6		\$30.01	Practitioner Level 3, Out-of-Clinic	H0004	HS	U3	U7		\$36.68

Family Outpatient Services: Family Counseling

therapy (w/o client present)	Practitioner Level 4, In-Clinic	H0004	HS	U4	U6	\$20.30	Practitioner Level 4, Out-of-Clinic	H0004	HS	U4	U7	\$24.36
	Practitioner Level 5, In-Clinic	H0004	HS	U5	U6	\$15.13	Practitioner Level 5, Out-of-Clinic	H0004	HS	U5	U7	\$18.15
Family – BH counseling/therapy (with client present)	Practitioner Level 2, In-Clinic	H0004	HR	U2	U6	\$38.97	Practitioner Level 2, Out-of-Clinic	H0004	HR	U2	U7	\$46.76
	Practitioner Level 3, In-Clinic	H0004	HR	U3	U6	\$30.01	Practitioner Level 3, Out-of-Clinic	H0004	HR	U3	U7	\$36.68
	Practitioner Level 4, In-Clinic	H0004	HR	U4	U6	\$20.30	Practitioner Level 4, Out-of-Clinic	H0004	HR	U4	U7	\$24.36
	Practitioner Level 5, In-Clinic	H0004	HR	U5	U6	\$15.13	Practitioner Level 5, Out-of-Clinic	H0004	HR	U5	U7	\$18.15
Family Psychotherapy w/o the patient present (appropriate license required)	Practitioner Level 2, In-Clinic	90846	U2	U6		\$38.97	Practitioner Level 2, Out-of-Clinic	90846	U2	U7		\$46.76
	Practitioner Level 3, In-Clinic	90846	U3	U6		\$30.01	Practitioner Level 3, Out-of-Clinic	90846	U3	U7		\$36.68
	Practitioner Level 4, In-Clinic	90846	U4	U6		\$20.30	Practitioner Level 4, Out-of-Clinic	90846	U4	U7		\$24.36
	Practitioner Level 5, In-Clinic	90846	U5	U6		\$15.13	Practitioner Level 5, Out-of-Clinic	90846	U5	U7		\$18.15
Conjoint Family Psychotherapy w/ the patient present a portion or the entire session (appropriate license required)	Practitioner Level 2, In-Clinic	90847	U2	U6		\$38.97	Practitioner Level 2, Out-of-Clinic	90847	U2	U7		\$46.76
	Practitioner Level 3, In-Clinic	90847	U3	U6		\$30.01	Practitioner Level 3, Out-of-Clinic	90847	U3	U7		\$36.68
	Practitioner Level 4, In-Clinic	90847	U4	U6		\$20.30	Practitioner Level 4, Out-of-Clinic	90847	U4	U7		\$24.36
	Practitioner Level 5, In-Clinic	90847	U5	U6		\$15.13	Practitioner Level 5, Out-of-Clinic	90847	U5	U7		\$18.15
Unit Value	15 minutes						Maximum Daily Units*			16 units (Family Training and Family Counseling combined)		
Initial Authorization*	If a MICP Registration is submitted - 32 units (combined with Family Training) If a MICP New Episode is submitted - 60 units (combined with Family Training)						Reauthorization*			60 units (Family Training and Family Counseling combined)		
Authorization Period*	180 days						Utilization Criteria			CAFAS scores: 10-240		
Service Definition	<p>A therapeutic intervention or counseling service shown to be successful with identified family populations, diagnoses and service needs. Services are directed toward achievement of specific goals defined by the individual youth and by the parent(s)/responsible caregiver(s) and specified in the Individualized Resiliency Plan. The focus of family counseling is the family or subsystems within the family, e.g. the parental couple. The service is always provided for the benefit of the individual and may or may not include the individual's participation as indicated by the CPT code.</p> <p>Family counseling provides systematic interactions between the identified individual, staff and the individual's family members directed toward the restoration, development, enhancement or maintenance of functioning of the identified individual/family unit. This may include specific clinical interventions/activities to enhance family roles; relationships, communication and functioning that promote the resiliency of the individual/family unit. Specific goals/issues to be addressed though these services may include the restoration, development, enhancement or maintenance of:</p> <ol style="list-style-type: none"> 1) cognitive processing skills; 2) healthy coping mechanisms; 3) adaptive behaviors and skills; 4) interpersonal skills; 5) family roles and relationships; 6) the family's understanding of the person's mental illness and substance-related disorders and methods of intervention, interaction and mutual support the family can use to assist their family member therapeutic goals. 											

Family Outpatient Services: Family Counseling

	Best practices such as Multi-systemic Family Therapy, Multidimensional Family Therapy, Behavioral Family Therapy, Functional Family Therapy or others appropriate for the family and issues to be addressed should be utilized in the provision of this service.
Admission Criteria	<ol style="list-style-type: none"> 1. Individual must have an emotional disturbance and/or substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); and 2. Individual's level of functioning does not preclude the provision of services in an outpatient milieu; and 3. Individual's assessment indicates needs that may be supported by a therapeutic intervention shown to be successful with identified family populations and individual's diagnoses.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual continues to meet Admission Criteria as articulated above; and 2. Progress notes document progress relative to goals identified in the Individualized Resiliency Plan, but all treatment/support goals have not yet been achieved.
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Resiliency Plan have been substantially met; or 3. Individual/family requests discharge and individual is not in imminent danger of harm to self or others; or 4. Transfer to another service is warranted by change in individual's condition; or 5. Individual requires more intensive services.
Service Exclusions	Intensive Family Intervention
Clinical Exclusions	<ol style="list-style-type: none"> 1. This service is not intended to supplant other services such as MR/DD Personal and Family Support or any day services where the individual may more appropriately receive these services with staff in various community settings. 2. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a qualifying psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, and traumatic brain injury.
Required Components	<ol style="list-style-type: none"> 1. The treatment orientation, modality, and goals must be specified and agreed upon by the youth/family/caregiver. 2. The Individualized Resiliency Plan for the individual includes goals and objectives specific to the family for whom the service is being provided.
Clinical Operations	Models of best practice delivery may include (as clinically appropriate) Multidimensional Family Therapy, Behavioral Family Therapy, Functional Family Therapy, and others as appropriate the family and issues to be addressed.
Service Accessibility	Services may not exceed 16 Billable units (combined Family Counseling and Family Therapy) in a single day. If clinical need indicates this level of intensity, other services may need to be considered for authorization.
Documentation Requirements	<ol style="list-style-type: none"> 1. If there are multiple family members in the Family Counseling session who are enrolled individuals for whom the focus of treatment is related to goals on their treatment plans, we recommend the following: <ol style="list-style-type: none"> a. Document the family session in the charts of each individual for whom the treatment is related to a specific goal on the individual's IRP b. Charge the Family Counseling session units to one of the served individuals. c. Indicate "NC" (No Charge) on the documentation for the other individual(s) in the family session and have the note reflect that the charges for the session are assigned to another family member in the session.
Billing and Reporting Requirements	If a Medicaid claim for this service denies for a Procedure-to-Procedure edit, a modifier (59) can be added to the claim and resubmitted to the MMIS for payment.

Family Outpatient Services: Family Training

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Family Skills Training and Development	Practitioner Level 4, In-Clinic, w/o client present	H2014	HS	U4	U6		\$20.30	Practitioner Level 4, In-Clinic, w/ client present	H2014	HR	U4	U6		\$20.30
	Practitioner Level 5, In-Clinic, w/o client present	H2014	HS	U5	U6		\$15.13	Practitioner Level 5, In-Clinic, w/ client present	H2014	HR	U5	U6		\$15.13
	Practitioner Level 4, Out-of-Clinic, w/o client present	H2014	HS	U4	U7		\$24.36	Practitioner Level 4, Out-of-Clinic, w/ client present	H2014	HR	U4	U7		\$24.36
	Practitioner Level 5, Out-of-Clinic, w/o client present	H2014	HS	U5	U7		\$18.15	Practitioner Level 5, Out-of-Clinic, w/ client present	H2014	HR	U5	U7		\$18.15
Unit Value	15 minutes							Maximum Daily Units*	16 units (Family Training and Family Counseling combined)					
Initial Authorization*	If a MICP Registration is submitted - 32 units (combined with Family Counseling) If a MICP New Episode is submitted - 60 units (combined with Family Counseling)							Reauthorization *	60 units (Family Training and Family Counseling combined)					
Authorization Period*	180 days							Utilization Criteria	<u>CAFAS scores:10-240</u>					
Service Definition	<p>A therapeutic interaction shown to be successful with identified family populations, diagnoses and service needs, provided by qualified staff. Services are directed toward achievement of specific goals defined by the individual youth and by the parent(s)/responsible caregiver(s) and specified in the Individualized Resiliency Plan (note: although interventions may involve the family, the focus or primary beneficiary of intervention must always be the individual).</p> <p>Family training provides systematic interactions between the identified individual, staff and the individual's family members directed toward the restoration, development, enhancement or maintenance of functioning of the identified individual/family unit. This may include support of the family, as well as training and specific activities to enhance family roles; relationships, communication and functioning that promote the resiliency of the individual/family unit.</p> <p>Specific goals/issues to be addressed through these services may include the restoration, development, enhancement or maintenance of:</p> <ol style="list-style-type: none"> 1) illness and medication self-management knowledge and skills (e.g. symptom management, behavioral management, relapse prevention skills, knowledge of medications and side effects, and motivational/skill development in taking medication as prescribed/helping a family member to take medication as prescribed); 2) problem solving and practicing functional support; 3) healthy coping mechanisms; 4) adaptive behaviors and skills; 5) interpersonal skills; 6) daily living skills; 7) resource access and management skills; and 8) the family's understanding of mental illness and substance related disorders, the steps necessary to facilitate recovery/resiliency, and methods of intervention, interaction and mutual support the family can use to assist their family member. 													
Admission Criteria	<ol style="list-style-type: none"> 1. Individual must have an emotional disturbance and/or substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); and 2. Individual's level of functioning does not preclude the provision of services in an outpatient milieu; and 3. Individual's assessment indicates needs that may be supported by a therapeutic intervention shown to be successful with identified family populations and individual's diagnoses. 													

Family Outpatient Services: Family Training

Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual continues to meet Admission Criteria as articulated above; and 2. Progress notes document progress relative to goals identified in the Individualized Resiliency Plan, but all treatment/support goals have not yet been achieved
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Resiliency Plan have been substantially met; or 3. Individual/family requests discharge and individual is not in imminent danger of harm to self or others; or 4. Transfer to another service is warranted by change in individual's condition; or 5. Individual requires more intensive services.
Service Exclusions	<ol style="list-style-type: none"> 1. Designated Crisis Stabilization Unit services and Intensive Family Intervention 2. This service is not intended to supplant other services such as Personal and Family Support or any day services where the individual may more appropriately receive these services with staff in various community settings
Clinical Exclusions	<ol style="list-style-type: none"> 1. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, and traumatic brain injury.
Required Components	<ol style="list-style-type: none"> 1. The treatment orientation, modality and goals must be specified and agreed upon by the youth/family/caregiver. 2. The Individualized Resiliency Plan for the individual includes goals and objectives specific to the youth and family for whom the service is being provided.
Service Accessibility	<ol style="list-style-type: none"> 1. Services may not exceed 16 Billable units (combined Family Counseling and Family Therapy) in a single day. If clinical need indicates this level of intensity, other services may need to be considered for authorization. 2. Family Training may not be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital, psychiatric residential treatment facility or Crisis Stabilization Unit with greater than 16 beds), jail, youth development center (YDC) or prison system. 3. This service may not be provided and billed for youth who are involuntarily detained in Regional Youth Detention Centers (RYDCs) awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings. Any exception to this requires supporting documentation from the DJJ partners. The provider holds the risk for assuring the youth's eligibility.
Documentation Requirements	<ol style="list-style-type: none"> 1. If there are multiple family members in the Family Training session who are enrolled individuals for whom the focus of treatment in the group is related to goals on their treatment plans, we recommend the following: <ol style="list-style-type: none"> a. Document the family session in the charts of each individual for whom the treatment is related to a specific goal on the individual's IRP b. Charge the Family Training session units to one of the individuals. c. Indicate "NC" (No Charge) on the documentation for the other individual(s) in the family session and have the note reflect that the charges for the session are assigned to another family member in the session.

Group Outpatient Services: Group Counseling

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Group – Behavioral health counseling and therapy	Practitioner Level 2, In-Clinic	H0004	HQ	U2	U6		\$8.50	Practitioner Level 2, Out-of-Clinic, Multi-family group, with client present	H0004	HQ	HR	U2	U7	\$10.39
	Practitioner Level 3, In-Clinic	H0004	HQ	U3	U6		\$6.60	Practitioner Level 3, Out-of-Clinic, Multi-family group, with client present	H0004	HQ	HR	U3	U7	\$8.25
	Practitioner Level 4, In-Clinic	H0004	HQ	U4	U6		\$4.43	Practitioner Level 4, Out-of-Clinic, Multi-family group, with client present	H0004	HQ	HR	U4	U7	\$5.41
	Practitioner Level 5, In-Clinic	H0004	HQ	U5	U6		\$3.30	Practitioner Level 5, Out-of-Clinic, Multi-family group, with client present	H0004	HQ	HR	U5	U7	\$4.03
	Practitioner Level 2, Out-of-Clinic	H0004	HQ	U2	U7		\$10.39	Practitioner Level 2, In-Clinic, Multi-family group, without client present	H0004	HQ	HS	U2	U6	\$8.50

Group Outpatient Services: Group Counseling

	Practitioner Level 3, Out-of-Clinic	H0004	HQ	U3	U7		\$8.25	Practitioner Level 3, In-Clinic, Multi-family group, without client present	H0004	HQ	HS	U3	U6	\$6.60
	Practitioner Level 4, Out-of-Clinic	H0004	HQ	U4	U7		\$5.41	Practitioner Level 4, In-Clinic, Multi-family group, without client present	H0004	HQ	HS	U4	U6	\$4.43
	Practitioner Level 5, Out-of-Clinic	H0004	HQ	U5	U7		\$4.03	Practitioner Level 5, In-Clinic, Multi-family group, without client present	H0004	HQ	HS	U5	U6	\$3.30
	Practitioner Level 2, In-Clinic, Multi-family group, w/ client present	H0004	HQ	HR	U2	U6	\$8.50	Practitioner Level 2, Out-of-Clinic, Multi-family group, without client present	H0004	HQ	HS	U2	U7	\$10.39
	Practitioner Level 3, In-Clinic, Multi-family group, w/ client present	H0004	HQ	HR	U3	U6	\$6.60	Practitioner Level 3, Out-of-Clinic, Multi-family group, without client present	H0004	HQ	HS	U3	U7	\$8.25
	Practitioner Level 4, In-Clinic, Multi-family group, w/ client present	H0004	HQ	HR	U4	U6	\$4.43	Practitioner Level 4, Out-of-Clinic, Multi-family group, without client present	H0004	HQ	HS	U4	U7	\$5.41
	Practitioner Level 5, In-Clinic, Multi-family group, w/ client present	H0004	HQ	HR	U5	U6	\$3.30	Practitioner Level 5, Out-of-Clinic, Multi-family group, without client present	H0004	HQ	HS	U5	U7	\$4.03
Group Psychotherapy other than of a multiple family group (appropriate license required)	Practitioner Level 2, In-Clinic	90853	U2	U6			\$8.50	Practitioner Level 2, Out-of-Clinic	90853	U2	U7			\$10.39
	Practitioner Level 3, In-Clinic	90853	U3	U6			\$6.60	Practitioner Level 3, Out-of-Clinic	90853	U3	U7			\$8.25
	Practitioner Level 4, In-Clinic	90853	U4	U6			\$4.43	Practitioner Level 4, Out-of-Clinic	90853	U4	U7			\$5.41
	Practitioner Level 5, In-Clinic	90853	U5	U6			\$3.30	Practitioner Level 5, Out-of-Clinic	90853	U5	U7			\$4.03
Unit Value	15 minutes							Maximum Daily Units *	16 units for Brief Registration 20 units for Ongoing MICP					
Initial Authorization*	If a MICP Registration is submitted - 32 units If a MICP New Episode is submitted - 200 units							Re-Authorization*	200 units					
Authorization Period*	180 days							Utilization Criteria	CAFAS scores:10-240					
Service Definition	A therapeutic intervention or counseling service shown to be successful with identified populations, diagnoses and service needs. Services are directed toward achievement of specific goals defined by the youth and by the parent(s)/responsible caregiver(s) and specified in the Individualized Resiliency Plan. Services may address goals/issues such as promoting resiliency, and the restoration, development, enhancement or maintenance of: 1) cognitive skills; 2) healthy coping mechanisms; 3) adaptive behaviors and skills; 4) interpersonal skills; 5) Identifying and resolving personal, social, intrapersonal and interpersonal concerns.													
Admission Criteria	1. Youth must have a primary emotional disturbance/substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); and 2. The youth's level of functioning does not preclude the provision of services in an outpatient milieu; and 3. The individual's resiliency goal/s that are to be addressed by this service must be conducive to response by a group milieu.													

Group Outpatient Services: Group Counseling

Continuing Stay Criteria	<ol style="list-style-type: none"> Youth continues to meet admission criteria; and Youth demonstrates documented progress relative to goals identified in the Individualized Resiliency Plan, but treatment goals have not yet been achieved.
Discharge Criteria	<ol style="list-style-type: none"> An adequate continuing care plan has been established; and one or more of the following: Goals of the Individualized Resiliency Plan have been substantially met; or Youth and family requests discharge and the youth is not in imminent danger of harm to self or others; or Transfer to another service/level of care is warranted by change in youth's condition; or Youth requires more intensive services.
Service Exclusions	See Required Components, Item 2, below.
Clinical Exclusions	<ol style="list-style-type: none"> Severity of behavioral health issue precludes provision of services. Severity of cognitive impairment precludes provision of services in this level of care. There is a lack of social support systems such that a more intensive level of service is needed. This service is not intended to supplant other services such as MR/DD Personal and Family Support or any day services where the individual may more appropriately receive these services with staff in various community settings.
Required Components	<ol style="list-style-type: none"> The treatment orientation, modality and goals must be specified and agreed upon by the youth/family/caregiver. If there are disparate goals between the youth and family, this is addressed clinically as part of the resiliency-building plans and interventions. When billed concurrently with IFI services, this service must be curriculum based and/or targeted to a very specific clinical issue (e.g. incest survivor groups, perpetrator groups, sexual abuse survivor groups).
Staffing Requirements	<ol style="list-style-type: none"> Maximum face-to-face ratio cannot be more than 10 individuals to 1 direct service staff based on average group attendance
Clinical Operations	<ol style="list-style-type: none"> The membership of a multiple family group (H0004 HQ) consists of multiple family units such as a group of two or more parent(s) from different families either with (HR) or without (HS) participation of their child/children. Practitioners and supervisors of those providing this service are expected to maintain knowledge and skills regarding group practice such as selecting appropriate participants for a particular group, working with the group to establish necessary group norms and goals, and understanding and managing group dynamics and processes.
Billing and Reporting Requirements	<ol style="list-style-type: none"> When using 90853, and the intervention meets the definition of Interactive Complexity, the 90785 code will be submitted with the 90853 base code. If a Medicaid claim for this service denies for a Procedure-to-Procedure edit, a modifier (59) can be added to the claim and resubmitted to the MMIS for payment.

Group Outpatient Services: Group Training

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Group Skills Training & Development	Practitioner Level 4, In-Clinic	H2014	HQ	U4	U6		\$4.43	Practitioner Level 4, Out-of-Clinic, w/ client present	H2014	HQ	HR	U4	U7	\$5.41
	Practitioner Level 5, In-Clinic	H2014	HQ	U5	U6		\$3.30	Practitioner Level 5, Out-of-Clinic, w/ client present	H2014	HQ	HR	U5	U7	\$4.03
	Practitioner Level 4, Out-of-Clinic	H2014	HQ	U4	U7		\$5.41	Practitioner Level 4, In-Clinic, w/o client present	H2014	HQ	HS	U4	U6	\$4.43
	Practitioner Level 5, Out-of-Clinic	H2014	HQ	U5	U7		\$4.03	Practitioner Level 5, In-Clinic, w/o client present	H2014	HQ	HS	U5	U6	\$3.30
	Practitioner Level 4, In-Clinic, w/	H2014	HQ	HR	U4	U6	\$4.43	Practitioner Level 4, Out-of-Clinic, w/o	H2014	HQ	HS	U4	U7	\$5.41

Group Outpatient Services: Group Training

	client present Practitioner Level 5, In-Clinic, w/w client present	H2014	HQ	HR	U5	U6	\$3.30	client present Practitioner Level 5, Out-of-Clinic, w/o client present	H2014	HQ	HS	U5	U7	\$4.03
Unit Value	15 minutes							Maximum Daily Units*	16 units					
Initial Authorization*	If a MICP Registration is submitted - 32 units If a MICP New Episode is submitted - 200 units							Re-Authorization*	200 units					
Authorization Period*	180 days							Utilization Criteria	CAFAS scores: 10-240					
Service Definition	<p>A therapeutic interaction shown to be successful with identified populations, diagnoses and service needs. Services are directed toward achievement of specific goals defined by the youth and by the parent(s)/responsible caregiver(s) and specified in the Individualized Resiliency Plan. Services may address goals/issues such as promoting resiliency, and the restoration, development, enhancement or maintenance of:</p> <ol style="list-style-type: none"> 1) illness and medication self-management knowledge and skills (e.g. symptom management, behavioral management, relapse prevention skills, knowledge of medications and side effects, and motivational/skill development in taking medication as prescribed); 2) problem solving skills; 3) healthy coping mechanisms; 4) adaptive skills; 5) interpersonal skills; 6) daily living skills; 7) resource management skills; 8) knowledge regarding emotional disturbance, substance related disorders and other relevant topics that assist in meeting the youth's and family's needs; and skills necessary to access and build community resources and natural support systems. 													
Admission Criteria	<ol style="list-style-type: none"> 1. Youth must have a primary emotional disturbance/substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); and 2. The youth's level of functioning does not preclude the provision of services in an outpatient milieu; and 3. The individual's resiliency goal/s that are to be addressed by this service must be conducive to response by a group milieu. 													
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Youth continues to meet admission criteria; and 2. Youth demonstrates documented progress relative to goals identified in the Individualized Resiliency Plan, but treatment goals have not yet been achieved. 													
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Resiliency Plan have been substantially met; or 3. Youth and family requests discharge and the youth is not in imminent danger of harm to self or others; or 4. Transfer to another service/level of care is warranted by change in youth's condition; or 5. Youth requires more intensive services. 													
Service Exclusions	<ol style="list-style-type: none"> 1. When billed concurrently with IFI services, this service must be curriculum based and/or targeted to a very specific clinical issue (e.g. incest survivor groups, perpetrator groups, sexual abuse survivor groups). 													
Clinical Exclusions	<ol style="list-style-type: none"> 1. Severity of behavioral health issue precludes provision of services. 2. Severity of cognitive impairment precludes provision of services in this level of care. 3. There is a lack of social support systems such that a more intensive level of service is needed. 4. This service is not intended to supplant other services such as MR/DD Personal and Family Support or any day services where the individual may more appropriately receive these services with staff in various community settings. 5. Youth with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, and traumatic brain injury. 													

Group Outpatient Services: Group Training

Required Components	The functional goals addressed through this service must be specified and agreed upon by the youth/family/caregiver. If there are disparate goals between the youth and family, this is addressed clinically as part of the resiliency building plans and interventions.
Staffing Requirements	Maximum face-to-face ratio cannot be more than 10 individuals to 1 direct service staff based on average group attendance
Clinical Operations	<ol style="list-style-type: none"> 1. Out-of-clinic group skills training is allowable and clinically valuable for some individuals; therefore, this option should be explored to the benefit of the individual. In this event, staff must be able to assess and address the individual needs and progress of each individual consistently throughout the intervention/activity (e.g. in an example of teaching 2-3 individuals to access public transportation in the community, group training may be given to help each individual individually to understand the bus schedule in a way that makes sense to them, to address questions/concerns each may have about how to use the bus, perhaps to spend time riding the bus with the individuals and assisting each to understand and become comfortable with riding the bus in accordance with <i>individual</i> goals, etc.) 2. The membership of a multiple family Group Training session (H2014 HQ) consists of multiple family units such as a group of two or more parent(s) from different families either with (HR) or without (HS) participation of their child/children.
Reporting and Billing Requirements	<ol style="list-style-type: none"> 1. Out-of-clinic group skills training is denoted by the U7 modifier.

Individual Counseling

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive face-to face w/patient and/or family member	-30 minutes	Practitioner Level 2, In-Clinic	90832	U2	U6		64.95	Practitioner Level 2, Out-of-Clinic	90832	U2	U7			77.93
		Practitioner Level 3, In-Clinic	90832	U3	U6		50.02	Practitioner Level 3, Out-of-Clinic	90832	U3	U7			61.13
		Practitioner Level 4, In-Clinic	90832	U4	U6		33.83	Practitioner Level 4, Out-of-Clinic	90832	U4	U7			40.59
		Practitioner Level 5, In-Clinic	90832	U5	U6		25.21	Practitioner Level 5, Out-of-Clinic	90832	U5	U7			30.25
	-45 minutes	Practitioner Level 2, In-Clinic	90834	U2	U6		116.90	Practitioner Level 2, Out-of-Clinic	90834	U2	U7			140.28
		Practitioner Level 3, In-Clinic	90834	U3	U6		90.03	Practitioner Level 3, Out-of-Clinic	90834	U3	U7			110.04
		Practitioner Level 4, In-Clinic	90834	U4	U6		60.89	Practitioner Level 4, Out-of-Clinic	90834	U4	U7			73.07
		Practitioner Level 5, In-Clinic	90834	U5	U6		45.38	Practitioner Level 5, Out-of-Clinic	90834	U5	U7			54.46
	-60 minutes	Practitioner Level 2, In-Clinic	90837	U2	U6		155.87	Practitioner Level 2, Out-of-Clinic	90837	U2	U7			187.04
		Practitioner Level 3, In-Clinic	90837	U3	U6		120.04	Practitioner Level 3, Out-of-Clinic	90837	U3	U7			146.71
		Practitioner Level 4, In-Clinic	90837	U4	U6		81.18	Practitioner Level 4, Out-of-Clinic	90837	U4	U7			97.42
		Practitioner Level 5, In-Clinic	90837	U5	U6		60.51	Practitioner Level 5, Out-of-Clinic	90837	U5	U7			72.61
Psychotherapy Add-on with patient and/or family in conjunction with E&M	-30 minutes	Practitioner Level 1, In-Clinic	90833	U1	U6		97.02	Practitioner Level 1, Out-of-Clinic	90833	U1	U7			123.48
		Practitioner Level 2, In-Clinic	90833	U2	U6		64.95	Practitioner Level 2, Out-of-Clinic	90833	U2	U7			77.93
		Practitioner Level 1	90833	GT	U1		97.02	Practitioner Level 2	90833	GT	U2			64.95
	-45 minutes	Practitioner Level 1, In-Clinic	90836	U1	U6		174.63	Practitioner Level 1, Out-of-Clinic	90836	U1	U7			226.26
		Practitioner Level 2, In-Clinic	90836	U2	U6		116.90	Practitioner Level 2, Out-of-Clinic	90836	U2	U7			140.28
		Practitioner Level 1	90836	GT	U1		174.63	Practitioner Level 2	90836	GT	U2			116.90

Individual Counseling

Unit Value	1 encounter (Note: Time-in/Time-out is required in the documentation as it justifies which code above is billed)	Maximum Daily Units	2 units
Initial Authorization	24 units	Re-Authorization*	24 units
Authorization Period*	180 days	Utilization Criteria	CAFAS scores: 10-240
Service Definition	<p>A therapeutic intervention or counseling service shown to be successful with identified youth populations, diagnoses and service needs, provided by a qualified clinician. Techniques employed involve the principles, methods and procedures of counseling that assist the youth in identifying and resolving personal, social, vocational, intrapersonal and interpersonal concerns. Individual counseling may include face-to-face in or out-of-clinic time with family members as long as the individual is present for part of the session and the focus is on the individual. Services are directed toward achievement of specific goals defined by the youth and by the parent(s)/responsible caregiver(s) and specified in the Individualized Resiliency Plan. These services address goals/issues such as promoting resiliency, and the restoration, development, enhancement or maintenance of:</p> <ol style="list-style-type: none"> 1) the illness/emotional disturbance and medication self-management knowledge and skills (e.g. symptom management, behavioral management, relapse prevention skills, knowledge of medications and side effects, and motivational/skill development in taking medication as prescribed); 2) problem solving and cognitive skills; 3) healthy coping mechanisms; 4) adaptive behaviors and skills; 5) interpersonal skills; and 6) knowledge regarding the emotional disturbance, substance related disorders and other relevant topics that assist in meeting the youth's needs. 7) Best/evidence based practice modalities may include (as clinically appropriate): Motivational Interviewing/Enhancement Therapy, Cognitive Behavioral Therapy, Behavioral Modification, Behavioral Management, Rational Behavioral Therapy, Dialectical Behavioral Therapy, Interactive Play Therapy, and others as appropriate to the individual and clinical issues to be addressed. 		
Admission Criteria	<ol style="list-style-type: none"> 1. Youth must have a primary emotional disturbance/substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); and 2. The youth's level of functioning does not preclude the provision of services in an outpatient milieu; and 		
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual continues to meet admission criteria; and 2. Individual demonstrates documented progress relative to goals identified in the Individualized Resiliency Plan, but treatment goals have not yet been achieved. 		
Discharge Criteria	<ol style="list-style-type: none"> 1. Adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Resiliency Plan have been substantially met; or 3. Individual/family requests discharge and individual is not in imminent danger of harm to self or others; or 4. Transfer to another service is warranted by change in individual's condition; or 5. Individual requires a service approach which supports less or more intensive need. 		
Service Exclusions	Designated Crisis Stabilization Unit services and Intensive Family Intervention		
Clinical Exclusions	<ol style="list-style-type: none"> 1. Severity of behavioral health disturbance precludes provision of services. 2. Severity of cognitive impairment precludes provision of services in this level of care. 3. There is a lack of social support systems such that a more intensive level of service is needed. 4. There is no outlook for improvement with this particular service 5. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder and traumatic brain injury. 		

Individual Counseling

Required Components	The treatment orientation, modality and goals must be specified and agreed upon by the youth/family/caregiver.
Clinical Operations	<ol style="list-style-type: none"> Practitioners and supervisors of those providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based counseling practices. 90833 and 90836 are utilized with E/M CPT Codes as an add-on for psychotherapy and may not be billed individually.
Billing and Reporting Requirements	<ol style="list-style-type: none"> When 90833 or 90836 are provided with an E/M code, these are submitted together to encounter/claims system. 90833 is used for any intervention which is 16-37 minutes in length. 90836 is used for any intervention which is 38-52 minutes in length. 90837 is used for any intervention which is greater than 53 minutes. If a Medicaid claim for this service denies for a Procedure-to-Procedure edit, a modifier (59) can be added to the claim and resubmitted to the MMIS for payment with two exceptions: If the billable base code is either 90833 or 90836 and is denied for Procedure-to-Procedure edit, then a (25) modifier should be added to the claim resubmission.
Documentation Requirements	<ol style="list-style-type: none"> When 90833 or 90836 are provided with an E/M code, they are recorded on the same intervention note but the distinct services must be separately identifiable. When 90833 or 90836 are provided with an E/M code, the psychotherapy intervention must include time in/time out in order to justify which code is being utilized (each code shall have time recorded for the two increments of service as if they were distinct and separate services). Time associated with activities used to meet criteria for the E/M service is not included in the time used for reporting the psychotherapy service.

Interactive Complexity

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Interactive Complexity	Interactive complexity (List separately in addition to the code for primary procedure)	90785					\$0.00	Interactive complexity (List separately in addition to the code for primary procedure)	90785	TG				\$0.00
Unit Value	1 Encounter							Maximum Daily Units*	4 units					
Initial Authorization*	48 units							Re-Authorization*	48 units					
Authorization Period*	180 days							Utilization Criteria	180 days					
Service Definition	<p>Interactive Complexity is not a direct service but functions as a modifier to Psychiatric Treatment, Diagnostic Assessment, Individual Therapy, and Group Counseling. This modifier is used when:</p> <ol style="list-style-type: none"> Communication with the individual participant/s is complicated perhaps related to, e.g., high anxiety, high reactivity, repeated questions, or disagreement and therefore delivery of care is challenging. Caregiver emotions/behaviors complicate the implementation of the treatment plan. Evidence/disclosure of a sentinel event and mandated report to a third party (e.g., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with the individual and supporters. Use of play equipment, physical devices, interpreter or translator to overcome significant language barriers (when individual served is not fluent in same language as practitioner, or when the individual has not developed or has lost expressive/receptive communication skills necessary for interactive participation in the intervention). 													

Admission Criteria	These elements are defined in the specific companion service to which this modifier is anchored to in reporting/claims submission.
Continuing Stay Criteria	
Discharge Criteria	
Clinical Exclusions	
Documentation Requirements	<ol style="list-style-type: none"> When this code is submitted, there must be: <ol style="list-style-type: none"> Record of base service delivery code/s AND the Interactive Complexity code on the single note; and Evidence within the multi-code service note which indicates the specific category of complexity (from the list of items 1-4 in the definition above) utilized during the intervention. The interactive complexity component relates only to the increased work intensity of the psychotherapy service, but <i>does not</i> change the time for the psychotherapy service.
Reporting and Billing Requirements	<ol style="list-style-type: none"> This service may only be reported/billed in conjunction with one of the following codes: 90791, 90792, 90832, 90834, 90837, 90853, and with the following codes only when paired with 90833 or 90836: 99201, 99211, 99202, 99212, 99203, 99213, 99204, 99214, 99205, 99215. This Service Code paired with the TG modifier is only used when the complexity type from the Service Definition above is categorized under Item 4 AND an interpreter or translator is used during the intervention. So, if play equipment is the only complex intervention utilized, then TG is not utilized. Interactive Complexity is utilized as a modifier and therefore is not required in an order or in an Individualized Recovery/Resiliency Plan.

Medication Administration

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Comprehensive Medication Services	Practitioner Level 2, In-Clinic	H2010	U2	U6			\$33.40	Practitioner Level 2, Out-of-Clinic	H2010	U2	U7			\$42.51
	Practitioner Level 3, In-Clinic	H2010	U3	U6			\$25.39	Practitioner Level 3, Out-of-Clinic	H2010	U3	U7			\$33.01
	Practitioner Level 4, In-Clinic	H2010	U4	U6			\$17.40	Practitioner Level 4, Out-of-Clinic	H2010	U4	U7			\$22.14
	Practitioner Level 5, In-Clinic	H2010	U5	U6			\$12.97							
Therapeutic, prophylactic or diagnostic injection	Practitioner Level 2, In-Clinic	96372	U2	U6			\$33.40	Practitioner Level 2, Out-of-Clinic	96372	U2	U7			\$42.51
	Practitioner Level 3, In-Clinic	96372	U3	U6			\$25.39	Practitioner Level 3, Out-of-Clinic	96372	U3	U7			\$33.01
	Practitioner Level 4, In-Clinic	96372	U4	U6			\$17.40	Practitioner Level 4, Out-of-Clinic	96372	U4	U7			\$22.14
Alcohol, and/or drug services, methadone administration and/or service	Practitioner Level 2, In-Clinic	H0020	U2	U6			\$33.40	Practitioner Level 4, In-Clinic	H0020	U4	U6			\$17.40
	Practitioner Level 3, In-Clinic	H0020	U3	U6			\$25.39							
Unit Value	1 encounter							Maximum Daily Units*			1 unit			
Initial Authorization*	With the submission of MICP Registration - 6 units shared With the submission of MICP New Episode: H2010 & 96372 = 60 units shared							Re-Authorization*			H2010 & 96372 = 60 units shared			
Authorization Period*	180 days							Utilization Criteria			CAFAS scores:10-240			

Medication Administration

<p>Service Definition</p>	<p>As reimbursed through this service, medication administration includes the act of introducing a drug (any chemical substance that, when absorbed into the body of a living organism, alters normal bodily function) into the body of another person by any number of routes including, but not limited to the following: oral, nasal, inhalant, intramuscular injection, intravenous, topical, suppository or intraocular. Medication administration requires a written service order for Medication Administration and a written order for the medication and the administration of the medication that complies with guidelines in Part II, Section 1, Subsection 6—Medication of the Provider Manual. The order for and administration of medication must be completed by members of the medical staff pursuant to the Medical Practice Act of 2009, Subsection 43-34-23 Delegation of Authority to Nurse and Physician Assistant and must be administered by licensed or credentialed* medical personnel under the supervision of a physician or registered nurse in accordance with O.C.G.A. This service does not cover the supervision of self-administration of medications (See Clinical Exclusions below).</p> <p>The service must include:</p> <ol style="list-style-type: none"> 1. An assessment, by the licensed or credentialed medical personnel administering the medication, of the youth's physical, psychological and behavioral status in order to make a recommendation regarding whether to continue the medication and/or its means of administration, and whether to refer the youth to the physician for a medication review. 2. Education to the youth and/or family/responsible caregiver(s), by appropriate licensed medical personnel, on the proper administration and monitoring of prescribed medication in accordance with the youth's resiliency plan. <p>For individuals who need opioid maintenance, the Opioid Maintenance service should be requested.</p>
<p>Admission Criteria</p>	<ol style="list-style-type: none"> 1. Youth presents symptoms that are likely to respond to pharmacological interventions; and 2. Youth has been prescribed medications as a part of the treatment array; and 3. Youth/family/responsible caregiver is unable to self-administer/administer prescribed medication because: <ol style="list-style-type: none"> a. Although the youth is willing to take the prescribed medication, it is in an injectable form and must be administered by licensed medical personnel; or b. Although youth is willing to take the prescribed medication, it is a Class A controlled substance which must be stored and dispensed by medical personnel in accordance with state law; or c. Administration by licensed/credentialed medical personnel is necessary because an assessment of the youth's physical, psychological and behavioral status is required in order to make a determination regarding whether to continue the medication and/or its means of administration and/or whether to refer the youth to the physician for a medication review. d. Due to the family/caregiver's lack of capacity there is no responsible party to manage/supervise self-administration of medication (refer youth/family for CSI and/or Family or Group Training in order to teach these skills)
<p>Continuing Stay Criteria</p>	<p>Youth continues to meet admission criteria.</p>
<p>Discharge Criteria</p>	<ol style="list-style-type: none"> 1. Youth no longer needs medication; or 2. Youth/Family/Caregiver is able to self-administer, administer, or supervise self-administration medication; and 3. Adequate continuing care plan has been established.
<p>Service Exclusions</p>	<ol style="list-style-type: none"> 1. Medication administered as part of Ambulatory Detoxification is billed as "Ambulatory Detoxification" and is not billed via this set of codes. 2. Must not be billed in the same day as Nursing Assessment. 3. For individuals who need opioid maintenance, the Opioid Maintenance service should be requested.
<p>Clinical Exclusions</p>	<p>This service does not cover the supervision of self-administration of medications. Self-administration of medications can be done by anyone physically and mentally capable of taking or administering medications to himself/herself. Youth with mental health issues, or developmental disabilities are very often capable of self-administration of medications even if supervision by others is needed in order to adequately or safely manage self-administration of medication and other activities of daily living.</p>
<p>Required Components</p>	<ol style="list-style-type: none"> 1. There must be a written service order for Medication Administration and a written order for the medication and the administration of the medication that complies with guidelines in Part II, Section 1, Subsection 6—Medication of the Provider Manual. The order for and administration of medication must be completed by members of the medical staff pursuant to the Medical Practice Act of 2009, Subsection 43-34-23 Delegation of Authority to Nurse and Physician Assistant The order must be in the

Medication Administration

	<p>youth's chart. Telephone orders are acceptable provided they are co-signed by the appropriate members of the medical staff in accordance with DBHDD requirements.</p> <ol style="list-style-type: none"> Documentation must support that the individual is being trained in the risks and benefits of the medications being administered and that symptoms are being monitored by the staff member administering the medication. Documentation must support the medical necessity of administration by licensed/credentialed medical personnel rather than by the youth, family or caregiver. Documentation must support that the youth AND family/caregiver is being trained in the principles of self-administration of medication and supervision of self-administration or that the youth/family/caregiver is physically or mentally unable to self-administer/administer. This documentation will be subject to scrutiny by the External Review Organization in reauthorizing services in this category. This service does not include the supervision of self-administration of medication.
Staffing Requirements	<ol style="list-style-type: none"> Qualified Medication Aides working in a Community Living Arrangement (CLA) may administer medication only in a CLA.
Clinical Operations	<ol style="list-style-type: none"> Medication administration may not be billed for the provision of single or multiple doses of medication that an individual has the ability to self-administer, either independently or with supervision by a caregiver, either in a clinic or a community setting. In a group home setting, for example, medications may be managed by the house parents or residential care staff and kept locked up for safety reasons. Staff may hand out medication to the residents but this does not constitute administration of medication for the purposes of this definition and, like other watchful oversight and monitoring functions, are not reimbursable treatment services. If individual/family requires training in skills needed in order to learn to manage his/her own medications and their safe self-administration and/or supervision of self-administration, this skills training service can be provided via the Community Support or Family/Group Training services in accordance with the person's individualized recovery/resiliency plan. Agency employees working in residential settings such as group homes, are not eligible for CSI or Family/Group Training in the supervision of medication self-administration by youth in their care.
Service Accessibility	<ol style="list-style-type: none"> Medication Administration may not be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital, psychiatric residential treatment facility or Crisis Stabilization Unit with greater than 16 beds), jail, youth development center (YDC) or prison system. This service may not be provided and billed for youth who are involuntarily detained in Regional Youth Detention Centers (RYDCs) awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings. Any exception to this requires supporting documentation from the DJJ partners. The provider holds the risk for assuring the youth's eligibility.
Billing & Reporting Requirements	If a Medicaid claim for this service denies for a Procedure-to-Procedure edit, a modifier (59) can be added to the claim and resubmitted to the MMIS for payment.

Nursing Assessment and Health Services

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Nursing Assessment/ Evaluation	Practitioner Level 2, In-Clinic	T1001	U2	U6			\$38.97	Practitioner Level 2, Out-of-Clinic	T1001	U2	U7			\$46.76
	Practitioner Level 3, In-Clinic	T1001	U3	U6			\$30.01	Practitioner Level 3, Out-of-Clinic	T1001	U3	U7			\$36.68
	Practitioner Level 4, In-Clinic	T1001	U4	U6			\$20.30	Practitioner Level 4, Out-of-Clinic	T1001	U4	U7			\$24.36
RN Services, up to 15 minutes	Practitioner Level 2, In-Clinic	T1002	U2	U6			\$38.97	Practitioner Level 2, Out-of-Clinic	T1002	U2	U7			\$46.76
	Practitioner Level 3, In-Clinic	T1002	U3	U6			\$30.01	Practitioner Level 3, Out-of-Clinic	T1002	U3	U7			\$36.68

Nursing Assessment and Health Services

LPN Services, up to 15 minutes	Practitioner Level 4, In-Clinic	T1003	U4	U6	\$20.30	Practitioner Level 4, Out-of-Clinic	T1003	U4	U7	\$24.36
Health and Behavior Assessment, Face-to-Face w/ Patient, Initial Assessment	Practitioner Level 2, In-Clinic	96150	U2	U6	\$38.97	Practitioner Level 2, Out-of-Clinic	96150	U2	U7	\$46.76
	Practitioner Level 3, In-Clinic	96150	U3	U6	\$30.01	Practitioner Level 3, Out-of-Clinic	96150	U3	U7	\$36.68
	Practitioner Level 4, In-Clinic	96150	U4	U6	\$20.30	Practitioner Level 4, Out-of-Clinic	96150	U4	U7	\$24.36
Health and Behavior Assessment, Face-to-Face w/ Patient, Re-assessment	Practitioner Level 2, In-Clinic	96151	U2	U6	\$38.97	Practitioner Level 2, Out-of-Clinic	96151	U2	U7	\$46.76
	Practitioner Level 3, In-Clinic	96151	U3	U6	\$30.01	Practitioner Level 3, Out-of-Clinic	96151	U3	U7	\$36.68
	Practitioner Level 4, In-Clinic	96151	U4	U6	\$20.30	Practitioner Level 4, Out-of-Clinic	96151	U4	U7	\$24.36
Unit Value	15 minutes					Maximum Daily Units*		16 units (32 for Ambulatory Detox)		
Initial Authorization*	With the submission of MICP Registration - 12 units With the submission of MICP New Episode - 60 units					Re-Authorization*		60 units		
Authorization Period	180 Days					Utilization Criteria		<u>CAFAS scores:10-240</u>		
Service Definition	<p>This service requires face-to-face contact with the youth/family/caregiver to monitor, evaluate, assess, and/or carry out orders of appropriate medical staff pursuant to the Medical Practice Act of 2009, Subsection 43-34-23 Delegation of Authority to Nurse and Physician Assistant regarding the psychological and/or physical problems and general wellness of the youth. It includes:</p> <ol style="list-style-type: none"> 1) Providing nursing assessments and interventions to observe, monitor and care for the physical, nutritional, behavioral health and related psychosocial issues, problems or crises manifested in the course of the youth's treatment; 2) Assessing and monitoring the youth's response to medication(s) to determine the need to continue medication and/or to determine the need to refer the youth for a medication review; 3) Assessing and monitoring a youth's medical and other health issues that are either directly related to the mental health or substance related disorder, or to the treatment of the disorder (e.g. diabetes, cardiac and/or blood pressure issues, substance withdrawal symptoms, weight gain and fluid retention, seizures, etc.); 4) Consulting with the youth's family/caregiver about medical, nutritional and other health issues related to the individual's mental health or substance related issues; 5) Educating the youth and family/responsible caregiver(s) on medications and potential medication side effects (especially those which may adversely affect health such as weight gain or loss, blood pressure changes, cardiac abnormalities, development of diabetes or seizures, etc.); 6) Consulting with the youth and family/caregiver (s) about the various aspects of informed consent (when prescribing occurs/APRN) 7) Training for self-administration of medication; 8) Venipuncture required to monitor and assess mental health, substance disorders or directly related conditions, and to monitor side effects of psychotropic medications, as ordered by appropriate members of the medical staff; and 9) Providing assessment, testing, and referral for infectious diseases. 									
Admission Criteria	<ol style="list-style-type: none"> 1. Youth presents with symptoms that are likely to respond to medical/nursing interventions; or 2. Youth has been prescribed medications as a part of the treatment array or has a confounding medical condition. 									
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Youth continues to demonstrate symptoms that are likely to respond to or are responding to medical interventions; or 2. Youth exhibits acute disabling conditions of sufficient severity to bring about a significant impairment in day-to-day functioning; or 3. Youth demonstrates progress relative to medical/medication goals identified in the Individualized Resiliency Plan, but treatment goals have not yet been achieved. 									

Nursing Assessment and Health Services

Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Youth no longer demonstrates symptoms that are likely to respond to or are responding to medical/nursing interventions; or 3. Goals of the Individualized Resiliency Plan have been substantially met; or 4. Youth/family requests discharge and youth is not in imminent danger of harm to self or others.
Service Exclusions	Medication Administration, Opioid Maintenance
Clinical Exclusions	Routine nursing activities that are included as a part of ambulatory detoxification and medication administration/methadone administration
Required Components	<ol style="list-style-type: none"> 1. Nutritional assessments indicated by a youth's confounding health issues might be billed under this code (96150, 96151). No more than 8 units specific to nutritional assessments can be billed for an individual within a year. This specific assessment must be provided by a Registered Nurse or by a Licensed Dietician (LD). 2. This service does not include the supervision of self-administration of medication. 3. Each nursing contact should document the checking of vital signs (Temperature, Pulse, Blood Pressure, Respiratory Rate, and weight, if medically indicated or if related to behavioral health symptom or behavioral health medication side effect) in accordance with general psychiatric nursing practice.
Clinical Operations	<ol style="list-style-type: none"> 1. Venipuncture billed via this service must include documentation that includes canula size utilized, insertion site, number of attempts, location, and individual tolerance of procedure. 2. All nursing procedures must include relevant individual-centered, family-oriented education regarding the procedure.
Billing & Reporting Requirements	If a Medicaid claim for this service denies for a Procedure-to-Procedure edit, a modifier (59) can be added to the claim and resubmitted to the MMIS for payment.

Pharmacy & Lab

Utilization Criteria	<u>CAFAS scores: 10-240</u>
Service Definition	Pharmacy & Lab Services include operating/purchasing services to order, package, and distribute prescription medications. It includes provision of assistance to access indigent medication programs, sample medication programs and payment for necessary medications when no other fund source is available. This service provides for appropriate lab work, such as drug screens and medication levels, to be performed. This service ensures that necessary medication/lab services are not withheld/delayed based on inability to pay
Admission Criteria	Individual has been assessed by a prescribing professional to need a psychotropic, anti-cholinergic, addiction specific, or anti-convulsant (as related to behavioral health issue) medication and/or lab work required for persons entering services, and/or monitoring medication levels.
Continuing Stay Criteria	Individual continues to meet the admission criteria as determined by the prescribing professional
Discharge Criteria	<ol style="list-style-type: none"> 1. Individual no longer demonstrates symptoms that are likely to respond to or are responding to pharmacologic interventions; or 2. Individual requests discharge and individual is not imminently dangerous or under court order for this intervention.
Required Components	<ol style="list-style-type: none"> 1. Service must be provided by a licensed pharmacy or through contract with a licensed pharmacy. 2. Agency must participate in any pharmaceutical rebate programs or pharmacy assistance programs that promote individual access in obtaining medication. 3. Providers shall refer all individuals who have an inability to pay for medications or services to the local county offices of the Division of Family and Children Services for the purposes of determining Medicaid eligibility.

Additional
Medicaid
Requirements

Not a DBHDD Medicaid service. Medicaid recipients may access the general Medicaid pharmacy program as prescribed by the Department of Community Health.

Psychiatric Treatment																		
Transaction Code		Code Detail		Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail		Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	
E/M New Patient	10 minutes	Practitioner Level 1, In-Clinic		99201	U1	U6			38.81	Practitioner Level 2, In-Clinic		99201	U2	U6			25.98	
		Practitioner Level 1, Out-of-Clinic		99201	U1	U7			49.39	Practitioner Level 2, Out-of-Clinic		99201	U2	U7			31.17	
		Practitioner Level 1		99201	GT	U1			38.81	Practitioner Level 2		99201	GT	U2			25.98	
	20 minutes	Practitioner Level 1, In-Clinic		99202	U1	U6			77.61	Practitioner Level 2, In-Clinic		99202	U2	U6			51.96	
		Practitioner Level 1, Out-of-Clinic		99202	U1	U7			98.79	Practitioner Level 2, Out-of-Clinic		99202	U2	U7			62.35	
		Practitioner Level 1		99202	GT	U1			77.61	Practitioner Level 2		99202	GT	U2			51.96	
	30 minutes	Practitioner Level 1, In-Clinic		99203	U1	U6			116.42	Practitioner Level 2, In-Clinic		99203	U2	U6			77.94	
		Practitioner Level 1, Out-of-Clinic		99203	U1	U7			148.18	Practitioner Level 2, Out-of-Clinic		99203	U2	U7			93.52	
		Practitioner Level 1		99203	GT	U1			116.42	Practitioner Level 2		99203	GT	U2			77.94	
	45 minutes	Practitioner Level 1, In-Clinic		99204	U1	U6			174.63	Practitioner Level 2, In-Clinic		99204	U2	U6			116.90	
		Practitioner Level 1, Out-of-Clinic		99204	U1	U7			222.26	Practitioner Level 2, Out-of-Clinic		99204	U2	U7			140.28	
		Practitioner Level 1		99204	GT	U1			174.63	Practitioner Level 2		99204	GT	U2			116.90	
	60 minutes	Practitioner Level 1, In-Clinic		99205	U1	U6			232.84	Practitioner Level 2, In-Clinic		99205	U2	U6			155.88	
		Practitioner Level 1, Out-of-Clinic		99205	U1	U7			296.36	Practitioner Level 2, Out-of-Clinic		99205	U2	U7			187.04	
		Practitioner Level 1		99205	GT	U1			232.84	Practitioner Level 2		99205	GT	U2			155.88	
	E/M Established Patient	5 minutes	Practitioner Level 1, In-Clinic		99211	U1	U6			19.40	Practitioner Level 2, In-Clinic		99211	U2	U6			12.99
			Practitioner Level 1, Out-of-Clinic		99211	U1	U7			24.70	Practitioner Level 2, Out-of-Clinic		99211	U2	U7			15.59
			Practitioner Level 1		99211	GT	U1			19.40	Practitioner Level 2		99211	GT	U2			12.99
10 minutes		Practitioner Level 1, In-Clinic		99212	U1	U6			38.81	Practitioner Level 2, In-Clinic		99212	U2	U6			25.98	
		Practitioner Level 1, Out-of-Clinic		99212	U1	U7			49.39	Practitioner Level 2, Out-of-Clinic		99212	U2	U7			31.17	
		Practitioner Level 1		99212	GT	U1			38.81	Practitioner Level 2		99212	GT	U2			25.98	
15 minutes		Practitioner Level 1, In-Clinic		99213	U1	U6			58.21	Practitioner Level 2, In-Clinic		99213	U2	U6			38.97	
		Practitioner Level 1, Out-of-Clinic		99213	U1	U7			74.09	Practitioner Level 2, Out-of-Clinic		99213	U2	U7			46.76	
		Practitioner Level 1		99213	GT	U1			58.21	Practitioner Level 2		99213	GT	U2			38.97	
25 minutes		Practitioner Level 1, In-Clinic		99214	U1	U6			97.02	Practitioner Level 2, In-Clinic		99214	U2	U6			64.95	
		Practitioner Level 1, Out-of-Clinic		99214	U1	U7			123.48	Practitioner Level 2, Out-of-Clinic		99214	U2	U7			77.93	
		Practitioner Level 1		99214	GT	U1			97.02	Practitioner Level 2		99214	GT	U2			64.95	
40 minutes		Practitioner Level 1, In-Clinic		99215	U1	U6			155.23	Practitioner Level 2, In-Clinic		99215	U2	U6			103.92	
		Practitioner Level 1, Out-of-Clinic		99215	U1	U7			197.57	Practitioner Level 2, Out-of-Clinic		99215	U2	U7			124.69	
		Practitioner Level 1		99215	GT	U1			155.23	Practitioner Level 2		99215	GT	U2			103.92	

Psychiatric Treatment

Unit Value	1 encounter (Note: Time-in/Time-out is required in the documentation as it justifies which code above is billed)	Maximum Daily Units	2 units (see qualifier in definition below)
Initial Authorization	24 units	Re-Authorization	24units
Authorization Period	180 days	Utilization Criteria	<u>LOCUS scores: 1-6</u>
Service Definition	<p>The provision of specialized medical and/or psychiatric services that include, but are not limited to:</p> <ol style="list-style-type: none"> Psychotherapeutic services with medical evaluation and management including evaluation and assessment of physiological phenomena (including co-morbidity between behavioral and physical health care issues); Assessment and monitoring of an youth's status in relation to treatment with medication, Assessment of the appropriateness of initiating or continuing services. <p>Youth must receive appropriate medical interventions as prescribed and provided by members of the medical staff pursuant to the Medical Practice Act of 2009, Subsection 43-34-23 Delegation of Authority to Nurse and Physician Assistant that shall support the individualized goals of recovery as identified by the individual and their parent/guardians and their Individualized Recovery Plan (within the parameters of the youth/family's informed consent).</p>		
Admission Criteria	<ol style="list-style-type: none"> Individual is determined to be in need of psychotherapy services and has confounding medical issues which interact with behavioral health diagnosis, requiring medical oversight; or Individual has been prescribed medications as a part of the treatment array 		
Continuing Stay Criteria	<ol style="list-style-type: none"> Individual continues to meet the admission criteria; or Individual exhibits acute disabling conditions of sufficient severity to bring about a significant impairment in day-to-day functioning; or Individual continues to present symptoms that are likely to respond to pharmacological interventions; or Individual continues to demonstrate symptoms that are likely to respond or are responding to medical interventions; or Individual continues to require management of pharmacological treatment in order to maintain symptom remission. 		
Discharge Criteria	<ol style="list-style-type: none"> An adequate continuing care plan has been established; and one or more of the following: Individual has withdrawn or been discharged from service; or Individual no longer demonstrates symptoms that need pharmacological interventions. 		
Service Exclusions	Not offered in conjunction with ACT		
Clinical Exclusions	Services defined as a part of ACT		
Required Components	Telemedicine may be utilized for an initial Psychiatric Diagnostic Examination as well as for ongoing Psychiatric Diagnostic Examination via the use of appropriate procedure codes with the GT modifier.		

Psychiatric Treatment

Clinical Operations	<ol style="list-style-type: none"> 1. In accordance with recovery philosophy, it is expected that individuals will be treated as full partners in the treatment regimen/services planned and received. As such, it is expected that practitioners will fully discuss treatment options with individuals and allow for individual choice when possible. Discussion of treatment options should include a full disclosure of the pros and cons of each option (e.g. full disclosure of medication/treatment regimen potential side effects, potential adverse reactions--including potential adverse reaction from not taking medication as prescribed, and expected benefits). If such full discussion/disclosure is not possible or advisable according to the clinical judgment of the practitioner, this should be documented in the individual's chart (including the specific information that was not discussed and a compelling rationale for lack of discussion/disclosure). 2. Assistive tools, technologies, worksheets, etc. can be used by the served individual to facilitate communication about treatment, symptoms, improvements, etc. with the treating practitioner. If this work falls into the scope of Interactive Complexity it is noted in accordance with that definition. 3. This service may be provided with Individual Counseling codes 90833 and 90836, but the two services must be separately identifiable. 4. For purposes of this definition, a "new patient" is an individual who has not received an E/M code service from that agency within the past three years. If an individual has engaged with the agency, and has seen a non-physician for a BH Assessment, they are still considered a "new patient" until after the first E/M service is completed.
Service Accessibility	<p>Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's health. Electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site.</p>
Additional Medicaid Requirements	<ol style="list-style-type: none"> 1. The daily maximum within a CSU for E/M is 1 unit/day. 2. Even if a physician also has his/her own Medicaid number, the physician providing behavioral health treatment and care through this code should bill via the approved provider agency's Medicaid number through the Medicaid Category of Service (COS) 440.
Reporting and Billing Requirements	<ol style="list-style-type: none"> 1. Within this service group, a second unit with a U1 modifier may be used in the event that a Telemedicine Psychiatric Treatment unit is provided and it indicates a need for a face-to-face assessment (e.g. 99213GTU1 is billed and it is clinically indicated that a face-to-face by an on-site physician needs to immediately follow based upon clinical indicators during the first intervention, then 99213U1, can also be billed in the same day). 2. Within this service group, there is an allowance for when a U2 practitioner conducts an intervention and, because of clinical indicators presenting during this intervention, a U1 practitioner needs to provide another unit due to the concern of the U2 supervisee (e.g. Physician's Assistant provides and bills 90805U2U6 and because of concerns, requests U1 intervention following his/her billing of U2 intervention). The use of this practice should be rare and will be subject to additional utilization review scrutiny. 3. These E/M codes are based upon time (despite recent CPT guidance). The Georgia Medicaid State Plan (June 6, 2012) is priced on time increments and therefore time will remain the basis of justification for the selection of codes above for the near term. 4. The Rounding protocol set forth in the Community Service Requirements for All Providers, Section III, Documentation Requirements must be used when determining the billing code submitted to DBHDD or DCH. Specific billing guidance for rounding time for Psychiatric Treatment is as follows: <ul style="list-style-type: none"> 99201 is billed when time with a new person-served is 5-15 minutes. 99202 is billed if the time with a new person-served is 16-25 minutes. 99203 is billed if the time with a new person-served is 26-37 minutes. 99204 is billed if the time with a new person-served is 38-52 minutes. 99205 is billed if the time with a new person-served is 53 minutes or longer. 99211 is billed when time with an established person-served is 3-7 minutes. 99212 is billed if the time with an established person-served is 8-12 minutes. 99213 is billed if the time with an established person-served is 13-20 minutes. 99214 is billed if the time with an established person-served 21-32 minutes. 99215 is billed if the time with an established person-served is 33 minutes or longer. 5. If a Medicaid claim for this service denies for a Procedure-to-Procedure edit, a modifier (25) can be added to the claim and resubmitted to the MMIS for payment.

Psychological Testing: Psychological Testing – Psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psycho-pathology

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
per hour of psychologist's or physician's time, both face-to-face with the patient and time interpreting test results and preparing report)	Practitioner Level 2, In-Clinic	96101	U2	U6			155.87	Practitioner Level 2, Out-of-Clinic	96101	U2	U7			187.04
with qualified healthcare professional interpretation and report, administered by technician, per hour of technician time, face-to-face	Practitioner Level 3, In-Clinic	96102	U3	U6			120.04	Practitioner Level 4, In-Clinic	96102	U4	U6			81.18
	Practitioner Level 3, Out-of-Clinic	96102	U3	U7			146.71	Practitioner Level 4, Out-of-Clinic	96102	U4	U7			97.42
Unit Value	1 hour							Maximum Daily Units	5 units					
Initial Auth	5 units							Re-Authorization	5 units					
Authorization Period	180 days							Utilization Criteria	CAFAS scores: 10-240					
Service Definition	<p>Psychological testing consists of a face-to-face assessment of emotional functioning, personality, cognitive functioning (e.g. thinking, attention, memory) or intellectual abilities using an objective and standardized tool that has uniform procedures for administration and scoring and utilizes normative data upon which interpretation of results is based.</p> <p>Psychological tests are only administered and interpreted by those who are properly trained in their selection and application. The practitioner administering the test ensures that the testing environment does not interfere with the performance of the examinee and ensures that the environment affords adequate protections of privacy and confidentiality.</p> <p>This service covers both the face-to-face administration of the test instrument(s) by a qualified examiner as well as the time spent by a psychologist or physician (with the proper education and training) interpreting the test results and preparing a written report.</p>													
Admission Criteria	<ol style="list-style-type: none"> 1. A known or suspected mental illness or substance-related disorder; and 2. Initial screening/intake information indicates a need for additional undetermined supports and recovery/resiliency planning; and 3. Youth meets Core Customer eligibility. 													
Continuing Stay Criteria	The youth's situation/functioning has changed in such a way that previous assessments are outdated.													
Discharge Criteria	Each intervention is intended to be a discrete time-limited service that modifies treatment/support goals or is indicated due to change in illness/disorder.													
Staffing Requirements	1. The term "psychologist" is defined in the Approved Behavioral Health Practitioners table in Section II of this manual (Reference § 43-39-1 and § 43-39-7).													

Psychological Testing: Psychological Testing – Psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psycho-pathology

Required Components	<ol style="list-style-type: none"> There may be no more than one comprehensive battery of 96101 and 96102 provided to one individual within a year. There may be no more than 10 combined hours of 96101 and 96012 provided to one individual within a year.
Clinical Operations	The individual (and caregiver/responsible family members etc. as appropriate) must actively participate in the assessment processes.
Documentation Requirements	In addition to the authorization produced through this service, documentation of clinical assessment findings from this service should also be completed and placed in the individual's chart.
Billing & Reporting Requirements	If a Medicaid claim for this service denies for a Procedure-to-Procedure edit, a modifier (59) can be added to the claim and resubmitted to the MMIS for payment.

Service Plan Development

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Service Plan Development	Practitioner Level 2, In-Clinic	H0032	U2	U6			\$38.97	Practitioner Level 2, Out-of-Clinic	H0032	U2	U7			\$46.76
	Practitioner Level 3, In-Clinic	H0032	U3	U6			\$30.01	Practitioner Level 3, Out-of-Clinic	H0032	U3	U7			\$36.68
	Practitioner Level 4, In-Clinic	H0032	U4	U6			\$20.30	Practitioner Level 4, Out-of-Clinic	H0032	U4	U7			\$24.36
	Practitioner Level 5, In-Clinic	H0032	U5	U6			\$15.13	Practitioner Level 5, Out-of-Clinic	H0032	U5	U7			\$18.15
Unit Value	15 minutes							Maximum Daily Units*	24 units (Combined with H0031)					
Initial Authorization*	32 units (Combined with H0031)							Re-Authorization*	32 units (Combined with H0031)					
Authorization Period*	180 days							Utilization Criteria	CAFAS scores:10-240					
Service Definition	<p>Youth/Families access this service when it has been determined through an initial screening that the youth has mental health or addictive disease concerns. The Individualized Recovery/Resiliency Plan (IRP) results from the Diagnostic and Behavioral Health Assessments and is required within the first 30 days of service, with ongoing plans completed as demanded by individual need and/or by service policy.</p> <p>Information from a comprehensive assessment should ultimately be used to develop, together with the youth and/or caretakers an IRP that supports resilience and that is based on goals identified by the individual with parent(s)/responsible caregiver(s) involvement. As indicated, medical, nursing, peer, school, nutritional, etc. staff should provide information from records, and various multi-disciplinary assessments for the development of the IRP.</p> <p>The cornerstone component of the youth IRP involves a discussion with the child/adolescent and parent(s)/responsible caregiver(s) regarding what resiliency means to them personally (e.g. the youth having more friends, improvement of behavioral health symptoms, staying in school, improved family relationships etc.), and the development of goals (i.e. outcomes) and objectives that are defined by and meaningful to the youth based upon the individual's articulation of their recovery hopes. Concurrent with the development of the IRP, an individualized safety plan should also be developed, with the individual youth and parent(s)/responsible caregiver(s) guiding the process through the free expression of their wishes and through their assessment of the components developed for the safety plan as being realistic for them.</p> <p>The entire process should involve the youth as a full partner and should focus on service and resiliency goals/outcomes as identified by the youth and his/her family as well as collateral agencies/treatment providers/relevant individuals.</p>													

Service Plan Development

	<p>Recovery/Resiliency planning shall set forth the course of care by:</p> <ul style="list-style-type: none"> • Prioritizing problems and needs; • Stating goals which will honor achievement of stated hopes, choice, preferences and desired outcomes of the youth/family; • Assuring goals/objectives are related to the assessment; • Defining goals/objectives that are individualized, specific, and measurable with achievable timeframes; • Defining discharge criteria and desired changes in levels of functioning and quality of life to objectively measure progress; • Transition planning at onset of service delivery; • Selecting services and interventions of the right duration, intensity, and frequency to best accomplish these objectives; • Assuring there is a goal/objective that is consistent with the service intent; and • Identifying qualified staff who are responsible and designated for the provision of services.
Admission Criteria	<ol style="list-style-type: none"> 1. A known or suspected mental illness or substance-related disorder; and 2. Initial screening/intake information indicates a need for additional undetermined supports and recovery/resiliency planning; and 3. Youth meets Core Customer eligibility.
Continuing Stay Criteria	The youth's situation/functioning has changed in such a way that previous assessments are outdated.
Discharge Criteria	Each intervention is intended to be a discrete time-limited service that modifies treatment/support goals or is indicated due to change in illness/disorder.
Required Components	The service plan must include elements articulated in the Community Requirements chapter in this Provider Manual.
Clinical Operations	<ol style="list-style-type: none"> 1. The individual (and caregiver/responsible family members etc. as appropriate) should actively participate in planning processes. 2. The Individualized Resiliency Plan should be directed by the individual's/family's personal resiliency goals as defined by them. 3. Safety/crisis planning should be directed by the youth/family and their needs/wishes to the extent possible and clinically appropriate. Plans should not contain elements/components that are not agreeable to, meaningful for, or realistic for the youth/family and that the youth/family is therefore not likely to follow through with. 4. The Multipurpose Informational Consumer Profile (MICP) format for treatment planning does not meet the requirements for a comprehensive IRP and should not be used as such. Detailed guidelines for treatment planning are contained in the "Community Requirements" in this Provider Manual and must be adhered to. 5. For youth at or above age 17 who may need long-term behavioral health supports, plan elements should include transitional elements related to post-primary education, adult services, employment (supported or otherwise), and other transitional approaches to adulthood.

CHILD & ADOLESCENT SPECIALTY SERVICES

Community Based Inpatient Psychiatric & Substance Detoxification

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Psychiatric Health Facility Service, Per Diem		H2013												
Unit Value	Per Diem							Maximum Daily Units	1 unit					
Initial Authorization	5 days							Re-Authorization	3 days					
Authorization Period	5 days							Utilization Criteria	CAFAS scores:190-240:					
Service Definition	A short-term stay in a licensed and accredited community-based hospital for the treatment or rehabilitation of a psychiatric and/or substance related disorder. Services are of short duration and provide treatment for an acute psychiatric or behavioral episode. For clinically appropriate transitional age youth, this service may also include Medically Managed Inpatient Detoxification at ASAM Level 4-WM.													
Admission Criteria	<ol style="list-style-type: none"> Youth with SED that is experiencing serious impairment; persistent, recurrent, severe, or major symptoms (such as psychoses); or who is experiencing major suicidal, homicidal or high risk tendencies as a result of the mental illness; or Youth's need is assessed for 24/7 supports which must be one-on-one and may not be met by any service array which is available in the community; or Youth is assessed as meeting diagnostic criteria for a Substance Related Disorder according to the latest version of the DSM; and one or more of the following: <ol style="list-style-type: none"> Youth is experiencing signs of severe withdrawal, or there is evidence (based on history of substance intake, age, gender, withdrawal history, present symptoms, physical condition, and/or emotional/behavioral condition) that severe withdrawal syndrome is imminent; or Level 4-WM is the only available level of service that can provide the medical support and comfort needed by the youth, as evidenced by: <ol style="list-style-type: none"> A withdrawal management regimen or Youth's response to that regimen that requires monitoring or intervention more frequently than hourly, or The youth's need for withdrawal management or stabilization while pregnant, until she can be safely treated in a less intensive service. 													
Continuing Stay Criteria	<ol style="list-style-type: none"> Youth continues to meet admission criteria; and Youth's withdrawal signs and symptoms are not sufficiently resolved to the extent that they can be safely managed in less intensive services; 													
Discharge Criteria	<ol style="list-style-type: none"> An adequate continuing care plan has been established; and one or more of the following: Youth no longer meets admission and continued stay criteria; or Family requests discharge and youth is not imminently dangerous to self or others; or Transfer to another service/level of care is warranted by change in the individual's condition; or Individual requires services not available in this level of care. 													
Service Exclusions	This service may not be provided simultaneously to any other service in the service array excepting short-term access to services that provide continuity of care or support planning for discharge from this service.													
Clinical Exclusions	Youths with any of the following unless there is clearly documented evidence of an acute psychiatric/addiction episode overlaying the primary diagnosis: Autism, Mental Retardation/Developmental Disabilities, Organic Mental Disorder; or Traumatic Brain Injury													
Required Components	<ol style="list-style-type: none"> If providing withdrawal management services, the program must be licensed by DCH/HFR under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2 OR is licensed as a hospital/specialty hospital. A physician's order in the individual's record is required to initiate withdrawal management services. Verbal orders or those initiated by a Physician's Assistant or Clinical Nurse Specialist are acceptable provided they are signed by the physician within 24 hours or the next working day. 													

Staffing Requirements	Only nursing or other licensed medical staff under supervision of a physician may provide withdrawal management services.
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Crisis Stabilization Unit (CSU) Services															
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	
Behavioral Health; Short-term Residential (Non-Hospital Residential Treatment Program Without Room & Board, Per Diem)		H0018	HA	U2			209.22								
Behavioral Health; Short-term Residential (Non-Hospital Residential Treatment Program Without Room & Board, Per Diem)		H0018	HA	TB	U2		209.22								
Unit Value	1 day							Maximum Daily Units	1 unit						
Initial Authorization	20 units							Utilization Criteria	CAFAS scores: 140-240; OR "clinical information to justify the service provided in the "justification text" on the MICP if CAFAS scores are higher/lower.						
Authorization Period	20 days														
Service Definition	<p>This is a residential alternative to or diversion from inpatient hospitalization, offering psychiatric stabilization and withdrawal management services. The program provides medically monitored residential services for the purpose of providing psychiatric stabilization and/or withdrawal management on a short-term basis. Specific services may include:</p> <ol style="list-style-type: none"> 1) Psychiatric medical assessment; 2) Crisis assessment, support and intervention; 3) Medically Monitored Residential Substance Withdrawal Management (at ASAM Level 3.7-WM); 4) Medication administration, management and monitoring; 5) Brief individual, group and/or family counseling; and 6) Linkage to other services as needed. 														

Crisis Stabilization Unit (CSU) Services

Admission Criteria	<ol style="list-style-type: none"> 1. Treatment at a lower level of care has been attempted or given serious consideration; and #2 and/or #3 are met: 2. Child/Youth has a known or suspected illness/disorder in keeping with target populations listed above; or 3. Child/Youth is experiencing a severe situational crisis which has significantly compromised safety and/or functioning; and one or more of the following: <ol style="list-style-type: none"> a. Child/Youth presents a substantial risk of harm or risk to self, others, and/or property or is so unable to care for his or her own physical health and safety as to create a life-endangering crisis. Risk may range from mild to imminent; or b. Child/Youth has insufficient or severely limited resources or skills necessary to cope with the immediate crisis; or c. Child/youth demonstrates lack of judgment and/or impulse control and/or cognitive/perceptual abilities to manage the crisis; or d. For withdrawal management services, individual meets admission criteria for Medically Monitored Residential Withdrawal Management.
Continuing Stay Criteria	<p>This service may be utilized at various points in the child's course of treatment and recovery; however, each intervention is intended to be a discrete time-limited service that stabilizes the individual</p>
Discharge Criteria	<ol style="list-style-type: none"> 1. Youth no longer meets admission guidelines requirements; or 2. Crisis situation is resolved and an adequate continuing care plan has been established; or 3. Youth does not stabilize within the evaluation period and must be transferred to a higher intensity service.
Clinical Exclusions	<ol style="list-style-type: none"> 1. Youth is not in crisis. 2. Youth does not present a risk of harm to self or others or is able to care for his/her physical health and safety. 3. Severity of clinical issues precludes provision of services at this level of intensity.
Required Components	<ol style="list-style-type: none"> 1. CSUs providing medically monitored short-term residential psychiatric stabilization and/or withdrawal management services shall be designated by the Department as both an emergency receiving facility and an evaluation facility and must be surveyed and licensed by the DBHDD. 2. In addition to all service qualifications specified in this document, providers of this service must adhere to the DBHDD Rules and Regulations for Children and Adolescent Crisis Stabilization Units, Chapter 82-4-1 3. The maximum length of stay in a crisis bed is 14 adjusted days (excluding Saturdays, Sundays and state holidays) for children and adolescents. 4. The maximum length of stay in crisis AND transitional beds combined is 29 adjusted calendar days (excluding Saturdays, Sundays and state holidays). 5. Youth occupying transitional beds must receive services from outside the CSU (i.e. community-based services) on a daily basis. 6. Services must be provided in a facility designated as an emergency receiving and evaluation facility that is not also an inpatient hospital, a freestanding Institute for Mental Disease (IMD), or a licensed substance abuse detoxification facility. 7. A CSU must have documented operating agreements and referral mechanisms for psychiatric disorders, addictive disorders, and physical healthcare needs that are beyond the scope of the CSU and that require inpatient treatment. Operating agreements must delineate the type and level of service to be provided by the private or public inpatient hospital or treatment facility. These agreements must specifically address the criteria and procedures for transferring the youth to a designated treatment facility when the CPS is unable to stabilize the youth.
Staffing Requirements	<ol style="list-style-type: none"> 1. A physician or a staff member under the supervision of a physician, practicing within the scope of State law, must provide CSU Services. 2. All services provided within the CPS must be delivered under the direction of a physician. A physician must conduct an assessment of new admissions, address issues of care, and write orders as required. 3. A CSU must employ a fulltime Nursing Administrator who is a Registered Nurse. 4. A CSU must have a Registered Nurse present at the facility at all times. 5. A CSU must have an independently licensed clinician (or a supervised S/T) on staff and available to provide individual, group, and family therapy. 6. Staff-to-client ratios must be established based on the stabilization needs of clients being served and in accordance with the aforementioned Rules and Regulations. 7. Functions performed by Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, Registered Nurses, and Licensed Practical Nurses must be performed within the scope of practice allowed by State law and Professional Practice Acts.

Crisis Stabilization Unit (CSU) Services

Clinical Operations	<ol style="list-style-type: none"> 1. A physician must evaluate a child/youth referred to a CSU within 24 hours of the referral. 2. A CSU must follow the seclusion and restraint procedures included in the Department's Rules and Regulations for Crisis Stabilization Units. 3. For youth with co-occurring diagnoses including mental retardation/developmental disabilities, this service must target the symptoms, manifestations, and skills-development related to the identified behavioral health issue. 4. Youth served in transitional beds may access an array of community-based services in preparation for their transition out of the CSU, and are expected to engage in community-based services daily while in a transitional bed. 																		
Additional Medicaid Requirements	<ol style="list-style-type: none"> 1. Crisis Stabilization Units with 16 beds or less should bill individual/discrete services for Medicaid recipients. 2. The individual services listed below may be billed up to the daily maximum listed when provided in a CSU. Billable services and daily limits within CSUs are as follows: <table border="1" data-bbox="525 454 1785 763"> <thead> <tr> <th>Service</th> <th>Daily Maximum Billable Units</th> </tr> </thead> <tbody> <tr> <td>Crisis Intervention</td> <td>8 units</td> </tr> <tr> <td>Diagnostic Assessment</td> <td>2 units</td> </tr> <tr> <td>Psychiatric Treatment</td> <td>1 unit (Pharmacological Mgmt only)</td> </tr> <tr> <td>Nursing Assessment and Care</td> <td>5 units</td> </tr> <tr> <td>Medication Administration</td> <td>1 unit</td> </tr> <tr> <td>Group Training/Counseling</td> <td>4 units</td> </tr> <tr> <td>Behavioral Health Assessment & Serv. Plan Development</td> <td>24 units</td> </tr> <tr> <td>Medication Administration</td> <td>1 unit</td> </tr> </tbody> </table> 3. Medicaid claims for the services in E.2. above may not be billed for any service provided to Medicaid-eligible individuals in CSUs with greater than 16 beds. 	Service	Daily Maximum Billable Units	Crisis Intervention	8 units	Diagnostic Assessment	2 units	Psychiatric Treatment	1 unit (Pharmacological Mgmt only)	Nursing Assessment and Care	5 units	Medication Administration	1 unit	Group Training/Counseling	4 units	Behavioral Health Assessment & Serv. Plan Development	24 units	Medication Administration	1 unit
Service	Daily Maximum Billable Units																		
Crisis Intervention	8 units																		
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Medication Administration	1 unit																		
Group Training/Counseling	4 units																		
Behavioral Health Assessment & Serv. Plan Development	24 units																		
Medication Administration	1 unit																		
Reporting and Billing Requirements	<ol style="list-style-type: none"> 1. Providers must report information on all individuals served in CSUs no matter the funding source: <ol style="list-style-type: none"> a. The CSU shall submit MICPs for all individuals served (state-funded, Medicaid funded, private pay, other third party payer, etc.); b. The CSU shall submit per diem encounters (H0018HAU2 or H0018HATBU2) for all individuals served (state-funded, Medicaid funded, private pay, other third party payer, etc.) even if sub-parts cited in E.2 above are also billed as a claim to Medicaid; c. Providers must designate either CSU bed use or transitional bed use in encounter submissions through the absence of or use of the TB modifier. TB represents "Transitional Bed." 2. Unlike all other DBHDD residential services, the start date of a CSU span encounter submission may be in one month and the end date may be in the next. The span of reporting must cover continuous days of service and the number of units must equal the days in the span. 																		
Documentation Requirements	<ol style="list-style-type: none"> 1. Individuals receiving services within the CSU shall be reported as a per diem encounter based upon occupancy at 11:59PM. At 11:59PM, each individual reported must have a verifiable physician's order for CSU level of care [or order written by delegation of authority to nurse or physician assistant under protocol as specified in § 43-34-23]. Individuals entering and leaving the CSU on the same day (prior to 11:59PM) will not have a per diem encounter reported. 2. For individuals transferred to transitional beds, the date of transfer must be documented in a progress note and filed in the individual's chart. 3. Daily engagement in community-based services must also be documented in progress notes for those occupying transitional beds. 4. The notes for the program must have documentation to support the per diem AND, if the program bills sub-parts to Medicaid (in accordance with Additional Medicaid Requirements above), each discrete service delivered must have documentation to support that sub-billable code (e.g. Group is provided for 1 hour, Group is billed for 1 hour, Group note is for 4 units at the 15 minute rate and meets all the necessary components of documentation for that sub-code). 																		

