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15.1 Description

Medicaid covers behavioral health services (mental health and/or substance abuse services) within certain limits for all recipients based on recipient age. Adults who are not members of the Behavioral Health Managed Care Plan have limited benefits. Children up to age 21 years of age have no limits on medically necessary services.

15.2 Amount, Duration, Scope

As listed below.

15.3 Exclusions

- Biofeedback
- Care Home Visits
- Concurrent Care. Patients must receive therapy from only one authorized therapist except when combined therapy is part of the treatment plan. Authorization for outpatient therapy will be given only to the requesting therapist identified on an approved Form 1018. Subsequent requests from other therapists for the same period may not be approved unless the current therapist transfers the patient to the new therapist.
- Consortium
- Crisis team services
- Day Care Visits
- Diet Counseling
- Employment Counseling
- Hawaii State Hospital. Medicaid does not pay for services to persons requiring institutionalization at the Hawaii State Hospital including transportation to that facility.
- Inpatient Care, Long Term
- Long Term Character Analysis
- Marathon Group Therapy
- Marriage Counseling

- Nursing Conferences. Provider conferences with nursing staff regarding the care of an institutionalized patient are not payable.
- Partial Hospitalization
- Primal Therapy
- Private Duty Nursing
- Residential Treatment Centers
- SNF/ICF Visits
- Telephone Consultation. Telephone services, including long distance calls, are not recognized as valid medical services and may not be billed to Medicaid as an office visit.
- Transsexualism. Treatment for transsexualism or gender reassignment, including counseling, is excluded from Medicaid.

15.4 General Limitations

15.4.1 Air Transportation

Air transportation may be provided to eligible Neighbor Island Medicaid recipients for psychiatric admission to an Oahu general hospital licensed as a psychiatric facility. See Chapter 16 “Transportation, Meals, Lodging and Foreign Language Translation/Sign Language Interpretation”. Additionally the following criteria must be met:

- a) The patient is primarily psychotic with uncontrollable behavior, which may result in harm to him/herself or others. The patient must be diagnosed and, whenever possible, given a trial therapeutic intervention, which may include medication, at the initial receiving hospital prior to transfer.
- b) Non-psychiatric physicians must consult with a psychiatrist and indicate on the Form 208 that consultation was received from a psychiatrist.
- c) Molokai and Lanai patients must be transferred directly to Maui or Oahu depending on the patient’s needs.
- d) The following are not authorized for air transportation:
 - Transfer to a non-medical facility such as residential treatment centers if one is available on the recipient’s island;

- Transfer to a provider not participating under the Medicaid Program;
- Transfer to Hawaii State Hospital; and
- Transfer of individuals under the jurisdiction of the judicial system.

15.4.2 Ground Transportation

Ground transportation is covered for medically necessary services. Ground transportation to the Hawaii State Hospital is not covered. See Chapter 16 “Transportation, Meals, Lodging and Foreign Language Translation/Sign Language Interpretation”.

15.4.3 Substance Abuse

- a) Oahu patients requiring only detoxification for alcohol or non-alcohol substance abuse are to be referred to a detoxification facility for treatment. On neighbor islands, the attending physician may admit the patient to a licensed general hospital. The maximum hospital stay for patients requiring only detoxification is 10 days.
- b) Patients requiring detoxification in addition to psychiatric or medical care are to be referred to an authorized inpatient psychiatric facility for psychiatric care or to a licensed general hospital for medical care.
- c) Authorization is not required for the initial 48 hours of emergency care. If the patient requires further inpatient care, transfer to an appropriate facility should be made.

Patients with substance abuse problems may require monitoring by pertinent laboratory data. The treating physician will determine the need for monitoring of data

15.4.4 Electro-Convulsive Therapy (ECT)

Must be prior authorized. If on an outpatient basis only 1 ECT session per day is allowable. More frequent sessions would have to be justified as medically necessary.

