



BEHAVIORAL HEALTH SERVICES MANUAL

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Introduction

The Behavioral Health Services Manual contains policy and procedures for providing behavioral health services to MO HealthNet covered participants. Covered behavioral health services include psychotherapy/counseling services for mental health conditions and substance use disorders that are provided by licensed mental health professionals. Coverage also includes applied behavior analysis for participants under age 21 with an autism spectrum disorder (ASD) and transcranial magnetic stimulation for participants age 18 and over with severe major depression.

Medically necessary behavioral health services are available to MO HealthNet eligible children under the age of 21 (0-20 years old) and to MO HealthNet eligible adults age 21 and older. Medically necessary is defined in the [General Sections Manual](#).

Independent foster care adolescents with a Medical Eligibility (ME) code of 38 and who are ages 21 through 25 will receive a comprehensive benefit package for children in state care and custody; however, for Missouri's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, Healthy Children and Youth (HCY), the screenings are not covered. Refer to the [General Sections Manual](#) for a description of all ME codes.

Section 1 - Benefits and Limitations

1.1 Participant Eligibility

The MO HealthNet Division (MHD) pays for approved behavioral health services when furnished within the provider's scope of practice. The participant must be eligible on the date the service is furnished. Participants may have specific limitations for behavioral health services according to the type of assistance for which they have been determined eligible and their age. It is the provider's responsibility to determine the coverage benefits for a patient based on their type of assistance and age. Prior to performing services, the provider shall ascertain a participant's eligibility. Providers must verify participant eligibility in accordance with methodology outlined in the [General Sections Manual](#).

1.2 Provider Participation Requirements

The following providers are eligible to enroll with MHD:

- Licensed and provisional licensed psychologists
- Licensed clinical social workers
- Licensed master social workers
- Licensed and provisional licensed professional counselors
- Licensed and provisional licensed marital and family therapists

- Psychiatrists
- Psychiatric/mental health nurse practitioners
- Psychiatric/mental health clinical nurse specialists
- Licensed behavior analysts
- Licensed assistant behavior analysts
- Nationally Certified School Psychologist (NCSP) credentialed school psychologists (limited to services in school setting)

To participate in the MHD Behavioral Health Services Program, the provider must satisfy the following requirements:

- Hold a valid license within the state of practice or NCSP credential if a school psychologist rendering services in a school
- Have a signed and accepted Participation Agreement in effect with the Missouri Department of Social Services (DSS), Missouri Medicaid Audit and Compliance (MMAC)

The enrolled MHD provider shall agree to keep any records necessary to disclose the extent of services the provider furnishes to patients, and on request, furnish to MHD or State Medicaid Fraud Control Unit any information regarding payments claimed by the provider for furnishing services covered by MO HealthNet.

Refer to the [**General Sections Manual**](#) for additional information on provider conditions of participation. Providers interested in enrolling with MO HealthNet should contact [**MMAC Provider Enrollment**](#).

Psychologists, Provisional Licensed Psychologists and Psychology Interns

A psychologist, provisional licensed psychologist (PLP), or psychology intern may provide behavioral health services for children and adults. Psychology intern services are limited to services provided as part of an American Psychological Association (APA) accredited internship program.

A psychologist or PLP must have and maintain one (1) of the following:

- A valid permanent or provisional license issued by the State Committee of Psychologists when practicing in Missouri
- A valid permanent or provisional license issued by the psychology licensing authority of the state in which they practice

The provider's National Provider Identifier (NPI) must be on file with MHD. Claims are submitted to MHD with the provider's NPI. Services provided in a group/clinic setting must be filed under the

group/clinic NPI with the individual's NPI reported as the performing provider when the claim is submitted for reimbursement.

A psychology intern must be:

- A doctoral psychology intern in good standing in an internship program that is:
 - Accredited by the APA
 - A member of the Association of Psychology Postdoctoral and Internship Centers
- Under the direct supervision of the MO HealthNet enrolled licensed psychologist responsible for the participant's care

The supervising psychologist for the psychology intern must:

- Be enrolled with MO HealthNet as a psychologist
- Supervise and be responsible for the quality of work performed by the psychology intern under their direct supervision
- Assure compliance with MHD rules and regulations
- Retain the name of the participating intern and training dates in the psychology intern's personnel record

NOTE: A PLP must only provide services allowed under the provisional licensure. PLPs may not operate as an independent practitioner, receive direct payment from MHD, or own their own business in the practice as a PLP. PLPs must submit a copy of their permanent license to MMAC Provider Enrollment Unit upon receipt. Providers may fax a completed and signed [Provider Update Request](#) along with a copy of their permanent license to (573) 634-3105.

Licensed Clinical Social Workers and Licensed Master Social Workers

Licensed Clinical Social Workers (LCSW) and Licensed Master Social Workers (LMSW) may provide behavioral health services for children and adults.

LCSWs and LMSWs must have and maintain one (1) of the following:

- A valid license issued by the State Committee for Social Workers if practicing in Missouri
- A valid license issued by the social work licensing authority of the state in which they practice

The provider's NPI must be on file with MHD. Claims are submitted to MHD with the provider's NPI. Services provided in a group/clinic setting must be filed under the group/clinic NPI with the individual's NPI reported as the performing provider when the claim is submitted for reimbursement.

LMSWs must adhere to the following guidelines:

- Only provide services allowed under the licensure
- Only practice clinically for 48 months
- May not operate as an independent practitioner, receive direct payment from MHD, or own their own business in the practice as an LMSW
- Must submit a copy of the LCSW license to MMAC Provider Enrollment Unit upon receipt of their license to continue as an MHD provider. Providers may fax a completed and signed [**Provider Update Request**](#) along with a copy of their permanent license to (573) 634-3105.

Licensed Professional Counselors and Provisional Licensed Professional Counselors

Licensed Professional Counselors (LPC) and Provisional Licensed Professional Counselors (PLPC) may provide behavioral health services for children and adults.

LPCs and PLPCs must have and maintain one (1) of the following:

- A valid permanent or provisional license issued by the State Committee of Professional Counselors if practicing in Missouri
- A valid permanent or provisional license issued by the professional counselor licensing authority of the state in which they practice

The provider's NPI must be on file with MHD. Claims are submitted to MHD with the provider's NPI. Services provided in a group/clinic setting must be filed under the group/clinic NPI with the individual's NPI reported as the performing provider when the claim is submitted for reimbursement.

PLPCs must adhere to the following guidelines:

- Only provide services allowed under the provisional licensure
- May not operate as an independent practitioner, receive direct payment from MHD, or own their own business in the practice as a PLPC
- Must submit a copy of their permanent license to MMAC Provider Enrollment Unit upon receipt of license to continue as an MHD provider. Providers may fax a completed and signed [**Provider Update Request**](#) along with a copy of their permanent license to (573) 634-3105.

Licensed and Provisional Licensed Marital and Family Therapists

Licensed Marital and Family Therapists (LMFT) and Provisional Licensed Marital and Family Therapists (PLMFT) may provide behavioral health services for children and adults.

LMFTs and PLMFTs must have and maintain one (1) of the following:

- A valid permanent or provisional license issued by the State Committee of Marital and Family Therapists if practicing in Missouri
- A valid permanent or provisional license issued by the marital and family therapy licensing authority of the state in which they practice

The provider's NPI must be on file with MHD. Claims are submitted to MHD with the provider's NPI. Services provided in a group/clinic setting must be filed under the group/clinic NPI with the individual's NPI reported as the performing provider when the claim is submitted for reimbursement.

PLMFTs must adhere to the following guidelines:

- Only provide services allowed under the provisional licensure
- May not operate as an independent practitioner, receive direct payment from MHD, or own their own business in the practice as a PLMFT
- Must submit a copy of their permanent license to MMAC Provider Enrollment Unit upon receipt of license to continue as an MHD provider. Providers may fax a completed and signed [**Provider Update Request**](#) along with a copy of their permanent license to (573) 634-3105.

Licensed Psychiatrists and Psychiatric Advanced Practice Registered Nurses

A licensed psychiatrist must have and maintain a valid permanent license within the state of practice.

A psychiatric advanced practice registered nurse (P-APRN) must have and maintain a valid Registered Nurse (RN) license and a national certification in a population focus that includes a specialization in mental health or psychiatry within the state of practice.

Recognized psychiatric certifications for APRNs include:

- Adult psychiatric/mental health nurse practitioner
- Adult psychiatric/mental health clinical nurse specialist
- Family psychiatric/mental health nurse practitioner
- Family psychiatric/mental health clinical nurse specialist
- Child-adolescent psychiatric/mental health clinical nurse specialist

For all provider types listed above, the provider's NPI must be on file with MHD. Claims are submitted to MHD with the provider's NPI. Services provided in a group/clinic setting must be filed under the group/clinic NPI with the individual's NPI reported as the performing provider when the claim is submitted for reimbursement.

Applied Behavior Analysis Providers: Licensed and Provisional Licensed Behavior Analysts, Assistant Behavior Analysts, and Psychologists

MHD reimburses behavior analysts, assistant behavior analysts and psychologists for Applied Behavior Analysis (ABA) services provided to participants under age 21 who have a diagnosis of Autism Spectrum Disorder (ASD).

Behavior analysts and assistant behavior analysts must have and maintain one of the following:

- A valid permanent or provisional license issued by the Division of Professional Registration, State Committee of Psychologists, Behavior Analyst Advisory Board if practicing in Missouri
- A valid permanent or provisional licensed issued by the relevant licensing authority of the state in which they practice

MHD reimburses psychologists for ABA services only if they have been approved for the ABA specialty. MHD enrolled psychologists who have ABA in their scope of education, training, and competence may submit documentation of their credentials for consideration for the ABA specialty. Providers may fax a completed and signed [Provider Update Request](#) and the documentation to the MMAC Provider Enrollment Unit at (573) 634-3105.

If not already enrolled as a MO HealthNet provider, upon completion of the [enrollment application](#), psychologists may submit supporting documentation via fax to (573) 634-3105 and request approval for the ABA specialty.

Psychologists will be notified from MMAC by email whether they have been approved for the ABA specialty.

Psychologists providing ABA must have and maintain the ABA specialty through MMAC Provider Enrollment and maintain one (1) of the following:

- A valid license or provisional license issued by the State Committee of Psychologists when practicing in Missouri
- A valid license or provisional license issued by the licensing authority of the state in which they practice

The provider's NPI must be on file with MHD. Claims are submitted to MHD with the provider's NPI. Services provided in a group/clinic setting must be billed under the group/clinic NPI with the individual's NPI reported as the performing provider when the claim is submitted for reimbursement.

Technicians who provide direct implementation of ABA services under the supervision of a licensed provider may provide services for up to 90 days from the date they pass the registered behavior technician (RBT™) initial competency assessment. After 90 days they must be credentialed by the Behavior Analyst Certification Board as a RBT™ to continue rendering ABA services. The supervisory relationship must be documented in writing, and the licensed supervisor is responsible for the work performed by the RBT. Services provided by an RBT must be billed by the licensed supervisor using

the codes and modifiers specified in this manual. RBTs are not allowed to enroll as MO HealthNet providers.

School Psychologists

MHD reimburses for NCSP credentialed school psychologists for school-based Individualized Education Plan (IEP) Behavioral Health Direct Services. NCSPs who are employed in a duly accredited public or charter school and perform services within the scope of their employment for such school; and within the scope of their education, training, and experience, are eligible to enroll and provide services to MO HealthNet participants.

MO HealthNet enrolled school psychologists (unless licensed) must be supervised by a licensed practitioner. Documentation of supervision must be available upon request of the state agency. Services provided by school psychologists must be billed by the MHD enrolled school district. See [Section 1.12](#) in this manual for more information about school-based services.

Notification of Provider Changes

The MMAC Provider Enrollment Unit must be notified in writing of any changes in provider records within 90 days of the change except for change of ownership, which must be reported within 30 days. The notification must include the provider's NPI, the requested changes, the provider's signature, and must be submitted on the [Provider Update Request](#) via fax to (573) 634-3105. Refer to the [General Sections Manual](#) for more information.

1.3 Adequate Documentation

All services provided must be adequately documented in the medical record. The requirement to document services and to release records to representatives of DSS or the U.S. Department of Health and Human Services (DHHS) is stated in [13 CSR 70-3](#), Conditions of Provider Participation, Reimbursement and Procedure of General Applicability. These requirements are also repeated in the Title XIX Participation Agreement, which is a document signed by all providers upon enrollment as a MO HealthNet provider.

Per [13 CSR 70-3.030\(2\)\(A\)](#) adequate documentation is defined as follows:

- Documentation from which services rendered and the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty.

In addition, [13 CSR 70-3.030\(2\)\(A\)](#), defines adequate medical records as follows:

- Records which are of the type and in a form from which symptoms, conditions, diagnosis, treatments, prognosis, and the identity of the patient to which these things relate can be readily discerned and verified with reasonable certainty. All documentation must be made available at the same site at which the service was rendered.

An adequate and complete patient record is a record which is legible, which is made contemporaneously with the delivery of the service, which addresses the patient/client specifics, which include, at a minimum, individualized statements that support the assessment or treatment encounter, and shall include documentation of the following information:

- First name, last name, and either middle initial or date of birth of the MO HealthNet participant
- An accurate, complete, and legible description of each service(s) provided
- Name, title, and signature of the MO HealthNet enrolled provider delivering the service.

Inpatient hospital services must have signed and dated physician or psychologist orders within the patient's medical record for the admission and for services billed to MO HealthNet.

For patients registered on hospital records as outpatient, the patient's medical record must contain signed and dated physician orders for services billed to MHD.

Services provided by an individual under the direction or supervision are not reimbursed by MHD.

Services provided by a person not enrolled with MO HealthNet are not reimbursed by MHD.

- The name of the referring entity, when applicable
- The date of service (month/day/year)
- For those MO HealthNet programs and services that are reimbursed according to the amount of time spent in delivering or rendering a service(s) (except for services identified by the American Medical Association Current Procedural Terminology procedure codes 99291-99292 and targeted case management services administered through the Department of Mental Health and as specified under [**13 CSR 70-91.010**](#) Personal Care Program (4)(A)) the actual begin and end time taken to deliver the service (for example, 4:00-4:30 p.m.) must be documented
- The setting in which the service was rendered
- The plan of treatment, evaluation(s), test(s), findings, results, and prescription(s) as necessary. Where a hospital acts as an independent laboratory or independent radiology service for persons considered by the hospital as "non-hospital" patients, the hospital must have a written request or requisition slip ordering the tests or procedures
- The need for the service(s) in relationship to the participant's treatment plan

- The participant's progress toward the goals stated in the treatment plan (Progress Notes)

Timeliness of Documentation

For documentation to be considered timely, services must be documented in the medical record at the time the service was performed or within five (5) business days of the time the service was provided. This is in accordance with the definition of “contemporaneous” in [13 CSR 70-3.030\(2\)\(D\)](#).

Electronic signatures are accepted. Stamped signatures are not acceptable. Refer to [13 CSR 65 3.050](#) for more information on acceptable electronic signatures.

All documentation must be legible, written, and submitted in English.