Intensive Customized Care Coordination

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Community-based wrap-around services, monthly	Community-based wrap-around services	H2022	HK				
Unit Value	1 month	Maximum Daily Units					
Initial Authorization	12 units	Re-Authorization		1 year			
Authorization Period	1 year	Utilization Criteria		See Admission Criteria below			
Service Definition	<p>Intensive Customized Care Coordination is a provider-based High Fidelity Wraparound intervention, as defined by the National Wraparound Initiative, comprised of a team selected by the family/caregiver in which the family and team identify the goals and the appropriate strategies to reach the goals. Intensive Customized Care Coordination assists individuals in identifying and gaining access to required services and supports, as well as medical, social, educational, developmental and other services and supports, regardless of the funding source for the services to which access is sought. Intensive Customized Care Coordination encourages the use of community resources through referral to appropriate traditional and non-traditional providers, paid, unpaid and natural supports. Intensive Customized Care Coordination is a set of interrelated activities for identifying, planning, budgeting, documenting, coordinating, securing, and reviewing the delivery and outcome of appropriate services for individuals through a wraparound approach. Care Coordinators (CC), who deliver this intervention, work in partnership with the individual and their family/caregivers/legal guardian are responsible for assembling the Child and Family Team (CFT), including both professionals and non-professionals who provide individualized supports and whose combined expertise and involvement ensures plans are individualized and person-centered, build upon strengths and capabilities and address individual health and safety issues.</p> <p>Intensive Customized Care Coordination is differentiated from traditional case management by:</p> <ul style="list-style-type: none"> • Coaching and skill building of the youth and parent/caregiver to empower their self-activation and self-management of their personal resiliency, recovery and wellness towards stability and independence. • The intensity of the coordination: an average of three hours of coordination weekly • The frequency of the coordination: an average of one face-to-face meeting weekly • The caseload: an average of ten youth per care coordinator • The average duration: 12 – 18 months • The partnership with a High Fidelity Wraparound trained certified parent peer specialist (CPS-P) as a part of the Wrap Team • Development of a Child and Family Team, minimally comprised of the youth, parent/caregiver, Wrap Team (CC and CPS-P and one natural support • A Child and Family Team Meeting (CFTM), held minimally every 30 days, where all decisions regarding the Individual Recovery Plan are made. <p>Intensive Customized Care Coordination includes the following components as frequently as necessary:</p> <ul style="list-style-type: none"> • Comprehensive youth-guided and family-directed assessment and periodic reassessment of the individual to determine service needs, including activities that focus on needs identification to determine the need for any medical, educational, social, developmental or other services and include activities such as: taking client history; identifying the needs, strengths, preferences and physical and social environment of the individual, and completing related documentation; 						

Intensive Customized Care Coordination

	<p>gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the individual.</p> <ul style="list-style-type: none"> • Development and periodic revision of an individualized recovery plan (IRP), based on the assessment, that specifies the goals of providing care management and the actions to address the medical, social, educational, developmental and other services needed by the individual, including activities that ensure active participation by the individual and others. The IRP will include transition goals and plans. If an individual declines services identified in the IRP, it must be documented. • Referral and related activities to help the individual obtain needed services/supports, including activities that help link the eligible individual with medical, social, educational, developmental providers, and other programs or services that are capable of providing services to address identified needs and achieve goals in the IRP. • Monitoring and follow-up activities that are necessary to ensure that the IRP is effectively implemented and adequately addresses the needs of the individual. Monitoring includes direct observation and follow-up to ensure that IRPs have the intended effect and that approaches to address challenging behaviors, medical and health needs, and skill acquisition are coordinated in their approach and anticipated outcome. Monitoring includes reviewing the quality and outcome of services and the ongoing evaluation of the satisfaction of individuals and their families/caregivers/legal guardians with the IRP. These activities may be with the individual, family members, providers, or other entities, and may be conducted as frequently as necessary to help determine: whether services/supports are being furnished in accordance with the individual's IRP; whether the services in the IRP are adequate to meet the needs of the individual; whether there are changes in the needs or status of the individual. If changes have occurred, the individual IRP and service arrangements with providers will be updated to reflect changes. • Intensive Customized Care Coordination may include contacts and coordination with individuals that are directly related to the identification of the individual's needs and care, for the purposes of assisting individuals' access to services, identifying needs and supports to assist the individual in obtaining services, providing Care Coordinators with useful feedback, and alerting Care Coordinators to changes in the individual's needs. Examples of these individuals include, but are not limited to, school personnel, child welfare representatives, juvenile justice staff, primary care physicians, etc. • Intensive Customized Care Coordination also assists individuals and their families or representatives in making informed decisions about services, supports and providers.
Admission Criteria	<p>Based on CANS-Georgia scoring:</p> <p>At least 1 rating of "2" or "3" on the following Child Behavioral/Emotional Needs:</p> <ul style="list-style-type: none"> • Psychosis • Attention/Concentration • Impulsivity • Depression • Anxiety • Substance Use • Attachment • Anger Control • Eating Disturbance <p style="text-align: center;">AND</p> <p>At least 1 rating of "2" or "3" in the following functioning needs:</p> <ul style="list-style-type: none"> • Social Functioning • School Behavior

Intensive Customized Care Coordination

- Sleep
- Recreational
- Legal

AND

At least 1 rating of "2" or two ratings of "1" on the risk behaviors

OR

At least 1 rating of "2" or "3" on the following Child Behavioral/Emotional Needs:

- Psychosis
- Attention/Concentration
- Impulsivity
- Depression
- Anxiety
- Substance Use
- Attachment
- Anger Control
- Eating Disturbance

AND

At least 1 rating of "3" in the following functioning needs:

- Family
- Living Situation

and one or more of the following:

1. Youth has shown serious risk of harm in the past ninety (90) days, as evidenced by the following:

A. Current suicidal or homicidal ideation with clear, expressed intentions and/or current suicidal or homicidal ideation with past history of carrying out such behavior; and at least one of the following:

1. Indication or report of significant and repeated impulsivity and/or physical aggression, with poor judgment and insight, and that is significantly endangering to self or others.
2. Recent pattern of excessive substance use (co-occurring with a mental health diagnoses as indicated in target population definition above) resulting in clearly harmful behaviors with no demonstrated ability of child/adolescent or family to restrict use.
3. Clear and persistent inability, given developmental abilities, to maintain physical safety and/or use environment for safety; OR

2. The clinical documentation supports the need for the safety and structure of treatment provided in a high level of care and the Youth's behavioral health issues are unmanageable as evidenced by both:

A. There is a documented history of multiple admissions to crisis stabilization programs or psychiatric hospitals (in the past 12 months) and youth has not progressed sufficiently or has regressed; and two of the following:

1. Less restrictive or intensive levels of treatment have been tried and were unsuccessful, or are not appropriate to meet the individual's needs, and
2. Past response to treatment has been minimal, even when treated at high levels of care for extended periods of time, or
3. Symptoms are persistent and functional ability shows no significant improvement despite extended treatment exposure.

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	<p>AND</p> <p>B. Youth and/or family has history of attempted, but unsuccessful follow through with elements of a Resiliency/Recovery Plan which has resulted in of specific mental, behavioral or emotional behaviors that place the recipient at imminent risk for disruption of current living arrangement including:</p> <ol style="list-style-type: none"> 1. lack of follow through taking prescribed medications, 2. following a crisis plan, or 3. maintaining family and community-based integration.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual has shown serious risk of harm in the past ninety (90) days, as evidenced by the following: <ol style="list-style-type: none"> A. Current suicidal or homicidal ideation with clear, expressed intentions and/or current suicidal or homicidal ideation with past history of carrying out such behavior; and at least one of the following: <ol style="list-style-type: none"> i. Indication or report of significant and repeated impulsivity and/or physical aggression, with poor judgment and insight, and that is significantly endangering to self or others. ii. Recent pattern of excessive substance use (co-occurring with a mental health diagnoses as indicated in target population definition above) resulting in clearly harmful behaviors with no demonstrated ability of child/adolescent or family to restrict use. iii. Clear and persistent inability, given developmental abilities, to maintain physical safety and/or use environment for safety; OR B. The clinical documentation supports the need for the safety and structure of treatment provided in a high level of care and the individual's behavioral health issues are unmanageable as evidenced by both: <ol style="list-style-type: none"> A. There is a documented history of multiple admissions to crisis stabilization programs or psychiatric hospitals (in the past 12 months) and youth has not progressed sufficiently or has regressed; and two of the following: <ol style="list-style-type: none"> i. Less restrictive or intensive levels of treatment have been tried and were unsuccessful, or are not appropriate to meet the individual's needs, and ii. Past response to treatment has been minimal, even when treated at high levels of care for extended periods of time, or iii. Symptoms are persistent and functional ability shows no significant improvement despite extended treatment exposure; and B. The individual remains under the age of 22; and 2. The individual is actively participating in High Fidelity Wraparound, or there are active efforts being made that can reasonably be expected to lead to the child's engagement in treatment; and 3. Unless contraindicated, the family, guardian, and/or custodian is involved in the treatment and supports as required by the IRP, or there are active efforts being made (and documented) to involve them. 4. If progress is not evident, then there is documentation of action plan adjustments to address such lack of progress.
Discharge Criteria	<ol style="list-style-type: none"> 1. At least 1 rating of "2" or "3" on the following CANS Child Behavioral/Emotional Needs: <ul style="list-style-type: none"> • Psychosis • Attention/Concentration • Impulsivity • Depression • Anxiety • Substance Use • Attachment • Anger Control • Eating Disturbance; AND 2. Either: <ol style="list-style-type: none"> A. At least 1 rating of "2" or two ratings of "1" on the CANS risk behaviors; OR B. At least 1 rating of "2" in the following functioning needs: <ul style="list-style-type: none"> • Family

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	<ul style="list-style-type: none"> • Living Situation • Social Functioning • School Behavior • Sleep • Recreational • Legal; AND <p>3. An adequate transition plan has been established; AND</p> <p>4. One or more of the following:</p> <ul style="list-style-type: none"> • Goals of Individualized Action Plan have been substantially met and youth no longer meets continuing stay criteria; or • Youth's family requests discharge and the youth is not imminently in danger of harm to self or others; or • Transfer to another service is warranted by change in the youth's condition.
Service Exclusions	<p>Intensive Customized Care Coordination providers cannot bill the following services while providing Intensive Customized Care Coordination to an individual:</p> <ul style="list-style-type: none"> • Behavioral Health Assessment • Service Plan Development • Community Support Individual
Clinical Exclusions	<ol style="list-style-type: none"> 1. Individuals with the following conditions are excluded from admission because the severity of cognitive impairment precludes provision of services in this level of care: Severe and Profound Mental Retardation 2. The following diagnoses are not considered to be a sole diagnosis for this service: <ul style="list-style-type: none"> • Personality Disorders • Rule-Out (R/O) diagnoses 3. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence that a psychiatric diagnosis is the foremost consideration for psychiatric intervention: <ul style="list-style-type: none"> • Organic mental disorder • Traumatic brain injury 4. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence that an additional psychiatric diagnosis is the foremost consideration for psychiatric intervention: <ul style="list-style-type: none"> • Conduct Disorder 5. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence that a psychiatric diagnosis is the foremost consideration for this psychiatric intervention: <ul style="list-style-type: none"> • Mild Mental Retardation • Moderate Mental Retardation • Autistic Disorder
Required Components	<ol style="list-style-type: none"> 1. Access to parent peer support shall be offered. 2. The family must be contacted within 48 hours of the initial referral. 3. The family must be met face-to-face by care coordinator and/or family peer support staff within 72 hours of the initial referral to begin the engagement and assessment processes. 4. An initial CFTM must be held within 14 days from the initial enrollment for all youth. 5. CFTMs must be held at a minimum of every 30 days to minimally include the parent or legal guardian (or their representative), youth, one natural support and Wrap Team (To accommodate full participation, parent or legal guardian (or their representative), youth and natural support may participate telephonically or through other electronic means). Service providers (behavioral health and medical), child-serving agency personnel (child welfare, juvenile justice, education) and other natural

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- and informal supports should also be a part of the Child and Family Team.
6. The CFTM process should be family-driven and youth-guided
 7. All ECFTMs must be held within 72 hours of a crisis.
 8. Direct supervision by the supervisor must occur at least monthly utilizing the supervision tools indicated by the National Wraparound Initiative.
 9. Group/team case consultation by the supervisor must occur at least twice monthly.
 10. Provision of direct observation of staff in the field by the supervisor at least monthly.
 11. Provision of direct observation of staff in the field by Master Trainers/Coaches.
 12. All staff must be trained in High Fidelity Wraparound through the Georgia Center of Excellence for Child and Adolescent Behavioral Health (COE) before providing this service.
 13. Ensure that families are utilizing natural supports and low-cost, no-cost options that are sustainable. Provision of crisis response, 24/7/365 to the youth they serve, to include face-to-face response when clinically indicated.
 14. Care Coordinator will average 3 hours of care coordination per week per consumer
 15. Care Coordinator will average 1 face-to-face per week per consumer
 16. All coordination will be documented in accordance with the DBHDD Provider Manual for Community Behavioral Health Providers.
 17. Providers must participate in the Care Management Entity (CME) Quality Consortium

Staffing Requirements

- Intensive Customized Care Coordination providers will minimally have:
1. Care Coordinators who can serve at a 10 youth to 1 care coordinator ratio.
 - a. Care Coordinators must possess a minimum of B.A or B.S. degree in social work, psychology or related field with a minimum of two years clinical intervention experience in serving youth with SED or youth adults with mental illness. All Bachelor level and unlicensed care coordinators must be supervised at minimum by a licensed mental health professional (e.g. LCSW, LPC, LMFT). Experience can be substituted for education. Ability to create effective relationships with individuals of different cultural beliefs and lifestyles.
 - b. Effective verbal and written communication skills.
 - c. Strong interpersonal skills and the ability to work effectively with a wide range of constituencies in a diverse community.
 - d. Ability to develop and deliver case presentations.
 - e. Ability to analyze complex information, and to define and solve problems.
 - f. Ability to work effectively in a team environment.
 2. Wraparound Supervisor for every six (6) care coordinators
 - a. Wraparound Supervisor must possess a minimum of M.A. or M.S. degree in social work, psychology or related field with a minimum of two years clinical intervention experience in serving youth with SED or youth adults with mental illness. All unlicensed Wraparound Supervisor must be supervised at minimum by a licensed mental health professional (e.g. LCSW, LPC, LMFT). Education can be substituted for experience. Ability to create effective relationships with individuals of different cultural beliefs and lifestyles.
 - b. Effective verbal and written communication skills.
 - c. Strong interpersonal skills and the ability to work effectively with a wide range of constituencies in a diverse community.
 - d. Ability to develop and deliver case presentations.
 - e. Ability to analyze complex information, and to define and solve problems.
 - f. Ability to work effectively in a team environment.
 3. A Program Director who is responsible for the overall management of this service. The CME Director oversees the implementation of numerous activities that are critical to CME administration and management including but not limited to supervision of team personnel; model adherence, principles, values, and fidelity;

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	participation and monitoring of continuous quality improvement,
Clinical Operations	<ol style="list-style-type: none"> 1. Providers must adhere to the DBHDD CME Procedures Manual. 2. Provider must accept all coordination responsibility for the youth and family. 3. Provider must ensure that all possible resources (services, formal supports, natural supports, etc.) have been exhausted to sustain the individual in a community based setting prior to institutional care being presented as an option. 4. Provider must ensure care coordination and tracking of services and dollars spent. 5. Provider must ensure that all updated action plans or authorization plans are submitted to the authorizer of services per the state guidelines of 7 days after the CFTM. 6. Provider must have an organizational plan that addresses how the provider will ensure the following: <ul style="list-style-type: none"> • Direct supervision by the supervisor must occur at least monthly utilizing the supervision tools indicated by the National Wraparound Initiative. • Group/team case consultation by the supervisor must occur at least twice monthly. • Provision of oversight and guidance around the quality and fidelity of Wrap Process by the supervisor. • Provision of oversight and guidance around the quality and fidelity to family-driven and youth-guided care by the supervisor • Ongoing training and support from the Center of Excellence regarding introductory and advanced Wraparound components as identified by CME Staff, COE or DBHDD in maintaining effective statewide implementation. • Supervisors complete Georgia Document Review Form (see DBHDD CME Manual) with Care Coordinators monthly for each child and family team. • Provision of crisis response, 24/7/365 to the youth they serve, to include face-to-face response when clinically indicated.
Service Accessibility	<ol style="list-style-type: none"> 1. Providers will be available for meetings at times and days conducive to the families, to include weekends and evenings for Child and Family Team meetings. 2. Families must be given their choice of family support organizations for parent peer support, where available. If unavailable in their county, the provider of Intensive Customized Care Coordination must provide parent peer support to the family, as the Wrap Team is defined as a care coordinator and a High Fidelity Wraparound trained certified parent peer specialist (CPS-P).
Documentation Requirements	<p>The following must be documented:</p> <ol style="list-style-type: none"> 1. Youth/Young adult and family orientation to the program, to include family and youth expectations 2. Wrap Team progress notes are documented for all child, youth, family interventions and coordination. These notes adhere to the content set forth in the DBHDD Provider Manual for Community Behavioral Health providers. 3. Evidence that the youth/young adult's needs have been assessed, eligibility established, and needs prioritized; 4. Evidence of youth/young adult participation, consent and response to support are present; 5. Evidence that methods used to deliver services and supports to meet the basic needs of youth are in a manner consistent with normal daily living as much as possible. 6. Evidence of minimal participation in each CFTM as described in Required Components. 7. Evidence of CFTMs and ECFTMs occurring as described in Required Components.
Billing & Reporting Requirements	<ol style="list-style-type: none"> 1. The provider must report data to the DBHDD or COE as required by the DBHDD CME Quality Improvement Plan or any other data request. 2. The provider must provide requested data to the DBHDD and/or DCH in their roles as state medical and behavioral health authorities. 3. The provider must document the provision of direct observation of staff in the field by the supervisor at least monthly. 4. The provider must document the provision of direct observation of staff in the field by Master Trainers/Coaches.
Additional Medicaid Requirements	<ol style="list-style-type: none"> 1. The Care Coordinator is responsible for seeking service authorization in accordance with the criteria herein through the benefit manager.

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Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Intensive Family Intervention	Practitioner Level 3, In-Clinic	H0036	U3	U6			\$30.01	Practitioner Level 3, Out-of-Clinic	H0036	U3	U7			\$41.26
	Practitioner Level 4, In-Clinic	H0036	U4	U6			\$22.14	Practitioner Level 4, Out-of-Clinic	H0036	U4	U7			\$27.06
	Practitioner Level 5, In-Clinic	H0036	U5	U6			\$16.50	Practitioner Level 5, Out-of-Clinic	H0036	U5	U7			\$20.17
Unit Value	15 minutes							Maximum Daily Units	48 Units is the standard maximum					
Initial Authorization	288 units							Re-Authorization	288 units					
Authorization Period	90 days							Utilization Criteria	Available to those with CAFAS scores: 100-240					
Service Definition	<p>A service intended to improve family functioning by clinically stabilizing the living arrangement, promoting reunification or preventing the utilization of out of home therapeutic venues (i.e. psychiatric hospital, psychiatric residential treatment facilities, or residential treatment services) for the identified youth. Services are delivered utilizing a team approach and are provided primarily to youth in their living arrangement and within the family system. Services promote a family-based focus in order to:</p> <ul style="list-style-type: none"> Defuse the current behavioral health crisis, evaluate its nature and intervene to reduce the likelihood of a recurrence; Ensure linkages to needed psychiatric, psychological, medical, nursing, educational, and other community resources, including appropriate aftercare upon discharge (i.e. medication, outpatient appointments, etc.); and Improve the individual child's/adolescent's ability to self-recognize and self-manage behavioral health issues, as well as the parents'/responsible caregivers' capacity to care for their children. <p>Services should include crisis intervention, intensive supporting resources management, individual and/or family counseling/training, and other rehabilitative supports to prevent the need for out-of-home placement or other more intensive/restrictive services. Services are based upon a comprehensive, individualized assessment and are directed towards the identified youth and his or her behavioral health needs/strengths and goals as identified in the Individualized Resiliency Plan.</p> <p>Services shall also include resource coordination/acquisition to achieve the youth's and their family's' goals and aspirations of self-sufficiency, resiliency, permanency, and community integration.</p>													
Admission Criteria	<ol style="list-style-type: none"> Youth has a diagnosis and duration of symptoms which classify the illness as SED (youth with SED have a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet DSM diagnostic criteria and results in a functional impairment which substantially interferes with or limits the child's role or functioning in the family, school, or community activities) and/or is diagnosed with a Substance Related Disorder; and one or more of the following: Youth has received documented services through other services such as Core Services and exhausted less intensive out-patient programs. Treatment at a lower intensity has been attempted or given serious consideration, but the risk factors for out-of-home placement are compelling (see item G.1. below); The less intensive services previously provided must be documented in the clinical record (even if it via by self-report of the youth and family). or Youth and/or family has insufficient or severely limited resources or skills necessary to cope with an immediate behavioral health crisis; or Youth and/or family behavioral health issues are unmanageable in traditional outpatient treatment and require intensive, coordinated clinical and supportive intervention; or Because of behavioral health issues, the youth is at immediate risk of out-of-home placement; or Because of behavioral health issues, the youth is at immediate risk of legal system intervention or is currently involved with DJJ for behaviors/issues related to SED and/or the Substance-related disorder 													

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Continuing Stay Criteria	Same as above.
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Youth no longer meets the admission criteria; or 3. Goals of the Individualized Resiliency Plan have been substantially met; or 4. Individual and family request discharge, and the individual is not imminently dangerous; or 5. Transfer to another service is warranted by change in the individual's condition; or 6. Individual requires services not available within this service.
Service Exclusions	<ol style="list-style-type: none"> 1. Not offered in conjunction with Individual Counseling, Family Counseling/Training, Crisis Intervention Services, and/or Crisis Stabilization Unit, PRTF, or inpatient hospitalization. 2. Community Support may be used for transition/continuity of care. 3. This service may not be provided to youth who reside in a congregate setting in which the caregivers are paid (such as group homes, or any other living environment that is not comprised of family, guardians, or other more permanent caregivers). A short-term exception would be if the youth were preparing for transition back to a single-family unit, the family member is present during the intervention, and the service is directed to supporting the unification/reunification of the youth and his/her identified family/caregiver and takes place in that home and community. 4. The billable activities of IFI do not include: <ol style="list-style-type: none"> a) Transportation b) Observation/Monitoring c) Tutoring/Homework Completion d) Diversionary Activities (i.e. activities without therapeutic value)
Clinical Exclusions	<ol style="list-style-type: none"> 1. Youth with any of the following unless there is clearly documented evidence of an acute psychiatric/addiction episode overlaying the primary diagnosis: Autism Spectrum Disorders including Asperger's Disorder, Mental Retardation/Developmental Disabilities, Organic Mental Disorder; or Traumatic Brain Injury 2. Youth can effectively and safely be treated at a lower intensity of service. This service may not be used in lieu of family preservation and post-adoption services for youth who do not meet the admission criteria for IFI.
Required Components	<ol style="list-style-type: none"> 1. The organization has procedures/protocols for emergency/crisis situations that describe methods for intervention when youth require psychiatric hospitalization. 2. Each IFI provider must have policies and procedures governing the provision of outreach services, including methods for protecting the safety of staff that engage in outreach activities. 3. The organization must have an Intensive Family Intervention Organizational Plan that addresses the description of: <ul style="list-style-type: none"> • Particular evidence-based family preservation, resource coordination, crisis intervention and wraparound service models utilized (MST, DBT, MDFT, etc.), types of intervention practiced. The organization must show documentation that each staff member is trained in the model for in-home treatment (i.e., certification, ongoing supervision provided by the training entity, documentation of annual training in the model). • The organization must have demonstrable evidence that they are working towards fidelity to the model that they have chosen (via internal Quality Assurance documentation, staff training documentation, etc.). There should not be an eclectic approach to utilizing models. Fidelity to the chosen model is the expectation for each IFI team. If an agency chooses to develop a plan which incorporates more than one evidenced-based model within the organization, there must be a particular evidenced-based model chosen for each IFI team (e.g. an agency administers 3 teams, 2 which will adhere to one model, one to another model). Documentation of training for each staff person on the evidenced-based in-home model they will be utilizing in the provision of services should exist in their personnel files. Some models do not have the stringent staffing requirements that this service requires. The expectation is that staffing patterns in accordance with the specific model used are in compliance with staffing requirements noted in this service definition, <ul style="list-style-type: none"> • Hours of operation, the staff assigned, and types of services provided to individuals, families, parents, and/or guardians, • How the plan for services is modified or adjusted to meet the needs specified in each Individualized Resiliency Plan, and 4. At least 60% of service units must be provided face-to-face with youth and their families and 80% of all face-to-face service units must be delivered in non-clinic

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	<p>settings over the authorization period.</p> <ol style="list-style-type: none"> 5. At least 50% of IFI face-to-face units must include the identified youth. However, when the child is not included in the face-to-face contacts, the focus of the contacts must remain on the child and their goals as identified on their IRP. 6. Documentation of how the team works with the family and other agencies/support systems (such as LIPTs, provider agencies, etc.) to build a clinically oriented transition and discharge plan is required and should be documented in the clinical record of the individual. 7. IFI is an individual intervention and may not be provided or billed for more than 1 youth at the same time (including siblings); however, youth participating in an IFI program may receive group skills training and/or group counseling in keeping with his/her individual recovery plan. Siblings who are each authorized to receive IFI must receive individualized services, but family interventions can be done jointly, with only one bill being submitted to the payer (For example, Sibling 1 and Sibling 2 are being seen for 2 units with the parents. Sibling 1 and Sibling 2 each have the documentation in both records, but only one claim for 2 units of reimbursement may be submitted to the payer source.) 8. IFI is intended to be provided to youth/families in their living arrangement. Services provided in school settings are allowable up to 3 hours/week as a general rule and the clinical record shall include documentation of partnership with the school. Exceptions to this 3 hours/week should be documented to include approval by the IFI Team Leader of clinical need (CAFAS scores, recent discharge from inpatient hospitalization, PRTF, CSU, etc.). The record should indicate why a specific intervention took place in the school during school hours instead of after school in the home or community. Youth receiving this service must never be taken out of the classroom for the convenience of the service provider. IFI should not supplant what schools must provide for support of a child based on the IEP.
<p>Staffing Requirements</p>	<ol style="list-style-type: none"> 1. Intensive Family Intervention is provided by a team consisting of the family and the following practitioners: <ul style="list-style-type: none"> • One fulltime Team Leader who is licensed (and/or certified as a CAC II if the target population is solely diagnosed with substance related disorders) by the State of Georgia under the Practice Acts and has at least 3 years of experience working with children with severe emotional disturbances. AMFT, LMSW, APC staff do not qualify for this position. The team leader must be actively engaged in the provision of the IFI service in the following manner: <ol style="list-style-type: none"> a) convene, at least weekly, team meetings that serve as the way to staff a child with the team, perform case reviews, team planning, and to provide for the team supervision and coordination of treatment/supports between and among team members. When a specific plan for a specific youth results from this meeting, there shall be an administrative note made in the youth's clinical record. In addition, there should exist a log of meeting minutes from this weekly team meeting that documents team supervision. In essence, there should be two documentation processes for these meetings; one child specific in the clinical record, and the other a log of meeting minutes for each team meeting that summarizes the team supervision process. This supervision and team meeting process is not a separately-billable activity, but the cost is accounted for within the rate methodology and supports the team approach to treatment. Weekly time for group supervision and case review is scheduled and protected. b) meet at least twice a month with families face-to-face or more often as clinically indicated. c) provide weekly, individual, clinical supervision to each IFI team member (outside of the weekly team meeting) for all services provided by that member of the IFI team. The individual supervision process is to be one-on-one supervision, documented in a log, with appropriate precautions for individual confidentiality and indicating date/time of supervision, issues addressed, and placed in the personnel file for the identified IFI team staff. d) be dedicated to a single IFI team ("Dedicated" means that the team leader works with only one team at least 32 hours/week [up to 40 hours/week] and is a full-time employee of the agency [not a subcontractor/1099 employee]). The Team Leader is available 24/7 to IFI staff for emergency consultation/supervision. • Two to three fulltime equivalent paraprofessionals who work under the supervision of the Team Leader. • The team may also include an additional mental health professional, substance abuse professional or paraprofessional. The additional staff may be used .25 percent between 4 teams. 2. To facilitate access for those families who require it, the specialty IFI providers must have access to psychiatric and psychological services, as provided by a Physician, Psychiatrist or a Licensed Psychologist (via contract or referral agreement). These contracts/agreements must be kept in the agency's administrative files and be available for review. 3. Practitioners providing this service are expected to maintain knowledge/skills regarding current research trends in best/evidence based practices. Some examples of best/evidence based practice are multi-systemic therapy, multidimensional family therapy, dialectic behavioral therapy and others as appropriate to the child, family

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- and issues to be addressed. Their personnel files must indicate documentation of training and/or certification in the evidenced-based model chosen by the organization. There shall be training documentation indicating the evidenced-based in-home practice model each particular staff person will be utilizing in the provision of services.
4. The IFI Team's family-to-staff ratio must not exceed 12 families for teams with two paraprofessional, and 16 families for teams with three paraprofessionals (which is the maximum limit which shall not be exceeded at any given time). The staff-to-family ratio takes into consideration evening and weekend hours, needs of special populations, and geographic areas to be covered.
 5. Documentation must demonstrate that at least 2 team members (one of whom must be licensed/credentialed) are providing IFI services in the support of each individual served by the team in each month of service. One of these team members must be appropriately licensed/credentialed to provide the professional counseling and treatment modalities/interventions needed by the individual and must provide these modalities/interventions as clinically appropriate according to the needs of the youth.
 6. It is critical that IFI team members are fully engaged participants in the supports of the served individuals. To that end, no more than 50% of staff can be "contracted"/1099 team members. Team members must work for only one IFI organization at a time and cannot be providing this service when they are a member of another team because they cannot be available as directed by families need or for individual crises while providing on-call services for another program.
 7. When a team is newly starting, there may be a period when the team does not have a "critical mass" of individuals to serve. During this time, a short-term waiver may be granted to the agency's team by the DBHDD Regional Coordinator/s for the counties served. The waiver request may address the part-time nature of a team leader and the paraprofessionals serving less than individual-load capacity. For example, a team may only start by serving 4-6 families (versus full capacity 12-16 families) and therefore could request to have the team leader serve half-time and a single paraprofessional. A waiver of this nature will not be granted for any time greater than 6 months. The waiver request to a Regional Coordinator must include:
 - (a) the agency's plan for building individual capacity (not to exceed 6 months)
 - (b) the agency's corresponding plan for building staff capacity which shall be directly correlated to the item aboveThe Regional Coordinator has the authority to approve these short-term waivers and must copy APS Healthcare on its approval and/or denial of these waiver requests. No extension on these waivers will be granted.
 8. It is understood that there may be periodic turn-over in the Team Leader position; however, the service fails to meet model-integrity in the absence of a licensed/credentialed professional to provide supervision, therapy, oversight of Individualized Recovery/Resiliency Plans, and team coordination. Understanding this scenario, an IFI team who loses a Team Leader must provide the critical functions articulated via one of the following means:
 - Documentation that there is a temporary contract for Team Leader who meets the Team Leader qualifications; or
 - Documentation that there is another fully licensed/credentialed professional who meets the Team Leader qualifications and is currently on the team providing the Team Leader functions temporarily (this would reduce the team staff to either 2 or 3 members based on the numbers of families served by the team); or
 - Documentation that there is another fully licensed/credentialed professional who meets the Team Leader qualifications and is currently employed by the agency providing the Team Leader functions temporarily (this professional would devote a minimum of 15-20 hours/week to supervision, therapy, oversight of Individualized Recovery/Resiliency Plans, and team coordination); or
 - Documentation that there is an associate-licensed professional who could work full-time dedicated to therapy, oversight of Individualized Recovery/Resiliency Plans, and team coordination with a fully licensed/credentialed professional supporting the team for 5 hours/week for clinical supervision.For this to be allowed, the agency must be able to provide documentation that recruitment is underway. Aggressive recruitment shall be evidenced by documentation in administrative files of position advertising. In the event that a position cannot be filled within 60 days OR in the event that there is no ability to provide the coverage articulated in this item (B.8.), there shall be notification to the State DBHDD Office and the Regional Coordinator of the intent to cease billing for the IFI service.
 9. IFI providers may not share contracted team members with other IFI agencies. Staff may not work part-time for one agency and part-time with another agency due to the need for staff availability in accord with the specific needs, requirements, and requests of the families served. Team members must be dedicated to each specific team to ensure intensity, consistency, and continuity for the individuals served.

Intensive Family Intervention

Clinical Operations	<ol style="list-style-type: none"> 1. In-home services include consultation with the individual, parents, or other caregivers regarding medications, behavior management skills, and dealing with the responses of the individual, other caregivers and family members, and coordinating with other child-serving treatment providers. 2. Individuals receiving this service must have a qualifying and verified diagnosis present in the medical record prior to the initiation of services. 3. The Individualized Resiliency Plan must be individualized, strengths-based, and not developed from a template used for other individuals and their families. Team services are individually designed for each family, in full partnership with the family, to minimize intrusion and maximize independence. 4. IFI must be provided through a team approach (as evidenced in documentation) and flexible services designed to address concrete therapeutic and environmental issues in order to stabilize a situation quickly. Services are family-driven, child focused, and focus on developing resiliency in the child. They are active and rehabilitative, and delivered primarily in the home or other locations in the community. Services are initiated when there is a reasonable likelihood that such services will lead to specific, observable improvements in the individual's functioning (with the family's needs for intensity and time of day as a driver for service delivery). 5. Service delivery must be preceded by a thorough assessment of the child and the family in order to develop an appropriate and effective treatment plan. This assessment must be clearly documented in the clinical record. 6. IFI services provided to children and youth must be coordinated with the family and significant others and with other systems of care such as the school system, the juvenile justice system, and children's protective services when appropriate to treatment and educational needs. 7. The organization must have policies that govern the provision of services in natural settings and can document that it respects the youth's and/or family's right to privacy and confidentiality when services are provided in these settings. 8. When a projected discharge date for the service has been set, the youth may begin to receive more intensified Community Support services two weeks prior to IFI discharge for continuity of care purposes only. 9. When there is a crisis situation identified or there is potential risk of youth harm to self or others, there must be documentation that a licensed/credentialed practitioner is involved in that crisis resolution. 10. The IFI organization will be expected to develop and demonstrate comprehensive crisis protocols and policies, and must adhere to all safety planning criteria as specified below. Safety planning with the family must be evident at the beginning of treatment, and must include evidence that safety needs are assessed for all youth and families. The family shall be a full participant in the safety planning, and all crisis stabilization steps will be clearly identified. All parties involved, including community partners, will need to know the plan and who is responsible for supporting its implementation. When aggression is an issue within the family, a written safety plan must be developed and signed by the parents/caregivers, staff, youth, and other agency staff involved in the plan. Safety plans should also include natural supports and should not rely exclusively on professional resources. This plan must be given to the family, other agency staff, the youth, and a copy kept in the individual's record. 11. Service delivery should be organized in a way such that there is a high frequency of services delivered at the onset of support and treatment and a tapering off as the youth moves toward discharge. As it applies to the specific youth, this shall be documented in the record.
Service Accessibility	<ol style="list-style-type: none"> 1. Services must be available 24 hours a day, 7 days a week, through on-call arrangements with practitioners skilled in crisis intervention. A team response is preferable when a family requires face-to-face crisis intervention. 2. Due to the intensity of the service, providers must offer a minimum of 3 contacts per week with the youth/family except during periods where service intensity is being tapered toward the goal of transition to another service or discharge. 3. Intensive Family Intervention may not be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital, psychiatric residential treatment facility or Crisis Stabilization Unit with greater than 16 beds), jail, youth development center (YDC) or prison system. 4. This service may not be provided and billed for youth who are involuntarily detained in Regional Youth Detention Centers (RYDCs) awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings. Any exception to this requires supporting documentation from the DJJ partners. The provider holds the risk for assuring the youth's eligibility 5. Services provided for over 6 hours on any given day must be supported with rigorous reasons in the documentation. Anything over 6 hours would need to relate to a crisis situation and the support administrative documentation should spell out the reasons for extended hours and be signed by the Team Leader.

Intensive Family Intervention

Documentation Requirements	<ol style="list-style-type: none"> 1. If admission criteria #2 is utilized to establish admission, notation of other services provision intensity/failure should be documented in the record (even if it is self-reported by the youth/family). 2. As the team, youth, and family work toward discharge, documentation must indicate planning with the youth/family for the supports and treatment needed post-discharge from the IFI service. Referrals to subsequent services should be a part of this documentation.
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Structured Residential Supports

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Structured Residential	Child Program	H0043	HA				As negotiated							
Unit Value	1 day							Maximum Daily Units	1 unit					
Initial Authorization	180 days							Re-Authorization	180 days					
Authorization Period	180 days							Utilization Criteria	CAFAS scores: 140-240					
Service Definition	<p>Structured Residential Supports (formerly Rehabilitation Supports for Individuals in Residential Alternatives, Levels 1 & 2) are comprehensive rehabilitative services to aid youth in developing daily living skills, interpersonal skills, and behavior management skills; and to enable youth to learn about and manage symptoms; and aggressively improve functioning/behavior due to SED, substance abuse, and/or co-occurring disorders. This service provides support and assistance to the youth and caregivers to identify, monitor, and manage symptoms; enhance participation in group living and community activities; and, develop positive personal and interpersonal skills and behaviors to meet the youth's developmental needs as impacted by his/her behavioral health issues.</p> <p>Services are delivered to youth according to their specific needs. Individual and group activities and programming must consist of services to develop skills in functional areas that interfere with the ability to live in the community, participate in educational activities; develop or maintain social relationships; or participate in social, interpersonal, recreational or community activities.</p> <p>Rehabilitative services must be provided in a licensed residential setting with no more than 16 individuals and must include supportive counseling, psychotherapy and adjunctive therapy supervision, and recreational, problem solving, and interpersonal skills development. Residential supports must be staffed 24 hours/day, 7 days/week.</p>													
Admission Criteria	<ol style="list-style-type: none"> 1. Youth must have symptoms of a SED or a substance related disorder; and one or more of the following: 2. Youth's symptoms/behaviors indicate a need for continuous monitoring and supervision by 24-hour staff to ensure safety; or 3. Youth/family has insufficient or severely limited skills to maintain an adequate level of functioning, specifically identified deficits in daily living and social skills and/or community/family integration; or 4. Youth has adaptive behaviors that significantly strain the family's or current caretaker's ability to adequately respond to the youth's needs; or 5. Youth has a history of unstable housing due to a behavioral health issue or a history of unstable housing which exacerbates a behavioral health condition. 													
Continuing Stay Criteria	Youth continues to meet Admissions Criteria.													
Discharge Criteria	<ol style="list-style-type: none"> 1. Youth/family requests discharge; or 2. Youth has acquired rehabilitative skills to independently manage his/her own housing; or 3. Transfer to another service is warranted by change in youth's condition 													

Structured Residential Supports

Service Exclusions	Cannot be billed on the same day as Crisis Stabilization Unit.
Clinical Exclusions	<ol style="list-style-type: none"> 1. Severity of identified youth issues precludes provision of services in this service 2. Youth with the following conditions are excluded from admission unless there is clearly documented evidence of psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, or traumatic brain injury. 3. Youth is actively using unauthorized drugs or alcohol (which should not indicate a need for discharge, but for a review of need for more intensive services). 4. Youth can effectively and safely be supported with a lower intensity service.
Required Components	<ol style="list-style-type: none"> 1. The organization must have an executive director or program director charged with the responsibility for day-to-day management of the organization. 2. If applicable, the organization must be licensed by the Georgia Department of Human Services/CCI or the Department of Community Health/HRF to provide residential services to youth with SED and/or substance abuse diagnosis. If the agency does not have a license/letter from either the DHS/CCI or DCH/HRF related to operations, there must be enough administrative documentation to support the non-applicability of a license. 3. The residential program must provide a structured and supported living environment 24 hours a day, 7 days a week. 4. Structured Residential Supports must provide at least 5 hours per week of structured programming and/or services.
Staffing Requirements	<ol style="list-style-type: none"> 1. Any Level 5 and higher practitioner may provide all Residential Rehabilitation Services. 2. If applicable, facilities must comply with any staffing requirements set forth for mental health and substance abuse facilities by the Department of Community Health, Healthcare Facilities Regulation Division (see Required Components, Item 2 above). 3. An independently licensed practitioner/CACII/MAC/CADC must provide clinical supervision for Residential Support Services. This person is available for emergencies 24 hours/7 days a week. 4. The organization that provides direct residential services must have written policies and procedures for selecting and hiring residential and clinical staff in accordance with their applicable license/accreditation/certification. 5. The organization must have a mechanism for ongoing monitoring of staff licensure, certification, or registration such as an annual confirmation process concurrent with a performance evaluation that includes repeats of screening checks outlined above.
Clinical Operations	<ol style="list-style-type: none"> 1. The organization must have a written description of the Structured Residential Support services it offers that includes, at a minimum, the purpose of the service; the intended population to be served; treatment modalities provided by the service; level of supervision and oversight provided; and typical treatment objectives and expected outcomes. 2. Structured Residential Supports assist youth in developing daily living skills that enable them to manage the symptoms and behaviors linked to their psychiatric or addictive disorder. Services must be delivered to individuals according to their specific needs. Individual and group activities and programming consists of services geared toward developing skills in functional areas that interfere with the youth's ability to participate in the community, retain school tenure, develop or maintain social relationships, or age-appropriately participate in social, interpersonal, or community activities. 3. Structured Residential Supports must include symptom management or supportive counseling; behavioral management; medication education, training and support; support, supervision, and problem solving skill development; development of community living skills that serve to promote age-appropriate utilization of community-based services; and/or social or recreational skill training to improve communication skills, manage symptoms, and facilitate age-appropriate interpersonal behavior.
Add'l Medicaid Requirements	This is not a Medicaid-billable service.
Documentation Requirements	<ol style="list-style-type: none"> 1. The organization must develop and maintain sufficient written documentation to support the Structured Residential Support Services for which billing is made. This documentation, at a minimum, must confirm that the individual for whom billing is requested was a resident of the residential service on the date of service. The youth's record must also include each week's programming/service schedule in order to document the provision of the required amount of service. 2. Weekly progress notes must be entered in the youth's record to enable the monitoring of the youth's progress toward meeting treatment and rehabilitation goals and to reflect the Individualized Resiliency Plan implementation. Each note must be signed and dated and must include the professional designation of the individual making the entry. 3. Documentation must be legible and concise and include the printed name and the signature of the treating practitioner. The name, title, and credentials of the

Structured Residential Supports

	individual providing the service must reflect the staffing requirements established for the Rehabilitation Service being delivered.
Facilities Management	<p>Applicable to traditional residential settings such as group homes, treatment facilities, etc.</p> <ol style="list-style-type: none"> 1. Structured Residential Supports may only be provided in facilities that have no more than 16 beds. 2. Each residential facility must be arranged and maintained to provide adequate measures for the health, safety, access and well-being of the residents. 3. Each residential facility must comply with all relevant fire safety codes. 4. All areas of the residential facility must appear clean, safe, appropriately equipped, and furnished for the services delivered. 5. The organization must comply with the Americans with Disabilities Act. 6. The organization must maintain a written evacuation plan to be used in the case of fire or other disaster. An appropriate written certificate of compliance must be obtained indicating that all applicable fire and safety code requirements have been satisfied. Periodic fire drills must be conducted. 7. Evacuation routes must be clearly marked by exit signs. 8. The program must be responsible for providing physical facilities that are structurally sound and meet all applicable federal, state, and local regulations for adequacy of construction, safety, sanitation, and health.

Substance Abuse Intensive Outpatient Package: (SA Adolescent Day Treatment)

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
See Additional Medicaid Requirements below.														
Unit Value	See Authorization/Group Package Detail							Maximum Daily Units	See Authorization/Group Package Detail					
Initial Authorization	See Authorization/Group Package Detail							Re-Authorization	See Authorization/Group Package Detail					
Authorization Period	180 Days							Utilization Criteria	CAFAS Scores 100-240					
Service Definition	<p>A time limited multi-faceted approach treatment service for adolescents who require structure and support to promote resiliency and achieve and sustain recovery from substance related disorders. These specialized services are available after school and/or weekends and include:</p> <ol style="list-style-type: none"> 1. Behavioral Health Assessment 2. Nursing Assessment 3. Psychiatric Treatment 4. Diagnostic Assessment 5. Community Support 6. Individual Counseling 7. Group Counseling (including psycho-educational groups focusing, relapse prevention and recovery) 8. Family Counseling/Psycho-Educational Groups for Family Members <p>These services are to be available at least 5 days per week to allow youth's access to support and treatment within his/her community, school, and family. These services are to be age appropriate and providers are to use best/evidenced based practices for service delivery to adolescents. Intense coordination with schools and other child serving agencies is mandatory. This service promotes resiliency and recovery from substance abuse disorders incorporating the basic tenets of clinical practice. These services should follow Adolescent ASAM Level Guidelines. The maximum number of units that can be billed differs depending on the individual service. Please refer to the table below or in the Mental Health and Addictive Disease Orientation to Authorization Packages Section of this manual.</p> <p>An individual may have variable length of stay. The level of care should be determined as a result of individuals' multiple assessments. It is recommended that individuals attend at a frequency appropriate to their level of need. Ongoing clinical assessment should be conducted to determine step down in level of care.</p>													

Substance Abuse Intensive Outpatient Package: (SA Adolescent Day Treatment)

Admission Criteria	<ol style="list-style-type: none"> 1. A DSM IV diagnosis of Substance Abuse or Dependence or substance- related disorder with a co-occurring DSM IV-TR diagnosis of mental illness and 2. Individual meets the age criteria for adolescent treatment; and 3. Youth's biomedical conditions are stable or are being concurrently addressed (if applicable) and one or more of the following: <ol style="list-style-type: none"> a. Youth is currently unable to maintain behavioral stability for more than a 72 hour period, as evidenced by distractibility, negative emotions, or generalized anxiety or b. Youth has a diagnosed emotional/behavioral disorder that requires monitoring and/or management due to a history indicating a high potential for distracting the individual from recovery/treatment, or c. There is a likelihood of drinking or drug use without close monitoring and structured support d. The substance use is incapacitating, destabilizing or causing the individual anguish or distress and the individual demonstrates a pattern of alcohol and/or drug use that has resulted in a significant impairment of interpersonal, occupational and/or educational <p>See also Adolescent ASAM Level 2 continued service criteria</p>
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Youth continues to meet admission criteria 1, 2, and/or 3 or 2. Youth is responding to treatment as evidenced by progress towards goals, but has not yet met the full expectation of the objectives or 3. Youth begins to recognize and understand his/her responsibility for addressing his/her illness, but still requires services and strategies to sustain personal responsibility and progress in treatment or 4. Youth recognizes and understands relapse triggers, but has not developed sufficient coping skills to interrupt or postpone gratification or to change related inadequate impulse control behaviors or 5. Youth's substance seeking behaviors, while diminishing, have not been reduced sufficiently to support function outside of a structure treatment environment
Discharge Criteria	<p>An adequate continuing care or discharge plan is established and linkages are in place; and one or more of the following:</p> <ol style="list-style-type: none"> 1. Goals of the treatment plan have been substantially met; or 2. Youth's problems have diminished in such a way that they can be managed through less intensive services; or 3. Youth recognizes the severity of his/her drug/alcohol usage and is beginning to apply the skills necessary to maintain recovery by accessing appropriate community supports; or 4. Clinical staff determines that youth no longer needs ASAM Level 2 and is now eligible for aftercare and/or transitional services. <p>Transfer to a higher level of service is warranted by change in the</p> <ol style="list-style-type: none"> 1. Youth's condition or nonparticipation; or 2. The youth refuses to submit to random drug screens; or 3. Youth's exhibits symptoms of acute intoxication and/or withdrawal or 4. The youth requires services not available at this level or 5. Youth has consistently failed to achieve essential treatment objectives despite revisions to the treatment plan and advice concerning the consequences of continues alcohol/drug use to such an extent that no further process is likely to occur. <p>See also Adolescent ASAM Level 2 discharge criteria.</p>
Service Exclusions	<ol style="list-style-type: none"> 1. Substance Abuse C&A Intensive Outpatient Package cannot be offered at the same time as C&A Mental Health IOP Package. Documentation must indicate efforts to minimize duplication of services and effectively transition the individual to the appropriate services. This combination of services is subject to review by the ERO.
Clinical Exclusions	<ol style="list-style-type: none"> 1. Youth manifests overt physiological withdrawal symptoms 2. Youth with any of the following unless there is clearly documented evidence of an acute psychiatric/addiction episode overlaying primary diagnosis: Autism, Developmental Disabilities, Organic mental disorder, Traumatic Brain Injury.
Required Components	<ol style="list-style-type: none"> 1. This service must be licensed by DCH/HFR under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2. 2. The program provides structured treatment or therapeutic services, utilizing activity schedules as part of its operational method, i.e., plans or schedules of days or times of day for certain activities. The program should also utilize group and/or individual counseling and/or therapy.

Substance Abuse Intensive Outpatient Package: (SA Adolescent Day Treatment)

	<ol style="list-style-type: none"> 3. Best/evidence based practice must be utilized. Some examples are motivational interviewing, behavioral family therapy, functional family therapy, brief strategic family therapy, cognitive behavioral therapy, seven challenges, teen MATRIX and ACRA. 4. The program utilizes methods, materials, settings, and outside resources appropriate to the developmental and cognitive levels, capabilities, age, and gender of participants. 5. The program utilizes methods, materials, approaches, activities, settings, and outside resources appropriate for and targeted to individuals with co-occurring disorders of mental illness and substance abuse and targeted to individuals with co-occurring and substance abuse when such individuals are referred to the program. 6. The program conducts random drug screening and uses the results of these tests for marking individuals' progress toward goals and for service planning. 7. The program is provided over a period of several weeks or months and often follows withdrawal management or residential services and should be evident in individual youth records. 8. Intense coordination with schools and other child serving agencies is mandatory. 9. This service must operate at an established site approved to bill Medicaid for services. However, limited individual or group activities may take place off-site in natural community settings as is appropriate to each individual's treatment plan. <ol style="list-style-type: none"> a. Narcotics Anonymous (NA) and/or Alcoholics Anonymous (AA) meetings offsite may be considered part of these limited individual or group activities for billing purposes only when time limited and only when the purpose of the activity is introduction of the participating individual to available NA and/or AA services, groups or sponsors. NA and AA meetings occurring during the SA C&A Intensive Outpatient Package may not be counted toward the billable hours for any individual outpatient services, nor may billing related to these meetings be counted beyond the basic introduction of an individual to the NA/AA experience.
<p>Required Components, continued</p>	<ol style="list-style-type: none"> 10. This service may operate in the same building as other services; however, there must be a distinct separation between services in staffing, program description, and physical space during the hours the SA Intensive Outpatient Services is in operation. 11. Adequate space, equipment, furnishings, supplies, and other resources must be provided in order to effectively provide services and so that the program environment is clean and in good repair. Space, equipment, furnishings, supplies, transportation, and other resources for participating individuals' use within the Substance Abuse C&A Intensive Outpatient package must not be substantially different from that provided for other uses for similar numbers of individuals.
<p>Staffing Requirements</p>	<ol style="list-style-type: none"> 1. The program must be under the clinical supervision of a Level 4 or above who is onsite a minimum of 50% of the hours the service is in operation. 2. Services must be provided by staff who are at least: <ol style="list-style-type: none"> a. An APC, LMSW, CACII, CADC, CCADC, and Addiction Counselor Trainee with supervision b. Paraprofessionals, RADTs under the supervision of a Level 4 or above 3. It is necessary for staff who treat "co-occurring capable" services to have basic knowledge in best practices serving co-occurring individuals 4. Programs must have documentation that there is one Level 4 staff (excluding Addiction Counselor Trainee) that is "co-occurring capable." This person's knowledge must go beyond basic understanding and must demonstrate actual staff capabilities in using that knowledge for individuals with co-occurring disorders. Personnel documentation should demonstrate that this staff person has received a minimum of 4 hours of training in co-occurring treatment within the past 2 years. 5. There must be at least a Level 4 on-site at all times the service is in operation, regardless of the number of individuals participating. 6. The maximum face-to-face ratio cannot be more than 10 youths to 1 direct program staff based on average daily attendance of individuals in the program. 7. A physician and/or a Registered Nurse or a Licensed Practical Nurse with appropriate supervision must be available to the program either by a physician and/or nurse employed by the agency, through a contract with a licensed practitioner, or by written referral or affiliation agreement with another agency or agencies that offer such services. <ol style="list-style-type: none"> a. The physician is responsible for addiction/psychiatric consultation/assessment/care (including but not limited to ordering medications and/or laboratory testing) as needed. b. The nurse is responsible for nursing assessments, health screening, medication administration, health education, and other nursing duties as needed. 8. Staff identified in Item 2. above may be shared with other programs as long as they are available as required for supervision and clinical operations and as long as their time is appropriately allocated to staffing ratios for each program.

Substance Abuse Intensive Outpatient Package: (SA Adolescent Day Treatment)

Clinical
Operations

1. It is expected that the transition planning for less intensive service will begin at the onset of these services. Documentation must demonstrate this planning.
2. Each individual must be assisted in the development/acquisition of skills and resources necessary to achieve sobriety and/or reduction in abuse/maintenance of recovery.
3. Substance Abuse C&A Intensive Outpatient Package must offer a range of skill-building and recovery activities within the program. The functions/activities of the Substance Abuse C&A Intensive Outpatient Package include but are not limited to:
 - a. **Group Outpatient Services:**
 - i. Age appropriate psycho-educational activities focusing on the disease of addiction, prevention, and recovery
 - ii. Therapeutic group treatment and counseling
 - iii. Linkage to natural supports and self-help opportunities
 - b. **Individual Outpatient Services**
 - i. Individual counseling
 - ii. Individualized treatment, service, and recovery planning
 - c. **Family Outpatient Services**
 - i. Family education and engagement focusing on adolescent developmental issues and impact of addiction on the family
 - ii. Interpersonal skills building including family communication and developing relationships with healthy individuals
 - d. **Community Support**
 - e. Educational/Vocational readiness and support
 - i. Services/resources coordination unless provided through another service provider
 - ii. Community living skills
 - iii. Linkage to health care
 - f. **Structured Activity Supports**
 - i. Leisure and social skill-building activities without the use of substances
 - g. **Behavioral Health Assessment & Service Plan Development and Diagnostic Assessment**
 - i. Assessment and reassessment
 - h. **Pharmacy/Labs (Core providers may report cost via "Pharmacy/Lab")**
 - i. Drug screening/toxicology examinations
4. In addition to the above required activities within the program, the following must be offered as needed either within the program or through referral to/or affiliation with another agency or practitioner, and may be billed in addition to the billing for Substance Abuse C&A Intensive Outpatient Package:
 - a. Community Support –for housing, legal and other issues
 - b. Individual counseling in exceptional circumstances for traumatic stress and other mental illnesses for which special skills or licenses are required
 - c. Physician assessment and care
 - d. Psychological testing
 - e. Health screening (Nursing Assessment & Care)
5. Services are to be age appropriate and include an educational component, relapse prevention/refusal skills, healthy coping mechanisms and sober social activities.
6. The program must have a Substance Abuse C&A Intensive Outpatient Services Organizational Plan addressing the following:
 - a. The philosophical model of the program and the expected outcomes for program participants (i.e., harm reduction, abstinence, beginning of or maintaining individually defined recovery, employment readiness, relapse prevention, stabilization and treatment of those with co-occurring disorders).
 - b. The schedule of activities and hours of operations.
 - c. Staffing patterns for the program.
 - d. How assessments will be conducted.
 - e. How staff will be trained in the administration of addiction services and technologies
 - f. How staff will be trained in the recognition and treatment of substance abuse and treatment in an adolescent population

Substance Abuse Intensive Outpatient Package: (SA Adolescent Day Treatment)

	<ul style="list-style-type: none"> g. How services for individuals with co-occurring disorders will be flexible and will include services and activities addressing both mental health and substance abuse issues of varying intensities and dosages based on the symptoms, presenting problems, functioning, and capabilities of such individuals. h. How individuals with co-occurring disorders who cannot be served in the regular program activities will be provided and/or referred for time-limited special integrated services that are co-occurring enhanced as described in the Georgia Suggested Best Practices i. How services will be coordinated with the substance abuse array of services including assuring or arranging for appropriate referrals and transitions. j. How the requirements in these service guidelines will be met. 																											
Service Access	This package is to be available at least 5 days per week to allow youth's access to support and treatment within his/her community, school, and family.																											
Additional Medicaid Requirements	<p>The Substance Abuse C&A Intensive Outpatient Package allows providers to select all services that will be offered in a substance abuse outpatient setting. Billable services and daily limits within SA C&A Intensive Outpatient are as follows:</p> <table border="1" data-bbox="485 493 1780 824"> <thead> <tr> <th>Service</th> <th>Maximum Authorization Units</th> <th>Maximum Daily Units</th> </tr> </thead> <tbody> <tr> <td>Behavioral Health Assessment & Service Plan Development</td> <td>32</td> <td>24</td> </tr> <tr> <td>Diagnostic Assessment</td> <td>4</td> <td>2</td> </tr> <tr> <td>Psychiatric Treatment</td> <td>12</td> <td>1</td> </tr> <tr> <td>Nursing Assessment & Care</td> <td>48</td> <td>16</td> </tr> <tr> <td>Community Support</td> <td>200</td> <td>96</td> </tr> <tr> <td>Individual Outpatient Services</td> <td>36</td> <td>1</td> </tr> <tr> <td>Group Outpatient Services</td> <td>1170</td> <td>20</td> </tr> <tr> <td>Family Outpatient Services</td> <td>100</td> <td>8</td> </tr> </tbody> </table>	Service	Maximum Authorization Units	Maximum Daily Units	Behavioral Health Assessment & Service Plan Development	32	24	Diagnostic Assessment	4	2	Psychiatric Treatment	12	1	Nursing Assessment & Care	48	16	Community Support	200	96	Individual Outpatient Services	36	1	Group Outpatient Services	1170	20	Family Outpatient Services	100	8
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Family Outpatient Services	100	8																										
Documentation Requirements	<ol style="list-style-type: none"> 1. Every admission and assessment must be documented. 2. Progress notes must include written daily documentation of important occurrences; level of functioning; acquisition of skills necessary for recovery; progress on goals identified in the IRP including acknowledgement of addiction, progress toward recovery and use/abuse reduction and/or abstinence; use of drug screening results by staff; and evaluation of service effectiveness. 3. Daily attendance of each youth participating in the program must be documented showing the number of units in attendance for billing purposes. 																											

ADULT CORE SERVICES

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Addictive Diseases Support Services	Practitioner Level 4, In-Clinic	H2015	HF	U4	U6		\$20.30	Practitioner Level 4, Out-of-Clinic	H2015	HF	U4	U7		\$24.36
	Practitioner Level 5, In-Clinic	H2015	HF	U5	U6		\$15.13	Practitioner Level 5, Out-of-Clinic	H2015	HF	U5	U7		\$18.15
	Practitioner Level 4, In-Clinic	H2015	HF	UK	U4	U6	\$20.30	Practitioner Level 4, Out-of-Clinic	H2015	HF	UK	U4	U7	\$24.36
	Practitioner Level 5, In-Clinic	H2015	HF	UK	U5	U6	\$15.13	Practitioner Level 5, Out-of-Clinic	H2015	HF	UK	U5	U7	\$18.15
Unit Value	15 minutes							Maximum Daily Units	48 units					
Initial Authorization	300 units							Re-Authorization	300 units					
Authorization Period	180 days							Utilization Criteria	<u>LOCUS scores: 1-6</u>					
Service Definition	<p>Specific to adults with addictive disease issues, Addictive Diseases Support Services (ADSS) consist of substance abuse recovery services and supports which build on the strengths and resilience of the individual and are necessary to assist the person in achieving recovery and wellness goals as identified in the Individualized Recovery Plan. The service activities include:</p> <ul style="list-style-type: none"> • Assistance to the person and other identified recovery partners in the facilitation and coordination of the Individual Recovery Plan (IRP) including the use of motivational interviewing and other skills support to promote the person's self-articulation of personal goals and objectives; • Relapse Prevention Planning to assist the person in managing and/or preventing crisis and relapse situations with the understanding that when individuals do experience relapse, this support service can help minimize the negative effects through timely re-engagement/intervention and, where appropriate, timely connection to other treatment supports; • Individualized interventions through all phases of recovery (pre-recovery preparation, initiation of recovery, continuing recovery, and relapse) which shall have as objectives: <ol style="list-style-type: none"> 1) Identification, with the person, of strengths which may aid him/her in achieving and maintaining recovery from addiction issues, as well as barriers that impede the development of skills necessary for functioning in work, with peers, and with family/friends; 2) Support to facilitate enhanced natural supports (including comprehensive support/assistance in connecting to a recovery community); 3) Assistance in the development of interpersonal, community coping and functional skills (which may include adaptation to home, adaptation to work, adaptation to healthy social environments, learning/practicing skills such as personal financial management, medication self-monitoring, symptom self-monitoring, etc.); 4) Assistance in the skills training for the person to self-recognize emotional triggers and to self-manage behaviors related to the addiction issues; 5) Assistance with personal development, work performance, and functioning in social and family environments through teaching skills/strategies to reduce the effects of addiction symptoms; 6) Assistance in enhancing social and coping skills that reduce life stresses resulting from the person's addiction; 7) Facilitating removal of barriers and swift entry to necessary supports and resources. Supports/Resources may include but are not limited to medical services, employment, education, etc. 8) ADSS focuses on building and maintaining a therapeutic relationship with the individual and monitoring, coordinating, and facilitating treatment and recovery goals. 													

Admission Criteria	<ol style="list-style-type: none"> 1. Individuals with one of the following: Substance-Related Disorder, Co-Occurring Substance-Related Disorder and MH Diagnosis, or Co-Occurring Substance-Related Disorder and DD and 2. Individual may need assistance and access to service(s) targeted to reduce and/or stop the use of any mood altering substances; or 3. Individual may need assistance with developing, maintaining, or enhancing social supports or other community coping skills; or 4. Individual may need assistance with daily living skills including coordination to gain access to necessary rehabilitative and medical services.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual continues to meet admission criteria; and 2. Individual demonstrates documented progress or maintenance of community skills relative to goals identified in the Individualized Recovery Plan
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: <ol style="list-style-type: none"> a. Goals of the Individualized Recovery Plan have been substantially met; or b. Individual requests discharge and the individual is not in imminent danger of harm to self or others; or c. Transfer to another service/level of care is warranted by change in individual's condition; or d. Individual requires more intensive services.
Clinical Exclusions	<ol style="list-style-type: none"> 1. The individual's current status precludes his/her ability to understand the information presented and participate in the recovery planning and support/treatment process; 2. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a co-occurring Substance Use Disorder: Developmental Disability, Autism, Organic Mental Disorder, Traumatic Brain Injury
Service Exclusions	<ol style="list-style-type: none"> 1. ACT and ADSS may be provided concurrently during transition between these services for support and continuity of care for a maximum of four units of ADSS per month. If services are provided concurrently, ADSS should not be duplication of ACT services. This service must be adequately justified in the Individualized Resiliency Plan. 2. CM/ICM and ADSS may be authorized/provided at the same time to individuals with co-occurring mental health/addiction issues, but there is an expectation that one of these services serves as the primary coordination resource for the person. If these services co-occur, there must be documentation of coordination of supports in a way that no duplication occurs.
Required Components	<ol style="list-style-type: none"> 1. The agency providing this service must be a CORE provider, an Intensive Outpatient Program (IOP) specialty provider, or a WTRS provider. Contact must be made with the individual receiving ADSS services a minimum of twice each month. At least one of these contacts must be face-to-face and the second may be either face-to-face or telephone contact depending on the individual's support needs and documented preferences. 2. At least 50% of ADSS service units must be delivered face-to-face with the identified individual receiving the service. In the absence of the required monthly face-to-face contact and if at least two unsuccessful attempts to make face-to-face contact have been tried and documented, the provider may bill for a maximum of two telephone contacts in that specified month.
Staffing Requirements	ADSS practitioners have a recommended individual-to-staff caseload ratio of 30 individuals per staff member but must not exceed a maximum caseload ratio of 50 individuals per staff member.
Clinical Operations	<ol style="list-style-type: none"> 1. ADSS may include (with the written permission of the Adult individual) coordination with family and significant others and with other systems/supports (e.g., work, religious entities, corrections, aging agencies, etc.) when appropriate for treatment and recovery needs. 2. Any necessary monitoring and follow-up to determine if the services and resources accessed have adequately met the person's needs in achieving and sustaining recovery are allowable. Coordination is an essential component of ADSS when directly related to the support and enhancement of the person's recovery. 3. The organization must have an ADSS Organizational Plan that addresses the following: <ul style="list-style-type: none"> • description of the particular rehabilitation, recovery and natural support development models utilized, types of intervention practiced, and typical daily schedule for staff • description of the staffing pattern and how staff are deployed to assure that the required staff-to-individual ratios are maintained, including how unplanned staff absences, illnesses, or emergencies are accommodated, case mix, access, etc. • description of the hours of operations as related to access and availability to the individuals served and

	<ul style="list-style-type: none"> description of how the plan for services is modified or adjusted to meet the needs specified in every Individualized Recovery Plan <p>4. Utilization (frequency and intensity) of ADSS should be directly related to the LOCUS and to other functional elements in the assessment. In addition, when clinical/functional needs are great, there should be complementary therapeutic services by licensed/credentialed professionals paired with the provision of ADSS (individual, group, family, etc.).</p>
Reporting and Billing Requirements	<p>1. Unsuccessful attempts to make contact with the individual are not billable.</p> <p>2. When a billable collateral contact is provided, that is documented as a part of the progress note. A collateral contact is classified as any contact that is not face-to-face with the individual.</p>
Documentation Requirements	<p>Orders for Service and Treatment Plans which have an effective date of 5/31/2013 or prior and name CSI will be accepted as an Order or Treatment Plan, respectively, for CM, PSR-I, and ADSS. This is effective for the authorization period which corresponds to the Order and Treatment Plan. Any Treatment Plan or Order with a start date on or after 6/1/2013 may not include CSI, and instead, must reflect CM, PSR-I, and/or ADDS as medically necessary. (While the above allowances are being made, please note that when providing the above services on or after 6/1/2013, providers must bill and document (via progress notes) the new service and their corresponding codes as appropriate. CSI may not be provided to adults effective 6/1/2013.)</p>

Behavioral Health Assessment

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Mental Health Assessment by a non-Physician	Practitioner Level 2, In-Clinic	H0031	U2	U6			\$38.97	Practitioner Level 2, Out-of-Clinic	H0031	U2	U7			\$46.76
	Practitioner Level 3, In-Clinic	H0031	U3	U6			\$30.01	Practitioner Level 3, Out-of-Clinic	H0031	U3	U7			\$36.68
	Practitioner Level 4, In-Clinic	H0031	U4	U6			\$20.30	Practitioner Level 4, Out-of-Clinic	H0031	U4	U7			\$24.36
	Practitioner Level 5, In-Clinic	H0031	U5	U6			\$15.13	Practitioner Level 5, Out-of-Clinic	H0031	U5	U7			\$18.15
Unit Value	15 minutes							Maximum Daily Units	24 units (Combined with H0032)					
Initial Authorization	32 units (Combined with H0032)							Re-Authorization	32 units (Combined with H0032)					
Authorization Period	180 days							Utilization Criteria	<u>LOCUS scores: 1-6</u>					
Service Definition	<p>The Behavioral Health Assessment process consists of a face-to-face comprehensive clinical assessment with the individual, which must include the individual's perspective as a full partner, and may also include individual-identified family and/or significant others as well as collateral agencies, treatment providers (including Certified Peer Specialists who have been working with individuals on goal discovery), and other relevant individuals.</p> <p>The purpose of the assessment process is to gather all information needed to determine the individual's problems, strengths, needs, abilities, resources, and preferences, to develop a social (extent of natural supports and community integration) and medical history, to determine functional level and degree of ability versus disability, and to engage with collateral contacts for other assessment information. A suicide risk assessment shall also be completed. The information gathered should support the determination of a differential diagnosis and assist in screening for/ruling-out potential co-occurring disorders.</p> <p>As indicated, information from medical, nursing, peer, vocational, nutritional, etc. staff should serve as content basis for the comprehensive assessment and the resulting IRP.</p>													
Admission Criteria	<p>1. Individual has a known or suspected mental illness or substance-related disorder; and</p> <p>2. Initial screening/intake information indicates a need for further assessment; and</p> <p>3. It is expected that individual meets Core Customer eligibility.</p>													

Continuing Stay Criteria	Individual's situation/functioning has changed in such a way that previous assessments are outdated.
Discharge Criteria	1. An adequate continuing care plan has been established; and one or more of the following: 2. Individual has withdrawn or been discharged from service.
Service Exclusions	Assertive Community Treatment
Required Components	1. Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. 2. As indicated, medical, nursing, peer, school, nutritional, etc. staff can provide information from records, and various multi-disciplinary resources to complete the comprehensive nature of the assessment and time spent gathering this information may be billed as long as the detailed documentation justifies the time and need for capturing said information. 3. An initial Behavioral Health Assessment is required within the first 30 days of service with ongoing assessments completed as demanded by changes with an individual.

Case Management (Added Effective 6/1/13 partially replacing Community Support for MH Adults)														
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Case Management	Practitioner Level 4, In-Clinic	T1016	U4	U6			\$20.30	Practitioner Level 4, In-Clinic, Collateral Contact	T1016	UK	U4	U6		\$20.30
	Practitioner Level 5, In-Clinic	T1016	U5	U6			\$15.13	Practitioner Level 5, In-Clinic, Collateral Contact	T1016	UK	U5	U6		\$15.13
	Practitioner Level 4, Out-of-Clinic	T1016	U4	U7			\$24.36	Practitioner Level 4, Out-of-Clinic, Collateral Contact	T1016	UK	U4	U7		\$24.36
	Practitioner Level 5, Out-of-Clinic	T1016	U5	U7			\$18.15	Practitioner Level 5, Out-of-Clinic, Collateral Contact	T1016	UK	U5	U7		\$18.15
Unit Value	15 minutes							Maximum Daily Units	24 units					
Initial Authorization	80 units							Re-Authorization	80 units					
Authorization Period	180 days							Utilization Criteria	<u>LOCUS scores</u> : 1-6					
Service Definition	<p>Case Management services consist of providing environmental support and care coordination considered essential to assist the individual with improving his/her functioning, gaining access to necessary services, and creating an environment that promotes recovery as identified in his/her Individual Recovery Plan (IRP). The focus of interventions include assisting the individual with: 1) developing natural supports to promote community integration; 2) identifying service needs; 3) referring and linking to services and resources identified through the service planning process; 4) coordinating services identified on the IRP to maximize service integration and minimize service gaps; and 5) ensuring continued adequacy of the IRP to meet his/her ongoing and changing needs.</p> <p>The performance outcome expectations for individuals receiving this service include decreased hospitalizations, decreased incarcerations, decreased episodes of homelessness, increased housing stability, increased participation in employment or job related activities, increased community engagement, and recovery maintenance.</p>													

Case Management Services shall consist of four (4) major components that cover multiple domains that impact one's overall wellness including medical, behavioral, wellness, social, educational, vocational, co-occurring, housing, financial, and other service needs of the individual:

Engagement & Needs Identification

The case manager engages the individual in a recovery-based partnership that promotes personal responsibility and provides support, hope, and encouragement. The case manager assists the individual with developing a community-based support network to facilitate community integration and maintain housing stability. Through engagement, the case manager partners with the individual to identify and prioritize housing, service and resource needs to be included in the IRP.

Care Coordination

The case manager coordinates care activities and assists the individual as he/she moves between and among services and supports. Care coordination requires information sharing among the individual, his/her core provider, specialty provider(s), residential provider, primary care physician, and other identified supports in order to: 1) ensure that the individual receives a full range of integrated services necessary to support a life in recovery that includes health, home, purpose, and community; 2) ensure that the individual has an adequate and current crisis plan; 3) reduce barriers to accessing services and resources; 4) minimize disruption, fragmentation, and gaps in service; and 5) ensure all parties work collaboratively for the common benefit of the individual.

Referral & Linkage

The case manager assists the individual with referral and linkage to services and resources identified on the IRP including housing, social supports, family/natural supports, entitlements (SSI/SSDI, Food Stamps, VA), income, transportation, etc. Referral and linkage activities may include assisting the individual to: 1) locate available resources; 2) make and keep appointments; 3) complete the application process; and 4) make transportation arrangements when needed.

Monitoring and Follow-Up The case manager visits the individual in the community to jointly review progress made toward achievement of IRP goals and to seek input regarding his/her level of satisfaction with treatment and any recommendations for change. The case manager monitors and follows-up with the individual in order to: 1) determine if services are provided in accordance with the IRP; 2) determine if services are adequately and effectively addressing the individual's needs; 3) determine the need for additional or alternative services related to the individual's changing needs or circumstances; and 4) notify the treatment team when monitoring indicates the need for IRP reassessment and update.

Admission
Criteria for
Individuals
served by
CORE
PROVIDERS
OF CASE
MANAGEMENT

1. Individual must meet Core customer eligibility criteria

AND

2. Individual has functional impairments that interfere with maintaining their recovery and **needs assistance with one (1) or more of the following areas:**

- a. navigate and self-manage necessary services;
- b. maintain personal hygiene;
- c. meet nutritional needs;
- d. care for personal business affairs;
- e. obtain or maintain medical, legal, and housing services;
- f. recognize and avoid common dangers or hazards to self and possessions;
- g. perform daily living tasks ;
- h. obtain or maintain employment at a self-sustaining level or consistently perform homemaker roles (e.g., household meal preparation, washing clothes, budgeting, or childcare tasks and responsibilities);
- i. maintain a safe living situation

AND

3. Individual is engaged in their Recovery Plan but demonstrates difficulty implementing the plan which has led to the exacerbation of problematic symptoms. Individual **needs assistance with one (1) or more of the following areas** in order to successfully implement their Recovery Plan and maintain their recovery:

	<ul style="list-style-type: none"> a. taking prescribed medications; or b. following a crisis plan; or c. maintaining community integration; or d. keeping appointments with needed services.
<p>Admission criteria for Individuals served by STATE FUNDED ADA DESIGNATED PROVIDERS OF CASE MANAGEMENT</p>	<ol style="list-style-type: none"> 1. Individual must meet Core customer eligibility criteria: <ul style="list-style-type: none"> <li style="text-align: center;">AND 2. Individual has a mental health diagnosis or co-occurring mental health and substance-related disorder and one or more of the following: <ul style="list-style-type: none"> a. Admission to a psychiatric inpatient setting or crisis stabilization unit (i.e. within past 2 years); b. Released from jail or prison (i.e. within past 2 years); c. Demonstrates difficulty maintaining stable housing evidenced by two or more episodes of homelessness (i.e. within past 2 years); d. Frequent use of emergency rooms for reasons related to their mental illness evidenced by 3 or more visits (i.e. within past 2 years); e. Transitioning or recently discharged from Assertive community Treatment (ACT), Community Support Team (CST), or Intensive Case Management (ICM) services. <ul style="list-style-type: none"> <li style="text-align: center;">OR 3. Individual has functional impairments that interfere with maintaining their recovery and needs assistance with one (1) or more of the following areas: <ul style="list-style-type: none"> a. navigate and self-manage necessary services; b. maintain personal hygiene; c. meet nutritional needs; d. care for personal business affairs; e. obtain or maintain medical, legal, and housing services; f. recognize and avoid common dangers or hazards to self and possessions; g. perform daily living tasks ; h. obtain or maintain employment at a self-sustaining level or consistently perform homemaker roles (e.g., household meal preparation, washing clothes, budgeting, or childcare tasks and responsibilities); i. maintain a safe living situation <ul style="list-style-type: none"> <li style="text-align: center;">AND 4. Individual is engaged in their Recovery Plan but demonstrates difficulty implementing the plan which has led to the exacerbation of problematic symptoms. Individual needs assistance with one (1) or more of the following areas in order to successfully implement their Recovery Plan and maintain their recovery: <ul style="list-style-type: none"> a. taking prescribed medications; or b. following a crisis plan; or c. maintaining community integration; or d. keeping appointments with needed services.
<p>Continuing Stay Criteria</p>	<ol style="list-style-type: none"> 1. Individual continues to have a documented need for CM interventions at least twice monthly; and 2. Individual continues to meet the admission criteria; or 3. Continued difficulty participating in traditional clinic-based services or a community setting at a less intensive level of service/support; or 4. Living in substandard housing, homeless, or at imminent risk of becoming homeless due to functional impairments associated with behavioral health issues.
<p>Discharge Criteria</p>	<ol style="list-style-type: none"> 1. There has been a planned reduction of units of service delivered and related evidence of the individual sustaining functioning through that reduction plan; and 2. Individual has established recovery support networks to assist in maintenance of recovery (such as peer supports, AA, NA, etc.); and 3. Individual has demonstrated ownership and engagement with her/his own illness self-management as evidenced by: <ul style="list-style-type: none"> a. navigating and self-managing necessary services; b. maintaining personal hygiene; c. meeting his/her own nutritional needs; d. caring for personal business affairs;

	<ul style="list-style-type: none"> e. obtaining or maintaining medical, legal, and housing services; f. recognizing and avoiding common dangers or hazards to self and possessions; g. performing daily living tasks ; h. obtaining or maintaining employment at a self-sustaining level or consistently performing homemaker roles (e.g., household meal preparation, washing clothes, budgeting, or childcare tasks and responsibilities); and i. maintaining a safe living situation.
Service Exclusions	<ol style="list-style-type: none"> 1. This service may not duplicate any discharge planning efforts which are part of the expectation for hospitals, ICF-MRs, Institutions for Mental Disease (IMDs), and Psychiatric Residential Treatment Facilities (PRTFs). 2. This service is not available to any individual who receives a waiver service via the Department of Community Health. Payment for Intensive Case Management Services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. 3. Individuals with a substance-related disorder are excluded from receiving this service unless there is clearly documented evidence of a primary psychiatric diagnosis. 4. ACT, CST, ICM are service exclusions. Individuals may receive CM and one of these services for a limited period of time to facilitate a smooth transition.
Clinical Exclusions	Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition co-occurring with the diagnosis of: mental retardation; and/or autism; and/or organic mental disorder; and/or traumatic brain injury.
Required Components	<ol style="list-style-type: none"> 1. Each provider must have policies and procedures related to referral including providing outreach to agencies who may serve the targeted population including but not limited to psychiatric inpatient hospitals, Crisis Stabilization Units, jails, prisons, homeless shelters, etc.. 2. The organization must have policies and procedures for protecting the safety of staff that engage in these community-based service delivery activities. 3. Because of the complex needs of this target population, CM services may only be delivered by a DBHDD designated Core Provider. 4. Contact must be made with the individual receiving CM a minimum of two (2) times a month. At least one of the monthly contacts must be face-to-face in non-clinic/community-based setting and the other may be either face-to-face or telephone contact (denoted by the UK modifier) depending on the individual's identified support needs. While the minimum number of contacts is stated above, individual clinical need is always to be met and may require a level of service higher than the established minimum criteria for contact. 5. At least 50% of CM service units must be delivered face-to-face with the identified individual receiving the service and the majority of all face-to-face service units must be delivered in non-clinic settings over the authorization period (these units are specific to single individual records and are not aggregate across an agency/program or multiple payers). 6. The majority of all face-to-face service units must be delivered in non-clinic settings (i.e. any place that is convenient for the individual such as FOHC, place of employment, community space) over the course of the authorization period (these units are specific to single individual consume records and are not aggregate across an agency/program or multiple payers). 7. In the absence of meeting the minimum monthly face-to-face-contact and if at least two (2) unsuccessful attempts to make face-to-face contact have been tried and documented, the provider may bill for a maximum of one (1) telephone contact in that specified month (denoted by the UK modifier). Billing for collateral contact only may not exceed 30 consecutive days. 8. After four (4) unsuccessful attempts at making face to face contact with an individual, the CM and members of the treatment team will re-evaluate the IRP and utilization of services. 9. In the event that a CM has documented multiple attempts to locate and make contact with an individual and has demonstrated diligent search, after 60 days of unsuccessful attempts the individual may be discharged. 10. Individuals for whom there is a written transition/discharge plan may receive a tapered benefit based upon individualized need as documented in that plan. 11. When the primary focus of CM is on medication maintenance, the following allowances apply: <ol style="list-style-type: none"> a. These individuals are not counted in the off-site service requirement or the individual-to-staff ratio; and b. These individuals are not counted in the monthly face-to-face contact requirement; however a minimum of one (1) face-to-face contact is required every three (3) months; and monthly calls are an allowed billable service.

Staffing Requirements	<ol style="list-style-type: none"> 1. Oversight of CM is provided by an independently licensed practitioner. 2. It is recommended that the CM caseload not exceed 50 enrolled individuals. 3. Individuals who receive only medication maintenance are not counted in the staff ratio calculation. 4. A practitioner delivering Case Management should be able to provide skills training when needed by the individual, but the skills training activity must be billed as PSR-I and not Case Management.
Clinical Operations	<ol style="list-style-type: none"> 1. CM may include (with the consent of the Adult) coordination with family and significant others and other systems/supports (e.g., work, religious entities, corrections, aging agencies, etc.) when appropriate for treatment and recovery needs. 2. CM providers must have the ability to deliver services in various environments, such as homes, homeless shelters, or street locations. The provider should keep in mind that individuals may prefer to meet staff at a community location other than their homes or other conspicuous locations (e.g. their place of employment), especially if staff drive a vehicle that is clearly marked as a state or agency vehicle, or if staff must identify themselves and their purpose to gain access to the individual in a way that may potentially embarrass the individual or breach the individual's privacy/confidentiality. Staff should be sensitive to and respectful of individuals' privacy/confidentiality rights and preferences in this regard to the greatest extent possible (e.g. if staff must meet with an individual during their work time, if the individual wishes, mutually agree upon a meeting place nearby that is the least conspicuous from the individual's point of view). 3. CM is expected to participate in planning, coordinating, and accessing services and resources when an enrolled individual experiences an episode of psychiatric hospitalization, incarceration, and/or homelessness. 4. It is expected that the individual served will receive ongoing physician assessment and treatment as well as other recovery-supporting services. These services may be provided by a Core Provider or by an external agency. There shall be documentation during each Authorization Period to demonstrate the team's efforts at consulting and collaborating with the physician and other recovery-supporting services. 5. It is expected that the Case Management practitioner will assist all eligible individuals with the application process to obtain entitlement benefits including SSI/SSDI, Food Stamps, VA, Medicaid, etc. including making appointments, completing applications and related paperwork. 6. The organization must have policies that govern the provision of services in natural settings and can document that the organization respects individuals' rights to privacy and confidentiality when services are provided in these settings. 7. The organization has established procedures/protocols for handling emergency and crisis situations that includes: <ol style="list-style-type: none"> a. joint development of a crisis plan between the individual, organization, core provider, and other providers where the organization is engaged with the individual to ensure that the plan is complete, current, adequate, and communicated to all appropriate parties; and b. an evaluation of the adequacy of the individual's crisis plan and its implementation occurs at periodic intervals including post-crisis events. <ul style="list-style-type: none"> ▪ while respecting the individual's crisis plan and identified points of first response, the policies should articulate the role of the core provider agency to be the primary responsible provider for providing crisis supports and intervention as clinically necessary. 8. The organization must have an CM Organizational Plan that addresses the following: <ol style="list-style-type: none"> a. description of the role of a Case Management practitioner during a crisis in partnership with the individual's core services either within the agency or with an outside clinical home where the individual receives ongoing physician assessment and treatment, as well as other recovery support services. b. description of the staffing pattern and how staff are deployed to assure that the required staff-to-individual ratios are maintained, including how unplanned staff absences, illnesses, or emergencies are accommodated, case mix, access, etc.; c. description of the hours of operations as related to access and availability to the individuals served; d. description of how the IRP plan constructed, modified and/or adjusted to meet the needs of the individual and to facilitate broad natural and formal support participation; and e. description of how CM agencies engage with other agencies who may serve the target population.
Service Accessibility	<ol style="list-style-type: none"> 1. There must be documented evidence that service hours of operation include evening, weekend, and holiday hours. 2. "Medication Maintenance Track," individuals who require more than 4 contacts per quarter for two consecutive quarters (as based upon need) are expected to be re-evaluated with LOCUS for enhanced access to CM. The designation of "medication maintenance track" should be lifted and exceptions stated above are no longer allowed.