15.5 Outpatient Limitations

15.5.1 Combined Therapy

- a) Authorization from the DHS Consultant on Form 1018 is required.
- b) A combination of individual and group visits, not to exceed thirty (30) per twelve month (12) period is allowed with the following restriction:
 - For individual psychotherapy services, a visit is defined as an equivalent of one hour of therapy. Therefore, two (2) half hour visits are considered one individual therapy visit.

- Twenty-four (24) one-hour visits are allowed for individual therapy or twenty-four (24) visits for group therapy are the maximum for the primary modality. An additional six (6) visits of another modality are allowed within the same twelve (12) month period.
- Only one (1) visit per day is allowed. Visits may be either for group or individual therapy, but not both on the same day.

The patient may have different therapists for group and individual psychotherapy. The therapists involved are responsible for coordinating the patient's care and treatment.

15.5.2 Consultations

- a) A consultation requested by a practicing physician from a psychiatrist may be utilized for diagnostic evaluation and treatment planning of a patient.
- b) Consultations are not to exceed a total of two (2) hours, in one or two visits, for interview and documentation.
- c) Consultations and treatments are not covered on the same day.
- d) Consultations requested by friends, relatives and other interested parties are not covered.

Upon request, a copy of a consultation report is to be forwarded to the DHS Psychiatric Consultant.

15.5.3 Drug Management

- a) Drug management alone is considered general medical care and not psychiatric care.
- b) Payment for this service is as follows:
 - Psychiatrists and non-psychiatric physicians accepting referrals to prescribe or evaluate psychiatric medications are reimbursed at a general medical visit rate.
 - The use of clozapine requires close medical supervision according to the current standard of care, which includes but is not limited to regular laboratory testing and monitoring for adverse effects.
 - Psychiatrists may prescribe most agents without prior authorization approval.
 - Non-psychiatrists must use the prior authorization forms for clozapine, olanzapine, risperidone, quetiapine and ziprasidone. Refer to Appendix 4 for a sample of this form (1162).

15.5.4 Group Therapy

Reimbursement is limited to only one visit per day and the recipient must be 21 years or older.

- Therapy sessions should not exceed two (2) hours.
- A group shall consist of four (4) to ten (10) patients.
- Marathon group therapy is not covered.
- Authorization from the DHS Consultant is required.

Use the appropriate CPT procedure code for this service.

15.5.5 Maintenance Therapy

- a) Maintenance therapy is defined as psychiatric treatment of patients who do not require intensive psychiatric care, but require medication (drug management) and supportive care to remain functional.
- b) When provided by physicians other than psychiatrists, the following apply:
 - Reimbursement is made for one visit a month. Justification and authorization from the DHS Consultant on Form 1018 is required if more frequent visits are needed.
 - A psychiatrist to provide psychiatric consultation must be readily available to the physician providing the maintenance therapy.

Reimbursement is equivalent to a general medical office visit.

15.5.6 Mental Impairment Determination

Initial and subsequent evaluation for the determination and certification of mental impairment is done by authorized examiners only. A list of these authorized examiners is maintained by DHS. These determinations are limited to applicants/recipients for General Assistance (GA).

15.5.7 Methadone Maintenance

Methadone maintenance or LAMM is covered by Medicaid. The medication itself and one clinic visit a week is allowable. Visits for Methadone dispensing are not considered toward outpatient psychiatric benefit limits. However, visits for counseling are considered toward this benefit.