Specific Documentation Guidelines for Psychotherapy Services

Based on [13 CSR 70-3.030\(2\)\(A\)](#), the following specific guidance is offered for diagnostic assessments, treatment plans, and progress notes. Documentation must be individualized to the participant receiving services. Review [Behavioral Health Documentation Templates](#) for examples of acceptable documentation formats. MHD does not require the use of these templates.

For diagnostic assessments, it is a best practice recommendation to screen for anxiety, depression, substance use disorder (SUD), suicide risk, and trauma at a minimum.

Diagnostic Assessment

Diagnostic assessment is a required component in the health record. A diagnostic assessment must include the following elements:

- First name, last name, and either middle initial or date of birth of the participant
- Referral source, when applicable
- Date(s) of service and begin and end times
- Setting in which the service was rendered (e.g., home, office)
- Presenting problem
- Statement of needs, goals, and treatment expectations from individual/family requesting services
- Summary of relevant behavioral health (i.e., mental health and/or SUD) treatment history
- Current behavioral health symptoms

- Developmental (if under age six (6)), family, social, legal, and vocational/educational status and functioning. Historical information related to these domains should also be included if pertinent.
- Current medications
- Personal and social resources and strengths, such as family, peers, and other natural supports
- Diagnostic impression in accordance with the current edition of the Diagnostic and Statistical Manual of Mental Disorders (must be supported by symptoms, significant distress or impairment in functioning).
- Provider signature and date

Documentation must support billing in terms of dates and time spent assessing the participant. If the assessment spans multiple days, progress notes may be used to indicate dates of service and begin and end times and to ensure services are documented within five (5) business days.

If the participant needs further services, the diagnostic assessment should form the basis for a treatment plan. Providers should update the diagnostic assessment annually for adults and adolescents (age 13 to 20) or within six (6) months for children under age 13.

Refer to the [**MO HealthNet Template for Diagnostic Assessment**](#) for a sample document.

Treatment Plan

A treatment plan is a required document in the overall record of the participant. The treatment plan is a working document, and providers should incorporate updates into the plan as needed on an ongoing basis. For example, the treatment plan should reflect when goals are met or revised, when new goals are added, and when interventions are added or updated. The treatment plan must reflect the participant's unique needs and goals and must include:

- Measurable goals or outcomes
- Services, supports, and actions to accomplish each goal/outcome. For example, provider interventions, action steps for participant, other family or social supports or resources.
- Projected time frame for the completion of each goal/outcome not to exceed 12 months
- Estimated completion/discharge date
- Provider signature and date

Providers must update the treatment plan annually for adults and adolescents (age 13 to 20) or within six (6) months for children under age 13.

Refer to the [**MO HealthNet Template for Treatment Plan**](#) for a sample document.

Progress Notes

Providers must document each treatment encounter with an individualized progress note that includes the following elements:

- First and last name of participant
- The specific service rendered (e.g., group therapy) or the procedure code
- The date (month/date/year) and the actual begin and end time (e.g., 4:00 p.m. - 4:30 p.m.) of the face-to-face service
- The setting in which the service was rendered
- Description of the immediate issue(s) addressed in therapy
- Participant's report of recent symptoms and/or behaviors related to diagnosis and treatment plan goals
- Therapist intervention(s) and participant response
- Progress toward treatment goal(s)
- For family therapy, identify each family member present
- For group therapy, the number of group members present
- Provider's name, signature and date

Refer to the [MO HealthNet Template for Progress Note](#) for a sample document.

Retention of Records

MO HealthNet providers must retain for six (6) years, from the date of service, fiscal and medical records that coincide with and fully document services billed to MHD. MO HealthNet providers must also furnish or make the records available for inspection or audit by DSS or its representative upon request. Failure to furnish, reveal and retain adequate documentation for services billed to MHD may result in recovery of the payments for those services not adequately documented and may result in sanctions to the provider's participation in MO HealthNet. This policy continues to apply in the event of the provider's discontinuance as an actively participating MO HealthNet provider through change of ownership or any other circumstance.

1.4 Patient Nonliability

MO HealthNet covered services rendered to an eligible patient are not billable to the patient if MHD would have paid had the provider followed the proper policies and procedures for obtaining payment through the MO HealthNet Program as set forth in [13 CSR 70-4.030](#).

1.5 Precertification of Psychotherapy Services

Prior to requesting precertification, a counseling/psychotherapy provider may deliver 14 hours of psychotherapy services to a participant for whom they have not precertified services within the last rolling year. The 14 hours may include any combination of individual therapy, family therapy without patient present, family therapy, or group therapy (procedure codes: 90832, 90834, 90837, 90846, 90847, 90849 or 90853). Refer to [Section 1.10](#) in this manual for more information on procedure codes.

Prior to delivering additional services (beyond the initial 14 hours), a provider must request precertification. The provider is responsible for checking participant eligibility on the date of service, and the provider must be enrolled and eligible to bill for the services. Precertification of services is not a guarantee of payment.

The number of hours precertified is based on the patient's age, diagnosis, type of therapy, and Medical Eligibility (ME) Code. Refer to [Section 1.8](#) in this manual for hours issued for adults (ages 21 and over) and [Section 1.9](#) for hours issued for children (ages 0 through 20 and ME code 38 ages 21 through 25). The default precertification period is 12 months.

Refer to the [General Sections Manual](#) for a description of all ME codes.

Providers must use diagnostic criteria in the current edition of the Diagnostic and Statistical Manual of Mental Disorders to establish diagnosis. Providers must use the corresponding diagnosis code from the current edition of the International Classification of Diseases (ICD) when requesting precertification and submitting claims (required for compliance with the Health Insurance Portability and Accountability Act (HIPAA)). Refer to [Section 4.3](#) in this manual for behavioral health services diagnosis codes.

With the exception of psychiatric diagnostic evaluation (procedure codes: 90791 and 90792), all covered behavioral health services for patients age birth through two (2) years (i.e., psychological testing, family therapy) require precertification.

Requesting Precertification

The provider is responsible for checking participant eligibility on the date of service, and the provider must be enrolled and eligible to bill for the services. Precertification of services is not a guarantee of payment. Providers must verify participant eligibility in accordance with methodology outlined in the [General Sections Manual](#).

If psychotherapy services are required beyond the initial 14 hours, the provider must request precertification prior to delivering additional services. To request precertification the provider or designated staff may make the request in one (1) of the following ways:

- Online through [CyberAccess](#). To become a CyberAccessSM user, contact the Conduent help desk at (888) 581-9797 or (573) 632-9797, or send an email to CyberAccessHelpdesk@Conduent.com.
- Fax the completed [Behavioral Health Services Request for Precertification](#) to (573) 635-6516
- By calling the Behavioral Health Services help desk at (866) 771-3350. It is recommended that providers complete the [Behavioral Health Services Request for Precertification](#) prior to calling as the information on the form is required to complete the request.
- Mail completed [Behavioral Health Services Request for Precertification](#) to:

MO HealthNet Division
PO Box 4800
Jefferson City, MO 65102

If the therapist providing the service is part of a clinic or group, the precertification should be requested using the clinic/group NPI. If the provider is not part of a group or clinic (solo practice), the precertification should be requested using the providers individual NPI. Precertification for services being delivered by a member of a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or Community Mental Health Center (CMHC) must be requested by using the FQHC, RHC, or CMHC NPI.

Precertification with Third Party Insurance

Precertification is required when third party insurance coverage exists. Original Medicare is not considered third party insurance; however, if Medicare does not cover the service, a precertification is required for payment by MHD. Also, Medicare Advantage Plans (Medicare Part C) are considered third party insurance, and precertification is required for non-Qualified Medicare Beneficiary (QMB) participants. Services for QMB participants with a Medicare Advantage Plan do not require precertification.

Precertification in Nursing Home

Precertification is required for patients residing in a nursing home. Refer to the [Nursing Home Provider Manual](#) for more information on nursing home benefits and limitations.

Precertification Processing

All precertification requests must be complete in order to be processed. A precertification cannot be processed if the participant or provider identifying information is incomplete or inaccurate (e.g., NPI, Departmental Client Number (DCN)). The Behavioral Health Services help desk makes every attempt to reconcile any incorrect/inaccurate information with providers; however, it remains the

provider's responsibility to provide complete and accurate information when submitting a request for precertification.

A participant may have an open precertification with one (1) provider for individual therapy and/or family therapy and a second precertification open with the same or different provider for group therapy.

Precertification Changes

If a provider needs to change a precertification, the provider may call the Behavioral Health Services help desk at (866) 771-3350 or fax the change request to (573) 635-6516. A request to change the precertification must include the following information:

- Participant's name
- Participant's MO HealthNet ID or DCN
- Type of therapy
- Current precertification number
- Description of the desired change

Changing Providers

If the participant is changing providers for the same type of service, the provider listed on the current precertification must end that precertification by calling the Behavioral Health Services help desk at (866) 771-3350. This must be completed before the new provider can obtain a precertification.

If the current provider refuses to close the precertification, the new provider must submit a signed letter from the participant, or participant's guardian, requesting a change in provider. The signed release must include the following:

- Participant's name
- Participant's MO Healthnet ID or DCN
- Type of therapy to be closed
- Number of hours used
- Name of the therapist whose authorization is to be closed

When a participant changes providers any available units may be transferred from the closed precertification to the new provider's approved precertification if requested. The new provider does not receive an additional allotment of therapy hours, but rather the portion of therapy hours remaining for the current precertification period.

Clinical Exceptions

MHD recognizes there are instances when participants may need behavioral health services that exceed the program limits defined in this manual. For example, a provider may request a clinical exception to add hours to a precertification or to exceed daily, monthly, or annual limits for specific services for an individual due to medical necessity. To do so, a provider must submit, in advance of providing services, a completed [Behavioral Health Services Request for Precertification](#), a letter with clinical rationale, and any available supporting documentation via fax to the Behavioral Health Services help desk at (573) 635-6516. A clinical consultant will review all exception requests for medical necessity, and the provider will receive a faxed response indicating whether medical necessity is met.

Precertification Exemptions

The following services are exempt from the precertification process:

- Electroconvulsive therapy (ECT)
- Evaluation and management (E&M) services
- Health and behavior assessment and intervention
- Narcosynthesis
- Psychiatric diagnostic evaluation
- Psychological testing
- Psychotherapy for crisis
- Tobacco cessation counseling

Psychotherapy services provided in the following places of service (POS) are exempt from precertification requirements:

POS	Description
14	Group Home (Age three (3) to 20 only)
21	Inpatient Hospital
33	Custodial Care Facility (Age three (3) to 20 only)
51	Inpatient Psychiatric Facility
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center

Providers must report correct POS codes on claims submitted to MHD. Psychotherapy services for participants ages 21 and over in places of service 14 or 33 require precertification. Refer to [Section 3.3](#) in this manual for more information on POS codes.

In addition, services provided to children with a ME code of 07, 08, 37, or 88 who are residing in or are under the care of a residential treatment facility (i.e., POS 14, 33, 55, or 56) are exempt from the precertification process if the services are provided at a site other than the residential treatment facility. The TJ modifier should be used to indicate that the services were provided to a child residing in or under the care of a residential treatment facility at a site other than the facility (office, outpatient hospital, home, etc.). The TJ modifier should not be used for services provided at the facility. The POS codes above exempt those services from the precertification process. If psychotherapy services are provided via telehealth to participants residing in POS that are exempt from precertification, providers must use the POS where the participant is physically located and the GT modifier to indicate telehealth services rather than POS 02 (Telehealth Provided Other Than In Patient's Home). Refer to [Section 3.3](#) in this manual for more information on POS codes.

NOTE: All services, except assessment, for participants ages birth through two (2) years do require precertification, regardless of the child's placement.

Participant Appeal Rights

When a precertification request is denied, the participant will receive a letter that outlines the reason for the denial and the procedure for appeal. The participant may request a State Fair Hearing by calling the Participant Services Unit (PSU) at (800) 392-2161, email StateFairHearings@dss.mo.gov, or in writing to:

MO HealthNet Division
Participant Services Unit
P.O. Box 6500
Jefferson City, MO 65102

The participant must contact the PSU within 90 days of the date of the denial letter if they wish to request a hearing. After 90 days, requests to appeal are denied.

Refer to [Division of Legal Services Benefit Hearings](#) for more information.

1.6 Covered Psychotherapy Services

Covered psychotherapy services for adults and children are described in detail below. See [Section 1.5](#) in this manual for precertification requirements and this Section for specific procedure codes.

Psychiatric Diagnostic Evaluation

A psychiatric diagnostic evaluation (procedure codes 90791 and 90792) is an integrated biopsychosocial assessment, including history, mental status, and recommendations. The evaluation may include the following types of activities:

- Interview with the participant (if the participant is a child, include topics of family, peers, school relationships, behavior, emotions, observation of social skills, developmental level of planning skills and informal assessment of overall development)
- Interview with the parent and/or other family members
- Report from teachers or other collateral contacts

The psychiatric diagnostic evaluation is limited to one (1) unit per day per participant, per performing provider and two (2) units per participant, per performing provider, per rolling year. MHD does not edit claims for Psychiatric Diagnostic Evaluations for a behavioral health diagnosis. This means that a behavioral health diagnosis is not required for this service. Providers should report the most appropriate ICD-10 diagnostic code(s) as determined by the evaluation (including Z codes).

Psychiatric Diagnostic Evaluation for Children Under the Age of Six

For children under the age of six (6) years, providers may deliver up to five (5) units of procedure codes 90791 and 90792 per six (6)-month period with a maximum daily quantity of one (1) unit. Properly assessing children from birth through age five (5) with behavioral challenges may require multiple assessment sessions with and without the child present.¹ Different strategies may be necessary to build rapport and engage caregivers, observe the child and their interaction with caregivers, survey/interview the caregivers separately from the child, and determine child functioning across settings/caregivers. For complete young child assessments, a provider may need multiple practitioners with different specialties or practitioners may need to schedule multiple sessions in various settings. Often, because behaviors in very young children can have multiple causes, young children may be misdiagnosed if complete evaluation information cannot be gathered by qualified assessors.²

Psychological Testing

Psychologists, provisional licensed psychologists, qualified doctoral level psychology interns, and psychiatrists may provide psychological testing services in addition to diagnostic assessment when warranted for proper evaluation. Psychological testing (including any combination of the following procedure codes 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96105, 96112, 96113,

¹ Zero to Three (2016). DC:0-5, p. 8

² Spiro L. The Most Common Misdiagnoses in Children. Available at: <https://childmind.org/article/the-most-common-misdiagnoses-in-children/>

96116, and 96121) is limited to a maximum of four (4) hours per participant, per performing provider, per rolling year. Procedure code 96146 has a separate limit of one (1) unit per day, per participant, per provider. Daily maximum limits also apply to each procedure code and are published on the [MHD Fee Schedule](#) under “Qty.” MHD does not edit psychological testing procedure codes for a behavioral health diagnosis. This means that a behavioral health diagnosis is not required for this service. Providers should report the most appropriate ICD-10 diagnostic code(s) as determined by the evaluation (including Z codes).