Reporting and Billing Requirements	When a billable collateral contact is provided, the UK reporting modifier shall be utilized. A collateral contact is classified as any contact that is not face-to-face with the individual.
Documentation Requirements	Orders for Service and Treatment Plans which have an effective date of 5/31/2013 or prior and name CSI will be accepted as an Order or Treatment Plan, respectively, for CM, PSR-I, and ADSS. This is effective for the authorization period which corresponds to the Order and Treatment Plan. Any Treatment Plan or Order with a start date on or after 6/1/2013 may not include CSI, and instead, must reflect CM, PSR-I, and/or ADSS as medically necessary (While the above allowances are being made, please note that when providing the above services on or after 6/1/2013, providers must bill and document (via progress notes) the new service and their corresponding codes as appropriate. CSI may not be provided to adults effective 6/1/2013.).

Community Transition Planning														
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Community Transition Planning	Community Transition Planning (State Hospital)	T2038	ZH				\$20.92	Community Transition Planning (Jail /Prison)	T2038	ZJ				\$20.92
	Community Transition Planning (CSU)	T2038	ZC				\$20.92	Community Transition Planning (Other)	T2038	ZO				\$20.92
Unit Value	15 minutes							Authorization Period	90 days (Registration) 180 days (New Episode)					
Initial Authorization	50 units							Re-Authorization	50 units					
Service Definition	<p>Community Transition Planning (CTP) is a service for contracted Core and ACT providers to address the care, service, and support needs of adults with mental illness and/or addictive diseases to ensure a coordinated plan of transition from a qualifying facility to the community. Each episode of CTP must include contact with the individual and their identified supports with a minimum of one (1) face-to-face contact with the individual prior to release from the state hospital/facility. Additional Transition Planning activities include: educating the individual and identified supports on service options offered by the chosen primary service agency; participating in state hospital or facility treatment team meetings to develop a transition plan, and making collateral contacts with other agencies and community resources when indicated.</p> <p>In partnership between other community service providers and the hospital/facility staff, the community service agency maintains responsibility for carrying out transitional activities either by the individual's chosen primary service coordinator or by the service coordinator's designated Community Transition Liaison. CTP may also be used for Case Management/ICM/AD Support Services staff, ACT team members and CPSs who work with the individual in the community or will work with the individual in the future to maintain or establish contact.</p> <p>CTP consists of the following interventions to ensure the person transitions successfully from the facility to their local community:</p> <ul style="list-style-type: none"> • Establishing a connection or reconnection with the person through supportive contacts while in the qualifying facility. By engaging with the person, this helps to develop and strengthen a foundation for the therapeutic relationship. • Educating the person and his/her identified supports about local community resources and service options available to meet their needs upon transition into the community. This allows the person to make self-directed, informed choices on service options that they feel will best meet their needs and increases the likelihood of post-facility engagement • Participating in qualifying facility team meetings especially in person centered planning for those in a treatment facility for longer than 60 days, to share hospital 													

Community Transition Planning

	<p>and community information related to estimated length of stay, present problems related to admission, discharge/release criteria, progress toward treatment goals, personal strengths, available supports and assets, medical condition, medication issues, and community treatment needs.</p> <ul style="list-style-type: none"> Linking the adult with community services including visits between the person and the CM/ICM/AD Support Services staff, ACT team members and/or CPSs who will be working with the individual in the community (including visits and telephone contacts between the individual and the community-based providers).
Admission Criteria	<p>Individual who meet Core Customer Eligibility while in one of the following qualifying facilities:</p> <ol style="list-style-type: none"> State Operated Hospital Crisis Stabilization Unit (CSU) Jail/Prison Other (ex: Community Psychiatric Hospital)
Continuing Stay Criteria	Same as above.
Discharge Criteria	<ol style="list-style-type: none"> Individual/family requests discharge; or Individual no longer meets Core Customer Eligibility; or Individual is discharged from a state hospital or qualifying facility.
Service Exclusions	This service is utilized only when an individual is transitioning from an institutional setting and therefore is not provided concurrent to an ongoing community-based service package.
Clinical Exclusions	Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a co-occurring Behavioral Health condition: Developmental Disability, Autism, Organic Mental Disorder, Traumatic Brain Injury
Required Components	<u>Prior to Release from a State Hospital or Qualifying Facility:</u> When the person has had (a) a length of stay of 60 days or longer in a facility or (b) youth is readmitted to a facility within 30 days of discharge, a community transition plan in partnership with the facility is required. Evidence of planning shall be recorded and a copy of the Plan shall be included in both the adult's hospital and community records.
Clinical Operations	<p>Community Transition Planning activities shall include:</p> <ol style="list-style-type: none"> Telephone and Face-to-face contacts with individual and their identified family; Participating in individual's clinical staffing(s) prior to their discharge from the facility; Applications for resources and services prior to discharge from the facility including: <ol style="list-style-type: none"> Healthcare Entitlements (i.e., SSI, SSDI) for which they are eligible Self-Help Groups and Peer Supports Housing Employment, Education, Training Consumer Support Services
Service Accessibility	<ol style="list-style-type: none"> This service must be available 7 days a week (if the state hospital/qualifying facility discharges or releases 7 days a week). This service may be delivered via telemedicine technology or via telephone conferencing.
Reporting and Billing Requirements	<ol style="list-style-type: none"> The modifier on Procedure Code indicates setting from which the individual is transitioning. There must be a minimum of one face-to-face with the individual prior to release from hospital or qualifying facility in order to bill for any telephone contacts.
Documentation Requirements	<ol style="list-style-type: none"> A documented Community Transition Plan for: <ol style="list-style-type: none"> Individuals with a length of stay greater than 60 days; or Individuals readmitted within 30 days of discharge. Documentation of all face-to-face and telephone contacts and a description of progress with Community Transition Plan implementation and outcomes.

Crisis Intervention														
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Crisis Intervention	Practitioner Level 1, In-Clinic	H2011	U1	U6			\$58.21	Practitioner Level 1, Out-of-Clinic	H2011	U1	U7			\$74.09
	Practitioner Level 2, In-Clinic	H2011	U2	U6			\$38.97	Practitioner Level 2, Out-of-Clinic	H2011	U2	U7			\$46.76
	Practitioner Level 3, In-Clinic	H2011	U3	U6			\$30.01	Practitioner Level 3, Out-of-Clinic	H2011	U3	U7			\$36.68
	Practitioner Level 4, In-Clinic	H2011	U4	U6			\$20.30	Practitioner Level 4, Out-of-Clinic	H2011	U4	U7			\$24.36
	Practitioner Level 5, In-Clinic	H2011	U5	U6			\$15.13	Practitioner Level 5, Out-of-Clinic	H2011	U5	U7			\$ 18.15
Psychotherapy for Crisis	Practitioner Level 1, In-Clinic, first 60 minutes (base code)	90839	U1	U6			\$232.84	Practitioner Level 1, Out-of-Clinic	90840	U1	U6			\$116.42
	Practitioner Level 2, In-Clinic, first 60 minutes (base code)	90839	U2	U6			\$155.88	Practitioner Level 2, Out-of-Clinic, add-on each additional 30 mins.	90840	U2	U6			\$77.94
	Practitioner Level 3, In-Clinic, first 60 minutes (base code)	90839	U3	U6			\$120.04	Practitioner Level 3, Out-of-Clinic, add-on each additional 30 mins.	90840	U3	U6			\$60.02
	Practitioner Level 1, In-Clinic, first 60 minutes (base code)	90839	U1	U7			\$296.36	Practitioner Level 1, Out-of-Clinic, add-on each additional 30 mins.	90840	U1	U7			\$148.18
	Practitioner Level 2, In-Clinic, first 60 minutes (base code)	90839	U2	U7			\$187.04	Practitioner Level 2, Out-of-Clinic, add-on each additional 30 mins.	90840	U2	U7			\$93.52
	Practitioner Level 3, In-Clinic, first 60 minutes (base code)	90839	U3	U7			\$146.72	Practitioner Level 3, Out-of-Clinic, add-on each additional 30 mins.	90840	U3	U7			\$73.36
Unit Value	Crisis Intervention		15 minutes					Maximum Daily Units	Crisis Intervention		16 units			
	Psychotherapy for Crisis		1 Encounter						Psychotherapy for Crisis, base code		2 encounters			
									Psychotherapy for Crisis, add-ons		4 encounters			
Initial Authorization	48 Units							Re-Authorization	48 units					
Authorization Period	180 days								Utilization Criteria	<u>LOCUS scores:1-6</u>				
Service Definition	<p>Crisis Intervention supports the individual who is experiencing an abrupt and substantial change in behavior which is usually associated with a precipitating situation and which is in the direction of severe impairment of functioning or a marked increase in distress. Interventions are designed to prevent out of community placement or hospitalization. Often, a crisis exists at such time as an individual and his/her identified natural resources decide to seek help and/or the individual, identified natural resources, or practitioner identifies the situation as a crisis. Crisis services are time-limited and present-focused to address the immediate crisis and develop appropriate links to alternate services.</p> <p>The individual's current behavioral health care advanced directive, if existing, should be utilized to manage the crisis. Interventions provided should honor and respect the individual's wishes/choices by following the plan/advanced directive as closely as possible in line with clinical judgment. Plans/advanced directives developed during the Behavioral Health Assessment/IRP process should be reviewed and updated (or developed if the individual is a new consumer) as part of those services to help prevent or manage future crisis situations.</p>													

	Some examples of interventions that may be used to de-escalate a crisis situation could include: a situational assessment; active listening and empathic responses to help relieve emotional distress; effective verbal and behavioral responses to warning signs of crisis related behavior; assistance to, and involvement/participation of the individual (to the extent he or she is capable) in active problem solving planning and interventions; facilitation of access to a myriad of crisis stabilization and other services deemed necessary to effectively manage the crisis; mobilization of natural support systems; and other crisis interventions as appropriate to the individual and issues to be addressed.
Admission Criteria	<ol style="list-style-type: none"> 1. Treatment at a lower intensity has been attempted or given serious consideration; and #2 and/or #3 are met: 2. Individual has a known or suspected mental health diagnosis or Substance Related Disorder; or 3. Individual is experiencing severe situational crisis and is at risk of harm to self, others and/or property. Risk ranges from mild to imminent; and one/both of the following: <ol style="list-style-type: none"> a. Individual has insufficient or severely limited resources or skills necessary to cope with the immediate crisis; or b. Individual demonstrates lack of judgment and/or impulse control and/or cognitive/perceptual abilities.
Continuing Stay Criteria	This service may be utilized at various points in the individual's course of treatment and recovery, however, each intervention is intended to be a discrete time-limited service that stabilizes the individual and moves him/her to the appropriate level of care.
Discharge Criteria	<ol style="list-style-type: none"> 1. Individual no longer meets continued stay guidelines; and 2. Crisis situation is resolved and an adequate continuing care plan has been established.
Clinical Exclusions	Severity of clinical issues precludes provision of services at this level of care.
Clinical Operations	In any review of clinical appropriateness of the service, the mix of services offered to the individual is key. Crisis units will be looked at by the External Review Organization in combination with other supporting services. For example, if an individual presents in crisis and the crisis is alleviated within an hour but ongoing support continues, it is expected that 4 units of crisis is billed and then some supporting service such as individual counseling will be utilized to support the individual during that interval of service
Staffing Requirements	<ol style="list-style-type: none"> 1. 90839 and 90840 are only utilized when the content of the service delivered is Crisis Psychotherapy. Therefore, the only practitioners who can do this are those who are recognized as practitioners for Individual Counseling in the Service X Practitioner Table A. included herein. 2. The practitioner who will bill 90839 (and 90840 if time is necessary) must devote full attention to the individual served and cannot provide services to other individuals during the time identified in the medical record and in the related claim/encounter/submission.
Service Accessibility	<ol style="list-style-type: none"> 1. All crisis service response times for this service must be within 2 hours of the individual or other constituent contact to the provider agency. 2. Services are available 24-hours/day, 7 days/week, and may be offered by telephone and/or face-to-face in most settings (e.g. home, jail, community hospital, clinic etc.).
Additional Medicaid Requirements	The daily maximum within a CSU for Crisis Intervention is 8 units/day.
Reporting and Billing Requirements	<ol style="list-style-type: none"> 1. Any use of a telephonic intervention must be coded/reported with a U6 modifier as the person providing the telephonic intervention is not expending the additional agency resources in order to be in the community where the person is located during the crisis. 2. Any use beyond 16 units will not be denied but will trigger an immediate retrospective review. 3. Psychotherapy for Crisis (90839, 90840) may be billed if the following criteria are met: <ul style="list-style-type: none"> • The nature of the crisis intervention is urgent assessment and history of a crisis situation, assessment of mental status, and disposition and is paired with psychotherapy, mobilization of resources to defuse the crisis and restore safety and the provision of psychotherapeutic interventions to minimize trauma, AND • the practitioner meets the definition to provide therapy in the Georgia Practice Acts, AND • the presenting situation is life-threatening and requires immediate attention to an individual who is experiencing high distress. 4. Other payers may limit who can provide 90839 and 90840 and therefore a providing agency must adhere to those third party payers' policies regarding billing practitioners. 5. The 90839 code is utilized when the time of service ranges between 45-74 minutes and may only be utilized once in a single day. Anything less than 45 minutes can

- be provided either through an Individual Counseling code or through the H2011 code above (whichever best reflects the content of the intervention).
6. Add-on Time Specificity:
 - If additional time above the base 74 minutes is provided and the additional time spent is greater than 23 minutes, an additional encounter of 90840 may be billed.
 - If the additional time spent (above base code) is 45 minutes or greater, a second unit of 90840 may be billed.
 - If the additional time spent (above base code) is 83 minutes or greater, a third unit of 90840 may be billed.
 - If the additional time spent (above base code) is 113 minutes or greater, a fourth unit of 90840 may be billed.
 7. 90839 and 90840 cannot be submitted by the same practitioner in the same day as H2011 above.
 8. 90839 and 90840 cannot be provided/submitted for billing in the same day as 90791, 90792, 90833, or 90836.

Diagnostic Assessment

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Psychiatric Diagnostic Evaluation (no medical service)	Practitioner Level 2, In-Clinic	90791	U2	U6			\$116.90	Practitioner Level 3, In-Clinic	90791	U3	U6			\$90.03
	Practitioner Level 2, Out-of-Clinic	90791	U2	U7			\$140.28	Practitioner Level 3, Out-of-Clinic	90791	U3	U7			\$110.04
	Practitioner Level 2, Via interactive audio and video telecommunication systems	90791	GT	U2			\$116.90	Practitioner Level 3, Via interactive audio and video telecommunication systems*	90791	GT	U3			\$90.03
Psychiatric Diagnostic Evaluation with medical services)	Practitioner Level 1, In-Clinic	90792	U1	U6			\$174.63	Practitioner Level 2, Via interactive audio and video telecommunication systems	90792	GT	U2			\$116.90
	Practitioner Level 1, Out-of-Clinic	90792	U1	U7			\$222.26	Practitioner Level 2, In-Clinic	90792	U2	U6			\$116.90
	Practitioner Level 1, Via interactive audio and video telecommunication systems	90792	GT	U1			\$174.63	Practitioner Level 2, Out-of-Clinic	90792	U2	U7			\$140.28
Unit Value	1 encounter							Maximum Daily Units*	1 unit per procedure code					
Initial Auth	2 units							Re-Authorization*	2 units					
Auth Period	180 days							Utilization Criteria	LOCUS scores:1-6					
Service Definition	Psychiatric diagnostic interview examination includes a history; mental status exam; evaluation and assessment of physiological phenomena (including co-morbidity between behavioral and physical health care issues); psychiatric diagnostic evaluation (including assessing for co-occurring disorders and the development of a differential diagnosis); screening and/or assessment of any withdrawal symptoms for the individual with substance related diagnoses; assessment of the appropriateness of initiating or continuing services; and a disposition. These are completed by face-to-face evaluation of the individual (which may include the use of telemedicine) and may include communication with family and other sources and the ordering and medical interpretation of laboratory or other medical diagnostic studies.													
Admission Criteria	<ol style="list-style-type: none"> 1. Individual has a known or suspected mental illness or a substance-related disorder and has recently entered the service system; or 2. Individual is in need of annual assessment and re-authorization of service array; or 3. Individual has need of an assessment due to a change in clinical/functional status. 													
Continuing Stay Criteria	Individual's situation/functioning has changed in such a way that previous assessments are outdated.													

Diagnostic Assessment

Discharge Criteria	1. An adequate continuing care plan has been established; and one or more of the following: b. Individual has withdrawn or been discharged from service; or c. Individual no longer demonstrates need for additional assessment.
Service Exclusions	Assertive Community Treatment
Required Components	Telemedicine may be utilized for an initial Psychiatric Diagnostic Examination as well as for ongoing Psychiatric Diagnostic Examination via the use of appropriate procedure codes with the GT modifier.
Staffing Requirements	The only U3 practitioner who can provide Diagnostic Assessment is an LCSW.
Billing and Reporting Requirements	1. 90791 is used when an initial evaluation is provided by a non-physician 2. 90792 is used when an initial evaluation is provided by a physician, PA, or APRN. This 90792 intervention content would include all general behavioral health assessment as well as Medical assessment/Physical exam beyond mental status as appropriate. 3. If a Medicaid claim for this service denies for a Procedure-to-Procedure edit, a modifier (59) can be added to the claim and resubmitted to the MMIS for payment.
Additional Medicaid Requirements	The daily maximum within a CSU for Diagnostic Assessment (Psychiatric Diagnostic Interview) for adults is 2 units. Two units should be utilized only if it is necessary in a complex diagnostic case for the physician extender (PA or APRN) to call in the physician for an assessment of the individual to corroborate or verify the correct diagnosis.

Family Outpatient Services: Family Counseling

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Family – BH counseling/therapy (w/o client present)	Practitioner Level 2, In-Clinic	H0004	HS	U2	U6		\$38.97	Practitioner Level 2, Out-of-Clinic	H0004	HS	U2	U7		\$46.76
	Practitioner Level 3, In-Clinic	H0004	HS	U3	U6		\$30.01	Practitioner Level 3, Out-of-Clinic	H0004	HS	U3	U7		\$36.68
	Practitioner Level 4, In-Clinic	H0004	HS	U4	U6		\$20.30	Practitioner Level 4, Out-of-Clinic	H0004	HS	U4	U7		\$24.36
	Practitioner Level 5, In-Clinic	H0004	HS	U5	U6		\$15.13	Practitioner Level 5, Out-of-Clinic	H0004	HS	U5	U7		\$18.15
Family – BH counseling/therapy (with client present)	Practitioner Level 2, In-Clinic	H0004	HR	U2	U6		\$38.97	Practitioner Level 2, Out-of-Clinic	H0004	HR	U2	U7		\$46.76
	Practitioner Level 3, In-Clinic	H0004	HR	U3	U6		\$30.01	Practitioner Level 3, Out-of-Clinic	H0004	HR	U3	U7		\$36.68
	Practitioner Level 4, In-Clinic	H0004	HR	U4	U6		\$20.30	Practitioner Level 4, Out-of-Clinic	H0004	HR	U4	U7		\$24.36
	Practitioner Level 5, In-Clinic	H0004	HR	U5	U6		\$15.13	Practitioner Level 5, Out-of-Clinic	H0004	HR	U5	U7		\$18.15
Family Psychotherapy w/o the patient present (appropriate license required)	Practitioner Level 2, In-Clinic	90846	U2	U6			\$38.97	Practitioner Level 2, Out-of-Clinic	90846	U2	U7			\$46.76
	Practitioner Level 3, In-Clinic	90846	U3	U6			\$30.01	Practitioner Level 3, Out-of-Clinic	90846	U3	U7			\$36.68
	Practitioner Level 4, In-Clinic	90846	U4	U6			\$20.30	Practitioner Level 4, Out-of-Clinic	90846	U4	U7			\$24.36
	Practitioner Level 5, In-Clinic	90846	U5	U6			\$15.13	Practitioner Level 5, Out-of-Clinic	90846	U5	U7			\$18.15
Conjoint Family Psychotherapy w/ the patient present a portion or the entire session	Practitioner Level 2, In-Clinic	90847	U2	U6			\$38.97	Practitioner Level 2, Out-of-Clinic	90847	U2	U7			\$46.76
	Practitioner Level 3, In-Clinic	90847	U3	U6			\$30.01	Practitioner Level 3, Out-of-Clinic	90847	U3	U7			\$36.68
	Practitioner Level 4, In-Clinic	90847	U4	U6			\$20.30	Practitioner Level 4, Out-of-Clinic	90847	U4	U7			\$24.36
	Practitioner Level 5, In-Clinic	90847	U5	U6			\$15.13	Practitioner Level 5, Out-of-Clinic	90847	U5	U7			\$18.15

Family Outpatient Services: Family Counseling

(appropriate license required)									
Unit Value	15 minutes				Maximum Daily Units*	8 units (Family Training and Family Counseling combined)			
Initial Authorization*	If a MICP Registration is submitted -32 units (combined with Family Training) If a MICP New Episode is submitted - 60 units (combined with Family Training)				Reauthorization*	60 units (Family Training and Family Counseling combined)			
Authorization Period*	180 days				Utilization Criteria	<u>LOCUS scores:</u> 1-6			
Service Definition	<p>A therapeutic intervention or counseling service shown to be successful with identified family populations, diagnoses and service needs, provided by a qualified clinician or practitioner. Services are directed toward achievement of specific goals defined with/by the individual and targeted to the individual-identified family and specified in the Individualized Recovery Plan. The focus of family counseling is the family or subsystems within the family, e.g. the parental couple. The service is always provided for the benefit of the individual and may or may not include the individual's participation as indicated by the CPT code.</p> <p>Family counseling provides systematic interactions between the identified individual, staff and the individual's identified family members directed toward the restoration, development, enhancement or maintenance of functioning of the identified individual/family unit. This includes support of the family and specific therapeutic interventions/activities to enhance family roles, relationships, communication and functioning that promote the recovery of the individual. Specific goals/issues to be addressed though these services may include the restoration, development, enhancement or maintenance of:</p> <ol style="list-style-type: none"> 1. processing skills; 2. healthy coping mechanisms; 3. adaptive behaviors and skills; 4. interpersonal skills; 5. family roles and relationships; 6. the family's understanding of mental illness and substance related disorders, the steps necessary to facilitate recovery, and methods of intervention, interaction and mutual support the family can use to assist their family member. <p>Best practices such as Multi-systemic Family Therapy, Multidimensional Family Therapy, Behavioral Family Therapy, Functional Family Therapy or others appropriate for the family and issues to be addressed should be utilized in the provision of this service.</p>								
Admission Criteria	<ol style="list-style-type: none"> 1. Individual must have a mental illness and/or substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); and 2. Individual's level of functioning does not preclude the provision of services in an outpatient milieu; and 3. Individual's assessment indicates needs that may be supported by therapeutic intervention shown to be successful with identified family populations and individual's diagnoses. 								
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual continues to meet Admission Criteria as articulated above; and 2. Progress notes document progress relative to goals identified in the Individualized Recovery Plan, but all treatment/support goals have not yet been achieved. 								
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Recovery Plan have been substantially met; or 3. Individual requests discharge and individual is not in imminent danger of harm to self or others; or 4. Transfer to another service is warranted by change in individual's condition; or 5. Individual requires more intensive services 								
Service Exclusions	ACT								

Family Outpatient Services: Family Counseling

Clinical Exclusions	<ol style="list-style-type: none"> 1. Severity of behavioral health impairment precludes provision of services. 2. Severity of cognitive impairment precludes provision of services in this level of care. 3. There is a lack of social support systems such that a more intensive level of service is needed. 4. This service is not intended to supplant other services such as MR/DD Personal and Family Support or any day services where the individual may more appropriately receive these services with staff in various community settings. 5. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: developmental disability, autism, organic mental disorder and traumatic brain injury.
Required Components	<ol style="list-style-type: none"> 1. The treatment orientation, modality and goals must be specified and agreed upon by the individual. 2. Couples counseling is included under this service code as long as the counseling is directed toward the identified individual and his/her goal attainment as identified in the Individualized Recovery Plan. 3. The Individualized Recovery Plan for the individual includes goals and objectives specific to the individual-identified family for whom the service is being provided.
Clinical Operations	Models of best practice delivery may include (as clinically appropriate) Multidimensional Family Therapy, Behavioral Family Therapy, Functional Family Therapy, and others as appropriate the family and issues to be addressed.
Service Accessibility	Services may not exceed 8 Billable units (combined Family Counseling and Family Therapy) in a single day. If clinical need indicates this level of intensity, other services may need to be considered for authorization.
Documentation Requirements	<p>If there are multiple family members in the Family Counseling session who are enrolled individuals for whom the focus of treatment is related to goals on their treatment plans, the following applies:</p> <ol style="list-style-type: none"> 1. Document the family session in the charts of each individual for whom the treatment is related to a specific goal on the individual's IRP 2. Charge the Family Counseling session units to <u>one</u> of the individuals. 3. Indicate "NC" (No Charge) on the documentation for the other individual(s) in the family session and have the note reflect that the charges for the session are assigned to another family member in the session.
Billing and Reporting Requirements	If a Medicaid claim for this service denies for a Procedure-to-Procedure edit, a modifier (59) can be added to the claim and resubmitted to the MMIS for payment.

Family Outpatient Services: Family Training

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Family Skills Training and Development	Practitioner Level 4, In-Clinic, without client present	H2014	HS	U4	U6		\$20.30	Practitioner Level 4, In-Clinic, with client present	H2014	HR	U4	U6		\$20.30
	Practitioner Level 5, In-Clinic, without client present	H2014	HS	U5	U6		\$15.13	Practitioner Level 5, In-Clinic, with client present	H2014	HR	U5	U6		\$15.13
	Practitioner Level 4, Out-of-Clinic, without client present	H2014	HS	U4	U7		\$24.36	Practitioner Level 4, Out-of-Clinic, with client present	H2014	HR	U4	U7		\$24.36
	Practitioner Level 5, Out-of-Clinic, without client present	H2014	HS	U5	U7		\$18.15	Practitioner Level 5, Out-of-Clinic, with client present	H2014	HR	U5	U7		\$18.15
Unit Value	15 minutes						Maximum Daily Units*			8 units (Family Training and Family Counseling combined)				
Initial Authorization*	If a MICP Registration is submitted - 32 units (combined with Family Training) If a MICP New Episode is submitted - 60 units (combined with Family Training)						Reauthorization*			60 units (Family Training and Family Counseling combined)				

Family Outpatient Services: Family Training

Authorization Period*	180 days	Utilization Criteria	<u>LOCUS scores:1-6</u>
Service Definition	<p>A therapeutic interaction shown to be successful with identified family populations, diagnoses and service needs. Services are directed toward achievement of specific goals defined by the individual and targeted to the individual-identified family and specified in the Individualized Recovery Plan (note: although interventions may involve the family, the focus or primary beneficiary of intervention must always be the individual). Family training provides systematic interactions between the identified individual, staff and the individual's identified family members directed toward the enhancement or maintenance of functioning of the identified individual/family unit. This may include support of the family, as well as training and specific activities to enhance functioning that promote the recovery of the individual. Specific goals/issues to be addressed though these services may include the restoration, development, enhancement or maintenance of:</p> <ol style="list-style-type: none"> 1. illness and medication self-management knowledge and skills (e.g. symptom management, behavioral management, relapse prevention skills, knowledge of medications and side effects, and motivational/skill development in taking medication as prescribed); 2. problem solving and practicing functional skills; 3. healthy coping mechanisms; 4. adaptive behaviors and skills; 5. interpersonal skills; 6. daily living skills; 7. resource access and management skills; and 8. the family's understanding of mental illness and substance related disorders, the steps necessary to facilitate recovery, and methods of intervention, interaction and mutual support the family can use to assist their family member. 		
Admission Criteria	<ol style="list-style-type: none"> 1. Individual must have a mental illness and/or substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); and 2. Individual's level of functioning does not preclude the provision of services in an outpatient milieu; and 3. Individual's assessment indicates needs that may be supported by a therapeutic intervention shown to be successful with identified family populations and diagnoses. 		
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual continues to meet Admission Criteria as articulated above; and 2. Progress notes document progress relative to goals identified in the Individualized Recovery Plan, but all treatment/support goals have not yet been achieved. 		
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Recovery Plan have been substantially met; or 3. Individual requests discharge and individual is not in imminent danger of harm to self or others; or 3. Transfer to another service is warranted by change in individual's condition; or 4. Individual requires more intensive services. 		
Service Exclusions	ACT		
Clinical Exclusions	<ol style="list-style-type: none"> 1. Severity of behavioral health impairment precludes provision of services. 2. Severity of cognitive impairment precludes provision of services in this level of care. 3. There is a lack of social support systems such that a more intensive level of service is needed. 4. There is no outlook for improvement with this particular service. 5. This service is not intended to supplant other services such as Personal and Family Support or any day services where the individual may more appropriately receive these services with staff in various community settings. 6. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: developmental disability, autism, organic mental disorder and traumatic brain injury. 		
Required Components	<ol style="list-style-type: none"> 1. The treatment orientation, modality and goals must be specified and agreed upon by the individual. 2. The Individualized Recovery Plan for the individual includes goals and objectives specific to the individual-identified family for whom the service is being provided. 		

Family Outpatient Services: Family Training

Service Accessibility	Services may not exceed 8 Billable units (combined Family Counseling and Family Therapy) in a single day. If clinical need indicates this level of intensity, other services may need to be considered for authorization.
Documentation Requirements	<p>If there are multiple family members in the Family Training session who are enrolled individuals for whom the focus of treatment in the group is related to goals on their treatment plans, the following applies:</p> <ol style="list-style-type: none"> Document the family session in the charts of each individual for whom the treatment is related to a specific goal on the individual's IRP Charge the Family Training session units to <u>one</u> of the individuals. Indicate "NC" (No Charge) on the documentation for the other individual(s) in the family session and have the note reflect that the charges for the session are assigned to another family member in the session.

Group Outpatient Services: Group Counseling

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Group – Behavioral health counseling and therapy	Practitioner Level 2, In-Clinic	H0004	HQ	U2	U6		\$8.50	Practitioner Level 2, Out-of-Clinic, Multi-family group, w/ client present	H0004	HQ	HR	U2	U7	\$10.39
	Practitioner Level 3, In-Clinic	H0004	HQ	U3	U6		\$6.60	Practitioner Level 3, Out-of-Clinic, Multi-family group, w/ client present	H0004	HQ	HR	U3	U7	\$8.25
	Practitioner Level 4, In-Clinic	H0004	HQ	U4	U6		\$4.43	Practitioner Level 4, Out-of-Clinic, Multi-family group, w/ client present	H0004	HQ	HR	U4	U7	\$5.41
	Practitioner Level 5, In-Clinic	H0004	HQ	U5	U6		\$3.30	Practitioner Level 5, Out-of-Clinic, Multi-family group, w/ client present	H0004	HQ	HR	U5	U7	\$4.03
	Practitioner Level 2, Out-of-Clinic	H0004	HQ	U2	U7		\$10.39	Practitioner Level 2, In-Clinic, Multi-family group, without client present	H0004	HQ	HS	U2	U6	\$8.50
	Practitioner Level 3, Out-of-Clinic	H0004	HQ	U3	U7		\$8.25	Practitioner Level 3, In-Clinic, Multi-family group, without client present	H0004	HQ	HS	U3	U6	\$6.60
	Practitioner Level 4, Out-of-Clinic	H0004	HQ	U4	U7		\$5.41	Practitioner Level 4, In-Clinic, Multi-family group, without client present	H0004	HQ	HS	U4	U6	\$4.43
	Practitioner Level 5, Out-of-Clinic	H0004	HQ	U5	U7		\$4.03	Practitioner Level 5, In-Clinic, Multi-family group, without client present	H0004	HQ	HS	U5	U6	\$3.30
	Practitioner Level 2, In-Clinic, Multi-family group, with client present	H0004	HQ	HR	U2	U6	\$8.50	Practitioner Level 2, Out-of-Clinic, Multi-family group, without client present	H0004	HQ	HS	U2	U7	\$10.39
	Practitioner Level 3, In-Clinic, Multi-family group, with client present	H0004	HQ	HR	U3	U6	\$6.60	Practitioner Level 3, Out-of-Clinic, Multi-family group, w/o client present	H0004	HQ	HS	U3	U7	\$8.25
	Practitioner Level 4, In-Clinic, Multi-family group, w/ client present	H0004	HQ	HR	U4	U6	\$4.43	Practitioner Level 4, Out-of-Clinic, Multi-family group, w/o client present	H0004	HQ	HS	U4	U7	\$5.41
	Practitioner Level 5, In-Clinic, Multi-family group, w/ client present	H0004	HQ	HR	U5	U6	\$3.30	Practitioner Level 5, Out-of-Clinic, Multi-family group, w/o client present	H0004	HQ	HS	U5	U7	\$4.03
Group Psychotherapy other than of a	Practitioner Level 2, In-Clinic	90853	U2	U6			\$8.50	Practitioner Level 2, Out-of-Clinic	90853	U2	U7			\$10.39
	Practitioner Level 3, In-Clinic	90853	U3	U6			\$6.60	Practitioner Level 3, Out-of-Clinic	90853	U3	U7			\$8.25
	Practitioner Level 4, In-Clinic	90853	U4	U6			\$4.43	Practitioner Level 4, Out-of-Clinic	90853	U4	U7			\$5.41

Group Outpatient Services: Group Counseling

multiple family group (appropriate license required)	Practitioner Level 5, In-Clinic	90853	U5	U6	\$3.30	Practitioner Level 5, Out-of-Clinic	90853	U5	U7	\$4.03	
Unit Value	15 minutes					Maximum Daily Units	20 units				
Initial Auth	If a MICP Registration is submitted - 32 units If a MICP New Episode is submitted - 200 units					Re-Authorization	200 units				
Auth Period	180 days					Utilization Criteria	LOCUS scores:1-6				
Service Definition	<p>A therapeutic intervention or counseling service shown to be successful with identified populations, diagnoses and service needs, provided in a group format by a qualified clinician or practitioner. Services are directed toward achievement of specific goals defined by the individual and specified in the Individualized Recovery Plan. Services may address goals/issues such as promoting recovery, and the restoration, development, enhancement or maintenance of:</p> <ol style="list-style-type: none"> 1) cognitive processing skills; 2) healthy coping mechanisms; 3) adaptive behaviors and skills; 4) interpersonal skills; 5) identifying and resolving personal, social, intrapersonal and interpersonal concerns 										
Admission Criteria	<ol style="list-style-type: none"> 1. Individual must have a primary mental illness/substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); and 2. The individual's level of functioning does not preclude the provision of services in an outpatient milieu; and 3. The individual's recovery goal/s which are to be addressed by this service must be conducive to response by a group milieu. 										
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual continues to meet admission criteria; and 2. Individual demonstrates documented progress relative to goals identified in the Individualized Recovery Plan, but treatment goals have not yet been achieved. 										
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Recovery Plan have been substantially met; or 3. Individual requests discharge and individual is not in imminent danger of harm to self or others; or 4. Transfer to another service/level of care is warranted by change in individual's condition; or 5. Individual requires more intensive services. 										
Service Exclusions	See Required Components, items 2 and 3 below.										
Clinical Exclusions	<ol style="list-style-type: none"> 1. Severity of behavioral health impairment precludes provision of services. 2. Severity of cognitive impairment precludes provision of services in this level of care. 3. There is a lack of social support systems such that a more intensive level of service is needed. 4. This service is not intended to supplant other services such as MR/DD Waiver Personal and Family Support Services or any day services where the individual may more appropriately receive these services with staff in various community settings. 5. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: developmental disability, autism, organic mental disorder and traumatic brain injury. 										
Required Components	<ol style="list-style-type: none"> 1. The treatment orientation, modality and goals must be specified and agreed upon by the individual. 2. Group outpatient services should very rarely be offered in addition to day services such as Psychosocial Rehabilitation. Any exceptions must be clinically justified in the record and may be subject to scrutiny by the external review organization. Exceptions in offering group outpatient services external to day services include such sensitive and targeted clinical issue groups as incest survivor groups, perpetrator groups, and sexual abuse survivors groups. When an exception is clinically justified, services must not duplicate day services activities. 3. When billed concurrently with ACT services, group counseling must be curriculum-based (See ACT Service Guideline for requirements). 										

Group Outpatient Services: Group Counseling

Staffing Requirements	Maximum face-to-face ratio cannot be more than 10 individuals to 1 direct service staff based on average group attendance
Clinical Operations	<ol style="list-style-type: none"> 1. The membership of a multiple family group (H0004 HQ) consists of multiple family units such as a group of two or more parent(s) from different families either with (HR) or without (HS) participation of their child/children. 2. Practitioners and supervisors of those providing this service are expected to maintain knowledge and skills regarding group practice such as selecting appropriate participants for a particular group, working with the group to establish necessary group norms and goals, and understanding and managing group dynamics and processes.
Billing and Reporting Requirements	If a Medicaid claim for this service denies for a Procedure-to-Procedure edit, a modifier (59) can be added to the claim and resubmitted to the MMIS for payment.
Additional Medicaid Requirements	The daily maximum within a CSU for combined Group Training/Counseling is 4 units/day.

Group Outpatient Services: Group Training

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Group Skills Training & Development	Practitioner Level 4, In-Clinic	H2014	HQ	U4	U6		\$4.43	Practitioner Level 4, Out-of-Clinic, with client present	H2014	HQ	HR	U4	U7	\$5.41
	Practitioner Level 5, In-Clinic	H2014	HQ	U5	U6		\$3.30	Practitioner Level 5, Out-of-Clinic, with client present	H2014	HQ	HR	U5	U7	\$4.03
	Practitioner Level 4, Out-of-Clinic	H2014	HQ	U4	U7		\$5.41	Practitioner Level 4, In-Clinic, without client present	H2014	HQ	HS	U4	U6	\$4.43
	Practitioner Level 5, Out-of-Clinic	H2014	HQ	U5	U7		\$4.03	Practitioner Level 5, In-Clinic, without client present	H2014	HQ	HS	U5	U6	\$3.30
	Practitioner Level 4, In-Clinic, with client present	H2014	HQ	HR	U4	U6	\$4.43	Practitioner Level 4, Out-of-Clinic, without client present	H2014	HQ	HS	U4	U7	\$5.41
	Practitioner Level 5, In-Clinic, with client present	H2014	HQ	HR	U5	U6	\$3.30	Practitioner Level 5, Out-of-Clinic, without client present	H2014	HQ	HS	U5	U7	\$4.03
Unit Value	15 minutes							Maximum Daily Units			20 units			
Initial Auth	If a MICP Registration is submitted - 32 units If a MICP New Episode is submitted - 200 units							Re-Authorization			200 units			
Auth Period	180 days							Utilization Criteria			<u>LOCUS scores:1-6</u>			
Service Definition	<p>A therapeutic interaction shown to be successful with identified populations, diagnoses and service needs. Services are directed toward achievement of specific goals defined by the individual and specified in the Individualized Resiliency Plan. Services may address goals/issues such as promoting recovery, and the restoration, development, enhancement or maintenance of:</p> <ol style="list-style-type: none"> 1) illness and medication self-management knowledge and skills (e.g. symptom management, behavioral management, relapse prevention skills, knowledge of medications and side effects, and motivational/skill development in taking medication as prescribed); 2) problem solving skills; 3) healthy coping mechanisms; 4) adaptive skills; 													

Group Outpatient Services: Group Training

	<ul style="list-style-type: none"> 5) interpersonal skills; 6) daily living skills; 7) resource management skills; 8) knowledge regarding mental illness, substance related disorders and other relevant topics that assist in meeting the youth's and family's needs; and 9) skills necessary to access and build community resources and natural support systems.
Admission Criteria	<ul style="list-style-type: none"> 1. Individuals must have a primary mental illness/substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); and 2. The individual's level of functioning does not preclude the provision of services in an outpatient milieu; and 3. The individual's resiliency goal/s that are to be addressed by this service must be conducive to response by a group milieu.
Continuing Stay Criteria	<ul style="list-style-type: none"> 1. Individual continues to meet admission criteria; and 2. Individual demonstrates documented progress relative to goals identified in the Individualized Recovery Plan, but treatment goals have not yet been achieved.
Discharge Criteria	<p>An adequate continuing care plan has been established; and one or more of the following:</p> <ul style="list-style-type: none"> 1. Goals of the Individualized Recovery Plan have been substantially met; or 2. Individual requests discharge and the individual is not in imminent danger of harm to self or others; or 3. Transfer to another service/level of care is warranted by change in individual's condition; or 4. Individual requires more intensive services
Service Exclusions	See also Required Components, item 2. below.
Clinical Exclusions	<ul style="list-style-type: none"> 1. Severity of behavioral health issue precludes provision of services. 2. Severity of cognitive impairment precludes provision of services in this level of care. 3. There is a lack of social support systems such that a more intensive level of service is needed. 4. This service is not intended to supplant other services such as MR/DD Personal and Family Support or any day services where the individual may more appropriately receive these services with staff in various community settings. 5. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: developmental disability, autism, organic mental disorder, traumatic brain injury.
Required Components	<ul style="list-style-type: none"> 1. The functional goals addressed through this service must be specified and agreed upon by the individual. 2. Group outpatient services should very rarely be offered in addition to day services such as Psychosocial Rehabilitation. Any exceptions must be clinically justified in the record and may be subject to scrutiny by the external review organization. Exceptions in offering group outpatient services external to day services include such sensitive and targeted clinical issue groups as incest survivor groups, perpetrator groups, and sexual abuse survivors groups. When an exception is clinically justified, services must not duplicate day services activities.
Staffing Requirements	Maximum face-to-face ratio cannot be more than 10 individuals to 1 direct service staff based on average group attendance
Clinical Operations	<ul style="list-style-type: none"> 1. Practitioners providing this service are expected to maintain knowledge and skills regarding group practice such as selecting appropriate participants for a particular group, working with the group to establish necessary group norms and goals, and understanding and managing group dynamics and processes. 2. Out-of-clinic group skills training is allowable and clinically valuable for some individuals; therefore, this option should be explored to the benefit of the individual. In this event, staff must be able to assess and address the individual needs and progress of each individual consistently throughout the intervention/activity (e.g. in an example of teaching 2-3 individuals to access public transportation in the community, group training may be given to help each individual individually to understand the bus schedule in a way that makes sense to them, to address questions/concerns each may have about how to use the bus, perhaps to spend time riding the bus with the individuals and assisting each to understand and become comfortable with riding the bus in accordance with <i>individual goals</i>, etc.).

Group Outpatient Services: Group Training

Additional
Medicaid
Requirements

The daily maximum within a CSU for combined Group Training/Counseling is 4 units/day.

Individual Counseling

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive face-to-face w/ patient and/or family member	-30 minutes	Practitioner Level 2, In-Clinic	90832	U2	U6		64.95	Practitioner Level 2, Out-of-Clinic	90832	U2	U7			77.93
		Practitioner Level 3, In-Clinic	90832	U3	U6		50.02	Practitioner Level 3, Out-of-Clinic	90832	U3	U7			61.13
		Practitioner Level 4, In-Clinic	90832	U4	U6		33.83	Practitioner Level 4, Out-of-Clinic	90832	U4	U7			40.59
		Practitioner Level 5, In-Clinic	90832	U5	U6		25.21	Practitioner Level 5, Out-of-Clinic	90832	U5	U7			30.25
	-45 minutes	Practitioner Level 2, In-Clinic	90834	U2	U6		116.90	Practitioner Level 2, Out-of-Clinic	90834	U2	U7			140.28
		Practitioner Level 3, In-Clinic	90834	U3	U6		90.03	Practitioner Level 3, Out-of-Clinic	90834	U3	U7			110.04
		Practitioner Level 4, In-Clinic	90834	U4	U6		60.89	Practitioner Level 4, Out-of-Clinic	90834	U4	U7			73.07
		Practitioner Level 5, In-Clinic	90834	U5	U6		45.38	Practitioner Level 5, Out-of-Clinic	90834	U5	U7			54.46
	-60 minutes	Practitioner Level 2, In-Clinic	90837	U2	U6		155.87	Practitioner Level 2, Out-of-Clinic	90837	U2	U7			187.04
		Practitioner Level 3, In-Clinic	90837	U3	U6		120.04	Practitioner Level 3, Out-of-Clinic	90837	U3	U7			146.71
		Practitioner Level 4, In-Clinic	90837	U4	U6		81.18	Practitioner Level 4, Out-of-Clinic	90837	U4	U7			97.42
		Practitioner Level 5, In-Clinic	90837	U5	U6		60.51	Practitioner Level 5, Out-of-Clinic	90837	U5	U7			72.61
Psychotherapy Add-on with patient and/or family in conjunction with E&M	-30 minutes	Practitioner Level 1, In-Clinic	90833	U1	U6		97.02	Practitioner Level 1, Out-of-Clinic	90833	U1	U7			123.48
		Practitioner Level 2, In-Clinic	90833	U2	U6		64.95	Practitioner Level 2, Out-of-Clinic	90833	U2	U7			77.93
		Practitioner Level 1	90833	GT	U1		97.02	Practitioner Level 2	90833	GT	U2			64.95
	-45 minutes	Practitioner Level 1, In-Clinic	90836	U1	U6		174.63	Practitioner Level 1, Out-of-Clinic	90836	U1	U7			226.26
		Practitioner Level 2, In-Clinic	90836	U2	U6		116.90	Practitioner Level 2, Out-of-Clinic	90836	U2	U7			140.28
		Practitioner Level 1	90836	GT	U1		174.63	Practitioner Level 2	90836	GT	U2			116.90
Unit Value	1 encounter (Note: Time-in/Time-out is required in the documentation as it justifies which code above is billed)							Maximum Daily Units			2 units			
Initial Authorization	24 units							Re-Authorization			24 units			
Authorization Period	180 days							Utilization Criteria			LOCUS scores:1-6			
Service Definition	A therapeutic intervention or counseling service shown to be successful with identified populations, diagnoses and service needs, provided by a qualified clinician. Techniques employed involve the principles, methods and procedures of counseling that assist the person in identifying and resolving personal, social, vocational, intrapersonal and interpersonal concerns. Individual counseling may include face-to-face in or out-of-clinic time with family members as long as the individual is present for part of the session and the focus is on the individual. Services are directed toward achievement of specific goals defined by the individual and specified in the Individualized Recovery Plan. These services address goals/issues such as promoting recovery, and the restoration, development, enhancement or maintenance of:													

Individual Counseling

	<ol style="list-style-type: none"> 1. illness and medication self-management knowledge and skills (e.g. symptom management, behavioral management, relapse prevention skills, knowledge of medications and side effects, and motivational/skill development in taking medication as prescribed); 2. problem solving and cognitive skills; 3. healthy coping mechanisms; 4. adaptive behaviors and skills; 5. interpersonal skills; and 6. knowledge regarding mental illness, substance related disorders and other relevant topics that assist in meeting the individual's or the support system's needs. <p>Best/evidence based practice modalities may include (as clinically appropriate): Motivational Interviewing/Enhancement, Cognitive Behavioral Therapy, Behavioral Modification, Behavioral Management, Rational Behavioral Therapy, Dialectical Behavioral Therapy, and others as appropriate to the individual and clinical issues to be addressed.</p>
Admission Criteria	<ol style="list-style-type: none"> 1. Individual must have a primary mental illness/substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); and 2. The individual's level of functioning does not preclude the provision of services in an outpatient milieu.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual continues to meet admission criteria; and. 2. Individual demonstrates documented progress relative to goals identified in the Individualized Recovery Plan, but treatment goals have not yet been achieved.
Discharge Criteria	<ol style="list-style-type: none"> 1. Adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Recovery Plan have been substantially met; or 3. Individual requests discharge and individual is not in imminent danger of harm to self or others; or 4. Transfer to another service is warranted by change in individual's condition; or 5. Individual requires a service approach that supports less or more intensive need.
Service Exclusions	ACT and Crisis Stabilization Unit services
Clinical Exclusions	<ol style="list-style-type: none"> 1. Severity of behavioral health impairment precludes provision of services. 2. Severity of cognitive impairment precludes provision of services in this level of care. 3. There is a lack of social support systems such that a more intensive level of service is needed. 4. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: developmental disability, autism, organic mental disorder and traumatic brain injury.
Required Components	The treatment orientation, modality and goals must be specified and agreed upon by the individual.
Clinical Operations	<ol style="list-style-type: none"> 1. Practitioners and supervisors of those providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based counseling practices. 2. 90833 and 90836 are utilized with E/M CPT Codes as an add-on for psychotherapy and may not be billed individually.
Billing and Reporting Requirements	<ol style="list-style-type: none"> 1. When 90833 or 90836 are provided with an E/M code, these are submitted together to encounter/claims system. 2. 90833 is used for any intervention which is 16-37 minutes in length. 3. 90836 is used for any intervention which is 38-52 minutes in length. 4. 90837 is used for any intervention which is greater than 53 minutes. 5. If a Medicaid claim for this service denies for a Procedure-to-Procedure edit, a modifier (59) can be added to the claim and resubmitted to the MMIS for payment with two exceptions: If the billable base code is either 90833 or 90836 and is denied for Procedure-to-Procedure edit, then a (25) modifier should be added to the claim resubmission.

Individual Counseling

Documentation Requirements	<ol style="list-style-type: none"> When 90833 or 90836 are provided with an E/M code, they are recorded on the same intervention note but the distinct services must be separately identifiable. When 90833 or 90836 are provided with an E/M code, the psychotherapy intervention must include time in/time out in order to justify which code is being utilized. Time associated with activities used to meet criteria for the E/M service is not included in the time used for reporting the psychotherapy service.
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Interactive Complexity

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Interactive Complexity	Interactive complexity (List separately in addition to the code for primary procedure)	90785					\$0.00	Interactive complexity (List separately in addition to the code for primary procedure)	90785	TG				\$0.00
Unit Value	1 Encounter							Maximum Daily Units*	4 units					
Initial Authorization*	48 units							Re-Authorization*	48 units					
Authorization Period*	180 days							Utilization Criteria	180 days					
Service Definition	<p>Interactive Complexity is not a direct service but functions as a modifier to Psychiatric Treatment, Diagnostic Assessment, Individual Therapy, and Group Counseling. This modifier is used when:</p> <ol style="list-style-type: none"> Communication with the individual participant/s is complicated perhaps related to, e.g., high anxiety, high reactivity, repeated questions, or disagreement and therefore delivery of care is challenging. Caregiver emotions/behaviors complicate the implementation of the treatment plan. Evidence/disclosure of a sentinel event and mandated report to a third party (e.g., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with the individual and supporters. Use of play equipment, physical devices, interpreter or translator to overcome significant language barriers (when individual served is not fluent in same language as practitioner, or when the individual has not developed or has lost expressive/receptive communication skills necessary for interactive participation in the intervention). 													
Admission Criteria	These elements are defined in the specific companion service to which this modifier is anchored to in reporting/claims submission.													
Continuing Stay Criteria														
Discharge Criteria														
Clinical Exclusions														
Documentation Requirements	<ol style="list-style-type: none"> When this code is submitted, there must be: <ol style="list-style-type: none"> Record of base service delivery code/s AND the Interactive Complexity code on the single note; and Evidence within the multi-code service note which indicates the specific category of complexity (from the list of items 1-4 in the definition above) utilized during the intervention. The interactive complexity component relates only to the increased work intensity of the psychotherapy service, but <i>does not</i> change the time for the psychotherapy service. 													
Reporting and	1. This service may only be reported/billed in conjunction with one of the following codes: 90791, 90792, 90832, 90834, 90837, 90853, and with the following codes													

Billing Requirements	<p>only when paired with 90833 or 90836: 99201, 99211, 99202, 99212, 99203, 99213, 99204, 99214, 99205, 99215.</p> <ol style="list-style-type: none"> This Service Code paired with the TG modifier is only used when the complexity type from the Service Definition above is categorized under Item 4 AND an interpreter or translator is used during the intervention. So, if play equipment is the only complex intervention utilized, then TG is not utilized. Interactive Complexity is utilized as a modifier and therefore is not required in an order nor in an Individualized Recovery/Resiliency Plan.
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Legal Skills / Competency Training							
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod4	Rate
Patient Education, Not otherwise Classified, Non-Physician Provider, Individual per Session		S9445	H9				
Patient Education, Not otherwise Classified, Non-Physician Provider, Group per Session		S9446	H9				
Unit Value	15 minutes (1 Session = 1 Unit = 15 minutes)		Utilization Criteria		Available to anyone with a court order for competency restoration.		
Service Definition	<p>A therapeutic interaction shown to be successful with mentally ill or developmentally disabled individuals involved with the criminal justice system. Services are directed toward achievement of specific goals defined in a Court Order and/or pretrial forensic report. Services will address goals/issues related to development or restoration of skills related to competency to stand trial. This would include some or all of the following:</p> <ol style="list-style-type: none"> Communication skills that enable the individual to effectively convey information to another Listening skills that allow the individual to summarize information heard, maintain attention, and identify false statements Decision making skills to aid in responding to well-explained alternatives Knowledge of the role of courtroom participants and procedures Understanding of the adversarial nature of legal proceedings and one's role as a defendant 						
Admission Criteria	<ol style="list-style-type: none"> Individuals must have a court order authorizing community restoration for competency and The individual's level of functioning does not preclude the provision of services in an outpatient milieu. 						
Continuing Stay Criteria	<ol style="list-style-type: none"> Individual continues to be incompetent to stand trial or is presently competent, but needs additional intervention or refresher sessions to maintain competency until trial; and Individual remains under a court order that authorizes competency restoration. 						
Discharge Criteria	<ol style="list-style-type: none"> Individual is presently competent to stand trial as determined by a DHR Forensic Evaluator or judge and not in need of ongoing training to maintain competency for trial. Individual continues to be incompetent to stand trial and it has been determined by a DHR Forensic Evaluator or judge that the individual is not restorable or Individual has participated in this service for 12 consecutive months; or Transfer to another service/level of care is warranted by change in individual's condition; or Individual requires more intensive services. 						
Clinical Exclusions	Individual presents significant and imminent risk to self or other such that a more intensive level of service is needed.						
Required Components	<ol style="list-style-type: none"> The functional goals addressed through this service must be specified. Any service >3 hours in a given day (combination of individual legal/competency skills training, group legal/competency skills training) is subject to scrutiny by the ERO. Provider shall notify DHR Evaluator Contact of decompensation in individual mental status or need for more intensive services. Provider shall notify DHR Evaluator Contact in a timely manner of either of the following situations: <ol style="list-style-type: none"> the individual appears to have attained competency it is determined that the individual has achieved maximum benefits Practitioners are to utilize accepted or established competency training materials consistent with best practices. (Practitioners may request sample materials from DBHDD's Office of Forensic Services and may submit proposed materials for review.) 						

Staffing Requirements	<ol style="list-style-type: none"> 1. Training is provided by staff with a minimum education of bachelor's degree. 2. For Individual Interventions: Maximum individual to staff ratio cannot be more than one individual to one direct service staff. 3. For Group Interventions: Maximum individual to staff ratio cannot be more than 10 individuals to one direct service staff. 4. Practitioners providing this service are expected to maintain knowledge and skills regarding group training and competency restoration.
Service Accessibility	<ol style="list-style-type: none"> 1. Individuals will be referred by the Director of Forensic Services or designee at the state hospital in the catchment area of the provider. 2. The provider will notify the referring state hospital if the individual appears to be competent, is not likely to ever become competent, or is in need of more intensive services.
Additional Medicaid Requirements	This is not a Medicaid reimbursable service.
Reporting and Billing Requirements	Utilization shall be reported through the submission of encounters via the MICP reporting process.

Medication Administration

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Comprehensive Medication Services	Practitioner Level 2, In-Clinic	H2010	U2	U6			\$33.40	Practitioner Level 2, Out-of-Clinic	H2010	U2	U7			\$42.51
	Practitioner Level 3, In-Clinic	H2010	U3	U6			\$25.39	Practitioner Level 3, Out-of-Clinic	H2010	U3	U7			\$33.01
	Practitioner Level 4, In-Clinic	H2010	U4	U6			\$17.40	Practitioner Level 4, Out-of-Clinic	H2010	U4	U7			\$22.14
	Practitioner Level 5, In-Clinic	H2010	U5	U6			\$12.97							
Therapeutic, prophylactic or diagnostic injection	Practitioner Level 2, In-Clinic	96372	U2	U6			\$33.40	Practitioner Level 2, Out-of-Clinic	96372	U2	U7			\$42.51
	Practitioner Level 3, In-Clinic	96372	U3	U6			\$25.39	Practitioner Level 3, Out-of-Clinic	96372	U3	U7			\$33.01
	Practitioner Level 4, In-Clinic	96372	U4	U6			\$17.40	Practitioner Level 4, Out-of-Clinic	96372	U4	U7			\$22.14
Alcohol, and/or drug services, methadone administration and/or service (provision of the drug by a licensed program)								For individuals who need opioid maintenance, the Opioid Maintenance service should be requested						
Unit Value	1 encounter							Maximum Daily Units	1 encounter					
Initial Authorization*	With the submission of MICP Registration - 6 units shared With the submission of MICP New Episode: H2010 & 96372= 60 units shared							Re-Authorization*	H2010 & 96372= 60 units shared					
Authorization Period*	180 days							Utilization Criteria	LOCUS scores:1-6					
Service Definition	<p>As reimbursed through this service, medication administration includes the act of introducing a drug (any chemical substance that, when absorbed into the body of a living organism, alters normal bodily function) into the body of another person by any number of routes including, but not limited to the following: oral, nasal, inhalant, intramuscular injection, intravenous, topical, suppository or intraocular. Medication administration requires a written service order for Medication Administration and a written order for the medication and the administration of the medication that complies with guidelines in Part II, Section 1, Subsection 6—Medication of the Provider Manual. The order for and administration of medication must be completed by members of the medical staff pursuant to the Medical Practice Act of 2009, Subsection 43-34-23 Delegation of Authority to Nurse and Physician Assistant and must be administered by licensed or credentialed* medical personnel under the supervision of a physician or registered nurse in accordance with O.C.G.A.</p> <p>The service must include:</p> <ol style="list-style-type: none"> 1. An assessment by the licensed/credentialed medical personnel administering the medication of the individual's physical/psychological/behavioral status in order to 													

Medication Administration

	<p>make recommendations regarding whether to continue medication and/or its means of administration and whether to refer the individual to the physician for medication review.</p> <p>2. Education to the individual, by appropriate licensed medical personnel, on the proper administration and monitoring of prescribed medication in accordance with the individual's recovery plan.</p>
Admission Criteria	<p>1. Individual presents symptoms that are likely to respond to pharmacological interventions; and</p> <p>2. Individual has been prescribed medications as a part of the treatment array; and</p> <p>3. Individual /family/responsible caregiver is unable to self-administer/administer prescribed medication because:</p> <ol style="list-style-type: none"> Although the individual is willing to take the prescribed medication, it is in an injectable form and must be administered by licensed medical personnel; or Although individual is willing to take the prescribed medication, it is a Class A controlled substance which must be stored and dispensed by medical personnel in accordance with state law; or Administration by licensed/credentialed medical personnel is necessary because an assessment of the individual's physical, psychological and behavioral status is required in order to make a determination regarding whether to continue the medication and/or its means of administration and/or whether to refer the individual to the physician for a medication review. Due to the family/caregiver's lack of capacity there is no responsible party to manage/supervise self-administration of medication (refer individual /family for CSI and/or Family or Group Training in order to teach these skills)
Continuing Stay Criteria	Individual continues to meet admission criteria.
Discharge Criteria	<p>1. Individual no longer needs medication; or</p> <p>2. Individual is able to self-administer medication; and</p> <p>3. Adequate continuing care plan has been established</p>
Service Exclusions	<p>1. Does not include medication given as part of an Ambulatory Detoxification protocol. Medication administered as part of this protocol is billed as Ambulatory Detoxification.</p> <p>2. Must not be billed in the same day as Nursing Assessment.</p> <p>3. Must not be billed while enrolled in ACT except if this Medication Administration service is utilized only for the administration of methadone (for Medicaid recipients).</p> <p>4. May not be billed in conjunction with Intensive Day Treatment (Partial Hospitalization).</p>
Clinical Exclusions	This service does not cover supervision of self-administration of medications. Self-administration of medications can be done by anyone physically and mentally capable of taking or administering medications to himself/herself. Youth and adults with mental health issues, or developmental disabilities are very often capable of self-administration of medications even if supervision by others is needed in order to adequately or safely manage self-administration of medication and other activities of daily living.
Required Components	<p>1. There must be a written service order for Medication Administration and a written order for the medication and the administration of the medication that complies with guidelines in Part II, Section 1, Subsection 6—Medication of the Provider Manual. The order for and administration of medication must be completed by members of the medical staff pursuant to the Medical Practice Act of 2009, Subsection 43-34-23 Delegation of Authority to Nurse and Physician Assistant. The order must be in the individual's chart. Telephone/verbal orders are acceptable provided they are signed by an appropriate member of the medical staff in accordance with DBHDD requirements.</p> <p>2. Documentation must support that the individual is being trained in the risks and benefits of the medications being administered and that symptoms are being monitored by the staff member administering the medication.</p> <p>3. Documentation must support the medical necessity of administration by licensed/credentialed medical personnel rather than by the individual, family or caregiver.</p> <p>4. Documentation must support that the individual is being trained in the principle of self-administration of medication or that the individual is physically or mentally unable to self-administer. This documentation will be subject to scrutiny by the External Review Organization in reauthorizing services in this category.</p> <p>5. This service does not include the supervision of self-administration of medication.</p>

Medication Administration

Staffing Requirements	Qualified Medication Aides working in a Community Living Arrangement (CLA) may administer medication only in a CLA
Clinical Operations	<ol style="list-style-type: none"> 1. Medication administration may not be billed for the provision of single or multiple doses of medication that an individual has the ability to self-administer, either independently or with supervision by a caregiver, either in a clinic or a community setting. In a group home/CCI setting, for example, medications may be managed by the house parents or residential care staff and kept locked up for safety reasons. Staff may hand out medication to the residents but this does not constitute administration of medication for the purposes of this definition and, like other watchful oversight and monitoring functions, are not reimbursable treatment services. 2. If individual/family requires training in skills needed in order to learn to manage his/her own medications and their safe self-administration and/or supervision of self-administration, this skills training service can be provided via the PSR-I, AD Support Services, or Family/Group Training services in accordance with the person's individualized recovery/resiliency plan.
Billing & Reporting Requirements	If a Medicaid claim for this service denies for a Procedure-to-Procedure edit, a modifier (59) can be added to the claim and resubmitted to the MMIS for payment.
Additional Medicaid Requirements	As in all other settings, the daily maximum within a CSU for Medication Administration is 1 unit/day.

Nursing Assessment and Health Services

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Nursing Assessment/ Evaluation	Practitioner Level 2, In-Clinic	T1001	U2	U6			\$38.97	Practitioner Level 2, Out-of-Clinic	T1001	U2	U7			\$46.76
	Practitioner Level 3, In-Clinic	T1001	U3	U6			\$30.01	Practitioner Level 3, Out-of-Clinic	T1001	U3	U7			\$36.68
	Practitioner Level 4, In-Clinic	T1001	U4	U6			\$20.30	Practitioner Level 4, Out-of-Clinic	T1001	U4	U7			\$24.36
RN Services, up to 15 minutes	Practitioner Level 2, In-Clinic	T1002	U2	U6			\$38.97	Practitioner Level 2, Out-of-Clinic	T1002	U2	U7			\$46.76
	Practitioner Level 3, In-Clinic	T1002	U3	U6			\$30.01	Practitioner Level 3, Out-of-Clinic	T1002	U3	U7			\$36.68
LPN Services, up to 15 minutes	Practitioner Level 4, In-Clinic	T1003	U4	U6			\$20.30	Practitioner Level 4, Out-of-Clinic	T1003	U4	U7			\$24.36
Health and Behavior Assessment, Face-to-Face w/ Patient, Initial Assessment	Practitioner Level 2, In-Clinic	96150	U2	U6			\$38.97	Practitioner Level 2, Out-of-Clinic	96150	U2	U7			\$46.76
	Practitioner Level 3, In-Clinic	96150	U3	U6			\$30.01	Practitioner Level 3, Out-of-Clinic	96150	U3	U7			\$36.68
	Practitioner Level 4, In-Clinic	96150	U4	U6			\$20.30	Practitioner Level 4, Out-of-Clinic	96150	U4	U7			\$24.36
Health and Behavior Assessment, Face-to-Face w/ Patient, Re-assessment	Practitioner Level 2, In-Clinic	96151	U2	U6			\$38.97	Practitioner Level 2, Out-of-Clinic	96151	U2	U7			\$46.76
	Practitioner Level 3, In-Clinic	96151	U3	U6			\$30.01	Practitioner Level 3, Out-of-Clinic	96151	U3	U7			\$36.68
	Practitioner Level 4, In-Clinic	96151	U4	U6			\$20.30	Practitioner Level 4, Out-of-Clinic	96151	U4	U7			\$24.36
Unit Value	15 minutes							Maximum Daily Units			16 units (32 for Ambulatory Detox)			
Initial Authorization	With the submission of MICP Registration -12 units With the submission of MICP New Episode- 60 units							Re-Authorization			60 units			

Nursing Assessment and Health Services

Auth Period	180 days	Utilization Criteria	LOCUS scores:1-6
Service Definition	<p>This service requires face-to-face contact with the individual to monitor, evaluate, assess, and/or carry out a physician's orders regarding the physical and/or psychological problems of the individual. It includes:</p> <ol style="list-style-type: none"> 1) Providing nursing assessments and interventions to observe, monitor and care for the physical, nutritional, behavioral health and related psychosocial issues, problems or crises manifested in the course of an individual's treatment; 2) Assessing and monitoring individual's response to medication(s) to determine the need to continue medication and/or to determine the need to refer the individual for a medication review; 3) Assessing and monitoring an individual's medical and other health issues that are either directly related to the mental health or substance related disorder, or to the treatment of the disorder (e.g. diabetes, cardiac and/or blood pressure issues, substance withdrawal symptoms, weight gain and fluid retention, seizures, etc.); 4) Consulting with the individual and individual-identified family and significant other(s) about medical, nutritional and other health issues related to the individual's mental health or substance related issues; 5) Educating the individual and any identified family about potential medication side effects (especially those which may adversely affect health such as weight gain or loss, blood pressure changes, cardiac abnormalities, development of diabetes or seizures, etc.); 6) Consulting with the individual and the individual-identified family and significant other(s) about the various aspects of informed consent (when prescribing occurs); 7) Training for self-administration of medication; 8) Venipuncture required to monitor and assess mental health, substance disorders or directly related conditions, and to monitor side effects of psychotropic medications, as ordered by as ordered by an appropriate member of the medical staff; and 9) Providing assessment, testing, and referral for infectious diseases. 		
Admission Criteria	<ol style="list-style-type: none"> 1. Individual presents with symptoms that are likely to respond to medical/nursing interventions; or 2. Individual has been prescribed medications as a part of the treatment array or has a confounding medical condition. 		
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual continues to demonstrate symptoms that are likely to respond to or are responding to medical interventions; or 2. Individual exhibits acute disabling conditions of sufficient severity to bring about a significant impairment in day-to-day functioning; or 3. Individual demonstrates progress relative to goals identified in the Individualized Recovery Plan, but treatment goals have not yet been achieved. 		
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Individual no longer demonstrates symptoms that are likely to respond to or are responding to medical/nursing interventions; or 3. Goals of the Individualized Recovery Plan have been substantially met; or 4. Individual requests discharge and individual is not in imminent danger of harm to self or others. 		
Service Exclusions	ACT, Medication Administration, Opioid Maintenance.		
Clinical Exclusions	Routine nursing activities that are included as a part of medication administration/methadone administration		
Required Components	<ol style="list-style-type: none"> 1. Nutritional assessments indicated by an individual's confounding health issues may be billed under this code (96150, 96151). No more than 8 units specific to nutritional assessments can be billed for an individual within a year. This specific assessment must be provided by a Registered Nurse or by a Licensed Dietician. 2. This service does not include the supervision of self-administration of medication. 3. Each nursing contact should document the checking of vital signs (Temperature, Pulse, Blood Pressure, Respiratory Rate, and weight, if medically indicated or if related to behavioral health symptom or behavioral health medication side effect) in accordance with general psychiatric nursing practice. 4. Nursing assessments will assess health risks, health indicators, and health conditions given that behavioral health conditions, behavioral health medications, and physical health are intertwined. Personal/family history of Diabetes, Hypertension, and Cardiovascular Disease should be explored as well as tobacco use history, substance use history, blood pressure status, and Body Mass Index (BMI). Any sign of major health concerns should yield a medical referral to a primary health care 		

Nursing Assessment and Health Services

	physician/center.
Clinical Operations	<ol style="list-style-type: none"> 1. Venipuncture services must include documentation that includes canula size, insertion site, number of attempts, location, and individual tolerance of procedure. 2. All nursing procedures must include relevant individual centered education regarding the procedure.
Billing & Reporting Requirements	If a Medicaid claim for this service denies for a Procedure-to-Procedure edit, a modifier (59) can be added to the claim and resubmitted to the MMIS for payment.
Additional Medicaid Requirements	The daily maximum within a CSU for Nursing Assessment and Health Services is 5 units/day.

Pharmacy & Lab

Service Definition	Pharmacy and Lab Services include operating or purchasing services to order, package, and distribute prescription medications. It includes provision of assistance to individuals to access indigent medication programs, sample medication programs and payment for necessary medications when no other funding source is available. This service provides for appropriate lab work, such as drug screens and medication levels to be performed. This service is to ensure that necessary medication and lab services are not withheld or delayed to individuals based on inability to pay.
Admission Criteria	Individual has been assessed by a prescribing professional to need a psychotropic, anti-cholinergic, addiction specific, or anti-convulsant (as related to behavioral health issue) medication and/or lab work required for persons entering services, and/or monitoring medication levels.
Continuing Stay Criteria	Individual continues to meet the admission criteria as determined by the prescribing professional
Discharge Criteria	<ol style="list-style-type: none"> 1. Individual no longer demonstrates symptoms that are likely to respond to or are responding to pharmacologic interventions; or 2. Individual requests discharge and individual is not imminently dangerous or under court order for this intervention.
Required Components	<ol style="list-style-type: none"> 1. Service must be provided by a licensed pharmacy or through contract with a licensed pharmacy. 2. Agency must participate in any pharmaceutical rebate programs or pharmacy assistance programs that promote individual access in obtaining medication. 3. Providers shall assist individuals who have an inability to pay for medications in accessing the local Division of Family & Children Services or the Social Security Administration to explore options for Medicaid eligibility.
Additional Medicaid Requirements	Not a Medicaid Rehabilitation Option "service." Medicaid recipients may access the general Medicaid pharmacy program as defined by the Department of Community Health.
Reporting and Billing Requirements	The agency shall adhere to expectations set forth in its contract for reporting related information.

Psychiatric Treatment

Transaction Code		Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	
E/M New Patient	10 minutes	Practitioner Level 1, In-Clinic	99201	U1	U6			38.81	Practitioner Level 2, In-Clinic	99201	U2	U6			25.98	
		Practitioner Level 1, Out-of-Clinic	99201	U1	U7			49.39	Practitioner Level 2, Out-of-Clinic	99201	U2	U7			31.17	
		Practitioner Level 1	99201	GT	U1			38.81	Practitioner Level 2	99201	GT	U2			25.98	
	20 minutes	Practitioner Level 1, In-Clinic	99202	U1	U6			77.61	Practitioner Level 2, In-Clinic	99202	U2	U6			51.96	
		Practitioner Level 1, Out-of-Clinic	99202	U1	U7			98.79	Practitioner Level 2, Out-of-Clinic	99202	U2	U7			62.35	
		Practitioner Level 1	99202	GT	U1			77.61	Practitioner Level 2	99202	GT	U2			51.96	
	30 minutes	Practitioner Level 1, In-Clinic	99203	U1	U6			116.42	Practitioner Level 2, In-Clinic	99203	U2	U6			77.94	
		Practitioner Level 1, Out-of-Clinic	99203	U1	U7			148.18	Practitioner Level 2, Out-of-Clinic	99203	U2	U7			93.52	
		Practitioner Level 1	99203	GT	U1			116.42	Practitioner Level 2	99203	GT	U2			77.94	
	45 minutes	Practitioner Level 1, In-Clinic	99204	U1	U6			174.63	Practitioner Level 2, In-Clinic	99204	U2	U6			116.90	
		Practitioner Level 1, Out-of-Clinic	99204	U1	U7			222.26	Practitioner Level 2, Out-of-Clinic	99204	U2	U7			140.28	
		Practitioner Level 1	99204	GT	U1			174.63	Practitioner Level 2	99204	GT	U2			116.90	
	60 minutes	Practitioner Level 1, In-Clinic	99205	U1	U6			232.84	Practitioner Level 2, In-Clinic	99205	U2	U6			155.88	
		Practitioner Level 1, Out-of-Clinic	99205	U1	U7			296.36	Practitioner Level 2, Out-of-Clinic	99205	U2	U7			187.04	
		Practitioner Level 1	99205	GT	U1			232.84	Practitioner Level 2	99205	GT	U2			155.88	
	E/M Established Patient	5 minutes	Practitioner Level 1, In-Clinic	99211	U1	U6			19.40	Practitioner Level 2, In-Clinic	99211	U2	U6			12.99
			Practitioner Level 1, Out-of-Clinic	99211	U1	U7			24.70	Practitioner Level 2, Out-of-Clinic	99211	U2	U7			15.59
			Practitioner Level 1	99211	GT	U1			19.40	Practitioner Level 2	99211	GT	U2			12.99
		10 minutes	Practitioner Level 1, In-Clinic	99212	U1	U6			38.81	Practitioner Level 2, In-Clinic	99212	U2	U6			25.98
			Practitioner Level 1, Out-of-Clinic	99212	U1	U7			49.39	Practitioner Level 2, Out-of-Clinic	99212	U2	U7			31.17
			Practitioner Level 1	99212	GT	U1			38.81	Practitioner Level 2	99212	GT	U2			25.98
		15 minutes	Practitioner Level 1, In-Clinic	99213	U1	U6			58.21	Practitioner Level 2, In-Clinic	99213	U2	U6			38.97
			Practitioner Level 1, Out-of-Clinic	99213	U1	U7			74.09	Practitioner Level 2, Out-of-Clinic	99213	U2	U7			46.76
			Practitioner Level 1	99213	GT	U1			58.21	Practitioner Level 2	99213	GT	U2			38.97
25 minutes		Practitioner Level 1, In-Clinic	99214	U1	U6			97.02	Practitioner Level 2, In-Clinic	99214	U2	U6			64.95	
		Practitioner Level 1, Out-of-Clinic	99214	U1	U7			123.48	Practitioner Level 2, Out-of-Clinic	99214	U2	U7			77.93	
		Practitioner Level 1	99214	GT	U1			97.02	Practitioner Level 2	99214	GT	U2			64.95	
40 minutes		Practitioner Level 1, In-Clinic	99215	U1	U6			155.23	Practitioner Level 2, In-Clinic	99215	U2	U6			103.92	
		Practitioner Level 1, Out-of-Clinic	99215	U1	U7			197.57	Practitioner Level 2, Out-of-Clinic	99215	U2	U7			124.69	
		Practitioner Level 1	99215	GT	U1			155.23	Practitioner Level 2	99215	GT	U2			103.92	
Unit Value		1 encounter (Note: Time-in/Time-out is required in the documentation as it justifies which code above is billed)							Maximum Daily Units	2 units (see qualifier in definition below)						
Initial Authorization		24units							Re-Authorization	24units						
Authorization Period		180 days							Utilization Criteria	LOCUS scores: 1-6						

Psychiatric Treatment

Service Definition	<p>The provision of specialized medical and/or psychiatric services that include, but are not limited to:</p> <ol style="list-style-type: none"> a. Psychotherapeutic services with medical evaluation and management including evaluation and assessment of physiological phenomena (including co-morbidity between behavioral and physical health care issues); b. Assessment and monitoring of an individual's status in relation to treatment with medication, c. Assessment of the appropriateness of initiating or continuing services. <p>Individuals must receive appropriate medical interventions as prescribed and provided by appropriate members of the medical staff pursuant to the Medical Practice Act of 2009, Subsection 43-34-23 Delegation of Authority to Nurse and Physician Assistant that shall support the individualized goals of recovery as identified by the individual and their Individualized Recovery Plan (within the parameters of the person's informed consent).</p>
Admission Criteria	<ol style="list-style-type: none"> 1. Individual is determined to be in need of psychotherapy services and has confounding medical issues which interact with behavioral health diagnosis, requiring medical oversight; or 2. Individual has been prescribed medications as a part of the treatment array
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual continues to meet the admission criteria; or 2. Individual exhibits acute disabling conditions of sufficient severity to bring about a significant impairment in day-to-day functioning; or 3. Individual continues to present symptoms that are likely to respond to pharmacological interventions; or 4. Individual continues to demonstrate symptoms that are likely to respond or are responding to medical interventions; or 5. Individual continues to require management of pharmacological treatment in order to maintain symptom remission.
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Individual has withdrawn or been discharged from service; or 3. Individual no longer demonstrates symptoms that need pharmacological interventions.
Service Exclusions	Not offered in conjunction with ACT
Clinical Exclusions	Services defined as a part of ACT
Required Components	Telemedicine may be utilized for an initial Psychiatric Diagnostic Examination as well as for ongoing Psychiatric Diagnostic Examination via the use of appropriate procedure codes with the GT modifier.
Clinical Operations	<ol style="list-style-type: none"> 1. In accordance with recovery philosophy, it is expected that individuals will be treated as full partners in the treatment regimen/services planned and received. As such, it is expected that practitioners will fully discuss treatment options with individuals and allow for individual choice when possible. Discussion of treatment options should include a full disclosure of the pros and cons of each option (e.g. full disclosure of medication/treatment regimen potential side effects, potential adverse reactions--including potential adverse reaction from not taking medication as prescribed, and expected benefits). If such full discussion/disclosure is not possible or advisable according to the clinical judgment of the practitioner, this should be documented in the individual's chart (including the specific information that was not discussed and a compelling rationale for lack of discussion/disclosure). 2. Assistive tools, technologies, worksheets, etc. can be used by the served individual to facilitate communication about treatment, symptoms, improvements, etc. with the treating practitioner. If this work falls into the scope of Interactive Complexity it is noted in accordance with that definition. 3. This service may be provided with Individual Counseling codes 90833 and 90836, but the two services must be separately identifiable. 4. For purposes of this definition, a "new patient" is an individual who has not received an E/M code service from that agency within the past three years. If an individual has engaged with the agency, and has seen a non-physician for a BH Assessment, they are still considered a "new patient" until after the first E/M service is completed.
Service Accessibility	Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's health. Electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site.

Psychiatric Treatment

Additional Medicaid Requirements	<ol style="list-style-type: none"> The daily maximum within a CSU for E/M is 1 unit/day. Even if a physician also has his/her own Medicaid number, the physician providing behavioral health treatment and care through this code should bill via the approved provider agency's Medicaid number through the Medicaid Category of Service (COS) 440.
Reporting and Billing Requirements	<ol style="list-style-type: none"> Within this service group, a second unit with a U1 modifier may be used in the event that a Telemedicine Psychiatric Treatment unit is provided and it indicates a need for a face-to-face assessment (e.g. 99213GTU1 is billed and it is clinically indicated that a face-to-face by an on-site physician needs to immediately follow based upon clinical indicators during the first intervention, then 99213U1, can also be billed in the same day). Within this service group, there is an allowance for when a U2 practitioner conducts an intervention and, because of clinical indicators presenting during this intervention, a U1 practitioner needs to provide another unit due to the concern of the U2 supervisee (e.g. Physician's Assistant provides and bills 90805U2U6 and because of concerns, requests U1 intervention following his/her billing of U2 intervention). The use of this practice should be rare and will be subject to additional utilization review scrutiny. These E/M codes are based upon time (despite recent CPT guidance). The Georgia Medicaid State Plan (June 6, 2012) is priced on time increments and therefore time will remain the basis of justification for the selection of codes above for the near term. The Rounding protocol set forth in the Community Service Requirements for All Providers, Section III, Documentation Requirements must be used when determining the billing code submitted to DBHDD or DCH. Billing guidance for rounding of Psychiatric Treatment is as follows: 99201 is billed when time with a new person-served is 5-15 minutes. 99202 is billed if the time with a new person-served is 16-25 minutes. 99203 is billed if the time with a new person-served is 26-37 minutes. 99204 is billed if the time with a new person-served is 38-52 minutes. 99205 is billed if the time with a new person-served is 53 minutes or longer. 99211 is billed when time with an established person-served is 3-7 minutes. 99212 is billed if the time with an established person-served is 8-12 minutes. 99213 is billed if the time with an established person-served is 13-20 minutes. 99214 is billed if the time with an established person-served 21-32 minutes. 99215 is billed if the time with an established person-served is 33 minutes or longer. If a Medicaid claim for this service denies for a Procedure-to-Procedure edit, a modifier (25) can be added to the claim and resubmitted to the MMIS for payment.