15.5.8 Outpatient Psychotherapy

- a) Authorization on Form 1018 is required for all outpatient psychotherapy. The completed form signed and dated by the psychiatrist or psychologist must be received by the Medicaid fiscal agent within five (5) working days from the time of the patient's first visit. Reimbursements may be denied if forms are not received within that time.
- b) Outpatient visits are reimbursed for up to a maximum of one hour for individual therapy and two hours for group therapy.
- c) Up to twenty-four (24) one-hour outpatient visits may be authorized for each twelve-month period. The hour visit can be broken up into a shorter period such as two one-half hour visits. This is based on a service year (12 months from initial visit.)
- d) No more than one visit a day is allowed, either for individual or group therapy and both cannot occur on the same day.
- e) Unused authorized visits may not be carried over to the next approval period allowed for the following year.
- f) A summary of the patient-therapist relationship may be requested by the DHS Consultant at any interval after the onset of treatment to determine the number of subsequent outpatient visits that may be authorized. The summary should include justification for the diagnosis, a logical expressed treatment plan, and observed changes since the onset of the patient-therapist relationship.

Patients under continuous psychiatric treatment for three (3) years or more are surveyed by the DHS Psychiatric Consultant for progress towards rehabilitation and general productivity of therapy before further outpatient visits are approved. Providers disagreeing with the Consultant's determination may request referral to the DHS established peer review committee for review.

15.5.9 Home Visits

Home visits to a residence, care home, boarding home or other living arrangement are normally not covered; however, allowances may be made in an emergency situation. Justification must be provided.

15.5.10 Psychological Testing

- a) Medical authorization on Form 1144 is required. The names of the tests to be given are to be listed. Authorization shall be for a maximum of six (6) hours per 12-month period if comprehensive testing is justified.

- b) The number of hours authorized includes time for interview, appraisal and concluding documentation.
- c) Testing and treatments are not approved if done on the same day.
- d) Only time spent by a qualified psychologist in administering, monitoring and evaluating tests are reimbursable. Time spent by a technician is not reimbursable.
- e) A copy of the testing report is to be provided to the DHS psychiatric or medical consultant upon request.

Testing requested by friends, relatives and other interested persons for these persons' or agencies' own use are not covered.

15.5.11 Therapeutic Teams

- a) Only State community mental health centers and psychiatric outpatient clinics attached to a general hospital with a separate license as a psychiatric facility may provide psychiatric care through the centers' therapeutic teams.
- b) Limitations:
 - The therapeutic team must be under the direct supervision of a psychiatrist who must be present and available in the inpatient facility or outpatient clinic attached to a general hospital or State community mental health center to provide assistance or direction.
 - The team must provide care that meets the patient's specified needs.

15.5.12 Preadmission Screening Resident Review (PAS/RR) Level II

PAS/RR is a requirement for nursing facility Medicaid participation and must be performed for all individuals. The Level II process involved the performance of necessary evaluation(s) and determination of need for nursing facility placement and specialized services. To assure Medicaid reimbursement for psychiatric evaluations for PAS/RR, the psychiatrist performing the evaluation should use CPT code 90801 with the modifier X9 when submitting a Medicaid claim.

15.6 Benefit Exchange

- a) Detoxification, whether provided in a hospital or in a non-hospital facility, shall be considered part of the inpatient benefit limit.
- b) Each inpatient day may be substituted for two outpatient hours, if the 24 hours of outpatient benefit is exhausted.

15.7 Inpatient Limitations

15.7.1 Emergency Inpatient Care

- a) In communities (excluding Oahu) where a psychiatric facility is not readily available, emergency inpatient service of up to forty-eight (48) hours may be provided at the closest licensed general hospital.

On Oahu, an emergency exists only when all authorized psychiatric facilities are filled and no beds are available. Patients determined by the attending physician to require inpatient care beyond the 48-hour period are to be transferred to an authorized psychiatric facility.

15.7.2 Emergency Room Care

Emergency room services in a licensed general hospital may consist of examination for clinical impression and treatment.

15.7.3 Hospital Passes

- a) Voluntary patients may obtain passes as needed for discharge planning purposes.
- b) Involuntary patients should be regulated according to legal requirements.
- c) Patients are authorized eight (8) hours to assist in discharge preparation. The hours may be used in a flexible and judicious manner throughout the duration of admission.
- d) Exceptions may be made for patients who will benefit from a program under the auspices of the treating hospital.