MHD reimburses for the following testing services:

Procedure Code	Description
96130	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s), or caregiver(s), when performed; first hour
96131	Psychological testing evaluation services, each additional hour (list separately in addition to code for primary procedure)
96132	Neuropsychological testing evaluation services; first hour
96133	Neuropsychological testing evaluation services; each additional hour
96136	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two (2) or more tests, any method, first 30 minutes
96137	Psychological or neuropsychological test administration and scoring, each additional 30 minutes (List separately in addition to code for primary procedure)
96138	Psychological or neuropsychological test administration and scoring by technician; first 30 min
96139	Psychological or neuropsychological test administration and scoring by technician; each additional 30 min
96146	Psychological or neuropsychological test administration, with single automated instrument via electronic platform, with automated result only (limit one (1) per day)

96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g. by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour
96112	Developmental test administration by qualified health care professional with interpretation and report, first 60 minutes
96113	Developmental test administration by qualified health care professional with interpretation and report, additional 30 minutes
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g. acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report, first hour
96121	Neurobehavioral status exam, each additional hour (list separately in addition to code for primary procedure)

The patient record must include the clinical justification for conducting the test as well as the intended purpose of the results.

Individual Psychotherapy

Per Current Procedural Terminology (CPT®), the psychotherapy service codes include ongoing assessment and adjustment of psychotherapeutic interventions and may include involvement of informants in the treatment process. 90832, 90834, and 90837 describe psychotherapy for the individual patient; times are for face-to-face services with patient and may include informant(s). The patient must be present for all or a majority of the service.

Procedure Code	Description
90832	Psychotherapy, approximately 16 to 37 minutes face-to-face with the patient
90834	Psychotherapy, approximately 38 to 52 minutes face-to-face with patient
90837	Psychotherapy, 53 or more minutes face-to-face with patient

Individual psychotherapy is limited to one (1) unit per day/five (5) units per month. The daily limit applies in all POS. The monthly limit does not apply in the following places of service:

POS	Description
14	Group Home (Age 3-20 only)
21	Inpatient Hospital
33	Custodial Care Facility (Age 3-20 only)
51	Inpatient Psychiatric Facility
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
61	Comprehensive Inpatient Rehabilitation Facility

Special Considerations for Young Children

Evidence-Based Practice and Family Therapy Encouraged

Whenever possible, providers are encouraged to utilize evidence-based practices that address the specific clinical issues and demographic characteristics of the individual(s) being treated. Many evidence-based practices for children actively involve parents/caregivers in the intervention. Providers are encouraged to involve parents/caregivers in the interventions (e.g., providing family therapy), especially when treating younger children. In addition to incorporating family therapy, most evidence-based practices for children zero (0) to five (5) years of age are hybrid treatments that incorporate cognitive behavior therapy, play, and/or other treatment strategies.

Competence in Treating Young Children

Consistent with the ethical standards for behavioral health, providers are expected to practice within the boundaries of their competence. This applies equally to services for the early childhood population as it does to services for other age groups. If providers do not have the knowledge and skills to work with a particular clinical population, they are urged to seek learning experiences to gain the necessary knowledge and skills or refer the child to a competent provider.

Consideration of the Developmental Level of the Child

Providers treating young children are expected to base their plan of intervention on a comprehensive and individualized assessment that takes into consideration, among other factors, the developmental level of the child and the specific clinical issues being treated. When working with young children who have behavioral health concerns, best practice is to screen development to determine if developmental delays play a role in socio-emotional difficulties and to guide developmentally appropriate treatment planning. If developmental delays are found or suspected, providers should refer clients for further assessment and treatment as needed. One developmental consideration is that a young child may not have the expressive language skills to explain their symptoms and

response to treatment, or the receptive language skills to understand the clinician if they were to use ordinary adult language. Treatments for young children typically incorporate activities, pictures, drawing, role-playing, books, play, etc. to facilitate communication, make therapeutic concepts and skills concrete, build the therapeutic relationship, and help the child change.

Play Therapy Guidelines

Play therapy includes a variety of treatment techniques that may be effective with young children. The appropriate procedure code used to report an intervention that incorporates play therapy techniques depends on the specific therapeutic approach used and could be individual therapy or family therapy. Documentation should clearly reflect how the play therapy techniques were utilized in a therapeutic manner to address the issue(s) being treated. Observing children playing in a playroom, playing on playground equipment, playing at daycare, or playing at home in their normal routine is not play therapy and is not reimbursable by MHD.

Documentation

Regardless of the treatment approach used (e.g., trauma-focused cognitive-behavioral therapy, parent-child interaction therapy, or play therapy), the treatment plan should include the billable service (e.g., family therapy), either by procedure code or name of service. The treatment plan should also describe specific planned interventions, strategies, and actions. If specific techniques are planned, they may be included, but a specific strategy (e.g., play therapy) alone is not a sufficient description of an intervention. The same considerations apply to progress notes. Progress notes must include the specific MO HealthNet billable services rendered.

Refer to [Section 1.3](#) in this manual for more information on adequate documentation.

Family Therapy

Family therapy is defined as the treatment of family members as a family unit, rather than as individual patients. When family therapy without the patient present (procedure code 90846) or family therapy with the patient present (procedure code 90847) is provided, the session is billed as one (1) service (one (1) family unit), regardless of the number of individuals present at the session. Providers may not bill family therapy for each family member. Parental issues may not be billed and family therapy is only billable when defined in the treatment plan as necessary on behalf of the identified patient.

Only one (1) precertification per household is approved and open at a time for family therapy. If there is more than one (1) eligible child and no child is exclusively identified as the primary patient, then the oldest child's DCN must be used for precertification and billing purposes. When a specific child is identified as the primary patient, that child's DCN must be used for precertification and billing purposes. Providers should not request more than one (1) family therapy precertification per household, unless submitting a clinical exception request with justification as to why separate treatment is needed.

A family may be defined as biological, foster, adoptive, or other family configuration. A family is not a group and providers may not submit a claim for each eligible person attending the same family therapy session. At least seventy five percent (75%) of the session must have both child/children and parent(s) present.

Group Therapy

Group therapy (procedure code 90853) must consist of at least two (2) but no more than 10 individuals who are not members of the same family. This applies to inpatient group therapy sessions also.

Multiple-family group therapy is billed with procedure code 90849.

Group therapy may not be billed on the same date of service as family therapy (procedure code 90846 or 90847) unless the patient is inpatient, in a residential treatment facility, or custodial care facility. Services must be provided at the facility location.

Psychotherapy for Crisis

Psychotherapy for crisis is used to offer immediate, short-term help to patients who experience an event that produces emotional, mental, physical, and behavioral distress or problems. A crisis can refer to any situation in which the patient perceives a sudden loss of the ability to use effective problem-solving and coping skills. Psychotherapy for crisis aims to reduce the intensity of the patient's emotional, mental, physical, and behavioral reactions to a crisis and help the patient return to their level of functioning before the crisis. Psychotherapy for crisis is appropriate for children, adolescents, and younger and older adults. Elements of psychotherapy for crisis include helping the individual understand the crisis and their response to it as well as becoming aware of and expressing feelings, such as anger and guilt. A major focus of psychotherapy for crisis is exploring coping strategies.

Psychotherapy for crisis (procedure codes 90839 and 90840) must be a face-to-face contact with the participant (in person or via telemedicine) to defuse a situation of immediate crisis. Psychotherapy for crisis services cannot be scheduled in advance. Procedure code 90839 is used to report the first 30 to 74 minutes of psychotherapy for crisis on a given date. Procedure code 90840 is used to report additional blocks of time of up to 30 minutes each beyond the first 74 minutes. Psychotherapy for crisis of less than 30 minutes should be reported with procedure code 90832.

Tobacco Cessation Counseling

MHD reimburses for both behavioral counseling and medications for tobacco cessation for eligible participants. Both individual (procedure codes 99406 and 99407) and group counseling (procedure codes 90849 and 90853) are covered for tobacco cessation. See [Section 1.10](#) in this manual for more information on procedure codes, limits, and modifiers.

Medications for tobacco cessation are reimbursed through the MHD Pharmacy Program. Refer to the [**Pharmacy Provider Manual**](#) for more information.

MO HealthNet Managed Care health plans cover the behavioral tobacco cessation interventions for their members. Participants should contact their assigned [**Managed Care Health Plan**](#) for information.

MHD covers unlimited quit attempts per lifetime, including behavioral and pharmacologic interventions.

Providers are encouraged to review the evidence and recommendations outlined in [**Treating Tobacco Use and Dependence: 2008 Update – Clinical Practice Guideline**](#), sponsored by the United States Department of Health and Human Services.

Based on the evidence, this document recommends:

- The “5 A’s,” a brief intervention for the primary care setting:
 1. **Ask** about tobacco use – All patients should be screened for tobacco use at every visit.
 2. **Advise** to quit – All physicians should strongly advise every patient who smokes to quit.
 3. **Assess** willingness to quit – Once identified as a smoker, willingness to quit should be assessed.
 4. **Assist** in quit attempt – offer medication and provide or refer for additional treatment; for patients unwilling to quit, provide interventions designed to increase future quit attempts (e.g., motivational interviewing).
 5. **Arrange** follow-up – For patients willing to quit, arrange follow-up contacts, beginning the first week after quit date; for patients unwilling to quit, address tobacco dependence and willingness to quit at next visit.
- Because of the serious risks of smoking to the pregnant smoker and the fetus, whenever possible pregnant smokers should be offered person-to-person psychosocial interventions that exceed minimal advice to quit.
- The combination of behavioral intervention and medication is more effective than either alone.
- Behavioral interventions should include both support/encouragement and practical counseling, such as problem-solving skills/skills training.
- Even behavioral counseling lasting less than three (3) minutes increases abstinence rates.
- Longer behavioral counseling sessions increase abstinence rates further.

- Providing four (4) or more sessions of behavioral counseling is especially effective in increasing abstinence rates.
- Use of telephone quit lines is effective in increasing abstinence rates.
- Use of educational materials tailored to the individual, both print and web-based, appear to be effective in increasing abstinence rates.
- Missouri offers free help to smokers who want to quit using tobacco.
- Smoking cessation information, including educational materials for youth, pregnant women, and other adults, is available at [Tobacco Use Prevention and Control](#).
- The Missouri Tobacco Quitline provides counseling, information, and referrals. In order to register to talk to a trained quit coach, individuals can call the Quitline number at (800) QUIT-NOW (800-784-8669) or [register online](#).
- Calls to the Missouri Tobacco Quitline are answered 24 hours a day, seven (7) days a week, excluding federal holidays and quit coaches are on duty 24 hours a day, seven (7) days a week.

Healthcare professionals can call the Quitline for information about the service. They can learn about proper use and dosing of nicotine replacement therapy. They can also learn about written materials covering a broad range of topics related to tobacco cessation. Visit [Resources for HealthCare Providers](#) for more information.

Diagnosis Codes for Tobacco Cessation

To be reimbursed by MHD, the claim for the behavioral intervention must contain a diagnosis code in one (1) of the following ranges:

Diagnosis Codes for Tobacco Cessation				
F17200-F17209	F17290-F17299	O09211-O09219	O0940-O0943	Z3400-Z3403
F17210-F17219	O0900-O0903	O09291-O09299	O99330-O99335	Z3480-Z3483
F17220-F17229	O0910-O0913	O0930-O0932	Z331	Z3490-Z3493

Reimbursement is limited to one (1) session per day. The behavioral intervention must be face-to-face with the patient (in person or via telemedicine).

The behavioral intervention is included in the global fee for prenatal/delivery/post-partum care billed by physicians and nurse midwives and should not be billed separately.

Health and Behavior Assessment and Intervention Services

MHD reimburses for medically necessary Health and Behavior Assessment and Intervention Services (HBAI) services. Covered practitioners include:

- Licensed psychologists, provisional licensed psychologists, psychology interns;
- Licensed clinical social workers, licensed master social workers;
- Licensed professional counselors, provisional licensed professional counselors;
- Licensed marital and family therapists, provisional licensed marital and family therapists.

HBAI services are used to identify and address the psychological, behavioral, emotional, cognitive, and social factors important to the treatment and management of physical health problems. HBAI is an established intervention designed to enable the participant to overcome the perceived barriers to self-management of their chronic condition(s).

HBAI services are not to be used for the treatment of a behavioral health condition. These services are specifically intended to address any or all of the following barriers to disease self-management of a chronic physical condition:

- Cognitive
- Emotional
- Social
- Behavioral functioning

Eligibility Criteria for HBAI Services

To determine eligibility for HBAI Services, the following criteria must be met:

- The participant must have an underlying physical illness or injury
- There must be indications that there are biopsychosocial factors that may be affecting treatment or self-management of the condition
- The participant must be alert, oriented, and have the capacity to understand and respond to information related to the condition
- The behavioral health provider must have medical records documenting the specific physical health condition diagnosed by a physician, nurse practitioner, physician assistant, or assistant physician. This requirement may be met through an integrated health record or through records or correspondence containing a diagnosis received from the medical provider.

Refer to [Section 1.10](#) in this manual for more information on procedure codes and limitations. Precertification is not required for HBAI services. HBAI services are covered for both children and adults. Providers must bill with the following modifiers for HBAI services.

Provider	Modifier
LCSW	AJ
LMFT	HE
LMSW	AJ
LPC	UD
PLMFT	HE
PLP	AH
PLPC	UD
Psychologists	AH
Supervisors billing for psychology intern services	AH and HL

Behavioral Health Services in a Nursing Facility

Effective December 13, 2024, MO HealthNet added coverage for counseling/psychotherapy services provided in a nursing facility. Place of service (POS) codes 31 (Skilled Nursing Facility) and 32 (Nursing Facility) are accepted for the following services:

- Psychiatric diagnostic evaluation (90791, 90792)
- Individual, family, and group psychotherapy (90832, 90834, 90837, 90846, 90847, 90849, 90853)
- Psychotherapy for crisis (90839, 90840)
- Health behavior assessment and intervention (96156, 96158, 96159, 96164, 96165, 96167, 96168)
- Tobacco cessation counseling (99406, 99407)

Providers should report the most appropriate POS code when delivering services in a nursing home. The above services may also be provided to nursing facility residents via telehealth. If counseling/psychotherapy services are delivered to nursing home residents via telehealth, POS code 02 (Telehealth Provided other than in Patient's Home) should be reported. Counseling/psychotherapy services delivered to nursing home residents are subject to the

precertification requirements outlined in [Section 1.5](#) of this manual. Claims must be submitted with the appropriate modifier for the performing provider's specialty (see [Section 1.22](#) in this manual).

1.7 Evidence-Based Treatment of Children Who Have Experienced Severe Trauma

MO HealthNet enrolled behavioral health providers who have been certified in the following evidence-based practices (EBP) are eligible for enhanced reimbursement:

- Eye Movement Desensitization Reprocessing (EMDR)
- Trauma Focused Cognitive-Behavioral Therapy (TF-CBT)
- Dialectical Behavior Therapy (DBT)
- Child Parent Psychotherapy (CPP)

Participant Criteria

Eligible participants are MHD covered (either FFS or Managed Care Health Plan) individuals under age 21 who have experienced severe physical, sexual, or emotional trauma due to abuse or neglect.

Validation of Provider Credentials

MHD and the Managed Care Health Plans review state and national EBP registries to ensure that enrolled providers participating in the program are currently certified. If any changes in certification occur (e.g., loss of certification or name change) providers must email MHD.BehavioralHealth@dss.mo.gov and/or the relevant Managed Care health plan(s).