Psychological Testing: Psychological Testing – Psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psycho-pathology

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
per hr of psychologist or physician time, both face-to-face w/ the patient and time interpreting test results and preparing report)	Practitioner Level 2, In-Clinic	96101	U2	U6			\$155.87	Practitioner Level 2, Out-of-Clinic	96101	U2	U7			\$187.04
w/ qualified healthcare professional interpretation and	Practitioner Level 3, In-Clinic	96102	U3	U6			\$120.04	Practitioner Level 4, In-Clinic	96102	U4	U6			\$81.18

Psychological Testing: Psychological Testing – Psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psycho-pathology

report, administered by technician, per hr of technician time, face-to-face	Practitioner Level 3, Out-of-Clinic	96102	U3	U7		\$146.71	Practitioner Level 4, Out-of-Clinic	96102	U4	U7		\$97.42	
Unit Value	1 hour						Maximum Daily Units	5 units					
Initial Authorization	5 units						Re-Authorization	5 units					
Authorization Period	180 days						Utilization Criteria	LOCUS scores:1-6					
Service Definition	<p>Psychological testing consists of a face-to-face assessment of emotional functioning, personality, cognitive functioning (e.g. thinking, attention, memory) or intellectual abilities using an objective and standardized tool that has uniform procedures for administration and scoring and utilizes normative data upon which interpretation of results is based.</p> <p>Psychological tests are only administered and interpreted by those who are properly trained in their selection and application. The practitioner administering the test ensures that the testing environment does not interfere with the performance of the examinee and ensures that the environment affords adequate protections of privacy and confidentiality.</p> <p>This service covers both the face-to-face administration of the test instrument(s) by a qualified examiner as well as the time spent by a psychologist or physician (with the proper education and training) interpreting the test results and preparing a written report.</p>												
Admission Criteria	<ol style="list-style-type: none"> 1. A known or suspected mental illness or substance-related disorder; and 2. Initial screening/intake information indicates a need for additional undetermined supports and recovery/resiliency planning; and 3. Individual meets Core Customer eligibility. 												
Continuing Stay Criteria	The Individual's situation/functioning has changed in such a way that previous assessments are outdated.												
Discharge Criteria	Each intervention is intended to be a discrete time-limited service that modifies treatment/support goals or is indicated due to change in illness/disorder.												
Staffing Requirements	The term "psychologist" is defined in the Approved Behavioral Health Practitioners table in Section II of this manual (Reference § 43-39-1 and § 43-39-7).												
Required Components	<ol style="list-style-type: none"> 1. There may be no more than one comprehensive battery of 96101 and 96102 provided to one individual within a year. 2. There may be no more than 10 combined hours of 96101 and 96012 provided to one individual within a year. 												
Billing & Reporting Requirements	If a Medicaid claim for this service denies for a Procedure-to-Procedure edit, a modifier (59) can be added to the claim and resubmitted to the MMIS for payment.												

Psychosocial Rehabilitation-Individual (Added Effective 6/1/13 partially replacing Community Support for MH Adults)

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Psychosocial Rehabilitation	Practitioner Level 4, In-Clinic	H2017	HE	U4	U6		\$20.30	Practitioner Level 4, Out-of-Clinic	H2017	HE	U4	U7		\$24.36
	Practitioner Level 5, In-Clinic	H2017	HE	U5	U6		\$15.13	Practitioner Level 5, Out-of-Clinic	H2017	HE	U5	U7		\$18.15

Psychosocial Rehabilitation-Individual (Added Effective 6/1/13 partially replacing Community Support for MH Adults)

Unit Value	15 minutes	Maximum Daily Units	48 units
Initial Authorization	80 units	Re-Authorization	80 units
Authorization Period	180 days	Utilization Criteria	<u>LOCUS scores</u> : 1-6
Service Definition	<p>Psychosocial Rehabilitation-Individual (PSR-I) services consist of rehabilitative skills building, the personal development of environmental and recovery supports considered essential in improving a person's functioning, learning skills to promote the person's self-access to necessary services and in creating environments that promote recovery and support the emotional and functional improvement of the individual. The service activities of Psychosocial Rehabilitation-Individual include:</p> <ul style="list-style-type: none"> • Providing skills support in the person's self-articulation of personal goals and objectives; • Assisting the person in the development of skills to self-manage or prevent crisis situations; • Individualized interventions in living, learning, working, other social environments, which shall have as objectives: <ol style="list-style-type: none"> 1) Identification, with the person, of strengths which may aid him/her in achieving recovery, as well as barriers that impede the development of skills necessary for functioning in work, with peers, and with family/friends; 2) Supporting skills development to build natural supports (including support/assistance with defining what wellness means to the person in order to assist them with recovery-based goal setting and attainment); 3) Assistance in the development of interpersonal, community coping and functional skills (which may include adaptation to home, adaptation to work, adaptation to healthy social environments, learning/practicing skills such as personal financial management, medication self-monitoring, symptom self-monitoring, etc.); 4) Assistance in the acquisition of skills for the person to self-recognize emotional triggers and to self-manage behaviors related to the behavioral health issue; 5) Assistance with personal development, work performance, and functioning in social and family environments through teaching skills/strategies to ameliorate the effect of behavioral health symptoms; 6) Assistance in enhancing social and coping skills that ameliorate life stresses resulting from the person's mental illness/addiction; 7) Assist the person in his/her skills in gaining access to necessary rehabilitative, medical, social and other services and supports; 8) Assistance to the person and other supporting natural resources with illness understanding and self-management (including medication self-monitoring); 9) Identification, with the individual and named natural supporters, of risk indicators related to substance related disorder relapse, and the development of skills and strategies to prevent relapse. <p>This service is provided in order to promote stability and build towards functioning in the person's daily environment. Stability is measured by a decreased number of hospitalizations, by decreased frequency and duration of crisis episodes and by increased and/or stable participation in community/work activities. Supports based on the person's needs are used to promote recovery while understanding the effects of the mental illness and/or substance use/abuse and to promote functioning.</p>		
Admission Criteria	<ol style="list-style-type: none"> 1. Individuals with one of the following: Mental Health (MH) Diagnosis, Substance-Related Disorder, Co-Occurring Substance-Related Disorder and MH Diagnosis, Co-Occurring MH Diagnosis and Developmental Disabilities (DD), or Co-Occurring Substance-Related Disorder and DD and one or more of the following: 2. Individual may need assistance with developing, maintaining, or enhancing social supports or other community coping skills; or 3. Individual may need assistance with daily living skills including coordination to gain access to necessary rehabilitative and medical services 		
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual continues to meet admission criteria; and 2. Individual demonstrates documented progress or maintenance of community skills relative to goals identified in the Individualized Recovery Plan 		
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Recovery Plan have been substantially met; or 3. Individual requests discharge and the individual is not in imminent danger of harm to self or others; or 4. Transfer to another service/level of care is warranted by change in individual's condition; or 5. Individual requires more intensive services. 		

Psychosocial Rehabilitation-Individual (Added Effective 6/1/13 partially replacing Community Support for MH Adults)

Clinical Exclusions	<ol style="list-style-type: none"> 1. There is a significant lack of community coping skills such that a more intensive service is needed. 2. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a co-occurring Behavioral Health condition: <u>Developmental Disability, Autism, Organic Mental Disorder, Traumatic Brain Injury</u>
Required Components	<ol style="list-style-type: none"> 1. Psychosocial Rehabilitation-Individual services must include a variety of interventions in order to assist the individual in developing: <ul style="list-style-type: none"> • Symptom self-monitoring and self-management of symptoms • Strategies and supportive interventions for avoiding out-of-community treatment for adults and building stronger knowledge of the adult's strengths and limitations • Relapse prevention strategies and plans 2. Psychosocial Rehabilitation-Individual services focus on building and maintaining a therapeutic relationship with the individual and facilitating treatment and recovery goals. 3. Contact must be made with the individual receiving PSR-I services a minimum of twice each month. 4. In the absence of the required monthly face-to-face contact and if at least two unsuccessful attempts to make face-to-face contact have been tried and documented, the provider may bill for a maximum of two telephone contacts in that specified month. 5. There may be instances where a person has an order and authorization to receive PSR-Group in addition to PSR-I. When the person is in attendance at the PSR-Group program and a staff provides support to the served individual on a one-to-one basis, the PSR Specialty provider may bill this PSR-I code. In this specific circumstance, the PSR group program shall not count for that time within in its hourly claims submission. There must be a PSR-I note which is individualized and indicates the one-to-one nature of the intervention. 6. When the primary focus of PSR-I is for medication maintenance, the following allowances apply: <ol style="list-style-type: none"> a. These individuals are not counted in the offsite service requirement or the individual-to-staff ratio; and b. These individuals are not counted in the monthly face-to-face contact requirement; however, face-to-face contact is required every 3 months and monthly calls are an allowed billable service.
Staffing Requirements	<p>PSR-I practitioners may have the recommended individual-to-staff ratio of 30 individuals per staff member and must maintain a maximum ratio of 50 individuals per staff member. Individuals who receive only medication maintenance are not counted in the staff ratio calculation.</p>
Clinical Operations	<ol style="list-style-type: none"> 1. The organization must have a Psychosocial Rehabilitation-Individual Organizational Plan that addresses the following: <ul style="list-style-type: none"> ▪ description of the particular rehabilitation, recovery and natural support development models utilized, types of intervention practiced, and typical daily schedule for staff; ▪ description of the staffing pattern and how staff are deployed to assure that the required staff-to-individual ratios are maintained, including how unplanned staff absences, illnesses, or emergencies are accommodated, case mix, access, etc.; ▪ description of the hours of operations as related to access and availability to the individuals served; ▪ description of how the plan for services is modified or adjusted to meet the needs specified in every Individualized Recovery Plan; and ▪ if the service is offered through an agency which provides PSR-Group, then there is a description of how the agency has protocols and accountability procedures to assure that there is no duplication of billing when the person is being supported through the group model. 2. Utilization (frequency and intensity) of PSR-I should be directly related to the LOCUS and to other functional elements in the assessment. In addition, when clinical/functional needs are great, there should be complementary therapeutic services by licensed/credential professionals paired with the provision of PSR-I (individual, group, family, etc.).
Service Accessibility	<ol style="list-style-type: none"> 1. There must be documented evidence that service hours of operation include evening, weekend, and holiday hours. 2. "Medication Maintenance Track," individuals who require more than 4 contacts per quarter for two consecutive quarters (as based upon need) are expected to be re-evaluated with LOCUS for enhanced access to PSR-I. The designation of PSR-I "medication maintenance track" should be lifted and exceptions stated above are no longer allowed.

Psychosocial Rehabilitation-Individual (Added Effective 6/1/13 partially replacing Community Support for MH Adults)

Reporting and Billing Requirements	Unsuccessful attempts to make contact with the individual are not billable.
Documentation Requirements	Orders for Service and Treatment Plans which have an effective date of 5/31/2013 or prior and name CSI will be accepted as an Order or Treatment Plan, respectively, for CM, PSR-I, and ADSS. This is effective for the authorization period which corresponds to the Order and Treatment Plan. Any Treatment Plan or Order with a start date on or after 6/1/2013 may not include CSI, and instead, must reflect CM, PSR-I, and/or ADSS as medically necessary (While the above allowances are being made, please note that when providing the above services on or after 6/1/2013, providers must bill and document (via progress notes) the new service and their corresponding codes as appropriate. CSI may not be provided to adults effective 6/1/2013.).

Service Plan Development

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Service Plan Development	Practitioner Level 2, In-Clinic	H0032	U2	U6			\$38.97	Practitioner Level 2, Out-of-Clinic	H0032	U2	U7			\$46.76
	Practitioner Level 3, In-Clinic	H0032	U3	U6			\$30.01	Practitioner Level 3, Out-of-Clinic	H0032	U3	U7			\$36.68
	Practitioner Level 4, In-Clinic	H0032	U4	U6			\$20.30	Practitioner Level 4, Out-of-Clinic	H0032	U4	U7			\$24.36
	Practitioner Level 5, In-Clinic	H0032	U5	U6			\$15.13	Practitioner Level 5, Out-of-Clinic	H0032	U5	U7			\$18.15
Unit Value*	15 minutes							Maximum Daily Units*	24 units (Combined with H0031)					
Initial Authorization*	32 units (Combined with H0031 – Behavioral Health Assessment)							Re-Authorization*	32 units (Combined with H0031)					
Authorization Period*	180 days							Utilization Criteria	<u>LOCUS scores</u> :1-6					

Service Definition	<p>Individuals access this service when it has been determined through an assessment that the individual has mental health or addictive disease concerns. The Individualized Recovery Plan (IRP) results from the Diagnostic and Behavioral Health Assessments and is required within the first 30 days of service, with ongoing plans completed as demanded by individual need and/or by service policy.</p> <p>Information from a comprehensive assessment should ultimately be used to develop with the individual an IRP that supports recovery and is based on goals identified by the individual. Friends, family and other natural supports may be included at the discretion and direction of the individual for whom services/supports are being planned. Also, as indicated, medical, nursing, peer support, community support, nutritional staff, etc. should provide information from records, and various multi-disciplinary assessments for the development of the IRP.</p> <p>The cornerstone component of the IRP involves a discussion with the individual regarding what recovery means to him/her personally (e.g. getting/keeping a job, having more friends/improved relationships, improvement of behavioral health symptoms, etc.), and the development of goals (i.e. outcomes) and objectives that are defined by and meaningful to the individual based upon his/her articulation of their recovery hopes. Concurrent with the development of the IRP, the individual should be offered the opportunity to develop an Advanced Directive for behavioral healthcare with the individual guiding the process through the free expression of their wishes and through his/her assessment of the components developed for the Advanced Directive as being realistic for him/her.</p> <p>The entire process should involve the individual as a full partner and should focus on service and recovery goals/outcomes as identified by the individual.</p> <p>Recovery planning shall set forth the course of care by:</p> <ul style="list-style-type: none"> • Prioritizing problems and needs; • Stating goals which will honor achievement of stated hopes, choice, preferences and desired outcomes of the individual;
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Service Plan Development

	<ul style="list-style-type: none"> • Assuring goals/objectives are related to the assessment; • Defining goals/objectives that are individualized, specific, and measurable with achievable timeframes; • Defining discharge criteria and desired changes in levels of functioning and quality of life to objectively measure progress; • Transition planning at onset of service delivery; • Selecting services and interventions of the right duration, intensity, and frequency to best accomplish these objectives; • Assuring there is a goal/objective that is consistent with the service intent; and • Identifying qualified staff who are responsible and designated for the provision of services.
Admission Criteria	<ol style="list-style-type: none"> 1. A known or suspected mental illness or substance-related disorder; and 2. Initial screening/intake information indicates a need for additional undetermined supports and recovery/resiliency planning; and 3. Individual meets Core Customer eligibility.
Continuing Stay Criteria	The individual's situation/functioning has changed in such a way that previous assessments are outdated.
Discharge Criteria	Each intervention is intended to be a discrete time-limited service that modifies treatment/support goals or is indicated due to change in illness/disorder.
Service Exclusions	Assertive Community Treatment
Required Components	The service plan must include elements articulated in the Documentation Guideline chapter in this Provider Manual.
Clinical Operations	<ol style="list-style-type: none"> 1. The individual (and any other individual-identified natural supports) should actively participate in planning processes. 2. The Individualized Recovery Plan should be directed by the individual's personal recovery goals as defined by that individual. 3. Advanced Directive/Crisis Planning shall be directed by the individual served and their needs/wishes to the extent possible and clinically appropriate. Plans should not contain elements/components that are not agreeable to, meaningful for, or realistic for the person and that the person is, therefore, not likely to follow through with. 4. Guidelines for treatment planning are contained in the DBHDD Requirements for Community Providers in this Provider Manual.
Additional Medicaid Requirements	The daily maximum within a CSU for combined Behavioral Health Assessment and Service Plan Development is 24 units/day
Documentation Requirements	<ol style="list-style-type: none"> 1. The initial authorization/IRP and each subsequent authorization/IRP must be completed within the time-period specified by DBHDD. 2. Every record must contain an IRP in accordance with these Service Guidelines and with the DBHDD Requirements contained in this Provider Manual.

ADULT SPECIALTY SERVICES:

AD Peer Support Services- Group (effective 3/1/13)														
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
AD Peer Support Services	SA Program, Group Setting, Practitioner Level 4, In-Clinic	H0038	HF	HQ	U4	U6	17.72	SA Program, Group Setting, Practitioner Level 4, Out-of-Clinic	H0038	HF	HQ	U4	U7	21.64
	SA Program, Group Setting, Practitioner Level 5, In-Clinic	H0038	HF	HQ	U5	U6	13.20	SA Program, Group Setting, Practitioner Level 5, Out-of-Clinic	H0038	HF	HQ	U5	U7	16.12
Unit Value	1 hour							Maximum Daily Units	5 units					
Initial Authorization	3600 units (combined with other Peer Support services)							Re-Authorization	3600 units (combined with other Peer Support services)					
Authorization Period	180 days							Utilization Criteria	<u>LOCUS scores: 3-6</u>					
Service Definition	<p>This service provides structured activities (in an agency or community-based setting) which promote recovery, self-advocacy, relationship enhancement, self-awareness and values, and self-directed care. Individuals served are introduced to the reality that there are many different pathways to recovery and each individual determines his or her own way. Supports are recovery-oriented. This occurs when individuals share the goal of long-term recovery. Individuals served are encouraged to initiate and lead group activities and each participant identifies his/her own individual goals for recovery. Activities must promote self-directed recovery by honoring the many pathways to recovery, by tapping into each participant's strengths and by helping each to recognize his/her "recovery capital", the reality that each individual has internal and external resources that they can draw upon to keep them well.</p> <p>Interventions are approached from a lived experience perspective but also are based upon the Science of Addiction Recovery framework. Supportive interactions include motivational interviewing, recovery planning, resource utilization, strengths identification and development, support in considering theories of change, building recovery empowerment and self-efficacy. There is also advocacy support with the individual to have recovery dialogues with their identified natural and formal supporters.</p>													
Admission Criteria	<ol style="list-style-type: none"> 1. Individual must have a primary substance related issue; and one or more of the following: <ol style="list-style-type: none"> a. Individual needs peer-based recovery support for the acquisition of skills needed to engage in and maintain recovery, or b. Individual needs assistance to develop self-advocacy skills to achieve decreased dependency on formalized treatment systems; or c. Individual needs assistance and support to prepare for a successful work experience; or d. Individual needs peer modeling to increase responsibilities for his /her own recovery. 													
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual continues to meet admission criteria; and 2. Progress notes document progress relative to goals identified in the Individualized Recovery Plan, but treatment/recovery goals have not yet been achieved. 													
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Recovery Plan have been substantially met; or 3. Individual served/family requests discharge; or 4. Transfer to another service/level is more clinically appropriate. 													
Service Exclusions	Crisis Stabilization Unit (however, those utilizing transitional beds within a Crisis Stabilization Unit may access this service).													
Clinical Exclusions	<ol style="list-style-type: none"> 1. Individuals diagnosed with a mental illness that have no co-occurring Substance-Related Disorder. 													

AD Peer Support Services- Group (effective 3/1/13)

Required Components	<ol style="list-style-type: none"> 1. AD Peer Support services may operate as a program within a CORE provider, an Intensive Outpatient Provider (IOP) specialty provider, a WTRS provider or an established peer program. 2. AD Peer Support Services must be operated for no less than 3 days a week, no less than 12 hours/week, no less than 4 hours per day, typically during day, evening and weekend hours. Any agency may offer additional hours on additional days in addition to these minimum requirements (up to the daily max). 3. Individuals participating in the service at any given time must have the opportunity to participate in and make decisions about the activities that are conducted or services offered within the AD Peer Support program, and about the schedule of those activities and services, as well as other operational issues. 4. AD Peer Support should operate as an integral part of the agency's scope of services. 5. When needed and in collaboration with a participant, the Program Leader may call multidisciplinary team meetings regarding that individual's needs and desires, and a Certified Peer Specialist Addictive Diseases (CPS-AD) providing services for and with an individual must be allowed to participate in multidisciplinary team meetings.
Staffing Requirements	<ol style="list-style-type: none"> 1. The individual leading and managing the day-to-day operations of the program must be a CPS-AD. 2. AD Peer Support shall be supervised by an independently licensed practitioner or one of the following addiction credentials: CAC II, GCADC II/III, or MAC. 3. CPS-AD Program Leader is dedicated to the service at least 20 hours per week. 4. The Program Leader and other CPS-ADs AD Peer Support Recovery program may be shared with other programs as long as the Program Leader is present at least 50% of the hours the Peer Recovery program is in operation, and as long as the Program leader and the CPS-AD are available as required for supervision and clinical operations, and as long as they are not counted in individual to staff ratios for 2 different programs operating at the same time. 5. Services must be provided and/or activities led by staff who are CPS-ADs or other individuals under the supervision of a CPS-AD. A specific activity may be led by someone who is a consumer but is an invited guest. 6. The maximum face-to-face ratio cannot be more than 15 individuals to 1 CPS-AD direct service/program staff, based on the average daily attendance in the past three (3) months of individuals in the program. 7. All CPS-ADs providing this support must have an understanding of recovery principles as defined by the Substance Abuse Mental Health Services Administration and the Recovery Bill of Rights published by Faces and Voices of Recovery, Inc. and must possess the skills and abilities to assist other individuals in their own recovery processes.
Clinical Operations	<ol style="list-style-type: none"> 1. This service must operate at an established site approved to bill Medicaid for services. However, individuals or group activities may take place offsite in natural community settings as appropriate for the individualized Recovery Plan (IRP) developed by each individual with assistance from the Program Staff. 2. Individuals receiving AD Peer Support services must demonstrate or express a need for recovery assistance. 3. Individuals entering AD Peer Support services must have a qualifying diagnosis present in the medical record prior to the initiation of formal clinical services. The diagnosis must be given by persons identified in O.C.G.A. Practice Acts as qualified to provide a diagnosis. 4. This service may operate in the same building as other day services; however, there must be a distinct separation between services in staffing, program description, and physical space during the hours the Peer Recovery program is in operation except as noted above. 5. Adequate space, equipment, furnishings, supplies, and other resources must be provided in order to effectively provide services and so that the program environment is clean and in good repair. Space, equipment, furnishings, supplies transportation, and other resources for individual use within the Peer Recovery program must not be substantially different from space provided for other uses for similar numbers of individuals. 6. Staff of the AD Peer Support program must be treated as equal to any other staff of the facility or organization and must be provided equivalent opportunities for training (both mandated and offered) and pay and benefits competitive and comparable to the state's peer workforce and based on experience and skill level. 7. When this service is used in conjunction with Psychosocial Rehabilitation or ACT, documentation must demonstrate careful planning to maximize the effectiveness of this service as well as appropriate reduction in service amounts. Utilization of this service in conjunction with these services is subject to review by the External Review Organization. 8. Each individual must be provided the opportunity for peer assistance in the form of recovery coaches and allies and community networking to achieve stated goals. 9. AD Peer Support Programs must offer a range recovery activities developed and led by consumers, with the recognition of and respect for the fact that there are many pathways to recovery. 10. The program must have an AD Peer Support <i>Organizational Plan</i> addressing the following: <ol style="list-style-type: none"> a. A Recovery Bill of Rights as developed and promoted by Faces and Voices of Recovery, Inc. This philosophy must be actively incorporated into all services and

AD Peer Support Services- Group (effective 3/1/13)

<p>Clinical Operations, continued</p>	<p>activities and:</p> <ol style="list-style-type: none"> 1. View each individual as the driver of his/her recovery process 2. Promote the value of self-help, peer support, and personal empowerment to foster recovery 3. Promote information about the science of addiction, recovery 4. Promote peer-to-peer training of individual skills, community resources, group and individual advocacy and the concept of "giving back". 5. Promote the concepts of employment and education to foster self-determination and career advancement 6. Support each individual to embrace SAMHSA's <i>Recovery Principles</i> and to utilize community resources and education regarding health, wellness and support from peers to replace the need for clinical treatment services 7. Support each individual to fully participate in communities of their choosing in the environment most supportive of their recovery and that promotes housing of his/her choice and to build and support recovery connections and supports within his/her own community. 8. Actively seek ongoing input into program and service content so as to meet each individual's needs and goals and fosters the recovery process. <ol style="list-style-type: none"> b. A description of the particular consumer empowerment models utilized, types of activities offered, and typical daily activities and schedule. If offered, meals must be described as an adjunctive peer relation building activity rather than as a central activity. c. A description of the staffing pattern plans for staff who have or will have CPS-AD and appropriate addiction counselor credentials, and how staff are deployed to assure that the required staff-to-individual ratios are maintained, including how unplanned staff absences, illnesses, and emergencies are accommodated. d. A description of how peer practitioners within the agency are given opportunities to meet with or otherwise receive support from other peers (including CPS-AD) both within and outside the agency. e. A description of how individuals are encouraged and supported to seek Georgia certification as CPS-AD through participation in training opportunities and peer or other counseling regarding anxiety following certification. f. A description of test-taking skills and strategies, assistance with study skills. Information about training and testing opportunities, opportunities to hear from and interact with peers who are already certified, additional opportunities for peer staff to participate in clinical team meetings at the request of a participant, and the procedure for the Program Leader to request a team meeting. g. A description of the hours of operation, the staff assigned, and the types of services and activities provided for and by individuals served, as well as for families, parents, and /or guardians. h. A description of the program's decision-making processes, including how participants' direct decision-making about both individual and program-wide activities and about key policies and dispute resolution processes. i. A description of how individuals participating in the service at any given time are given the opportunity to participate in and make decisions about the activities that are conducted or services offered within the Peer Recovery program, about the schedule of those activities and services, and other operational issues. j. A description of the space furnishings, materials, supplies, transportation, and other resources available for individuals participating in the Peer Recovery services. k. A description of the governing body and /or advisory structures indicating how this body/structure meets requirements for peer leadership and cultural diversity. l. A description of how the plan for services and activities is modified or adjusted to meet the needs specified in IRP m. A description of how individual requests for discharge and change in service or service intensity are handled. <p>11. Assistive tools, technologies, worksheets, (e.g. SOAR; Recovery Check-Ins; Motivational Interviewing; Cultural Competence, Stigma & Labeling etc.) can be used by the Peer Recovery staff to work with the served individual to improve his/her communication about treatment, symptoms, improvements, etc. with treating behavior health and medical practitioners.</p>
<p>Documentation Requirements</p>	<ol style="list-style-type: none"> 1. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section III of the Provider Manual. 2. The provider has several alternatives for documenting progress notes: <ol style="list-style-type: none"> a. Weekly progress notes must document the individual's progress relative to functioning and skills related to the person-centered goals identified in his/her IRP. This progress note aligns the weekly PSR-Group activities reported against the stated interventions on the individualized recovery plan, and documents progress toward goals. This progress note may be written by any practitioner who provided services over the course of that week; or b. If the agency's progress note protocol demands a detailed daily note which documents the progress above, this daily detail note can suffice to demonstrate functioning, skills, and progress related to goals and related to the content of the group intervention; or

AD Peer Support Services- Group (effective 3/1/13)

- c. If the agency's progress note protocol demands a detailed hourly note which documents the progress above, this daily detail note can suffice to demonstrate functioning, skills, and progress related to goals and related to the content of the group intervention.
3. While billed in increments, the Peer Support service is a program model. Daily time in/time out is tracked for while the person is present in the program, but due to time/in out not being required for each intervention, the time in/out may not correlate with the units billed as the time in/out will include breaks taken during the course of the program. However, the units noted on the log should be consistent with the units billed and, if noted, on the weekly progress note. If the units documented are not consistent, the most conservative number of units will be utilized and may result in a billing discrepancy.
 4. Rounding is applied to the person's cumulative hours/day at the Peer program (excluding non-programmatic time). The provider shall follow the guidance in the rounding policy included in this Provider Manual, and, specific to this service, the person served must have participated in at least 50% of the hour in order to bill for one unit of this service. So for instance, if an individual participates in the program from 9-1:15 excluding a 30 minute break for lunch, his/her participating hours are 3.75 hours. The rounding policy is applied to the .75 hour and the units billed for that day are 4 units. Practitioner type must still be addressed and so that 4 units must be adequately assigned to either a U4 or U5 practitioner type as reflected in the log for that day's activities.
 5. A provider shall only record units in which the individual was actively engaged in services. Meals and breaks must not be included in the reporting of units of service delivered. Should an individual leave the program or receive other services during the range of documented time in/time out for Peer Support hours, the absence should be documented on the log.

AD Peer Support Services- Individual (effective 3/1/13)

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
AD Peer Support Services	SA Program, Practitioner Level 4, In-Clinic	H0038	HF	U4	U6		20.30	SA Program, Practitioner Level 4, Out-of-Clinic	H0038	HF	U4	U7		24.36
	SA Program, Practitioner Level 5, In-Clinic	H0038	HF	U5	U6		15.13	SA Program, Practitioner Level 5, Out-of-Clinic	H0038	HF	U5	U7		18.15
Unit Value	15 minutes							Maximum Daily Units	48 units					
Initial Authorization	3600 unit (combined with other Peer Support services)							Re-Authorization	3600 unit (combined with other Peer Support services)					
Authorization Period	180 days							Utilization Criteria	<u>LOCUS scores: 3-6</u>					
Service Definition	<p>This service provides interventions (in an agency or community-based setting) which promote recovery, self-advocacy, relationship enhancement, self-awareness and values, and self-directed care. Individuals served are introduced to the reality that there are many different pathways to recovery and each individual determines his or her own way. Supports are recovery-oriented and occur when individuals share the goal of long-term recovery. Each participant identifies his/her own individual goals for recovery. Interventions must promote self-directed recovery by honoring the many pathways to recovery, by tapping into each participant's strengths and by helping each to recognize his/her "recovery capital", the reality that each individual has internal and external resources that they can draw upon to keep them well.</p> <p>Interventions are approached from a lived experience perspective but also are based upon the Science of Addiction Recovery framework. Supportive interactions include motivational interviewing, recovery planning, resource utilization, strengths identification and development, support in considering theories of change, building recovery empowerment and self-efficacy. There is also advocacy support with the individual to have recovery dialogues with their identified natural and formal supporters.</p>													
Admission Criteria	<ol style="list-style-type: none"> 1. Individual must have a primary substance related issue; and one or more of the following: <ol style="list-style-type: none"> a. Individual needs peer-based recovery support for the acquisition of skills needed to engage in and maintain recovery, or b. Individual needs assistance to develop self-advocacy skills to achieve decreased dependency on formalized treatment systems; or c. Individual needs assistance and support to prepare for a successful work experience; or d. Individual needs peer modeling to increased responsibilities for his /her own recovery. 													

AD Peer Support Services- Individual (effective 3/1/13)

Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual continues to meet admission criteria; and 2. Progress notes document progress relative to goals identified in the Individualized Recover Plan, but treatment/recovery goals have not yet been achieved.
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Recovery Plan have been substantially met; or 3. Individual served/family requests discharge; or 4. Transfer to another service/level is more clinically appropriate.
Service Exclusions	Crisis Stabilization Unit (however, those utilizing transitional beds within a Crisis Stabilization Unit may access this service).
Clinical Exclusions	<ol style="list-style-type: none"> 1. Individuals diagnosed with a mental illness that have no co-occurring Substance-Related Disorder.
Required Components	<ol style="list-style-type: none"> 1. AD Peer Supports are provided in 1:1 CPS-AD to person-served ratio. 2. If an agency is providing AD Peer Supports-Individual, it shall also operate an AD Peer Supports group model program, meeting all of the expectations of AD Peer Support Group as set forth in this manual. 3. This service will operate within one of the following administrative structures: as a CORE provider, an Intensive Outpatient Provider (IOP) specialty provider, a WTRS provider or an established peer program. 4. Individuals participating in the service at any given time must have the opportunity to participate in and make decisions about person-centered interactions offered by the CPS-AD. 5. AD Peer Support should operate as an integral part of the agency's scope of services. 6. When needed and in collaboration with a participant, the Program Leader may call multidisciplinary team meetings regarding that individual's needs and desires, and a Certified Peer Specialist Addictive Diseases (CPS-AD) providing services for and with an individual must be allowed to participate in multidisciplinary team meetings.
Staffing Requirements	<ol style="list-style-type: none"> 1. The providing practitioner is a Georgia-Certified Peer Specialist- Addictive Diseases (CPS-AD). 2. The work of the CPS-AD shall be supervised by an independently licensed practitioner or one of the following addiction credentials; CAC II, GCADC II/III, or MAC. 3. The individual leading and managing the day-to-day operations of the program is a CPS-AD. 4. There must be at least 1 CPS-AD on staff who may also serve as the program leader. 5. The maximum caseload ratio for CPS-AD cannot be more than 30 individuals to 1 CPS-AD direct service/program staff, based on the average daily attendance in the past three (3) months of individuals in the program. 6. All CPS-ADs providing this support must have an understanding of recovery principles as defined by the Substance Abuse Mental Health Services Administration and the Recovery Bill of Rights published by Faces and Voices of Recovery, Inc. and must possess the skills and abilities to assist other individuals in their own recovery processes.
Clinical Operations	<ol style="list-style-type: none"> 1. Individuals receiving AD Peer Support services must demonstrate or express a need for recovery assistance. 2. Individuals entering AD Peer Support services must have a qualifying diagnosis present in the medical record prior to the initiation of formal clinical services. The diagnosis must be given by persons identified in O.C.G.A. Practice Acts as qualified to provide a diagnosis. 3. If a CPS-AD serves as staff for an AD Peer Support- Group program and provides AD Peer Support-Individual, the agency has written work plans which establish the CPS-AD's time allocation in a manner that is distinctly attributed to each program. 4. CPS-ADs providing this service must be treated as equal to any other staff of the facility or organization and must be provided equivalent opportunities for training (both mandated and offered) and pay and benefits competitive and comparable to the state's peer workforce and based on experience and skill level. 5. Individuals should set their own individualized goals each will be assisted and encouraged to identify and utilize his/her existing "recovery capital". 6. Each service intervention is provided only in a 1:1 ratio between a CSP-AD and a person-served. 7. Each individual must be provided the opportunity for peer assistance in the form of recovery coaches and allies and community networking to achieve stated goals. 8. AD Peer Support Programs must offer a range recovery activities developed and led by consumers, with the recognition of and respect

AD Peer Support Services- Individual (effective 3/1/13)

<p>Clinical Operations, continued</p>	<p>for the fact that there are many pathways to recovery.</p> <ol style="list-style-type: none"> 9. The program must have an AD Peer Support <i>Organizational Plan</i> addressing the following: <ol style="list-style-type: none"> a. A Recovery Bill of Rights as developed and promoted by Faces and Voices of Recovery, Inc. This philosophy must be actively incorporated into all services and activities and: <ol style="list-style-type: none"> 1. View each individual as the driver of his/her recovery process 2. Promote the value of self-help, peer support, and personal empowerment to foster recovery 3. Promote information about the science of addiction, recovery 4. Promote peer-to-peer training of individual skills, community resources, group and individual advocacy and the concept of "giving back". 5. Promote the concepts of employment and education to foster self-determination and career advancement 6. Support each individual to embrace SAMHSA's <i>Recovery Principles</i> and to utilize community resources and education regarding health, wellness and support from peers to replace the need for clinical treatment services 7. Support each individual to fully participate in communities of their choosing in the environment most supportive of their recovery and that promotes housing of his/her choice and to build and support recovery connections and supports within his/her own community. 8. Actively seek ongoing input into program and service content so as to meet each individual's needs and goals and fosters the recovery process. b. A description of the particular consumer empowerment models utilized, types of activities offered, and typical daily activities and schedule. If offered, meals must be described as an adjunctive peer relation building activity rather than as a central activity. c. A description of the staffing pattern plans for staff who have or will have CPS-AD and appropriate addiction counselor credentials, and how staff are deployed to assure that the required staff-to-individual ratios are maintained, including how unplanned staff absences, illnesses, and emergencies are accommodated. d. A description of how CPS-ADs within the agency are given opportunities to meet with or otherwise receive support from other peers both within and outside the agency. e. A description of how individuals are encouraged and supported to seek Georgia certification as CPS-AD through participation in training opportunities and peer or other counseling regarding anxiety following certification. f. A description of test-taking skills and strategies, assistance with study skills. Information about training and testing opportunities, opportunities to hear from and interact with peers who are already certified, additional opportunities for peer staff to participate in clinical team meetings at the request of a participant, and the procedure for the Program Leader to request a team meeting. g. A description of the hours of operation, the staff assigned, and the types of services and activities provided for and by individuals served, as well as for families, parents, and /or guardians. h. A description of the program's decision-making processes, including how participants' direct decision-making about both individual and program-wide activities and about key policies and dispute resolution processes. i. A description of how individuals participating in the service at any given time are given the opportunity to participate in and make decisions about the activities that are conducted or services offered within the Peer Recovery program, about the schedule of those activities and services, and other operational issues. j. A description of the materials, supplies, transportation, and other resources available for individuals participating in the Peer Recovery services. k. A description of the governing body and /or advisory structures indicating how this body/structure meets requirements for peer leadership and cultural diversity. l. A description of how the plan for services and activities is modified or adjusted to meet the needs specified in IRP. m. A description of how individual requests for discharge and change in service or service intensity are handled, and n. Assistive tools, technologies, worksheets, (e.g. SOAR; Recovery Check-Ins; Motivational Interviewing; Cultural Competence, Stigma & Labeling etc.) can be used by the Peer Recovery staff to work with the served individual to improve his/her communication about treatment, symptoms, improvements, etc. with treating behavior health and medical practitioners.
<p>Documentation Requirements</p>	<p>Providers must document services in accordance with the specifications for documentation requirements in Part II, Section III of the Provider Manual.</p>

Ambulatory Substance Abuse Detoxification

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Alcohol And/Or Drug Services; Ambulatory Detoxification	Practitioner Level 2, In-Clinic	H0014	U2	U6			38.97	Practitioner Level 4, In-Clinic	H0014	U4	U6			20.30
	Practitioner Level 3, In-Clinic	H0014	U3	U6			30.01							
Unit Value	15 minutes							Maximum Daily Units	32 units					
Initial Authorization	60 units							Re-Authorization	60 units					
Authorization Period	30 days							Utilization Criteria	LOCUS score: 4-Medically-monitored Non-Residential					
Service Definition	<p>This service is the medical monitoring of the physical process of withdrawal from alcohol or other drugs in an outpatient setting for those individuals with an appropriate level of readiness for behavioral change and level of community/social support. It is indicated when the individual experiences physiological dysfunction during withdrawal, but life or significant bodily functions are not threatened.</p> <p>This service must reflect ASAM (American Society of Addiction Medication) Levels 1-WM (Ambulatory Without Extended On-Site Monitoring) and 2-WM (Ambulatory With Extended Onsite Monitoring) and focuses on rapid stabilization and entry into the appropriate level of care/treatment based upon the ASAM guidelines placement criteria. These services may be provided in traditional Outpatient, Intensive Outpatient, Day Treatment, Intensive Day Treatment or other ambulatory settings.</p>													
Admission Criteria	<p>Individual has a Substance Related Disorder (ASAM PPC-2, Dimension-1) that is incapacitating, destabilizing or distressing. If the severity is incapacitating, there must be sufficient optimization in other dimensions of the individual's life to provide for safe withdrawal management in an outpatient setting, and individual meets the following three criteria:</p> <ol style="list-style-type: none"> 1. Individual is experiencing signs and symptoms of withdrawal, or there is evidence (based on history of substance intake, age, gender, previous withdrawal history, present symptoms, physical condition, and/or emotional/behavioral condition) that withdrawal is imminent; and the individual is assessed to be at minimal (Level 1-WM) to moderate (Level 2-WM) risk of severe withdrawal syndrome outside the program setting and can safely be managed at this service level; and 2. Individual has no incapacitating physical or psychiatric complications that would preclude ambulatory detoxification services; and 3. Individual is assessed as likely to complete needed withdrawal management and to enter into continued treatment or self-help recovery as evidenced by: 1) Individual or support persons clearly understand and are able to follow instructions for care, and 2) Individual has adequate understanding of and expressed interest to enter into ambulatory detoxification services, or 3) Individual has adequate support services to ensure commitment to completion of withdrawal management and entry into ongoing treatment or recovery, or 4) Individual evidences willingness to accept recommendations for treatment once withdrawal has been managed. 													
Continuing Stay Criteria	Individual's withdrawal signs and symptoms are not sufficiently resolved so that the individual can participate in self-directed recovery or ongoing treatment without the need for further medical or withdrawal management monitoring.													
Discharge Criteria	<ol style="list-style-type: none"> 1. Adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Recovery Plan have been substantially met; or 3. Individual/family requests discharge and individual is not imminently dangerous; or 4. Withdrawal signs and symptoms have failed to respond to treatment and have intensified (as confirmed by higher scores on CIWA-Ar or other comparable standardized scoring system) such that transfer to a more intensive level of withdrawal management service is indicated, or 5. Individual has been unable to complete Level 1-WM/2-WM despite an adequate trial. 													

Ambulatory Substance Abuse Detoxification

Service Exclusions	ACT, Nursing and Medication Administration (Medication administered as a part of Ambulatory Detoxification is not billed separately as Medication Administration.)
Clinical Exclusions	<ol style="list-style-type: none"> 1. Substance Abuse issue has incapacitated the individual in all aspects of daily living, there is resistance to treatment as in ASAM Dimension 4, relapse potential is high (Dimension 5), and the recovery environment is poor (Dimension 6). 2. Concomitant medical condition and/or other behavioral health issues warrant inpatient/residential treatment. 3. This service code does not cover withdrawal management treatment for cannabis, amphetamines, cocaine, hallucinogens and phencyclines.
Required Components	<ol style="list-style-type: none"> 1. This service must be licensed by DCH/HFR under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2. 2. There must be a written service order for Ambulatory Detoxification and must be completed by members of the medical staff pursuant to the Medical Practice Act of 2009, Subsection 43-34-23 Delegation of Authority to Nurse and Physician Assistant and in the individual's record is required to initiate ambulatory detoxification services. Verbal orders or those initiated by other appropriate members of the medical staff are acceptable provided the physician signs them within 24 hours or the next working day.
Clinical Operations	<ol style="list-style-type: none"> 1. The severity of the individual's symptoms, level of supports needed, and the authorization of appropriate medical staff for the service will determine the setting, as well as the amount of nursing and physician supervision necessary during the withdrawal process. The individual may or may not require medication, and 24-hour nursing services are not required. However, there is a contingency plan for "after hours" concerns/emergencies. 2. Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. 3. In order for this service to have best practice impact, the Individualized Recovery/Resiliency Plan should consider group and individual counseling and training to fully support recovery.

Assertive Community Treatment

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Assertive Community Treatment	Practitioner Level 1, In-Clinic	H0039	U1	U6			\$32.46	Practitioner Level 3, Out-of-Clinic	H0039	U3	U7			\$32.46
	Practitioner Level 2, In-Clinic	H0039	U2	U6			\$32.46	Practitioner Level 4, Out-of-Clinic	H0039	U4	U7			\$32.46
	Practitioner Level 3, In-Clinic	H0039	U3	U6			\$32.46	Practitioner Level 5, Out-of-Clinic	H0039	U5	U7			\$32.46
	Practitioner Level 4, In-Clinic	H0039	U4	U6			\$32.46	Practitioner Level 1, Via interactive audio and video telecommunication systems	H0039	GT	U1			\$32.46
	Practitioner Level 5, In-Clinic	H0039	U5	U6			\$32.46	Practitioner Level 2, Via interactive audio and video telecommunication systems	H0039	GT	U2			\$32.46
	Practitioner Level 1, Out-of-Clinic	H0039	U1	U7			\$32.46	Multidisciplinary Team Meeting	H0039	HT				\$0.00
	Practitioner Level 2, Out-of-Clinic	H0039	U2	U7			\$32.46	Practitioner Level 3, Group, In-Clinic	H0039	HQ	U3	U6		\$6.60
	Practitioner Level 4, Group, In-Clinic	H0039	HQ	U4	U6		\$4.43	Practitioner Level 5, Group, In-Clinic	H0039	HQ	U5	U6		\$3.30

Assertive Community Treatment

Unit Value	15 minutes	Maximum Daily Units	96 units
Initial Auth	480 units	Re-Authorization	480 units
Auth Period	365 days	Utilization Criteria	LOCUS scores: 4-6

Service Definition	<p>ACT is an Evidence Based Practice that is client-centered, recovery-oriented, and a highly intensive community based service for individuals who have serious and persistent mental illness. The individual's mental illness has significantly impaired his or her functioning in the community. The individual has been unsuccessfully treated in the traditional mental health service system because of his/her high level of mental health acuity. The use of the traditional clinic based services for the individual in the past or present have usually been greater than 8 hours of service per month. The recipient may have experienced chronic homelessness and/or criminal justice involvement; and may have had multiple and/or extended stays in state psychiatric/public hospitals. ACT provides a variety of interventions twenty-four (24) hours, seven days a week. The service utilizes a multidisciplinary mental health team from the fields of psychiatry, nursing, psychology, social work, substance abuse, and vocational rehabilitation; additionally, a Certified Peer Specialist is an active member of the ACT Team providing assistance with the development of natural supports, promoting socialization, and the strengthening of community living skills. The ACT Team works as one organizational unit providing community based interventions that are rehabilitative, intensive, integrated, and stage specific. Services emphasize social inclusiveness through relationship building and the active involvement in assisting individuals to achieve a stable and structured life style. The service providers must develop programmatic goals that clearly articulate the use of best/evidence-based practices for ACT recipients using co-occurring and trauma-informed service delivery and support. Practitioners of this service are expected to maintain knowledge and skills according to the current research trends in best/evidence-based practices. ACT is a unique treatment model in which the majority of mental health services are directly provided internally by the ACT program in the recipient's natural environment. ACT services are individually tailored with each individual to address his/her preferences and identified goals, which are the basis of the Individualized Recovery Plan (IRP). Based on the needs of the individual, services may include (in addition to those services provided by other systems):</p> <ol style="list-style-type: none"> 1. Assistance to facilitate the individual's active participation in the development of the IRP; 2. Psycho educational and instrumental support to individuals and their identified family; 3. Crisis planning, Wellness Recovery Action Plan (WRAP), assessment, support and intervention; 4. Psychiatric assessment and care; nursing assessment and care; psychosocial and functional assessment which includes identification of strengths, skills, resources and needs; 5. Curriculum-based group treatment; 6. Individualized interventions, which may include: <ol style="list-style-type: none"> a. Identification, with the individual, of barriers that impede the development of skills necessary for independent functioning in the community; as well as existing strengths which may aid the individual in recovery and goal achievement; b. Support to facilitate recovery (including emotional/therapeutic support/assistance with defining what recovery means to the individual in order to assist individual with recovery-based goal setting and attainment); c. Service and resource coordination to assist the individual with the acquisition and maintenance of recovery capital (i.e. gaining access to necessary internal and external rehabilitative, medical and other services) required for recovery initiation and self-maintenance; d. Family counseling/training for individuals and their families (as related to the person's IRP); e. Assistance to develop both mental illness and physical health symptom monitoring and illness self-management skills in order to identify and minimize the negative effects of symptoms which interfere with the individual's daily living (may include medication administration and/or observation and assistance with self- medication motivation and skills) and to promote wellness; f. Assistance with accessing entitlement benefits and financial management skill development; g. Motivational assistance to develop and work on goals related to personal development and school or work performance; h. Substance abuse counseling and intervention (e.g. motivational interviewing, stage based interventions, refusal skill development, cognitive behavioral therapy, psycho educational approaches, instrumental support such as helping individual relocate away from friends/neighbors who influence drug use, relapse prevention planning and techniques etc.); i. Individualized, restorative one-to-one psychosocial rehabilitation and skill development, including assistance in the development of interpersonal/social and community coping and functional skills (i.e. adaptation/functioning in home, school and work environments);
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Assertive Community Treatment

	<ul style="list-style-type: none"> j. Psychotherapeutic techniques involving the in depth exploration and treatment of interpersonal and intrapersonal issues, including trauma issues; and k. Any necessary monitoring and follow-up to determine if the services accessed have adequately met the individual's needs. l. Individuals receiving this intensive level of community support are expected to experience increased community tenure and decreased frequency and/or duration of hospitalization/crisis services. Through individualized, team-based supports, it is expected that individuals will achieve housing stability, decreased symptomatology (or a decrease in the debilitating effects of symptoms), improved social integration and functioning, and increased movement toward self-defined recovery.
Admission Criteria	<ol style="list-style-type: none"> 1. Individuals with serious and persistent mental illness that seriously impairs the ability to live in the community. Priority is given to people recently discharged from an institutional setting with schizophrenia, other psychotic disorders, or bipolar disorder, because these illnesses more often cause long-term psychiatric disability; and 2. Individuals with significant functional impairments as demonstrated by the need for assistance in 3 or more of the following areas which despite support from a care giver or behavioral health staff continues to be an area that the individual cannot complete: <ol style="list-style-type: none"> a. Maintaining personal hygiene; b. Meeting nutritional needs; c. Caring for personal business affairs; d. Obtaining medical, legal, and housing services; e. Recognizing and avoiding common dangers or hazards to self and possessions; f. Persistent or recurrent failure to perform daily living tasks except with significant support or assistance from others such as friends, family, or relatives; g. Employment at a self-sustaining level or inability to consistently carry out homemaker roles (e.g., household meal preparation, washing clothes, budgeting or childcare tasks and responsibilities); h. Maintaining a safe living situation (e.g., evicted from housing, or recent loss of housing, or imminent risk of loss of housing); and 3. Past (within 180 days of admission) or current response to other community-based intensive behavioral health treatment has shown minimal effectiveness (e.g. Psychosocial Rehabilitation, CS, etc).* Admission documentation must include evidence to support this criterion. 4. Individuals with two or more of the following issues that are indicators of continuous high-service needs (i.e., greater than 8 hours of service per month): <ol style="list-style-type: none"> a. High use of acute psychiatric hospitals or crisis/emergency services including mobile, in-clinic or crisis residential (e.g., 3 or more admissions in a year) or extended hospital stay (60 days in the past year) or psychiatric emergency services. b. Persistent, recurrent, severe, or major symptoms that place the individual at risk of harm to self or others (e.g., command hallucinations, suicidal ideations or gestures, homicidal ideations or gestures, self-harm). c. Coexisting substance use disorder of significant duration (e.g., greater than 6 months) or co-diagnosis of substance abuse. d. High risk for or a recent history of criminal justice involvement related to mental illness (e.g., arrest and incarceration). e. Chronically homeless (e.g., 1 extended episode of homelessness for a year, or 4 episodes of homelessness within 3 years). f. Residing in an inpatient bed (i.e., state hospital, community hospital, CSU) or in a supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement if more intensive services are not available. g. Inability to participate in traditional clinic-based services (must provide evidence of multiple agency trials if this is the only requirement met on the list). 5. Individuals meet one or more of the criteria below, criteria #3 above is waived, other criterion 1,2,4, must be met: <ol style="list-style-type: none"> a. Individual is transitioning from a state forensic or adult mental health unit after an extended length of stay <u>and</u> the hospital's treatment team determines that due to the individual's history and/or potential risk if non-compliant with clinic-based community services a period of ACT is clinically necessary prior to transition to less intensive services. b. Within the last 180 days, the individual has been incarcerated 2 or more times related to a behavioral health condition; or c. Within the last 180 days, individual has been admitted to a psychiatric hospital or crisis stabilization unit 2 or more times.

Assertive Community Treatment

Continuing Stay Criteria	<p>Individual meets two (2) or more of the requirements below:</p> <ol style="list-style-type: none"> 1. Individual has been admitted to an inpatient psychiatric hospital and/or received crisis intervention services one or more times in the past six (6) months; 2. Individual has had contact with Police/Criminal Justice System due to behavioral health problems in the past six (6) months; 3. Individual has displayed inability to maintain stable housing in the community due to behavioral health problems during the past six (6) months; 4. Individual continues to demonstrate significant functional impairment s and/or difficulty developing a natural support system which allows for consistent maintenance of medical, nutritional, financial, and legal responsibilities without incident in the past six (6) months; 5. Individual has displayed persistent, recurrent, severe, or major symptoms that place him/her at risk of harm to self or others (e.g. command hallucinations, suicidal ideation or gestures, homicidal ideation or gestures, self-harm) in the past six (6) months. 6. Documented efforts of multiple attempts to transition an individual within the prior 3 months have resulted in unsuccessful engagement in traditional clinic-based behavioral health services and the subsequent need for ACT level intensity of services continues.
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; team has adhered to 45 consecutive days of assertive outreach attempts to re-engage individuals; and one or more of the following: <ol style="list-style-type: none"> a. Individual no longer meets admission criteria; or b. Goals of the Individualized Recovery Plan have been substantially met; or c. Individual requests discharge and is not in imminent danger of harm to self or others, or d. Transfer to another service/level of care is warranted by a change in individual's condition, or e. Individual requires services not available in this level of care. f. No individual should be considered for discharge prior to 45 days of consecutive outreach and documentation of attempted contacts (calls, visits to various locations, collateral/informal contacts etc.).
Service Exclusions	<ol style="list-style-type: none"> 1. ACT is a comprehensive team intervention and most services are excluded, with the exceptions of <ul style="list-style-type: none"> • Peer Supports, • Residential Supports, • Community Transition Planning (to be utilized as a person is transitioning to/from an inpatient setting, jail, or CSP) • Group Training/Counseling (within parameters listed in Section A), and • Supported Employment • Psychosocial Rehabilitation • SA Intensive Outpatient (If an addiction issue is identified and documented as a clinical need unable to be met by the ACT team Substance Abuse counselor, and the individual's current treatment progress indicates that provision of ACT services alone, without an organized SA program model, is not likely to result in the individual's ability to maintain sobriety ACT teams may assist the individual in accessing this service, but must ensure clinical coordination in order to avoid duplication of services. If ACT and SAIOP are provided by the same agency, the agency may update the existing authorization to include group services to be utilized by the SAIOP program. (effective 5/1/13). • Group therapy is not a service exclusion when the needs of an individual exceed that which can be provided by the ACT team, the individual may participate in SA group treatment provided by a Core provider or SA-IOP provider upon documentation of the demonstrated need. 2. On an individual basis, up to four (4) weeks of some services may be provided to ACT consumers to facilitate a smooth transition from ACT to these other community services. A transition plan must be adequately documented in the IRP and clinical record. These services are: <ul style="list-style-type: none"> • Case Management/Intensive Case Management • Psychosocial Rehabilitation Individual/Group • AD Support Services • Behavioral Health Assessment • Service Plan Development • Diagnostic Assessment

Assertive Community Treatment

	<ul style="list-style-type: none"> • Physician Assessment (specific to engagement only) • Individual Counseling (specific to engagement only) <ol style="list-style-type: none"> 3. ACT recipients who also receive a DBHDD Residential Service may not receive ACT-provided skills training which is a part of the “residential” service. The ACT provider shall be in close coordination with the Residential provider such that there is no duplication of services supports/efforts. 4. Those receiving Medicaid DD Waivers who meet the admission criteria above may be considered for this service as long as his/her waiver service plan is not so comprehensive in nature as to be duplicative to the ACT service scope.
Clinical Exclusions	Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of psychiatric condition overlaying the primary diagnosis: developmental disability, autism, organic mental disorder, substance-related disorder.
Required Components	<ol style="list-style-type: none"> 1. Assertive Community Treatment must include a comprehensive and integrated set of medical and psychosocial services provided in non-office settings 80% of the time by a mobile multidisciplinary team. The team must provide community support services interwoven with treatment and rehabilitative services and regularly scheduled team meetings which will be documented in the served individual's medical record. 2. Ideally, and in accordance with the Dartmouth Assertive Community Treatment Scale (DACTS), the Treatment Team meeting must be held a minimum of 4 times a week with time dedicated to discussion of support to a specific individual, and documentation in the log of the Treatment Team Meetings as indicated in the Documentation Requirements section below. Each individual must be discussed, even if briefly, in each Treatment Team Meeting. The Treatment Team Meetings are to review the status of all individuals and the outcome of the most recent staff contacts, develop a master staff work schedule for the day's activities, and all ACT team members are expected to attend; exception of nonattendance can be made and documented by the Team Leader. Effective 7/1/11, the psychiatrist must participate at least one time/week in the ACT team meetings. 3. Each ACT team will identify an Individual Treatment Team (ITT) for each enrolled ACT individual. 4. Services and interventions must be individually tailored to the needs, goals, preferences and assets of the individual with the goals of maximizing independence and recovery as defined by the individual. 5. At least 80% of all service units must involve face-to-face contact with individuals. Eighty percent (80%) or more of face-to-face service units must be provided outside of program offices in locations that are comfortable and convenient for individuals (including the individual's home, based on individual need and preference and clinical appropriateness). 6. During the course of ACT service delivery, the ACT Team will provide the intensity and frequency of service needed for each individual. ACT teams are expected to achieve fidelity with the DACTS Model. To achieve a score of "4" in the Frequency of Contact Measure within DACTS, ACT Teams must provide a median of 3-3.99 face-to-face contacts per week across a sample of agency's ACT individuals (“minimum contact” no longer expected effective 5/1/13). This measure is calculated by determining the median of the average weekly face-to-face contacts of each individual in the sample. At least one of these monthly contacts must include symptom assessment/management and management of medications. 7. During discharge transition, the number of face-to-face visits per week will be determined based on the person's mental health acuity with the expectation that these individuals participating in ACT transitioning must receive a minimum of 4 face-to-face contacts per month during the active transition period. 8. Service may be delivered by a single team member to 2 ACT individuals at the same time if their goals are compatible, however, this cannot be a standard practice. Services cannot be offered to more than 2 individuals at a time (exception: Item A.8.). 9. ACT recipients can receive limited Group Training/Counseling (up to 20 units/week) when a curriculum-based therapeutic group is offered such as Dialectical Behavioral Therapy (DBT), Motivational Enhancement, or Integrative Dual Diagnosis Treatment (IDDT). For this to be allowable, the ACT participants must have clinical needs and recovery goals that justify intervention by staff trained in the implementation of the specific curriculum-based therapy. <ol style="list-style-type: none"> a. This group may be offered to no less than 3 individuals and no more than 10 ACT participants at one time (2 practitioner requirement no longer required effective 5/1/13). b. Only ACT enrolled-individuals are permitted to attend these group services. c. Acceptable group practitioners are those on the ACT team who meet the practitioner levels as follows: <ul style="list-style-type: none"> • Practitioner Level 1: Physician/Psychiatrist • Practitioner Level 2: Psychologist, CNS-PMH

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	<ul style="list-style-type: none"> • Practitioner Level 3: LCSW, LPC, LMFT, RN • Practitioner Level 4: LMSW; APC; AMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology (may only perform these functions related to treatment of addictive diseases). • Practitioner Level 5: CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent (practitioners at this level may only perform these functions related to treatment of addictive diseases). <p>d. Ideally, 50% of individuals with co-occurring substance use disorders will participate in a substance abuse group once per month with their ACT provider. If there are 2 practitioners leading the group who are the same practitioner level (i.e. two U3 practitioners), then each may split the responsibility for documentation and singly sign a note. In this situation, there must be evidence in the note of who was the co-leader of that group to document the compliance expectations for two practitioners.</p> <p>e. If a group is facilitated by two practitioners who are not the same U-level (i.e. one is a U3 and one is a U4), then these co-leaders may split the responsibility for documenting group progress notes. If the lower-leveled practitioner writes the progress note, the upper level person's practitioner level can be billed if the higher practitioner-leveled person co-signs the note. If the higher level practitioner writes the note, then he/she shall document the co-leaders participation and can solely sign that note.</p> <p>f. There is no penalty to a provider for using the "in-clinic" code when a group is provided in a community-based setting, as there is no code currently available to document "out-of-clinic" groups (effective 5/1/13).</p>
Staffing Requirements	<p>1. Assertive Community Treatment Team members must include:</p> <ul style="list-style-type: none"> ○ (1 FT Employee required) A fulltime Team Leader who is the clinical and administrative supervisor of the team and also functions as a practicing clinician on the team; this individual must have at least 2 years of documented experience working with adults with a SPMI and one of the following qualifications to be an "independently licensed practitioner." It is expected that the practicing ACT Team Leader provides direct services at least 50% of the time. The Team Leader must be a FT employee and dedicated to only the ACT team. <ul style="list-style-type: none"> ▪ Physician ▪ Psychologist ▪ Physician's Assistant ▪ APRN ▪ RN with a 4-year BSN ▪ LCSW ▪ LPC ▪ LMFT ▪ One of the following as long as the practitioner below is under supervision in accordance with O.C.G.A. § 43-10A-11: <ul style="list-style-type: none"> ○ LMSW* ○ APC* ○ AMFT* ○ (Variable: 4-1.0 FTE required) Depending on individual enrollment, a full or part time Psychiatrist who: <ul style="list-style-type: none"> ▪ provides clinical and crisis services to all team consumers; ▪ delivers services in the recipient's natural environment when the individual is unable or unwilling to access a traditional service setting (this allowance is only for psychiatrists. Also, adherence to the 80% of the entire team's services provided in non-office settings requirement above is still maintained),

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- works with the team leader to monitor each individual's clinical and medical status and response to treatment, and
- directs psychopharmacologic and medical treatment (at a minimum, must provide monthly medication management for each individual),
- must provide a minimum of 16 hours per week of direct support to the ACT team/ACT consumers
- the psychiatrist must participate in at least one time/week in the ACT team meetings
- The psychiatrist to ACT individual ratio must not be greater than 1:100. Specifically:
 - With 1-50 consumers, the requirement for the ACT team is to employ a Psychiatrist minimally .35-.5 FTE (14 hrs./wk-20 hrs./wk) providing support to the team and;
 - With 51-65 consumers, the requirement for the ACT team is to employ a Psychiatrist minimally .36-.65 FTE (14.4 hrs./wk-26 hrs./wk) providing support to the team and;
 - With 66-75 consumers, the requirement for the ACT team is to employ a Psychiatrist minimally .47-.75 FTE (18.8 hrs./wk-30 hrs./wk) providing support to the team and;
 - With 76-100 consumers, the requirement for the ACT team is to employ a Psychiatrist minimally .54 FTE-1 FTE (21.6 hrs./wk-40 hrs./wk) providing support to the team.
- (1-2 Fulltime Employee/s) RN/s who provide nursing services for all individuals, including health and psychiatric assessments, education on adherence to treatment, prevention of medical issues, rehabilitation, nutritional practices and works with the team to monitor each individual's overall physical health and wellness, clinical status and response to treatment
 - With 1-50 consumers, the requirement for the ACT team is to employ a Registered Nurse minimally .7-1 FTE (28 hrs./wk-40 hrs./wk) providing support to the team and;
 - With 51-65 consumers, the requirement for the ACT team is to employ a Registered Nurse minimally .73 FTE-1.3 FTE (29.2 hrs./wk-52 hrs./wk) providing support to the team and;
 - With 66-75 consumers, the requirement for the ACT team is to employ a Registered Nurse(s) .93 FTE-1.5 FTE (37.2 hrs./wk-60 hrs./wk) providing support to the team and;
 - With 76-100 consumers, the requirement for the ACT team is to employ a Registered Nurse (s) 1.3 FTE -2 FTE (52 hrs./wk-80 hrs./wk providing support to the team.
- A substance abuse practitioner who holds a CACI (or an equally recognized SA certification equivalent or higher) and assesses the need for and provides and/or accesses substance abuse treatment and supports for team consumers.
 - With 1-50 consumers, the requirement for the ACT team is to employ a SA practitioner minimally .7-1 FTE (28 hrs./wk-40 hrs./wk) providing support to the team and;
 - With 51-65 consumers, the requirement for the ACT team is to employ a SA practitioner minimally .73 FTE-1.3 FTE (29.2 hrs./wk-52 hrs./wk) providing support to the team and;
 - With 66-75 consumers, the requirement for the ACT team is to employ a SA practitioner .93 FTE-1.5 FTE (37.2 hrs./wk-60 hrs./wk) providing support to the team and;
 - With 76-100 consumers, the requirement for the ACT team is to employ a SA practitioner 1.3 FTE -2 FTE (52 hrs./wk-80 hrs./wk providing support to the team.
- (1 FT employee) A full-time practitioner licensed to provide psychotherapy/counseling under the practice acts or a person with an associate license who is supervised by a fully licensed clinician, and provides individual and group support to team consumers (this position is in addition to the Team Leader).
- (1 FTE) One FTE Certified Peer Specialist who is fully integrated into the team and promotes individual self-determination and decision-making and provides essential expertise and consultation to the entire team to promote a culture in which each client's point of view and preferences are recognized, understood, respected and integrated into treatment, rehabilitation and community self-help activities. CPSs must be supervised by an independently licensed/credentialed practitioner on the team.
- (2 FTEs) Two paraprofessional mental health workers who provide rehabilitation and support services under the supervision of a Licensed Clinician. The sum of

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	<p>the FTE counts for the following two bullets must equal 2 FTEs.</p> <ul style="list-style-type: none"> ○ (1 FTE) One of these staff must be a Vocational Rehabilitation Specialist. A VRS is a person with a minimum of one year verifiable vocational rehabilitation training and/or experience. ○ (1 FTE) Other Paraprofessional <ol style="list-style-type: none"> 2. It is critical that ACT team members build a sound relationship with and fully engage in supporting the served individuals. To that end, no more than 1/3 of the team can be "contracted"/1099 team members. 3. The ACT team maintains a small consumer-to-clinician ratio, of no more than 10 individuals per staff member. This does not include the psychiatrist, program assistant/s, transportation staff, or administrative personnel. Staff-to-individual ratio takes into consideration evening and weekend hours, needs of special populations, and geographical areas to be served. 4. Documentation must demonstrate that multiple members across disciplines from the ACT team are engaged in the support of individuals served by the team including direct and indirect service delivery for each intervention (excluding the substance abuse practitioner, if substance related issues have been ruled out). 5. At least one ACT RN must be employed by an ACT team. The RN works with a team at least 32 hours/week (up to 40 hours/week) and is a full-time employee of the agency (not a subcontractor/1099 employee).
Clinical Operations	<ol style="list-style-type: none"> 1. Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. 2. ACT Teams must incorporate assertive engagement techniques to identify, engage, and retain the most difficult to engage individuals which include using street outreach approaches and legal mechanisms such as outpatient commitment and collaboration with parole and probation officers. 3. Because ACT-eligible individuals may be difficult to engage, the initial treatment/recovery plan for an individual may be more generic at the onset of treatment/support. It is expected that the treatment plan be individualized and recovery-oriented after the team becomes engaged with the individual and comes to know the individual. The allowance for "generic" content of the IRP shall not extend beyond one initial authorization period. 4. Because many individuals served may have a mental illness and co-occurring addiction disorder, the ACT team may not discontinue services to any individual based solely upon a relapse in his/her addiction recovery. 5. Each ACT provider must have policies and procedures governing the provision of outreach services, including methods for protecting the safety of staff that engage in outreach activities. 6. The organization must have established procedures/protocols for handling emergency and crisis situations that describe methods for supporting and handling individuals who require psychiatric hospitalization and/or crisis stabilization. 7. The organization must have an Assertive Community Treatment Organizational Plan that addresses the following descriptions: <ol style="list-style-type: none"> a. Particular rehabilitation, recovery and resource coordination models utilized, types of intervention practiced, and typical daily schedule for staff b. Staffing pattern and how staff are deployed to assure that the required staff-to-individual ratios are maintained, including how unplanned staff absences, illnesses, and emergencies are accommodated c. Hours of operation, the staff assigned, and types of services provided to individuals, families, and/or guardians d. How the plan for services is modified or adjusted to meet the needs specified in the Individualized Recovery Plan e. Inter-team communication plan regarding individual support (e.g., e-mail, team staffings, staff safety plan such as check-in protocols etc.) f. A physical health management plan g. How the organization will integrate individuals into the community including assisting individuals in preparing for employment h. How the organization (team) will respond to crisis for individuals served. 8. The ACT team is expected to work with informal support systems at least 2 to 4 times a month with or without the individual present to provide support and skill training as necessary to assist the individual in his or her recovery (i.e., family, landlord, employers, probation officers). Monthly maximum billing for informal support contacts without an individual being present shall not exceed 4 hours. 9. For the individuals which the ACT team supports, the ACT team must be involved in all hospital admissions and hospital discharges. The agency will be reviewed for fidelity by the standard that the ACT team will be involved with 95% of all hospital admissions and hospital discharges. This is evidenced by documentation in the clinical record. 10. The entire ACT team is responsible for completing the ACT Comprehensive Assessment for newly enrolled individuals. The ACT Comprehensive Assessment results

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from the information gathered and are used to establish immediate and longer-term service needs with each individual and to set goals and develop the first individualized recovery plan. Because of the complexity of the mental illness and the need to build trust with the served individual, the comprehensive mental health, addiction, and functional assessments may take up to 60 days. Enrolled individuals will be re-assessed at 6 month intervals from date of completion of the comprehensive assessment. It is expected that when a person identifies and allows his/her natural supports to be partners in recovery that they will be fully involved in assessment activities and ACT team documentation will demonstrate this participation. The ACT Comprehensive Assessment shall (at a minimum) include:

- a. Psychiatric History, Mental Status/Diagnosis
- b. Physical Health
- c. Substance Abuse assessment
- d. Education and Employment
- e. Social Development and Functioning
- f. Family Structure and Relationships

11. Treatment and recovery support to the individual is provided in accordance with a Recovery Plan. Treatment and recovery planning shall be in accordance with the following:
 - a. The Individual Treatment Team (ITT) is responsible for providing much of the individual's treatment, rehabilitation, and support services and is charged with the development and continued adaptation of the person's recovery plan (along with that person as an active participant). The ITT is a group or combination of three to five ACT staff members who together have a range of clinical and rehabilitation skills and expertise. The ITT members are assigned by the team leader to work collaboratively with an individual and his/her family and/or natural supports in the community by the time of the first treatment planning meeting or thirty days after admission. The core members are the primary practitioner and at least one clinical or rehabilitation staff person who shares case coordination and service provision tasks for each individual. ITT members are assigned to take separate service roles with the individual as specified by the individual and the ITT in the treatment plan.
 - b. The Treatment Plan Review is a thorough, written summary describing the individual's and the ITT's evaluation of the individual's progress/goal attainment, the effectiveness of the interventions, and satisfaction with services since the last person-centered treatment plan.
 - c. Treatment Planning Meeting is a regularly scheduled meeting conducted under the supervision of the team leader and the psychiatric prescriber. The purpose of these meetings is for the staff, as a team, and the individual and his/her family/natural supports, to thoroughly prepare for their work together. The group meets together to present and integrate the information collected through assessment in order to learn as much as possible about the individual's life, his/her experience with mental illness, and the type and effectiveness of the past treatment they have received. The presentations and discussions at these meetings make it possible for all staff to be familiar with each individual and his/her goals and aspirations and for each individual to become familiar with each ITT staff person. The treatment plan shall be reevaluated and adjusted accordingly (at least quarterly) via the Treatment Planning Meeting prior to each reauthorization of service (Documentation is guided by elements G.2. and G.3. below).
12. In order to maintain compliance with the DACTS fidelity model, each ACT team may enroll a maximum of 8 individual admissions per month. Allowing teams to meet and maintain the expectation of an active average daily census of 75 individuals.
13. It is expected that 90% or more of the individuals have face to face contact with more than one staff member in a 2 week period.

Service Accessibility

1. Services must be available by ACT Team staff skilled in crisis intervention 24 hours a day, 7 days a week with emergency response coverage, including psychiatric services. Answering devices/services/Georgia Crisis and Access Line do not meet the expectation of "emergency response."
2. The team must be able to rapidly respond to early signs of relapse and decompensation and must have the capability of providing multiple contacts daily to individuals in acute need.
3. An ACT staff member must provide this on-call coverage.
4. There must be documented evidence that service hours of operation include evening, weekend and holiday hours.
5. Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's health. Electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. The ACT Physician may use telemedicine to provide this service by using the code above with the GT modifier. Telemedicine is not to be utilized as the primary means of delivery of psychiatric services for ACT consumers.

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Billing & Reporting Requirements	<ol style="list-style-type: none"> 1. All time spent between 2 or more team practitioners discussing a served individual must be reported as H0039HT. While this claim/encounter is reimbursed at \$0, it is imperative that the team document these encounters (see Documentation Requirements below) to demonstrate program integrity AND submit the claim/encounter for this so this service can be included in future rate setting. 2. The following elements (at a minimum) shall be documented in the clinical record and shall be accessible to the DBHDD monthly as requested: <ul style="list-style-type: none"> • Served individual's employment status; • Served individual's residential status (including homelessness); • Served individual's involvement with criminal justice system/s; • Served individual's interactions with crisis support services (including acute psychiatric hospitals, emergency room visits, crisis stabilization program interactions, etc.). 3. ACT may not be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital or crisis stabilization program with greater than 16 beds), jail, or prison system. 4. The ACT team can provide and bill for Community Transition Planning as outlined in the Guideline for this service. This includes supporting individuals who are eligible for ACT and are transitioning from Jail/Prison. 5. When group services are provided via an ACT team to an enrolled ACT-recipient, then the encounter shall be submitted as a part of the ACT package defined in the Orientation to Services section of Part I, Section 1 of this manual. 6. Each ACT program shall provide monthly outcomes data as defined by the DBHDD. The outcomes form will be submitted by the 10th of every month via ThinkHIE at https://gahie.ehealthobjects.com/thinkhieportal/app/login
Documentation Requirements	<ol style="list-style-type: none"> 1. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section IV of the Provider Manual and in keeping with this section G. 2. All time spent between 2 or more team practitioners discussing a served individual must be documented in the medical record as H0039HT. While this claim/encounter is reimbursed at \$0, it is imperative that the team document these encounters to demonstrate program integrity AND submit the claim/encounter for this so this service can be included in future rate setting. HT documentation parameters include: <ol style="list-style-type: none"> a. If the staff interaction is specific to a single individual for 15 minutes, then the H0039HT code shall be billed to that individual (through claims or encounters). b. If the staff interaction is for multiple individuals served and is for a minimum single 15 minute unit and: <ol style="list-style-type: none"> 1) the majority of time is for a single individual served, then the claim/encounter shall be submitted attached to the individual's name who was the focus of this staffing conversation; or 2) the time is spent discussing multiple individuals (with no one individual being the focus of the time), then the team should create a rotation list (see below) in which a different individual would be selected for each of these staffing notes in order to submit claims and account for this staffing time, and c. An agency is not required to document every staff-to-staff conversation in the individual's medical record; however every attempt should be made to accurately document the time spent in staffing or case conferencing for individual consumers. The exceptions (which shall be documented in a medical record) are: <ul style="list-style-type: none"> • when the staffing conversation modifies an individual's treatment planning or intervention strategy, • when observations are discussed that may lead to treatment or intervention changes, and/or that change the course of treatment 3. The ACT team must have documentation (e.g., notebook, binder, file, etc.) which contains all H0039HT staffing interactions (which shall become a document for audit purposes, and by which claims/encounters can be revoked-even though there are no funds attached). In addition to the requirements in Section G.2.above, a log of staff meetings is required to document staff meetings as outlined in Section A.2. The documentation notebook shall include: <ol style="list-style-type: none"> a. the team's protocol for submission of H0039HT encounters (how the team is accounting for the submissions of H0039HT in accordance with the above); b. the protocol for staffings which occur ad hoc (e.g. team member is remote supporting an individual and calls a clinical supervisor for a consult on support, etc.); c. date of staffing; d. time start/end for the "staffing" interaction; e. if a regular team meeting, names of team participants involved in staffing (signed/certified by the team leader or team lead designee in the absence of the team leader);

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- f. if ad hoc staffing note, names of the team participants involved (signed by any one of the team members who is participating);
 - g. name all of individuals discussed/planned for during staffing;
 - h. minimal documentation of content of discussion specific to each individual (1-2 sentences is sufficient).
4. If the group location is documented in the note as a community-based setting (despite the absence of an "out-of-clinic" code for group reporting), then it will be counted for reviews/audits as an out-of-clinic service (effective 5/1/13).
 5. All expectations set forth in this "Additional Service Components" section shall be documented in the record in a way which demonstrates compliance with the said items.

Community Based Inpatient Psychiatric & Substance Detoxification*

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Psychiatric Health Facility Service, Per Diem		H2013					Per negotiation							
Unit Value	1 day							Maximum Daily Units	1 unit					
Initial Authorization	5 days							Re-Authorization	3 days					
Authorization Period	5 days							Utilization Criteria	<u>LOCUS score:</u> 6: Medically Managed Residential					
Service Definition	A short-term stay in a licensed and accredited community-based hospital for the treatment or habilitation of a psychiatric and/or substance related disorder. Services are of short duration and provide treatment for an acute psychiatric or behavioral episode. This service may also include Medically Managed Inpatient Withdrawal Management at ASAM Level 4-WM.													
Admission Criteria	1. Individual with serious mental illness/SED that is experiencing serious impairment; persistent, recurrent, severe, or major symptoms (such as psychoses); or who is experiencing major suicidal, homicidal or high risk tendencies as a result of the mental illness; or 2. Individual's need is assessed for 24/7 supports which must be one-on-one and may not be met by any service array which is available in the community; or 3. Individual is assessed as meeting diagnostic criteria for a Substance Related Disorder according to the latest version of the DSM; and one or more of the following: A. Individual is experiencing signs of severe withdrawal, or there is evidence (based on history of substance intake, age, gender, previous withdrawal history, present symptoms, physical condition, and/or emotional/behavioral condition) that severe withdrawal syndrome is imminent; or B. Level 4-WM is the only available level of service that can provide the medical support and comfort needed by the individual, as evidenced by: i. A withdrawal management regimen or individual's response to that regimen that requires monitoring or intervention more frequently than hourly, or ii. The individual's need for withdrawal management or stabilization while pregnant, until she can be safely treated in a less intensive service.													
Continuing Stay Criteria	1. Individual continues to meet admission criteria; and 2. Individual's withdrawal signs and symptoms are not sufficiently resolved to the extent that they can be safely managed in less intensive services;													
Discharge Criteria	1. An adequate continuing care plan has been established; and one or more of the following: 2. Individual no longer meets admission and continued stay criteria; or 3. Individual requests discharge and individual is not imminently dangerous to self or others; or 4. Transfer to another service/level of care is warranted by change in the individual's condition; or 5. Individual requires services not available in this level of care.													

Service Exclusions	This service may not be provided simultaneously to any other service in the service array excepting short-term access to services that provide continuity of care or support planning for discharge from this service.
Clinical Exclusions	Individuals with any of the following unless there is clearly documented evidence of an acute psychiatric/addiction episode overlaying the primary diagnosis: Autism, Developmental Disabilities, Organic Mental Disorder; or Traumatic Brain Injury
Required Components	1. This service must be licensed by DCH/HFR under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2 2. A physician's order in the individual's record is required to initiate withdrawal management services. Verbal orders or those initiated by a Physician's Assistant or Clinical Nurse Specialist are acceptable provided the physician signs them within 24 hours or the next working day.
Staffing Requirements	Withdrawal management services must be provided only by nursing or other licensed medical staff under supervision of a physician.