All other types of hospital passes are not covered.

15.7.4 Inpatient Care

- a) Care must be provided in an authorized psychiatric facility.
- b) Admissions must be by a psychiatrist; or if by a non-psychiatrist physician, with the concurrence of a psychiatrist.
- c) Authorization on Form 1144 for all admissions.
- d) Form 1144 must be received by the Medicaid Fiscal Agent, within five (5) working days of the patient's admission. Payments may be denied if the form is not received within that time.
- e) Form 1018 must be used for patients admitted for a medical reason who require more than four psychiatric visits during that hospitalization.

- f) Total hospital days should not exceed thirty (30) days per calendar year. Unused hospital days during a calendar year may not be carried over to the following calendar year but may be exchanged for outpatient care.
- g) The number of inpatient days available through a third party coverage is to be applied to the days available under Medicaid.

15.8 Behavioral Health Managed Care (BHMC) Plan

Adult recipients who have been initially determined by their provider and confirmed by DHS to have a serious mental illness (SMI) shall be enrolled in the behavioral health managed care (BHMC) plan on a voluntary basis. All dual eligibles (Medicare and Medicaid) and Medically Needy (with spend down) may elect to receive services on a fee-for-service basis and refuse to join the BHMC plan. The BHMC offers an enriched and expanded array of medically necessary services individually tailored to meet the behavioral health needs of each of the plan's members.

- b) Persons who are SMI are defined as persons who, as the result of a mental disorder, exhibit emotional, cognitive or behavioral functioning which is so impaired as to interfere substantially with their capacity to remain in the community without supportive treatment or services or a long-term or indefinite duration. In these persons, mental disability is severe and persistent resulting in a long-term limitation in their functional capacities for primary activities of daily living such as interpersonal relationships, self-care, homemaking, employment and recreation. Criteria for designation of a recipient as SMI, the referral form and the actual SMI process can be found in Appendix 6.
- c) The BHMC plan shall provide to its adult members a full range of behavioral health services including but not limited to inpatient, outpatient therapy and drug treatment, including clozaril and tests to monitor the member's response to therapy, and intensive case management. Adult members who have been designated as being SMI and who require alcohol abuse and/or drug abuse diagnosis, treatment and/or rehabilitative services shall receive these services from the BHMC plan. The following is a listing of required service components of the BHMC plan. It is not meant to be an all-inclusive listing and additional services may be required based on the individual needs of the members:
- Hospital services
 - Outpatient hospital services
 - 24-hour, 7 days per week emergency/crisis services
 - Mental health rehabilitation services

- Behavioral healthcare specialist services such as psychiatrists, psychologists, geriatricians, Qualified Mental Retardation Professionals (QMRPs) or other professionals trained to manage MR/DD members, social workers, certified substance abuse counselors, counselors and nurses trained in psychiatry.
 - Day treatment programs
 - Residential treatment programs
 - Case management/care coordination services
 - Pharmacy services
 - Laboratory services
 - Substance abuse services
 - Pre-vocational programs
 - Social/recreational services
 - Occupational therapy
 - Interpretation services
 - Transportation services including emergency ground and air
 - Lodging and meals associated with obtaining necessary care
- d) BHMC adult members, who no longer meet the clinical criteria of being SMI, shall be disenrolled from the BHMC plan after a transition period.
- e) Recipients not eligible for enrollment in the BHMC plan include persons who are:
- Residing in a hospital and waitlisted for nursing facility placement;
 - Participating in Program for All-Inclusive Care for the Elderly (PACE);
 - Residing in an ICF-MR;
 - Receiving Medicaid and Medicare (dual eligible) and choose to remain in the FFS program;

- Medically needy (with spenddown) and choose to remain in the FFS program;
- Children and youth 0-18 years old;
- Persons committed for evaluation or treatment under Chapter 706 HRS.