MHD and the Managed Care Health Plans will consider the following sources as evidence of provider certification:

- CPP: [University of California San Francisco Child Trauma Research Program CPP Provider Roster](#)
- DBT: [DBT-Linehan Board of Certification](#) or [DBTMO Certification](#)
- EMDR: [EMDR International Association Membership](#)
- TF-CBT: [Missouri Academy of Child Trauma Studies \(MOACTS\) Roster](#) or [TF-CBT National Therapist Certification Program](#)

Practitioners with certification from other sources may submit credentials for consideration to MHD.BehavioralHealth@dss.mo.gov and/or to the relevant Managed Care Health Plan(s).

Procedure Codes and Modifiers

The following tables list the enhanced reimbursement procedure codes and modifiers by provider type. The HK modifier must be used to indicate the service is eligible for enhanced reimbursement. If eligible services are performed in home, **do not report the U8 modifier**. Services provided as documented in an IEP are reimbursed at the Federal Financial Participation rate. The remainder of the allowed amount is the responsibility of the school district originating the IEP.

Psychiatrist			
Procedure Code	Mod 1	Mod 2	CPT® Code Description
90832	HK		Psytx W Pt 30 Minutes
90837	HK		Psytx W Pt 60 Minutes

Psychiatric Advanced Practice Registered Nurse			
Procedure Code	Mod 1	Mod 2	CPT® Code Description
90832	SA	HK	Psytx W Pt 30 Minutes
90834	SA	HK	Psytx W Pt 45 Minutes
90837	SA	HK	Psytx W Pt 60 Minutes
90846	SA	HK	Family Psytx W/O Pt 50 Min
90847	SA	HK	Family Psytx W/Pt 50 Min
90853	SA	HK	Group Psychotherapy

Licensed Clinical Social Worker, Licensed Master Social Worker			
Procedure Code	Mod 1	Mod 2	CPT® Code Description
90832	HK	AJ	Psytx W Pt 30 Minutes
90834	HK	AJ	Psytx W Pt 45 Minutes
90837	HK	AJ	Psytx W Pt 60 Minutes

90846	HK	AJ	Family Psytch W/O Pt 50 Min
90847	HK	AJ	Family Psytch W/Pt 50 Min
90853	HK	AJ	Group Psychotherapy

Licensed or Provisional Licensed Psychologist, Psychology Intern

Procedure Code	Mod 1	Mod 2	CPT® Code Description
90832	HK	AH	Psytch W Pt 30 Minutes
90834	HK	AH	Psytch W Pt 45 Minutes
90837	HK	AH	Psytch W Pt 60 Minutes
90846	HK	AH	Family Psytch W/O Pt 50 Min
90847	HK	AH	Family Psytch W/Pt 50 Min
90853	HK	AH	Group Psychotherapy

Licensed or Provisional Licensed Marital & Family Therapist

Procedure Code	Mod 1	Mod 2	CPT® Code Description
90832	HK	HE	Psytch W Pt 30 Minutes
90834	HK	HE	Psytch W Pt 45 Minutes
90837	HK	HE	Psytch W Pt 60 Minutes
90846	HK	HE	Family Psytch W/O Pt 50 Minutes
90847	HK	HE	Family Psytch W/Pt 50 Minutes
90853	HK	HE	Group Psychotherapy

Psychiatrist, P-APRN, Psychologist, PLP, Psychology Intern, LCSW, LMSW, LPC, PLPC, LMFT and PLMFT for School-Based IEP Direct Services

Procedure Code	Mod 1	Mod 2	CPT® Code Description
90832	TM	HK	Psytx W Pt 30 Minutes
90834	TM	HK	Psytx W Pt 45 Minutes
90837	TM	HK	Psytx W Pt 60 Minutes
90846	TM	HK	Family Psytx W/O Pt 50 Minutes
90847	TM	HK	Family Psytx W/Pt 50 Minutes
90853	TM	HK	Group Psychotherapy

1.8 Precertification Guidelines for Adults

Individual, group, and family therapy services (beyond the first 14 hours) provided to adults (21 years of age or older) must be precertified. See [Section 1.10](#) in this manual for procedure codes and modifiers.

See [Section 1.5](#) in this manual for additional information regarding the precertification process.

Providers are expected to establish a participant's diagnosis using diagnostic criteria in the current edition of the Diagnostic and Statistical Manual of Mental Disorders. Providers must use the corresponding diagnostic code from the current edition of the ICD when requesting precertification and submitting claims (required for HIPAA compliance). Refer to [Section 4.3](#) in this manual for more information.

Precertifications for psychotherapy services for adults are issued for a maximum of 10 hours per rolling year for adjustment disorder, Z-code, or unspecified current version ICD diagnostic codes. For all other covered diagnosis codes, refer to the table below for the maximum hours issued for a 12-month period. All precertifications expire 12 months from the date requested.

Requests for continued services beyond the 12-month precertification must include:

- (1) Completed [Behavioral Health Services Request for Precertification](#) form
- (2) Letter explaining the rationale for continued services
- (3) Supporting clinical documentation (assessment, treatment plan, and most recent three (3) progress notes)

A clinical consultant will review all continued service requests for medical necessity. Providers must fax requests to the Behavioral Health Services help desk at (573) 635-6516.

Maximum Hours Precertified Per 12 Months for Adults

	Individual* 90832/ 90834/ 90837	Family* 90847	Family without patient 90846	Group 90849/ 90853
Max Hours First 12 months	15	10	10	25
Max Hours Continued Tx	20	10	10	30

*NOTE: For the first 12 months, providers may precertify up to 25 hours of individual, or family, or a combination. For continued treatment, providers may precertify up to 30 hours of individual, or family, or a combination.

1.9 Precertification Guidelines for Children and Youth

Precertification is required for family, individual, and group psychotherapy (beyond the first 14 hours) for children and youth, ages three (3) through 20 years old, who are not in state custody and for children and youth in foster care (ME Codes 07, 08, 37, and 38), not residing in a residential treatment facility. With the exception of diagnostic evaluation, precertification is required for all covered services (i.e., psychological testing and family therapy) provided to children age birth through two (2) years, regardless of the ME code or placement of the child. Refer to the [General Sections Manual](#) for a description of all ME codes.

Providers are expected to establish a participant's diagnosis using diagnostic criteria in the current edition of the Diagnostic and Statistical Manual of Mental Disorders. Providers must use the corresponding diagnostic code from the current edition of the ICD when requesting precertification and submitting claims (required for HIPAA compliance. Refer to [Section 4.3](#) in this manual for more information.

Precertifications for psychotherapy services for children and youth are issued for a maximum of 10 hours per rolling year for adjustment disorder, Z-code, or unspecified current version ICD diagnostic codes. For all other covered diagnosis codes, refer to the table below for the maximum hours issued for a 12 month period. All precertifications expire 12 months from the date requested. Requests for continued services beyond the 12-month precertification must include the following:

- Completed [Behavioral Health Services Request for Precertification](#)
- Letter explaining the rationale for continued services
- Supporting clinical documentation (assessment, treatment plan, and most recent three (3) progress notes)

A clinical consultant will review all continued service requests for medical necessity. Providers must fax requests to the Behavioral Health Services help desk at (573) 635-6516.

If multiple therapies (e.g., individual and family) are needed during the authorization period, the treatment plan must document the needs.

If a child's age changes during the precertification period, the precertification continues as authorized. However, if the child turns 21 during the authorization period, the policy for services provided to adults applies.

Only one (1) precertification per household is approved at any given time for family therapy. If there is more than one (1) eligible child and no child is exclusively identified as the primary patient, the oldest child's DCN must be used for precertification and billing purposes. Family therapy may be provided without the primary patient present; however, documentation should clearly state the reason the primary patient was not present. When a specific child is identified as the primary patient, that child's DCN must be used for precertification and billing purposes. **Providers should not request more than one (1) family therapy precertification per household.**

Refer to [Section 1.5](#) in this manual for additional information regarding precertification.

Precertification for Children and Youth by Age Group – Children Not in State Custody

Family therapy is the preferred modality for children through age 12 due to the evidence regarding the effectiveness of actively involving parents in the therapy process.

Children Not In State Custody: Maximum Hours Precertified per 12 Months: Each Cell Shows First 12 Months / Continued Treatment

Age	Testing*	Individual 90832/ 90834/ 90837	Family 90847	Family without Patient 90846	Group 90849/ 90853
0-2	4	N/A	20 / 20	10 / 10	N/A
3	N/A	5 / 10	15 / 20	10 / 10	N/A
4	N/A	15 / 20	15 / 20	10 / 10	N/A
5-12	N/A	16 / 20	37 / 40	10 / 10	13 / 16
13-17	N/A	27 / 30	26 / 30	10 / 10	13 / 16
18-20	N/A	37 / 40	16 / 20	10 / 10	13 / 16

*Note: Precertification not required for testing unless under age three (3). Annual limit for testing is listed.

Precertification for Children and Youth by Age Group – Foster Care: Each Cell Shows First 12 Months / Continued Treatment

Children in Foster Care (ME Codes 07, 08, 37, and 38): Maximum Hours Precertified per 12 Months

Age	Testing*	Individual 90832/90834/90837	Family 90847	Family without Patient 90846	Group 90849/90853
0-2	4	N/A	50 / 50	10 / 10	N/A
3	N/A	15 / 20	35 / 40	10 / 10	N/A
4	N/A	35 / 40	35 / 40	10 / 10	N/A
5-12	N/A	37 / 40	37 / 40	10 / 10	36 / 40
13-17	N/A	37 / 40	37 / 40	10 / 10	36 / 40
18-20	N/A	37 / 40	37 / 40	10 / 10	36 / 40
21-25	N/A	37 / 40	37 / 40	10 / 10	36 / 40

*Note: Precertification not required for testing unless under age 3. Annual limit for testing is listed.

Additional Family Therapy Services for Children and Youth in Foster Care

MHD recognizes there are instances with children and youth in foster care when additional family therapy services may be required. If a child in foster care requires family therapy sessions with the foster parent and separate family therapy sessions with the biological parent/parents, the provider should obtain one (1) family therapy precertification for the child.

The provider must develop an integrated treatment plan for the family therapy with objectives and outcomes for therapy with the foster family and biological family. The hours may be split between the two (2) families, i.e. family therapy sessions with foster parents and separate family therapy sessions with the biological parent(s). Hours will be issued in accordance with the guidelines above. Hours required beyond these guidelines may be requested through the Clinical Exception process, as outlined in [Section 1.5](#) of this manual.

Regardless of precertification, providers are required to adhere to the maximum daily and monthly unit limitations and all other program restrictions. Units billed over the daily, monthly, yearly limits are not reimbursed unless approved in advance through the clinical exception process.

Foster families that consist of several unrelated children should request one (1) family therapy precertification per family. Rare circumstances may arise when each unrelated child in a foster family requires a separate family therapy session with the foster parent. Requests for multiple family therapy precertifications per foster family will only be considered through the clinical exceptions process as stated in [Section 1.5](#) of this manual.

1.10 Procedure Codes for Psychotherapy Services

The current reimbursement amount may be accessed at the [MHD Fee Schedule](#).

Psychotherapy Services Requiring Precertification

CPT® CODE	CPT® CODE DESCRIPTION	UNIT	LIMITATIONS
90832	Psychotherapy	30 minutes with patient (approx 16 to 37 minutes face-to-face with the patient)	Maximum of one (1) unit per day, five (5) units per month, per patient, per provider
90834	Psychotherapy	45 minutes with patient (approx 38 to 52 minutes face-to-face with the patient)	Maximum of one (1) unit per day, five (5) units per month, per patient, per performing provider
90837	Psychotherapy	60 minutes with patient (53 or more minutes face-to-face with the patient)	Maximum of one (1) unit per day, five (5) units per month, per patient, per performing provider
90846	Family psychotherapy (without patient present)	50 minutes	Maximum of one (1) unit of 90846 or 90847 per day, five (5) units of 90846 or 90847 or combination per month, per household, per performing provider
90847	Family psychotherapy (conjoint psychotherapy)	50 minutes	Maximum of one (1) unit of 90846 or 90847 per day, five (5) units of 90846 or 90847 or combination per month, per patient, per performing provider

90849	Multiple family group psychotherapy	Untimed	Maximum of one (1) unit per day, five (5) units per month, per patient, per performing provider
90853	Group psychotherapy (other than a multi-family group)	Untimed	Maximum of one (1) unit per day, five (5) units per month, per patient, per performing provider

Psychotherapy Services not Requiring Precertification

CPT® CODE	CPT® CODE DESCRIPTION	UNIT	LIMITATIONS
90791	Psychiatric Diagnostic Evaluation	Untimed	Maximum of two (2) units per patient, per performing provider, per rolling year; for patients under the age of six (6), a maximum of five (5) units per patient, per performing provider, for a six (6)-month period with a maximum daily quantity of one (1) unit
90792	Psychiatric diagnostic evaluation with medical services	Untimed	Maximum of two (2) units per patient, per performing provider, per rolling year; for patients under the age of six (6), a maximum of five (5) units per patient, per performing provider, for a six (6)-month period with a maximum daily quantity of one (1) unit
90865	Narcosynthesis for psychiatric diagnostic and therapeutic purposes (e.g. sodium amobarbital (Amytal) interview)		Maximum of one (1) unit per day

90867	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management		
90868	Therapeutic repetitive TMS treatment; subsequent delivery and management, per session		
90869	Therapeutic repetitive TMS treatment; subsequent motor threshold re-determination with delivery and management		
90870	Electroconvulsive therapy (includes necessary monitoring)	MHD defined 30 minute unit	
90885	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes	MHD defined 60 minute unit	

96130	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s), or caregiver(s), when performed; first hour.	60 minute unit	Maximum of four (4) hours of testing (any combination of 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96105, 96112, 96113, 96116, and/or 96121 per rolling year, per participant, per performing provider)
96131	Psychological testing evaluation services, each additional hour (List separately in addition to code for primary procedure)	60 minute unit	Maximum of four (4) hours of testing (any combination of 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96105, 96112, 96113, 96116, and/or 96121 per rolling year, per participant, per performing provider)
96132	Neuropsychological testing evaluation services; first hour	60 minute unit	Maximum of four (4) hours of testing (any combination of 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96105, 96112, 96113, 96116, and/or 96121 per rolling year, per participant, per performing provider)
96133	Neuropsychological testing evaluation services; each additional hour	60 minute unit	Maximum of four (4) hours of testing (any combination of 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96105, 96112, 96113, 96116, and/or 96121 per rolling year, per participant, per performing provider)

96136	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, first 30 minutes.	30 minute unit	Maximum of four (4) hours of testing (any combination of 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96105, 96112, 96113, 96116, and/or 96121 per rolling year, per participant, per performing provider)
96137	Psychological or neuropsychological test administration and scoring, each additional 30 minutes (List separately in addition to code for primary procedure)	30 minute unit	Maximum of four (4) hours of testing (any combination of 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96105, 96112, 96113, 96116, and/or 96121 per rolling year, per participant, per performing provider)
96138	Psychological or neuropsychological test administration and scoring by technician; first 30 min	30 minute unit	Maximum of four (4) hours of testing (any combination of 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96105, 96112, 96113, 96116, and/or 96121 per rolling year, per participant, per performing provider)
96139	Psychological or neuropsychological test administration and scoring by technician; each additional 30 min	30 minute unit	Maximum of four (4) hours of testing (any combination of 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96105, 96112, 96113, 96116, and/or 96121 per rolling year, per participant, per performing provider)
96146	Psychological or neuropsychological test administration, with single automated instrument via electronic platform, with automated result only.	Untimed	Maximum of four (4) units per day