Community Support Team														
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Community Support Team	Practitioner Level 3, In-Clinic	H0039	TN	U3	U6		\$30.01	Practitioner Level 3, Out-of-Clinic	H0039	TN	U3	U7		\$36.68
	Practitioner Level 4, In-Clinic	H0039	TN	U4	U6		\$20.30	Practitioner Level 4, Out-of-Clinic	H0039	TN	U4	U7		\$24.36
	Practitioner Level 5, In-Clinic	H0039	TN	U5	U6		\$15.13	Practitioner Level 5, Out-of-Clinic	H0039	TN	U5	U7		\$18.15
Unit Value	15 minutes							Maximum Daily Units	60 units					
Initial Authorization	400 units							Re-Authorization	400 units					
Authorization Period	180 days							Utilization Criteria	LOCUS scores: 3-6					
Service Definition	<p>Community Support Team (CST) is an intensive behavioral health service for individuals with severe mental illness living in rural areas of the State who are discharged from a hospital after multiple or extended stays or from multiple discharges from crisis stabilization unit(s), or discharged from correctional facilities or other institutional settings, or those leaving institutions who are difficult to engage in treatment. This service utilizes a mental health team led by a licensed clinician to support individuals in decreasing hospitalizations, incarcerations, emergency room visits, and crisis episodes and increasing community tenure/independent functioning; increasing time working or with social contacts; and increasing personal satisfaction and autonomy. Through active assistance and based on identified, individualized needs, the individual will be engaged in the recovery process.</p> <p>CST is a restorative/recovery focused intervention to assist individuals with:</p> <ol style="list-style-type: none"> 1. Gaining access to necessary services; 2. Managing (including teaching skills to self-manage) their psychiatric and, if indicated, co-occurring addictive and physical diseases; 3. Developing optimal independent community living skills; 4. Achieving a stable living arrangement (independently or supported); and 5. Setting and attaining individual-defined recovery goals. <p>CST elements and interventions (as medically necessary) include:</p> <ol style="list-style-type: none"> 1. Comprehensive behavioral health assessment; 2. Nursing services; 3. Symptom assessment/management; 4. Medication management/monitoring; 5. Medication Administration 													

	<ol style="list-style-type: none"> 6. Linkage to services and resources including rehabilitation/recovery services, medical services, wellness and nutrition supports, general entitlement benefits; 7. Care Coordination 8. Individual Counseling 9. Psychosocial Rehabilitation-Individual for skills training including: <ol style="list-style-type: none"> a. Daily living skills training; b. Illness self-management training; c. Problem-solving, social, interpersonal, and communication skills training; 10. Relapse prevention skills training and substance abuse recovery support; 11. Development of personal support networks; 12. Crisis planning and, if necessary, crisis intervention services; 13. Consultation and psycho-educational support for the individual and his/her family/natural supporters (if this family interaction is endorsed by the individual served).
Admission Criteria	<ol style="list-style-type: none"> 1. Individual with a severe and persistent mental illness that seriously interferes with their ability to live in the community as evidenced by: <ol style="list-style-type: none"> a. transitioning or recently discharged (i.e., within past 6 months) from an institutional setting because of psychiatric issue; or b. frequently admitted to a psychiatric inpatient facility (i.e. 3 or more times within past 12 months) or crisis stabilization unit for psychiatric stabilization and/or treatment; or c. chronically homeless due to a psychiatric issue (i.e. continuously homeless for a year or more, or 4 episodes of homelessness within past 3 years); or d. recently released from jail or prison (i.e. within past 6 months); or e. frequently seen in the emergency room for behavioral health needs (i.e. 3 or more times within past 12 months); or f. having a "forensic status" and the relevant court has found that aggressive community services are appropriate; <p style="text-align: center;">and</p> 2. Individual with significant functional impairments as demonstrated by the inability to consistently engage in at least two (2) of the following: <ol style="list-style-type: none"> a. Maintaining personal hygiene; b. Meeting nutritional needs; c. Caring for personal business affairs; d. Obtaining medical, legal, and housing services; e. Recognizing and avoiding common dangers or hazards to self and possessions; f. Performing daily living tasks except with significant support or assistance from others such as friends, family, or other relatives; g. Employment at a self-sustaining level or consistently performing homemaker roles (e.g., household meal preparation, washing clothes, budgeting, or childcare tasks and responsibilities); h. Maintaining a safe living situation (e.g., evicted from housing, or recent loss of housing, or imminent risk of loss of housing); <p style="text-align: center;">and</p> 3. Individual with one (1) or more of the following as indicators of continuous high-service needs (i.e., greater than 8 hours of service per month): <ol style="list-style-type: none"> a. High use of acute psychiatric hospitals or crisis/emergency services including mobile, in-clinic or crisis residential (e.g., 3 or more admission per year) or extended hospital stay (60 days within the past year) or psychiatric emergency services. b. Persistent, recurrent, severe, or major symptoms (e.g., affective, psychotic, suicidal). c. Coexisting substance use disorder of significant duration (e.g., greater than 6 months) or co-diagnosis of substance abuse (ASAM Levels I, II.1, II.5, III.3, III.5). d. High risk or a history of criminal justice involvement (e.g., arrest and incarceration). e. Chronically homeless defined as a) continuously homeless for one full year; OR b) having at least four (4) episodes of homelessness within the past three (3) years. f. Residing in an inpatient bed or in a supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement if more intensive services are not available. g. Inability to participate in traditional clinic-based services;

	<p style="text-align: center;">and</p> <p>4. A lower level of service/support has been tried or considered and found inappropriate at this time.</p>
Continuing Stay Criteria	<p>1. Individual continues to have a documented need for a CST intervention at least four (4) times monthly such as to maintain newly established housing stability (within past 6 months), improved community functioning and/or self-care and illness self-management skills (such as attending scheduled appointments and taking medications as prescribed without significant prompting, using crisis plan as needed, accessing community resources as needed most of the time).</p> <p style="text-align: center;">and</p> <p>2. Individual continues to meet the admission criteria above; or</p> <p>3. Individual has continued difficulty participating in traditional clinic-based services or a community setting at a less intensive level of service/supports; or</p> <p>4. Individual is in substandard housing, homeless, or at imminent risk of becoming homeless due to functional impairments associated with behavioral health issues.</p>
Discharge Criteria	<p>1. There has been a planned reduction of units of service delivered and related evidence of the individual sustaining functioning through the reduction plan; and</p> <p>2. An adequate continuing care plan has been established; and one (1) or more of the following:</p> <ol style="list-style-type: none"> a. Individual no longer meets admission criteria; or b. Goals of the Individualized Recovery Plan have been substantially met; or c. Individual requests discharge and is not in imminent danger of harm to self or others, or d. Transfer to another service/level of care is warranted by a change in individual's condition, or e. Individual requires services not available in this level of care.
Service Exclusions	<p>1. It is expected that the CST attempt to engage the individual in other rehabilitation and recovery-oriented services such as Housing Supports, Residential Services, group-oriented Peer Supports, group-oriented Psychosocial Rehabilitation, Supported Employment, etc.; however, ACT, Nursing Assessment, ICM and CM are Service Exclusions. Individuals may receive CST and one of these services for a limited period of time to facilitate a smooth transition.</p>
Clinical Exclusions	<p>Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, substance-related disorder.</p>
Required Components	<ol style="list-style-type: none"> 1. Team meetings must be held a minimum of once a week and time dedicated to discussion of support and service to individuals must be documented in the Treatment Team Meetings log. Each individual must be discussed, even if briefly, at least one time monthly. CST staff members are expected to attend Treatment Team Meetings. 2. Services and interventions must be individually tailored to the needs, goals, preferences and assets of the individual with the goals of maximizing independence and recovery as defined by the individual. 3. At least 60% of all service units must involve face-to-face contact with individuals. The majority of face-to-face service units must be provided outside of program offices in locations that are comfortable and convenient for individuals (including the individual's home, based on individual need and preference and clinical appropriateness). 4. A median of 4 face-to-face visits must be delivered <u>monthly</u> by the CST as measured quarterly. Additional contacts above the monthly minimum may be either face-to-face or telephone collateral contact depending on the individual's support needs. 5. CST is expected to retain a high percentage of enrolled individuals in services with few drop-outs. In the event that the CST documents multiple attempts to locate and make contact with an individual and has demonstrated diligent search, after 60 days of unsuccessful attempts the individual may be discharged due to drop out. 6. While the minimum percentage of contacts is stated above, individual clinical need is always to be met and may require a level of service higher than the established minimum criteria for contact. CST teams will provide the clinically required level of service in order to achieve and maintain desired outcomes.
Staffing Requirements	<ol style="list-style-type: none"> 1. A CST shall have a minimum of 3.5 team members which must include: <ul style="list-style-type: none"> o (1 FTE) A fulltime dedicated Team Leader ("Dedicated" means that the team leader works with only one team at least 32 hours and up to 40 hours/week) who is a licensed clinician (LPC, LCSW, LMFT) and provides clinical and administrative supervision of the team. The team lead shall not supervise more than 4 team members. This individual must have at least 4 years of documented experience working with adults with a SPMI and preferably certified/credentialed addiction counselor/s (CAC), the TL is responsible for working with the team to monitor each individual's physical health, clinical status and response to treatment. o (1 FTE) A fulltime or two half-time (.5 FTE) Certified Peer Specialist (s) who is/are fully integrated into the team and promotes individual self-determination and decision-making and provides essential expertise and consultation to the entire team to promote a culture in which each client's point of view and preferences are

	<p>recognized, understood, respected and integrated into treatment, rehabilitation, medical, and community self-help activities. Registered nurses may be clinic based with provision of community-based/in-home services as needed.</p> <ul style="list-style-type: none"> o (.5 FTE) A half-time registered nurse (RN). This person will provide nursing care, health evaluation/reevaluation, and medication administration and will make referrals as medically necessary to psychiatric and other medical services. Registered nurses may be clinic based with provision of community-based/ in the home services as needed o (1 FTE) A fulltime Paraprofessional level team member, minimally BA level, preferably with certified/credentialed addiction counselor/s (CAC) <ol style="list-style-type: none"> 2. CST is a service that is provided in rural areas, in areas with less consumer demand, and/or in areas with professional workforce shortages that make a full ACT team not feasible. As such, the staffing requirements are adjusted accordingly and the rates that are paid are consistent with the practitioner level and location of service as with other out-of-clinic services. 3. The CST maintains a small individual-to-staff ratio, with a minimum of 10 individuals served per full time staff member (10:1) and a maximum of 20 individuals served per staff member (20:1), yielding a 3-person team's minimum capacity of 30 and a team maximum capacity of 60. The Individual-to-staff ratio range should consider evening and weekend hours, needs of the target population, and geographical areas to be served. 4. Nursing face-to-face contact with each individual served by the team is determined based on the IRP, physician assessment, and is delivered at a frequency that is clinically and/or medically indicated.
Clinical Operations	<ol style="list-style-type: none"> 1. CST must incorporate assertive engagement techniques to identify, locate, engage, and retain the most difficult to engage individuals who cycle in and out of intensive services. CST must demonstrate the implementation of well thought out engagement strategies to minimize discharges due to drop out including the use of street and shelter outreach approaches, legal mechanisms such as outpatient commitment (when clinically indicated), and collaboration with family, friends, parole and/or probation officers. 2. CST is expected to gather assessment information from internal or external provider sources on existing individuals in order to identify the individual's strengths, needs, abilities, resources, and preferences. CST Team Lead may complete a comprehensive behavioral health assessment on new individuals as well as ongoing assessments to ensure meeting the individual's changing needs or circumstances. When a comprehensive behavioral health assessment is conducted by the CST Team Lead, it may be billed as CST (see Billing & Reporting Requirements below). 3. CST is expected to assertively participate in transitional planning, coordinating, and accessing services and resources when an enrolled individual is being discharged from a psychiatric hospital; released from jail; or experiencing an episode of homelessness. A CST provider must also be a Core Provider and may use Community Transition Planning to establish a connection or reconnection to the individual while in a state operated hospital, crisis stabilization unit, jail/prison, or other community psychiatric hospital, and participate in discharge planning meetings. 4. Because CST-eligible individuals may be difficult to engage, the initial treatment/recovery plan for an individual may be more generic at the onset of treatment/support. It is expected that the treatment plan be individualized and recovery-oriented after the team becomes engaged with the individual and comes to know the individual. The allowance for "generic" content of the IRP shall not extend beyond one initial authorization period. 5. Because of the complexity of the target population, it is expected that the individual served will receive ongoing physician assessment and treatment as well as other recovery-supporting services. These services may be provided by a Core Provider agency or by an external agency. There shall be documentation during each Authorization Period to demonstrate the team's efforts at consulting and collaborating with the physician and other recovery-supporting services. 6. CST will assist all eligible individuals with the application process to obtain entitlement benefits including SSI/SSDI, Food Stamps, VA, Medicaid, etc. including making appointments, completing applications and related paperwork. 7. Because many individuals served may have a mental illness and co-occurring addiction disorder, the CST team may not discontinue services to any individual based solely upon a relapse in his/her addiction recovery. 8. CST must be designed to deliver services in various environments, such as homes, schools, homeless shelters, and street locations. The provider should keep in mind that individuals may prefer to meet staff at community locations other than their homes or other conspicuous locations (e.g. their place of employment or school), especially if staff drive a vehicle that is clearly marked as a state or agency vehicle, or if staff must identify themselves and their purpose to gain access to the individual in a way that may potentially embarrass the individual or breach the individual's privacy/confidentiality. Staff should be sensitive to and respectful of individuals' privacy/confidentiality rights and preferences in this regard to the greatest extent possible (e.g. if staff meet with an individual during their work hours, mutually agree upon a meeting place nearby that is the least conspicuous from the individual's point of view). 9. The CST Crisis Plan must include a clear comprehensive approach for provision of 24/7 crisis response and emergency management of crisis situation that may occur

	<p>after regular business hours, and on weekends, and holidays. The Crisis Plan should demonstrate a supportive linkage and connection between the organization and CST. A CST will ensure coordination with the Core services provider, or if non-Core the clinical home service provider, in all aspects of the treatment plan.</p> <p>10. The CST agency must have established procedures that support the individual in preventing admission into psychiatric hospitalization/crisis stabilization. There shall be evidence that these procedures are utilized in the support of the individual when a crisis situation occurs.</p> <p>11. Using the information collected through assessments, the CST staff work in partnership with the individual's core provider, specialty provider, residential provider, primary care physician, and other identified supports to develop a Wellness Recovery Action Plan (WRAP) that meets the medical, behavioral, wellness, social, educational, vocational, co-occurring, housing, financial, and other service needs of the eligible individual.</p> <p>12. The organization must have an CST Organizational Plan that addresses the following:</p> <ol style="list-style-type: none"> Particular rehabilitation, recovery and resource coordination models utilized, types of intervention practiced, and typical daily schedule for staff; Organizational Chart, Staffing pattern, and a description of how staff are deployed to assure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences, illnesses, and emergencies are accommodated; Hours of operation, the staff assigned, and types of services provided to individuals, families, and/or guardians; How the plan for services is modified or adjusted to meet the needs specified in the Individualized Recovery Plan; Mechanisms to assure the individual has access to methods of transportation that support their ability engage in treatment, rehabilitation, medical, daily living and community self-help activities. Transportation is not a reimbursed element of this service; Intra-team communication plan regarding individual support (e.g., e-mail, team staffings, staff safety plan such as check-in protocols etc.); The team's approach to monitoring an individual's medical and other health issues and to engaging with health entities to support health/wellness; How the organization will integrate individuals into the community including assisting individual in preparing for employment.
Service Accessibility	<ol style="list-style-type: none"> Services must be available 24 hours a day, 7 days a week with emergency response coverage. Answering devices/services/Georgia Crisis and Access Line do not meet the expectation of "emergency response". There must be documented evidence that service hours of operation include evening, weekend and holiday hours. At the time of provider application, the DBHDD will determine, through its Provider Enrollment process, the current need for a CST team in a given area based upon a review of relevant information including, but not limited to available tools such as utilization data for existing services, Metropolitan Statistical Areas (MSA) maps, Mental Health Professional Shortage Area maps, State of Georgia Office of Rural Health maps, and/or data from the most current version of the Georgia County Guide.
Billing & Reporting Requirements	While a comprehensive assessment is clinically recommended to be provided as an integral part of CST, the provision and billing of Behavioral Health Assessment is also allowed by a non-CST practitioner in certain circumstances (such as assessment by a specialty practitioner for trauma, addiction, etc.; person presents in crisis and requires immediate assessment, etc.).

Crisis Respite Apartments

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Crisis Respite Service	Crisis Respite	H0045	HE				
Unit Value	1 day				Maximum Length of Stay		30 days
Initial Authorization	20 days				Re-Authorization		20 days
Authorization Period	20 days				Utilization Criteria		LOCUS scores: 4-5

Crisis Respite Apartments

Service Definition	The service offers crisis respite for an individual who needs a supportive environment (1) when transitioning back into the community from a psychiatric inpatient facility, Crisis Stabilization Unit (CSU), or 23 hour observation area; or 2) when preventing an admission or readmission into a psychiatric inpatient facility, CSU, or 23 hour observation area and can be safely served in a voluntary community-based setting. Crisis Respite services include individualized engagement, crisis planning, linkage to treatment and other community resources necessary for the individual to safely reside in the community, and transportation assistance when needed to access appropriate levels of care. A typical period of crisis respite is 14 days or less but may be provided for up to 30 consecutive days.
Admission Criteria	<ol style="list-style-type: none"> 1. Individual with a severe and persistent mental illness that seriously interferes with their ability to live in the community <u>and</u> at least one of the below: <ol style="list-style-type: none"> a. transitioning or recently discharged from a psychiatric inpatient setting; or b. frequently admitted to a psychiatric inpatient facility or crisis stabilization unit (e.g., 3 or more admissions within past 12 months or extended hospital stay of 60 days within past 12 months); or c. chronically homeless (e.g., 1 extended episode of homelessness for one year, or 4 episodes of homelessness with 3 years, ; or d. recently released from jail or prison; or e. frequently seen in emergency rooms for behavioral health needs (e.g., 3 or more visits within past 12 months). 2. Individual is free of medical issues that require daily nursing or physician care; and 3. Individual (does not demonstrate danger to self or others) is able to safely remain in an open, community-based placement; and 4. Individual demonstrates need for short-term crisis support which could delay or prevent the need for higher levels of service intensity (such as acute hospitalization); and/or 5. Individual has a circumstance which destabilizes their current living arrangement and the provision of this service would provide short-term crisis relief and support.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual continues to meet admission criteria as defined above; and 2. Individual has a Recovery goal to develop natural supports, but needs assistance implementing natural supports to assist in illness self-management; and 3. Individual demonstrates progress towards recovery goal and crisis resolution, however continues to have documented need for this service.
Discharge Criteria	<ol style="list-style-type: none"> 1. Individual requests discharge; or 2. Individual's medical necessity indicates a need for an alternate level of care; or 3. Individual has received two consecutive episodes of care authorization; met the maximum length of stay of 30 consecutive days.
Service Exclusions	Intensive, Semi-Independent, and Independent Residential Services. Crisis stabilization unit services, community based in-patient
Clinical Exclusions	<ol style="list-style-type: none"> 1. Individuals experiencing a medical crisis are excluded from admission. 2. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition co-occurring with a diagnosis of Mental retardation; and/or Autism; and/or Organic mental disorder; and/or Traumatic brain injury. 3. Danger to self or others.
Required Components	<ol style="list-style-type: none"> 1. Each provider must have a defined standardized admission process which is shared with other referring agencies. 2. Crisis Respite services must be available daily including evening and weekend hours. 3. Agency must have a 24/7 Staffing Plan that includes on-call coverage with a response time of 30 minutes such that the ability to respond to individuals in crisis is provided. 4. At least one (1) face-to-face contact daily with each individual receiving Crisis Respite service. 5. Crisis Plan development to formulate and implement a crisis response. 6. To meet basic boarding expectation which includes clean linens/towels, the provision of 3 nutritious meals per day and nutritional snacks, access to laundry facilities, cleaning, and transportation assistance to access treatment and care. 7. Single person per room but if shared bedroom must be gender specific with dividing partition or wing wall allowing for privacy. Bedrooms utilized for more than one person shall have a minimum of 60- sq. ft. per individual, a single room shall not be less than 100 sq. ft. 8. Shower/bathing facility shall be provided, not requiring access through another individual's bedroom.

Crisis Respite Apartments

Staffing Requirements	<ol style="list-style-type: none"> 1. The following practitioners may provide Crisis Respite Services: <ul style="list-style-type: none"> • Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 4 rate) • Practitioner Level 2: Psychologist, APRN, PA (reimbursed at Level 4 rate) • Practitioner Level 3: LCSW, LPC, LMFT, RN (reimbursed at Level 4 rate) • Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); CPS, PP, CPRP, CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology • Practitioner Level 5: CPS; PP; CPRP; or, when an individual served is co-occurring diagnosed with a mental illness and addiction issue CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent under supervision of one of the licensed/credentialed professionals above. 2. When provided by one of the practitioners cited below, must be under the documented supervision (organizational charts, supervisory notation, etc.) of an independently licensed/credentialed professionals: <ul style="list-style-type: none"> • Certified Peer Specialists • Paraprofessional staff • Certified Psychiatric Rehabilitation Professional • Certified Addiction Counselor-I • Registered Alcohol and Drug Technician (I,II, or III)k • Addiction Counselor Trainee 3. Specific staffing requirements for each service provider are dependent upon how the service is integrated into an existing community-based service array and the providers' proposal for delivering the service. These requirements will be outlined in the provider-specific contracts and annexes.
Clinical Operations	<ol style="list-style-type: none"> 1. Not to exceed up to six (6) Crisis Respite beds located in a single integrated community setting. 2. Crisis Respite is not accessible to individuals by walk-ins and there is no signage identifying the nature of this service. All individuals receiving Crisis Respite Services must come through a referring agency such as a Core Provider, hospital, CSU, 23 hour observation area, emergency room, etc... Crisis Respite is not an emergency receiving facility and shall not receive individuals under emergency conditions. Any individual who presents under emergency conditions (1013) should be directed to a local emergency receiving facility. 3. Agency has a Crisis Respite Service Organizational Plan that addresses the following: <ol style="list-style-type: none"> a. Description of the staffing pattern and how staff are deployed to assure that the required staff-to-individual ratios are maintained, including how unplanned staff absences, illnesses, or emergencies are accommodated, case mix, access, etc.; b. Description of the hours of operations as related to access and availability to the individuals served; c. Description of how the IRP? plan constructed, modified and/or adjusted to meet the needs of the individual and to facilitate broad natural and formal support participation; and d. Description of how Crisis Respite Service agency engages with other agencies who may serve the target population. e. Description of protocol to secure client personal items including medications. 4. For the individual connected to a behavioral health provider, the Crisis Respite staff shall engage the behavioral health agency to facilitate crisis resolution while meeting treatment and medication needs during brief respite period. 5. For the individual not connected to a behavioral health provider, the Crisis Respite staff shall engage and link that individual to behavioral health services upon admission. 6. Every individual will be assisted in developing a crisis plan at the time of admission or the individual's existing crisis plan will be reviewed in concert with existing behavioral health provider and updated as needed. 7. Expectation of privacy, no signage to indicate the presence of a behavioral health service.

Crisis Respite Apartments

Service Accessibility	<ol style="list-style-type: none"> 1. Referrals must be accepted daily between the hours of 9 am and 5 pm. When vacancies exist, referrals and admissions must be accepted 7 days per week. 2. Each provider is responsible for establishing a system with priority referral sources (hospitals, CSUs, Temporary Observation units, emergency rooms, Mobile Crisis Team) and the DBHDD through which the status of bed availability is accessible to referral sources 24 hours per day. This may be through a website or automated phone greeting. 3. A maximum of 30 days may be provided to a single individual in a single episode of care.
Reporting and Billing Requirements	All applicable MICP and DBHDD reporting requirements must be met.
Additional Medicaid Requirements	Not a Medicaid-billable service.

Crisis Service Center

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Crisis Service Center	Crisis Service Center (CSC)	S9484					
Unit Value	1 day (contact)	Maximum Daily Units	1 unit				
Initial Authorization	7 Units	Re-Authorization	N/A				
Authorization Period	7 Days	Utilization Criteria	Available to those with LOCUS scores: 1-6				
Service Definition	<p>A Crisis Service Center (CSC) provides short-term, 24/7, facility-based, walk-in psychiatric/substance related crisis evaluation and brief intervention services to support an individual who is experiencing an abrupt and substantial change in behavior noted by severe impairment of functioning typically associated with a precipitating situation or a marked increase in personal distress. These services also include screening and referral for appropriate outpatient services and community resources for those who are not in crisis but who are seeking access to behavioral health care. Interventions are provided by licensed and unlicensed behavioral health professionals, with supervision of the facility provided by a licensed professional and designed to prevent out of community treatment or hospitalization. Interventions used to de-escalate a crisis situation may include assessment of crisis; active listening and empathic responses to help relieve emotional distress; effective verbal and behavioral responses to warning signs of crisis related behavior; assistance to, and involvement/participation of the individual (to the extent he/she is capable) in active problem solving, planning, and interventions; referral to appropriate levels of care for adults experiencing crisis situations which may include a crisis stabilization unit or other services deemed necessary to effectively manage the crisis; to mobilize natural support systems; and to arrange transportation when needed to access appropriate levels of care..</p>						
Admission Criteria	<ol style="list-style-type: none"> 1. Adult with a suspected or known mental illness diagnosis or substance related disorder; AND 2. Expressing a need for behavioral healthcare services, OR 3. Experiencing a severe situational crisis, OR 4. At risk of harm to self, others, and/or property. Risk may range from mild to imminent; and at least one of the following; <ol style="list-style-type: none"> a. Individual has insufficient or severely limited resources or skills necessary to cope with the immediate crisis; or b. Individual demonstrates lack of judgment and/or impulse control and/or cognitive/perceptual abilities which are necessary to cope with immediate crisis. 						
Continuing Stay Criteria	Not applicable, as this service is intended to be a discrete time-limited service that stabilizes the individual and moves them to the appropriate level of care.						

Discharge Criteria	Crisis situation is resolved and/or referral to appropriate service is provided.												
Service Exclusions	No exclusions. However, if the individual is enrolled in ACT, it is the expectation that the ACT provider serve as the primary crisis response resource.												
Clinical Exclusions	<ol style="list-style-type: none"> 1. A stand-alone Crisis Service Center (not co-located with or within a facility that is a Behavioral Health Crisis Center (BHCC)) is not an emergency receiving facility and shall not receive individuals under emergency conditions. Any individual who presents under emergency conditions (1013/213/probate court order) to a stand-alone CSC must be directed to the nearest available emergency receiving facility. 2. If a CSC operates as part of a Behavioral Health Crisis Center (BHCC), the CSC (or the associated Temp Obs or CSU service) must accept individuals referred under emergency conditions (1013/2013/probate court order) and perform a face-to-face evaluation in order to determine the most appropriate level of care. 3. If after face-to-face assessment by licensed staff, if it is determined that the severity individual requires services at a different level of care, the CSC will make the necessary referrals and/or arrangements for transfer to an appropriate level of care. 												
Required Components	Crisis Service Center is a facility-based service which is operational 24 hours a day, 7 days a week, offering a safe environment for individuals receiving crisis assessments, stabilization, and referral services using licensed mental health professionals.												
Staffing Requirements	As specified per contract.												
Clinical Operations	<ol style="list-style-type: none"> 1. All Physicians, Physician Assistants, and Advanced Practice Registered Nurses are under the supervision of a board-eligible Psychiatrist who provides direction, supervision and oversight of program quality. 2. On-Call Physicians, Physician Assistants, or Advanced Practice Registered Nurses may provide services, face-to-face, or via telemedicine. 3. Response time for On-Call Physicians, Physician Assistants, or Advanced Practice Registered Nurses must be within 1 hour of initial contact by Crisis Service Center Staff. 												
Service Accessibility	This service is available 7 days a week, 24 hours a day.												
Reporting and Billing Requirements	<p>Providers must report information on all individuals served in CSC no matter the funding source:</p> <ol style="list-style-type: none"> a. The CSC shall submit MICPs for all individuals served (state-funded, Medicaid funded, private pay, other third party payer, etc.); b. The CSC shall submit per diem encounters (1 per day) for service (S9484) for all individuals served (state-funded, Medicaid funded, private pay, other third party payer, etc.) even if sub-parts cited in service package (P0015) are billed as a claim to Medicaid or other payer source; c. The CSC is allowed a 24-hour window for completion of Orders up to one 91) calendar day following the start of services, must document this exception on the Order, and note the name of the staff member responsible for obtaining the Order for service. 												
Additional Medicaid Requirements	<ol style="list-style-type: none"> 1. The Crisis Service Center should bill individual discrete services for Medicaid recipients. There is a Crisis Service Center Package available for use by Crisis Service Centers (stand-alone and within a BHCC). 2. The individual services listed below may be billed up to the daily maximum listed for services provided in the Crisis Service Center. Billable services and daily units within the CSC are as follows: <table border="1" data-bbox="676 1177 1480 1479"> <thead> <tr> <th>Service</th> <th>Max Daily Units</th> </tr> </thead> <tbody> <tr> <td>Beh Health Assessment & Service Plan Development</td> <td>12</td> </tr> <tr> <td>Psychological Testing</td> <td>5</td> </tr> <tr> <td>Diagnostic Assessment</td> <td>2</td> </tr> <tr> <td>Interactive Complexity</td> <td>4</td> </tr> <tr> <td>Crisis Intervention</td> <td>14</td> </tr> </tbody> </table>	Service	Max Daily Units	Beh Health Assessment & Service Plan Development	12	Psychological Testing	5	Diagnostic Assessment	2	Interactive Complexity	4	Crisis Intervention	14
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	Psychiatric Treatment	2
	Nursing Assessment & Care	14
	Medication Administration	1
	Psychosocial Rehabilitation – Individual	8
	Addictive Disease Support Services	16
	Individual Outpatient Services	1
	Family Outpatient Services	4
	Case Management	12

Crisis Stabilization Unit Services														
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Behavioral Health; Short-term Residential (Non-Hospital Residential Treatment Program W/o Rm & Board, Per Diem)		H0018	U2				Per negotiation and specific to Medicaid, see item E.2. below.	Behavioral Health; Short-term Residential (Non-Hospital Residential Treatment Program W/o Rm & Board, Per Diem)	H0018	TB	U2			Per negotiation
Unit Value	1 day							Maximum Daily Units	1 unit					
Initial Auth	20 units							Re-Authorization						
Auth Period	20 Days							Utilization Criteria	LOCUS scores: 4(residential detox only)-6					
Service Definition	<p>This is a residential alternative to or diversion from inpatient hospitalization, offering psychiatric stabilization and withdrawal management services. The program provides medically monitored residential services for the purpose of providing psychiatric stabilization and substance withdrawal management services on a short-term basis. Services may include:</p> <ol style="list-style-type: none"> 1) Psychiatric medical assessment; 2) Crisis assessment, support and intervention; 3) Medically Monitored Residential Substance Withdrawal Management (at ASAM Level III.7-D). 4) Medication administration, management and monitoring; 5) Brief individual, group and/or family counseling; and 6) Linkage to other services as needed. 													

Crisis Stabilization Unit Services

Admission Criteria	<ol style="list-style-type: none"> 1. Treatment at a lower level of care has been attempted or given serious consideration; and #2 and/or #3 are met: 2. Individual has a known or suspected illness/disorder in keeping with target populations listed above; or 3. Individual is experiencing a severe situational crisis which has significantly compromised safety and/or functioning; and one or more of the following: <ol style="list-style-type: none"> a. Individual presents a substantial risk of harm to self, others, and/or property or is so unable to care for his or her own physical health and safety as to create a life-endangering crisis. Risk may range from mild to imminent; or b. Individual has insufficient or severely limited resources or skills necessary to cope with the immediate crisis; or c. Individual demonstrates lack of judgment and/or impulse control and/or cognitive/perceptual abilities to manage the crisis; or d. For withdrawal management services, individual meets admission criteria for Medically Monitored Residential Withdrawal Management.
Continuing Stay Criteria	This service may be utilized at various points in the course of treatment and recovery; however, each intervention is intended to be a discrete time-limited service that stabilizes the individual.
Discharge Criteria	<ol style="list-style-type: none"> 1. Individual no longer meets admission guidelines requirements; or 2. Crisis situation is resolved and an adequate continuing care plan has been established; or 3. Individual does not stabilize within the evaluation period and must be transferred to a higher intensity service.
Service Exclusions	<p>This is a comprehensive service intervention that is not to be provided with any other service(s), except for the following:</p> <ul style="list-style-type: none"> • Methadone Administration
Clinical Exclusions	<ol style="list-style-type: none"> 1. Individual is not in crisis. 2. Individual does not present a risk of harm to self or others or is able to care for his or her own physical health and safety. 3. Severity of clinical issues precludes provision of services at this level of intensity.
Required Components	<ol style="list-style-type: none"> 1. Crisis Stabilization Units (CSU) providing medically monitored short-term residential psychiatric stabilization and withdrawal management services shall be designated by the Department as both an emergency receiving facility and an evaluation facility and must be surveyed and licensed by the DBHDD. 2. In addition to all service qualifications specified in this document, providers of this service must adhere to content in the DBHDD Rules and Regulations for Adult Crisis Stabilization Units, Chapter 82-3-1. 3. Individual referred to a CSU must be evaluated by a physician within 24 hours of the referral. 4. The maximum length of stay in a crisis bed is 10 adjusted days (excluding Saturdays, Sundays and state holidays) for adults (an adult occupying a transitional bed may remain in the CSU for an unlimited number of additional days if the date of transfer and length of stay in the transitional bed is documented). 5. Individuals occupying transitional beds must receive services from outside the CSU (i.e. community-based services) on a daily basis. 6. Services must be provided in a facility designated as an emergency receiving and evaluation facility that is not also an inpatient hospital, a freestanding Institute for Mental Disease (IMD), or a licensed substance abuse detoxification facility. 7. All services provided within the CSU must be delivered under the direction of a physician. A physician must conduct an assessment of new admissions, address issues of care, and write orders as required.
Staffing Requirements	<ol style="list-style-type: none"> 1. Crisis Stabilization Unit (CSU) Services must be provided by a physician or a staff member under the supervision of a physician, practicing within the scope of State law. 2. A CSU must employ a fulltime Nursing Administrator who is a Registered Nurse. 3. A CSU must have a Registered Nurse present at the facility at all times. 4. Staff-to-client ratios must be established based on the stabilization needs of clients being served and in accordance with rules and regulations. 5. Functions performed by Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, Registered Nurses, and Licensed Practical Nurses must be performed within the scope of practice allowed by State law and Professional Practice Acts.

Crisis Stabilization Unit Services

Clinical Operations	<ol style="list-style-type: none"> 1. CSU must have documented operating agreements and referral mechanisms for psychiatric disorders, addictive disorders, and physical healthcare needs that are beyond the scope of the CSU and that require inpatient treatment. Operating agreements must delineate the type and level of service to be provided by the private or public inpatient hospital or treatment facility. These agreements must specifically address the criteria and procedures for transferring an individual to a designated treatment facility when the CSU is unable to stabilize the individual. 2. CSUs must follow the seclusion and restraint procedures included in the Department's "Crisis Stabilization Unit Rules and Regulations" and in related policy. 3. For individuals with co-occurring diagnoses including developmental disability/developmental disabilities, this service must target the symptoms, manifestations, and skills-development related to the identified behavioral health issue. 4. Individuals served in transitional beds may access an array of community-based services in preparation for their transition out of the CSU, and are expected to engage in community-based services daily while in a transitional bed. 																		
Additional Medicaid Requirements	<ol style="list-style-type: none"> 1. Crisis Stabilization Units with 16 beds or less should bill individual discrete services for Medicaid recipients. 2. The individual services listed below may be billed up to the daily maximum listed for services provided in a Crisis Stabilization Unit. Billable services and daily limits within CSUs are as follows: <table border="1" data-bbox="478 558 1745 865"> <thead> <tr> <th>Service</th> <th>Daily Maximum Billable Units</th> </tr> </thead> <tbody> <tr> <td>Crisis Intervention</td> <td>8 units</td> </tr> <tr> <td>Diagnostic Assessment</td> <td>2 units</td> </tr> <tr> <td>Psychiatric Treatment</td> <td>1 unit (Pharmacological Mgmt only)</td> </tr> <tr> <td>Nursing Assessment and Care</td> <td>5 units</td> </tr> <tr> <td>Medication Administration</td> <td>1 unit</td> </tr> <tr> <td>Group Training/Counseling</td> <td>4 units</td> </tr> <tr> <td>Beh Health Assmnt & Serv. Plan Development</td> <td>24 units</td> </tr> <tr> <td>Medication Administration</td> <td>1 unit</td> </tr> </tbody> </table> 3. Medicaid claims for the services above may not be billed for any service provided to Medicaid-eligible individuals in CSUs with greater than 16 beds. 	Service	Daily Maximum Billable Units	Crisis Intervention	8 units	Diagnostic Assessment	2 units	Psychiatric Treatment	1 unit (Pharmacological Mgmt only)	Nursing Assessment and Care	5 units	Medication Administration	1 unit	Group Training/Counseling	4 units	Beh Health Assmnt & Serv. Plan Development	24 units	Medication Administration	1 unit
Service	Daily Maximum Billable Units																		
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Medication Administration	1 unit																		
Reporting & Billing Requirements	<ol style="list-style-type: none"> 1. Providers must report information on all individuals served in CSUs no matter the funding source: <ol style="list-style-type: none"> a. The CSU shall submit MICPs for all individuals served (state-funded, Medicaid funded, private pay, other third party payer, etc.); b. The CSU shall submit per diem encounters (H0018HAU2 or H0018HATBU2) for all individuals served (state-funded, Medicaid funded, private pay, other third party payer, etc.) even if sub-parts cited in E.2 above are also billed as a claim to Medicaid; c. Providers must designate either CSU bed use or transitional bed use in encounter submissions through the presence or absence of the TB modifier. TB represents "Transitional Bed." 2. Unlike all other DBHDD residential services, the start date of a CSU span encounter submission may be in one month and the end date may be in the next. The span of reporting must cover continuous days of service and the number of units must equal the days in the span. 																		
Documentation Requirements	<ol style="list-style-type: none"> 1. Individuals receiving services within the CSU shall be reported as a per diem encounter based upon occupancy at 11:59PM. At 11:59PM, each individual reported must have a verifiable physician's order for CSU level of care [or order written by delegation of authority to nurse or physician assistant under protocol as specified in § 43-34-23]. Individuals entering and leaving the CSU on the same day (prior to 11:59PM) will not have a per diem encounter reported. 2. For individuals transferred to transitional beds, the date of transfer must be documented in a progress note and filed in the individual's chart. 3. Specific to item F.1. above, the notes for the program must have documentation to support the per diem AND, if the program bills sub-parts to Medicaid (in accordance with E. above), each discrete service delivered must have documentation to support that sub-billable code (e.g. Group is provided for 1 hour, Group is billed for 1 hour, Group note is for 4 units at the 15 minute rate and meets all the necessary components of documentation for that sub-code). 4. Daily engagement in community-based services must also be documented in progress notes for those occupying transitional beds. 																		

Intensive Case Management														
HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Intensive Case Management	Practitioner Level 4, In-Clinic	T1016	HK	U4	U6		\$20.30	Practitioner Level 4, In-Clinic, Collateral Contact	T1016	HK	UK	U4	U6	\$20.30
	Practitioner Level 5, In-Clinic	T1016	HK	U5	U6		\$15.13	Practitioner Level 5, In-Clinic, Collateral Contact	T1016	HK	UK	U5	U6	\$15.13
	Practitioner Level 4, Out-of-Clinic	T1016	HK	U4	U7		\$24.36	Practitioner Level 4, Out-of-Clinic, Collateral Contact	T1016	HK	UK	U4	U7	\$24.36
	Practitioner Level 5, Out-of-Clinic	T1016	HK	U5	U7		\$18.15	Practitioner Level 5, Out-of-Clinic, Collateral Contact	T1016	HK	UK	U5	U7	\$18.15
Unit Value	15 minutes							Maximum Daily Units	24 units					
Initial Authorization	208 units							Re-Authorization	208 units					
Authorization Period	180 days							Utilization Criteria	LOCUS scores: 4-6					
Service Definition	<p>Intensive Case Management consists of providing environmental supports and care coordination considered essential to assist a person with improving his/her functioning, gaining access to necessary services, and creating an environment that promotes recovery as identified in his/her Individual Recovery Plan (IRP). The focus of the interventions include assisting the individual with: 1) developing natural supports to promote community integration; 2) identifying service needs; 3) referring and linking to services and resources identified through the service planning process; 4) coordinating services identified on the IRP to maximize service integration and minimize service gaps; and 5) ensuring continued adequacy of the IRP to meet his/her ongoing and changing needs.</p> <p>The performance outcome expectations for individuals receiving this service include decreased hospitalizations, decreased incarcerations, decreased episodes of homelessness, increased housing stability, increased participation in employment activities, and increased community engagement.</p> <p>Intensive Case Management shall consist of four (4) major components and cover multiple domains that impact one's overall wellness including medical, behavioral, wellness, social, educational, vocational, co-occurring, housing, financial, and other service needs of the individual:</p> <p><u>Engagement & Needs Identification</u> The case manager engages the individual in a recovery-based partnership that promotes personal responsibility, and provides support, hope and encouragement. The case manager assists the individual with developing a community-based support network to facilitate community integration and maintain housing stability. Through engagement, the case manager partners with the individual to identify and prioritize housing, service, and resource needs to be included in the IRP.</p> <p><u>Care Coordination</u> The case manager coordinates care activities and assist the individual as he/she moves between and among services and supports. Case Coordination requires information sharing among the individual, his/her core provider, specialty provider(s), residential provider, primary care physician, and other identified supports in order to: 1) ensure the individual receives a full range of integrated services necessary to support a life in recovery including health, home, purpose, and community; 2) ensure the individual has an adequate and current crisis plan; 3) reduce barriers to accessing services and resources; 4) minimize disruption, fragmentation, and gaps in service; and 5) ensure all parties work collaboratively for the common benefit of the individual.</p>													

	<p>Referral & Linkage The case manager assists the individual with referral and linkage to services and resources identified on the IRP including housing, social supports, family/natural supports, entitlements (SSI/SSDI, Food Stamps, VA), income, transportation, etc. Referral and linkage activities may include assisting the individual to: 1) locate available resources; 2) make and keep appointments; 3) complete intake and application processes and 4) arrange transportation when needed.</p> <p>Monitoring & Follow-Up The case manager visits the individual in the community to jointly review progress toward achievement of IRP goals and to seek input regarding his/her level of satisfaction with treatment and any recommendations for change. The case manager monitors and follows-up with the individual in order to: 1) determine if services are provided in accordance with the IRP; 2) determine if services are adequately and effectively addressing the individual's needs; 3) determine the need for additional or alternative services related to the individual's changing needs or circumstances; and 4) notify the treatment team when monitoring indicates the need for an IRP reassessment and update.</p>
<p>Admission Criteria</p>	<ol style="list-style-type: none"> 1. Individual must meet Core customer eligibility criteria: AND 2. Individual has a severe and persistent mental illness that seriously interferes with their ability to live in the community and: <ol style="list-style-type: none"> a. transitioning or recently discharged (i.e., within past 6 months) from a psychiatric inpatient setting; or b. frequently admitted to a psychiatric inpatient facility (i.e. 3 or more times within past 12 months) or crisis stabilization unit for psychiatric stabilization and/or treatment; or c. chronically homeless (i.e. continuously homeless for a year or more, or 4 episodes of homelessness within past 3 years); or d. recently released from jail or prison (i.e. within past 6 months); or e. frequently seen in the emergency room (i.e. 3 or more times within past 12 months) for behavioral health needs; or f. transitioning or have been recently discharged from Assertive Community Treatment services; AND 3. Individual has significant functional impairments that interfere with integration in the community and needs assistance in two (2) or more of the following areas which, despite support from a care giver or behavioral health staff (i.e. CM, AD Support Services) continues to be an area that the individual cannot complete. Needs significant assistance to: <ol style="list-style-type: none"> a. navigate and self-manage necessary services; b. maintain personal hygiene; c. meet nutritional needs; d. care for personal business affairs; e. obtain or maintain medical, legal, and housing services; f. recognize and avoid common dangers or hazards to self and possessions; g. perform daily living tasks ; h. obtain or maintain employment at a self-sustaining level or consistently perform homemaker roles (e.g., household meal preparation, washing clothes, budgeting, or childcare tasks and responsibilities); i. maintain a safe living situation (e.g. evicted from housing, or recent loss of housing, or imminent risk of loss of housing);AND 4. Individual is engaged in their Recovery Plan but needs assistance with one (1) or more of the following areas as an indicator of demonstrated ownership and engagement with his/her own illness self-management: <ol style="list-style-type: none"> a. taking prescribed medications, or b. following a crisis plan, or c. maintaining community integration, or d. keeping appointments with needed services which have resulted in the exhibition of specific behaviors that have led to two or more of the following within the past 18 months: <ol style="list-style-type: none"> i. hospitalization, ii. incarceration, iii. homelessness, or use of other crisis services (i.e. CSU, ER, etc.)

Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual continues to have a documented need for an ICM intervention at least four (4) times monthly AND 2. Individual continues to demonstrate significant functional impairment as demonstrated by the need for assistance in 2 or more of the following areas which, despite support from a caregiver or behavioral health staff continues to be an area that the individual cannot complete. Needs significant assistance to: <ul style="list-style-type: none"> • Access, navigate and/or manage multiple necessary community services • Maintain personal hygiene • Meet nutritional needs • Care for personal business affairs • Obtain or maintain medical, legal, and housing services • Recognize and avoid common dangers or hazards to self and possessions • Perform daily living tasks except with significant support or assistance from others such as friends, family, or other relatives • Obtain or maintain employment at a self-sustaining level or inability to consistently carry out homemaker roles (e.g. household meal preparation, washing clothes, budgeting, or childcare tasks and responsibilities) • Maintain a safe living situation (e.g. evicted from housing, or recent loss of housing, or imminent risk of loss of housing) • Keep appointments with needed services including mental health appointments • Take medications as prescribed • Budgeting money (including prioritizing expenses) to ensure necessary living expenses are maintained 3. One of the following: <ul style="list-style-type: none"> • Continued difficulty participating in traditional clinic-based services or a community setting at a less intensive level of service/supports; • Substandard housing, homeless, or at imminent risk of becoming homeless due to functional impairments associated with behavioral health issues • Living arrangement through a Georgia Housing Voucher and needs ongoing support to maintain stable housing • Experienced recent life changing event (Examples include Death of Significant Other or close family member, Change in marital status, Involvement with criminal justice system, Serious Illness or injury of self or close family member, Financial issues including loss of job, disability check, etc.) and needs intensive support to prevent the utilization of crisis level services.
Discharge Criteria	<ol style="list-style-type: none"> 1. There has been a planned reduction of units of service delivered and related evidence of the individual sustaining functioning through that reduction plan; and 2. Individual has established recovery support networks to assist in maintenance of recovery (such as peer supports, AA, NA, etc.); and 3. Individual has demonstrated some ownership and engagement with her/his own illness self-management as evidenced by: <ol style="list-style-type: none"> a. navigating and self-managing necessary services; b. maintaining personal hygiene; c. meeting his/her own nutritional needs; d. caring for personal business affairs; e. obtaining or maintaining medical, legal, and housing services; f. recognizing and avoiding common dangers or hazards to self and possessions; g. performing daily living tasks; h. obtaining or maintaining employment at a self-sustaining level or consistently performing homemaker roles (e.g., household meal preparation, washing clothes, budgeting, or childcare tasks and responsibilities); and i. maintaining a safe living situation.
Service Exclusions	<ol style="list-style-type: none"> 1. This service may not duplicate any discharge planning efforts which are part of the expectation for hospitals, ICF-MRs, Institutions for Mental Disease (IMDs), and Psychiatric Residential Treatment Facilities (PRTFs) for youth transition population.

	<ol style="list-style-type: none"> 2. This service is not available to any individual who receives a waiver service via the Department of Community Health. Payment for ICM Services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. 3. Individuals with a substance-related disorder are excluded from receiving this service unless there is clearly documented evidence of a primary psychiatric diagnosis. 4. For individuals receiving this service, "Service Plan Development" authorization via the current service package will be limited and supplanted with this service. 5. ACT, CST, and CM are Service Exclusions. Individuals may receive ICM and one of these services for a limited period of time to facilitate a smooth transition.
Clinical Exclusions	<p>Individuals with the following conditions are excluded from admission <u>unless</u> there is clearly documented evidence of a psychiatric condition co-occurring with the diagnosis of:</p> <ul style="list-style-type: none"> • mental retardation; and/or • autism; and/or • organic mental disorder; and/or • traumatic brain injury;
Required Components	<ol style="list-style-type: none"> 1. Each provider must have policies and procedures related to referral including providing outreach to agencies who may serve the targeted population, including but not limited to psychiatric inpatient hospitals, Crisis Stabilization Units, jails, prisons, homeless shelters, etc.. 2. The organization must have policies and procedures for protecting the safety of staff that engage in these community-based service delivery activities. 3. Maintain face-to-face contact with individuals receiving Intensive Case Management services, providing a supportive and practical environment that promotes recovery and maintain adherence to the desired performance outcomes that have been established for individuals receiving ICM services. It is expected that frequency of face-to-face contact is increased when clinically indicated in order to achieve the performance outcomes, and the intensity of service is reflected in the individual's IRP. 4. A median of 4 face-to-face visits must be delivered on a <u>monthly</u> basis. Additional contacts may be either face-to-face or telephone collateral contact (denoted by the UK modifier) depending on the individual's support needs. 5. 60% of total units must be face-to-face contacts with the individual. 6. At least 50% of all face-to-face service units must be delivered in non-clinic/community-based settings (i.e., any place that is convenient for the individual such as a FQHC, place of employment, community space) over the authorization period (these units are specific to single individual records and are not aggregate across an agency/program or multiple payers). 7. In the absence of monthly face-to-face contacts and if at least two unsuccessful attempts to make face-to-face contact have been tried and documented, the provider may bill for a maximum of <u>2</u> telephone contacts in that specified month (denoted by the UK modifier). This may occur for no more than <u>60</u> consecutive days. 8. After <u>8</u> unsuccessful attempts at making face to face contact with an individual, the ICM and members of the treatment team will re-evaluate the standing IRP and utilization of services. 9. ICM is expected to retain a high percentage of enrolled individuals in services with few drop-outs. In the event that an ICM has documented multiple attempts to locate and make contact with an individual and has demonstrated diligent search, after <u>60</u> days of unsuccessful attempts the individual may be discharged due to drop out. 10. Individuals for whom there is a written transition/discharge plan may receive a tapered benefit based upon individualized need as documented in that plan. 11. Team meetings must be held a minimum of once a week and time dedicated to discussion of support and service to individuals must be documented in the Treatment Team Meetings Log. Each individual must be discussed, even if briefly, at least one time monthly. ICM staff members are expected to attend Treatment Team Meetings
Staffing Requirements	<ol style="list-style-type: none"> 1. The following practitioners may provide ICM services: <ul style="list-style-type: none"> • Practitioner Level 1: Physician/Psychiatrist (reimbursed at Level 4 rate) • Practitioner Level 2: Psychologist, APRN, PA (reimbursed at Level 4 rate) • Practitioner Level 3: LCSW, LPC, LMFT, RN (reimbursed at Level 4 rate) • Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAC-II, CADC, CCADC, GCADC (II, III); CPS, PP, CPRP, CAC-I or Addiction Counselor Trainees with at least a Bachelor's degree in one of the helping

	<p>professions such as social work, community counseling, counseling, psychology, or criminology</p> <ul style="list-style-type: none"> • Practitioner Level 5: CPS; PP; CPRP; or, when an individual served is co-occurring diagnosed with a mental illness and addiction issue CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent under supervision of one of the licensed/credentialed professionals above. <p>2. Each ICM provider shall have a minimum of 11 staff members which must include 1 full-time licensed supervisor and 10 full-time case managers. When provided by one of the practitioners cited below, must be under the documented supervision (organizational charts, supervisory notation, etc.) of one of the independently licensed/credentialed professionals above:</p> <ul style="list-style-type: none"> • Certified Peer Specialists • Paraprofessional staff • Certified Psychiatric Rehabilitation Professional • Certified Addiction Counselor-I • Registered Alcohol and Drug Technician (I,II, or III)k • Addiction Counselor Trainee <p>3. Oversight of an intensive case manager is provided by an independently licensed practitioner.</p> <p>4. Staff to consumer ratio for ICM services shall be a maximum caseload of 1:20 quarterly in rural areas and 1:30 in urban areas. Minimum caseloads in rural areas are 1:15 and 1:25 in urban areas. These ratios reflect a maximum team capacity of 200 in rural areas and 300 in urban areas. Urban counties are delineated in the annual Georgia County Guide with the term "Metropolitan County."</p>
Clinical Operations	<p>1. ICM may include (with the consent of the Adult) coordination with family and significant others and with other systems/supports (e.g., work, religious entities, corrections, aging agencies, etc.) when appropriate for treatment and recovery needs.</p> <p>2. ICM providers must have the ability to deliver services in various environments, such as homes, homeless shelters, or street locations. The provider should keep in mind that individuals may prefer to meet staff at a community location other than their homes or other conspicuous locations (e.g. their place of employment), especially if staff drive a vehicle that is clearly marked as a state or agency vehicle, or if staff must identify themselves and their purpose to gain access to the individual in a way that may potentially embarrass the individual or breach the individual's privacy/confidentiality. Staff should be sensitive to and respectful of individuals' privacy/confidentiality rights and preferences in this regard to the greatest extent possible (e.g. if staff must meet with an individual during their work time, if the individual wishes, mutually agree upon a meeting place nearby that is the least conspicuous from the individual's point of view).</p> <p>3. ICM must incorporate assertive engagement techniques to identify, locate, engage, and retain the most difficult to engage enrolled individuals who cycle in and out of intensive services. ICM must demonstrate the implementation of well thought out engagement strategies to minimize discharges due to drop out including the use of street and shelter outreach approaches and collateral contacts with family, friends, probation or parole officers.</p> <p>4. ICM is expected to assertively participate in transitional planning, coordinating, and accessing services and resources when an enrolled individual is being discharged from a psychiatric hospital; released from jail; or experiencing an episode of homelessness. An ICM provider that is also a Core Provider may use Community Transition Planning to establish a connection or reconnection to the individual while in a state operated hospital, crisis stabilization unit, jail/prison, or other community psychiatric hospital, and participate in discharge planning meetings. Because of the complex needs of the target population, ICM may only be delivered by a Core Provider. It is expected that any individual receiving ICM services will be connected to a Core Provider or a non-core service provider where they receive ongoing physician assessment and treatment as well as other recovery-supporting services. There shall be documentation during each Authorization Period that demonstrates ICM collaboration efforts with the individual's physician and other recovery supporting services.</p> <p>5. The organization must have policies that govern the provision of services in natural settings and can document that the organization respects individuals' rights to privacy and confidentiality when services are provided in these settings.</p> <p>6. The organization has established procedures/protocols for handling emergency and crisis situations:</p> <ol style="list-style-type: none"> a. The organization jointly develops the crisis plan in partnership with the individual. The organization is engaged with the individual to ensure that the plan is complete, current, adequate and communicated to all appropriate parties. b. There is evaluation of the adequacy of the individual's crisis plan and its implementation at periodic intervals including post-crisis events. <ul style="list-style-type: none"> ○ while respecting the individual's crisis plan and identified points of first response, the policies should articulate the role of the core provider agency to be the primary responsible provider for providing crisis supports and intervention as clinically necessary ○ describe methods for supporting individuals as they transition to and from psychiatric hospitalization/crisis stabilization.

	<p>7. The organization must have an ICM Organizational Plan that addresses the following:</p> <ol style="list-style-type: none"> Description of the role of ICM during a crisis in partnership with the individual, and core provider or non-core clinical home service provider where the individual receives ongoing physician assessment and treatment as well as other recovery supporting services. Description of the staffing pattern and how staff are deployed to assure that the required staff-to-individual ratios are maintained, including how unplanned staff absences, illnesses, or emergencies are accommodated, case mix, access, etc. Description of the hours of operations as related to access and availability to the individuals served; Description of how the IRP plan constructed, modified and/or adjusted to meet the needs of the individual and to facilitate broad natural and formal support participation; and Description of how ICM agencies engage with other agencies who may serve the target population.
Service Accessibility	There must be documented evidence that service hours of operation include evening, weekend, and holiday hours.
Reporting and Billing Requirements	When a billable collateral contact is provided, the UK reporting modifier shall be utilized. A collateral contact is classified as any contact that is not face-to-face with the individual.

Housing Supplements														
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Housing Supplements		ROOM1					Actual cost							
Unit Value	1 day							Maximum Daily Units	1					
Initial Auth	180 days							Re-Authorization	180 days					
Auth Period	180 days							Utilization Criteria	LOCUS scores: 2-6					
Service Definition	This is a rental/housing subsidy that must be justified by a personal consumer budget. This may include a one-time rental payment to prevent eviction/homelessness.													
Admission Criteria	<ol style="list-style-type: none"> Individual meets target population as identified above; and Based upon a personal budget, individual has a need for financial support for a living arrangement. 													
Continuing Stay Criteria	<ol style="list-style-type: none"> Individual continues to meet admission criteria as defined above; and Individual has developed a Recovery goal to develop natural supports that promote the family/caregiver-management of these needs. 													
Discharge Criteria	<ol style="list-style-type: none"> Individual requests discharge; or Individual has acquired natural supports that supplant the need for this service. 													
Clinical Exclusions	Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of psychiatric condition overlaying the primary diagnosis: developmental disability, autism, organic mental disorder, traumatic brain injury.													
Documentation Requirements	<ol style="list-style-type: none"> If the individual supported is sharing rent with another person, then agency may only utilize and report the assistance provided to the served individual (rounded to the nearest dollar). The individual clinical record must have documentation of the actual payment by the agency to the leaser/landlord. A receipt for this payment must also be kept in the clinical record. 													

MH Peer Support Services-Group

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Peer Support Services	Practitioner Level 4, In-Clinic	H0038	HQ	U4	U6		\$17.72	Practitioner Level 4, Out-of-Clinic	H0038	HQ	U4	U7		\$21.64
	Practitioner Level 5, In-Clinic	H0038	HQ	U5	U6		\$13.20	Practitioner Level 5, Out-of-Clinic	H0038	HQ	U5	U7		\$16.12
Unit Value	1 hour							Maximum Daily Units	5					
Initial Authorization	3600 units							Re-Authorization	3600 units					
Authorization Period	180 days							Utilization Criteria	<u>LOCUS scores: 1-4</u>					
Service Definition	<p>This service provides structured activities within a peer support center that promote socialization, recovery, wellness, self-advocacy, development of natural supports, and maintenance of community living skills. Activities are provided between and among individuals who have common issues and needs, are consumer motivated, initiated and/or managed, and assist individuals in living as independently as possible. Activities must promote self-directed recovery by exploring individual purpose beyond the identified mental illness, by exploring possibilities of recovery, by tapping into individual strengths related to illness self-management (including developing skills and resources and using tools related to communicating recovery strengths, communicating health needs/concerns, self-monitoring progress), by emphasizing hope and wellness, by helping individuals develop and work toward achievement of specific personal recovery goals (which may include attaining meaningful employment if desired by the individual), and by assisting individuals with relapse prevention planning. A Consumer Peer Support Center may be a stand-alone center or housed as a "program" within a larger agency, and must maintain adequate staffing support to enable a safe, structured recovery environment in which individuals can meet and provide mutual support.</p>													
Admission Criteria	<ol style="list-style-type: none"> Individual must have a primary mental health issue; and one or more of the following: Individual requires and will benefit from support of peer professionals for the acquisition of skills needed to manage symptoms and utilize community resources; or Individual may need assistance to develop self-advocacy skills to achieve decreased dependency on the mental health system; or Individual may need assistance and support to prepare for a successful work experience; or Individual may need peer modeling to take increased responsibilities for his/her own recovery; or Individual needs peer supports to develop or maintain daily living skills. 													
Continuing Stay Criteria	<ol style="list-style-type: none"> Individual continues to meet admission criteria; and Progress notes document progress relative to goals identified in the Individualized Recovery/Resiliency Plan, but treatment/recovery goals have not yet been achieved. 													
Discharge Criteria	<ol style="list-style-type: none"> An adequate continuing care plan has been established; and one or more of the following: <ol style="list-style-type: none"> Goals of the Individualized Recovery Plan have been substantially met; or Individual/family requests discharge; or Transfer to another service/level is more clinically appropriate. 													
Service Exclusions	Crisis Stabilization Unit (however, those utilizing transitional beds within a Crisis Stabilization Unit may access this service).													
Clinical Exclusions	<ol style="list-style-type: none"> Individuals diagnosed with a Substance-Related Disorder and no other concurrent mental illness; or Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: developmental disability, autism, organic mental disorder, or traumatic brain injury 													
Required Components	<ol style="list-style-type: none"> A Peer Supports service may operate as a program within: <ul style="list-style-type: none"> A freestanding Peer Support Center A Peer Support Center that is within a clinical service provider A larger clinical or community human service provider administratively, but with complete programmatic autonomy. A Peer Supports service must be operated for no less than 3 days a week, no less than 12 hours a week, no less than 4 hours per day, typically during day, evening 													

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	<p>and weekend hours. Any agency may offer additional hours on additional days in addition to these minimum requirements.</p> <ol style="list-style-type: none"> 3. The governing board of a freestanding Peer Center must be composed of 75% consumers and represent the cultural diversity of the population of the community being served. The board is encouraged to have either board members or operating relationships with someone with legal and accounting expertise. For programs that are part of a larger organizational structure that is not consumer led and operated, the Peer Supports Program must have an advisory body with the same composition as a freestanding Peer Center's board. The board or advisory committee must have the ability to develop programmatic descriptions and guidelines (consistent with state and federal regulations, accreditation requirements, and sponsoring agency operating policies), review and comment on the Peer Support Program's budgets, review activity offerings, and participate in dispute resolution activities for the program. 4. Individuals participating in the service at any given time must have the opportunity to participate in and make decisions about the activities that are conducted or services offered within the Peer Supports program, and about the schedule of those activities and services, as well as other operational issues. 5. Regardless of organizational structure, the service must be directed and led by consumers themselves. 6. Peer Supports may include meals or other social activities for purpose of building peer relationships, but meals cannot be the central or core activity offered. The focus of the service must be skill maintenance and enhancement and building individual's capacity to advocate for themselves and other consumers. 7. Peer Supports cannot operate in isolation from the rest of the programs within the facility or affiliated organization. The Program Leader must be able to call multidisciplinary team meetings regarding a participating individual's needs and desires, and a Certified Peer Specialist providing services for and with a participating individual must be allowed to participate in multidisciplinary team meetings.
Staffing Requirements	<ol style="list-style-type: none"> 1. The individual leading and managing the day-to-day operations of the program, the Program Leader, must be a Georgia-certified Peer Specialist, who is a CPRP or can demonstrate activity toward attainment of the CPRP credential. 2. The Program Leader must be employed by the sponsoring agency at least 0.5 FTE. 3. The Program Leader and Georgia-certified Peer Specialists in the Peer Supports program may be shared with other programs as long as the Program Leader is present at least 75% of the hours the Peer Supports program is in operation, and as long as the Program Leader and the Georgia-certified Peer Specialists are available as required for supervision and clinical operations, and as long as they are not counted in individual to staff ratios for 2 different programs operating at the same time. 4. Services must be provided and/or activities led by staff who are Georgia-certified Peer Specialists or other consumers under the supervision of a Georgia-certified Peer Specialist. A specific activity may be led by someone who is not a consumer but is an invited guest. 5. There must be at least 2 Georgia-certified Peer Specialists on staff either in the Peer Supports Program or in a combination of Peer Supports and other programs and services operating within the agency. 6. The maximum face-to-face ratio cannot be more than 30 individuals to 1 Certified Peer Specialist based on average daily attendance in the past three (3) months of individuals in the program. 7. The maximum face-to-face ratio cannot be more than 15 individuals to 1 direct service/program staff, based on the average daily attendance in the past three (3) months of individuals in the program. 8. All staff must have an understanding of recovery and psychosocial rehabilitation principles as defined by the Georgia Consumer Council and psychosocial rehabilitation principles published by USPRA and must possess the skills and ability to assist other individuals in their own recovery processes.
Clinical Operations	<ol style="list-style-type: none"> 1. This service must operate at an established site approved to bill Medicaid for services. However, individual or group activities may take place offsite in natural community settings as appropriate for the Individualized Recovery Plan (IRP) developed by each individual with assistance from the Program Staff. 2. Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. 3. This service may operate in the same building as other day services; however, there must be a distinct separation between services in staffing, program description, and physical space during the hours the Peer Supports program is in operation except as noted above. 4. Adequate space, equipment, furnishings, supplies, and other resources must be provided in order to effectively provide services and so that the program environment is clean and in good repair. Space, equipment, furnishings, supplies, transportation, and other resources for individual use within the Peer Supports program must not be substantially different from space provided for other uses for similar numbers of individuals. 5. Staff of the Peer Supports Program must be treated as equal to any other staff of the facility or organization and must be provided equivalent opportunities for

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- training (both mandated and offered) and pay and benefits competitive and comparable to other staff based on experience and skill level.
6. When this service is used in conjunction with Psychosocial Rehabilitation and ACT, documentation must demonstrate careful planning to maximize the effectiveness of this service as well as appropriate reduction in service amounts. Utilization of this service in conjunction with these services is subject to review by the External Review Organization.
 7. Individuals should set their own individualized goals and assess their own skills and resources related to goal attainment. Goals are set by exploring strengths and needs in the individual's living, learning, social, and working environments. Goal attainment should be supported through a myriad of approaches (e.g. coaching approaches, assistance via technology, etc.)
 8. Implementation of services may take place individually or in groups.
 9. Each individual must be provided the opportunity for peer assistance in the development and acquisition of needed skills and resources necessary to achieve stated goals.
 10. A Peer Supports Program must offer a range of skill-building and recovery activities developed and led by consumers. These activities must include those that will most effectively support achievement of the individual's rehabilitation and recovery goals.
 11. The program must have a Peer Supports Organizational Plan addressing the following:
 - A service philosophy reflecting recovery principles as articulated by the Georgia Consumer Council, August 1, 2001. This philosophy must be actively incorporated into all services and activities and:
 - (a) View each individual as the director of his/her rehabilitation and recovery process
 - (b) Promote the value of self-help, peer support, and personal empowerment to foster recovery
 - (c) Promote information about mental illness and coping skills
 - (d) Promote peer-to-peer training of individual skills, social skills, community resources, and group and individual advocacy
 - (e) Promote the concepts of employment and education to foster self-determination and career advancement
 - (f) Support each individual to "get a life" using community resources to replace the resources of the mental health system no longer needed
 - (g) Support each individual to fully integrate into accepting communities in the least intrusive environment that promote housing of his/her choice
 - (h) Actively seek ongoing consumer input into program and service content so as to meet each individual's needs and goals and foster the recovery process
 - A description of the particular consumer empowerment models utilized, types of activities offered, and typical daily activities and schedule. If offered, meals must be described as an adjunctive peer relationship building activity rather than as a central activity.
 - A description of the staffing pattern, plans for staff who have or will have achieved Certified Peer Specialist and CPRP credentials, and how staff are deployed to assure that the required staff-to-individual ratios are maintained, including how unplanned staff absences, illnesses, and emergencies are accommodated.
 - A description of how consumer staff within the agency are given opportunities to meet with or otherwise receive support from other consumers (including Georgia-certified Peer Specialists) both within and outside the agency.
 - A description of how individuals are encouraged and supported to seek Georgia certification as a Peer Specialist through participation in training opportunities and peer or other counseling regarding anxiety following certification.
 - A description of test-taking skills and strategies, assistance with study skills, information about training and testing opportunities, opportunities to hear from and interact with consumers who are already certified, additional opportunities for consumer staff to participate in clinical team meetings at the request of an individual, and the procedure for the Program Leader to request a team meeting.
 - A description of the hours of operation, the staff assigned, and the types of services and activities provided for and by consumers as well as for families, parents, and/or guardians.
 - A description of the program's decision-making processes including how consumers direct decision-making about both individual and program-wide activities and about key policies and dispute resolution processes.
 - A description of how individuals participating in the service at any given time are given the opportunity to participate in and make decisions about the activities that are conducted or services offered within the Peer Supports program, about the schedule of those activities and services, and other operational issues.
 - A description of the space, furnishings, materials, supplies, transportation, and other resources available for individuals participating in the Peer Supports services.

Clinical
Operations,
continued

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	<ul style="list-style-type: none"> A description of the governing body and/or advisory structures indicating how this body/structure meets requirements for consumer leadership and cultural diversity. A description of how the plan for services and activities is modified or adjusted to meet the needs specified in each IRP. A description of how individual requests for discharge and change in services or service intensity are handled. <p>12. Assistive tools, technologies, worksheets, etc. can be used by the Peer Support staff to work with the served individual to improve his/her communication about treatment, symptoms, improvements, etc. with treating behavioral health and medical practitioners.</p>
Documentation Requirements	<ol style="list-style-type: none"> Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section III of the Provider Manual. The provider has several alternatives for documenting progress notes: <ol style="list-style-type: none"> Weekly progress notes must document the individual's progress relative to functioning and skills related to the person-centered goals identified in his/her IRP. This progress note aligns the weekly PSR-Group activities reported against the stated interventions on the individualized recovery plan, and documents progress toward goals. This progress note may be written by any practitioner who provided services over the course of that week; or If the agency's progress note protocol demands a detailed daily note which documents the progress above, this daily detail note can suffice to demonstrate functioning, skills, and progress related to goals and related to the content of the group intervention; or If the agency's progress note protocol demands a detailed hourly note which documents the progress above, this daily detail note can suffice to demonstrate functioning, skills, and progress related to goals and related to the content of the group intervention. While billed in increments, the Peer Support service is a program model. Daily time in/time out is tracked for while the person is present in the program, but due to time/in out not being required for each intervention, the time in/out may not correlate with the units billed as the time in/out will include breaks taken during the course of the program. However, the units noted on the log should be consistent with the units billed and, if noted, on the weekly progress note. If the units documented are not consistent, the most conservative number of units will be utilized. Other approaches may result in a billing discrepancy. Rounding is applied to the person's cumulative hours/day at the Peer program (excluding non-programmatic time). The provider shall follow the guidance in the rounding policy included in this Provider Manual, and, specific to this service, the person served must have participated in at least 50% of the hour in order to bill for one unit of this service. So for instance, if an individual participates in the program from 9-1:15 excluding a 30 minute break for lunch, his/her participating hours are 3.75 hours. The rounding policy is applied to the .75 hour and the units billed for that day are 4 units. Practitioner type must still be addressed and so that 4 units must be adequately assigned to either a U4 or U5 practitioner type as reflected in the log for that day's activities. A provider shall only record units in which the individual was actively engaged in services. Meals and breaks must not be included in the reporting of units of service delivered. Should an individual leave the program or receive other services during the range of documented time in/time out for Peer Support hours, the absence should be documented on the log.

MH Peer Support Services-Individual

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Peer Support Services	Practitioner Level 4, In-Clinic	H0038	U4	U6			\$20.30	Practitioner Level 4, Out-of-Clinic	H0038	U4	U7			\$24.36
	Practitioner Level 5, In-Clinic	H0038	U5	U6			\$15.13	Practitioner Level 5, Out-of-Clinic	H0038	U5	U7			\$18.15
Unit Value	15 minutes							Maximum Daily Units	48					
Initial Authorization	3600 units (combined with other Peer Support services)							Re-Authorization	3600 units (combined with other Peer Support services)					
Authorization Period	180 days							Utilization Criteria	<u>LOCUS scores: 1-5</u>					

MH Peer Support Services-Individual

Service Definition	This service provides interventions which promote socialization, recovery, wellness, self-advocacy, development of natural supports, and maintenance of community living skills. Activities are provided between and among individuals who have common issues and needs, are individual motivated, initiated and/or managed, and assist individuals in living as independently as possible. Activities must promote self-directed recovery by exploring individual purpose beyond the identified mental illness, by exploring possibilities of recovery, by tapping into individual strengths related to illness self-management (including developing skills and resources and using tools related to communicating recovery strengths, communicating health needs/concerns, self-monitoring progress), by emphasizing hope and wellness, by helping individuals develop and work toward achievement of specific personal recovery goals (which may include attaining meaningful employment if desired by the individual), and by assisting individuals with relapse prevention planning. Peer Supports must be provided by a Certified Peer Specialist.
Admission Criteria	<ol style="list-style-type: none"> 1. Individual must have a primary mental health issue; and one or more of the following: 2. Individual requires and will benefit from support of peer professionals for the acquisition of skills needed to manage symptoms and utilize community resources; or 3. Individual may need assistance to develop self-advocacy skills to achieve decreased dependency on the mental health system; or 4. Individual may need assistance and support to prepare for a successful work experience; or 5. Individual may need peer modeling to take increased responsibilities for his/her own recovery; or 6. Individual needs peer supports to develop or maintain daily living skills.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual continues to meet admission criteria; and 2. Progress notes document progress relative to goals identified in the Individualized Recovery/Resiliency Plan, but treatment/recovery goals have not yet been achieved.
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Recovery Plan have been substantially met; or 3. Individual/family requests discharge; or Transfer to another service/level is more clinically appropriate.
Service Exclusions	Crisis Stabilization Unit (however, those utilizing transitional beds within a Crisis Stabilization Unit may access this service).
Clinical Exclusions	<ol style="list-style-type: none"> 1. Individuals diagnosed with a Substance-Related Disorder and no other concurrent mental illness; or 2. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: developmental disability, autism, organic mental disorder, or traumatic brain injury
Required Components	<ol style="list-style-type: none"> 1. Peer Supports are provided in 1:1 CPS to person-served ratio. 2. If an agency is providing Peer Supports-Individual it shall also be operating a Peer Supports group model program, meeting all of the expectations of Peer Support Group as set forth in this manual. 3. Individuals participating in the service at any given time must have the opportunity to participate in and make decisions about the person-centered interactions offered by the Certified Peer Specialist/s. 4. Peer Supports cannot operate in isolation from the rest of the programs within the facility or affiliated organization. The CPS shall be empowered to convene multidisciplinary team meetings regarding a participating individual's needs and desires, and the Certified Peer Specialist must be allowed to participate as an equal practitioner partner with all staff in multidisciplinary team meetings. He/she also has the unique role as an advocate to the person-served, encouraging that person to steer goals and objectives in Individualized Recovery Planning
Staffing Requirements	<ol style="list-style-type: none"> 1. The providing practitioner is a Georgia-Certified Peer Specialist (CPS). 2. The work of the CPS is under supervision of a Physician, Psychologist, LCSW, LPC, LMFT, RN, APRN, PA, LMSW, APC, or AMFT 3. There must be at least 2 Georgia-certified Peer Specialists on staff within an agency either in the Peer Supports Group program or in a combination of Peer Supports-Group, Peer Support-Individual and other programs and services operating within the agency. 4. The maximum caseload ratio for CPS to persons-served cannot be more than 1:50. 5. All CPSs providing this support must be able to articulate an understanding of recovery as defined by SAMHSA and psychiatric rehabilitation principles published by USPRA and must demonstrate the skills and ability to assist other individuals in their own recovery processes.

MH Peer Support Services-Individual

<p>Clinical Operations</p>	<ol style="list-style-type: none"> 1. Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. 2. If a CPS serves as staff for a Peer Support-Group program and provides Peer Support-Individual, the agency has written work plans which establish the CPS's time allocation in a manner that is distinctly attributed to each program. 3. CPSs providing this service must be treated as equal to any other staff of the facility or organization and must be provided equivalent opportunities for training (both mandated and offered) and pay and benefits competitive and comparable to other staff based on experience and skill level. 4. Individuals should set their own individualized goals and assess their own skills and resources related to goal attainment. Goals are set by exploring strengths and needs in the individual's living, learning, social, and working environments. Goal attainment should be supported through a myriad of approaches (e.g. coaching approaches, assistance via technology, etc.) 5. Each service intervention is provided only in a 1:1 ratio between a CPS and a person-served. 6. Each individual must be provided the opportunity for peer assistance in the development and acquisition of needed skills and resources necessary to achieve stated goals. 7. The program must have a Peer Supports Organizational Plan addressing the following: <ul style="list-style-type: none"> • A service philosophy reflecting recovery principles as articulated by the Georgia Consumer Council, August 1, 2001. This philosophy must be actively incorporated into all services and activities and: <ol style="list-style-type: none"> (a) View each individual as the director of his/her rehabilitation and recovery process (b) Promote the value of self-help, peer support, and personal empowerment to foster recovery (c) Promote information about mental illness and coping skills (d) Promote peer-to-peer training of individual skills, social skills, community resources, and group and individual advocacy (e) Promote the concepts of employment and education to foster self-determination and career advancement (f) Support each individual to "get a life" using community resources to replace the resources of the mental health system no longer needed (g) Support each individual to fully integrate into accepting communities in the least intrusive environment that promote housing of his/her choice (h) Actively seek ongoing consumer input into program and service content so as to meet each individual's needs and goals and foster the recovery process • A description of the particular consumer empowerment models utilized and types of recovery-support activities offered which are reflective of that model. • A description of the staffing pattern including how caseloads are evaluated to assure that the required staff-to-individual ratios are maintained, including how unplanned staff absences, illnesses, and emergencies are accommodated. • A description of how CPSs within the agency are given opportunities to meet with or otherwise receive support from other consumers (including Georgia-Certified Peer Specialists) both within and outside the agency. • A description of how CPSs are encouraged and supported to seek continuing education and/or other certifications through participation in training opportunities. • A description of the standard by which CPSs participate in, and, if necessary, request clinical team meetings at the request of an individual. • A description of the program's decision-making processes including how individuals direct decision-making about both individual and program-wide activities and about key policies and dispute resolution processes. • A description of the governing body and/or advisory structures indicating how this body/structure meets requirements for consumer leadership and cultural diversity. • A description of how the plan for services and activities is modified or adjusted to meet the needs specified in each IRP. • A description of how individual requests for discharge and change in services or service intensity are handled. 8. Assistive tools, technologies, worksheets, etc. can be used by the CPS to work with the served individual to improve his/her communication about treatment, symptoms, improvements, etc. with treating behavioral health and medical practitioners.
<p>Clinical Operations, continued</p>	
<p>Documentation Requirements</p>	<p>Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section III of the Provider Manual.</p>

Opioid Maintenance Treatment

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Alcohol and/or Drug Services; Methadone Administration and/or Service	H0020	U2	U6				33.40	H0020	U4	U6				17.40
	H0020	U3	U6				25.39							
Unit Value	1 encounter							Maximum Daily Units	1 unit					
Initial Authorization	With the submission of MICP New Episode: 180 units							Re-Authorization	180 units					
Auth Period	180 days							Utilization Criteria	LOCUS scores:1-3					
Service Definition	An organized, usually ambulatory, addiction treatment service for opiate-addicted individuals. The nature of the services provided (such as dosage, level of care, length of service or frequency of visits) is determined by the individual's clinical needs, but such services always includes scheduled psychosocial treatment sessions and medication visits (often occurring on a daily basis) within a structured program. Services function under a defined set of policies and procedures, including admission, discharge and continued service criteria stipulated by state law and regulation and the federal regulations at FDA 21 CFR Part 291. Length of service varies with the severity of the individual's illness, as well as his or her response to and desire to continue treatment. Treatment with methadone or LAAM is designed to address the individual's goal to achieve changes in his or her level of functioning, including elimination of illicit opiate and other alcohol or drug use. To accomplish such change, the Individualized Recovery/Resiliency Plan must address major lifestyle, attitudinal and behavioral issues that have the potential to undermine the goals of recovery. The Individualized Recovery/Resiliency Plan should also include individualized treatment, resource coordination, and personal health education specific to addiction recovery (including education about human immunodeficiency virus [HIV], tuberculosis [TB], and sexually transmitted diseases [STD]).													
Admission Criteria	Must meet criteria established by the Georgia Regulatory body for opioid administration programs (Department of Community Health, Healthcare Facilities Regulation Division) and the Food and Drug Administration's guidelines for this service.													
Continuing Stay Criteria														
Discharge Criteria														
Required Components	<ol style="list-style-type: none"> 1. This service must be licensed by DCH/HFR under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2. 2. Must meet and follow criteria established by the Georgia regulatory body for opioid administration programs (Department of Community Health, Healthcare Facilities Regulation Division) and the Food and Drug Administration's guidelines for this service. 													
Additional Medicaid Requirements	Core providers who are approved to bill Medication Administration may bill H0020 for Medicaid recipients who receive this service.													
Documentation Requirements	If medically necessary for the individual, the Individualized Recovery/Resiliency Plan should also include individualized treatment, resource coordination, and personal health education specific to addiction recovery (including education about human immunodeficiency virus [HIV], tuberculosis [TB], and sexually transmitted diseases [STD]).													

Peer Support Whole Health & Wellness

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Health and Wellness Supports <small>(Behavioral Health Prevention Education Service) (Delivery Of Services With Target Population To Affect Knowledge, Attitude And/Or Behavior)</small>	Practitioner Level 3, In-Clinic	H0025	U3	U6			\$ 30.01	Practitioner Level 3, Out-of-Clinic	H0025	U3	U7			\$ 36.68
	Practitioner Level 4, In-Clinic	H0025	U4	U6			\$ 20.30	Practitioner Level 4, Out-of-Clinic	H0025	U4	U7			\$ 24.36
	Practitioner Level 5, In-Clinic	H0025	U5	U6			\$ 15.13	Practitioner Level 5, Out-of-Clinic	H0025	U5	U7			\$ 18.15
Unit Value	15 minutes							Maximum Daily Units	6 Units					
Initial Authorization	400 units							Re-Authorization	400 units					
Authorization Period	180 Days							Utilization Criteria	<u>LOCUS Scores: 3-6</u>					
Service Definition	<p>Definition of Service: This is a one-to-one service in which the Whole Health & Wellness Coach (CPS) assists the individual with setting his/her personal expectations, introducing health objectives as an approach to accomplishing overall life goals, helping identify personal and meaningful motivation, and health/wellness self-management. The individual served should be supported to be the director of his/her health through identifying incremental and measurable steps/objectives that make sense to the person, considering these successes as a benchmark for future success.</p> <p>Health engagement and health management for the individual are key objectives of the service. These should be accomplished by facilitating health dialogues; exploring the multiple choices for health engagement; supporting the individual in overcoming fears and anxiety related to engaging with health care providers and procedures; promoting engagement with health practitioners including, at a minimum, participating in an annual physical; assisting the individual in the work of finding a compatible primary physician who is trusted; among other engagement activities.</p> <p>Another major objective is promoting access to health supports. This is accomplished by using technology to support the individual's goals; providing materials which assist in structuring the individual's path to prevention, healthcare, and wellness; partnering with the person to navigate the health care system; assisting the person in developing his/her own natural support network which will promote that individual's wellness goals; creating solutions with the person to overcome barriers which prevent healthcare engagement (e.g. transportation, food stamps, shelter, medications, safe environments in which to practice healthy choices, etc.); and linking the individual with other health and wellness resources (physical activity, fitness, healthy/nutritional food).</p> <p>The Whole Health & Wellness Coach (CPS) and supporting nurse also provide the following health skill-building and supports:</p> <ul style="list-style-type: none"> • share basic health information which is pertinent to the individual's personal health; • promote awareness regarding health indicators; • assist the individual in understanding the idea of whole health and the role of health screening; • support behavior changes for health improvement; • make available wellness tools (e.g. relaxation response, positive imaging, education, wellness toolboxes, daily action plans, stress management, etc.) to support the individual's identified health goals; 													

Peer Support Whole Health & Wellness

- provide concrete examples of basic health changes and work with the individual in his/her selection of incremental health goals;
- teach/model/demonstrate skills such as nutrition, physical fitness, healthy lifestyle choices;
- promote and offer healthy environments and skills-development to assist the individual in modifying his/her own living environments for wellness;
- support the individual as they practice creating healthy habits, personal self-care, self-advocacy and health communication (including but not limited to disclosing history, discussing prescribed medications, asking questions in health settings, etc.);
- support the individual to identify and understand how his/her family history, genetics, etc. contribute to their overall health picture;
- support the individual in understanding medication and related health concerns; and
- promote health skills, considering fitness, healthy choices, nutrition, healthy meal preparation, teaching early warning signs/symptoms which indicate need for health intervention, etc.

