

Therapeutic and Evaluative Mental Health Services (T&E) for Expanded Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Purpose

This document is intended to provide information regarding Therapeutic and Evaluative Mental Health Services (T&E) for Expanded Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and must be utilized as a reference only.

General

- Standardized behavioral health screens are screening tools provided through the Expanded Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit, or as dictated by medical need to identify mental/behavioral health conditions.
- Evaluative mental health services are services that provide mental health assessments of beneficiaries that encompass background and information gathering, evaluation, feedback.
- Therapeutic mental health services, also referred to as psychotherapy services, are intentional, face-to-face interactions in which a therapeutic relationship is established between a beneficiary and a mental health practitioner to help resolve symptoms of the beneficiary's mental and/or emotional disturbance.

Provider Information

- A therapeutic and evaluative mental health provider must be currently enrolled as a Mississippi Medicaid provider acting within their scope of practice and be one (1) of the following licensed providers:
 - Medical Doctor (MD)
 - Doctor of Osteopathy (DO)
 - Psychologist (Ph.D.) or (Psy.D.)
 - Licensed Certified Social Worker (LCSW)
 - Licensed Professional Counselor (LPC) **Effective January 1, 2016**
 - Psychiatric Mental Health Nurse Practitioner (PMHNP)
 - Board Certified Behavior Analyst (BCBA) **Effective July 1, 2016**
- Only mental health practitioners listed above can be reimbursed for services provided outside of a Department of Mental Health (DMH) certified community/private mental health center.
- Providers employing any evidence-based practices (EBP) in the course of treatment must have completed the appropriate training for the specific EBP.

- Providers are responsible for developing and implementing a treatment plan no later than the third therapy session.
- Each initial and updated treatment plan must be reviewed, signed and dated by an approved practitioner listed above and maintained in the medical/case record.
- The treatment plan should be updated at a minimum of every three months or as medically indicated.
- Signatures from the beneficiary or guardian/legal representative must be obtained yearly for consent for treatment and maintained in the medical/case record unless written notice is obtained from the beneficiary or guardian/legal representative requesting withdrawal from treatment.
- Providers should refer to the **Billing Guidelines for Therapeutic and Evaluative Mental Health Services for Expanded EPSDT (T&E)** found on the Envision web portal under the heading **Fee Schedules** at <http://www.medicaid.ms.gov/providers/fee-schedules-and-rates>.

Prior Authorization

- Prior authorization is required for:
 - All mental health services for beneficiaries under the age of three (3)
 - Any mental health service for beneficiaries that exceeds the service limits
 - All mental health evaluations (psychological, developmental, and neuropsychological)
- Prior authorization is to be requested from either the Utilization Management and Quality Improvement Organization (UMQIO) or the appropriate Coordinated Care Organization (CCO) whichever is applicable.
- Preparatory (background/information gathering) and follow-up (feedback) requirements do not require prior authorization.

Services

- **Individual Therapy** is defined as one-on-one psychotherapy that takes place between a mental health therapist and a beneficiary. Only one (1) individual therapy service (regardless of the length of the session) per beneficiary per day is reimbursable.
- **Interactive Individual Therapy** is defined as one-on-one psychotherapy using non-verbal communication and/or physical aids, that takes place between a mental health practitioner and a beneficiary and should be provided to beneficiaries who have not yet developed, or have lost their expressive communication ability or do not have the cognitive ability to understand the mental health practitioner if ordinary adult language is used. Only one (1) interactive individual therapy (regardless of the length of session) per beneficiary per day is reimbursable.

- **Family Therapy** is defined as psychotherapy that takes place between a mental health therapist and a beneficiary's family members, with or without the presence of the child. Only one (1) family therapy service per beneficiary per day is reimbursable, whether the beneficiary is present for the service or not. Family therapy cannot be provided on the same day as a psychiatric diagnostic evaluation.
- **Interactive Group Therapy** is defined as psychotherapy using non-verbal communication and/or physical aids, that takes place between a mental health therapist and no more than six (6) individuals under the age of twenty-one (21) at the same time. Only one (1) unit of interactive group psychotherapy per beneficiary per day is reimbursable.
- **Group Therapy** is defined as psychotherapy that takes place between a mental health practitioner and no more than eight (8) individuals under the age of twenty-one (21) at the same time. One unit (session) of group psychotherapy per beneficiary per day may be reimbursed.
- **Psychiatric Diagnostic Evaluation** is defined as a comprehensive assessment taking place at the beginning of a treatment relationship between a beneficiary and mental health practitioner and includes the beneficiary's presenting problem, problem history, family background, medical history, current medications, educational/vocational achievement, history of previous mental health treatment, source of referral or any other pertinent information necessary to determine the most appropriate course of treatment. Only one (1) psychiatric diagnostic evaluation service per beneficiary per day is reimbursable. This service cannot be provided on the same day as family therapy.
- **Brief Emotional/Behavioral Health Assessment** is defined as a brief screening used to assess a beneficiary's emotional and/or behavioral health and covers a variety of standardized assessments aimed to identify the need for more in-depth evaluation for a number of mental/behavioral conditions. The maximum number of instruments allowable per beneficiary per day is two (2). The yearly service standard for brief behavioral assessments are limited to twelve (12) per state fiscal year.
- **Psychological Evaluation** is defined as the assessment of a beneficiary's cognitive, emotional, behavioral, and social functioning by a licensed psychologist using standardized test, interviews, and behavioral observations. Psychological evaluation service units are calculated on an hourly basis. The maximum number of service units allowable per beneficiary per day is four (4) units. The yearly standard for a psychological evaluation is four (4) units.
- **Neuropsychological Evaluation** is defined as a performance-based method to assess cognitive functioning which includes the collection of diagnostic information, differential diagnostic information, assessment of treatment response, and prediction of functional potential and recovery potential. Neuropsychological evaluation service units are calculated on an hourly basis. The maximum number of service units allowable per beneficiary per day is eight (8) units. The yearly standard for neuropsychological evaluation is ten (10) units.

- Educational interventions of an academic nature, related to educational needs are not reimbursable psychotherapy services.
- Family therapy sessions billed for multiple siblings in a family on the same day are not reimbursable psychotherapy services.
- Psychotherapy services billed for the time spent completing the plan of care forms or prior authorization requests online via web portal are not reimbursable.
- Providers are responsible for coordinating services with the beneficiary and guardian/legal representative to avoid service duplication when the beneficiary is receiving mental health services at more than one (1) location from more than one (1) provider. In cases where duplicate service claims have been filed, the claim that is filed first is reimbursable.
- Providers should only bill for the actual time spent in service delivery.
- Staff travel time, field trips, and routine recreational activities are not reimbursable.