96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g. by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour	60 minute unit	Maximum of four (4) hours of testing (any combination of 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96105, 96112, 96113, 96116, and/or 96121 per rolling year, per participant, per performing provider)
96112	Developmental test administration by qualified health care professional with interpretation and report, first 60 minutes	60 minute unit	Maximum of four (4) hours of testing (any combination of 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96105, 96112, 96113, 96116, and/or 96121 per rolling year, per participant, per performing provider)
96113	Developmental test administration by qualified health care professional with interpretation and report, additional 30 minutes	30 minute unit	Maximum of four (4) hours of testing (any combination of 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96105, 96112, 96113, 96116, and/or 96121 per rolling year, per participant, per performing provider)

96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report, first hour	60 minute unit	Maximum of four (4) hours of testing (any combination of 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96105, 96112, 96113, 96116, and/or 96121 per rolling year, per participant, per performing provider)
96121	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report, additional hour.	60 minute unit	Maximum of four (4) hours of testing (any combination of 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96105, 96112, 96113, 96116, and/or 96121 per rolling year, per participant, per performing provider)
90839	Psychotherapy for crisis	60 minute unit	Maximum of one (1) unit per day
90840	Psychotherapy for crisis; each additional 30 min	30 minute unit	Maximum of three (3) units per day

Tobacco Cessation Counseling Procedures

CPT® CODE	CPT® CODE DESCRIPTION	UNIT	LIMITATIONS
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99406	Smoking and tobacco use cessation counseling visit	Intermediate, greater than 3 minutes up to 10 minutes	Maximum of one (1) unit per day
99407	Smoking and tobacco use cessation counseling visit	Intensive, greater than 10 minutes	Maximum of one (1) unit per day
HBAI Procedures			
CPT® CODE	CPT® CODE DESCRIPTION	UNIT	LIMITATIONS
96156	Health and behavior assessment or re-assessment (e.g., health-focused clinical interview, behavioral observations, clinical decision making)	Untimed	Limit of one (1) unit per day, two (2) per rolling year
96158	Health and behavior intervention, individual, face-to-face; initial 30 minutes	30 minutes	Limit of one (1) unit per day, eight (8) units per rolling year
96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	15 minutes	Limit of two (2) units per day, eight (8) units per rolling year, per participant
96164	Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes	30 minutes	Limit of one (1) unit per day, 12 units per rolling year
96165	Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	15 minutes	Limit of two (2) units per day, 24 per rolling year

96167	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes	30 minutes	Limit of one (1) unit per day, nine (9) units per rolling year
96168	Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	15 minutes	Limit of one (1) unit per day, 18 per rolling year

Psychotherapy Procedure Codes by Provider Specialty

Psychiatrists and P-APRNs should utilize **either** the appropriate Evaluation and Management (E&M) code **or** the appropriate psychotherapy code listed below. The billing of a combination of psychotherapy and E&M code for a single date of service by the same billing or performing provider is not allowed.

The U8 Modifier should be used for services billed with POS 12 (home). The appropriate modifiers must be used for all codes. The procedure codes and modifiers are listed by provider type below.

Provider	Modifier
LCSW	AJ
LMFT	HE
LMSW	AJ
LPC	UD
PLMFT	HE
PLP	AH
PLPC	UD
Psychologists	AH
Counseling/Psychotherapy for P-APRN	SA

CPT® Code & Modifier by Provider Specialty									
CPT® Code	CPT® Code Description	Psychiatrist	P-APRN	Psychologist PLP	Psychology Intern	LCSW LMSW	LPC PLPC	LMFT PLMFT	Precert Req
90791	Psychiatric diagnostic evaluation	90791	90791 SA	90791 AH	90791 HL AH	90791 AJ	90791 UD	90791 HE	No
90792	Psychiatric diagnostic evaluation with medical services	90792	90792 SA	N/A	N/A	N/A	N/A	N/A	No
90832	Psychotherapy, 30 min	90832	90832 SA	90832 AH	90832 HL AH	90832 AJ	90832 UD	90832 HE	Yes
90834	Psychotherapy, 45 min	90834	90834 SA	90834 AH	90834 HL AH	90834 AJ	90834 UD	90834 HE	Yes
90837	Psychotherapy, 60 min	90837	90837 SA	90837 AH	90837 HL AH	90837 AJ	90837 UD	90837 HE	Yes
90839	Psychotherapy for Crisis, first 60 minutes	90839	90839 SA	90839 AH	90839 HL AH	90839 AJ	90839 UD	90839 HE	No
90840	Psychotherapy for Crisis, each additional 30 minutes	90840	90840 SA	90840 AH	90840 HL AH	90840 AJ	90840 UD	90840 HE	No
90846	Family Psychotherapy without Patient, 50 min	90846	90846 SA	90846 AH	90846 HL AH	90846 AJ	90846 UD	90846 HE	Yes

90847	Family Psychotherapy with Patient, 50 min	90847	90847 SA	90847 AH	90847 HL AH	90847 AJ	90847 UD	90847 HE	Yes
90849	Multiple family group psychotherapy	90849	90849 SA	90849 AH	90849 HL AH	90849 AJ	90849 UD	90849 HE	Yes
90853	Group Psychotherapy	90853	90853 SA	90853 AH	90853 HL AH	90853 AJ	90853 UD	90853 HE	Yes
90865	Narcosynthesis	90865	90865 SA	N/A	N/A	N/A	N/A	N/A	No
90867	TMS; initial	90867	90867	N/A	N/A	N/A	N/A	N/A	No
90868	TMS; subsequent delivery and management	90868	90868	N/A	N/A	N/A	N/A	N/A	No
90869	TMS; subsequent motor threshold re-determination with delivery and management	90869	90869	N/A	N/A	N/A	N/A	N/A	No
90870	Electroconvulsive therapy (includes monitoring)	90870	90870 SA	N/A	N/A	N/A	N/A	N/A	No
90880	Hypnotherapy	90880	90880 SA	90880 AH	90880 HL AH	N/A	N/A	N/A	No
90885	Psychiatric evaluation of records	90885	90885 SA	90885 AH	90885 HL AH	N/A	N/A	N/A	No

96130	Psych testing evaluation services, first hour	96130	N/A	96130 AH	96130 HL AH	N/A	N/A	N/A	No
96131	Psych testing evaluation services, each additional hour	96131	N/A	96131 AH	96131 HL AH	N/A	N/A	N/A	No
96132	Neuropsychological testing evaluation services; first hour	96132	N/A	96132 AH	96132 HL AH	N/A	N/A	N/A	No
96133	Neuropsychological testing evaluation services; each additional hour	96133	N/A	96133 AH	96133 HL AH	N/A	N/A	N/A	No
96136	Psych test admin and scoring by professional, first 30 min	96136	N/A	96136 AH	96136 HL AH	N/A	N/A	N/A	No
96137	Psych test admin and scoring by professional, each additional 30 min	96137	N/A	96137 AH	96137 HL AH	N/A	N/A	N/A	No
96138	Psychological or neuropsychological test administration and scoring by	96138	N/A	96138 AH	96138 HL AH	N/A	N/A	N/A	No

	technician; first 30 min								
96139	Psychological or neuropsychological test administration and scoring by technician; each additional 30 min	96139	N/A	96139 AH	96139 HL AH	N/A	N/A	N/A	No
96146	Single automated test with automated result only	96146	N/A	96146 AH	96146	N/A	N/A	N/A	No
96105	Assessment of aphasia	96105	N/A	96105 AH	96105 HL AH	N/A	N/A	N/A	No
96112	Developmental testing, first hour	96112	N/A	96112 AH	96112 HL AH	N/A	N/A	N/A	No
96113	Developmental testing, each additional 30 min	96113	N/A	96113 AH	96113 HL AH	N/A	N/A	N/A	No
96116	Neurobehavior status exam, first hour	96116	N/A	96116 AH	96116 HL AH	N/A	N/A	N/A	No
96121	Neurobehavior status exam, each additional hour	96121	N/A	96121 AH	96121 HL AH	N/A	N/A	N/A	No
99406	Tobacco cessation counseling, 3-10 min	99406	99406 SA	99406 AH	99406 HL AH	99406 AJ	99406 UD	99406 HE	No

99407	Tobacco cessation counseling, greater than 10 min	99407	99407 SA	99407 AH	99407 HL AH	99406 AJ	99407 UD	99407 HE	No
96156	Health behavior assessment or re-assessment	N/A	N/A	96156 AH	96156 HL AH	96156 AJ	96156 UD	96156 HE	No
96158	Health behavior intervention, individual, face-to-face; initial 30 minutes	N/A	N/A	96158 AH	96158 HL AH	96158 AJ	96158 UD	96158 HE	No
96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes	N/A	N/A	96159 AH	96159 HL AH	96159 AJ	96159 UD	96159 HE	No
96164	Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes	N/A	N/A	96164 AH	96164 HL AH	96164 AJ	96164 UD	96164 HE	No
96165	Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes	N/A	N/A	96165 AH	96165 HL AH	96165 AJ	96165 UD	96165 HE	No

96167	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes	N/A	N/A	96167 AH	96167 HL AH	96167 AJ	96167 UD	96167 HE	No
96168	Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes	N/A	N/A	96168 AH	96168 HL AH	96168 AJ	96168 UD	96168 HE	No

1.11 Biopsychosocial Treatment of Obesity

Biopsychosocial Treatment of Obesity services are covered for both FFS and Managed Care participants.

Biopsychosocial Treatment of Obesity provides integrated medical nutrition therapy (MNT), when available, and behavioral health services, coordinated by the primary care or referring physician, or other licensed practitioner, to facilitate behavior changes to manage obesity and associated comorbidities for youth and adult participants. MNT is a recommended but not required component of the Biopsychosocial Treatment of Obesity program. However, a lack of available MNT should not preclude a participant from receiving behavioral health services for treatment of obesity if eligibility criteria is met. This program offers services consistent with the United States Preventive Services Task Force (USPSTF) recommendations for intensive, multicomponent behavioral interventions to improve weight status for adults and youth with obesity.

Participant Eligibility

For participants to be eligible for Biopsychosocial Treatment of Obesity services the following criteria must be met:

- Ages 0 through 20 years for youth services or 21 years of age or older for adult services
- Not currently pregnant
- Meet the definition of obese by meeting the following criteria:
 - For youth participants a Body Mass Index (BMI) percentile equal to or greater than the ninety-fifth percentile for age and gender on the pediatric BMI chart
 - For adult participants a BMI equal to or greater than 30
- Be referred to the program by a physician or other practitioner of the healing arts as part of an office visit for evaluation and management.

Participants may receive Biopsychosocial Treatment of Obesity services in addition to other weight reduction services such as medication.

Provider Qualifications

All Biopsychosocial Treatment of Obesity providers must enroll as a MO HealthNet provider.

Medical Nutrition Therapy

To provide MNT for obesity a provider must be licensed to practice as a Registered Dietitian or Registered Dietitian Nutritionist in the state in which they practice and must complete a qualified MNT training program (defined below). In lieu of completing a qualified MNT training program, an MNT provider must meet one (1) of the following requirements:

- Have a minimum of 1,000 hours of experience delivering weight management treatment for individuals, families, or youth with obesity within the past five (5) years of applying for the BT provider specialty

- Earned a commission on Dietetic Registration (CDR) Certificate of Training in Obesity for Pediatrics and Adults
- Earned a CDR Specialist Certification in Obesity and Weight Management (CSOWM)
- Earned a CDR Adult Weight Management Certificate of Training
- Earned a CDR Childhood and Adolescent Weight Management Certificate of Training

Providers must also complete three (3) hours of weight management CEU every two (2) years.

Qualified Medical Nutrition Therapy Training Program

A qualified training program for MNT must be developed by professionals with demonstrated expertise in MNT and sponsored by or conducted in affiliation with a university accredited by an entity recognized by the U.S. Department of Education to accredit degree-granting colleges and universities. This training program may be delivered face-to-face or in an electronic format. The training program should consist of both didactics and simulation work and contain evidence-based approaches to effectively deliver weight management and obesity treatment for adult and/or youth patients using a family-centered, comprehensive approach. Upon completion, a certificate should be given to the trainee.

Intensive Behavioral Therapy and Family-Based Behavioral Treatment

To provide individual and/or group intensive behavioral therapy (IBT) and/or family-based behavioral treatment (FBT) providers are required to be licensed to practice as a psychiatrist, clinical social worker, psychologist, professional counselor, marital and family therapist, or psychiatric advanced practice registered nurse. Registered dietitians are also eligible to provide group IBT and/or FBT as long as the provider also meets the IBT/FBT provider qualifications. All providers of IBT and/or FBT will be required to obtain a specialist certificate attained through completion of a qualified IBT/FBT training program (defined below) that addresses delivery of behaviorally based intervention for adult and/or youth participants diagnosed with obesity or have 1,000 hours of experience delivering weight management behavioral treatment for individuals, families, and/or youth with obesity within the past five (5) years of applying for the BT provider specialty. Biopsychosocial Treatment of Obesity providers must maintain six (6) hours of obesity or weight management CEUs or professional equivalent every two (2) years for the patient population served.

Qualified Intensive Behavioral Therapy/Family-Based Treatment Training Program

A qualified training program for IBT/FBT must be developed by professionals with demonstrated expertise in IBT/FBT and sponsored by or conducted in affiliation with a university accredited by an entity recognized by the U.S. Department of Education to accredit degree-granting colleges and universities. This training program may be delivered face-to-face or in an electronic format. The training program should consist of both didactics and simulation work and contain evidence-based

approaches to effectively deliver weight management and obesity treatment for adult and/or youth patients using a family-centered, comprehensive approach. Upon completion, a certificate should be given to the trainee. Licensed professionals who complete the initial specialist certification for IBT and/or FBT are additionally required within the first year to consultation from an experienced behavioral health professional in an individual or small group format to review patient cases and receive feedback.

Consultation requires an experienced behavioral health clinician who meets provider requirements for IBT outlined in this manual to evaluate and support the newly certified provider's competency in delivering behaviorally based intervention to patients diagnosed with obesity. The newly certified provider will participate in 24 consultation sessions over one (1) year (e.g., twice monthly for 12 months or weekly for six (6) months) including case reviews and simulations of key treatment strategies, by the newly certified provider. If the newly certified provider is unable to meet competency, the experienced evaluator will provide corrective feedback. Following this feedback, additional simulations will be conducted to evaluate and confirm proficiency.

Prior Authorization

Biopsychosocial Treatment of Obesity services require a referral or a prescription for the service in the participant's plan of care by a physician or other licensed practitioner authorized to prescribe within their scope of practice directly or by protocol consistent with their scope of practice under State law. Prior authorization is not required for participation in Biopsychosocial Treatment of Obesity services.