Specific interventions may also include supporting the individual in being able to have conversations with various providers to access health support and treatment and assisting individuals in gaining confidence in asserting their personal health concerns and questions, while also assisting the person in building and maintaining self-management skills. Health should be discussed as a process instead of a destination.

Assistance will be provided to the individual to facilitate his/her active participation in the development of the Individualized Recovery Plan (IRP) health goals which may include but not be limited to attention to dental health, healthy weight management, cardiac health/hypertension, vision care, addiction, smoking cessation, vascular health, diabetes, pulmonary, nutrition, sleep disorders, stress management, reproductive health, human sexuality, and other health areas.

These interventions are necessarily collaborative: partnering with health providers and partnering with the individual served in dialogues with other community partners and supporters to reinforce and promote healthy choices. The Whole Health & Wellness Coach (CPS) must also be partnered with the identified supporting nurse and other licensed health practitioners within the organization to access additional health support provided by the organization or to facilitate health referral and access to medical supports external to the organization providing this service.

The interventions are based upon respectful and honest dialogue supported by motivational coaching. The approach is strengths-based: sharing positive perspectives and outcomes about managing one's own health, what health looks like when the person gets there (visioning), assisting a person with re-visioning his/her self-perception (not as "disabled"), assisting the person in recognizing his/her own strengths as a basis for motivation, and identifying capabilities and opportunities upon which to build enhanced health and wellness. The peer-to-peer basis for the service allows the sharing of personal experience, including modeling wellness and mutual respect and support that is also respectful of the individualized process and journey of recovery. This equality partnership between the supported individual and the Whole Health & Wellness Coach (CPS) should serve as a model for the individual as he/she then engages in other health relationships with health services practitioners. As such the identified nurse member of the team is in a supporting role to the Whole Health & Wellness Coach (CPS).

A mind/body/spirit approach is essential to address the person's whole health. Throughout the provision of these services the practitioner addresses and accommodates an individual's unique sense of culture, spirituality, and self-discovery, assisting individuals in understanding shared-decision making, and in building a relationship of mutual trust with health professionals.

Admission Criteria

1. Individual must have two co-existing serious health conditions (hypertension, diabetes, obesity, cardiovascular issues, pulmonary issues, etc.), one of which is a mental health condition; **and one or more of the following:**
2. Individual requires and will benefit from support of Whole Health & Wellness Coaches (CPSs) for the acquisition of skills needed to manage health symptoms and utilize/engage community health resources; **or**
3. Individual may need assistance to develop self-advocacy skills in meeting health goals, engaging in health activities, utilizing community-health resources, and accessing health systems of care; **or**
4. Individual may need peer modeling to take increased responsibilities for his/her own recovery and wellness.

Peer Support Whole Health & Wellness

Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual continues to meet admission criteria; and 2. Progress notes document progress relative to health goals identified in the Individualized Recovery/Resiliency Plan, but treatment/recovery/wellness goals have not yet been achieved.
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Recovery Plan have been substantially met; or 3. Individual/family requests discharge.
Service Exclusions	Individuals receiving Assertive Community Treatment are excluded from this service. (If an ACT team has a Whole Health & Wellness Coach (CPS), then that Whole Health & Wellness Coach (CPS) can provide this intervention but would bill through that team's existing billing mechanisms).
Clinical Exclusions	Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition co-existing with one of the following diagnoses: mental retardation/developmental disabilities, autism, organic mental disorder, substance-related disorder, or traumatic brain injury.
Required Components	<ol style="list-style-type: none"> 1. There is documentation available which evidences a minimum monthly team meeting during which the Whole Health & Wellness Coach/s and the agency-designated RN/s convene to: <ol style="list-style-type: none"> a. promote communication strategies, b. confer about specific individual health trends, c. consult on health-related issues and concerns, and d. brainstorm partnered approaches in supporting the person in achieving his/her whole health goals. 2. Services and interventions must be individually tailored to the needs, goals, preferences and assets of the individual with the goals of wellness and recovery as defined by the individual. 3. At least 60% of all service units must involve face-to-face contact with individuals. The remainder of direct billable service includes telephonic intervention directly with the person or is contact alongside the person to navigate and engage in health and wellness systems/activities.
Staffing Requirements	<ol style="list-style-type: none"> 1. This service is delivered in a one-to-one service model by a single practitioner to single individual served. 2. The following practitioners can provide Peer Supported Whole Health & Wellness: <ul style="list-style-type: none"> • Practitioner Level 3: RN (only when he/she is identified in the agency's organizational chart as being the specific support nurse to the CPS) • Practitioner Level 4: Whole Health & Wellness Coach (CPS) with Master's or Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology. under supervision of a licensed independent practitioners • Practitioner Level 5: Whole Health & Wellness Coach (CPS) with high school diploma/equivalent under supervision of one of the licensed/credentialed professionals above 3. Partnering team members must include: <ul style="list-style-type: none"> ○ A Whole Health & Wellness Coach (CPS) who promotes individual self-determination, whole health goal setting, decision-making and provides essential health coaching and support to promote activities and outcomes specified above. ○ An agency-designated Registered Nurse/s who provides back-up support to the Whole Health & Wellness Coach (CPS) in the monitoring of each individual's health and providing insight to the Whole Health & Wellness Coach (CPS) as they engage in the health coaching activities described above. 4. There is no more than a 1:30 CPS-to-individual ratio. 5. The Whole Health & Wellness Coach (CPS) shall be supervised by a licensed independent practitioner (who may also be the RN partner). 6. The Whole Health & Wellness Coach (CPS) is the lead practitioner in the service delivery. The RN will be in a health consultation role to the Whole Health & Wellness Coach (CPS) and the individual served. The nurse should also be prepared to provide clinical consultation to the Whole Health & Wellness Coach (CPS) if there is an emerging health need; however, the individual is in charge of his/her own health process and this self-direction must be acknowledged throughout the practice of this service. 7. The agency supports and promotes the participation of Whole Health & Wellness Coaches (CPSs) in statewide technical assistance initiatives which enhance the skills and development of the CPS.

Peer Support Whole Health & Wellness

Clinical Operations	<p>The program shall have an Organizational Plan which will describe the following:</p> <ol style="list-style-type: none"> How the served individual will access the service; How the preferences of the individual will be supported in accomplishing health goals; Relationship of this service to other resources of the organization; An organizational chart which delineates the relationship between the Whole Health & Wellness Coach (CPS) and the RN. Whole Health & Wellness Coach (CPS) engagement expectations with the individuals served (e.g. planned frequency of contact, telephonic access, etc.) The consultative relationship between the Whole Health & Wellness Coach (CPS) and the RN.
Service Accessibility	There is a minimum contact expectation with an individual weekly, either face-to-face or telephonically to track progress on the identified health goal. Unsuccessful attempts to make contact shall be documented.
Documentation Requirements	<ol style="list-style-type: none"> All applicable Medicaid, MICP, and other DBHDD reporting requirements must be met. There is documentation available which demonstrates a minimum monthly team meeting during which the Whole Health & Wellness Coach CPSs and the agency-designated RN/s convene to discuss items identified in Required Components Item 1 in this definition.
Reporting and Billing Requirements	The only RN/s who are allowed to bill this service are those who are identified in the agency's organizational chart as being the specific support nurse to the CPS for this wellness service.

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Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Psychosocial Rehabilitation	Practitioner Level 4, In-Clinic	H2017	HQ	U4	U6		\$17.72	Practitioner Level 4, Out-of-Clinic	H2017	HQ	U4	U7		\$21.64
	Practitioner Level 5, In-Clinic	H2017	HQ	U5	U6		\$13.20	Practitioner Level 5, Out-of-Clinic	H2017	HQ	U5	U7		\$16.12
Unit Value	Unit=1 hour							Maximum Daily Units	5 units					
Initial Auth	300 units							Re-Authorization	300 units					
Auth Period	180 days							Utilization Criteria	LOCUS scores: 3-6					
Service Definition	<p>A therapeutic, rehabilitative, skill building and recovery promoting service for individuals to gain the skills necessary to allow them to remain in or return to naturally occurring community settings and activities. Services include, but are not limited to:</p> <ol style="list-style-type: none"> Individual or group skill building activities that focus on the development of skills to be used by individuals in their living, learning, social and working environments, Social, problem solving and coping skill development; Illness and medication self-management; Prevocational skills (for example: preparing for the workday; appropriate work attire and personal presentation including hygiene and use of personal effects such as makeup, jewelry, perfume/cologne etc. as appropriate to the work environment; time management; prioritizing tasks; taking direction from supervisors; appropriate use of break times and sick/personal leave; importance of learning and following the policies/rules and procedures of the workplace; workplace safety; problem solving/conflict resolution in the workplace; communication and relationships with coworkers and supervisors; resume and job application development; on-task behavior and task completion skills such as avoiding distraction from work tasks, following a task through to completion, asking for help when needed, making sure deadlines are clarified and adhered to, etc.; learning common work tasks or daily living tasks likely to be utilized in the workplace such as telephone skills, food preparation, organizing/filing, scheduling/participating in/leading meetings, computer skills etc.) and Recreational activities/leisure skills that improve self-esteem and recovery. <p>The programmatic goals of the service must be clearly articulated by the provider, utilizing a best/evidence based model for service delivery and support. These</p>													

Psychosocial Rehabilitation-Group (Effective 6/1/13 replacing Psychosocial Rehabilitation)

	<p>best/evidence based models may include: the Boston University Psychosocial Rehabilitation approach, the Lieberman Model, the International Center for Clubhouse Development approach, or blended models/approaches in accordance with current psychosocial rehabilitation research. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based models and practices for psychosocial rehabilitation.</p> <p>This service is offered in a group setting. Group activities and interventions should be made directly relevant to the needs, desires and IRP goals of the individual participants (i.e. an additional activity/group should be made available as an alternative to a particular group for those individuals who do not need or wish to be in that group, as clinically appropriate).</p>
Admission Criteria	<ol style="list-style-type: none"> 1. Individual must have primary behavioral health issues (including those with a co-occurring substance abuse disorder or MR/DD) and present a low or no risk of danger to themselves or others; and one or more of the following: 2. Individual lacks many functional and essential life skills such as daily living, social skills, vocational/academic skills and/or community/family integration; or 3. Individual needs frequent assistance to obtain and use community resources.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Primary behavioral health issues that continue to present a low or no imminent risk of danger to themselves or others (or is at risk of moderate to severe symptoms); and one or more of the following: 2. Individual improvement in skills in some but not all areas; or 3. If services are discontinued there would be an increase in symptoms and decrease in functioning
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Individual has acquired a significant number of needed skills; or 3. Individual has sufficient knowledge and use of community supports; or 4. Individual demonstrates ability to act on goals and is self-sufficient or able to use peer supports for attainment of self-sufficiency; or 5. Individual/family need a different level of care; or 6. Individual/family requests discharge.
Service Exclusions	<ol style="list-style-type: none"> 1. Cannot be offered in conjunction with SA Day Services. 2. Service can be offered while enrolled in a Crisis Stabilization Unit in a limited manner when documentation supports this combination as a specific need of the individual. Time and intensity of services in PSR must be at appropriate levels when PSR is provided in conjunction with other services. (This will trigger a review by the External Review Organization). This service cannot be offered in conjunction with Medicaid MR Waiver services.
Clinical Exclusions	<ol style="list-style-type: none"> 1. Individuals who require one-to-one supervision for protection of self or others. 2. Individual has primary diagnosis of substance abuse, developmental disability, autism, or organic mental disorder without a co-occurring DSM IV mental disorder diagnosis.
Required Components	<ol style="list-style-type: none"> 1. This service must operate at an established clinic site approved to bill Medicaid for services. However, individual or group activities should take place offsite in natural community settings as is appropriate to the participating individual's Individualized Recovery Plan. 2. This service may operate in the same building as other day-model services; however, there must be a distinct separation between services in staffing, program description, and physical space during the hours the PSR program is in operation except as described above. 3. Adequate space, equipment, furnishings, supplies and other resources must be provided in order to effectively provide services and so that the program environment is clean and in good repair. Space, equipment, furnishings, supplies, transportation, and other resources for individual use within the PSR program must not be substantially different from that provided for other uses for similar numbers of individuals. 4. The program must be operated for no less than 25 hours/week, typically during day, evening and weekend hrs. No more than 5 hours/day may be billed per individual. 5. A PSR program must operate to assist individuals in attaining, maintaining, and utilizing the skills and resources needed to aid in their own rehabilitation and recovery.
Staffing Requirements	<ol style="list-style-type: none"> 1. The program must be under the direct programmatic supervision of a Certified Psychiatric Rehabilitation Practitioner (CPRP), or staff who can demonstrate activity toward attainment of certification (an individual can be working toward attainment of the certification for up to one year under a non-renewable waiver which will be granted by the DBHDD Regional Coordinator). For purposes of this service "programmatic supervision" consists of the day-to-day oversight of the program as it operates (including elements such as maintaining the required staffing patterns, staff supervision, daily adherence to the program model, etc.) 2. Additionally, the program must be under the clinical oversight of an independently licensed practitioner (this should include meeting with the programmatic leadership on

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	<p>a regular basis to provide direction and support on whether the individuals in the program are clinically improving, whether the design of the program promotes recovery outcomes, etc.).</p> <ol style="list-style-type: none"> 3. There must be a CPRP with a Bachelor's Degree present at least 80% of all time the service is in operation regardless of the number of individuals participating. 4. The maximum face-to-face ratio cannot be more than 12 individuals to 1 direct service/program staff (including CPRPS) based on average daily attendance of individuals in the program. 5. At least one CPRP (or someone demonstrating activity toward attainment of certification) must be onsite face-to-face at all times (either the supervising CPRP or other CPRP staff) while the program operates regardless of the number of individuals participating. All staff are encouraged to seek and obtain the CPRP credential. All staff must have an understanding of recovery and psychosocial rehabilitation principles as defined by USPRA and must possess the skills/ability to assist individuals in their own recovery processes. 6. Basic knowledge for all staff serving individuals with mental illness or substance abuse in "co-occurring capable" day services must include the content areas in <i>Georgia DBHDD Suggested Best Practices: Principles and Staff Capabilities for Day Services Serving Adults with Co-Occurring Disorders of Substance Abuse and Mental Illness</i>. 7. Programs must have documentation that there is one staff person that is "co-occurring capable." This person's knowledge must go beyond basic understanding and must demonstrate actual staff capabilities in using that knowledge for individuals with co-occurring disorders. Personnel documentation should demonstrate that this staff person has received a minimum of 4 hours of training in co-occurring treatment within the past 2 years. 8. If the program does not employ someone who meets the criteria for a MAC, CACII, and/or CADC, then the program must have documentation of access to an addictionologist and/or one of the above for consultation on addiction-related disorders as co-occurring with the identified mental illness.
Clinical Operations	<ol style="list-style-type: none"> 1. Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. 2. Rehabilitation services facilitate the development of an individual's skills in the living, learning, social, and working environments, including the ability to make decisions regarding: self-care, management of illness, life work, and community participation. The services promote the use of resources to integrate the individual into the community. 3. Rehabilitation services are individual-driven and are founded on the principles and values of individual choice and active involvement of individuals in their rehabilitation. Through the provision of both formal and informal structures individuals are able to influence and shape service development. 4. Rehabilitation services must include education on self-management of symptoms, medications and side effects; identification of rehabilitation preferences; setting rehabilitation goals; and skills teaching and development. 5. All individuals should participate in setting individualized goals for themselves and in assessing their own skills and resources related to goal attainment. Goals are set by exploring strengths and needs in the individual's living, learning, social, and working environments. Implementation of services may take place individually or in groups. 6. Each individual must be provided assistance in the development and acquisition of needed skills and resources necessary to achieve stated goals. 7. PSR programs must offer a range of skill-building and recovery activities from which individuals choose those that will most effectively support achievement of the individual's rehabilitation and recovery goals. These activities must be developed based on participating individual's input and stated interests. Some of these activities should be taught or led by consumers themselves as part of their recovery process. 8. A PSR program must be capable of serving individuals with co-occurring disorders of mental illness and substance abuse utilizing integrated methods and approaches that address both disorders at the same time (e.g. groups and occasional individual interventions utilizing approaches to co-occurring disorders such as motivational interviewing/building motivation to reduce or stop substance use, stage based interventions, refusal skill development, cognitive behavioral techniques, psychoeducational approaches, relapse prevention planning and techniques etc.). For those individuals whose substance abuse and dependence makes it difficult to benefit from the PSR program, even with additional or modified methods and approaches, the PSR program must offer co-occurring enhanced services or make appropriate referrals to specialty programs specifically designed for such individuals. 9. The program must have a PSR Organizational Plan addressing the following: <ol style="list-style-type: none"> a. Philosophical principles of the program must be actively incorporated into all services and activities including (adapted from Hughes/Weinstein): <ol style="list-style-type: none"> i. View each individual as the director of his/her rehabilitation process

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- ii. Solicit and incorporate the preferences of the individuals served
- iii. Believe in the value of self-help and facilitate an empowerment process
- iv. Share information about mental illness and teach the skills to manage it
- v. Facilitate the development of recreational pursuits
- vi. Value the ability of each individual with a mental illness to seek and sustain employment and other meaningful activities in a natural community environment
- vii. Help each individual to choose, get, and keep a job (or other meaningful daily activity)
- viii. Foster healthy interdependence
- ix. Be able to facilitate the use of naturally occurring resources to replace the resources of the mental health system
- b. Services and activities described must include attention to the following:
 - i. Engagement with others and with community
 - ii. Encouragement
 - iii. Empowerment
 - iv. Consumer Education and Training
 - v. Family Member Education and Training
 - vi. Assessment
 - vii. Financial Counseling
 - viii. Program Planning
 - ix. Relationship Development
 - x. Teaching
 - xi. Monitoring
 - xii. Enhancement of vocational readiness
 - xiii. Coordination of Services
 - xiv. Accommodations
 - xv. Transportation
 - xvi. Stabilization of Living Situation
 - xvii. Managing Crises
 - xviii. Social Life
 - xix. Career Mobility
 - xx. Job Loss
 - xxi. Vocational Independence
- c. A description of the particular rehabilitation models utilized, types of interventions practiced, and typical daily activities and schedule.
- d. A description of the staffing pattern, plans for staff who will achieve CPRP credentials, and how staff are deployed to assure that the required staff-to-individual ratios are maintained, including how unplanned staff absences, illnesses, and emergencies are accommodated.
- e. A description of how the program will assure that it is co-occurring capable and how it will adjust or make appropriate referrals for individuals needing a co-occurring enhanced PSR program.
- f. A description of the hours of operation, the staff assigned, and the types of services and activities provided for individuals, families, parents, and/or guardians including how individuals are involved in decision-making about both individual and program-wide activities.
- g. A description of the daily program model organized around 50 minutes of direct programmatic intervention per programmatic hour. The 10 remaining minutes in the hour allows supported transition between PSR-Group programs and interventions.
- h. A description of how the plan for services and activities will be modified or adjusted to meet the needs specified in each IRP.
- i. A description of services and activities offered for education and support of family members.

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	j. A description of how individual requests for discharge and change in services or service intensity are handled and resolved.
Service Access	A PSR program must be open for no less than 25 hours a week, typically during day, evening and weekend hours. No more than 5 hours per day may be billed per/individual.
Billing and Reporting Requirements	Units of service by practitioner level must be aggregated daily before claim submission.
Documentation Requirements	<ol style="list-style-type: none"> 1. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section III of the Provider Manual. 2. Each hour unit of service provided must be documented within the individual's medical record. Although there is no single prescribed format for documentation (a log may be used), the following elements MUST be included for every unit of service provided: <ol style="list-style-type: none"> a. the specific type of intervention must be documented b. the date of service must be named c. the number of unit(s) of service must be named d. the practitioner level providing the service/unit must be named <p>For example, a group led by a Practitioner Level 4 that lasts 1 hour should be documented as 4 units of H0017U4U6 and the intervention type should be noted (such as "Enhancement of Recovery Readiness" group).</p> 3. A weekly log should be present in the record which includes a summary of each day's participation in the programmatic group content. 4. The provider has several alternatives for documenting progress notes: <ol style="list-style-type: none"> a. Weekly progress notes must document the individual's progress relative to functioning and skills related to the person-centered goals identified in his/her IRP. This progress note aligns the weekly PSR-Group activities reported against the stated interventions on the individualized recovery plan, and documents progress toward goals. This progress note may be written by any practitioner who provided services over the course of that week; or b. If the agency's progress note protocol demands a detailed daily note which documents the progress above, this daily detail note can suffice to demonstrate functioning, skills, and progress related to goals and related to the content of the group intervention; or c. If the agency's progress note protocol demands a detailed hourly note which documents the progress above, this daily detail note can suffice to demonstrate functioning, skills, and progress related to goals and related to the content of the group intervention. 5. While billed in increments, the PSR-Group service is a program model. Daily time in/time out to the program is tracked for while the person is present in the program, but due to time/in out not being required for each hourly intervention, the time in/out may not correlate with the units billed for the day. However, the units noted on the log should be consistent with the units billed and, if noted, on the weekly progress note. If the units documented are not consistent, the most conservative number of units will be utilized. 6. A provider shall only record units in which the individual was actively engaged in services. Any time allocated in the programmatic description for meals typically does not include organized programmatic group content and therefore would not be included in the reporting of units of service delivered. Should an individual leave the program or receive other services during the range of documented time in/time out for PSR-Group hours, the absence should be documented on the log. 7. Rounding is applied to the person's cumulative hours/day at the PSR program (excluding non-programmatic time). The provider shall follow the guidance in the rounding policy included in this Provider Manual, and, specific to this service, the person served must have participated in at least 50% of the hour in order to bill for one unit of this service. So for instance, if an individual participates in the program from 9-1:15 excluding a 30 minute break for lunch, his/her participating hours are 3.75 hours. The rounding policy is applied to the .75 hour and the units billed for that day are 4 units. Practitioner type must still be addressed and so that 4 units must be adequately assigned to either a U4 or U5 practitioner type as reflected in the log for that day's activities. 8. When this service is used in conjunction with Crisis Stabilization Units, Peer Supports, and ACT (on a limited basis), documentation must demonstrate careful planning to maximize the effectiveness of this service as well as appropriate reduction in service amounts of PSR-group based upon current medical necessity. Utilization of psychosocial rehabilitation in conjunction with these services is subject to additional review by the External Review Organization.

Women's Treatment and Recovery Support (WTRS): Outpatient Services

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
RFW- Intensive Outpatient P0008														
Unit Value	1 hour							Maximum Daily Units	1 day					
Initial Authorization	180 days							Re-Authorization	180 days					
Authorization Period	180 days							Utilization Criteria	LOCUS scores: 2-4					
Service Definition	<p>WTRS Outpatient Services will provide comprehensive gender specific treatment for addictions. These services will encompass ASAM Level 1 Outpatient services and ASAM Level 2.1 Intensive Outpatient Services. ASAM Level 1 outpatient encompasses organized services that may be delivered in a wide variety of settings. Such services are provided in regularly scheduled sessions and follow a defined set of policies and procedures. ASAM Level 2.1 is an intensive outpatient set of services that maybe offered during the day, before or after work, in the evening or on weekends. Such programs provide essential support and treatment services while allowing the individual to apply his/her newly acquired skills in "real world "environments. The WTRS Outpatient Program assumes an average length of stay in outpatient treatment of 4 to 12 months or based on individual clinical need.</p>													
Admission Criteria	<ol style="list-style-type: none"> 1. Individual must: <ol style="list-style-type: none"> a. have a primary substance use disorder; and b. meet criteria for the DBHDD Core Customer eligibility (Part I of this manual). 2. These contracted slots are for any woman with no other means to pay for services (Corrections, DFCS, court referred, etc.). 3. Admissions and Interim Services Policy for Pregnant Consumers: Federal regulations gives priority admissions to certain populations in the following order: Pregnant injecting drug users, other pregnant drug users, other injecting drug users, and all other users. All addictions providers are required to adhere to the priority admission policy (including pregnant woman that are actively taking an opiate substitute). In the event a woman is unable to continue her medication regimen the provider must make the appropriate referral and contact the state office within 48 hours. 													
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. The individual's condition continues to meet the admission criteria; 2. Documentation reflects continuing progress of the individual's recovery plan within this level of care; 3. There is a reasonable expectation that the individual can achieve the goals in the necessary time frame; 4. In the event the length of stay needs to be extended, additional documentation is required to be submitted to the DBHDD Women's Treatment Coordinator. All services are individualized and clinical discretion is to be used when evaluating levels of care. The maximum length of stay is twelve (12) months. 													
Discharge Criteria	<ol style="list-style-type: none"> 1. A discharge/transition plan is completed and linkages are in place; and one or more of the following: <ol style="list-style-type: none"> a. Goals of the treatment plan have been substantially met; or b. If a consumer is involved with DFCS or another referring agency, a discharge staffing should be completed in collaboration with both WTRS and other referring organizations before discharge 2. To discharge an individual before clinically appropriate, a clinical staffing and a discharge summary must be completed. and the following information must be documented: 3. Transfer to a higher level of service is warranted if the individual requires services not available at this level. 													
Service Exclusions	<p>Services cannot be offered with Mental Health Intensive Outpatient Package, SA Intensive Outpatient Package, Psychosocial Rehabilitation, or other WTRS residential treatment service.</p>													

Women's Treatment and Recovery Support (WTRS): Outpatient Services

Clinical Exclusions	<ol style="list-style-type: none"> 1. If an individual is actively suicidal or homicidal with a plan and intent 2. Women should have no cognitive and/ or intellectual impairments which will prevent them from participating in and benefiting from the recommended level of care 3. Withdrawal Management and impairments needs must be met prior to admission to the program(alternative provider and/ or community resources should be used to serve women with acute treatment needs) 4. Women must be medically stable in order to participate in treatment. 						
Required Components	<ol style="list-style-type: none"> 1. Services must be licensed by DCH/HFR under the Rules and Regulations for Drug Abuse Treatment Program, 290-4-2. 2. Individuals receiving services must have a substance use disorder present in the medical record prior to initiation of services. The diagnosis must be given by a practitioner identified in O.C.G.A. Practice Acts as qualified to provide a diagnosis. 3. Each individual should participate in setting individualized goals for themselves. 4. Services may take place individually or in groups. 5. Each consumer must be oriented into the program and receive a copy of rules and regulations and client rights. A program handbook is recommended. 6. Treatment plan reviews must be completed every 60 days and staffing should be conducted involving all necessary participants WTRS Treatment Review Form is recommended. 7. Use of ASAM is required to determine level of care during each phase of treatment. These levels are to be assessed regularly, must be individualized, and clinical judgment must be used. 8. All WTRS work providers must provide all services included in the WTRS package. 9. All WTRS work providers must offer the following groups: Addiction Treatment Groups, Relapse Prevention, Trauma Groups, Criminal Addictive Thinking/Irrational Thinking, Anger Management, Co-Occurring Disorders, Life Skills, Family Dynamics and Health Relationships including HIV/AIDS. The recommended curricula for the above groups are: <ul style="list-style-type: none"> • The MATRIX with the Women Supplement , • Helping Women Recover, • A Woman's Way through the 12 Steps, • TREM, • Seeking Safety, • A New Direction Criminal and Addictive Thinking, • SAMHSA Anger Management, and • Matrix Family Component. 10. The chart below shows the required hours of treatment for each ASAM level. All services are individualized and clinical discretion should be used when evaluating levels of care: <table border="1" style="margin-left: 40px; margin-top: 10px; border-collapse: collapse; width: 50%;"> <thead> <tr> <th style="padding: 5px;">ASAM Level of Care</th> <th style="padding: 5px;">Hours Per Week</th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;">Level 2.1</td> <td style="padding: 5px;">15 hours</td> </tr> <tr> <td style="padding: 5px;">Level 1</td> <td style="padding: 5px;">up to 8 hours</td> </tr> </tbody> </table> 	ASAM Level of Care	Hours Per Week	Level 2.1	15 hours	Level 1	up to 8 hours
ASAM Level of Care	Hours Per Week						
Level 2.1	15 hours						
Level 1	up to 8 hours						
Staffing Requirements	<ol style="list-style-type: none"> 1. Program Coordinator Qualifications: <ol style="list-style-type: none"> a. At least two (2) years of documented work experience in a Gender Specific and/or Addiction Treatment Program. b. Level 4 or higher with co-occurring disorders experience defined in the DBHDD Provider Manual. This person's knowledge must go beyond basic understanding and must demonstrate actual staff capabilities in using knowledge for individuals with co-occurring disorders. Staff person must demonstrate a minimum of 5 hours per year of training in co-occurring treatment. Effective 1/1/10 programs must have documentation that there is at least 1 level 4 staff (excluding PP, ST and Addiction Counselor Trainee that is co-occurring capable) c. A CACI working towards obtaining a CAC II within two years can work in this position. The Provider is required to keep documentation of supervision and the anticipated test date 2. Program Manager or Lead Counselors Qualifications: <ol style="list-style-type: none"> a. At least one (1) year of documented work experience in a Gender Specific and/or Addiction Treatment Program. 						

Women's Treatment and Recovery Support (WTRS): Outpatient Services

	<ul style="list-style-type: none"> b. Level 4 practitioners or a CAC I with co-occurring disorders experience or higher staff as defined in the DBHDD Provider Manual <p>3. Programmatic Staff Qualifications:</p> <ul style="list-style-type: none"> a. All WTRS practitioners with no documented experience should be orientated on the biological and psychosocial dimensions of substance use disorders and trained in evidence-based models and best practices. This orientation should also include "Introduction to Women and Substance Use Disorders" On-line course. This must be completed within the first 90 days of employment b. Level 4 practitioner with co-occurring disorders experience or higher staff as defined in the DBHDD Provider Manual c. Non-clinical staff and Level 5 practitioners, must be under the supervision of an onsite Level 4 practitioner(excluding ACT, ST) as defined in the DBHDD Provider Manual <p>4. WTRS Provider must have at least one program director to oversee residential and outpatient.</p> <p>5. Each WTRS program must have a distinct separation in staff</p> <p>6. The provider must provide assurance that all program staff will have appropriate background checks and credential verifications.</p>
Clinical Operations	<ul style="list-style-type: none"> 1. The program must be under clinical supervision of a Level 4 or above excluding an ACT/ST who is onsite during normal operating hours. 2. All clinical services must be provided by the appropriate practitioner based on the DBHDD practitioner's guide. 3. The program shall conduct random drug screening and use the results of these tests for marking the individual's progress toward goals and for service planning. 4. Addiction treatment services and programming must demonstrate a primary focus on Group Counseling that consists of Cognitive Behavioral groups (which rearrange patterns of thinking and action that lead to addiction.) Group training, such as psychoeducational groups (which teach about substance use disorder and skills development groups, which hone the skills necessary to break free of addictions) may also be offered in combination with group counseling but must not serve as the only group component. At least fifty percent (50%) of groups provided on a weekly based on the ASAM Level of Care must be counseling. 5. Limited individual or group activities may take place off-site in natural community setting as is appropriate to each individual's treatment plan. (NO Services are to take place at the individual's place of residence unless it is outreach). 6. Recovery Support meetings may not be counted towards hours for any treatment sessions if the session goes beyond the basic introduction to the Recovery Support experience. 7. Hours of operation should be accommodating for individuals who work (i.e. evening/weekend hours). 8. WTRS services may operate in the same building as other services; however there must be a distinct separation between services, living space and staff. 9. Adequate space, equipment, furnishings, supplies and other resources must be provided in order to effectively provide services and so that the program environment is clean and in good repair. 10. The Department's Evidence Based Practices and curriculums are to be utilized for the target area of treatment. Practitioners providing these services are expected to maintain knowledge and skills regarding current research trends in best evidence based practices. 11. The program must have a WTRS Services Organizational Plan Addressing the Following: <ul style="list-style-type: none"> a. The philosophical model of the program and the expected outcomes for program participants (i.e., harm reduction, abstinence, beginning of or maintaining individually defined recovery, employment readiness, relapse, prevention, stabilization and treatment of those with co-occurring disorder) b. The schedule of activities and hours of operations c. Staffing patterns for the program d. How assessments will be conducted e. How the program will support pregnant women that require medication assisted treatment f. How staff will be trained in the administration of addiction services and treatment of co-occurring disorders according to the Georgia Best Practices g. How services for individuals with co-occurring disorders will be flexible and will include services and activities addressing both mental health and addictions. h. How individuals with co-occurring disorders or other special needs who cannot be served in the regular program activities will be provided and/or referred for time-limited special integrated services that are co-occurring enhanced as described in the Georgia Suggested Best Practices i. How services will be coordinated with addiction services including assuring or arranging for appropriate referrals and transitions (Including transportation) 12. Staff training and development is required to be addressed by the provider as evidenced by the following:

Women's Treatment and Recovery Support (WTRS): Outpatient Services

Clinical Operations, continued	<ul style="list-style-type: none"> a. All WTRS treatment prn staff are required to participate in staff development and ongoing training as required by the community standards, HFR regulations, and national accrediting bodies. b. As a part of this already mandated staff development and training, WTRS staff should have at least thirty (30) hours of addiction specific training annually, in accordance with HFR regulations. c. Licensed and certified staff is required to have at least Six (6) hours out of the Thirty (30) hours in the area of gender-specific women's addiction modalities and treatment skills d. All employees including house parents should complete the SAMHSA's Introduction to Women and Substance Use Disorders On-Line Course within 90 days of employment. To enroll in the Introduction to Women and Substance Use Disorders On-line course go to: http://healthknowledge.org/ addition modalities and treatment skills. e. All non-licensed and or non-certified staff that provide services must complete at least 6 hours of gender specific training, annually. f. All employees including house parents should complete the SAMHSA's Introduction to Women and Substance Use Disorders On-Line Course within 90 days of employment. To enroll in the Introduction to Women and Substance Use Disorders On-line course go to: http://healthknowledge.org/. g. Training can be provided via e-learning or face to face. h. Each treatment provider is required to train new program staff on the following: <ul style="list-style-type: none"> i. Understanding the WTRS program requirements; ii. Understanding Healthcare Facility Regulations (HFR); iii. Understanding of administering the MICP; iv. Understanding ASAM levels of care; v. Understanding current DFCS policies related to the WTRS program.
Documentation Requirements	<ol style="list-style-type: none"> 1. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section III of the Provider Manual. 2. Each consumer requires a New Episode MICP. If a registration MICP is completed at the time of intake, an ongoing MICP must be completed when consumer enters a WTRS program. Clients must be authorized und WTRS Outpatient packages. 3. Every admission and assessment must be documented. 4. Progress/Group notes must be written daily and signed by the staff that performed the service 5. Daily attendance of each individual participating in the program must be documented by evidence of a group sign-in roster. 6. Clinicians are to sign and date each note with only the correct approved DBHDD credentials based on the practitioners table. The individual that provides the service must complete the note. 7. Results of Drug Screen must be documented. 8. All WTRS providers are required to provide a complete biopsychosocial assessment in addition to the State of Georgia's Multipurpose Information Consumer Profile (MICP). All consumers require a MICP to be completed and submitted to APS Healthcare within the established time frame 9. The Level of Care will be determined according to the American Society of Addiction Medicine (ASAM) for assessing the severity and intensity of services a n d LOCUS score. The ASAM justification form must be included in consumer's chart. 10. Provider must complete the WTRS vocational assessment within 30 days of admissions. Assessment must be placed in consumer's medical record.

Women's Treatment and Recovery Support (WTRS): Residential Treatment

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
RFW-Residential P0009														
Unit Value	1 day							Maximum Daily Units	1 day					
Initial Authorization	180 days							Re-Authorization	180 days					
Authorization Period	180 days							Utilization Criteria	<u>LOCUS scores: 3-5</u>					
Service Definition	<p>Women's Treatment and Recovery Support Residential Program will provide comprehensive gender specific treatment for addictions. These services will encompass ASAM level 3.1 Clinically Managed Low -Intensity Residential Services and 3.5 Clinically Managed High-Intensity Residential Services level of care and Therapeutic ChildCare. ASAM Level 3.1 programs offer at least 10 hours per week of low-intensity treatment focusing on improving the individual's readiness to change. Services may include individual, group, and family therapy; medication management and medication education, mental health evaluation and treatment; vocational rehabilitation and job placement ; and either introductory or remedial life skills workshops. Level 3.1 is a structured recovery residence environment staffed 24 hours a day, which provides sufficient stability to prevent or minimize relapse or continued use. Interpersonal and group living skills generally are promoted through use of community or house meetings of residents and staff. Level 3.5 programs are designed to serve individuals who, because of specific functional limitations, need safe and stable living environments in order to develop and/or demonstrate sufficient recovery skills so that they do not immediately relapse or continue to use in an imminently dangerous manner upon transfer to a less intensive level of care . This level of care assist individuals who addiction is currently so out of control that they need a 24 hour supportive treatment environment to initiate or continue a recovery process that has failed to progress. 3.5 programs provides no less than 25 hours of treatment per week. An on-site safe and adequate living environment is provided for dependent children ages 13 and younger. The provider, may but is not required, to provide an onsite and safe living environment for children 14-17. Therapeutic Child Care provided to ensure the children of the women receive the necessary therapeutic preventions and interventions skills. The provider will comprehensively address wraparound services available on-site or off site, for dependent children 13years of age and younger. WTRS residential services are on-site or provided within walking distance of provider's residential facility</p>													
Admission Criteria	<p>1. Individuals must have a primary substance use disorder, meet the DBHDD Core Customer eligibility (Part I of this manual), and meets criteria for one of the following:</p> <p>A. TANF and or CPS Criteria:</p> <ul style="list-style-type: none"> a. Current TANF Recipients- Individuals with active TANF cash assistance cases b. Former TANF recipients- Individuals whose TANF assistance was terminated within the previous twelve months due to employment c. Families at Risk- Individuals with active DFCS child protective cases or referred by Family Support Services <p><u>To use a TANF funded slot a referral must come from DFCS. Referral form along with other required documents must be in individual's chart.</u></p> <p style="text-align: center;">OR</p> <p>B. Non-TANF Criteria:</p> <p>Individuals determined to be Non-TANF and does not meet the above criteria, but do meet the core customer definition may be served in a WTRS program. An individual is determined Non-TANF by the following:</p> <ul style="list-style-type: none"> a. A woman pregnant for the first time b. A woman has lost parental custody of her children (i.e. is not working on reunification) c. A woman who is not associated with DFCS (TANF or CPS, meets core customer definition and would benefit from gender specific treatment) d. A woman with no dependent children <p style="text-align: center;">OR</p> <p>C. SSBG and/or State funded slots</p> <ul style="list-style-type: none"> a. A women with dependent children who meet the Department's Core Customer definition. 													

Women's Treatment and Recovery Support (WTRS): Residential Treatment

	<ol style="list-style-type: none"> 2. Each time an individual is discharged they must meet the admission criteria and follow admission procedure if re-admittance is needed. 3. Federal regulations give priority admissions to certain populations in the following order: Pregnant injecting drug users, other pregnant drug users, other injecting drug users, and all other users. All addictions providers are required to adhere to the priority admission policy (including pregnant women that are actively taking opiate substitute). In the event a woman is unable to continue her medication regimen the provider must make appropriate referrals and contact the state office within 48 hours.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. The individual's condition continues to meet the admission criteria. 2. Documentation reflects continuing progress of the individual's recovery plan within this level of care. 3. There is a reasonable expectation that the individual can achieve the goals in the necessary time frame. 4. In the event the length of stay needs to be extended, additional documentation is required to be submitted to the DBHDD Women's Treatment Coordinator. All services are individualized and clinical discretion is to be used when evaluating levels of care. The maximum length of stay is six (6) months.
Discharge Criteria	<ol style="list-style-type: none"> 1. Goals of the treatment plan have been substantially met; and 2. Discharge/ transition plan is completed and linkages are in place; OR 3. Transfer to a higher level of service is warranted if the individual requires services not available at this level. To discharge an individual before clinically appropriate, a clinical staffing and a discharge summary must be completed with documentation of the clinical justification for the higher level of care. 4. If an individual is involved with DFCS, a discharge staffing should be completed in collaboration with WTRS providers and other referring organization(s) before discharge
Service Exclusions	Services cannot be offered with Mental Health Intensive Outpatient Package, SA Intensive Outpatient Package, WTRS Outpatient Treatment Service, Psychosocial Rehabilitation, or other residential treatment service.
Clinical Exclusions	<ol style="list-style-type: none"> 1. If an individual is actively suicidal or homicidal with a plan and intent. 2. Women should have no cognitive and/ or intellectual impairments which will prevent them from participating in and benefiting from the recommended level of care. 3. Withdrawal Management and impairments needs must be met prior to admission to the program (alternative provider and/ or community resources should be used to serve women with acute treatment needs). 4. Women must be medically stable in order to reside in group living conditions and participate in treatment.
Required Components	<ol style="list-style-type: none"> 1. Services must be licensed by DCH/HFR under the Rules and Regulations for Drug Abuse Treatment Program, 290-4-2. 2. Individuals receiving services must have a substance use disorder present in the medical record prior to initiation of services. The diagnosis must be given by a person identified in O.C.G.A. Practice Acts as qualified to provide a diagnosis. 3. Each individual should participate in setting individualized goals for themselves. 4. Services may take place individually or in groups. 5. Each individual must be oriented into the program and receive a copy of rules and regulations and client rights. A program handbook is recommended. 6. Treatment plan reviews must be completed every 30 days and staffing should be conducted involving all necessary participants including Therapeutic Childcare Staff. The WTRS Treatment Review Form is recommended. 7. Use of ASAM is required to determine level of care during each phase of treatment. These levels are to be assessed regularly and must be individualized, clinical judgment must be used. 8. All WTRS providers must be providing all services included in the WTRS package. 9. All WTRS providers must offer the following groups: Addiction Treatment Groups, Relapse Prevention, Trauma Groups, Criminal Addictive Thinking / Irrational Thinking, Anger Management, Co-Occurring Disorders, Life Skills, Family Dynamics and Health Relationships including HIV/AIDS Education. 10. The recommended curriculums for the above groups are: <ul style="list-style-type: none"> • The MATRIX with the women supplement, • Helping Women Recover, • A Woman's Way Through the 12 Steps, • Beyond Trauma, • TREM, • Seeking Safety, • A New Direction Criminal and Addictive Thinking,

Women's Treatment and Recovery Support (WTRS): Residential Treatment

- SAMHSA Anger Management,
- Matrix Family Component.

- Providers are required to maintain a waiting list. All individuals placed on waiting list should be contacted at least twice a month. If the provider has a priority admission on the waiting list. Interim services must be offered and documentation is required monthly to the state office.
- When a pregnant woman is seeking services the agency is required to give her preference in admission or on the waiting list. If the provider has insufficient capacity to provide services to any such pregnant woman the provider is required to refer the pregnant woman to the State DBHDD office.
- The provider is required to make interim services available within 48 hours if pregnant woman cannot be admitted because of lack of capacity
- The program is required to offered interim services at a minimum the following :
 - Counseling and education about HIV and TB, the risks of needle-sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIV and TB transmission does not occur;
 - Referral for HIV and TB treatment services, if necessary; and
 - Counseling pregnant women on the effects of alcohol and other drugs use on the fetus and referrals for prenatal care for pregnant women.
- The chart below shows the required ASAM content hours:

ASAM Level of Care	Hours Per Week
Level 3.5	25 hours
Level 3.1	10 hours

Staffing Requirements

- Program Coordinator Qualifications:
 - At least two (2) years of documented work experience in a Gender Specific and/or Addiction Treatment Program.
 - Level 4 or higher with co-occurring disorders experience defined in the DBHDD Provider Manual. This person's knowledge must go beyond basic understanding and must demonstrate actual staff capabilities in using knowledge for individuals with co-occurring disorders. Staff person must demonstrate a minimum of 5 hours per year of training in co-occurring treatment. Effective 1/1/10 programs must have documentation that there is at least 1 level 4 staff (excluding PP, ST and Addiction Counselor Trainee that is co-occurring capable).
 - A CACI working towards obtaining a CAC II within two years can work in this position. The Provider is required to keep documentation of supervision and anticipated the test date.
- Program Manager or Lead Counselors Qualifications:
 - At least one (1) year of documented work experience in a Gender Specific and /or Addiction Treatment Program.
 - Level 4 practitioners or a CAC I with co-occurring disorders experience or higher staff as defined in the DBHDD Provider Manual.
- Programmatic Staff Qualifications:
 - All WTRS practitioners with no documented experience should be orientated on the biological and psychosocial dimensions of substance use disorders and trained in evidence-based models and best practices. This orientation should also include "Introduction to Women and Substance Use Disorders" On-line course. This must be completed within the first 90 days of employment.
 - Level 4 practitioner with co-occurring disorders experience or higher staff as defined in the DBHDD Provider Manual.
 - Non-clinical staff and Level 5 practitioners must be under the supervision of an onsite Level 4 practitioner (excluding ACT, ST) as defined in the DBHDD Provider Manual.
- The WTRS Provider must have at least one program director to oversee residential and outpatient.
- Each WTRS program must have distinct separation in staff.
- The provider must provide assurance that all program staff will have appropriate background checks and credential verifications.

- The program must be under clinical supervision of a practitioner Level 4 or above (excluding an ACT/ST) who is onsite during normal operating hours.
- All clinical services must be provided by the appropriate practitioner based on the DBHDD practitioner's guide.
- The program shall conduct random drug screening and use the results of these tests for marking the individual's progress toward goals and for service planning.
- Addiction treatment services and programming must demonstrate a primary focus on Group Counseling that consists of Cognitive Behavioral groups (which rearrange

Women's Treatment and Recovery Support (WTRS): Residential Treatment

Clinical Operations

- patterns of thinking and action that lead to addiction), Group training, such as psychoeducational groups which teach about substance use disorders and skills development groups (which hone the skills necessary to break free of addictions) may also be offered in combination with group counseling but must not serve as the only group component. At least fifty percent (50%) of groups provided on a weekly basis on the ASAM Level of Care must be group counseling.
5. Limited individual or group activities may take place off-site in natural community setting as is appropriate to each individual's treatment plan. (NO Services are to take place at the individual's place of residence unless it is outreach).
 6. Recovery support meetings (such as AA, NA, etc.) may not be counted towards hours for any treatment sessions.
 7. WTRS services may operate in the same building as other services; however there must be a distinct separation between services, staff, and living space.
 8. Adequate space, equipment, furnishings, supplies and other resources must be provided in order to effectively provide services and so that the program environment is clean and in good repair.
 9. The Department's Evidence Based Practices and curriculums are to be utilized for the target areas of treatment. Practitioners providing these services are expected to maintain knowledge and skills regarding current research trends in best evidence based practices.
 10. The program must have a WTRS Services Organizational Plan Addressing the Following:
 - a) The philosophical model of the program and the expected outcomes for program participants (i.e., harm reduction, abstinence, beginning of or maintaining individually defined recovery, employment readiness, relapse, prevention, stabilization and treatment of those with co-occurring disorder)
 - b) The schedule of activities and hours of operations
 - c) Staffing patterns for the program
 - d) How assessments will be conducted
 - e) How the program will support pregnant women that require medication assisted treatment
 - f) How staff will be trained in the administration of addiction services and treatment of co-occurring disorders according to the Georgia Best Practices
 - g) How services for individuals with co-occurring disorders will be flexible and will include services and activities addressing both mental health and addictions
 - h) How individuals with co-occurring disorders or other special needs who cannot be served in the regular program activities will be provided and/or referred for time-limited special integrated services that are co-occurring enhanced as described in the Georgia Suggested Best Practices
 - i) How services will be coordinated with addiction services including assuring or arranging for appropriate referrals and transitions (Including transportation)
 11. Staff training and development is required to be addressed by the provider as evidenced by the following:
 - a) All WTRS treatment providers are required to participate in staff development and ongoing training as required by the community standards, HFR regulations, and national accrediting bodies.
 - b) As a part of this already mandated staff development and training, WTRS staff should have at least thirty (30) hours of addiction specific training annually, in accordance with HFR regulations.
 - c) Licensed and certified staff is required to have at least six (6) hours out of the thirty (30) hours in the area of gender-specific women's addiction modalities and treatment skills.
 - d) All non-licensed and or non-certified staff that provide educational or treatment services must complete at least 6 hours of gender specific training, annually.
 - e) All employees including house parents should complete the SAMHSA's Introduction to Women and Substance Use Disorders On-Line Course within 90 days of employment. To enroll in the Introduction to Women and Substance Use Disorders On-line course go to: <http://heatheknowledge.org>
 - f) It is recommended that house parents and other support staff have at least 3-6 hours of non-clinical gender specific training annually but provider's discretion can be used.
 - g) All training certificates shall be placed in the staff member's file for review.
 - h) Training can be provided via e-learning or face to face.
 - i) Each treatment provider is required to train new program staff and includes the following:
 - i. Understanding the WTRS program requirements
 - ii. Understanding Healthcare Facility Regulations (HFR)
 - iii. Understanding of administering the MICP
 - iv. Understanding ASAM levels of care

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Documentation Requirements	<ol style="list-style-type: none"> 1. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section III of the Provider Manual. 2. Each individual requires a New Episode MICP. If a registration MICP is completed at the time of intake, an ongoing MICP must be completed when individual enters a WTRS program. Individuals must be authorized under the WTRS Residential or WTRS Outpatient packages. 3. Every admission and assessment must be documented. 4. Progress/Group notes must be written daily and signed by the staff that performed the service. 5. Daily attendance of each individual participating in the program must be documented by evidence of a group sign in roster. 6. Clinicians are to sign and date each note with only the correct approved DBHDD credentials based on the practitioners table included within this manual. The individual that provides the service must complete the note. 7. Results of Drug Screens must be documented. 8. All WTRS providers are required to complete a biopsychosocial assessment in addition to the MICP. All individuals s require a MICP to be completed and submitted to the ERO within the established timeframe 9. The Level of Care will be determined according to the American Society of Addiction Medicine (ASAM) 3rd edition for assessing severity and intensity of services and the LOCUS score. The ASAM justification form must be included in the individual's medical record. 10. The provider must complete the WTRS vocational assessment within 30 days of admissions. Assessment must be placed in the individual's medical record. 11. TANF and CPS individuals must be referred by DFCS. 12. The following information must be maintained in the individual's chart, including all appropriate signatures: <ol style="list-style-type: none"> a. Substance Use Disorder Assessment Result Form: Substance Use Disorder Assessment Results form must be completed and submitted back to DFCS within 2 weeks from the completion of the assessment (Email or Fax documenting submission to DFCS) b. WTRS Referral Form completed by DFCS: <ol style="list-style-type: none"> i. Release of Information Form completed by DFCS ii. Email or Fax documenting transmission from DFCS. a. Monthly WTRS Compliance Form (Email or Fax documenting submission to DFCS from DFCS) 13. All WTRS providers must submit the WTRS Compliance Form to DFCS within 72 hours for the following : <ol style="list-style-type: none"> a. if individual fails to show for treatment appointments for three consecutive days; b. All other major non-compliant issues c. Email or Fax documenting submission to DFCS
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Women's Treatment and Recovery Services: Transitional Housing

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Service Definition	Ready For Work Transitional Housing provide a safe, stable, drug free residence and utilities (power and water) for no more than 6 months to any woman or woman with a child that has successfully completed all recommended treatment services. The environment should be gender specific and can include dependent children between birth and 18 years old. Transitional Housing is to be a step down in service from Ready For Work residential or outpatient programs; thus a successful completion of Ready for Work residential, outpatient, or least an ASAM level 2 program is necessary.													
Admission Criteria	<ol style="list-style-type: none"> 1. A woman or woman with a child(ren) that has successfully completed all recommended levels of treatment unless approval from Women's Program Coordinator 2. A woman that has provided evidence of needing a place of residence 3. A woman that has provided evidence being able to live in a community environment without the assistance of direct care staff 													

Women's Treatment and Recovery Services: Transitional Housing

Continuing Stay Criteria	<ol style="list-style-type: none"> 1. The individual's condition continues to meet the admission criteria. 2. Documentation reflects continuing progress of the individual's treatment plan. 3. There is a reasonable expectation that the individual can achieve the goals in the necessary time frame. 4. In the event the length of stay needs to be extended additional documentation is required to be submitted to the state Women Treatment Coordinator. All services are individualized and clinical discretion is to be used. 5. The maximum length of stay is six (6) months.
Discharge Criteria	<ol style="list-style-type: none"> 1. A discharge / transition plan completed and linkages are in place; and one or more of the following: <ol style="list-style-type: none"> a. Goals of the treatment plan have been substantially met; or b. If an individual is involved with DFCS, a discharge staffing should be completed in collaboration with WTRS providers and other referring organizations before discharge. c. To discharge an individual before clinically appropriate, a clinical staffing must be completed and provide the following information: <ol style="list-style-type: none"> i. documented reason for early discharge, and ii. an aftercare plan 2. Transfer to a higher level of service is warranted if the individual requires a higher level of supervision.
Service Exclusions	Services cannot be offered with Mental Health Intensive Outpatient Package, Psychosocial Rehabilitation, WTRS residential or other residential treatment service
Clinical Exclusions	<ol style="list-style-type: none"> 1. If an individual is actively suicidal or homicidal with a plan and intent. 2. Women should have no cognitive and/ or intellectual impairments which will prevent them from participating in and benefiting from the recommended level of care. 3. Withdrawal Management and impairments needs must be met prior to admission to the program (alternative provider and/ or community resources should be used to serve women with acute treatment needs). 4. Women must be medically stable in order to reside in an independent living condition and participate in treatment.
Required Components	<ol style="list-style-type: none"> 1. Provider will conduct a residence check twice a month to ensure cleanliness and safety 2. The housing must be in the community away from the primary residential treatment facilities 3. If children are residing with their mother, provider must child proof the home 4. The home must provide a bathroom for every four residents 5. The home must provide a living room and dining area, a kitchen and a bedroom for all residents 6. This is a step down program. Women living in transitional housing must be independent with support. 7. Transportation must be provided for the individuals to attend treatment services, this may include public transportation fare, staffing transporting individuals using agency vehicles and/or providing gas for individual's automobile 8. Provider should continue to work with the individual's referral source to ensure consistency of care
Staffing Requirements	No staffing requirements for this level of care. Follow outpatient staffing requirements when providing aftercare treatment and support services.

Women's Treatment and Recovery Services: Transitional Housing

Clinical Operations	<ol style="list-style-type: none"> 1. Transitional Housing Services must provide a schedule for aftercare programming and to ensure stability and consistency for individuals. 2. Individual should be in Level 1 outpatient/aftercare and have a MICP for WTRS outpatient if she meets the WTRS outpatient admission criteria. If she doesn't meet the criteria or the agency does not have a WTRS outpatient program the client should have an SA Outpatient MICP. 3. Transitional Housing Services may be in the same apartment complex (that is not owned by the provider) as residential services; however the living quarters must be distinctly different. Preferably (not required) apartments are away from residential services to assist with acclimation back into the community. 4. Food and shopping must be completed by individuals; providers should not charge or collect money/EBT cards. 5. Medications and medical needs should be the responsibility of the individual. The providers should not hold or dispense medications to individuals in transitional housing. 6. Transitional Housing must have an organizational plan addressing the following: <ol style="list-style-type: none"> a) Schedule of Activities and Hours; b) Policies and Procedures; c) House Rules for Consumers; d) Emergency Procedures. 7. Each individual should participate in setting individual goals for themselves and in assessing their own skills and resources related to sobriety. 8. Aftercare services must be provided to all participants in transitional housing unless otherwise approved by the Division. 9. The women living in Transitional Housing should have a MICP authorized for outpatient services. (Please see WTRS Outpatient Admission) 10. Aftercare is defined as the following; <ol style="list-style-type: none"> a) Provide Gender Specific continuing care groups at least once a week for 1 ½ hours b) Provide at least one individual session per month to the individual c) The individual must attend groups at least 3 times per month to be counted d) Connection to support services would include; job, home or school visits, aftercare group, which includes: parenting, mental health/developmental disabilities, support group meetings including NA and/ or AA e) Minimum of 2 drug screens per month f) Relapse prevention strategies including: Relapse Prevention, Parenting, Trauma Groups, Anger Management Healthy Relationships including HIV/AIDS education, Criminal Addictive Thinking, Co-Occurring Disorder and, Family Counseling as needed.
Documentation Requirements	<ol style="list-style-type: none"> 1. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section III of the Provider Manual. 2. Each consumer requires a New Episode MICP. If a registration MICP is completed at the time of intake, an ongoing MICP must be completed when consumer enters a WTRS program. Clients must be authorized under WTRS Outpatient packages. 3. Every admission of transitional housing must be documented. 4. Progress/Group notes must be written each time group meets and signed by the practitioner that performed the service 5. Group attendance of each individual participating in the program must be documented by evidence of a group sign in roster 6. Clinicians are to sign and date each note with only the correct approved DBHDD credentials based on the practitioners table. The practitioner that provides the service must complete the note. 7. Bi-weekly unit inspection must be documented for transitional housing. 8. Results of Drug Screen must be documented. 9. If individual is a CPS or TANF referral from DFCS, a Monthly WTRS Compliance Form is required (Email or Fax documenting submission to DFCS from DFCS) 10. If individual is a CPS or TANF referral from DFCS, the WTRS providers must submit the WTRS Compliance Form to DFCS within 72 hours (Email or Fax documenting submission to DFCS) for the following scenarios: <ol style="list-style-type: none"> a. if individual fails to show for treatment appointments for three consecutive days; b. All other major non-compliance issues.

Residential: Independent Residential Services

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Supported Housing	Mental Health	H0043	R1					Addictive Diseases	H0043	HF	R1			
Unit Value	Unit= 1 day							Maximum Daily Units	1 unit					
Initial Authorization	180 units							Re-Authorization	180 units					
Authorization Period	180 days							Benefit Information	LOCUS score:1-4					
Service Definition	Independent Residential Service (IRS) provides scheduled residential service to an individual who requires a low level of residential structure to maintain stable housing, continue with their recovery, and increase self-sufficiency. This residential placement will reflect individual choice and should be fully integrated in the community in a scattered site individual residence.													
Admission Criteria	<ol style="list-style-type: none"> 1. Individual must meet target population as indicated above, <i>and</i> 2. Individual demonstrates ability to live with minimal supports <i>and</i> 3. Individual, states a preference to live independently. 													
Continuing Stay Criteria	Individual continues to benefit from and require minimal community supports.													
Discharge Criteria	<ol style="list-style-type: none"> 1. Individual, or appropriate legal representative, no longer desires service, <i>or</i> 2. Individual no longer meets program and/or housing criteria. 													
Clinical Exclusions	Individuals with the following conditions are excluded from admission unless there is documented evidence of a psychiatric condition: developmentally disability, autism, organic mental disorder, or traumatic brain injury.													
Required Components	<ol style="list-style-type: none"> 1. The organization must have an executive director or program director charged with the responsibility for day-to-day management of the organization. 2. If applicable, the organization must be licensed by the Department of Community Health, Healthcare Facilities Regulation Division to provide residential services to individuals with mental illness and/or substance abuse diagnosis. 3. The Independent Residential Service provides scheduled visits to an individual's apartment or home to assist with residential responsibilities. 4. Services must be provided at a time that accommodates individuals' needs, which may include during evenings, weekends, and holidays. 5. This service requires a minimum of 1 face-to-face contact with the individual in their home each week (see also D. for an exception). 6. Independent Residential Services may only be provided within a supportive housing program or within the individual's own apartment or home. 7. There must be a written Residential Crisis Response Plan that guides the residential provider's response to an individual's crisis episode while receiving residential services that diverts the loss of housing and promotes housing stability. This plan shall be developed in partnership with the individual and offer 24/7 access to a residential services specialist in the event of a crisis. 													
Staffing Requirements	<ol style="list-style-type: none"> 1. Residential Managers may be persons with at least 2 years' experience providing MH or AD services and with at least a high school diploma; however, this person must be supervised by a licensed staff member (including LMSW, AMFT, APC or 4 year RN). 2. Persons with high school diplomas, GEDs, or higher degrees may provide direct support services under the supervision of a Residential Manager. 3. A staff person must be available 24/7 to respond to emergency calls within one hour. 4. A minimum of one staff per 35 individuals may not be exceeded. 													
Clinical Operations	<ol style="list-style-type: none"> 1. The organization must have a written description of the Independent Residential Service offered that includes, at a minimum, the purpose of the service; the intended population to be served; service philosophy/model; level of supervision and oversight provided; and outcome expectations for its residents. 2. The focus of service is to view each individual as the director of his/her own recovery; to promote the value of self-help and peer support; to provide information about mental illness and coping skills; to promote social skills, community resources, and individual advocacy; to promote employment and education to foster self-determination and career advancement; to support each individual in using community resources to replace the resources of the mental health system no longer 													

Residential: Independent Residential Services

	<p>needed; to support each individual to fully integrate into scattered site residential placement or in housing of his or her choice; and to provide necessary support and assistance to the individual that furthers recovery goals, including transportation to appointments and community activities that promote recovery.</p> <p>3. The goal of this service is to fully integrate the individual into an accepting community in the least intrusive environment that promotes housing of his/her choice.</p> <p>4. The outcomes of this service will focus on recovery, housing, employment and meaningful life in the community. These outcomes will be measured based upon:</p> <ol style="list-style-type: none"> Reduction in hospitalizations; Reduction in incarcerations; Maintenance of housing stability; Participation in education, vocational training or gainful employment, if this is a goal in the Individualized Recovery plan; Participation in community meetings and other social and recreational activities; Participation in activities that promote recovery and community integration.
Service Access	In addition to receiving Independent Residential Services, individuals should be linked to adult mental health and/or addictive disease services, as applicable, including Core or Private psychiatrist and Specialty services; however, individuals served shall not lose this support as a result of his/her choice to opt out of other behavioral health support/treatment services (unless these services are otherwise required by a federal program/fund source supporting a specific individual).
Billing and Reporting Requirements	<ol style="list-style-type: none"> All applicable MICP and other DBHDD reporting requirements must be met. Each month, the provider must submit a Monthly Residential Service Report developed by the Department that identifies the actual utilization of independent residential services including amount spent, number of units occupied, and number of individuals served.
Documentation Requirements	<ol style="list-style-type: none"> The organization must develop and maintain sufficient written documentation to support the services for which billing is submitted. This documentation, at a minimum, must confirm that the individual for whom billing is requested was enrolled in the Independent Residential Services on the billing date and that residential contact and support services are being provided at least once per week. The individual's record must also include each week's programming/service schedule in order to document the provision of the personal support activities. Providers must provide documentation that demonstrates compliance with a minimum of 1 face-to-face contact per week, which includes date and time in/time out. Weekly progress notes must be entered in the individual's record to enable the monitoring of the individual's progress toward recovery goals and to reflect the Individualized Recovery Plan implementation. The individual's record should include health issues or concerns and how they are being addressed, appointments for psychiatric and medical care that are scheduled for the individual, attendance at other treatments such as addictive diseases counseling that staff may be assisting the individual to attend, assistance provided to the individual to help him or her reach recovery goals and the individual's participation in other recovery activities. Each note must be signed and dated and must include the professional designation of the individual making the entry. Documentation must be legible and concise and include the printed name and the signature of the treating practitioner. The name, title, and credentials of the individual providing the service must reflect the staffing requirements established for Independent Residential Services being delivered.

Residential: Intensive Residential Services

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Supported Housing	Mental Health	H0043	R3					Addictive Diseases	H0043	HF	R3			
Unit Value	Unit= 1 day							Maximum Daily Units	1					
Initial Authorization	180 units							Re-Authorization	180 units					
Authorization Period	180 days							Utilization Criteria	LOCUS Score: 3-5					

Residential: Intensive Residential Services

Service Definition	Intensive Residential Service provides around the clock assistance to individuals within a residential setting that assists them to successfully maintain housing stability in the community, continue with their recovery, and increase self-sufficiency.
Admission Criteria	Adults aged 18 or older must meet the following criteria: <ol style="list-style-type: none"> 1. Serious Mental Illness, Addictive Disease Issues, or Co-occurring Mental Illness and Addictive Diseases Diagnosis and one or more of the following: 2. Frequent psychiatric hospitalizations, i.e., more than 2 admissions in the last year and/or lengthy admission in the last year (more than 30 days); or 3. Frequent incarcerations, i.e., more than 2 incarcerations in the last year or lengthy incarceration in the last year (more than 60 days) or 4. Requires a highly supportive environment with 24/7 awake staff to divert from going to a more intensive level of care. 5. Symptoms/behaviors indicate a need for continuous monitoring and supervision by 24/7 awake staff to ensure safety; or 6. Insufficient or severely limited skills needed to maintain stable housing and had failed using less intensive residential supports.
Continuing Stay Criteria	Individual continues to meet Admission Criteria
Discharge Criteria	<ol style="list-style-type: none"> 1. Individual can effectively and safely be supported with a more appropriate level of service due to change in individual's level of functioning; or 2. Individual or appropriate legal representative, requests discharge.
Clinical Exclusions	Individuals with the following conditions are excluded from admission unless there is documented evidence of psychiatric condition: developmentally disability, autism, organic mental disorder, or traumatic brain injury.
Required Components	<ol style="list-style-type: none"> 1. In addition to receiving Intensive Residential Services, individuals will be linked to adult mental health services including Core or private psychiatrist or Specialty Services. 2. The organization must have an executive director or program director charged with the responsibility for day-to-day management of the organization. 3. The residential program must provide a structured and supported living environment 24 hours a day, 7 days a week with AWAKE staff on-site at all times. 4. Intensive Residential Service must provide a minimum of 5 hours per week of skills training programming relevant to the individual's Individual Recovery Plan (IRP). 5. There must be a written Residential Crisis Response Plan that guides the residential provider's response to an individual's crisis episode while receiving residential services that diverts the loss of housing and promotes housing stability. This plan shall be developed in partnership with the individual and offer 24/7 access to a residential services specialist in the event of a crisis. 6. When this service is provided in traditional residential settings such as group homes, community living arrangement, etc., the following are required: <ol style="list-style-type: none"> a. Facility must be licensed by the Georgia HFR as a facility which can provide support to those with behavioral health concerns. b. Each resident facility must be arranged and maintained to provide adequate measures for the health, safety, access and well-being of the residents. c. Each resident facility must comply with all relevant safety codes. d. All areas of the residential facility must be clean, safe, appropriately equipped, and furnished for the services delivered. e. The facility must comply with the Americans with Disabilities Act. f. The facility must maintain a written evacuation plan to be used in the case of fire or other disaster. An appropriate written certification of compliance must be obtained indicating that all applicable fire and safety code requirements have been satisfied. Periodic fire and other safety drills must be conducted. g. Evacuation routes must be clearly marked by exit signs. h. The program must be responsible for providing physical facilities that are structurally sound and that meet all applicable federal, state, and local regulations for adequacy of construction, safety, sanitation, and health.
Staffing Requirements	<ol style="list-style-type: none"> 1. Residential Managers may be persons with at least 2 years' experience providing MH or AD services and at least a high school diploma; however this person must be directly supervised by a licensed staff member (including LMSW, AMFT, APC, or 4-year RN). 2. Persons with high school diplomas, GEDs or higher, who have completed the paraprofessional training required for DBHDD contracted organizations and under the supervision of a Residential Manager may perform residential services. 3. A minimum of at least one (1) awake on-site staff 24/7.

Residential: Intensive Residential Services

Clinical Operations	<p>1. The organization must have a written description of the Intensive Residential Service offered that includes, at a minimum, the purpose of the service; the intended population to be served; service philosophy/model, level of supervision and oversight provided; and outcome expectations for its residents.</p> <p>2. Intensive Residential Service assists those individuals with an intensive need for personal supports and skills training to restore, develop, or maintain skills in functional areas in order to live meaningful lives in the community; develop or maintain social relationships, and participate in social, interpersonal, vocational, recreational or community activities. Services must be delivered to individuals relevant to their individualized Recovery Plan.</p> <p>3. Intensive Residential Service must provide a minimum of 5 hours of skills training and/or support activities per week that relate to the individual's IRP.</p> <p><u>Skills Training</u> may include interpersonal skills training; coping skills/problem solving; symptom identification and management; cooking; maintaining a residence; using public transportation; shopping; budgeting and other needed skills training as identified in the IRP.</p> <p><u>Support Activities</u> may include daily contacts by Intensive Residential Service staff daily to monitor physical and mental health needs; crisis intervention when needed; assistance with scheduling of medical and mental health appointments; the supervision of the self-administration of medications; transportation to medical/dental/mental health/employment/recreational activities; participation in community activities; and other needed supports as identified in the IRP.</p>
Reporting and Billing Requirements	Each month, the provider must submit a Monthly Residential Service Report developed by the Department that identifies the actual utilization of intensive residential services including amount spent, number of units occupied, and number of individuals served.
Documentation Requirements	<p>1. The organization must develop and maintain sufficient written documentation to support the Intensive Residential Service for which billing is made. This documentation, at a minimum, must confirm that the individual for whom billing is requested was a resident of the Intensive Residential Service on the date of service. The individual's record must also include each week's programming/service schedule in order to document the provision of the required amount of skills training and support activities.</p> <p>2. Weekly progress notes must be entered in the individual's record to enable the monitoring of the individual's progress toward IRP and recovery goals.</p> <p>3. The record should include health issues and how they are being addressed; appointments for psychiatric and medical care that are scheduled for the individual; attendance at other treatments such as addictive diseases counseling that staff may be assisting individual to attend; assistance provided to the individual to help him or her reach recovery goals; and the individual's participation in other recovery activities.</p> <p>4. Each note must be signed and dated and must include the professional designation of the individual making the entry.</p> <p>5. Documentation must be legible and concise and include the printed name and the signature of the service provider. The name, title, and credentials of the individual providing the service must reflect the staffing requirements established for the Intensive Residential Service being delivered.</p>

Residential: Semi-Independent Residential Services

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Supported Housing	Mental Health	H0043	R2					Addictive Diseases	H0043	HF	R2			
Unit Value	Unit= 1 day							Maximum Daily Unit	1					
Initial Auth	180 units							Re-Authorization	180 units					
Auth Period	180 days							Benefit Information	LOCUS Score: 2-4					
Service Definition	Semi-Independent Residential Service on-site programming for individuals within a residential setting to assist them to successfully maintain stable housing, continue with their recovery, and increase self-sufficiency.													
Admission Criteria	<p>Adults aged 18 or older with:</p> <p>1. Serious Mental Illness, Addictive Disease Issues, or Co-occurring Mental Illness and Addictive Diseases Diagnoses and</p> <p>2. Demonstrates the need for 24/7 available staff support, daily contact, and moderate assistance with residential responsibilities and one or more of the following:</p> <p>3. Individual's symptoms/behaviors indicate a need for moderate skills training and personal supports; or</p>													

Residential: Semi-Independent Residential Services

	<p>4. Individual has limited skills needed to maintain stable housing and has failed using a less intensive residential service; or</p> <p>5. Individual requires frequent medication assistance to prevent relapse.</p>
Continuing Stay Criteria	Individual continues to meet Admission Criteria
Discharge Criteria	<p>1. Individual can effectively and safely be supported with a more appropriate level of service due to change in individual's level of functioning; or</p> <p>2. Individual or appropriate legal representative requests discharge.</p>
Clinical Exclusions	Individuals with the following conditions are excluded from admission unless there is documented evidence of psychiatric condition: developmentally disability, autism, organic mental disorder, or traumatic brain injury
Required Components	<ol style="list-style-type: none"> 1. Semi Independent Residential Services may only be provided by a DBHDD Contracted Provider. 2. The organization must have an executive director or program director charged with the responsibility for day-to-day management of the organization. 3. Traditional residential settings such as group homes, community living arrangements, etc. must: <ol style="list-style-type: none"> a. Be licensed by the Department of Community Health, Healthcare Facilities Regulation Division to provide residential services to individuals with mental illness and/or substance abuse diagnosis. b. Be arranged and maintained to provide adequate measures for the health, safety, access and well-being of the residents. c. Comply with all relevant safety codes. d. Be clean, safe, appropriately equipped, and furnished for the services delivered. e. Comply with the Americans with Disabilities Act for access. f. Maintain a written evacuation plan to be used in the case of fire or other disaster. An appropriate written certification of compliance must be obtained indicating that all applicable fire and safety code requirements have been satisfied. Periodic fire and other safety drills must be conducted. g. Have evacuation routes clearly marked by exit signs. h. Be responsible for providing physical facilities that are structurally sound and meet all applicable federal, state, and local regulations for adequacy of construction, safety, sanitation, and health. i. Provide a supported living environment 24 hours, 7 days a week. Staff will be on-site for at least 36 hours each week to accommodate residents' needs. There must be an emergency response plan when staff is not scheduled on-site. j. Provide, within the required 36 hours of staffing coverage, a minimum of 3 hours per week of skills training and/or personal support relevant to the individual's IRP k. Have a written Residential Crisis Response Plan that guides the residential provider's response to an individual's crisis episode that diverts the loss of housing and promotes housing stability. This plan shall be developed with the individual and offer 24/7 access to a residential services specialist in the event of a crisis.
Staffing Requirements	<ol style="list-style-type: none"> 1. Residential Managers may be persons with at least 2 years' experience providing MH or AD services and at least a high school diploma; however, this person must be directly supervised by a licensed staff member (including LMSW, AMFT, APC or 4 year RN). 2. Persons with high school diplomas, GEDs, or higher, who have completed the paraprofessional training required for DBHDD contracted organizations may provide direct support services under the supervision of a Residential Manager. 3. A staff person must be available 24/7 to respond to emergency calls within one (1) hour. 4. A staff person must be on site at least 36 hours a week.
Clinical Operations	<ol style="list-style-type: none"> 1. The organization must have a written description of the Semi-Independent Residential Service offered that includes, at a minimum, the purpose of the service; the intended population to be served; level of supervision and oversight provided; and outcome expectations for its residents. 2. The focus of Semi-Independent Residential Service is to view each individual as the director of his/her own recovery; to promote the value of self-help and peer support; to provide information about mental illness and coping skills; to promote social skills, community resources, and individual advocacy; to promote employment and education to foster self-determination and career advancement; to support each individual in using community resources to replace the resources of the mental health system no longer needed; and to support each individual to fully integrate into scattered site residential placement or in housing of his or her choice, and to provide necessary support and assistance to the individual that furthers recovery goals, including transportation to appointments and community activities that

Residential: Semi-Independent Residential Services

	<p>promote recovery.</p> <ol style="list-style-type: none"> 3. The Goal of Semi-Independent Residential Supports is to further integrate the individual into an accepting community in the least intrusive environment that promotes housing of his/her choice. 4. The outcomes of Semi-Independent Residential Supports will focus on recovery, housing, employment, and meaningful life in the community. These outcomes will be measured based upon: <ol style="list-style-type: none"> a. Reduction in hospitalizations; b. Reduction in incarcerations; c. Maintenance of housing stability; d. Participation in education, vocational training or gainful employment, if this is a goal in the Individualized Recovery Plan; e. Participation in community meetings and other social and recreational activities; f. Participation in activities that promote recovery and community integration. 5. Semi-Independent Residential Service assists those individuals who will benefit from a moderate level of personal support and skill training to restore, develop, or maintain skills in functional areas in order to live meaningful lives in the community; develop or maintain social relationships; and participate in social, interpersonal, recreational or community activities. Services must be delivered to individuals according to their IRP. 6. Semi-Independent Residential Service provides at least 36 hours of on-site residential service and a minimum of 3 hours of direct skills training and/or individual support each week. This level of residential service shall include: Skill Training Activities such as budgeting, shopping, menu planning and food preparation, leisure skill development, maintaining a residence, using public transportation, symptom identification and management, medication self-administering training, and other needed skills training as identified in the IRP. AND Personal Support Activities such as daily face-to-face contact with the individual by Residential Service staff to ensure needs are being met; supportive counseling; crisis intervention as needed; tracking of appointments, assistance with transportation to appointments, shopping, employment, academics, recreational and support activities, and other needed supports as identified in the IRP
Service Access	In addition to receiving Semi Independent Residential Services, individuals will be linked to adult mental health and/or addictive disease services including Core or private Psychiatrist or Specialty services.
Reporting and Billing Requirements	Each month, the provider must submit a Monthly Residential Service Report developed by the Department that identifies the actual utilization of semi-independent residential services including amount spent, number of units occupied, and number of individuals served.
Documentation Requirements	<ol style="list-style-type: none"> 1. Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiative of services. The diagnosis must be given by persons identified in O.C.G.A. Practice Acts as qualified to provide a diagnosis. 2. Providers must document services in accordance with the specifications for documentation found in "Documentation Guidelines" in Part II, Section IV of this manual. 3. The organization must develop and maintain sufficient written documentation to support that Semi-Independent Residential Services were provided to the individual, as defined herein and according to billing. This documentation must confirm that the individual for whom billing is requested was a resident of the Semi-Independent Residential Services on the date billed. The individual's record must also include each week's programming/ service schedule in order to document provision of the required amount of skill training and personal support activities. 4. Providers must provide documentation that demonstrates compliance with a minimum of 3 hours each week of skills training and personal support activities, which include date, and time in/time out of contact. 5. Weekly progress notes must be entered in the individual's record to enable the monitoring of the individual's progress toward meeting treatment and rehabilitation goals and to reflect the Individualized Recovery Plan implementation. 6. The record should include health issues or concerns and how they are being addressed, appointments for psychiatric and medical care that are scheduled for the individual, attendance at other treatments, such as addictive diseases counseling that staff may be assisting the individual to attend, assistance provided to the individual to help him or her reach recovery goals, and the individual's participation in other recovery activities. 7. Each note must be signed and dated and must include the professional designation of the individual making the entry.

Residential: Semi-Independent Residential Services

8. Documentation must be legible and concise and include the printed name and the signature of the treating practitioner. The name, title, and credentials of the individual providing the service must reflect the staffing requirements established for Semi-Independent Residential Services being delivered.

Residential Substance Detoxification

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Alcohol and/or Other Drug Services; Sub-acute Detoxification (Residential Addiction Program Outpatient)		H0012					\$85.00							
Unit Value	1 day (per diem)							Maximum Daily Units	1 unit					
Initial Authorization	30 days							Re-Authorization						
Authorization Period	30 days							Utilization Criteria	<u>LOCUS scores: 3-6</u>					
Service Definition	Residential Substance Detoxification is an organized and voluntary service that may be delivered by appropriately trained staff who provide 24-hour per day, 7 day per week supervision, observation and support for individuals during withdrawal management. Residential Withdrawal Management is characterized by its emphasis on medical monitoring and/or on peer/social support, and should reflect a range of residential detoxification service intensities from ASAM (American Society of Addiction Medication) Level III.2D to III.7D. These levels provide care for individuals whose intoxication/withdrawal signs and symptoms may only require 24-hour supervision, observation and support by appropriately trained staff with an emphasis on peer/social support that cannot be provided by the individual's natural support system, or that are sufficiently severe enough to require 24-hour medically monitored withdrawal management and support from medical and nursing professionals in a permanent facility with inpatient beds. All programs at these levels rely on established clinical protocols to identify individuals who are in need of medical services beyond the capacity of the facility and to transfer such individuals to more appropriate levels of service.													
Admission Criteria	<p>Adults/Older Adolescent</p> <ol style="list-style-type: none"> 1. Has a Substance Related Disorder with a DSM diagnosis of either 303.00, 291.81, 291.0, 292.89, 292.0, and 2. Per (ASAM PPC-2, Dimension-1) is experiencing signs of severe withdrawal, or there is evidence (based on history of substance intake, age, gender, previous withdrawal history, present symptoms, physical condition, and/or emotional/behavioral condition) that severe withdrawal syndrome is imminent; and is assessed as manageable at this level of service; and 3. There is strong likelihood that the individual will not complete withdrawal management at another level of service and enter into continued treatment or self-help recovery as evidenced by one of the following: <ol style="list-style-type: none"> a. individual requires medication and has recent history of withdrawal management at a less intensive service level, marked by past and current inability to complete withdrawal management and enter continuing addiction treatment; individual continues to lack skills or supports to complete withdrawal management, or b. individual has a recent history of withdrawal management at less intensive levels of service marked by inability to complete withdrawal management or enter into continuing addiction treatment and continues to have insufficient skills to complete withdrawal management, or c. individual has co-morbid physical or emotional/behavioral condition that is manageable in a Level III.7-D setting but which increases the clinical severity of the withdrawal and complicates withdrawal management. 													