Limits

Twelve Months of Service			
Service	Type	Unit	Total Units
MNT Services for Youth and Adults	Initial Assessment & Intervention	15 minutes	Three (3) units = 45 minutes
	Re-assessment & Intervention	15 minutes	Six (6) units = one (1) hour and 30 minutes
Behavioral Counseling for Youth	Individual/Family	15 minutes	20 units = five (5) hours
	Group Sessions	30 minutes	52 units = 24 hours
Behavioral Counseling for Adults	Individual/Family	15 minutes	16 units = four (4) hours
	Group Sessions	30 minutes	44 units = 11 hours

If a participant is having difficulty attaining a healthier weight during the program, it is strongly encouraged that the IBT provider consult with the referring provider regarding the participant having the necessary lab work to rule out the presence of other conditions (e.g., endocrine disorder) that may complicate weight management. If a condition is found to be present, the participant may receive treatment for the condition while continuing to participate in the Biopsychosocial Treatment of Obesity program.

Billing Procedures

Biopsychosocial Treatment of Obesity services must be billed on a professional claim, with the appropriate procedure code from the table below. For IBT/FBT services performed by dietitians, modifier AE should be reported. Behavioral health clinicians should report the modifier corresponding to their specialty – refer to [Section 1.21](#) in this manual.

Procedure Code	Description
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes
G0447	Face-to-face behavioral counseling for obesity, 15 minutes
G0473	Face-to-face behavioral counseling for obesity, group (2–10), 30 minutes

1.12 Behavioral Health Services in a School Setting

MHD reimburses for behavioral health services provided in a school setting, and billing procedures vary depending on whether services are part of an IEP. Behavioral health services, including psychotherapy/counseling services and ABA services, not included in an IEP for a child who is MO HealthNet eligible, may be billed by a MO HealthNet enrolled provider or by the school district. Providers must use POS code 03 for all behavioral health services provided in a school setting, including services provided in a school-based health center. All behavioral health services guidelines and limitations, including precertification requirements and daily, monthly, and annual limits, apply to non-IEP school-based services.

School districts cannot bill for non-IEP services under the same NPI and taxonomy as IEP services. In order to bill for non-IEP services, school districts must obtain either a new NPI or a new taxonomy for their current NPI. Once the school district obtains the new NPI or taxonomy, it must complete a web-based [enrollment application](#).

The following guidelines apply to non-IEP behavioral health services provided in school:

- School districts are encouraged to establish a formal agreement with any provider who will provide services on school property. The school district has discretion over which providers are allowed to provide services on school property.
- Providers must be enrolled as MHD FFS program providers or with a particular Managed Care Health Plan depending on the child's MHD coverage.
- MHD Managed Care Health Plans are responsible for all MHD covered psychotherapy/counseling services provided within schools that are not part of an IEP under the Individuals with Disabilities Education Act (IDEA). This includes services provided at a school-based health clinic. ABA services are covered through the FFS program, even if the child is enrolled in a MO HealthNet Managed Care Health Plan.
- All behavioral health services provided by a MHD and/or a Managed Care Health Plan enrolled provider, to an otherwise eligible child with the intent to bill MHD, require parental/legal guardian consent, except in those cases referenced in [RSMo 431.061](#) and [RSMo 431.056](#).
- Providers must contact the child's respective MHD Managed Care Health Plan to obtain coverage guidelines and limitations for children whose services are covered through the Managed Care Program.
- Each child must have a treatment plan and the plan must specify how a parent/legal guardian will be engaged in the behavioral health services provided to the child.
- School personnel designated by the district must approve and coordinate time and place for services within the school.
- Non-IEP services are not billed with the TM modifier. Services must be billed with the modifier corresponding to the performing provider (refer to [Sections 1.10](#) and [1.16](#) in this manual). For services provided by school psychologists, modifier AH must be used.

School-Based IEP Direct Services

MO HealthNet behavioral health services are included in the school-based services program for public and charter schools. The program allows the school district to receive the federal match portion of the funds allocated for certain medical services. Only the services identified in the IEP, up to the amount and duration identified in the IEP, are reimbursable. All behavioral health services guidelines

and limitations, including daily, monthly, and annual limits, apply to school-based services. School based IEP behavioral health services are exempt from precertification requirements.

School based IEP behavioral health services are medically necessary behavioral health services that include diagnostic assessment, psychological testing, individual therapy, family therapy, and group therapy as well as ABA services for children with ASD.

To participate in the MO HealthNet school-based Behavioral Health Services Program, the billing provider of the services must be a Department of Elementary and Secondary Education (DESE) recognized public or charter school district in the state of Missouri. The school district is considered the billing provider and all services included in the school based Behavioral Health Services Program must be billed by the school district. School districts must contract with a behavioral health services provider enrolled with MHD to provide behavioral health services. The arrangements made by the school district with the behavioral health service providers are between the school district and the provider. The behavioral health services provider delivering the school based behavioral health service is considered the performing provider and can only be shown as the performing provider on the school district's claim submitted to MHD for reimbursement of school-based services. An individually enrolled MO HealthNet behavioral health services program provider cannot bill directly for MO HealthNet school based behavioral health services.

The child receiving school-based behavioral health services must be eligible for MO HealthNet coverage for each date a service is rendered for reimbursement to be made. The child must be under the age of 21. All services rendered to a child must be billed under the child's individual MO HealthNet Identification Number (DCN).

Direct services provided as documented in an IEP are reimbursed on a cost basis at the Federal Financial Participation Rate (FFP). The remainder of the cost is the responsibility of the school district originating the IEP. Claims for all services are to be billed and interim payments at the FFP rate will be made based on the MHD maximum allowable rate. Direct services are then cost settled in accordance with the [School-Based IEP Direct Services Cost Settlement Manual](#). The MO HealthNet maximum allowable fee for each code can be found on the [MHD Fee Schedule](#).

The school district and the behavioral health services provider must maintain a copy of the official public school generated IEP and the treatment plan in the child's record to document the service as an IEP service.

Children enrolled in a MO HealthNet Managed Care Health Plan receive school-based behavioral health services that are identified in an IEP on a FFS basis outside of the MO HealthNet Managed Care Health Plan benefit package.

Provider Enrollment – School-Based Services

Each school district interested in billing MHD for school-based services must enroll as a MO HealthNet provider. Each performing provider that provides behavioral health services for a school district must

also enroll with MO HealthNet. For all enrollment information, refer to [MMAC Provider Enrollment](#).

School districts currently enrolled for therapy services who wish to expand to include other school-based services must contact MMAC Provider Enrollment to request each service be added to the provider file. This request can be faxed to (573) 634-3105 or mailed to:

Missouri Medicaid Audit and Compliance
Attn: Provider Enrollment
PO Box 6500
Jefferson City, MO 65102

If the school district is not actively enrolled with MO HealthNet to provide school based therapy services, a [provider application](#) must be completed online for any or all of the expanded services. Enrollment applications are not available on paper.

Information provided on the enrollment application must agree with the information on file with DESE.

The following providers are eligible to perform school-based IEP behavioral health direct services:

Psychotherapy Services:

- LCSW, LMSW
- LPC, PLPC
- LMFT, PLMFT
- Licensed psychologists, PLP
- NCSP credentialed school psychologist
- P-APRN
- Psychiatrist

Applied Behavior Analysis:

- Licensed psychologist with education and experience in ABA
- Licensed behavior analyst
- Licensed assistant behavior analyst
- Behavior technician, for up to 90 calendar days until becoming RBT™
- RBT™

Treatment Plan – School-Based IEP Direct Services

A provider-signed treatment plan must be maintained at the facility where services are performed and must be made available for audit purposes at any time. MHD does not require a standardized treatment plan format.

Services must be provided as indicated in the IEP and treatment plan. A child's treatment plan must be evaluated at regular intervals.

The treatment plan must specify:

- Diagnosis
- Desired outcome
- Nature of the treatment
- Frequency of treatment (number of minutes per day/per week/per month)
- Duration (weeks or months) of services

The child or their family may not be charged for development of the treatment plan. MHD does not reimburse the school district or the behavioral health services provider to participate in IEP meetings or when developing a treatment plan for a child.

The child's treatment record must also include all components, including adequate documentation as required in [13 CSR 70-98.015](#).

Procedure Codes for School-Based IEP Direct Services – Psychotherapy and Applied Behavior Analysis

The following procedure code/modifier combinations are the allowable codes for the school-based services program and must be utilized within the provider's scope of practice and in accordance with applicable licensure standards. See [Section 1.21](#) of this manual regarding use of modifiers.

Psychotherapy Service	Psychiatrist, P-APRN	Psychologist, PLP	LCSW, LMSW	LPC, PLPC	LMFT, PLMFT
Psychiatric diagnostic evaluation	90791 TM	90791 TM AH	90791 TM AJ	90791 UD TM	90791 TM HE
Psychiatric diagnostic evaluation with medical services	90792 TM	N/A	N/A	N/A	N/A

Psychotherapy, 30 min	90832 TM	90832 TM AH	90832 TM AJ	90832 UD TM	90832 TM HE
Psychotherapy, 45 min	90834 TM	90834 TM AH	90834 TM AJ	90834 UD TM	90834 TM HE
Family Psychotherapy without Patient	90846 TM	90846 TM AH	90846 TM AJ	90846 UD TM	90846 TM HE
Family Psychotherapy with Patient	90847 TM	90847 TM AH	90847 TM AJ	90847 UD TM	90847 TM HE
Multiple family group psychotherapy	90849 TM	90849 TM AH	90849 TM AJ	90849 UD TM	90849 TM HE
Group Psychotherapy	90853 TM	90853 TM AH	90853 TM AJ	90853 UD TM	90853 TM HE
Psychotherapy for Crisis, first 60 minutes	90839 TM	90839 TM AH	90839 TM AJ	90839 UD TM	90839 TM HE
Psychotherapy for Crisis, each additional 30 minutes	90840 TM	90840 TM AH	90840 TM AJ	90840 UD TM	90840 TM HE
Psych testing evaluation service, first hour	* 96130 TM	96130 TM AH	N/A	N/A	N/A
Psych testing evaluation service, each additional hour	*96131 TM	96131 TM AH	N/A	N/A	N/A
Test admin and scoring by professional, first 30 min	*96136 TM	96136 TM AH	N/A	N/A	N/A

Test admin and scoring by professional, each additional 30 min	*96137 TM	96137 TM AH	N/A	N/A	N/A
Single automated test with automated result	*96146 TM	96146 TM AH	N/A	N/A	N/A
Assessment of aphasia	* 96105 TM	96105 TM AH	N/A	N/A	N/A
Developmental testing, first hour	* 96112 TM	96112 TM AH	N/A	N/A	N/A
Developmental testing, each additional 30 min	*96113 TM	96113 TM AH	N/A	N/A	N/A
Neurobehavior status exam, first hour	* 96116 TM	96116 TM AH	N/A	N/A	N/A
Neurobehavior status exam, each additional hour	*96121	96121 TM AH	N/A	N/A	N/A

* These procedure codes cannot be performed by P-APRN.

ABA Service	Psychologist or Behavior Analyst	Assistant Behavior Analyst	Psychologist, Behavior Analyst or Assistant Behavior Analyst for RBT Services
Behavior identification assessment	97151 TM HO	N/A	N/A
Behavior identification-supporting assessment	97152 TM HO	97152 TM HN	97152 TM HM

Adaptive behavior treatment by protocol	97153 TM HO	97153 TM HN	97153 TM HM
Adaptive behavior treatment with protocol modification	97155 TM HO	97155 TM HN	N/A
Family adaptive behavior treatment guidance	97156 TM HO	97156 TM HN	N/A
Group adaptive behavior treatment with protocol modification	97158 TM HO	97158 TM HN	NA
Adaptive behavior treatment by protocol (2 or more techs)	0373T TM HO	N/A	N/A
Behavior identification supporting assessment (2 or more techs)	0362T TM HO	N/A	N/A

1.13 Time-Based Service Limitations

The provider must choose the code that most accurately describes the service provided.

Psychotherapy times, as defined in the CPT®, are for face-to-face services with patient and/or family member. The patient must be present for all or a majority of the service. In reporting, choose the code closest to the actual time (e.g., 16-37 minutes for 90832, 38-52 minutes for 90834, 53 or more minutes for 90837). Do not report psychotherapy of less than 16 minutes duration. Additional information about time-based limitations is noted throughout this manual in relation to specific procedures.

Travel time is not reimbursed and must not be included as part of the scheduled appointment time.

1.14 Postpayment Review

All services reimbursed through the MHD Behavioral Health Services Program are subject to post payment reviews to monitor compliance with established policies and procedures pursuant to Title 42 CFR 456.1 through 456.23. Non-compliance may result in recoupment according to State Regulation [**13 CSR 70-3.030\(5\)**](#) and the provider may be subjected to prepayment review on all MHD claims. Continued non-compliance may result in termination of the provider enrollment agreement.

1.15 Prepayment Review Process

Services that are on prepayment review must be billed on a paper claim [**form**](#) (CMS-1500 or the approved claim form at the time of submission). The required documentation must be attached. For psychotherapy services, the current diagnostic assessment, treatment plan, and relevant

progress note(s) must be attached to the claim form for review to determine if the services were medically necessary and billed correctly. For ABA services, the current ABA assessment for intervention planning, intervention plan, and relevant progress note(s) must be attached to the claim form for review. For the required elements of a Diagnostic Assessment, Treatment Plan, and Progress Note, refer to [Section 1.3](#) in this manual.

1.16 Applied Behavior Analysis Services

To be eligible for ABA services, participants must be under 21 and have a diagnostic evaluation performed by a licensed physician or licensed psychologist, resulting in a diagnosis of ASD, and recommending ABA services as medically necessary. In the Healthy Children and Youth (HCY)_Program, ABA is also covered for participants under 21 with other diagnoses if medically necessary. The diagnostic evaluation should be performed in accordance with [Autism Spectrum Disorders: Missouri Best Practice Guidelines for Screening, Diagnosis, and Assessment](#), published by the Missouri Autism Guidelines Initiative. Refer to the [HCY Provider Manual](#) for more information.

Participants enrolled in a MO HealthNet Managed Care Health Plan will receive ABA services on a FFS basis, outside of the MHD Managed Care Health Plan benefit package.

Applied Behavior Analysis Eligible Providers

The following providers are eligible to provide ABA services:

- Licensed psychologists with education and experience in ABA
- Licensed and provisional licensed behavior analysts
- Licensed and provisional licensed assistant behavior analysts
- Behavior technicians
- RBTs™

MHD will reimburse psychologists for ABA services only if they have been approved for the ABA specialty. MHD enrolled psychologists who have ABA in their scope of education, training, and competence may submit documentation of their credentials for consideration.

This documentation may be submitted as a provider update via fax to the MMAC Provider Enrollment Unit at (573) 634-3105. Providers should include the provider's NPI, the name of a contact person, an email address, and a phone number with the required documentation. If not already enrolled, psychologists may submit supporting documentation and request approval for the ABA specialty at the time of enrollment. Psychologists will be notified by email whether they have been approved for the ABA specialty.

Behavior technicians are paraprofessionals who practice under the supervision of a licensed ABA practitioner. Behavior technicians must:

1. Be at least 18 years of age.
2. Possess a minimum of a high school diploma or national equivalent.
3. Have completed forty (40) hours of Registered Behavior Technician (RBT™) training and passed the RBT™ initial competency assessment.

Behavior technicians may render services to MO HealthNet eligible participants for up to 90 calendar days from the date they passed the RBT™ initial competency assessment. Behavior technicians must pass the national RBT™ exam by the end of the 90-day grace period and be credentialed by the Behavior Analyst Certification Board as an RBT™ to continue rendering ABA services.

For behavior technicians and RBTs™, the supervisory relationship with a licensed ABA practitioner must be documented in writing, and the licensed supervisor is responsible for the work performed by unlicensed individuals, including reviewing and signing documentation for services provided by the behavior technicians and RBTs™ they supervise. Services provided by a behavior technician or RBT™ must be billed by the licensed supervisor using the codes and modifiers specified in the following table. Behavior technicians and RBTs™ are not allowed to enroll as MHD providers.

MHD recommends group practices to enroll as an Autism Clinic (Provider Type 50–Clinic/Group) with specialty AC if they have at least two (2) licensed behavior analysts. This allows precertification under the clinic number so that other performing providers within the clinic can provide services if needed for continuity of care.

Applied Behavior Analysis Procedure Codes by Provider Specialty

The following table includes procedure codes and modifiers billable for services performed by behavior analysts, assistant behavior analysts, and psychologists. The table also includes procedure codes and modifiers for services provided by behavior technicians or RBTs™ under the supervision of behavior analysts, assistant behavior analysts, or psychologists. The HM modifier must be used to indicate services provided by a behavior technician or RBT™. In addition, the licensed supervisor must use the appropriate modifier for their specialty (e.g., HO for Behavior Analyst or Psychologist; HN for Assistant Behavior Analyst). Do not use the U8 modifier when billing for behavior technician or RBT™ services. Psychologists should not use the AH modifier with these codes.

Services may be provided in POS 11 (office), 12 (home), 03 (school) or 99 (other). The U8 modifier should be used for services billed with a POS 12 (home) or 99 (other). Psychologists should not use the AH modifier with these codes.

CPT® Code	CPT® Code Description	Behavior Analyst/ Psychologist	Assistant Behavior Analyst	Behavior Analyst, Assistant Behavior Analyst, Psychologist for Registered Behavior Technician™ (RBT) Services	Precert Req'
97151	Behavior identification assessment, each 15 min	97151 HO	N/A	N/A	Yes
97151	Behavior identification assessment, each 15 min (in home)	97151 U8HO	N/A	N/A	Yes
97152	Behavior identification – supporting assessment, each 15 min	97152 HO	97152 HN	97152 HM and (HO or HN)	Yes
97152	Behavior identification – supporting assessment, each 15 min (in home)	97152 U8HO	97152 U8HN	97152 HM and (HO or HN)	Yes
0362T	Behavior identification – supporting assessment admin by professional with two (2) or more techs, each 15 min	0362T HO	N/A	N/A	Yes

0362T	Behavior identification – supporting assessment admin by professional with two (2) or more techs, each 15 min (in home)	0362T U8HO	N/A	N/A	Yes
97153	Adaptive behavior treatment by protocol administered by technician, each 15 min	97153 HO	97153 HN	97153 HM and (HO or HN)	Yes
97153	Adaptive behavior treatment by protocol administered by technician, each 15 min (in home)	97153 U8HO	97153 U8HN	97153 HM and (HO or HN)	Yes
97155	Adaptive behavior treatment with protocol modification administered by physician or other qualified healthcare professional, each 15 min	97155 HO	97155 HN	N/A	Yes
97155	Adaptive behavior treatment with protocol modification administered by physician or other qualified healthcare professional, each 15 min (in home)	97155 U8HO	97155 U8HN	N/A	Yes
97156	Family adaptive behavior treatment	97156 HO	97156 HN	N/A	Yes

	guidance, each 15 min				
97156	Family adaptive behavior treatment guidance, each 15 min (in home)	97156 U8HO	97156 U8HN	N/A	Yes
97158	Group adaptive behavior treatment with protocol modification, each 15 min	97158 HO	97158 HN	N/A	Yes
0373T	Adaptive behavior treatment with protocol modification admin by professional with two (2) or more techs, each 15 min	0373T HO	N/A	N/A	Yes
0373T	Adaptive behavior treatment with protocol modification admin by professional with two (2) or more techs, each 15 min (in home)	0373T U8HO	N/A	N/A	Yes

Precertification of ABA Services

All ABA services (except for school-based ABA services included in an IEP) require precertification. When requesting precertification of ABA services, fax the completed [**Request for Applied Behavior Analysis \(ABA\) Precertification**](#) form and required documentation to the Behavioral Health Services help desk at (573) 635-6516. The following table lists the additional documentation required according to the service for which precertification is being requested.

Precertification Being Requested	Required Documentation
ABA Assessment for Intervention Planning (Initial)	Diagnostic Evaluation
ABA Assessment for Intervention Planning (periodic re-assessment)	Clinical Rationale (e.g., re-administration of tools, new behavior observed, new environment and participant is responding differently, or lack of adequate progress)
ABA Intervention (initial)	Assessment for Intervention Planning, Intervention Plan
ABA Intervention (continued)	Current Intervention Plan, Progress, Data/Graphs (If progress is not evident, include identification of barriers and strategies to improve effectiveness of interventions.)

ABA intervention may be precertified for a period of up to six (6) months from the start date. If continued services are needed beyond the six (6) month period, additional precertification is required. Providers will receive a faxed response indicating the number of hours allowed, as well as precertification start and end dates.

Documentation Requirements

All services provided must be adequately documented in the medical record. The obligation to document services and to release records to representatives of DSS or the U.S. Department of Health and Human Services is required by the following documents:

- Missouri regulation ([**13 CSR 70-3.030**](#))
- The Title XIX Provider Participation Agreement, which is signed by all providers upon enrollment as a MO HealthNet provider

Refer to [**Section 1.3**](#) in this manual for the definitions of adequate documentation and adequate medical records.

1.17 Healthy Children and Youth Services

Missouri's Early Periodic Screening, Diagnostic and Treatment (EPSDT) program is called the Healthy Children and Youth (HCY) Program. Behavioral health services are covered when the need for treatment is a result of a complete, partial, or interperiodic HCY screening and the service is medically necessary. Refer to the [HCY Provider Manual](#) for additional information.

Partial Healthy Children and Youth Screens

Partial HCY screens for developmental mental health assessment may be performed by a Psychiatrist, P-APRN, Psychologist, PLP, LCSW, LMSW, LPC, PLPC, LMFT, or PLMFT.

A developmental mental health assessment includes the following assessments:

- Personal, social and language development
- Fine and gross motor skill development
- Emotional and psychological status

Age appropriate guides can be found in the [HCY Provider Manual](#).

The diagnosis code of one of the following: Z00110, Z00111, Z00121 or Z00129 must appear as the primary diagnosis in Field 23A on the [CMS-1500 claim form](#) when billing for HCY developmental screening service.

Developmental partial screens (99429 59 and 99429 59 UC) are covered for children under the age of 21. It is the provider's responsibility to encourage the child/youth to have an HCY examination to facilitate total health care that establishes the need for the treatment services.

Healthy Children and Youth Partial Screen for Developmental Assessment

Proc Code	Description
99429 59	Developmental/mental health partial screen
99429 59 UC	Developmental/mental health partial screen with referral

Partial Screeners

The provider of a partial medical screen should have a patient referral source for the remaining required components of the screen. Examples of partial screeners may include but are not limited to:

- Public Health Departments
- Early Childhood Programs
- School Districts

1.18 Transcranial Magnetic Stimulation

TMS is a noninvasive method of brain stimulation. The technique involves placement of a small coil over the scalp and passing a rapidly alternating current through the coil wire, which produces a magnetic field that passes unimpeded through the brain. Depending on stimulation parameters (frequency, intensity, pulse duration, and stimulation site), repetitive TMS to specific cortical regions can either increase or decrease the excitability of the affected brain structures. Providers typically perform TMS on an outpatient basis, and it does not require anesthesia or analgesia. When used as an antidepressant therapy, TMS produces a clinical benefit without the systemic side effects that may be associated with oral medications. TMS does not produce adverse effects on cognition. Unlike ECT, TMS does not induce amnesia or seizures. For more information, refer to [CMS: Local Coverage Determination TMS L34641](#).

Participant Eligibility for TMS

Below are the participant eligibility criteria for TMS:

1. Participant must be at least 15 years of age (For participants ages 15-18, a device cleared by the U.S. Food and Drug Administration (FDA) for this age group must be utilized.)
2. Have a confirmed diagnosis of major depressive disorder (MDD), severe (either recurrent or single episode), per Diagnostic and Statistical Manual Fifth Edition, Text Revision (DSM-5-TR) criteria

ICD-10 - CM Code	Description
F32.2	Major depressive disorder, single episode, severe without psychotic features
F33.2	Major depressive disorder, recurrent, severe without psychotic features

AND

3. One (1) or more of the following:
 - Resistance to treatment with psychopharmacologic agents as evidenced by a lack of clinically significant response to one (1) trial of psychopharmacologic agents in the current depressive episode from at least two (2) different agent classes. Each agent in the treatment trial must have been administered at an adequate course of mono- or poly-drug therapy
 - Inability to tolerate psychopharmacologic agents as evidenced by two (2) trials of psychopharmacologic agents from at least two (2) different agent classes, with distinct side effects

- History of good response to TMS in a previous depressive episode as evidenced by a greater than 50% improvement in a standardized rating scale for depressive symptoms
- Is a candidate for and has declined ECT, and TMS is considered a less invasive treatment option

AND

4. A prior trial (recent or by history) of an evidence-based psychotherapy known to be effective in the treatment of MDD (e.g., cognitive-behavioral therapy; interpersonal therapy) of an adequate frequency and duration without significant improvement in depressive symptoms as documented by a standardized rating scale for depressive symptoms

Provider Qualifications for Transcranial Magnetic Stimulation

A provider must meet both the following criteria in order to provide TMS:

1. An MHD enrolled psychiatrist or P-APRN who has examined the participant and reviewed the record must write the order for treatment. The psychiatrist or P-APRN must have experience in administering TMS therapy. The P-APRN must directly supervise the treatment (must be present in area but does not necessarily personally provide the treatment). Community Mental Health Centers (CMHCs, identified with provider type 56) may utilize a physician with experience administering TMS to order and directly supervise TMS treatment (must be present in area but does not necessarily personally provide the treatment).
2. Provider must administer TMS with a FDA cleared device for the treatment of MDD in a safe and effective manner according to the manufacturer's user manual and specified stimulation parameters. For participants between the ages of 15 and 18, a device cleared by the FDA for this age group must be utilized.

Exclusions for Transcranial Magnetic Stimulation

1. None of the following conditions or contraindications to TMS are present:
 - Seizure disorder or any history of seizures (except those induced by ECT or isolated febrile seizures in infancy without subsequent treatment or recurrence); or
 - Presence of acute or chronic psychotic symptoms or disorders (such as schizophrenia, schizophreniform or schizoaffective disorder) in the current depressive episode; or
 - Neurological conditions that include epilepsy, cerebrovascular disease, dementia, increased intracranial pressure, history of repetitive or severe head trauma, or primary or secondary tumors in the central nervous system, or
 - Presence of an implanted magnetic-sensitive medical device located less than or equal to 30 cm from the TMS magnetic coil or other implanted metal

items including, but not limited to a cochlear implant, implanted cardiac defibrillator (ICD), pacemaker, Vagus nerve stimulator (VNS), or metal aneurysm clips or coils, staples, or stents. (Dental amalgam fillings are not affected by the magnetic field and are acceptable for use with TMS).

2. TMS is not indicated for maintenance treatment. There is insufficient evidence in the published peer reviewed literature to support the efficacy of maintenance therapy with TMS.

Transcranial Magnetic Stimulation Procedure Codes and Limitations

TMS services are limited to one (1) per day, consistent with Medicaid National Correct Coding Initiative (NCCI) procedure to procedure edits.

CPT® Code	Description	Max Qty
90867	Therapeutic repetitive TMS treatment; initial, including cortical mapping, motor threshold determination, delivery and management (report only once per course of treatment)	One (1)
90868	Therapeutic repetitive TMS treatment; subsequent delivery and management, per session	One (1)
90869	Therapeutic repetitive TMS treatment; subsequent motor threshold re-determination with delivery and management	One (1)

MHD limits TMS services to 23 per month, 36 per rolling year. Providers must bill their usual and customary rate. MHD will reimburse the lesser of the billed amount or the maximum allowable amount.

Retreatment may be considered for participants who met the guidelines for initial TMS treatment and subsequently develop relapse of depressive symptoms if the patient responded to prior TMS treatments as evidenced by a greater than 50% improvement in a standardized rating scale for depression. Standardized rating scales that reliably measure depressive symptoms include but are not limited to the following:

- Patient Health Questionnaire-9 (PHQ-9)
- Beck Depression Inventory (BDI)
- Hamilton Depression Rating Scale (HAM-D)
- Montgomery Asberg Depression Rating Scale (MADRS)
- Quick Inventory of Depressive Symptomatology (QIDS)

- Inventory for Depressive Symptomatology Systems Review (IDS-SR)

1.19 Screening for Depression and Follow-Up

MHD accepts the following codes for depression screening for participants ages 12 and older.

HCPCS Code	Description	Max Allowable Amount
G8431	Screening for Depression is documented as being positive and follow-up plan is documented	\$13.55
G8510	Screening for Depression is documented as being negative, a follow-up plan is not required	\$13.55

MHD limits screening to one (1) unit per calendar year. Providers may add the TH modifier for pregnant or postpartum participants to increase the limit to four (4) screenings per year. Depression screening may be provided via telemedicine or in person.

The following qualifying professionals may bill for this service:

- Physician
- Physician Assistant
- APRN
- Pharmacist

Additional information can be found in the [Physician Provider Manual](#).

1.20 Noncovered Services

Services that are performed to treat individuals over 21 associated with a HCY child are not covered except for maternal depression screening which may be billed under the child's DCN using procedure code 96161 when the participant's mother is screened for depression during a well child visit. If it is determined that the parent/guardian or other individual is in need of service, the appropriate referral should be made.

MO HealthNet does not cover psychotherapy services provided by someone other than the enrolled provider, except for doctoral psychology interns under the supervision of a psychologist (see [Section 1.2](#) in this manual) or psychiatry residents under the supervision of a teaching psychiatrist (see the [Physician Provider Manual](#)). Psychological testing is not covered in POS 31 (Skilled Nursing Facility) or 32 (Nursing Facility).

The following services, among others, are not covered under the Behavioral Health Services Program:

- Biofeedback therapy

- Auditory Therapy

Non-covered services may be billed to the patient.

Non-Allowed Services

The following services are non-allowed under the Behavioral Health Services Program and may not be billed to a Medicaid patient:

- Courtesy calls such as patient drop in visits to give a progress report that was not scheduled, and therapy services were not rendered
- Missed appointments or failure to show
- Additional payment is not made for services that are performed after regularly scheduled office hours, on holidays, or on weekends
- Participation in IEP or Individualized Family Service Plan (IFSP) meeting
- Court appearances
- Mental health services that are performed to treat the parent of an MHD eligible child who is not in a Managed Care Health Plan are not covered on a FFS basis. If it is determined that the parent/guardian needs mental health services, the appropriate referral must be made.
- Testing when performed by a P-APRN, LCSW, LMSW, LPC, PLPC, LMFT, or PLMFT
- Add-on therapy and interactive codes (procedure codes: 90833, 90836, 90785, and 90840)
- Add-on psychotherapy code for E&M service (procedure code: 90838)
- Services that require precertification, but were performed without precertification
- Travel time is not reimbursed and must not be included as part of the scheduled appointment time

1.21 Telemedicine Services

Telemedicine services are health care services provided through information and communication technologies which facilitate the assessment, diagnosis, consultation, treatment, education care management, and self-management of a patient's health care while such patient is at the originating site and the health care provider is at the distant site. Telemedicine offers participants, particularly those in rural areas of the state, access to health care services without having to travel extensive miles for an appointment.