Residential Substance Detoxification

Continuing Stay Criteria	Individual's withdrawal signs and symptoms are not sufficiently resolved so that the individual can be managed in a less intensive service.
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Recovery Plan have been substantially met; or 3. Individual requests discharge and individual is not in imminent danger of harm to self or others; or 4. Individual's signs and symptoms of withdrawal have failed to respond to treatment and have intensified (as confirmed by higher scores on the CIWA-Ar or other comparable standardized scoring system), such that transfer to a Level 4-WM withdrawal management service is indicated.
Service Exclusions	Nursing Assessment and Medication Administration (Medication administered as a part of Residential Detoxification is not to be billed as Medication Administration.)
Clinical Exclusions	Concomitant medical condition and/or other behavioral health issues warrant inpatient treatment or Crisis Stabilization Unit admission.
Required Components	<ol style="list-style-type: none"> 1. This service must be licensed by DCH/HFR under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2. 2. A physician's order in the individual's record is required to initiate a withdrawal management regimen. 3. Medication administration may be initiated only upon the order of a physician. 4. Verbal orders or those initiated by a Physician's Assistant or CNS are acceptable provided they are signed by the physician within 24 hours or the next working day.
Staffing Requirements	<ol style="list-style-type: none"> 1. Services must be provided by a combination of nursing, other licensed medical staff, and other residential support under supervision of a physician. 2. In programs that are designed to target older adolescents, staffing patterns must reflect staff expertise in the delivery of services to that age population. In addition, higher staffing ratios would be expected in these programs related to supervision.
Additional Medicaid Requirements	<ol style="list-style-type: none"> 1. For Medicaid recipients, certain individual services may be billed to Medicaid if the individual is receiving this service as a part of a Crisis Stabilization Unit (see CSU service description for billable services). 2. For those CSUs that bill Medicaid, the program bed capacity is limited to 16 beds.

Substance Abuse Intensive Outpatient (SA Day Treatment)

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
See Additional Medicaid Requirements below for billing codes, authorization, and unit information.														
Utilization Criteria	<p><u>LOCUS scores:</u> 3 and 4-6 (transition)</p>													
Service Definition	<p>A time limited multi-faceted approach treatment service for adults who require structure and support to achieve and sustain recovery from substance related disorders. These services are available during the day and evening hours to enable individuals to maintain residence in their community, continue to work or go to school and to be a part of their family life. The following elements of this service model will include:</p> <ol style="list-style-type: none"> 1. Behavioral Health Assessment 2. Psychiatric Treatment 3. Nursing Assessment 4. Diagnostic Assessment 5. AD Support Services 6. Individual Counseling 7. Group Counseling (including psycho-educational groups focusing, relapse prevention and recovery) 8. Family Counseling/Training (including psychoeducation) for Family Members <p>The SA Intensive Outpatient Package emphasizes reduction in use and abuse of substances and/or continued abstinence; the negative consequences of substance abuse; development of social support network and necessary lifestyle changes; educational skills; vocational skills leading to work activity by reducing substance abuse as a barrier to employment; social and interpersonal skills; improved family functioning; the understanding of addictive disease; and the continued commitment to a recovery and maintenance program.</p> <p>Services are provided according to individual needs and goals as articulated in the treatment plan. The programmatic goal of the service must be clearly articulated by the provider, utilizing the best/evidenced based practices for the service delivery and support that are based on the population(s) and issues to be addressed. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based practices.</p>													
Admission Criteria	<ol style="list-style-type: none"> 1. A DSM IV diagnosis of Substance Abuse or Dependence or substance-related disorder with a co-occurring DSM IV diagnosis of mental illness or DD; and 2. The individual is able to function in a community environment even with impairments in social, medical, family, or work functioning; and 3. The individual is sufficiently motivated to participate in treatment; and 4. One or more of the following: <ol style="list-style-type: none"> a. The substance use is incapacitating, destabilizing or causing the individual anguish or distress and the individual demonstrates a pattern of alcohol and/or drug use that has resulted in a significant impairment of interpersonal, occupational and/or educational functioning; or b. The individual's substance abuse history after previous treatment indicates that provision of outpatient services alone (without an organized program model) is not likely to result in the individual's ability to maintain sobriety; or c. There is a reasonable expectation that the individual can improve demonstrably within 3-6 months; or d. The individual is assessed as needing ASAM Level 2 or 3.1; or e. The individual has no significant cognitive and/or intellectual impairments that will prevent participation in and benefit from the services offered and has sufficient cognitive capacity to participate in and benefit from the services offered; or f. The individual is not actively suicidal or homicidal, and the individual's crisis, and/or inpatient needs (if any) have been met prior to participation in the program. 													

Continuing Stay Criteria	<ol style="list-style-type: none"> 1. The individual's condition continues to meet the admission criteria. 2. Progress notes document progress in reducing use and abuse of substances; developing social networks and lifestyle changes; increasing educational, vocational, social and interpersonal skills; understanding addictive disease; and/or establishing a commitment to a recovery and maintenance program, but the overall goals of the treatment plan have not been met. 3. There is a reasonable expectation that the individual can achieve the goals in the necessary reauthorization time frame.
Discharge Criteria	<ol style="list-style-type: none"> 1. An adequate continuing care or discharge plan is established and linkages are in place; and one or more of the following: <ol style="list-style-type: none"> a. Goals of the treatment plan have been substantially met; or b. Individual recognizes severity of his/her drug/alcohol usage and is beginning to apply skills necessary to maintain recovery by accessing appropriate community supports c. Clinical staff determines that individual no longer needs ASAM Level 2 and is now eligible for aftercare and/or transitional services; OR 2. Transfer to a higher level of service is warranted by the following: <ol style="list-style-type: none"> a. Change in the individual's condition or nonparticipation; or b. Individual refuses to submit to random drug screens; or c. Individual exhibits symptoms of acute intoxication and/or withdrawal or d. Individual requires services not available at this level or e. Individual has consistently failed to achieve essential treatment objectives despite revisions to the treatment plan and advice concerning the consequences of continues alcohol/drug use to such an extent that no further process is likely to occur.
Service Exclusions	<p>Services cannot be offered with Mental Health Intensive Outpatient Package or Psychosocial Rehabilitation. When offered with ACT, documentation must indicate efforts to minimize duplication of services and effectively transition the individual to the appropriate services. This combination of services is subject to review by the ERO.</p>
Required Components	<ol style="list-style-type: none"> 1. This service must be licensed by DCH/HFR under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2. 2. The program provides structured treatment or therapeutic services, utilizing activity schedules as part of its operational method, i.e., plans or schedules of days or times of day for certain activities. 3. These services should be scheduled and available at least 5 hours per day, 4 days per week (20 hrs./week), with no more than 2 consecutive days without service availability for high need individuals (ASAM Level 2.5). For programs that have a lower intensity program Level, it should be at least ASAM Level 2.1 which includes 9 hours of programming per week. 4. The program utilizes methods, materials, settings, and outside resources appropriate to the developmental and cognitive levels, capabilities, age, gender, and culture of participants. 5. The program utilizes methods, materials, approaches, activities, settings, and outside resources appropriate for and targeted to individuals with co-occurring disorders of mental illness and substance abuse and targeted to individuals with co-occurring developmental disabilities and substance abuse when such individuals are referred to the program. 6. The program conducts random drug screening and uses the results of these tests for marking participant's progress toward goals and for service planning. 7. The program is provided over a period of several weeks or months and often follows withdrawal management or residential services. 8. This service must operate at an established site approved to bill Medicaid for services. However, limited individual or group activities may take place off-site in natural community settings as is appropriate to each individual's treatment plan. (Narcotics Anonymous (NA) and/or Alcoholics Anonymous (AA) meetings offsite may be considered part of these limited individual or group activities for billing purposes only when time limited and only when the purpose of the activity is introduction of the participating individual to available NA and/or AA services, groups or sponsors. NA and AA meetings occurring during the SA Intensive Outpatient package may not be counted as billable hours for any individual outpatient services, nor may billing related to these meetings be counted beyond the basic introduction of an individual to the NA/AA experience.) 9. This service may operate in the same building as other services; however, there must be a distinct separation between services in staffing, program description, and physical space during the hours the SA Intensive Outpatient Services is in operation. 10. Adequate space, equipment, furnishings, supplies, and other resources must be provided in order to effectively provide services and so that the program environment is clean and in good repair. Space, equipment, furnishings, supplies, transportation, and other resources for participating individuals' use within the Substance Abuse Intensive Outpatient package must not be substantially different from that provided for other uses for similar numbers of individuals.

Staffing Requirements	<ol style="list-style-type: none"> 1. The program must be under the clinical supervision of a Level 4 or above who is onsite a minimum of 50% of the hours the service is in operation. 2. Services must be provided by staff who are: <ol style="list-style-type: none"> a. Level 4 (APC, LMSW, CACII, CADC, CCADC and Addiction Counselor Trainee with supervision) b. Level 5 (Paraprofessionals, high school graduates) under the supervision of an Level 4 or above 3. It is necessary for all staff who provide this "co-occurring capable" service to have basic knowledge in the Georgia DBHDD content areas in the <u>Suggested Best Practices Principles and Staff Capabilities for Services Serving Individuals with Co-Occurring Disorders</u> document included in this Provider Manual 4. Programs must have documentation that there is one Level 4 staff (excluding Addiction Counselor Trainee) that is "co-occurring capable." This person's knowledge must go beyond basic understanding and must demonstrate actual staff capabilities in using that knowledge for individuals with co-occurring disorders. Personnel documentation should demonstrate that this staff person has received a minimum of 4 hours of training in co-occurring treatment within the past 2 years. 5. There must be at least a Level 4 practitioner on-site at all times the service is in operation, regardless of the number of individuals participating. 6. The maximum face-to-face ratio cannot be more than 12 individuals to 1 direct program staff based on average daily attendance of individuals in the program. 7. The maximum face-to-face ratio cannot be more than 20 individuals to 1 SAP based on average daily attendance of individuals in the program. 8. A physician and/or a Registered Nurse or a Licensed Practical Nurse with appropriate supervision must be available to the program either by a physician and/or nurse employed by the agency, through a contract with a licensed practitioner, or by written referral or affiliation agreement with another agency or agencies that offer such services. <ol style="list-style-type: none"> a. An appropriate member of the medical staff pursuant to the Medical Practice Act of 2009, Subsection 43-34-23 Delegation of Authority to Nurse and Physician Assistant is responsible for addiction and psychiatric consultation, assessment, and care (including but not limited to ordering medications and/or laboratory testing) as needed. b. The nurse is responsible for nursing assessments, health screening, medication administration, health education, and other nursing duties as needed. Level 4 staff may be shared with other programs as long as they are available as required for supervision and clinical operations and as long as their time is appropriately allocated to staffing ratios for each program.
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1. It is expected that the transition planning for less intensive service will begin at the onset of these services. Documentation must demonstrate this planning.
2. An individual may have variable length of stay. The level of care should be determined as a result of individuals' multiple assessments. It is recommended that individuals attend at a frequency appropriate to their level of need. Ongoing clinical assessment should be conducted to determine step down in level of care.
3. Each individual should participate in setting individualized goals for themselves and in assessing their own skills and resources related to sobriety, use/abuse, and maintaining recovery. Goals are set by exploring strengths and needs in the individual's living, learning, social, and working environments. Implementation of services may take place individually or in groups.
4. Each individual must be provided assistance in the development/acquisition of needed skills and resources necessary to achieve sobriety and/or reduction in abuse and maintenance of recovery.
5. Substance Abuse Intensive Outpatient Package must offer a range of skill-building and recovery activities within the program.
6. The following the services must be included in the SA Intensive Outpatient Package. Many of these activities are reimbursable through Medicaid.
The activities include but not limited to:
 - a. **Group Outpatient Services:**
 - I. Psycho-educational activities focusing on the disease of addiction prevention, the health consequences of addiction, and recovery
 - II. Therapeutic group treatment and counseling
 - III. Leisure and social skill-building activities without the use of substances
 - IV. Linkage to natural supports and self-help opportunities
 - b. **Individual Outpatient Services**
 - I. Individual counseling
 - II. Individualized treatment, service, and recovery planning
 - III. Linkage to health care
 - c. **Family Outpatient Services**
 - I. Family education and engagement
 - d. **AD Support Services**
 - I. Vocational readiness and support
 - II. Service coordination unless provided through another service provider
 - e. **Behavioral Health Assessment & Service Plan Development and Diagnostic Assessment**
 - I. Assessment and reassessment
 - f. **Services not covered by Medicaid**
 - I. Drug screening/toxicology examinations
7. In addition to the above required activities within the program, the following must be offered as needed either within the program or through referral to/or affiliation with another agency or practitioner, and may be billed in addition to the billing for Substance Abuse Intensive Outpatient Package:
 - a. AD Support Services– for housing, legal and other issues
 - b. Individual counseling in exceptional circumstances for traumatic stress and other mental illnesses for which special skills or licenses are required
 - c. Physician assessment and care
 - d. Psychological testing
 - e. Health screening.

Clinical Operations continued	<p>8. The program must have a Substance Abuse Intensive Outpatient Services Organizational Plan addressing the following:</p> <ol style="list-style-type: none"> The philosophical model of the program and the expected outcomes for program participants (i.e., harm reduction, abstinence, beginning of or maintaining individually defined recovery, employment readiness, relapse prevention, stabilization and treatment of those with co-occurring disorders). The schedule of activities and hours of operations. Staffing patterns for the program. How the activities listed above in Items 4 and 5 will be offered and/or made available to those individuals who need them, including how that need will be determined. How assessments will be conducted. How staff will be trained in the administration of addiction services and technologies. How staff will be trained in the recognition and treatment of co-occurring disorders of mental illness & substance abuse pursuant to the Georgia Best Practices How services for individuals with co-occurring disorders will be flexible and will include services and activities addressing both mental health and substance abuse issues of varying intensities and dosages based on the symptoms, presenting problems, functioning, and capabilities of such individuals. How individuals with co-occurring disorders who cannot be served in the regular program activities will be provided and/or referred for time-limited special integrated services that are co-occurring enhanced as described in the Georgia Suggested Best Practices How services will be coordinated with the substance abuse array of services including assuring or arranging for appropriate referrals and transitions. How the requirements in these service guidelines will be met. 																											
Service Access	<p>The package is offered at least 5 hours per day at least 4 days per week with no more than 2 consecutive days between offered services, and distinguishes between those individuals needing between 9 and 20 hours per week of structured services per week (ASAM Level 2.1) and those needing 20 hours or more of structured services per week (ASAM Level 2.5 or 3.1) in order to begin recovery and learn skills for recovery maintenance. The program may offer services a minimum of only 3 hours per day for only 3 days per week with no more than 2 consecutive days between offered services if only individuals at ASAM Level 2.1 are served.</p>																											
Additional Medicaid Requirements	<p>1. Substance Abuse Intensive Outpatient Services are unbundled and billed per service. As mentioned above Substance Abuse Intensive Outpatient Package allows providers to select all services that will be offered in a substance abuse outpatient setting. Billable services and daily limits within SA Intensive Outpatient Package are as follows:</p> <table border="1" data-bbox="415 865 1696 1166"> <thead> <tr> <th>Service</th> <th>Maximum Authorization Units</th> <th>Daily Maximum Billable Units</th> </tr> </thead> <tbody> <tr> <td>Diagnostic Assessment</td> <td>4</td> <td>2</td> </tr> <tr> <td>Psychiatric Treatment</td> <td>12</td> <td>1</td> </tr> <tr> <td>Nursing Assessment and Care</td> <td>48</td> <td>16</td> </tr> <tr> <td>AD Support Services</td> <td>200</td> <td>96</td> </tr> <tr> <td>Individual Outpatient</td> <td>36</td> <td>1</td> </tr> <tr> <td>Family Outpatient</td> <td>100</td> <td>8</td> </tr> <tr> <td>Group Training/Counseling</td> <td>1170</td> <td>20</td> </tr> <tr> <td>Beh Health Assmnt & Serv. Plan Development</td> <td>32</td> <td>24</td> </tr> </tbody> </table>	Service	Maximum Authorization Units	Daily Maximum Billable Units	Diagnostic Assessment	4	2	Psychiatric Treatment	12	1	Nursing Assessment and Care	48	16	AD Support Services	200	96	Individual Outpatient	36	1	Family Outpatient	100	8	Group Training/Counseling	1170	20	Beh Health Assmnt & Serv. Plan Development	32	24
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Reporting and Billing Requirements	<ol style="list-style-type: none"> The maximum number of units that can be billed differs depending on the individual service. Please refer to the table below or in the Mental Health and Addictive Disease Orientation to Authorization Packages Section of this manual. Approved providers of this service may submit claims/encounters for the unbundled services listed in the package, up to the daily maximum amount for each service. Program expectations are that this model follow the content of this Service Guideline as well as the clearly defined service group elements. 																											

Documentation Requirements	<ol style="list-style-type: none"> 1. Every admission and assessment must be documented. 2. Progress notes must include written daily documentation of important occurrences; level of functioning; acquisition of skills necessary for recovery; progress on goals identified in the IRP including acknowledgement of addiction, progress toward recovery and use/abuse reduction and/or abstinence; use of drug screening results by staff; and evaluation of service effectiveness. 3. Daily attendance of each individual participating in the program must be documented showing the number of hours in attendance for billing purposes. 4. This service may be offered in conjunction with ACT or CSU for a limited time to transition individuals from one service to the more appropriate one. 5. When this service is used in conjunction with ACT or Crisis Residential services, documentation must demonstrate careful planning to maximize the effectiveness of this service as well as an appropriate reduction in service amounts of the service to be discontinued. Utilization of Substance Abuse Day Services in conjunction with these services is subject to review by the External Review Organization.
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Supported Employment															
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	
Supported Employment		H2024					\$410.00								
Unit Value	1 month – Weekly documentation via daily attendance or weekly time sheet.							Maximum Daily Units							
Initial Authorization	180 days							Re-Authorization	180 days						
Authorization Period	180 days							Utilization Criteria	<u>LOCUS scores: 3 – 6</u> See exception in Continuing Stay Criteria						
Service Definition	Supported Employment (SE) services are available to eligible individuals, who express a desire and have a goal for competitive employment in their Individual Recovery Plan (IRP); and who, due to the impact and severity of their mental illness have recently lost employment, or been underemployed or unemployed on a frequent or long term basis. Services include supports to access benefits counseling; identify vocational skills and interests; and develop and implement a job search plan to obtain competitive employment in an integrated community setting that is based on the individual's strengths, preferences, abilities, and needs. In accordance with current best practice, this service emphasizes that a rapid job search be prioritized above traditional prevocational training, work adjustment, or transitional employment services. After suitable employment is attained, services include job coaching to teach job-specific skills/tasks required for job performance and ongoing rehabilitative supports to teach the individual illness self-management, communication and interpersonal skills necessary to successfully retain a particular job. If the individual is terminated or desires a different job, services are provided to assist the individual in redefining vocational and long term career goals and in finding, learning and maintaining new employment aligned with these goals. Employment goals and services are integrated into the Individual Recovery Plan (IRP) and are available until the individual no longer desires or needs Supported Employment specialty services to successfully maintain employment.														
Admission Criteria	<ol style="list-style-type: none"> 1. Individuals who meet the target population criteria; and <ol style="list-style-type: none"> a. indicate an interest in competitive employment; and b. are unemployed or underemployed due to symptoms associated with chronic and severe mental illness; and c. have a documented service goal to attain and/or maintain competitive employment; and d. are able to actively participate in and benefit from these services. 2. Priority is given to individuals who meet the ADA Settlement criteria. 3. Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be provided by persons identified in O.C.G.A. Practice Acts as qualified to provide a diagnosis. 														
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual demonstrates documented progress relative to goals identified in the Individualized Recovery Plan for employment, but employment goals have not yet been achieved and significant support for job search and/or employment is still required. 														

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	<ol style="list-style-type: none"> 2. Individuals who were admitted prior to 10/1/13 who have a LOCUS score of 2 or 3 may remain enrolled until s/he meets below discharge criteria. 3. Individuals who are initially enrolled with a LOCUS score of 4-6, but who achieve a level of recovery which reflects a LOCUS of 2-3 may remain in service until s/he meets below discharge criteria.
Discharge Criteria	<ol style="list-style-type: none"> 1. Goals of the Individualized Recovery Plan related to employment have been substantially met; or 2. Individual requests a discharge from this service; or 3. Individual does not currently desire competitive employment; or 4. If after multiple outreach attempts and attempts to explore and resolve barriers to individual's engagement by Employment Specialist and individual's Behavioral Health Provider consistently made over the course of 90 days, the individual does not engage in services for 90 days; unless the individual is hospitalized or in jail, in which case the provider would be expected to continue contact with the individual, his/her service providers (including Vocational Rehabilitation Counselor), his/her employer and to participate in discharge planning; or 5. If after 180 days of steady employment, it has been demonstrated that the individual no longer needs intensive supported employment specialty services to maintain employment, and the individual has participated with the Employment Specialist, natural supports and other service providers to create a planned transition from supported employment to extended job supports provided by the individual's natural supports, behavioral health providers (e.g. Psychiatric Rehabilitation-Individual; Peer Support-Individual, etc.) and/or TORS provider. If the individual has or had an open case with the Georgia Vocational Rehabilitation Agency (GVRA) Vocational Rehabilitation (VR) program and received supported employment services paid for in whole or in part by GVRA/VR the extended supports must be provided by the individual's behavioral health provider, which may include, or be the TORS provider.
Clinical Exclusions	<p>Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: developmental disability, autism, organic mental disorder.</p>
Staffing Requirements	<ol style="list-style-type: none"> 1. Employment Specialists that do not hold licensure or certification as specified in the Provider Manual must comply with training requirements for paraprofessionals as outlined in the Provider Manual. 2. All Employment Specialists and SE Supervisors must complete at least 16 hours of documented training consistent with the IPS-25 model. 3. Each SE Provider shall employ a minimum of 1 FTE Employment Specialist. 4. All Employment Specialists shall maintain a SE caseload ratio no greater than 1 FTE Employment Specialist to 20 SE individuals. Employment Specialists who deliver TORS to individuals who have been discharged from SE services, should not count these individuals in the SE caseload and must subtract the average number of hours spent delivering TORS from the amount of time dedicated to SE services. For example, if an Employment Specialist works 40 hours a week (1 FTE), provides TORS and Supported Employment services 100% of the time and documents an average of 4 TORS billable hours each week, then 36 hours (90% of 40) would be dedicated to SE services on average each week. The 1:30 SE caseload ratio would be 90% FTE to 18 SE individuals. 5. All Employment Specialists must receive regular supervision from a designated SE Supervisor in accordance with the IPS-25 model. 6. Each SE Provider shall employ 1 FTE SE Supervisor to be dedicated to a maximum of 10 FTE Employment Specialists. Supervisors responsible for fewer than 10 FTE Employment Specialists may spend a percentage of time on other duties on a prorated basis. For example, a Supervisor responsible for 1 FTE Employment Specialist may spend 90% of time on other duties. 7. All SE Supervisors must have a minimum of a bachelor's degree in the social sciences/helping professions and 1 year experience of delivering SE services or certification by a nationally or state recognized evidence-based SE training program. If all of the provider's Employment Specialists hold a bachelor's degree or higher in the social sciences/helping professions; or have at least three years' experience in counseling, linking with community resources, special education or instruction, the Bachelor's degree requirement for the SE Supervisor is waived.
Required Components	<ol style="list-style-type: none"> 1. The programmatic goals of this service must be clearly articulated by the provider, utilizing evidence based practices for supported employment services as described in the IPS-25 Fidelity Scale (www.dartmouth.edu-ips). 2. Employment must be in an integrated community setting in which the majority of employees do not have disabilities, and there is no requirement for the applicant to have a disability. The job must pay minimum wage or equivalent to typical earnings/benefits for the job title, and be in compliance with all applicable Department of Labor requirements, including compensation, hours, and benefits. 3. If ACT, CST, Core, PSR-I, Peer Supports other behavioral health and/or vocational rehabilitation services are provided simultaneously, individual record must show

Supported Employment

	<p>evidence of integrated service coordination and effort to avoid duplication of services.</p> <ol style="list-style-type: none"> 4. A vocational profile, individualized plan of employment and individualized job support plan must be completed according to the individual's strengths and preferences; integrated in the individual's behavioral health service chart; and show evidence of periodic updates. If an individual has an open case with GVR/VR, all GVR/VR documentation must be included in the individual's behavioral service record. 5. The initial vocational profile must be completed and the individual or employment specialist on behalf of the individual, must make face-to face contact with a potential employer, specific to the individual's plan of employment, on average, within the first 30 days of individual's enrollment in SE services and be documented in the progress notes.
Clinical Operations	<ol style="list-style-type: none"> 1. Individuals receiving this service must have competitive employment as a goal in their IRP. Ninety percent (90%) of Individual treatment charts must demonstrate integration of behavioral health and employment goals and services. Charts of individuals who have open cases in Vocational Rehabilitation services must document fulfillment of Vocational Rehabilitation meeting, reporting and communication requirements. 2. Supported Employment Specialists must deliver each of the following six service components: <ol style="list-style-type: none"> a. Pre-Placement <ul style="list-style-type: none"> • Engage individual, and with permission, his/her behavioral health providers and natural supports in an exploratory discussion about the individual's interest in competitive employment and long term vocational goals. Provide or coordinate access to information about vocational services offered by GVR/VR; and according to the individual's desires and GVR/VR guidelines, assist and support the individual in completion and coordination of the GVR/VR application process and regular follow-up communication with GVR/VR staff to determine status of application. • Determine if the individual receives SSI, SSDI or other benefits which might be affected by an increase in income, and provide or coordinate access to informational resources about work incentives and benefits counseling. Ensure that the individual and with permission, his/her behavioral health providers and natural supports receive and understand individualized and written information about how new or increased wages will impact the individual's eligibility for and receipt of disability benefits, housing and/or other income-determined services and benefits, as well as how to complete any related and required financial reports. • Over several sessions, gather information from individual, and with permission, his/her behavioral health providers, Vocational Rehabilitation Counselor, natural supports, former employers, and/or existing records/reports to develop a vocational profile that provides insight to the individual's preferences, experiences, abilities, strengths, supports, resources, limitations and needs. Engage the individual, and if desired, his/her professional and/or natural supports in a discussion about his/her vocational profile to explore, identify and document desirable and suitable job types and work environments. Ensure the Vocational Profile is integrated into the individual's behavioral health service chart. • Educate individual about the pros and cons of disclosing aspects of his/her disability and discuss at frequent intervals to support and empower the individual to make informed decisions about what, if any details s/he wants communicated to the employer at any point in time. b. Service Integration: Provide direct or indirect efforts on behalf of the individual to integrate, coordinate and reduce duplication of the individual's SE service with TORS and other behavioral health and if applicable, Vocational Rehabilitation or other pertinent services, through regular, documented meetings and contact with members of the individual's multidisciplinary treatment team. c. Job Development: Cultivate relationships with potential employers in order to explore and develop competitive employment opportunities based on individual's vocational profiles and employment plans. for individuals. Competitive employment refers to a job to which anyone can apply, in an integrated community setting in which the majority of employees are not disabled, and which pays minimum wage or more. Relationships are to be based on an understanding of the potential employer's business needs; the services the Employment Specialist is able to provide to the company; and the employment plans of individuals served. Employer contacts should be documented weekly and reviewed regularly by the SE Supervisor according to IPS-25 model. d. Job Placement

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- Develop with the individual, and with permission, his/her behavioral health provider, VR Counselor and/or natural supports an individual plan of employment which includes the type of job and environment being sought, the type of supports the individual wants and clear statements about who will do what by when.
 - Teach, assist and support the individual to emphasize strengths and minimize consequences (i.e. criminal history, periods of unemployment, etc.) and functional challenges of mental illness in development of resumes, completion of applications and practice for interviews (which may include symptom management and coping skills).
 - Assist the individual in negotiating a mutually acceptable job offer in a competitive, community-integrated job that meets the individual's vocational goals and includes reasonable accommodations and/or adaptations to ensure the individual's success in the work environment.
 - Assist the individual, and his/her behavioral health providers, VR Counselor and/or natural supports to identify skills, resources and supports the individual will need to start a new job; and create and implement a plan to attain these things to ensure a successful transition to employment and first days on the job. The plan may include assistance in symptom management, acquiring appropriate work clothes and transportation to work; , as well as planning for meals, medication and other activities and supports needed to maintain wellness and stability at the work site. The individual's chart should contain this plan.
 - In the event that the individual desires a different job, quits or is terminated for whatever reason, the vocational profile must be updated and the individual assisted in updating his/her employment plan and resume; finding and applying for another job; and updating his/her job support plan.
- e. Job Coaching: Provide intensive one-on-one services designed to teach the individual job-specific skills, tasks, responsibilities and behaviors on or off the job site, according to the individual's disclosure preferences. This may include systematic job analysis, environmental assessment, vocational counseling, training and interventions to help the supported employee learn to perform job tasks to the employer's specifications and be accepted as an employee at the worksite. Provide training, consultation and support to the employer at the individual's request.
- f. Follow- Along Supports
- Work in partnership with the individual and his/her behavioral health providers, Vocational Rehabilitation Counselor and/or natural supports to update and implement an individualized job support plan that maximizes the use of natural supports and prepares the individual and his/her interdisciplinary treatment, rehabilitation and recovery teams for transition to extended job supports provided by behavioral health providers and/or natural supports. Provide and coordinate ongoing task-oriented rehabilitation and job-specific training and support for management of symptoms, crises and over-all job performance necessary for long term success, tenure and stability on the job. Per individual's preferences about disclosure, services may include, , proactive employment advocacy, supportive counseling, coaching, peer support and ancillary support services, at or away from the job site.
 - Employment Specialist must make a minimum of 2 face-to-face visits with supported employee at the worksite each month; or 2 face-to-face visits with employee off site and 1 employer contact monthly.

Reporting and Billing Requirements	<ol style="list-style-type: none"> 1. A monthly, standardized programmatic report is required by the DBHDD to monitor performance and outcomes as well as approve the amount requested via the MIERs. 2. In order to bill the monthly rate, the provider shall be engaged in supports and planning even when individual is in acute residential, hospital or jail. See discharge criteria #4. 3. If a provider has no face-to-face contact with the individual during the month, the monthly rate may be billed if the provider has documentation of service integration, job development or active participation in discharge planning if the individual is in acute residential, hospital or jail. See discharge criteria #4.
Service Accessibility	Employment Specialists are expected to spend at least 65% of scheduled work time delivering services to individuals and employers in the community and must be available during daytime, evening and weekend hours to accommodate the needs of individuals and employers.

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Documentation Requirements	<ol style="list-style-type: none"> 1. The individual client record must include documentation of services described in the Service Operations section. 2. Provider is required to complete a progress note for every contact with individual as well as for related collateral. 3. Progress notes must adhere to documentation requirements set forth in this manual.
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Task-Oriented Rehabilitation Services

Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Task-Oriented Rehabilitation Services	Practitioner Level 4, Out-of-Clinic	H2025	U4	U7			\$24.36	Practitioner Level 5, Out-of-Clinic	H2025	U5	U7			\$18.15
Unit Value	15 minutes							Maximum Daily Units	8 units					
Initial Authorization	300 Units							Re-Authorization	6 months					
Authorization Period	180 Days							Utilization Criteria	LOCUS scores: 3 – 6 See exception in Continuing Stay Criteria					
Service Definition	<p>Task Oriented Rehabilitation Services (TORS) provide the psychiatric rehabilitation interventions to address the barriers created by psychiatric disability that interfere with an individual's ability to develop or regain a meaningful and valued role, including the ability to successfully pursue and maintain satisfying competitive employment. TORS are delivered concurrently with and after discharge from evidence-based supported employment services (IPS-25; www.dartmouth.edu/~ips) in the worksite or community, in accordance with an individual's preferences about disclosure of his/her disability to employers. TORS must be based upon the Individual Recovery Plan (IRP) which identifies a desire and need to acquire the skills, resources and supports the individual needs to self-recognize emotional triggers and to self-manage behaviors related to behavioral health issues that may interfere with employment.</p> <p>TORS goals must complement and be closely coordinated with the goals, plans and activities of supported employment, behavioral health and other services and integrated into the Individual Recovery Plan (IRP). Interventions may include:</p> <ol style="list-style-type: none"> 1. the use of role-modeling or mentoring of a person working while managing a mental illness; 2. motivational and educational experiences, exercises, methods and tools to help an individual: <ol style="list-style-type: none"> a. Develop hope, confidence and motivation related to a meaningful and valued role including employment. b. Identify, articulate and self-advocate for his/her goals, interests, skills, strengths, needs and preferences; c. Identify and engage natural supporters to assist in achieving his/her vocational & recovery goals. d. Identify and develop meaningful roles while living with a mental illness. e. Identify consequences of increased income, develop and use a plan to manage these consequences in manner that supports the individual's preferences and attainment of recovery, financial and vocational goals. f. Use recovery, wellness and symptom management plans, coping skills and strategies to manage mental health needs and challenges that may arise while engaged in vocational activities. <p>Individuals receiving evidence-based supported employment services (IPS-25) are eligible to enroll in TORS and may continue receiving TORS if they are competitively employed at the time of discharge from supported employment services and do not meet discharge criteria.</p>													

Task-Oriented Rehabilitation Services

Admission Criteria	<ol style="list-style-type: none"> 1. Individual must meet Core Customer criteria and: <ol style="list-style-type: none"> a. Have a goal for competitive employment in his/her Individual Recovery Plan (IRP); and b. Be enrolled in supported employment services; and c. Need psychiatric rehabilitation services to address the barriers created by their psychiatric disability that interfere with the individual's ability to develop or regain a meaningful and valued role including the ability to successfully pursue and maintain satisfying competitive employment. 2. Priority is given to individuals who meet the ADA Settlement criteria. 3. Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be provided by persons identified in O.C.G.A. Practice Acts as qualified to provide a diagnosis.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Individual demonstrates documented progress relative to identified TORS goals but goals have not yet been achieved, and: <ol style="list-style-type: none"> a. is enrolled in evidence-based supported employment services; or b. is competitively employed but no longer needs and therefore has been discharged from evidence-based supported employment services. 2. If the individual has no behavioral health providers other than a psychiatrist, the individual may receive extended TORS from his/her supported employment provider if s/he is competitively employed at the time of supported employment discharge and needs these services to maintain his/her goal of competitive employment. 3. Individuals who were admitted prior to 10/1/13 who have a LOCUS score of 2 or higher may remain enrolled until s/he meets the discharge criteria listed below. 4. Individuals who are initially enrolled with a LOCUS score of 3-6, but who achieve a level of recovery which reflects a LOCUS of 2 may remain in service until s/he meets the discharge criteria listed below.
Discharge Criteria	<ol style="list-style-type: none"> 1. Individual no longer has goal to be competitively employed. 2. Individual requests discharge from TORS. 3. TORS goals in the Individualized Recovery Plan (IRP) have been substantially met; or 4. Individual is unemployed and no longer receiving supported employment services; or 5. If after 180 days of steady employment, individual has participated with natural supports and service providers in a planned transition from TORS to extended supports by the individual's behavioral health providers (e.g. Case Management; Peer Supports, etc.) and/or natural supports and has demonstrated the ability to continue successful employment without TORS.
Service Exclusions	<ol style="list-style-type: none"> 1. No service exclusions. 2. If Supported Employment, ACT, PSR-Individual, Peer Support – Individual, CST, Core, or other behavioral health and/or vocational rehabilitation services are provided simultaneously the individual's record must show evidence of integrated service coordination and effort to avoid duplication of services. Note that service integration may not be documented as a TORS billable unit.
Clinical Exclusions	<p>Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: developmental disabilities, autism, and organic mental disorders.</p>
Staffing Requirements	<ol style="list-style-type: none"> 1. The following practitioners will provide TOR Services in conjunction with current or recent delivery of evidence-based supported employment services: <ol style="list-style-type: none"> a. Practitioner Level 3: LPC, LCSW, LMFT; (May provide but must bill at Practitioner Level 4 rate) b. Practitioner Level 4: LAPC, LMSW, LAMFT, CPS, CPRP, and trained Paraprofessionals with Bachelor's degree or higher in the social sciences/helping professions; c. Practitioner Level 5 – CPS, CPRP and Paraprofessionals. d. TORS staff who do not hold licensure or certification as specified in the Provider Manual must comply with training requirements for paraprofessionals as outlined in the Provider Manual. e. TORS staff who do not have at least 1 year of delivering evidence-based supported employment services, must complete a minimum of 7.5 hours documented training on evidence-based supported employment (IPS) within first 90 days. f. The program must include at least (1) staff person with the Task Oriented Rehabilitation Service (TORS) who has a Certified Psychiatric Rehabilitation Practitioner (CPRP) certification, or staff who can demonstrate activity toward attainment of certification (e.g., current enrollment in CPRP courses/training). 2. If the CPRP is not the supervisor of the TORS program, then the role of this person is to provide recover oriented guidance as a member of the team.

Task-Oriented Rehabilitation Services

	<p>Providers of TORS shall demonstrate documentation of provision of evidence based Supported Employment (SE) as evidenced by an Individual Placement and Supports (IPS) Fidelity Review with a minimum total score of 74 within the last 12 months.</p>
<p>Required Components</p>	<ol style="list-style-type: none"> 1. TORS providers must provide documentation that the creation of the TORS goals/objectives/interventions involved input from and collaboration with the individual. With permission from the individual, provider will document involvement and collaboration with his/her chosen supporters, including the individual's supported employment, behavioral health and vocational rehabilitation service providers and is based upon knowledge gained from the assessments and service plans of these respective providers, as well as the TORS provider's own assessment process. 2. As indicated in the IRP, TORS goals and objectives should be based upon and reflect knowledge gained from the comprehensive assessment, as well as collaboration with the individual's BH, supported employment, vocational rehabilitation and any other pertinent service providers. If an individual does not want other providers, vocational rehabilitation, etc. involved in the TORS goals/objectives/interventions in the IRP, the individual's wishes will be respected and input from others will not be included. Documentation of the individual's wishes and coordination (or no coordination) should be included in assessments and progress notes. 3. The TORS component of the overall IRP must state what the individual, as well as the individual's BH, supported employment, vocational rehabilitation, and any other pertinent service providers will do to implement the plan and show evidence of periodic updates as objectives and goals are achieved. 4. Development of TORS goals in the IRP must include documented assessment of: <ol style="list-style-type: none"> a. emotional triggers and behaviors related to behavioral health issues that may interfere with employment and ongoing engagement in meaningful and satisfying competitive employment. b. the skills, resources, and supports an individual needs to overcome these identified barriers; and c. the individual's current interests, strengths, skills, resources, and supports that can be used to facilitate his/her achievement of employment goals. 5. All interventions must increase the individual's ability to manage the symptoms, conditions and consequences associated with his/her mental illness that interfere with his/her ability to pursue and achieve his/her employment goals. 6. Face to face contacts should be based on the needs of the individual but should not exceed the maximum of 8 units per day.
<p>Clinical/Service Operations</p>	<ol style="list-style-type: none"> 1. The programmatic goals of this service must be clearly articulated by the provider, based on best practices for psychiatric rehabilitation as applied to the pursuit of and long term engagement in meaningful and satisfying competitive employment. 2. The organization must have a TORS Organization Plan that clearly articulates the programmatic goals of this service and addresses: <ol style="list-style-type: none"> a. How the core principles and values of the Psychiatric Rehabilitation Association are utilized to support vocational goals (http://uspra.ipower.com/Board/Governing_Documents/USPRA_CORE_PRINCIPLES2009.pdf); b. The models and types of psychiatric interventions that will be utilized to support individuals in attainment of vocational goals; c. How programmatic oversight or guidance by a CPRP will be provided; d. Protocols to ensure coordination and avoid duplication of services that are provided by the supported employment specialist or other behavioral health and/or vocational rehabilitation providers; and e. When and how TORS will be provided in conjunction with evidence-based (IPS-25) supported employment services and delivered in a manner that supports and is congruent with fidelity to this model (www.dartmouth.edu/~jps). 3. Individuals should receive TORS from their current or most recent Supported Employment Provider. 4. TORS must complement and be closely coordinated with the goals, plans and activities of supported employment services and integrated into the Individual Recovery Plan (IRP).
<p>Service Accessibility</p>	<ol style="list-style-type: none"> 1. Providers are expected to deliver TORS 100% of the time in the individual's work site or a community setting according to the individual's preferences about disclosure of mental illness to employers, family, and friends and the individual's preferences for preferred location of service delivery. 2. TORS must be available during daytime, evening and weekend hours to accommodate the needs of the individual served.
<p>Documentation Requirements</p>	<ol style="list-style-type: none"> 1. Provider is required to complete a progress note for every TORS contact with the individual. When provided in conjunction with supported employment and/or other behavioral health or vocational rehabilitation services, coordination of services should be evident in documentation as applicable. 2. Documentation will reflect coordinated service integration as a "no charge". See #2 in Service Exclusions.

Task-Oriented Rehabilitation Services

	3. All applicable Medicaid, MICP and DBHDD reporting requirements must be met.
Additional Medicaid Requirements	1. TORS cannot be billed for the function of job development; training on job-specific skills or duties; or for any contact with or services provided to an employer. 2. TORS cannot be billed for service integration.

Temporary Observation Services

HIPAA Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod4	Rate
Crisis Intervention Mental Health Services	Temporary Observation Services	S9485					
Unit Value	1 encounter	Maximum Daily Units	1 unit				
Initial Authorization	7 units	Re-Authorization	N/A				
Authorization Period	20 Days	Utilization Criteria	Available to those with LOCUS level of 5 or 6. Available to those requiring ASAM III.7 level of care				
Service Definition	Temporary observation is a facility-based program that provides a physically secure and medically safe environment during which an individual in crisis is further assessed, stabilized and referred to the next appropriate level of care (generally within 24 hours). Interventions delivered during temporary observation may include any appropriate outpatient core service (e.g. psychiatric treatment, nursing assessment, medication administration, crisis intervention, psychosocial rehabilitation-individual, case management, etc.) as well as observation, monitoring of objective signs and symptoms of withdrawal, symptom management, discharge and follow-up planning and referral.						
Admission Criteria	<p>Adult with a psychiatric condition or issue related to substance use/ abuse that has demonstrated via clinical assessment a degree of instability or disability that needs to be monitored, evaluated, and further assessed to determine the most appropriate level of care. This may include either discharge to community based services or referral for admission to a higher level of care as needed; Individuals appropriate for temporary observation have demonstrated one or more of the following:</p> <ol style="list-style-type: none"> Further evaluation is indicated in order to clarify previously incomplete information prior to disposition; Further stabilization is indicated prior to disposition; There is evidence of an imminent or current psychiatric emergency without clear indication for admission to inpatient or crisis stabilization treatment; There are indications that the symptoms are likely to respond to medication, structured environment, or brief withdrawal management resulting in stabilization so that an alternative treatment in a psychiatric inpatient facility or crisis stabilization unit may be initiated; Observation and continued care is necessary while awaiting transfer or referral to a higher level of care; There is evidence of a substance withdrawal related crisis, or intoxication, presenting as risk of harm without clear indication for admission to psychiatric inpatient facility or crisis stabilization unit. 						
Discharge Criteria	<p>The individual is considered appropriate for discharge when it has been determined that one of the following is clinically appropriate and arrangements for transfer or aftercare have been completed:</p> <ol style="list-style-type: none"> A higher level of care, such as a crisis stabilization unit or psychiatric inpatient facility; or A lower level of care, such as outpatient care; or, less commonly, Home with no recommendation for follow-up. 						
Service Exclusions	An individual shall not receive Temporary Observation services while receiving Crisis Stabilization Unit (CSU) services.						

Clinical Exclusions	<ol style="list-style-type: none"> 1. The individual can be safely maintained and effectively treated at a less intensive level of care. 2. The primary problem is social, economic (i.e., housing, family conflict, etc.), or one of physical health without a concurrent major psychiatric episode meeting the criteria for this level of care 3. Presence of a condition of sufficient severity to require acute psychiatric inpatient, crisis stabilization unit, medical, or surgical care (unless being provided observation and care as described in Item (e) in Admission Criteria section above while awaiting transfer to crisis stabilization unit or inpatient psychiatric facility). 4. Admission is being used as an alternative to incarceration and is NOT accompanied by a covered DSM diagnosis of mental illness or substance use disorder. 5. Methadone Administration must occur in programs operating under 290-9-12, Narcotic Treatment Programs.
Required Components	<ol style="list-style-type: none"> 1. Temporary Observation is operational 24 hours a day, 7 days a week, offering a brief stay (generally less than 24 hours) in a medically monitored, safe environment for individuals requiring additional assessment and care, using licensed professionals. 2. Temporary Observation services are not a stand-alone service. Temporary Observation services must be associated with: <ol style="list-style-type: none"> a. a crisis stabilization unit [CSU]; or b. a 24/7 Crisis Service Center. 3. Temporary Observation services may vary in numbers of observation chairs or beds. This will be specified in contracts; 4. Temporary Observation services must include service delivery under a physician's order and supervision along with nursing services and medication administration.
Staffing Requirements	<p>Staff must include:</p> <ul style="list-style-type: none"> • Physician, APRN or PA to provide timely assessment, orders for presenting clients and temporary observation coverage may be shared with, a Crisis Service Center or Crisis Stabilization Unit, as long as contract requirements for coverage by specific level of professional are met.; • A Registered Nurse to provide observation and treatment for individuals admitted for Temporary Observation. Note that the RN may float to the Crisis Assessment area, as necessary, but remains the responsible license for the Temporary Observation service; • A Licensed Practical Nurse or a second Registered Nurse to provide coverage by a licensed professional [and other duties as assigned] when the primary RN floats to the Crisis Assessment area; • A properly trained direct care staff member to provide continuous observation and care needs for assigned clients, minimum of 1 tech per shift.; • Functions performed by Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, Registered Nurses, and Licensed Practical Nurses must be performed within the scope of practice allowed by State law and Professional Practice Acts.
Clinical Operations	<p>This program including all physicians are under the supervision of a board eligible Psychiatrist who provides direction and oversight of program operation. A physician or physician extender (APRN or PA) shall be on call 24-hours a day and shall make rounds seven days a week. The physician is not required to be on site 24-hours a day, however, the physician must respond to staff calls immediately, with delay not to exceed one hour. A physician extender may also be used in an on-call role but must always have access to consult with a physician or psychiatrist.</p> <ul style="list-style-type: none"> • Physician/physician extender coverage may include use of telemedicine. • On Call Physician/Psychiatrist/Physician Extender response time must be within 60 minutes of initial contact by Crisis Service Center staff. • On Call Physicians, APRNs or PAs may provide services face-to-face or via telemedicine.
Additional Medicaid Requirements	N/A
Service Accessibility	<ol style="list-style-type: none"> 1. Services must be available by required/qualified staff 24 hours a day, 7 days a week with on-call response coverage including psychiatric services. 2. A physician delivering Temporary Observation services may utilize telemedicine.
Reporting and Billing Requirements	TBD

Documentation Requirements	<ol style="list-style-type: none">1. Documentation during the period of temporary observation shall be the following:<ol style="list-style-type: none">a. Physician/physician extender order for admission to Temporary Observation;b. Verbal orders are acceptable if properly documented, as outlined in the Provider Manual (Part II, Section 3)c. Initial Assessment resulting in working diagnoses / diagnostic impression [including co-occurring diagnoses], and statement of plan for the Temporary Observation stay.d. Brief Psychiatric Historye. Brief Physical Screeningf. Brief Nursing Assessmentg. RN progress note at least Q shift [Q 12 hours max] to include status, course of treatment, response to treatment and significant events or findingsh. Discharge Order from Physician/physician extenderi. Discharge summary paragraph to include:<ol style="list-style-type: none">i. Care provided and outcome of careii. Discharge diagnosisiii. Disposition / follow-up planiv. Condition at discharge2. All individual services for which claims/encounters are submitted must be documented in accordance with requirements as specified in the Provider Manual.
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**SECTION IV
PRACTITIONER DETAIL**

Please see the next page for Practitioner Detail

- ¹ with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state
- ² with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology
- ³ addictions counselors may only perform these functions related to treatment of addictive diseases
- ⁴ with high school diploma/equivalent
- ⁵ under the documented supervision (organizational charts, supervisory notation, etc.) of one of the licensed/credentialed professionals who may provide this service
- ⁶ modifiers indicate services for which it is required to submit and document "U" levels; an "x" denotes services for which a "U" modifier is not required to submit an encounter
- ⁷ with a Master's/Bachelor's degree in behavioral or social science that is primarily psychological in nature under the supervision of a licensed practitioner
- ⁸ with high school diploma/equivalent under supervision of one of the licensed/credentialed professionals who may provide this service
- ⁹ working **only** within a Community Living Arrangement
- ¹⁰ in conjunction with a psychologist
- ¹¹ excludes LCSW, LPC, LMFT Supervisee/Trainee
- ¹² under supervision of a Physician, Psychologist, LCSW, LPC, LMFT, RN, APRN, PA, LMSW, LAPC, or LAMFT
- ¹³ LPNs who are "paraprofessionals" having completed the STR
- ¹⁴ Please see the Community Requirements for full titles of practitioners.
- ¹⁵ under supervision of a Physician, Psychologist, LCSW, LPC, LMFT, RN, APRN, PA, CAC II, GCADC II/III, or MAC
- ¹⁶ Supervisee/Trainers are not able to bill Crisis Psychotherapy codes 90839

TABLE B: Physicians, Physician’s Assistants and APRNs* may order any service. Please use the chart below to determine other appropriately licensed practitioner(s) authorized to recommend/order specific services.

Ordering Practitioner Guidelines		Licensed Psychologist	LPC, LMFT, LCSW
Core	Addictive Disease Support Services	X	X
	Behavioral Health Assessment & Service Plan Development	X	X
	Case Management (adults only)	X	X
	Community Support – Individual (youth only)	X	X
	Community Transition Planning	X	X
	Crisis Intervention	X	X
	Diagnostic Assessment	X	LCSW Only ¹
	Family Outpatient Services (Counseling & Training)	X	X
	Group Outpatient Services (Counseling & Training)	X	X
	Individual Counseling	X	X
	Legal Skills/Competency Training	X	X
	Medication Administration		
	Nursing A / H Services		
	Psychiatric Treatment		
Psychological Testing	X	X	
Psychosocial Rehabilitation-Individual (adults only)	X	X	
C&A Speciality	Community Inpatient / Detoxification		
	Crisis Stabilization Program		
	Intensive Family Intervention	X	X
	Structured Residential Supports	X	X
	SA Intensive Outpatient: C&A		
Adult Speciality	Ambulatory Detoxification		
	Assertive Community Treatment		
	Intensive Case Management	X	X
	Community Inpatient / Detoxification		
	Community Support Team	X	X
	Crisis Stabilization Unit Services		
	Housing Supplements	X	X
	Intensive Case Management	X	X
	Opioid Maintenance Treatment		
	Peer Support (includes MH, AD, Group & Individual)	X	X
	Peer Support Whole Health and Wellness	X	X
	Psychosocial Rehabilitation Group	X	X
	Residential SA Detoxification		
	Respite	X	X
Residential Supports	X	X	
SA Day Treatment			
Supported Employment/Task Oriented Rehabilitation	X	X	
Temporary Observation			

*APRNs include Clinical Nurse Specialists (CNS) and Nurse Practitioners (NP)

¹ The modification here for Diagnostic Assessment (while not included in previous Provider Manual editions) is effective 7/1/12.

PART II

Community Service Requirements for Behavioral Health Providers

Provider Manual for
Community Behavioral Health Providers

Fiscal Year 2015



**Georgia Department of Behavioral Health
& Developmental Disabilities**

April 2015

COMMUNITY SERVICE REQUIREMENTS FOR ALL PROVIDERS

SECTION I: POLICIES AND PROCEDURES

1. Guiding Principles

- a. **Integration into community:** Inclusion and community integration for both the provider and the individuals served is supported and evident.
 - i. Individuals have responsibilities in the community such as employment, volunteer activities, church and civic membership and participation, school attendance, and other age-appropriate activities
 - ii. The provider has community partnerships that demonstrate input and involvement by:
 1. Advocates;
 2. The person served;
 3. Families; and
 4. Business and community representatives.
 - iii. The provider makes known its role, functions and capacities to the community including other organizations as appropriate to its array of services, supports, and treatment as a basis for:
 1. Joint planning efforts;
 2. Continuity in cooperative service delivery, including the educational system;
 3. Provider networking;
 4. Referrals; and
 5. Sub-contracts.
 - iv. AD providers who receive SAPTBG funds shall publicize the availability of services and the preference extended to pregnant women through its outreach programs, ongoing public service announcements (radio/television), regular advertisements in local/regional print media, posters placed in targeted areas, and frequent notification of availability of such treatment distributed to the network of community based organizations, health care providers, and social service agencies. ^{SAPTBG}
 - v. Providers receiving SAPTBG grant dollars for treatment services for intravenous drug abusers must encourage the participation of such individuals through a strategy that reasonably can be expected to be an effective but, at a minimum, shall include:
 1. Selecting, training and supervising outreach workers;
 2. Contacting, communicating and following-up with substance abusers, their associates, and neighborhood residents, within the constraints of Federal and State confidentiality requirements, including 42 C.F.R. Pt 2;
 3. Promoting awareness among substance abusers about the relationship between intravenous drug abuse and communicable diseases such as HIV, and recommending steps to prevent disease transmission; and
 4. Encouraging entry into treatment. ^{SAPTBG}
 - vi. For agencies who provide any combination of Community Behavioral Health, Psychiatric Residential Treatment Facility (PRTF), and/or Room Board Watchful Oversight (RBWO) services, the agency must ensure appropriate distinctions between these programs to include but not limited to physical, financial, administrative, and programmatic separation. Additional guidance may be found in the PRTF Provider Manual.
- b. **Right to access individualized services**
 - i. Access to appropriate services, supports, and treatment is available regardless of, Age; Race, National Origin, Ethnicity; Gender; Religion; Social status; Physical disability; Mental disability; Gender identity; Sexual orientation.
 - ii. There are no barriers in accessing the services, supports, and treatment offered by the provider, including but not limited to:
 1. Geographic;
 2. Architectural;
 3. Communication;

- a. Language access is provided to individuals with limited English proficiency or who are sensory impaired;
 - b. All applicable DBHDD policies regarding Limited English Proficiency and Sensory Impairment are followed.
- 4. Attitudinal;
- 5. Procedural;
- 6. Organizational scheduling or availability; and
- 7. Providers that receive SAPTBG funds will treat the family as a unit and admit both women and their children into treatment services, if appropriate. Programs must provide, or arrange for the provision of, the following services to pregnant women and women with dependent children, including women who are attempting to regain custody of their children:
 - a. Primary medical care for women, including referral for prenatal care and, while the women are receiving services, childcare;
 - b. Primary pediatric care, including immunization, for their children;
 - c. Gender specific substance abuse treatment and other therapeutic interventions for women, which may address issues of relationships, sexual and physical abuse, parenting, and child care;
 - d. Therapeutic interventions for children in custody of women in treatment which may address developmental needs, sexual and physical abuse and neglect; and
 - e. Sufficient case management and transportation to ensure access to services.
- SAPTBG
 - 8. Providers that receive SAPTBG funds provide IV Drug Users access to a treatment program not later than:
 - a. Fourteen days after making the request for admission to a program; or
 - b. One hundred and twenty days after the date of such request, if:
 - i. No such program has the capacity to admit the individual on the date of such request, and
 - ii. Interim services, including referral for prenatal care, are made available to the individual not later than 48 hours after such request. ^{SAPTBG}
- iii. Wellness of individuals is facilitated through:
 - 1. Advocacy;
 - 2. Individual service/treatment practices;
 - 3. Education;
 - 4. Sensitivity to issues affecting wellness including but not limited to:
 - a. Gender;
 - b. Culture; and
 - c. Age.
 - 5. Incorporation of wellness goals within the individual plan.
- iv. Sensitivity to individual's differences and preferences is evident.
- v. Practices and activities that reduce stigma are implemented.
- vi. If services include provision in non-clinic settings, providers must have the ability to deliver services in various environments, such as homes, schools, homeless shelters, or street locations. Individuals/families may prefer to meet staff at community locations other than their homes or other conspicuous locations (e.g. their school, employer).
 - 1. The organization must have policies that govern the provision of services in natural settings and can document that it respects youth and/or families' right to privacy and confidentiality
 - 2. Staff should be sensitive to and respectful of the individual's privacy/confidentiality rights and preferences to the greatest extent possible (e.g. if staff must meet with an individual during their school/work time, choosing inconspicuous times and locations to promote privacy), especially if staff drive a vehicle that is clearly marked as a state or agency vehicle, or if staff must identify themselves and their purpose to engage with the

individual in a way that may potentially embarrass the individual or breach the individual's privacy/confidentiality.

- vii. Telemedicine may be used as a means to access individualized service when the Service Guideline allows this practice (See Section III). Telemedicine is the use of medical information exchanged from one secured site to another via electronic communications to improve a patient's health. Electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. The telemedicine connection must ensure HIPAA compliance related to Privacy and Security (employing authentication, access controls and encryption to allow for patient/client confidentiality, integrity and availability of their data).
- viii. Interactions with individuals demonstrate respect, careful listening, and are positive and supportive.

2. Required Business Practices and Policies

a. Program requirements, compliance, and structure

- i. Applicable statutory requirements, rules, regulations, licensing, accreditation, and contractual/agreement requirements are evident in organizational policies, procedures and practices. In the event that the above requirements and standards are more stringent than these Requirements, providers shall defer to those requirements which are most stringent.
 - 1. Providers receiving MHBG funds must comply with Public Law 102-321, Section 1912 and applicable code sections at www.mentalhealth.samhsa.gov.^{MHBG}
 - 2. Providers receiving SATBG funds must comply with 45 CFR 96 Rules and Regulations at www.samhsa.gov/centers/csat/csat.html.^{SAPTBG}
 - a. The provider shall adhere to companion requirements as published by the Department of Community Health
- ii. The provider clearly describes available services, supports, and treatment
 - 1. The provider has a description of the services that have been approved by DBHDD and DCH along with the supports, care and treatment provided which includes a description of:
 - a. The population served;
 - b. How the provider plans to strategically address the needs of those served; and
 - c. Services available to potential and current individuals.
 - 2. The provider has internal structures that support good business practices.
 - a. There are clearly stated current policies and procedures for all aspects of the operation of the organization;
 - b. Policies and corresponding procedures direct the practice of the organization; and
 - c. Staff is trained in organization policies and procedures.
 - 3. The provider details the desired expectation of the services, supports, and treatment offered and the outcomes for each of these services.
 - 4. The level and intensity of services, supports, and treatment offered is:
 - a. Within the scope of the organization;
 - b. According to benchmarked practices; and
 - c. Timely as required by individual need.
 - 5. The provider has administrative and clinical structures that are clear and that support individual services.
 - a. Administrative and clinical structures promote unambiguous relationships and responsibilities.
 - 6. The program description identifies staff to individual served ratios for each service offered:

- a. Ratios reflect the needs of individuals served, implementation of behavioral procedures, best practice guidelines and safety considerations.
- 7. Policies, procedures and practice describe processes for referral of the individual based on ongoing assessment of individual need:
 - a. Internally to different programs or staff; or
 - b. Externally to services, supports, and treatment not available within the organization including, but not limited to healthcare for:
 - i. Routine assessment such as annual physical examinations;
 - ii. Chronic medical issues (Specific to AD providers, if tuberculosis or HIV are identified medical issues, services such as diagnostic testing, counseling, etc. must be made available within the provider or through referrals to other appropriate entities [although these services are not required as a condition of receiving treatment services for substance abuse, and are undertaken voluntarily and with the informed consent of the individual ^{SAPTBG});
 - iii. Ongoing psychiatric issues;
 - iv. Acute and emergent medical and/or psychiatric needs;
 - v. Diagnostic testing such as psychological testing or labs; and
 - vi. Dental services.
 - c. In the event that the SAPTBG provider has insufficient capacity to serve any pregnant woman seeking AD treatment, the provider will refer the woman to the Regional Office. ^{SAPTBG}
 - d. In the event that the SAPTBG provider has insufficient capacity to serve any IV Drug user seeking AD treatment, the provider shall establish a system for reporting unmet demand to the Regional Office.
 - i. The provider, upon reaching 90 percent of service capacity, must notify the Regional Office within seven days.
 - ii. A waiting list shall use a unique patient identifier for each injecting drug abuser seeking treatment, including those receiving interim services while awaiting admission to such treatment. The reporting system shall ensure that individuals who cannot be placed in comprehensive treatment within 14 days receive ongoing contact and appropriate interim services while awaiting admission. ^{SAPTBG}

b. **Subcontracting**

- i. As permitted by provider agreement/contract, the provider that contracts with other organizations/practitioners ensures the affiliates' compliance and capacity to provide services to include compliance with:
 - 1. Contract/Agreement requirements;
 - 2. Requirements herein;
 - 3. Licensure requirements;
 - 4. Accreditation requirements; and
 - 5. Quality improvement and risk reduction activities.
- ii. The affiliate's capacity to provide quality services is monitored, including:
 - 1. Financial oversight and management of individual funds;

2. Staff competency and training;
 3. Mechanisms that assure service is provided according to the individual's IRP; and
 4. There is evidence of active oversight of the affiliate's capacity and compliance.
- iii. A report shall be made quarterly to the provider's Board of Directors regarding services delivered and quality of performance by affiliate;
 - iv. A report shall be made to the DBHDD Regional Office prior to the end of the first quarter and third quarter of the fiscal year that includes:
 1. Name of the affiliate or contractor;
 2. Contact name for affiliate or contractor;
 3. Contact information for affiliate or contractor;
 4. Disability group(s) served;
 5. Specific service(s) provided;
 6. Number of persons in service; and
 7. Annualized amount paid to affiliate.
- c. **Quality Improvement and Risk Management: Quality Improvement Processes and Management of Risk to Individuals, Staff and Others is a Priority**
- i. There is a well-defined quality improvement plan for assessing and improving organizational quality. The provider is able to demonstrate how:
 1. Issues are identified;
 2. Solutions are implemented;
 3. New or additional issues are identified and managed on an ongoing basis;
 4. Internal structures minimize risks for individuals and staff;
 5. Processes used for assessing and improving organizational quality are identified;
 6. The quality improvement plan is reviewed/updated at a minimum annually and this review is documented.
 - ii. Indicators of performance are in place for assessing and improving organizational quality. The provider is able to demonstrate:
 1. The indicators of performance established for each issue;
 - a. The method of routine data collection;
 - b. The method of routine measurement;
 - c. The method of routine evaluation;
 - d. Target goals/expectations for each indicator
 - e. Outcome Measurements determined and reviewed for each indicator on a quarterly basis;
 2. Distribution of Quality Improvement findings on a quarterly basis to:
 - a. Individuals served or their representatives as indicated;
 - b. Organizational staff;
 - c. The governing body; and
 - d. Other stakeholders as determined by the governance authority.
 3. At least five percent (5%) of records of persons served are reviewed each quarter. Records of individuals who are "at risk" are included. Record reviews must be kept for a period of at least two years.
 - a. Reviews include determinations that:
 - i. The record is organized, complete, accurate, and timely;
 - ii. Whether services are based on assessment and need;
 - iii. That individuals have choices;
 - iv. Documentation of service delivery including individuals' responses to services and progress toward IRP goals;
 - v. Documentation of health service delivery;
 - vi. Medication management and delivery, including the use of PRN /OTC medications; and their effectiveness;
 - vii. That approaches implemented for persons with challenging behaviors are addressed as specified in the *Guidelines for*

Supporting Adults with Challenging Behaviors in Community Settings. (www.dbhdd.georgia.gov).

4. Appropriate utilization of human resources is assessed, including but not limited to:
 - a. Competency;
 - b. Qualifications;
 - c. Numbers and type of staff, required based on the services, supports, treatment, and needs of persons served; and
 - d. Staff to individual ratios.
5. The provider has a governance or advisory board made up of citizens, local business providers, individuals and family members. The Board:
 - a. Meets at least semi-annually;
 - b. Reviews items such as but not limited to:
 - i. Policies;
 - ii. Risk management reports;
 - iii. Budgetary issues; and
 - iv. Provides objective guidance to the organization
6. The provider's practice of cultural diversity competency is evident by:
 - a. Staff articulating an understanding of the social, cultural, religious and other needs and differences unique to the individual;
 - b. Staff honoring these differences and preferences (such as worship or dietary preferences) in the daily services/treatment of the individual; and
 - c. The inclusion of cultural competency in Quality Improvement processes.
- iii. There is a written budget which includes expenses and revenue that serves as a plan for managing resources. Utilization of fiscal resources is assessed in Quality Improvement processes and/or by the Board of Directors.
- iv. Areas of risk to persons served and to the provider are identified based on services, supports, or treatment offered including, but not limited to:
 1. Incidents: There is evidence that incidents are reported to the DBHDD Office of Incident Management and Investigation as required by DBHDD Policy, [Reporting and Investigating Deaths and Critical Incidents in Community Services, 04-106](#);
 2. Accidents;
 3. Complaints;
 4. Grievances;
 5. Individual rights violations including breaches of confidentiality
 6. There is documented evidence that any restrictive interventions utilized must be reviewed by the provider's Rights Committee;
 7. Practices that limit freedom of choice or movement;
 8. Medication management; and
 9. Infection control (specifically, AD providers address tuberculosis and HIV ^{SAPT}BG).
- v. The provider participates in DBHDD consumer satisfaction and perception of care surveys for all identified populations. Providers are expected to make their facilities and individuals served accessible to teams who gather the survey responses (e.g., the *Georgia Mental Health Consumer Network*).
- vi. Providers are required to implement and complete a corrective action plan (CAP) in response to internal and DBHDD-related quality, compliance, performance management findings (such as, but not limited to, audits, compliance reviews, KPI measurement, QM reviews, etc.).
 - a. A CAP must be specific and must, at a minimum, include provisions aimed toward correction of the deficiencies, indicate reasonable completion dates, fully describe the methodology used to accomplish complete and permanent corrective action, and describe methods for ensuring full compliance with the CAP.

- b. It is the responsibility of the provider to maintain and update CAPs and have available for review upon request, in addition to supporting documentation regarding corrective actions and ongoing quality assurance.

3. Consumer Rights

a. Rights and Responsibilities

- i. All individuals are informed about their rights and responsibilities:
 2. At the onset of services, supports, and treatment;
 3. At least annually during services;
 4. Through information that is readily available, well prepared and written using language accessible and understandable to the individual; and
 5. Evidenced by the individual's or legal guardian signature on notification.
- ii. The provider has policies and promotes practices that:
 1. Do not discriminate;
 2. Promote receiving equitable supports from the provider;
 3. Provide services, supports, and treatment in the least restrictive environment;
 4. Emphasize using least restrictive interventions; and
 5. Incorporate Clients' Rights or Patients' Rights Rules found at <http://gadbhdd.policystat.com/policy/303970/latest/> as applicable to the provider; and
 6. Delineates the rights and responsibilities of persons served.
- iii. In policy and practice, the provider makes it clear that under no circumstances will the following occur:
 1. Threats (overt or implied);
 2. Corporal punishment;
 3. Fear-eliciting procedures;
 4. Abuse or neglect of any kind;
 5. Withholding nutrition or nutritional care; or
 6. Withholding of any basic necessity such as clothing, shelter, rest or sleep.
- iv. **For all community based programs**, practices promulgated by DBHDD or the Rules and Regulations for Clients Rights, Chapter 290-4-9 are incorporated into the treatment of individuals served.
- v. **For all crisis stabilization units serving adults, children or youth**, practices promulgated by DBHDD or the Rules and Regulations for Patients' Rights, Chapter 290-4-6 are incorporated into the treatment of adults, children and youth served in crisis stabilization units.
- vi. **For all programs serving individuals with substance use and abuse issues**, in addition to practices promulgated by DBHDD or the Rules and Regulations for Clients Rights, Chapter 290-4-9, confidentiality procedures for substance abuse individual records comply with 42 CFR, Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records, Final Rule (June 9, 1987), or subsequent revisions thereof.

b. Grievances

- i. Grievance, complaint and appeals of internal and external policies and processes are clearly written in language accessible to individuals served and are promulgated and consistent with all applicable DBHDD policies regarding *Complaints and Grievances* regarding community services. Notice of procedures is provided to individuals, staff and other interested parties, and providers maintain records of all complaints and grievances and the resolutions of same.

c. Safety Interventions

- i. Providers must work with each enrolled individual to develop, document, and implement, as needed, a crisis plan.
- ii. Providers must have a process in place to provide after-hours accessibility and have the ability to respond, face-to-face as clinically indicated, to crisis situations that occur with enrolled individuals in a timely manner per the contact/agreement with DBHDD. The

Georgia Crisis and Access Line GCAL) are not to be used as the crisis or after hour's access for enrolled individuals. However, providers may utilize GCAL in order to gain access to higher levels of care (e.g. Crisis Stabilization Units, other inpatient services, etc.) or facilitate coordination with Georgia Emergency Management Agency services (i.e. 911)

- iii. The organization must have established procedures/protocols for handling emergency and crisis situations that describe methods for supporting individuals/youth as they transition to and from psychiatric hospitalization.
- iv. In policy, procedures, and practice, the provider makes it clear whether and under what circumstances the following restrictive interventions can be implemented based on the service(s) provided by the provider and licensure requirements. In all cases, federal and state laws and rules are followed and include but are not limited to the following:
 1. Use of adaptive supportive devices or medical protective devices;
 - a. May be used in any service, support, and treatment environment; and
 - b. Use is defined by a physician's order (order not to exceed six calendar months).
 - c. Written order to include rationale and instructions for the use of the device.
 - d. Authorized in the individual resiliency/recovery plan (IRP).
 - e. Are used for medical and/or protective reason (s) and not for behavior control.
 2. Time out (used only in co-occurring DD or C&A services):
 - a. Under no circumstance is egress restricted;
 - b. Time out periods must be brief, not to exceed 15 minutes;
 - c. Procedure for time-out utilization incorporated in behavior plan;
 - d. Reason justification and implementation for time out utilization documented.
 3. Personal restraint (also known as manual hold or manual restraint): The application of physical force, without the use of any device, for the purpose of restricting the free movement of a person's body;
 - a. May be used in all community settings except residential settings licensed as Personal Care Homes;
 - b. Circumstances of use must represent an emergency safety intervention of last resort affecting the safety of the individual or of others;
 - c. Brief handholding (less than 10 seconds) support for the purpose of providing safe crossing, safety or stabilization does not constitute a personal hold;
 - d. If permitted, Personal Restraint (ten seconds or more), shall not exceed five (5) minutes and this intervention is documented.
 4. Physical restraint (also known as mechanical restraint): A device attached or adjacent to the individual's body that one cannot easily remove and that restricts freedom of movement or normal access to one's body or body parts.
 - a. Prohibited in community settings except in community programs designated as crisis stabilization units for adults, children or youth;
 - b. Circumstances of use in behavioral health, crisis stabilization units must represent an emergency safety intervention of last resort affecting the safety of the individual or of others.
 5. Seclusion: The involuntary confinement of an individual alone in a room or in any area of a room where the individual is prevented from leaving, regardless of the purpose of the confinement. The practice of "restrictive time-out" (RTO) is seclusion and may not be utilized except in compliance with the requirement related to seclusion. The phrase "prevented from leaving" includes not only the use of a locked door, but also the use of physical or verbal control to prevent the individual from leaving.

- a. Seclusion may be used in the community **only** in programs designated as crisis stabilization programs for adults, children or adolescents;
 - b. Circumstances of use in behavioral health crisis stabilization programs must represent an emergency safety intervention of last resort affecting the safety of the individual or of others;
 - c. Is not permitted in developmental disabilities services.
 6. **Chemical restraint may never be used under any circumstance.** Chemical restraint is defined as a medication or drug that is:
 - a. Not a standard treatment for the individual's medical or psychiatric condition;
 - b. Used to control behavior;
 - c. Used to restrict the individual's freedom of movement.
 7. Examples of chemical restraint are the following:
 - a. The use of over the counter medications such as Benadryl for the purpose of decreasing an individual's activity level during regular waking hours;
 - b. The use of an antipsychotic medication for a person who is not psychotic but simply 'pacing' or mildly agitated.
 8. PRN antipsychotic and mood stabilizer medications for behavior control are not permitted. See Part II, Section 1; Appendix 1 for list of medications.
- d. **Confidentiality:** The Provider Maintains a System of Information Management that Protects Individual Information and that is Secure, Organized and Confidential
 - i. All individuals determine how their right to confidentiality will be addressed, including but not limited to:
 1. Who they wish to be informed about their services, supports, and treatment
 2. Collateral information. When collateral information is gathered, information about the individual **may not be shared** with the person giving the collateral information unless the individual being served has given specific written consent
 - ii. The provider has clear policies, procedures, and practices that support secure, organized and confidential management of information, to include electronic individual records if applicable.
 - iii. Maintenance and transfer of both written and spoken information is addressed:
 1. Personal individual information;
 2. Billing information; and
 3. All service related information.
 - iv. The provider has a Confidentiality and HIPAA Privacy Policy that clearly addresses state and federal confidentiality laws and regulations. The provider has a Notice of Privacy Practices that gives the individual adequate notice of the provider's policies and practices regarding use and disclosure of their Protected Health Information. The notice must contain mandatory elements required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II). In addition, the provider must address:
 1. HIPAA Privacy Rules, as outlined at 45 CFR Parts 160 and 164 are specifically reviewed with staff and individuals;
 2. Appointment of the Privacy Officer;
 3. Training to be provided to all staff;
 4. Posting of the Notice of Privacy Practices in a prominent place;
 5. Maintenance of the individual's signed acknowledgement of receipt of Privacy Notice in their record.
 - v. A record of all disclosures of Protected Health Information (PHI) must be kept in the medical record, so that the provider can provide an accounting of disclosures to the individual for 6 years from the current date. The record must include:
 1. Date of disclosure
 2. Name of entity or person who received the PHI;
 3. A brief description of the PHI disclosed

4. A copy of any written request for disclosure
 5. Written authorization from the individual or legal guardian to disclose PHI, where applicable.
- vi. Confidentiality policies include procedures for substance abuse individual records comply with 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records.
 - vii. Authorization for release of information is obtained when PHI of an individual is to be released or shared between organizations or with others outside the organization. All applicable DBHDD policies and procedures and HIPAA Privacy Rules (45 CFR parts 160 and 164) related to disclosure and authorization of PHI are followed. Information contained in each release of information must include:
 1. Specific information to be released or obtained;
 2. The purpose for the authorization for release of information;
 3. To whom the information may be released or given;
 4. The time period that the release authorization remains in effect (reasonable based on the topic of information, generally not to exceed a year); and,
 5. A statement that authorization may be revoked at any time by the individual, to the extent that the provider has not already acted upon the authorization;
 - viii. Exceptions to use of an authorization for release of information are clear in policy:
 1. disclosure may be made if required or permitted by law;
 2. disclosure is authorized as a valid exception to the law;
 3. A valid court order or subpoena are required for behavioral health records;
 4. A valid court order and subpoena are required for alcohol or drug abuse records;
 5. When required to share individual information with the DBHDD or any provider under contract or agreement with the DBHDD for the purpose of meeting obligations to the department; or
 6. In the case of an emergency treatment situation as determined by the individual's physician, the chief clinical officer can release PHI to the treating physician or psychologist.
 - ix. The provider has written operational procedures, consistent with legal requirements governing the retention, maintenance and purging of records.
 1. Records are safely secured, maintained, and retained for a minimum of six (6) years from the date of their creation or the date when last in effect (whichever is later);
 2. Protocols for all records to be returned to or disposed of as directed by the contracting regions after specified retention period or termination of contract/agreement.
 - x. The provider has written policy, protocols and documented practice of how information in the record is transferred when an individual is relocated or discharged from service to include but not limited to:
 1. A complete certified copy of the record to the Department or the provider who will assume service provision, that includes individual's PHI, billing information, service related information such as current medical orders, medications, behavior plans as deemed necessary for the purposes of individual's continuity of care and treatment;
 2. In addition unused Special Medical Supplies (SMS), funds, personal belongings, burial accounts
 3. The time frames by which transfer of documents and personal belongings will be completed.
- e. **Funds Management: The Personal Funds of an Individual are Managed by the Individual and are Protected**
- i. Policies and clear accountability practices regarding individual valuables and finances comply with all applicable DBHDD policies and Social Security Guide for Organizational and/or Representative Payees regarding management of personal needs spending accounts for individuals served.

- ii. Providers are encouraged to utilize persons outside the organization to serve as “representative payee” such as, but not limited to:
 - 1. Family
 - 2. Other person of significance to the individual
 - 3. Other persons in the community not associated with the provider
- iii. The provider is able to demonstrate documented effort to secure a qualified, independent party to manage the individual’s valuables and finances when the person served is unable to manage funds and there is no other person in the life of the individual who is able to assist in the management of individual valuables or funds.
- iv. Individual funds cannot be co-mingled with the provider’s funds or other individuals’ funds.
- f. **Research: The Provider Policy must State Explicitly in Writing Whether Research is Conducted or Not on Individuals Served by the Provider.**
 - i. If the provider wishes to conduct research involving individuals, a research design shall be developed and must be approved by:
 - 1. The provider’s governing authority; and
 - 2. The Regional Coordinator for the DBHDD; and
 - 3. The Institutional Review Board operated by the Department of Community Health (DCH) and its policies regarding the Protection of Human Subjects found in DBHDD directive herein.
 - ii. The Research design shall include:
 - 1. A statement of rationale;
 - 2. A plan to disclose benefits and risks of research to the participating person;
 - 3. A commitment to obtain written consent of the persons participating;
 - 4. A plan to acquire documentation that the person is informed that they can withdraw from the research process at any time.
 - iii. The provider using unusual medication and investigational experimental drugs shall be considered to be doing research.
 - 1. Policies and procedures governing the use of unusual medications and unusual investigational and experimental drugs shall be in place;
 - 2. Policies, procedures, and guidelines for research promulgated by the DCH Institutional Review Board shall be followed;
 - 3. The research design shall be approved and supervised by a physician;
 - 4. Information on the drugs used shall be maintained including:
 - a. Drug dosage forms;
 - b. Dosage range;
 - c. Storage requirements;
 - d. Adverse reactions; and
 - e. Usage and contraindications.
 - 5. Pharmacological training about the drug(s) shall be provided to nurses who administer the medications; and
 - 6. Drugs utilized shall be properly labeled.
 - iv. If research is conducted, there is evidence that involved individuals are:
 - 1. Fully aware of the risks and benefits of the research;
 - 2. Have documented their willingness to participate through full informed consent; and
 - v. Can verbalize their wish to participate in the research. If the individual is unable to verbalize or otherwise communicate this information, there is evidence that a legal representative, guardian or guardian ad litem has received this information and consented accordingly.
- g. **Faith based organizations**
 - i. Individuals or recipients of services are informed about the following issues relative to faith or denominationally based organizations:
 - 1. Its religious character;
 - 2. The individual's freedom not to engage in religious activities;
 - 3. The individual's right to receive services from an alternative provider;

- a. The provider shall, within a reasonable time after the date of such objection, refer the individual to an alternative provider.
- ii. If the provider provides employment that is associated with religious criteria, the individual must be informed.
- iii. In no case may federal or state funds be used to support any inherently religious activities, such as but not limited to religious instruction or proselytizing.
- iv. Providers may use space in their facilities to provide services, supports, and treatment without removing religious art, icons, scriptures or other symbols.
- v. In all cases, rules found at 42 CFR Parts 54, 54a and 45 CFR Parts 96, 260 and 1050 *Charitable Choice Provisions and Regulations: Final Rules* shall apply.

4. Service Environment: The Service Environment Demonstrates Respect for the Persons Served and is Appropriate to the Services Provided

- a. Services are provided in an appropriate environment that is respectful of persons served. The environment is:
 - i. Clean;
 - ii. Age appropriate;
 - iii. Accessible (individuals who need assistance with ambulation shall be provided bedrooms that have access to a ground level exit to the outside or have access to exits with easily negotiable ramps or accessible lifts. The home shall provide at least two (2) exits, remote from each other that are accessible to the individuals served).
 - iv. Individual's rooms are personalized
 - v. Adequately lighted, ventilated, and temperature controlled.
- b. Children seventeen and younger may not be served with adults unless the children are residing with their parents or legal guardians in residential programs such as the Ready for Work program.
 - i. Emancipated minors and juveniles who are age 17 years may be served with adults when their life circumstances demonstrate they are more appropriately served in an adult environment.
 - ii. Situations representing exceptions to this Requirement must have written documentation from the DBHDD Regional Office. Exceptions must demonstrate that it would be disruptive to the living configuration and relationships to disturb the 'family' make-up of those living together.
- c. There is sufficient space, equipment and privacy to accommodate:
 - i. Accessibility;
 - ii. Safety of persons served and their families or others;
 - iii. Waiting;
 - iv. Telephone use for incoming and outgoing calls that is accessible and maintained in working order for persons served or supported; and
 - v. Provision of identified services and supports.
- d. The environment is safe:
 - i. All local and state ordinances are addressed;
 - 1. Copies of inspection reports are available;
 - 2. Licenses or certificates are current and available as required by the site or the service.
- e. There is evidence of compliance with state and county of residence fire and life safety codes for the following:
 - i. Installation of fire alarm system meets safety code;
 - ii. Fire drills are conducted for individuals and staff¹:
 - 1. Once a month at alternating times;
 - 2. Once annually for BH administrative or sites open one shift per day
 - 3. Twice a year during sleeping hours if residential services.
 - 4. All fire drills shall be documented with staffing involved

¹ Please note: Separate fire drill policies and requirements may exist for agencies/sites that provide services to individuals other than those identified in this Manual. Should the agency or site be regulated by additional policies or accreditation, providers must conform to those that are the most stringent. For example, should a site provide both Behavioral Health and Developmental Disability services, the provider must ensure compliance with both DBHDD Developmental Disabilities standards in addition to meeting the requirements outlined above.

5. DBHDD maintains the right to require an immediate demonstration of a fire drill during any on-site visit
- f. Policies, plans and procedures are in place that addresses emergency evacuation, relocation preparedness and Disaster Response. Supplies needed for emergency evacuation are maintained in a readily accessible manner, including individuals' information, family contact information and current copies of physician's orders for all individual's medications.
 - i. Plans include detailed information regarding evacuating, transporting, and relocating individuals that coordinate with the local Emergency Management Agency and at a minimum address:
 1. Medical emergencies;
 2. Missing persons;
 - a. Georgia's Mattie's Call Act provides for an alert system when an individual with developmental disabilities, dementia, or other cognitive impairment is missing. Law requires residences licensed as Personal Care Homes to notify law enforcement within 30 minutes of discovering a missing individual.
 3. Natural disasters known to occur, such as tornadoes, snow storms or floods;
 4. Power failures;
 5. Continuity of medical care as required;
 6. Notifications to families or designees; and
 7. Effective 7/1/2012, Continuity of Operation Planning to include identifying locations and providing a signed agreement where individuals will be relocated temporarily in case of damage to the site where services are provided (for more information: www.georgiadisaster.info, <http://www.fema.gov/about/org/ncp/coop/templates.shtm>)
 - ii. Emergency preparedness notice and plans are:
 1. Reviewed annually;
 2. Tested at least quarterly for emergencies that occur locally on a less frequent basis such as, but not limited to flood, tornado or hurricane;
 3. Drilled with more frequency if there is a greater potential for the emergency.
- g. Providers must comply with federal Public Law 103-227 which requires that smoking not be permitted in any portion of any indoor facility owned, leased, or contracted by the provider and used routinely or regularly for the provision of health care for youth under the age of 18. MHBG, SAPTBG
- h. Residential living support service options;
 - i. Are integrated and established within residential neighborhoods;
 - ii. Are single family units;
 - iii. Have space for informal gatherings;
 - iv. Have personal space and privacy for persons supported; and
 - v. Are understood to be the "home" of the person supported or served.
- i. Video cameras may be used in common areas of programs that are not personal residences such as Crisis Stabilization Units where visualization of blind areas is necessary for an individual's safety. Cameras **may not be used** in the following instances:
 - i. In an individual's personal residence;
 - ii. In lieu of staff presence; or
 - iii. In the bedroom of individuals
- j. There are policies, procedures, and practices for transportation of persons supported or served in residential services and in programs that require movement of persons served from place to place.
 - i. Policies and procedures apply to all vehicles used, including:
 1. Those owned or leased by the provider;
 2. Those owned or leased by subcontractors; and
 3. Use of personal vehicles of staff.
 - ii. Policies and procedures include, but are not limited to:
 1. Authenticating licenses of drivers, proof of insurance, and routine vehicle maintenance;
 2. Requirements for evidence of driver training;

3. Safe transport of persons served;
 4. Requirements for maintaining attendance of person served while in vehicles;
 5. Safe use of lift;
 6. Availability of first aid kits;
 7. Fire suppression equipment; and
 8. Emergency preparedness.
- k. Access is promoted at service sites deemed as intake, assessment or crisis programs through:
- i. Clearly labeled exterior signs; and
 - ii. Other means of direction to service and support locations as appropriate.
- l. Community services (other than Community Transition Planning) may **not** be provided in an Institution for Mental Diseases (IMD, e.g. state or private psychiatric hospital, psychiatric residential treatment facility or Crisis Stabilization Unit with greater than 16 beds), jail, youth development center (YDC) or prison system.
- m. Services may not may not be provided and billed for individuals who are involuntarily detained in Regional Youth Detention Centers (RYDCs) awaiting criminal proceedings, penal dispositions, or other involuntary detention proceedings. Any exception to this requires supporting documentation from the DJJ partners. The provider holds the risk for assuring the youth's eligibility.
5. **Infection Control: Practices are Evident in Service Settings**
- a. The provider, at a minimum, has a basic Infection Control Plan that includes the following:
 - i. Standard Precautions;
 - ii. Hand washing protocols;
 - iii. Proper disposal of biohazards, such as needles, lancets, scissors, tweezers, and other sharp instruments; and
 - iv. Management of common illness likely to be emergent in the particular service setting;
 - b. The provider has effective cleaning and maintenance procedures sufficient to maintain a sanitary and comfortable environment that prevents the development and transmission of infection.
 - c. The provider adheres to policies and procedures for controlling and preventing infections in the service setting. Staff is trained and monitored to ensure infection control policies and procedures are followed.
 - d. All staff adheres to Standard Precautions and follows the provider's written policies and procedures in infection control techniques.
 - e. The provider's infection control plan is reviewed bi-annually for effectiveness and revision, if necessary.
 - f. The provider has available the quantity of bed linens and towels, etc. essential for the proper care of individuals at all times. These items are washed, stored, and transported in a manner that prevents the spread of infection.
 - g. Routine laundering of an individual's clothing and personal items is done separately from the belongings of other individuals.
 - h. Procedures for the prevention of infestation by insects, rodents or pests shall be maintained and conducted continually to protect the health of individuals served.
 - i. The provider ensures that an individual's personal hygiene items, such as toothbrushes, hairbrushes, razors, nail clippers, etc., are maintained separately and in a sanitary condition.
 - j. Any pets living in the service setting must be in compliance with local, state, and federal requirements.
6. **Medications: Providers having Oversight for Medication or that Administer Medication Follow Federal and State Laws, Rules, Regulations and Best Practice Guidelines**
- a. A copy of the physician (s) order or current prescription dated/signed within the past year is placed in the individual's record for every medication administered or self-administered with supervision. These include:
 - i. Regular, on-going medications;
 - ii. Controlled substances;
 - iii. Over-the-counter medications;
 - iv. PRN (when needed) medications; or
 - v. Discontinuance order.

- b. A valid physician's order must contain:
 - i. The individual's name;
 - ii. The name of the medication;
 - iii. The dose;
 - iv. The route;
 - v. The frequency;
 - vi. Special instructions, if needed; and
 - vii. The physician's signature.
 - viii. A copy of the Medical Office Visit Record with the highlighted physician's medication order may also be kept as documentation.
- c. The order for and administration of medication must be completed by members of the medical staff pursuant to the Medical Practice Act of 2009, Subsection 43-34-23 Delegation of Authority to Nurse and Physician Assistant and must be administered by licensed or credentialed* medical personnel under the supervision of a physician or registered nurse in accordance with O.C.G.A.
- d. The provider has written policies, procedures, and practices for all aspects of medication management including, but not limited to:
 - i. Prescribing: requires the comparison of the physician's medication prescription to the label on the drug container and to the Medication Administration Record (MAR) to ensure they are all the same before each medication is administered or supervised self-administration is done.
 - ii. Ordering: describes the process by which medication orders are filled by a pharmacy.
 - iii. Authenticating orders: describes the required time frame for actual or faxed physician's signature on telephone or verbal orders accepted by a licensed nurse;
 - iv. Procuring medication and refills: procuring initial prescription medication and over-the-counter drugs within twenty-four hours of prescription receipt, and refills before twenty-four hours of the exhaustion of current drug supply.
 - v. Labeling: includes the Rights of Medication Administration
 - vi. Storing: includes prescribed medications, floor stock drugs, refrigerated drugs, and controlled substances.
 - vii. Security: signing out a dose for an individual, and at a minimum, a daily inventory for controlled medications and floor stock medications; and daily temperature logs for locked, refrigerated medications are required.
 - viii. Storage, inventory, dispensing and labeling of sample medications: requires documented accountability of these substances at all stages of possession.
 - ix. Dispensing: describes the process allowed for pharmacists and/or physicians only. Includes the verification of the individual's medications from other agencies and provides a documentation log with the pharmacist's or physician's signature and date when the drug was verified.
 - x. Supervision of individual self-administration: includes all steps in the process from verifying the physician's medication order to documentation and observation of the individual for the medication's effects. Makes clear that staff members may not administer medications unless licensed to do so, and the methods staff members may use to supervise or assist, such as via hand-over-hand technique, when an individual self-administers his/her medications.
 - xi. Administration of medications includes all aspects of the process to be done from verifying the physician's medication order, to who can administer the medications, to documentation and observation of the individual for the medication's effects. Administration of medications may be done only by those who are licensed in this state to do so.
 - xii. Recording: includes the guidelines for documentation of all aspects of medication management. This includes adding and discontinuing medication, charting scheduled and as needed medications, observations regarding the effects of drugs, refused and missing doses, making corrections, and a legend for recording. The legend includes initials, signature, and title of staff member.

- xiii. Disposal of discontinued or out-of-date medication: includes an environmentally friendly method or disposal by pharmacy.
 - xiv. Education to the individual and family (as desired by the individual) regarding all medications prescribed and documentation of the education provided in the clinical record;
 - xv. All PRN or "as needed" medications will be accessible for each individual as per his/her prescriber(s) order(s) and as defined in the individuals' IRP. Additionally, the provider must have written protocols and documented practice that ensures safe and timely accessibility that includes, at a minimum, how medication will be stored, secured or need refrigeration when transported to different programs and home visits.
- e. Organizational policy, procedures and documented practices stipulate that:
- i. Medical conditions are assessed, monitored, and recorded. This includes but is not limited to situations in which:
 - 1. Medication or other ongoing health interventions are required;
 - 2. Chronic or confounding health factors are present;
 - 3. Medication prescribed as part of DBHDD services has research indication necessary surveillance of the emergence of diabetes, hypertension, and/or cardiovascular disease;
 - 4. Allergies or adverse reactions to medications have occurred; or
 - 5. Withdrawal from a substance abuse is an issue
 - ii. In homes licensed as Community Living Arrangements (CLA)/Personal Care Homes (PCH), staff may administer medications in accordance with CLA Rules 290-9-37.01 through .25 and PCH Rules 111-8-62.01 through .25.
 - iii. Only physicians or pharmacists may re-package or dispense medications.
 - 1. This includes the re-packaging of medications into containers such as "day minders" and medications that are sent with the individual when the individual is away from his residence.
 - 2. Note that an individual capable of independent self-administration of medication may be coached in setting up their personal "day minder."
 - iv. There are safeguards utilized for medications known to have substantial risk or undesirable effects, including but not limited to:
 - 1. Storage;
 - 2. Handling;
 - 3. Insuring appropriate lab testing or assessment tools accompany the use of the medication;
 - 4. Obtaining and maintaining copies of appropriate lab testing and assessment tools that accompany the use of the medications prescribed from the individual's physician for the individual's clinical record, or at a minimum, documenting in the clinical record the requests for the copies of these tests and assessments; and follow-up appointments with the individual's physician(s) for any further actions needed.
 - v. Education regarding the risks and benefits of the medication is documented and explained in language the individual can understand. Medication education provided by the provider's staff must be documented in the clinical record. Informed consent for the medication is the responsibility of the physician; however, the provider obtains and maintains copies of these, or at a minimum, documents its request for copies of these in the clinical record
 - vi. Where medications are self-administered, protocols are defined for training to support individual self-administration of medication.
 - vii. Staff is educated regarding:
 - 1. Medications taken by individuals, including the benefits and risk;
 - 2. Monitoring and supervision of individual self-administration of medications;
 - 3. The individual's right to refuse medication;
 - 4. Documentation of medication requirements.

- viii. There are protocols for the handling of licit and illicit drugs brought into the service setting. This includes confiscating, reporting, documenting, educating, and appropriate discarding of the substances.
- ix. Requirements for safe storage of medication are as required by law includes single and double locks, shift counting of the medications, individual dose sign-out recording, documented planned destruction, refrigeration and daily temperature logs.
- x. The provider defines requirements for timely notification to the prescribing professional regarding:
 - 1. Drug reactions;
 - 2. Medication problems;
 - 3. Medication errors; and
 - 4. Refusal of medication by the individual.
- xi. When the provider allows verbal orders from physicians, those orders will be authenticated:
 - 1. Within 72 hours by fax with the physicians signature on the page (including electronic signature);
 - 2. The fax must be maintained in the individual's record;
- xii. There are practices for regular and ongoing physician review of prescribed medications including, but not limited to:
 - 1. Appropriateness of the medication;
 - 2. Documented need for continued use of the medication;
 - 3. Monitoring of the presence of side effects. Individuals on medications likely to cause tardive dyskinesia are monitored at prescribed intervals using an Abnormal Involuntary Movement Scale (AIMS testing);
 - 4. Monitoring of therapeutic blood levels, if required by the medication such as Blood Glucose testing, Dilantin blood levels and Depakote blood levels; such as kidney or liver function tests;
 - 5. Ordering specific monitoring and treatment protocols for diabetic, hypertensive, seizure disorder, and cardiac individuals, especially related to medications prescribed and required vital sign parameters for administration;
 - 6. Writing medication protocols for specific individuals in homes licensed as Community Living Arrangements or Personal Care Homes for identified staff members to administer:
 - a. epinephrine for anaphylactic reaction;
 - b. insulin required for diabetes;
 - c. suppositories for ameliorating serious seizure activity; and
 - d. medications through a nebulizer under conditions described in the Community Living Arrangement Rule 290-9-37-.20 (2).
 - 7. Monitoring of other associated laboratory studies.
- xiii. For providers that secure their medications from retail pharmacy and/or employ a licensed pharmacist, there is a biennial assessment of agency practice of management of medications **at all sites housing medications**. A licensed pharmacist or licensed registered nurse conducts the assessment. The report shall include, but may not be limited to:
 - 1. A written report of findings, including corrections required;
 - 2. A photocopy of the license of the pharmacist and/or registered nurse;
 - 3. A statement of attestation from the licensed pharmacist or licensed Registered Nurse that all issues have been corrected.
- xiv. For providers that conduct any laboratory testing on-site, documented evidence is provided that the provider's Clinical Laboratory Improvement Amendment (CLIA) Waiver is current. Refer to the list of waived tests updated January 15, 2010 on the Centers for Medicaid and Medicare Services website.
- f. The "Eight Rights" for medication administration are defined with detailed guidelines for staff to implement within the organization to verify that right:

- i. Right person: includes the use of at least two identifiers and verification of the physician's medication order with the label on the prescription drug container and the MAR entry to ensure that all are the same every time before a medication is taken via self-administration or administered by a licensed staff member.
 - ii. Right medication: includes verification of the medication order with the label on the prescription drug container and the MAR entry to verify that all are the same every time before a medication is taken via self-administration or administered by a licensed staff member. The medication is inspected for expiration date. Insulin must be verified with another person prior to administering.
 - iii. Right time: includes the times the provider schedules medications, or the specific physician's instructions related to the drug.
 - iv. Right dose: includes verification of the physician's medication order of dosage amount of the medication; with the label on the prescription drug container and the Medication Administration Record entry to ensure that all are the same every time before a medication is taken via self-administration or administered by a licensed staff member. The amount of the medication should make sense as to the volume of liquid or number of tablets to be taken.
 - v. Right route: includes the method of administration;
 - vi. Right position: includes the correct anatomical position; individual should be assisted to assume the correct position for the medication method or route to ensure its proper effect, instillation, and retention.
 - vii. Right documentation includes proper methods of the recording on the MAR; and
 - viii. Right to refuse medications: includes staff responsibilities to encourage compliance, document the refusal, and report the refusal to the administration, nurse administrator, and physician.
- g. A Medication Administration Record (MAR) is in place for each calendar month that an individual takes or receives medication(s):
- i. Documentation of routine, ongoing medications occur in one discreet portion of the MAR and include but may not be limited to:
 1. Documentation by calendar month that is sequential according to the days of the month;
 2. A listing of all medications taken or administered during that month including a full replication of information in the physician's order for each medication:
 - a. Name of the medication;
 - b. Dose as ordered;
 - c. Route as ordered;
 - d. Time of day as ordered; and
 - e. Special instructions accompanying the order, if any, such as but not limited to:
 - i. Must be taken with meals;
 - ii. Must be taken with fruit juice;
 - iii. May not be taken with milk or milk products.
 3. If the individual is to take or receive the medication more than one time during one calendar day, each time of day must have a corresponding line that permits as many entries as there are days in the month;
 4. All lines representing days and times preceding the beginning or ending of an order for medications shall be marked through with a single line;
 5. When a physician discontinues (D/C) a medication order, that discontinuation is reflected by the entry of "D/C" at the date and time representing the discontinuation followed by a mark through of all lines representing days and times that were discontinued.
 - ii. Documentation of medications that are taken or received on a periodic basis, including over the counter medications, occur in a separate discreet portion of the MAR and include but may not be limited to:

1. A listing of each medication taken or received on a periodic basis during that month including a full replication of information in the physician's order for each medication:
 - a. Name of the medication;
 - b. Dose as ordered;
 - c. Route as ordered;
 - d. Purpose of the medication
 - e. Frequency that the medication may be taken
 - i. The date and time the medication is taken or received is documented for each use.
 - ii. When 'PRN' or 'as needed' medication is used, the PRN medications shall be documented on the same MAR after the routine medications and clearly marked as "PRN" and the effectiveness is documented.
- iii. Each MAR shall include a legend that clarifies:
 1. Identity of authorized staff initials using full signature and title;
 2. Reasons that a medication may be not given, is held or otherwise not received by the individual, such as but not limited to:
 - "H" = Hospital
 - "R" = Refused
 - "NPO" = Nothing by mouth
 - "HM" = Home Visit
 - "DS" = Day Service

7. Waiver of Requirements

- a. The provider may not exempt itself from any of these requirements or any portion of the Provider Manual. All requests for waivers of these requirements must be done in accordance with Policy: Requests for Waivers of the Standards/Requirements for Mental Health, Developmental Disabilities and Addictive Diseases.
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COMMUNITY SERVICE REQUIREMENTS FOR ALL PROVIDERS

SECTION II: STAFFING REQUIREMENTS

1. Overview

- i. Unless otherwise specified by DBHDD Policy or within the contract/agreement with the Department, one or more professionals in the field must be attached to the organization as employees of the organization or as consultants on contract.
- ii. The professional(s) attached to the organization have experience in the field of expertise best suited to address the needs of the individual(s) served.
- iii. When medical, psychiatric services involving medication or withdrawal management services are provided, the provider receives direction for that service from a professional with experience in the field, such as medical director, physician consultant, psychiatrist or addictionologist.
- iv. Organizational policy and practice demonstrates that appropriate professional staff shall conduct the following services, supports, and treatment, including but not limited to:
 1. Overseeing the services, supports, and treatment provided to individuals;
 2. Supervising the formulation of the individual recovery plan;
 3. Conducting diagnostic, behavioral, functional, and educational assessments;
 4. Designing and writing behavior support plans;
 5. Implementing assessment, care, and treatment activities as defined in professional practice acts; and
 6. Supervising high intensity services such as screening or evaluation, assessment, partial hospitalization, and ambulatory or residential crisis services
- v. Providers must ensure an adequate staffing pattern to provide access to services. Please reference the Service Guideline for staffing requirements of Specialty Services. The below are minimum staffing requirements of Core Providers:
 1. Medical Director/Psychiatrist that is on site to provide direct services a minimum of 10 hours weekly
 2. RN that is on site a minimum of 10 hours weekly
 3. Licensed Clinicians (LCSW, LPC, LMFT)
 4. MAC, CACII, CADC, CCADC, or GCADC (II, III)
 5. Two Full-Time Equivalent (FTE) Certified Peer Specialists (applicable for Adult Core Services only)
 6. Paraprofessional
- vi. Effective July 1, 2013, each Core Provider must have a full time employee who is the Clinical Director. This individual must be independently licensed and must have at least 2 years' experience in behavioral health service delivery. He or she is responsible for the following within the organization:
 1. The clinical review and management of individual services
 2. Participation in the development, implementation and ongoing assessment of programs
 3. Assigning caseloads, providing supervision and/or ensuring adequate supervision is occurring
 4. Meeting with supervisory clinical staff to direct and review work
 5. Ensuring that all facility policies and regulations are upheld and fulfilled as it pertains to patient care
 6. Regularly training and evaluating staff members
 7. Ensuring that clinical practice is in line with chosen therapeutic models
- vii. Effective July 1, 2013, Providers of Specialty Services must maintain support from an independently licensed clinician to provide service review, service monitoring and assistance in directing an appropriate course of treatment. This individual may be an employee or contracted.
- viii. The type and number of professional staff attached to the organization are:
 1. Properly licensed or credentialed in the professional field as required;
 2. Present in numbers to provide adequate supervision to staff;

3. Present in numbers to provide services, supports, and treatment to individuals as required;
 4. Experienced and competent in the profession they represent; and
 5. In 24 hour or residential settings, at least one staff trained in first aid and Professional Rescuers level of CPR/AED training is scheduled at all times on each shift.
- ix. The type and number of all other staff attached to the organization are:
1. Properly trained or credentialed in the professional field as required;
 2. Present in numbers to provide services, supports, and treatment to individuals as required; and
 3. Experienced and competent in the services, supports, and treatment they provide.
- x. The provider has procedures and practices for verifying licenses, credentials, experience and competence of staff:
1. There is documentation of implementation of these procedures for all staff attached to the organization; and
 2. Licenses and credentials are current as required by the field.
- xi. The organization must have policies and procedures for protecting the safety of staff. Specific measures to ensure the safety of those staff that engage in community-based service delivery activities must be identified.
- xii. The status of students, trainees, and individuals working toward licensure must be disclosed to the individuals receiving services from trainees/ interns and signatures/titles of these practitioners must also include indication of that status (i.e. S/T or ACT).
- xiii. Federal law, state law, professional practice acts and in-field certification requirements are followed, including but not limited to:
1. Professional or non-professional licenses and qualifications required to provide the services offered. If it is determined that a service requiring licensure or certification by State law is being provided by an unlicensed staff, it is the responsibility of the provider to comply with DBHDD Policy regarding Licensing and Certification Requirements and the Reporting of Practice Act Violations.
 2. Laws governing hours of work such as but not limited to the Fair Labor Standards Act.
- xiv. Job descriptions are in place for all personnel that include:
1. Qualifications for the job;
 2. Duties and responsibilities;
 3. Competencies required;
 4. Expectations regarding quality and quantity of work; and
 5. Documentation that the individual staff has reviewed, understands, and is working under a job description specific to the work performed within the organization.
- xv. The provider has policies, procedures and documentation practices detailing all human resources practices, including but not limited to:
1. Processes for determining staff qualifications including: license or certification status, training, experience, and competence.
 2. Processes for managing personnel information and records including but not limited to:
 - a. Criminal records checks (including process for reporting CRC status change); and
 - b. Driver's license checks
 3. Provisions for and documentation of:
 - a. Timely orientation of personnel and development;
 - b. Periodic assessment and development of training needs;
 - c. Development of activities responding to those needs; and
 - d. Annual work performance evaluations.

4. Provisions for sanctioning and removal of staff when:
 - a. Staff are determined to have deficits in required competencies;
 - b. Staff is accused of abuse, neglect or exploitation.
- xvi. The provider details in policy by job classification:
 1. Training that must be refreshed annually;
 2. Additional training required for professional level staff;
 3. Additional training/recertification (if applicable) required for all other staff.
- xvii. Regular review and evaluation of the performance of all staff is evident at least annually by managers who are clinically, administratively, and experientially qualified to conduct evaluations.
- xviii. It is evident that the provider demonstrates administration of personnel policies without discrimination.
- xix. All staff, direct support volunteers, and direct support consultants shall be trained and show evidence of competence as indicated in the below chart titled **Training Requirements for all Staff, Direct Support Volunteers, and Direct Support Consultants**:

Training Requirements for all Staff, Direct Support Volunteers, and Direct Support Consultants
Orientation requirements are specified for all staff and are provided prior to direct contact with individuals and are as follows:
<ul style="list-style-type: none"> • The purpose, scope of services, supports, and treatment offered including related policies and procedures;
<ul style="list-style-type: none"> • HIPAA and Confidentiality of individual information, both written and spoken;
<ul style="list-style-type: none"> • Rights and Responsibilities of individuals;
<ul style="list-style-type: none"> • Requirements for recognizing and reporting suspected abuse, neglect, or exploitation of any individual: <ul style="list-style-type: none"> ○ To the DBHDD; ○ Within the organization; ○ To appropriate regulatory or licensing agencies; and, ○ To law enforcement agencies
Within the first sixty (60) days from date of hire, all staff having direct contact with individuals shall receive the following training including, but not limited to:
<ul style="list-style-type: none"> • Person centered values, principles and approaches;
<ul style="list-style-type: none"> • A holistic approach to treatment of the individual;
<ul style="list-style-type: none"> • Medical, physical, behavioral and social needs and characteristics of the persons served;
<ul style="list-style-type: none"> • Human rights and responsibilities (*);
<ul style="list-style-type: none"> • Promoting positive, appropriate and responsive relationships with persons served, their families and stakeholders;
<ul style="list-style-type: none"> • The utilization of: <ul style="list-style-type: none"> ○ Communication Skills (*); ○ Crisis intervention techniques to de-escalate challenging and unsafe behaviors (*) ○ Nationally benchmarked techniques for safe utilization of emergency interventions of last resort (if such techniques are permitted in the purview of the organization);
<ul style="list-style-type: none"> • Ethics, cultural preferences and awareness;
<ul style="list-style-type: none"> • Fire safety (*)
<ul style="list-style-type: none"> • Emergency and disaster plans and procedures (*)
<ul style="list-style-type: none"> • Techniques of Standard Precautions, including: <ul style="list-style-type: none"> ○ Preventative measures to minimize risk of HIV; ○ Current information as published by the Centers for Disease Control (CDC); and ○ Approaches to individual education.
<ul style="list-style-type: none"> • Current CPR/AED through the American Heart Association, Health & Safety Institute, or the American Red Cross. <ul style="list-style-type: none"> ○ All medically licensed staff (nurses, physicians, psychiatrists, dentists, and CNAs) are required to have the Professional Rescuers level of training (Basic Life Support for Healthcare Providers and AED or CPR/AED for the Professional Rescuer). ○ All other staff must have the Lay Rescuers level of training (Heartsaver CPR and AED or CPR/AED). ○ Staff working in CLAs must have professional rescuers level of training. ○ All CPR/AED training, regardless of level, includes both written and hands-on competency training.

<ul style="list-style-type: none"> • First aid and safety training is required for all staff as indicated above with the exception of medically licensed staff (i.e. nurses, physicians, psychiatrists, dentists, and CNAs);
<ul style="list-style-type: none"> • Specific individual medications and their side effects (*)
<ul style="list-style-type: none"> • Services, support, and treatment specific topics appropriate persons served, such as but not limited to: <ul style="list-style-type: none"> ○ Symptom management; ○ Principles of recovery relative to individuals with mental illness; ○ Principles of recovery relative to individuals with addictive disease; ○ Principles of recovery and resiliency relative to children and youth; and ○ Relapse prevention.
<p>A minimum of 16 hours of training must be completed annually to include the trainings noted by an asterisk (*) above</p>

2. Approved Behavioral Health Practitioners

The below table outlines the requirements of the approved behavioral health practitioners. Abbreviations for credentials recognized in the Practitioner Level system are noted below. These approved abbreviations must be on the signature lines in documentation where credentials are required (i.e. orders for services, progress notes, etc.). For those staff members (PP, CPS, S/T, etc.) whose practitioner level is affected by a degree, the degree initials must also be included. For example, if a Paraprofessional is working with an applicable Bachelor of Arts degree, he or she would include "PP, BA" as his or her credentials.

Professional Title & Abbreviation for Signature Line	Minimum Level of Education/Degree / Experience Required	License/ Certification Required	Requires Supervision?	State Code
Physician (M.D., D.O., etc.)	Graduate of medical or osteopathic college	Licensed by the Georgia Composite Board of Medical Examiners	No. Additionally, can supervise others	43-34-20 to 43-34-37
Psychiatrist (M.D., etc.)	Graduate of medical or osteopathic college and a residency in psychiatry approved by the American Board of Psychiatry and Neurology	Licensed by the Georgia Composite Board of Medical Examiners	No. Additionally, can supervise others	43-34-20 to 43-34-37
Physician's Assistant (PA)	Completion of a physician's assistant training program approved by the Georgia Composite Board of Medical Examiners -- at least 1 year of experience in behavioral healthcare required to supervise CPRP, CPS, or PP staff	Licensed by the Georgia Composite Board of Medical Examiners	Physician delegates functions to PA through Board-approved job description.	43-34-100 to 43-34-108
Advanced Practice Registered Nurse (APRN): Clinical Nurse Specialist/Psychiatric-Mental Health (CNS-PMH) and Nurse Practitioner (NP)	R.N. and graduation from a post-basic education program for Nurse Practitioners Master's degree or higher in nursing for the CNS/PMH -- Nurse Practitioners must have at least 1 year of experience in behavioral healthcare to supervise CPRP, CPS, or PP staff	Current certification by American Nurses Association, American Nurses Credentialing Center or American Academy of Nurse Practitioners and authorized as an APRN by the Georgia Board of Nursing	Physician delegates advanced practice functions to APRN, CNS-PMH, NP through Board-approved nurse protocol agreements.	43-26-1 to 43-26-13, 360-32
Licensed Pharmacist (LP)	Graduated and received an undergraduate degree from a college or school of pharmacy; completed a Board-approved internship and passed an examination.	Licensed by the Georgia State Board of Pharmacy	No	26-4
Registered Nurse (RN)	Georgia Board of Nursing-approved nursing education program -- at least 1 year of experience in behavioral healthcare required to supervise CPRP, CPS, or PP	Licensed by the Georgia Board of Nursing	By a physician	43-26-1 to 46-23-13

Professional Title & Abbreviation for Signature Line	Minimum Level of Education/Degree / Experience Required	License/ Certification Required	Requires Supervision?	State Code
Licensed Practical Nurse (LPN)	Graduation from a nursing education program approved by the Georgia Board of Licensed Practical Nursing.	Licensed by Georgia Board of Licensed Practical Nursing	By a Physician or RN	43-26-30 to 43-26-43
Licensed Dietician (LD)	- Bachelor's degree or higher with a degree in dietetics, human nutrition, food and nutrition, nutrition education or food systems management. - Satisfactory completion of at least 900 hours of supervised experience in dietetic practice	Licensed by Georgia Board of Licensed Dieticians	No	43-11A-1 to 43-11A-19
Qualified Medication Aide (QMA)	Completion of a prescribed course conducted by the Georgia Department of Technical and Adult Education and pass examination for qualified medication aides approved by the Georgia Board of Licensed Practical Nursing.	Certified by the Georgia Board of Licensed Practical Nursing	Supervised by RN performing certain medication administration tasks as delegated by RN or LPN.	43-26-50 to 43-26-60
Psychologist (PhD or PsyD)	Doctoral Degree	Licensed by the Georgia Board of Examiners of Psychologists	No. Additionally, can supervise others	43-39-1 to 43-39-20
Licensed Clinical Social Worker (LCSW)	Master's degree in Social Work plus 3 years' supervised full-time work in the practice of social work after the Master's degree.	Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	No. Additionally, can supervise others	43-10A
Licensed Professional Counselor (LPC)	Master's degree	Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	No. Additionally, can supervise others	43-10A
Licensed Marriage and Family Therapist (LMFT)	Master's degree	Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	No. Additionally, can supervise others	43-10A
Licensed Master's Social Worker (LMSW)	Master's degree in Social Work	Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	Works under direction and supervision of an appropriately licensed/credentialed professional.	43-10A
Associate Professional	Master's degree	Licensed by the Georgia Composite Board of Professional Counselors,	Works under direction and supervision of an appropriately	43-10A

Counselor (May be noted as LAPC and APC)		Social Workers, and Marriage and Family Therapists	licensed/credentialed professional	
Professional Title & Abbreviation for Signature Line	Minimum Level of Education/Degree / Experience Required	License/ Certification Required	Requires Supervision?	State Code
Associate Marriage and Family Therapist (May be noted as LAMFT and AMFT)	Master's degree	Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	Works under direction and supervision of an appropriately licensed/credentialed professional	43-10A
Certified Clinical Alcohol and Drug Counselor (CCADC)	Master's degree; Also requires minimum of 2 years or 4,000 hours experience in direct alcohol and drug abuse treatment with individual and/or group counseling and a total of 270 hours of addiction-specific education and 300 hours of supervised training.	Certification by the Alcohol and Drug Certification Board of Georgia; International Certification and Reciprocity Consortium / Alcohol and Other Drug Abuse (IC&RC)	Services limited to those practices sanctioned by the certifying board and shall in any event be limited to the provision of chemical dependency treatment	43-10A-7
Georgia Certified Alcohol and Drug Counselor Level III (GCADC III)	Master's degree; Also must have been certified by a national organization and have taken a written and oral examination in the past and must have been continuously certified for a period of 2 years; Must meet the standards outlined in the Ga. Code rules posted on the licensing board website: Perform the 12 core functions; Education and training; Supervised practicum; Experience and supervision	Certification by the Alcohol and Drug Certification Board of Georgia (ADACB-GA)	Services limited to those practices sanctioned by the certifying board and shall in any event be limited to the provision of chemical dependency treatment	43-10A-7
Master Addiction Counselor (MAC) National Board of Certified Counselors (NBCC)	Master's Degree Documentation of a minimum of 12 semester hours of graduate coursework in the area of OR 500 CE hours specifically in addictions. Three years supervised experience as an addictions counselor at no fewer than 20 hours per week. Two of the three years must have been completed after the counseling master's degree was conferred. A passing score on the Examination for Master Addictions Counselors (EMAC).	Certification by the National Board of Certified Counselors (NBCC) Nationally Certified Counselor (NCC) credential – must be Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	Services limited to those practices sanctioned by the certifying board and shall in any event be limited to the provision of chemical dependency treatment	43-10A-7
Master Addiction Counselor, (MAC) through National Association of Alcohol and Drug	Master's degree; 500 contact hours of specific alcoholism and drug abuse counseling training). Three years full-time or 6,000 hours of supervised experience, two years or 4,000 hours of which must be post master's degree award. Passing score on the national examination for the MAC	Certification by the National Association of Alcohol & Drug Counselors' Current state certification /licensure in alcoholism and/or drug abuse counseling. Passing score on the	Services limited to those practices sanctioned by the certifying board and shall in any event be limited to the provision of chemical dependency	43-10A-7

Counselors, (NAADC)		national examination for the MAC	treatment	
Certified Alcohol and Drug Counselor (CADC)	Bachelor's degree; Also requires minimum of 2 years or 4,000 hours experience in direct alcohol and drug abuse treatment with individual and/or group counseling and a total of 270 hours of addiction-specific education and 300 hours of supervised training	Certification by the Alcohol and Drug Certification Board of Georgia (ADACB-GA) International Certification and Reciprocity Consortium / Alcohol and Other Drug Abuse (IC&RC)	Services limited to those practices sanctioned by the certifying board and shall in any event be limited to the provision of chemical dependency treatment	43-10A-7
Professional Title & Abbreviation for Signature Line	Minimum Level of Education/Degree / Experience Required	License/ Certification Required	Requires Supervision?	State Code
Georgia Certified Alcohol and Drug Counselor II (GCADC II)	Bachelor's degree; Must be certified by a national organization and have taken a written and oral examination; Must have been continuously certified for a period of 2 years; Must meet the standards outlined in the Ga. Code rules posted on the licensing board website: Perform the 12 core functions; Education and training; Supervised practicum; Experience and supervision	Certification by the Alcohol and Drug Certification Board of Georgia (ADACB-GA)	Services limited to those practices sanctioned by the certifying board and shall in any event be limited to the provision of chemical dependency treatment	43-10A-7
Certified Addiction Counselor, Level II (CAC-II)	Bachelor's degree; Requires 3 years of experience in practice of chemical dependency/abuse counseling; 270 hours education in addiction field; and 144 hours clinical supervision	Certification by the Georgia Addiction Counselors' Association	Services limited to those practices sanctioned by the certifying board and shall in any event be limited to the provision of chemical dependency treatment	43-10A-7
Certified Addiction Counselor, Level I (CAC-I)	High School Diploma/Equivalent; Requires 2 years of experience in the practice of chemical dependency/abuse counseling; 180 hours education in addiction field; and 96 hours clinical supervision.	Certification by the Georgia Addiction Counselors' Association	Services limited to those practices sanctioned by the certifying board and shall in any event be limited to the provision of chemical dependency treatment, Under supervision of a Certified Clinical Supervisor	43-10A-7

Registered Alcohol and Drug Technician I, II, III (RADT-I, RADT-II, RADT-III)	High school diploma or its equivalent and must be enrolled in a junior college, college or university. Must document a minimum of one (1) year or two thousand (2000) hours experience of direct service (alcohol and drug counseling). Once the RADT has completed 30 college credit hours he/she is eligible to take the ICRC written exam. Upon passing the ICRC Written exam, a RADT-II certificate is issued. Once the RADT-II has completed 60 college credit hours, he/she is eligible to take the oral case presentation. Upon successful completion of the oral case presentation, receives a RADT-III certificate is issued. Upon completion of BS degree and experience a CADC will be issued	Registered/certified by the Alcohol and Drug Certification Board of	Services limited to those practices sanctioned by the certifying board and shall in any event be limited to the provision of chemical dependency treatment, Under supervision of a Certified Clinical Supervisor; CADC; CCADC, LPC, LCSW	43-10A-7
Addiction Counselor Trainees (ACT)	High school diploma/equivalent and actively pursuing certification as CAC-I, CAC-II, RADT I, II, III; CADC or CCADC or other addiction counselor certification recognized by practice acts. Completion of Standardized Training Requirement for Paraprofessionals approved by the Department of Community Health (includes training provided by the organization and online training outlined below).	Employed by an agency or facility that is licensed to provide addiction counseling	Under supervision of a Certified Clinical Supervisor (CCS); CADC; CCADC	
Professional Title & Abbreviation for Signature Line	Minimum Level of Education/Degree / Experience Required	License/ Certification Required	Requires Supervision?	State Code
Certified Psychiatric Rehabilitation Professional (CPRP)	High school diploma/equivalent, Associates Degree, Bachelor's Degree, Graduate Degree with required experience working in Psychiatric Rehabilitation (varies by level and type of degree)	Certified by the US Psychiatric Rehabilitation Association (USPRA, formerly IASPRS)	Under supervision of an appropriately licensed/credentialed professional	
Certified Peer Specialist (CPS)	High school diploma/equivalent	Certification by the Georgia Certified Peer Specialist Project Requires a minimum of 40 hours of Certified Peer Specialist Training, and successful completion of a certification exam.	Services shall be limited to those not requiring licensure, but are provided under the supervision of an appropriately licensed/credentialed professional.	

Certified Peer Specialist-Addictive Disease(CPS-AD)	High school diploma/equivalent	Certification by the Georgia Council on Substance Abuse as a CARES (Certified Addiction Recovery Empowerment Specialist). Requires CARES Training and successful completion of a certification exam.	Services shall be limited to those not requiring licensure, but are provided under the supervision of an appropriately licensed/credentialed professional.	
Certified Peer Specialist-Whole Health (CPS-WH) (Whole Health & Wellness Coach)	High school diploma/equivalent	Certification by the Georgia Certified Peer Specialist Project Requires a minimum of 40 hours of Certified Peer Specialist Training, and successful completion of a certification exam. Additionally, this requires health training as defined by the DBHDD.	Services shall be limited to those not requiring licensure, but are provided under the supervision of an appropriately licensed/credentialed professional.	
Paraprofessional (PP)	Completion of Standardized Training Requirement for Paraprofessionals approved by the Department of Community Health (includes training provided by the organization and online training outlined below.)	Completion of a minimum of 46 hours of paraprofessional training and successful completion of all written exams and competency-based skills demonstrations.	Under supervision of an appropriately licensed/credentialed professional	
Psychologist / LCSW / LPC / LMFT's supervisee/trainee (S/T)	Minimum of a Bachelor's degree and one or more of the following: a. Registered toward attaining an associate or full licensure; b. In pursuit of a Master's degree that would qualify the student to ultimately qualify as a licensed practitioner; c. Not registered, but is acquiring documented supervision toward full licensure (signed attestation by practitioner and supervisor to be on file with personnel office) d. Completion of Standardized Training Requirement for Paraprofessionals approved by the Department of Community Health (includes training provided by the organization and online training outlined below).	Under supervision in accordance with the GA Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists or enrolled in a practicum with an accredited educational Master's degree program which provides supervision as a part of a curriculum which is the foundation toward licensure	Under supervision of a licensed Psychologist/LCSW, LPC, or LMFT in accordance with the GA Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists or enrolled in a practicum with an accredited educational Master's degree program which provides supervision as a part of a curriculum which is the foundation toward licensure	43-10A
Vocational Rehabilitation Specialist (VS/PP or PP/VS)	Minimum of one year verifiable vocational rehabilitation experience.	Employed by an provider that is DBHDD approved to provide ACT.	Under supervision of an ACT team leader who is either a physician, psychologist, PA, APRN, RN with a 4-year BSN, LCSW, LPC, or LMFT.	

3. Documentation of Supervision for Individuals Working Towards Licensure

Psychologist/LCSW/LPC/LMFT's supervisee/trainee is defined as:

An individual with a minimum of a Bachelor's degree and one or more of the following:

1. Registered toward attaining an associate or full licensure;
2. In pursuit of a Master's degree that would qualify the student to ultimately qualify as a licensed practitioner(Psychologist, LCSW, LMFT,LPC, LMSW, AMFT, APC);
3. Not registered, but is acquiring documented supervision toward full licensure in accordance with O.C.G.A. 43-10A-3

These individuals must be under supervision of a licensed Psychologist/LCSW, LPC, or LMFT in accordance with the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists (hereafter referred to as the GA Composite Board) or enrolled in a practicum with an accredited educational Master's degree program which provides supervision as a part of a curriculum which is the foundation toward licensure.

Students and individuals who meet the definition of a Supervisee/Trainee above do not require a co-signature on progress notes unless required by the rules of the GA Composite Board.

In accordance with the GA Composite Board, interns and trainees must work under direction and documented clinical supervision of a licensed professional. Providers will be required to present documentation of supervision of Supervisee/Trainees upon request by DBHDD or the DBHDD's ERO. Supervision must be completed monthly; documentation of supervision for previous month must be in employee file by the 10th day of the following month. For example, January supervision must be recorded by February 10th.

Documentation of supervision is described by O.C.G.A. 43-10A-3 as, "a contemporaneous record of the date, duration, type (individual, paired, or group), and a brief summary of the pertinent activity for each supervision session". More information can be found online at <http://sos.georgia.gov/plb/counselors/>. Documentation of supervision as defined by O.C.G.A. 43-10A-3 must be present and current in personnel record. The three specialties governed by the GA Composite Board have different supervision requirements for individuals working toward licensure and it is the responsibility of the provider to ensure that the supervision requirements specified by the Board for the specialty (professional counseling, social work or marriage and family therapy) for which the individual is working toward licensure are met.

In addition, for Supervisee/Trainees who are either:

1. In pursuit of a Master's degree that would qualify the student to ultimately qualify as a licensed practitioner(Psychologist, LCSW, LMFT,LPC, LMSW, AMFT, APC), or
2. Not registered toward attaining licensure, but is acquiring documented supervision toward full licensure in accordance with O.C.G.A. 43-10A-3,

The provider will be required to present an attestation signed by both the supervisor and supervisee/trainee which either:

1. Confirms enrollment in a practicum with an accredited educational Master's degree program which provides supervision as a part of a curriculum which is the foundation toward licensure, or
2. Confirms that supervision is being provided towards licensure in accordance with O.C.G.A. 43-10A-3.

Documentation of Supervisee/Trainees who are receiving on-site supervision in addition to the supervision that they are receiving off-site towards their licensure must include:

1. A copy of the documentation showing supervision towards licensure, and
2. Documentation in compliance with the above-stated requirements.

For example, if a Supervisee/Trainee is working at Provider "A" as a supervisee-trainee and receiving supervision towards their licensure outside of Provider "A", the a copy of the documentation showing supervision towards licensure must be held at Provider "A".

4. Documentation of Supervision of Addiction Counselor Trainees

Addiction Counselor Trainees may provide certain services under Practitioner Level 5 as noted in the applicable Service Guidelines. The definition of Addiction Counselor Trainee (ACT) is "an individual who is actively seeking certification² as a CADC, CCADC, CAC II or MAC and is receiving appropriate Clinical Supervision". An ACT may perform counseling as a trainee for a period of up to 3 years if they meet the requirements in O.C.G.A. 43-10A. This is limited to the provision of chemical dependency treatment under direction and supervision of a clinical supervisor approved by the certification body under which the trainee is seeking certification. Providers should refer to O.C.G.A. 43-10A-3 for the definitions of "direction" and "supervision".

The Addiction Counselor Trainee Supervision Form³ and supporting documentation indicating compliance with the below requirements must be provided for all services provided by an ACT. The following outlines the definition of supervision and requirements of clinical supervision:

- Supervision means the direct clinical review, for the purpose of training or teaching, by a supervisor of a specialty practitioner's interaction with a client. It may include, without being limited to, the review of case presentations, audio tapes, video tapes, and direct observation in order to promote the development of the practitioner's clinical skills.
- Monthly Staff Supervision form must be present and current in personnel record. Supervision must be completed monthly; supervision form for previous month must be in employee file by the 10th day of the following month. For example, January supervision must be recorded by February 10th.
- Evidence must be available to show that supervising staff meet qualifications:
 - The following credentials are acceptable for Clinical Supervision: CCS; CADC; CCADC; CAC II; MAC **or** LPC/ LCSW/LMFT who have a minimum of 5 hours of Co-Occurring or Addiction specific Continuing Education hours per year; certification of attendance/completion must be on file.
- The ACT must have a certification test date that is within 3 years of hire as an ACT, and;
- The ACT may not have more than 3 years of cumulative experience practicing under supervision for the purpose of addiction certification, per GA Rule 43-10A, and;
- ACT must have a minimum of 4 hours of documented supervision monthly – this will consist of individual and group supervision.

DBHDD has added specificity regarding the supervision of these practitioners due to the volume of practice provided by LCSW/LPC/LMFT's supervisee/trainees and Addiction Counselor Trainees. Psychologists in training must adhere to the supervision requirements outlined in the Official Code of Georgia.

² Persons actively seeking certification are defined as: Persons who are training to be addiction counselors but only when such persons are: employed by an provider or facility that is licensed to provide addiction counseling; supervised and directed by a supervisor who meets the qualifications established by the certifying body; actively seeking certification, i.e. receiving supervision & direction, receiving required educational experience, completion of required work experience. (Georgia Rule 43-10A)

³ The Addiction Counselor Trainee Supervision Form can be found on the APS Knowledgebase (www.apsero.com) in the Provider Toolbox. Direct link: <http://www.apsero.com/webx/ee82258>

5. Standard Training Requirement for Paraprofessionals

Overview

In addition to the training requirements defined in this document, DBHDD requires that all behavioral health paraprofessionals complete the Standard Training Requirement. These trainings provide useful information necessary to fulfill requirements for delivering DBHDD behavioral health services and supports, while also providing paraprofessionals with access to information that will help them be more effective on the job. Demonstrated mastery of each topic area within the Standard Training Requirement is necessary in order for paraprofessionals to provide both state-funded and Medicaid-reimbursable behavioral health services.

The Standard Training Requirement for Paraprofessionals requires that paraprofessionals complete provider-based training as well as targeted, online trainings. In total, each paraprofessional must complete 46 hours of training (29 hours via online courses and 17 hours provided by the provider). In addition, a set number of training hours must be dedicated to specific subject areas. The number of required training hours by subject area is outlined below. See chart on following page for additional detail.

Subject Area	TOTAL Required Hours	Required via Online Courses	Required via Provider-Based Training
Corporate Compliance	2	1	1
Cultural Competence	2	2	
Documentation	5	3	2
First Aid and CPR	6	0	6
Mental Illness – Addictive Disorders	8	8	0
Pharmacology & Medication Self-Admin	2	2	0
Professional Relationships	2	2	0
Recovery Principles	2	2	0
Safety/ Crisis De-escalation	10	4	6
Explanation of Services	1	0	1
Service Coordination	4	3	1
Suicide Risk Assessment	2	2	0
Total Required Hours	46	29	17

At this time, there is no annual or continued training requirement related to the Standard Training Requirement for Paraprofessionals. However, it should be noted that all providers must comply with all training requirements outlined within this Manual.

Required Online Courses for Paraprofessionals

The required online training hours and education component must be completed through the DBHDD provided online courses. Provider agencies have two options to go about accessing the required online courses:

Option 1: DBHDD Online Courses

All behavioral health providers who have an executed contract or agreement with DBHDD have free, 24/7 access to course content at <http://georgiamhad.training.reliaslearning.com/>. For this option, in order to gain initial access to the online courses, providers must designate a Standard Training Requirement (STR) liaison to assign paraprofessionals for the online training. The liaison plays a key role in the successful use of the online curriculum. The liaisons have supervisor rights and can add and delete learners from the system. The liaisons may also assign courses in the Learning Catalog based on the particular need within their organization. Your organization may decide to allow learners to choose their own courses within the required topic areas or to assign learners to complete particular courses that best fit your organization's needs. Providers must ensure that the online courses assigned will meet compliance with the required number of hours per Subject Area (above). Once the paraprofessional has been given a username and password by the provider's liaison, s/he can go online and access the available courses and exams in the learning catalog.

Option 2: Individual Provider Essential/Relias Learning System

DBHDD provider agencies that hold separate contracts with Essential/Relias Learning⁴ may request to house Georgia DBHDD-specific courses and related employee records on their own Essential/Relias Learning systems, rather than using the DBHDD online system. To use this option, approval must be given for providers to have access to the DBHDD approved course that were modified by Georgia DBHDD to reflect Georgia DBHDD policies and procedures. Although the courses may change in the future, the list of courses modified by Georgia DBHDD for this purpose are indicated by an asterisk (*) in Appendix 1.

By notifying DBHDD of their intention to utilize their own Essential/Relias Learning system rather than the DBHDD system, the provider agency is agreeing to the following stipulations:

1. The provider agency must ask for permission before being allowed access to the DBHDD courses. Access is arranged by UGA's the Carl Vinson Institute of Government (UGA/CVIOG).
2. The provider agency must let their users (employees) know that their Essential/Relias Learning training records are being held by the provider agency and not by DBHDD or UGA/CVIOG.
3. Because their training records are being held by the provider agency and not by DBHDD or UGA/CVIOG, it will take longer to transfer training records between employers as Essential/Relias Learning will be required to transfer records between systems.
4. It is the provider agency's complete and total responsibility to keep course offerings current as designated in the DBHDD Provider Manual for Community Behavioral Health Providers. Auditing will continue to be conducted based on the requirements specified in the Provider Manual.

The chart in Appendix 1 below displays the courses available within the Standard Training Requirement for Paraprofessionals which may be satisfied via the online training. A total of 29 hours of online training is required to fulfill the training requirement and many subjects offer several courses that can meet the criteria.

⁴ Essential/Relias Learning is the vendor who provides the online courses under contract with DBHDD. Though the name of Essential Learning has changed to Relias, the course selection has remained available.

Providing Services as a Paraprofessional

The following individuals must complete the Standard Training Requirement in order to provide services as a Paraprofessional:

- 1) Individuals who are not licensed or do not hold an approved credential, regardless of education level. For example, an individual with a Masters in Social Work but not a license would need to complete the Standard Training Requirement.
- 2) Contract employees providing outsourced services who fall within the paraprofessional criterion
- 3) Individuals who have not yet completed the certification process to be Certified Peer Specialists
- 4) Individuals who may be eligible in the future to be licensed or certified but who are not yet licensed or certified
- 5) Individuals providing Psychiatric Residential Treatment Facility services but not staff providing services through foster care, Intensive Community Support Program, and child & adolescent group homes
- 6) Individuals who are working towards licensure and meet the qualifications of a Supervisee/Trainee must also complete the Standard Training Requirement.

Paraprofessional staff members must complete the Standard Training Requirements within the new hire orientation guidelines for their organization but no later than **90 days after hire**. Staff may provide and bill for services during this 90 days. If the Standard Training Requirement is not completed after 90 days, the individual may not bill until s/he fulfills the requirement. Any services that are provided outside of the 90 day grace period by an uncertified paraprofessional are subject to recoupment.

If an individual would like to bill a service for which they are not an approved practitioner, s/he may bill as a paraprofessional (providing that a paraprofessional is an approved practitioner). In order to do so s/he must have completed the Standard Training Requirement. When documenting this service, the noted credential of the practitioner must match the practitioner level billed. For example, if an LPN would like to provide Community Support (a service for which s/he is not an approved practitioner), s/he could bill as a paraprofessional and would therefore need to be in compliance with the Standard Training Requirement. The LPN would document his/her credentials as "LPN and PP" when billing at the paraprofessional rate.

Documentation for the Standard Training Requirement

Documentation of compliance must be available for each paraprofessional. An orientation agenda/checklist/spreadsheet with the name of the employee, date of topic, training, and number of hours must be available and is required for audit purposes. Proof of course completion must be kept in a personnel file for both provider-based training as well as online training. This may be documented via a certificate or transcript generated online by Essential/Relias Learning or by the "live" course provider.

Auditors may verify the information provided on the tracking sheet by viewing the training certificates. If this information is not available, services billed by the paraprofessional will be subject to recoupment. The date of hire must also be available for review.

If further questions or clarifications are needed regarding the Standard Training Requirement, please email questions to: DBHDD_Learning@thr.state.ga.us

Subject Area	Courses available to fulfill online training requirement	Online Hours available per Course
Corporate Compliance (Must complete at least 1 hour of online training)	Corporate Compliance and Ethics for Paraprofessionals	1
Cultural Competence (Must complete at least 2 hours of online training)	Cultural Diversity *	1
	Cultural Issues in Mental Health Treatment for Paraprofessionals*	3
Documentation (Must complete at least 3 hours of online training)	Essential Components of Documentation for Paraprofessionals	6
Mental Illness – Addictive Disorders (Must choose at least 8 hours of online training)	Bipolar Disorder in Children and Adolescents*	1
	Depressive Disorder in Children and Adolescents*	3
	Overview of Bipolar Disorder for Paraprofessionals	2
	Mental Health Issues in Older Adults for Paraprofessionals*	2
	Mood Disorders in Adults – A Summary for Paraprofessionals	1
	Overview of Family Psychoeducation – Evidenced Based Practices*	1.5
	Defining Serious Persistent Mental Illness and Recovery	2
	People with Serious Mental Illness for Paraprofessionals*	3
	Understanding Schizophrenia for Paraprofessionals*	2
	Alcohol and the Family for Paraprofessionals*	2.5
	Understanding the Addictive Process: An Overview for Paraprofessionals*	2
	Co-Occurring Disorders: An Overview for Paraprofessionals	1.5
Pharmacology and Medication Self Admin (Must choose at least 2 hours of online training)	Overview of Medications for Paraprofessionals	2
	Medication Administration & Monitoring for Paraprofessionals	4
Professional Relationships (Must complete at least 2 hours of online training)	Therapeutic Boundaries for Paraprofessionals*	2.5
Recovery Principles (Must choose at least 2 hours of online training)	WRAP – One on One*	3
	Path to Recovery*	2
Safety/Crisis De-escalation (Must complete at least 4 hours of online training)	Abuse, Neglect and Incident Reporting for Paraprofessionals	1
	Crisis Management for Paraprofessionals*	3
Service Coordination (Must choose at least 3 hours of online training)	Case Management for Paraprofessionals	3
	Coordinating Primary Care for Needs of Clients (for) Paraprofessionals	7.5
	Supported Employment – Evidenced Based Practices*	6
Suicide Risk Assessment (Must choose at least 2 hours of online training)	In Harm's Way: Suicide in America	1
	Suicide Prevention*	2
	Suicide: the Forever Decision*	3
Total Hours of Available Course Content		75

*: Online courses that may be accessed and housed by providers that have a separate contract with Essential/Relias Learning per the above requirements.

COMMUNITY SERVICE REQUIREMENTS FOR ALL PROVIDERS

SECTION III: DOCUMENTATION REQUIREMENTS

1. OVERVIEW OF DOCUMENTATION

The individual's record is a legal document that is current, comprehensive and includes those persons who are assessed, served, supported, or treated. There are three core components of consumer-related documentation. These include assessment and reassessment; treatment planning; and progress notes. These core components are independent and yet must be inter-related in order to create a sound medical record. The documentation guidelines outlined herein do not supersede service-specific requirements. This Provider Manual may list additional requirements and standards which are service-specific; when there is a conflict, providers must defer to those requirements which are most stringent.

- A. Information in the record must be:
 - i. Organized, Complete, Current, Meaningful, and Succinct;
 - ii. Written in black or blue ink (red ink may be used to denote allergies or precautions);
- B. All medical record documentation shall include the practitioner's printed name as listed on his or her practitioner's license⁵.
- C. At a minimum, the individual's information shall include:
 - i. The name of the individual, precautions, allergies (or no known allergies - NKA) and "volume #x of #y" on the front of the record. Note that the individual's name, allergies and precautions must also be flagged on the medication administration record;
 - ii. Individual's identification and emergency contact information;
 - iii. Medical necessity of the service is supported;
 - iv. Financial and insurance information necessary for adherence to Policy 6204-101;
 - v. Rights, consent and legal information including but not limited to:
 - 1. Consent for service;
 - 2. Release of information documentation;
 - 3. Any psychiatric or other advanced directive;
 - 4. Legal documentation establishing guardianship;
 - 5. Evidence that individual rights are reviewed at least one time a year;
 - 6. Evidence that individual responsibilities are reviewed at least one time a year; and
 - 7. Legal status as it relates to Title 37.
 - vi. Pertinent medical information;
 - vii. Records or reports from previous or other current providers;
 - viii. Correspondence.
 - ix. Frequency and style of documentation are appropriate to the frequency and intensity of services, supports, and treatment and in accordance with the Service Guideline

⁵ It is acceptable that the initials can be used for first and middle names. The last name must be spelled out and each of these must correlate with the names on the license. This is an effort to ensure that a connection can be made between the printed/stamped name on the chart entry and a license.

- x. Clear evidence that the services billed are the services provided.
 - xi. Documentation includes record of contacts with persons involved in other aspects of the individual's care, including but not limited to internal or external referrals.
 - xii. There is a process for ongoing communication between staff members working with the same individuals in different programs, activities, schedules or shifts.
- D. Individual records must be maintained onsite (DBHDD approved service locations) for review for a minimum of 90 days following the last date of service or discharge date as identified by the prior authorization for the individual served⁶.
- E. All signatures (and initials, where appropriate) must be original, belong to the person creating the signature or initials. Signatures (and initials, where appropriate) must be dated by the person signing or initialing to reflect the date on which the signature/initials occurred (e.g., no backdating, no postdating, etc.).

2. ASSESSMENT

Individualized services, supports, care and treatment determinations are made on the basis of an assessment of needs with the individual. The individual must be informed of the findings of the assessments in a language he or she can understand.

- A. Assessments must include but are not limited to the following:
- i. Justification of elements which support diagnosis;
 - ii. Summary of central themes of presenting symptoms/needs and precipitating factors;
 - iii. Individual strengths, needs, abilities, and preferences;
 - iv. Individual's hopes and dreams, or personal life goals;
 - v. Individual's Perception of the issue(s) of concern;
 - vi. Prior treatment and rehabilitation services used and outcomes of these services;
 - vii. Interrelationship of history and assessments;
 - viii. Preferences for treatment, individual choice and hopes for recovery;
 - ix. An assessment for co-occurring disorders;
 - x. Barriers impacting prospects for stabilization and recovery;
 - xi. Current issues placing the client most at risk;
 - xii. How needs are to be prioritized and addressed;
 - xiii. What interventions are needed, when, how quickly, in what services and settings, length of stay, and with what provider(s); and
 - xiv. The step-down services.
 - xv. Current ERO authorization
 - xvi. Biopsychosocial assessment
 - xvii. Integrated/interpretive summary
 - xviii. A current health status report, medical history, and medical screening
 - xix. Suicide risk assessment;

⁶ For audit purposes, records must be presented within the timeframes indicated in the APS Provider Handbook; records not submitted within stated timeframes will not be accepted by the auditors for review. Additional information related to audit procedures can be found in the APS Provider Handbook available online at APS KnowledgeBase at www.apsero.com.

- xx. Appropriate diagnostic tools such as impairment indices, psychological testing, or laboratory tests;
 - xxi. Social and Family history;
 - xxii. School records (for school age individuals);
 - xxiii. Collateral history from family or persons significant to the individual, if available.
 - xxiv. Review of legal concerns including:
 - 1. Advance directives;
 - 2. Legal competence;
 - 3. Legal involvement of the courts;
 - 4. Legal status as it relates to Title 37; and
 - 5. Legal status as adjudicated by a court.
- B. Additional assessments should be performed or obtained by the provider if required to fully inform the services, supports, and treatment provided. These may include but are not limited to:
- i. Assessment of trauma or abuse;
 - ii. Functional assessment;
 - iii. Cognitive assessment;
 - iv. Behavioral assessments;
 - v. Spiritual assessment;
 - vi. Assessment of independent living skills;
 - vii. Cultural assessment;
 - viii. Recreational assessment;
 - ix. Educational assessment;
 - x. Vocational assessment; and
 - xi. Nutritional assessment;

3. DIAGNOSIS

1. A verified diagnosis is defined as a behavioral health diagnosis that has been provided following a face-to-face (to include telemedicine) evaluation by a professional identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These include a Licensed Psychologist, a Licensed Clinical Social Worker, a Physician, or a Physician Assistant or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.
2. The diagnosing professional may rely on assessment information provided by other professionals and collateral informants, as permitted by the individual, but a face-to-face interaction by the diagnosing professional is essential. A signature by such a person on documentation leading to or supporting a diagnostic impression does not meet this requirement of performing an assessment adequate to support assigning a behavioral health diagnosis
3. At a minimum, all diagnoses must be verified annually by a licensed psychologist, licensed clinical social worker, medical doctor, APRN, or Physician Assistant.
4. For any diagnoses that are valid for less than one year, an assessment must be completed more often as indicated in the current DSM. If this requirement is not met due to individual refusal or choice, documentation in the record must reflect this.

5. Documentation of initial and annually verified diagnosis/diagnoses must⁷:
 - a. Reflect the steps taken by the qualified professional to determine the diagnosis and include necessary information to support the diagnosis gained from a face-to-face, clinical assessment of the individual;
 - i. Note: If the verified diagnosis is provided by a qualified practitioner/provider who is external to the provider, the validation of the face-to-face nature of that diagnosis determination is not required.
 - b. Clearly indicate the diagnosis or diagnoses and include a summary of findings to include any supporting documentation;
 - c. The diagnosing practitioner's printed name as listed on license;
 - d. His/her credential(s);
 - e. Date of diagnosis; and
 - f. Signature of the practitioner.
6. As defined in Part I, Section I of this Provider Manual a diagnostic impression is sufficient for brief or stabilization services. Diagnostic impressions may be provided by those professionals or paraprofessionals who are permitted to provide the Behavioral Health Assessment service.
7. Any diagnostic documentation or procedures that do not conform to the above requirements and O.C.G.A. Practice Acts may result in revocation of authorization.

4. ORDER/RECOMMENDATION FOR COURSE OF TREATMENT⁸

- A. All services must be recommended ("ordered") by a physician or other appropriately licensed practitioner. The practitioner(s) authorized to recommend/order specific services may be found within Part I, Section IV of this Provider Manual
- B. All recommendations/orders expire at the time of the expiration of the current authorization.
- C. The recommendation/order for a course of treatment must specify each service (by official Group Name) to be provided and shall be reviewed and signed by the appropriately licensed practitioner(s) on or before the initial date of service AND on or before the effective date of each reauthorization of service(s). If the provider utilizes service packages (i.e. Intensive Outpatient) to order services, each service included in the service package must be individually named (by official Group Name) in the recommendation/order.
- D. There are two formats that may be used for writing a recommendation/order:
 - i. An individualized recovery/resiliency plan (IRP) which fulfills the required components listed below, can be used as a recommendation/order for the applicable authorization period for services indicated within the plan.
 - ii. A stand-alone recommendation/order in the client record which fulfills the required components listed below.
- E. Required Components of the recommendation/order include:
 - i. Individual name,
 - ii. All services recommended as a course of treatment/ordered as indicated by Group Name as listed in the current DBHDD Provider Manual,
 - iii. Signature and credentials⁹ of appropriately licensed practitioner(s),

⁷ Applicable to diagnoses provided both internal and external to the provider unless otherwise noted.

⁸ Note that the following requirements apply only to recommendation/orders for **services** as defined in Part I of this Provider Manual. Standards regarding orders for medication and procedures can be found in Section I of these Community Service Standards for All Providers.

⁹ See Section II of the Community Service Standards for All Providers for additional information regarding credentials.

- iv. Printed or stamped name and credentials of appropriately licensed practitioner(s), and
 - v. Date of signature(s). Dates written to indicate the date of a signature may only be dated by the signer.
- F. When more than one physician is involved in an individual's treatment, there is evidence that a RN or MD has reviewed all in-field information to assure there are no contradictions or inadvertent contraindications within the services and treatment orders or plan.
- G. Should the recommendation for course of treatment (order) cross multiple pages in a paper record, the provider is responsible for ensuring that it is clear that the additional pages are a continuation of the order. For example, in a 2 page order, page 2 must contain the name of the individual, a page number, and indication that the signature of the practitioner indicates authorization for services as noted on page 1.
- H. Recommendation for course of treatment ("orders") may be made verbally. This required components of the verbal recommendation/order include:
- i. The provider must have policies and procedures which govern procedures for verbal orders;
 - ii. Recommendations/Orders must be documented in the medical record and include:
 - 1. Individual name,
 - 2. All services recommended as a course of treatment/ordered as indicated by official Group Name as listed in the current DBHDD Provider Manual,
 - 3. Printed or stamped name and credentials of appropriately licensed practitioner(s) recommending service, and
 - 4. Date of verbal order(s); and
 - 5. Printed or stamped name, credentials, original signature, and date signed by the staff member receiving the verbal order. Provider's policy must specify which staff can accept verbal orders for services.
 - iii. Verbal orders must be authenticated by the ordering practitioner's signature within seven (7) calendar days of the issuance of orders. This may be an original signature or faxed signed order.
 - iv. Faxed orders signed by the ordering practitioner are acceptable and a preferred alternative to verbal orders. The fax must be dated upon receipt and contain Required Components 1-5 above.

5. TREATMENT PLANNING

Treatment planning documentation is included in the individual's Individualized Recovery/Resiliency Plan (IRP). The IRP planning is intended to develop a plan which focuses on the individual's hopes, dreams and vision of a life well-lived. Every record must contain an IRP in accordance with content set forth in this Manual. The IRP should be reviewed frequently and evolve to best meet the individual's needs. This plan sets forth the course of services by integrating the information gathered from the current assessment, status, functioning, and past treatment history into a clinically sound plan.

- A. An individualized resiliency/recovery plan is developed with the guidance of an in-field professional. The individuals direct decisions that impact their lives. Others assisting in the development of the IRP are persons who are:
 - i. Significant in the life of the individual and from whom the individual gives consent for input;
 - ii. Involved in formal or informal support of the individual and from whom the individual gives consent for input;
 - iii. Will deliver the specific services, supports, and treatment identified in the plan. For individuals with coexisting, complex and confounding needs, cross disciplinary approaches to planning should be used;
- B. Individualized Treatment (Recovery/Resiliency) Planning must:
 - i. Be driven by the individual and focused on outcomes the individual wishes to achieve;
 - ii. Identify and prioritize the needs of the individual;
 - iii. Be fully explained to the individual using language he or she can understand and agreed to by the individual.

- iv. Document by individual signature and/or, when applicable, guardian signature that the individual served is an active participant in the planning and process of services (to the degree to which that is possible). Subsequent changes to the plan must also document individual and/or guardian signature via dated initials.
- v. State goals which will honor achievement of stated hopes, choice, preferences, and desired outcomes of the individual and/or family;
- vi. Assure goals/objectives are:
 - 1. Related to assessment/reassessment;
 - 2. Designed to ameliorate, rectify, correct, reduce or make symptoms manageable; and
 - 3. Indicative of desired changes in levels of functioning and quality of life to objectively measure progress.
- vii. Define goals/objectives that are individualized, specific and measurable with achievable timeframes;
- viii. Detail interventions which will assist in achieving the outcomes noted in the goals/objectives;
- ix. Identify and select services and interventions of the right duration, intensity and frequency to best accomplish these objectives;
 - 1. Be reflective of the interventions of the right duration, intensity and frequency to best accomplish the stated objectives. It is expected service provision is provided as outlined within this plan of care and that updates to the treatment plan will be made should the individual's needs change.
 - a. Crisis Intervention is an exception to the requirements above, in that: The Treatment Plan may indicate that the Crisis Intervention service is provided *as needed*. If Crisis Intervention is a part of the services outlined in the treatment plan, it is expected that a Crisis Plan be developed and in place in order to direct the crisis service. The Crisis Plan must conform to standards set forth in this manual.
- x. Identify staff responsible to deliver or provide the specific service, support, and treatment;
- xi. Assure there is a goal/objective that is consistent with the service intent;
- xii. Identify frequency and duration of services which are set to achieve optimal results with resource sensitive expenditures;
- xiii. Include a projected plan to modify or decrease the intensity of services, supports, and treatment as goals are achieved.
- xiv. Documents to be incorporated by reference into an individualized plan include but are not limited to:
 - 1. Medical updates as indicated by physician orders or notes;
 - 2. Addenda as required when a portion of the plan requires reassessment;
 - 3. A personal safety/crisis plan which directs in advance the individual's desires/wishes/plans/objectives in the event of a crisis;
 - 4. A Wellness Recovery Action Plan (WRAP) which:
 - a. Is developed with fidelity to WRAP Values and Ethics (www.mentalhealthrecovery.com);
 - b. Includes statements that work on a WRAP is completely voluntary;
 - c. Belongs to the individual who chooses where it will be kept and with whom it will be shared (Is in the clinical record only if self-directed by the individual for inclusion);
 - d. Is devoid of clinical language (is in the person's own language);
- xv. Individualized plans or portions of the plan must be reassessed as indicated by:
 - 1. Changing needs, circumstances and responses of the individual, including but not limited to:
 - a. Any life change;
 - b. Change in provider;
 - c. Change in medical, behavioral, cognitive or, physical status;
 - 2. As requested by the individual;

3. As required for re-authorization and Service Definitions;
 4. At least annually;
 5. When goals are not being met.
- C. When services are provided to youth during school hours, IRP must indicate how the intervention has been coordinated among family system, school, and provider. There must be documentation that indicates that the intervention is most effective when provided during school hours.

6. DISCHARGE/TRANSITION PLANNING

- A. Documents transition planning at the onset of service delivery and includes specific objectives to be met prior to decreasing the intensity of service or discharge.
- B. Defines discharge criteria which objectively measures progress by aligning with documented goals/objectives, desired changes in levels of functioning, and quality of life;
- C. Defines specific step-down service/activity/supports to meet individualized needs;
- D. Is measurable and includes anticipated step-down/transition date.

7. DISCHARGE SUMMARY

- A. At the time of discharge, a summary must be provided to the individual which indicates:
 - i. Strengths, needs, preferences and abilities of the individual;
 - ii. Services, supports, and treatment provided;
 - iii. Outcome of the goals and objectives made during the service provision period;
 - iv. Necessary plans for referral; and,
 - v. Service or organization to which the individual was discharged, if applicable.
- B. A summary of the course of services, supports, treatment, the Discharge Summary, must be placed in the record within 30 days of discharge. Documentation must include elements above and:
 - i. Document the reason for ending services;
 - ii. Living situation at discharge.

8. PROGRESS NOTES

Progress Note documentation includes the actual implementation and outcome(s) of the designated services in an individual's IRP. There are clear requirements related to the content, components, required characteristics, and format of progress note documentation.

The content in progress note documentation must provide all the necessary supporting evidence to justify the need for the services based on medical necessity criteria and support all requirements for billing and adjudication of the service claims. For this reason, progress notes for all billed services (e.g. face-to-face, telemedicine, collateral, etc.) must include observations of the individual's symptoms, behaviors, affect, level of functioning and reassessment for risk when indicated as well as information regarding the exact nature, duration, frequency and purpose of the service, intervention and/or modality. Review of sequential progress notes should provide a snapshot of the individual over a specified time frame.

- A. **Required components of progress note documentation:**
 - i. **Linkage** - Clear link between assessment and/or reassessment, Individualized Recovery/Resiliency Plan and intervention(s) provided.

- ii. **Consumer profile** – Description of the current status of the individual to include individual statements, shared information and quotes; observations and description of individual affect; behaviors; symptoms; and level of functioning.
- iii. **Justification** – Documentation of the need for services based on admission criteria and measurable criteria for medical necessity. This documentation must also reflect justification for payment of services provided and utilization of resources as it relates to the service definition and the needs/desires of the individual.
- iv. **Specific services/intervention/modality provided** – Specific detail of all provided activity(ies) or modality(ies) including date, time, frequency, duration, location and when appropriate, methodology.
- v. **Purpose or goal of the services/intervention/modality**- Clarification of the reasons the individual is participating in the above services, activities, and modalities and the demonstrated value of services.
- vi. **Consumer response to intervention(s)** – Identification of how and in what manner the service, activity, and modality have impacted the individual; what was the effect; and how was this evidenced.
- vii. **Monitoring** - Evidence that selected interventions and modalities are occurring and monitored for expected and desired outcomes.
- viii. **Consumer’s progress** – Identification of the individual's progress (or lack of progress) toward specific goals/objectives as well as the overall progress towards wellness.
- ix. **Next steps** – Targeted next steps in services and activities to support stability
- x. **Reassessment and Adjustment to plan** – Review and acknowledgement as to whether there is a need to modify, amend or update the individualized service/recovery plan and if so, how.

B. Required characteristics of progress note documentation¹⁰:

- i. **Presence of note** – For any claim or encounter submitted to DBHDD (including Medicaid Rehabilitation Option), a note must be present justifying that specific intervention. In addition, other ancillary or non-billable services which are related to the well-being of the individual served must be included in the individual's official medical record.
- ii. **Service billed** – All progress notes must contain the corresponding HIPAA code which must include any designated modifier. When documenting practitioner modifiers, the modifier must indicate the reimbursement level, which may differ from the practitioner level in certain cases. For example, if a RN provides CSI, the RN would include the modifier U4 to indicate the practitioner level even though an RN is generally a level 2 Practitioner.
- iii. **Timeliness** – All activities/services provided are documented (written and filed) within the current individual record within a pre-established time frame set by provider policy not to exceed 7 calendar days. Best practice standards require progress notes to be written within 24 hours of the clinical or therapeutic activity. Notes entered retroactively into the record after an event or a shift must be identified as a “late entry”.
- iv. **Legibility** – All documentation that is handwritten must be readable, decipherable and easily discernible to the all readers.
- v. **Conciseness and clarity** – Clear language, grammar, syntax, and sentence structure is used to describe the activity and related information.
- vi. **Standardized format** – Providers are expected to follow best practices and select a format or create a prescribed narrative that can be used consistently throughout their provider. Specific details regarding actual practice should be described in providers’ policies, procedures, training manuals and/or documentation instruction sheets. All formats require a clear match or link between the progress note, assessment and service and planning data.
- vii. **Security and confidentiality** – All documentation is managed in such a manner to ensure individual confidentiality and security while providing access and availability as appropriate.
- viii. **Activities dated** - Documentation specifies the date/time of service.

¹⁰ Any electronic records process shall meet all requirements set forth in this document.

- ix. **Dated entries** – All progress note entries are dated to reflect the date of signature of the individual providing the service (this date may differ from the actual date of service). Dates written to indicate the date of a signature may only be dated by the signer. In electronic records, the date of entry must reflect the date that the secure electronic signature was entered. Back-dating and post-dating are not permitted.
- x. **Duration of activities** – Documentation of the duration must be noted for all services to include the number of units, times, and dates. For those services in which the unit/rate is based on time (not per contact/encounter), documentation must include time-in and time-out for all services. This requirement applies for both face-to-face and collateral contacts. Residential services are excluded from the daily notation of time-in/time-out and must follow the specific guidelines outlined in each specific residential code. Further instruction related to Psychosocial Rehabilitation and Peer Supports services can be found in the respective Service Guidelines.
- xi. **Rounding of Units** – Rounding of units is permitted when a service meeting the service definition is provided in less time than the unit increment requirement. Each provider must have an internal policy regarding rounding of units. Regarding “rounding” of units, a unit may be billed for a service when an activity meets the service definition of the service billed but does not meet the full time/unit requirement. In order to bill a unit of service, at least 50% of the time required per unit must be provided and documented by the “time-in, time-out” documentation. For example, a provider may bill a single 15 minute unit for a service greater or equal to 8 minutes and less than 23 minutes. If the duration of the service is greater than or equal to 23 minutes and less than 38 minutes, then 2 units may be billed. Providers must document rounding practices in internal policy.
- xii. **Location of intervention** – For those services which may be billed as either in or out-of clinic¹¹, progress notes shall reflect the location as either in-clinic or out-of-clinic (unless otherwise noted in Service Guideline). If the intervention is in-clinic, no further specificity is required. If an intervention is “out-of-clinic”, the note must reflect the specific location of the intervention; this indication must be specific enough that it can be generally understood where the service occurred (for example: “...at the individual’s home,” “...at the grocery store”, etc.). Documenting that the service occurred “in the community” is not sufficient to describe the location.
 1. When services are provided to youth at or during school, documentation must indicate that the intervention is most effective when provided during school hours.
 2. Justification of Out of Clinic Billing: DBHDD allows for a modified billing rate for services provided in the community. This rate is provided as compensation for travel and reduced staff productivity associated with providing services in the community; Out of clinic billing may only be billed when this occurs and when it complies with the modifier definitions set forth in Part I, Section II of this Manual
- xiii. **Participation in intervention** – Progress notes shall reflect all the participants in the treatment and/or support intervention (individual, family, other natural supports, multi-disciplinary team members, etc.). Progress notes must reflect the specific interaction that occurred during the reported timeframe, and, therefore, not a duplication of another note.
- xiv. **Signature, Printed staff name, qualifications and/or title¹²** – The writer of the documentation is designated by name and credentials/qualifications and when required, degree and title. If an individual is a licensed practitioner, the printed name must be the name listed on his or her practitioner’s license on all medical record documentation¹³. An original signature is required. The printed name and qualifications and/or title may be recorded using a stamp or typed onto the document. Automated or electronic documentation must include a secure electronic signature¹⁴.

¹¹ Modifier U7 should be used to denote out of clinic services. Additional information related to use of this modifier can be found in Section I.

¹² See Requirements for All Behavioral Health Providers, Part II for additional information regarding credentials.

¹³ It is acceptable that the initials can be used for first and middle names. The last name must be spelled out and each of these must correlate with the names on the license. This is an effort to ensure that a connection can be made between the printed/stamped name on the chart entry and a license.

¹⁴ As defined in PART I POLICIES AND PROCEDURES FOR MEDICAID/PEACHCARE FOR KIDS, a Secure Electronic Signature means an electronic or digital signature, symbol, or process associated with a document which is created, transmitted, received, or stored by electronic means which (1) requires the application of a security procedure; (2) capable of verification/authentication; (3) adopted by a party with

- xv. **Recorded changes** – Any corrections or alternations made to existing documentation must be clearly visible. **No “white-out” or unreadable cross-outs** are allowed. A single line is used to strike an entry and that strike must be labeled with “error”, initialed, and dated. Any changes to the electronic record must include visible “edits” to include the date and the author of the edit. Additionally, if a document contains a Secure Electronic Signature, it must be linked to data in such a manner that if the data is changed the electronic signature is invalidated.
- xvi. **Consistency** – Documentation must follow a consistent, uniform format. Should the progress note cross multiple pages in a paper record, the provider is responsible for ensuring that it is clear that the additional pages are a continuation of the progress note. For example, in a 2 page note, page 2 must contain the name of the individual, date of service, a page number, and indication that the signature of the practitioner or paraprofessional is related to the progress note on page 1.
- xvii. **Diversions and non-billable activities:**
 - 1. Providers may not bill for multiple services which are direct interventions with the individual during the same time period. If multiple services are determined to have been billed at the same or overlapping time period, billing for those services are subject to recoupment. Allowable exceptions include an individual receiving a service during the same time period or overlapping time period as:
 - a. A service provided without client present as indicated with the modifier "HS", or
 - b. A collateral contact service as indicated by the modifier "UK".
 - c. For example, a provider may bill Individual Counseling with the individual while, simultaneously, CM is being billed for a collateral contact. This is only allowable when at least one of the services do not require that the individual be present and the progress note documents such.
 - 2. Non-billable activities are those activities or administrative work that does not fall within the Service Definition. For example, confirming appointments, observation/monitoring, tutoring, transportation, completing paperwork, and other administrative duties not explicitly allowed within the Service Guidelines are non-billable activities. Billing for non-billable activities is subject to recoupment.
 - 3. Billing for services that do not fall within the respective Service Definition is subject to recoupment.
 - 4. Diversions activities are activities/time during which a therapeutic intervention tied to a goal on the individual's treatment plan is not occurring. Diversions activities which are billed are subject to recoupment.

9. EVENT NOTES

In addition to progress notes which document intervention, records must also include event notes documenting:

- A. Issues, situations or events occurring in the life of the individual;
- B. The individual's response to the issues, situations or events;
- C. Relationships and interactions with family and friends, if applicable;
- D. Missed appointments including:
 - i. Documentation and result of follow-up (e.g. date of rescheduled appt.),
 - ii. Strategies to avoid future missed appointments.

the intent to be bound or to authenticate a record; (4) signed under penalty of perjury; (5) unique to the person using it; (6) under the sole control of the person using it; and (7) linked to data in such a manner that if the data is changed the electronic signature is invalidated.

PART III

General Policies and Procedures

Provider Manual for Community Behavioral Health Providers

Fiscal Year 2015

DBHDD PolicyStat enables community providers of mental health, developmental disabilities and/or addictive diseases services to have access to all DBHDD policies that are relevant for community services. DBHDD PolicyStat can be accessed online anytime at <https://qadbhdd.policystat.com/>. Beginning in April 2012, the placement of policies in DBHDD PolicyStat replaces the policies previously included in the *Provider Manual for Community Mental Health, Developmental Disabilities and Addictive Diseases Providers for the Department of Behavioral Health and Developmental Disabilities*. By virtue of their contract or agreement with DBHDD, providers are required to comply with DBHDD policies relevant to their contracted services and/or according to the applicability as defined in the policy itself.

Additional information about how to utilize DBHDD PolicyStat is included in the following policy: **ACCESS TO DBHDD POLICIES FOR COMMUNITY PROVIDERS, 04-100** which is posted at <https://qadbhdd.policystat.com/>.



DBHDD

**Georgia Department of Behavioral Health
& Developmental Disabilities**

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