Refer to the [General Sections Manual](#) for out-of-state, non-emergency services.

Covered Services

Services provided through telemedicine must meet the standard of care that would otherwise be expected should such services be provided in person.

Prior to the delivery of telemedicine services in a school, the parent or guardian of the child shall provide authorization for such service. The authorization shall include the ability for the parent or guardian to authorize services via telemedicine in the school for the remainder of the school year.

Eligible Providers

Any licensed health care provider may provide telemedicine services if such services are within the scope of practice for which the health care provider is licensed and are provided with the same standard of care as services provided in person. Additionally, a health care entity may reimburse nonclinical staff for services otherwise allowed by law. This includes applied behavior analysis services rendered by a behavior technician or RBT™ under the supervision of a licensed behavior analyst or licensed psychologist or any individual provider delivering services within a Department of Mental Health (DMH) licensed, contracted, and/or certified organization ([13 CSR 70-3.330\(2\)\(A\)](#)).

To be reimbursed for telemedicine services, health care providers treating patients in this state via telemedicine must be fully licensed to practice in this state and be enrolled as a MO HealthNet provider prior to rendering services.

Reimbursement

Reimbursement to the health care provider delivering the medical service at the distant site is equal to the current [Fee Schedule](#) amount for the service provided. Use the appropriate CPT® code for the service along with POS 02 (telemedicine not in home) or POS 10 (telemedicine in home).

When a provider is utilizing telemedicine to deliver behavioral health services that require prior authorization to a FFS participant located in a residential or inpatient POS (POS codes: 14, 21, 33, 51, 55, 56 or 61), then the provider must bill with the GT modifier and with the place of service where the participant is physically located. In these instances, providers must not bill with POS 02.

Distant site services provided on school grounds should be billed with POS 03 and a GT modifier.

The originating site is only eligible to receive a facility fee for the telemedicine service. Claims should be submitted with HCPCS code Q3014 (telemedicine originating site facility fee). Procedure code Q3014 is used by the originating site to receive reimbursement for the use of the facility while telemedicine services are being rendered.

Precertification and Utilization Review

All services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, before payment is made, or after payment is made.

Certain procedures or services can require precertification from MHD or its authorized agents. Services for which a precertification was obtained remain subject to utilization review at any point in the payment process. A service provided through telemedicine is subject to the same precertification and utilization review requirements which exist for the service when not provided through telemedicine.

Documentation for the Encounter

A health care provider is required to keep a complete medical record of a telemedicine service provided to a participant and follow applicable state and federal statutes and regulations for medical record keeping and confidentiality in accordance with [13 CSR 70-3.020](#) and [13 CSR 70-98.015](#).

1.22 Modifiers

Claims must be submitted using the appropriate modifier(s). The specialty modifier is always required.

Provider	Modifier
LCSW	AJ
LMFT	HE
LMSW	AJ
LPC	UD
PLMFT	HE
PLP	AH
PLPC	UD
P-APRN*	SA
Psychologists**	AH
Psychological Intern	HL AH

*Not needed for E&M or TMS services

**Do not use AH modifier with ABA codes

The following modifiers are required when appropriate. The appropriate NCCI modifier should be used when appropriate.

Modifier	Description
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U8	POS: in home (12). Not appropriate when billing 90849 or 90853, regardless of POS.
CR	Catastrophe/Disaster Related. The CR modifier is used to track services provided to patients identified as a catastrophe/disaster victims in any part of the country. This modifier is used in addition to any other required modifiers. There is no additional reimbursement associated with the use of this modifier.
TM	Used when billing School Based IEP Behavioral Health services

1.23 Frequently Used Place of Service Codes

POS	Description
02	Telehealth Provided Other Than In Patient's Home
03	School
04	Homeless Shelter
10	Telehealth Provided in Patient's Home
11	Office
12	Home
14	Group Home
15	Mobile Unit
21	Inpatient Hospital
22	Outpatient Hospital
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
50	FQHC
51	Inpatient Psychiatric Facility
55	Residential Substance Use Disorder Treatment Facility
56	Psychiatric Residential Treatment Facility

61	Comprehensive Inpatient Rehabilitation Facility
72	Rural Health Clinic
99	Other Place of Service

Refer to [Section 3.3](#) in this manual for a list of all POS codes and descriptions.

Place of Service Code

Services provided in a school setting must be billed with POS 03.

POS 99 can only be used for therapy provided in a public setting when the privacy of the therapy services can be safeguarded, such as in a private space at a community location. For example, a private room at a public library or health department. Providers must use the appropriate POS code for the setting in which services are rendered. If POS 99 is used, an explanation as to where the service actually took place must be included in the notes. If there is no POS code that matches the setting, services may not be billed to MHD.

The Centers for Medicare & Medicaid Services (CMS) define a mobile unit as a facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services. When providers deliver services in a mobile unit, it may be at a location for which another POS code exists. For example, a mobile unit may go to a school to deliver services. If the mobile unit is serving an entity for which another POS code already exists, providers should use the POS code for that entity, for example POS 03 for school. However, if the mobile unit is not serving an entity that has an existing POS code, the providers are to use POS 15 (mobile unit).

POS 11 (office) may be used for settings such as a Head Start. CMS defines an office as a location where the health professional routinely provides services.

POS 04 (homeless shelter) should be used when services are provided in a setting such as a crisis center or Salvation Army housing. The CMS definition of a homeless shelter is a facility or location that provides temporary housing.

Services provided to children who reside in a Residential Treatment Center and who are under the care and custody of the DSS Children's Division (CD) must use POS code 33 (custodial care facility) when the services are provided at the Residential Treatment Center.

Group therapy services are not covered in POS 12 (home).

When providing therapy to a group of children in a group home, group therapy (90853) is billed with POS 14 (group home). Documentation must show the reason for providing services in the home.

Refer to [Section 3.3](#) in this manual for a list of all POS codes and descriptions.

1.24 Referral Services

MHD covers behavioral health services for patients without regard to age when medically necessary.

Medically necessary behavioral health services are also available through DMH's Comprehensive Substance Treatment and Rehabilitation (CSTAR) Program, Community Psychiatric Rehabilitation (CPR) Program, or in an FQHC/RHC setting; however, these services are available under specific guidelines.

Third Party Liability Insurance Reporting Form

Many providers have requested the capability to report changes in insurance coverage directly to MHD when they learn new information from the patient or the insurance company. In the past, changes were to be reported to the patient's caseworker. The [Third Party Resource](#) form has been developed for providers to report changes or additions to a patient's insurance records.

Refer to Third Party Liability in the [General Sections Manual](#) for additional information.

1.25 Managed Care Behavioral Health Services

MHD Managed Care Health Plans provide behavioral health services for adults, children, and youth. ABA services for children and youth (under age 21) are provided to Managed Care Health Plan members on a FFS basis outside of the health plan. Refer to the [General Sections Manual](#) for further information about the MO HealthNet Managed Care Health Plan Program.

1.26 Reporting Child Abuse Cases

[RSMo 210.115](#) requires hospitals and other specified personnel to report possible child abuse cases to the Missouri Child Abuse and Neglect Hotline, (800) 392-3738, which accepts confidential reports of suspected child abuse, neglect, or exploitation. Reports are received through a toll-free telephone line which is answered seven (7) days a week, 24 hours a day. Members of certain occupational groups, such as psychologists, mental health professionals, teachers, social workers, and physicians, are mandated by law to make reports to the hotline. Any person may report, and anonymous reports are accepted from individuals who are not mandated by occupation to report. Missouri law requires mandated reporters to identify themselves when making a report.

If you are hearing or speech impaired, contact Relay Missouri at (800) 735-2466 (voice) or (800) 735-2966 (text).

Section 2 - Reimbursement Methodology

2.1 Behavioral Health Services

Reimbursement for behavioral health services is made on a Fee-For-Service (FFS) basis. The maximum allowable fee for a unit of service has been determined by MHD to be a reasonable fee, consistent with efficiency, economy, and quality of care. Payment for covered services is the lower of the provider's actual billed charge (should be the provider's usual and customary charge to the general public for the service), or the maximum allowable per unit of service. Refer to the [MO HealthNet Fee Schedule](#) more information. Refer to the [General Sections Manual](#) for additional information about reimbursement.

Section 3 - Billing Instructions

3.1 CMS-1500 Claim Filing Instructions

The **CMS-1500 claim form** is always used to bill MHD for all behavioral health services, unless a provider bills those services electronically. Instructions on how to complete the **CMS-1500 claim form** are on the following pages.

The CMS-1500 claim form is embedded in **eMOMED**. If submitting paper claims, type or print legibly. The form may be duplicated if the copy is legible. MHD claims should be mailed to:

Wipro Infocrossing
P.O. Box 5600
Jefferson City, MO 65102

NOTE: An asterisk (*) beside the field number indicates required fields. These fields must be completed, or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicate the field is required in specific situations.

Field Number	Field Name	Instruction for Completion
1	Type of Health Insurance Coverage	Show the type of health insurance coverage applicable to this claim by checking the appropriate box, e.g., if a Medicare claim is being filed, check the Medicare box, if a MHD claim is being filed, check the Medicaid box and if the participant has both Medicare and MO HealthNet, check both boxes
1a*	Insured's I.D.	Enter the patient's 8-digit MO HealthNet or MO HealthNet Managed Care ID number (DCN) as shown on the participant's ID card
2*	Patient's Name	Enter last name, first name, middle initial in that order as it appears on the ID card
3	Patient's Birth Date	Enter month, day, and year of birth
	Sex	Mark appropriate box
4**	Insured's Name	If there is individual or group insurance besides MO HealthNet, enter the name of primary policyholder. If this field is completed, also complete Fields 6, 7, 11 and 13.

5	Patient's Address	Enter address and telephone number if available
6**	Patient's Relationship to Insured	Mark appropriate box if there is other insurance. If no private insurance is involved, leave blank.
7**	Insured's Address	Enter the primary policy holder's address; enter policy holder's telephone number, if available. If no private insurance is involved, leave blank.
8	Patient Status	Not required
9**	Other Insured's Name	If there is other insurance coverage in addition to the primary policy, enter the secondary policyholder's name If no private insurance is involved, leave blank. This field is for private insurance information only. If no private insurance is involved leave blank. If Medicare, MO HealthNet, employers name or other information appears in this field, the claim will deny. See the General Sections Manual for further TPL information.
9a**	Other Insured's Group Number	Enter the secondary policyholder's insurance policy number or group number if the insurance is through a group such as an employer, union, etc. If no private insurance is involved, leave blank. This field is for private insurance information only. If no private insurance is involved leave blank. If Medicare, MO HealthNet, employers name or other information appears in this field, the claim will deny. See the General Sections Manual for further TPL information.

9b**	Other Insured's Date of Birth	Enter the secondary policyholder's date of birth and mark the appropriate box for sex. If no private insurance is involved, leave blank. This field is for private insurance information only. If no private insurance is involved leave blank. If Medicare, MO HealthNet, employers name or other information appears in this field, the claim will deny. See the General Sections Manual for further TPL information.
9c**	Employer's Name	Enter the secondary policyholder's employer name. If no private insurance is involved, leave blank. This field is for private insurance information only. If no private insurance is involved leave blank. If Medicare, MO HealthNet, employers name or other information appears in this field, the claim will deny. See the General Sections Manual for further TPL information.
9d**	Insurance Plan Name or Program Name	Enter the secondary policyholder's insurance plan name If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan. This field is for private insurance information only. If no private insurance is involved leave blank. If Medicare, MO HealthNet, employers name or other information appears in this field, the claim will deny. See the General Sections Manual for further TPL information.
10a-10c**	Is Patient's Condition Related to:	If services on the claim are related to participant's employment, auto accident or other accident, mark the appropriate box. If the services are not related to an accident, leave blank. This field is for private insurance information only. If no private insurance is involved leave blank. If Medicare, MO HealthNet, employers name or other information appears in this field, the claim will deny. See the General Sections Manual for further TPL information.

10d	Reserved for local use.	May be used for comments/descriptions. This field is for private insurance information only. If no private insurance is involved leave blank. If Medicare, MO HealthNet, employers name or other information appears in this field, the claim will deny. See the General Sections Manual for further TPL information.
11**	Insured's Policy or FECA Number	Enter the primary policyholder's insurance policy number or group number, if the insurance is through a group such as, an employer, union, etc. If no private insurance is involved, leave blank. This field is for private insurance information only. If no private insurance is involved leave blank. If Medicare, MO HealthNet, employers name or other information appears in this field, the claim will deny. See the General Sections Manual for further TPL information.
11a**	Insured's Date of Birth	Enter primary policyholder's date of birth and mark the appropriate box reflecting the sex of the primary policy holder. This field is for private insurance information only. If no private insurance is involved leave blank. If Medicare, MO HealthNet, employers name or other information appears in this field, the claim will deny. See the General Sections Manual for further TPL information.
11b**	Employer's Name	Enter the primary policyholder's employer name. This field is for private insurance information only. If no private insurance is involved leave blank. If Medicare, MO HealthNet, employers name or other information appears in this field, the claim will deny. See the General Sections Manual for further TPL information.

11c**	Insurance Plan Name	Enter the primary policyholder's insurance plan name. If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan. This field is for private insurance information only. If no private insurance is involved leave blank. If Medicare, MO HealthNet, employers name or other information appears in this field, the claim will deny. See the General Sections Manual for further TPL information.
11d**	Other Health Plan	Indicate whether the participant has another health insurance plan; if so, complete Fields 9-9d with the secondary insurance information. This field is for private insurance information only. If no private insurance is involved leave blank. If Medicare, MO HealthNet, employers name or other information appears in this field, the claim will deny. See the General Sections Manual for further TPL information.
12	Patient's Signature	Leave Blank
13	Insured's Signature	This field should only be completed when the participant has another health insurance policy. Obtain the policyholder's or authorized person's signature for assignment of benefits. The signature is necessary to ensure the insurance plan pays any benefits directly to the provider or MO HealthNet. Otherwise, payment may be issued to the policyholder requiring the provider to collect insurance benefits from the policyholder.
14	Date of Current Illness, Injury or Pregnancy	Leave blank
15	Date Same/Similar Illness	Leave blank
16	Dates Patient Unable to Work	Leave blank

17*	Name of Referring Physician or Other Source	Enter the name of the referring MO HealthNet enrolled primary care provider
17a*	Other ID	Enter the Provider Taxonomy qualifier ZZ in the first shaded area if the provider reported in 17b is required to report a Provider Taxonomy Code to MHD. Enter the corresponding 10-digit Provider Taxonomy Code in the second shaded area for the provider reported in 17b.
17b*	NPI	Enter the NPI number of the referring or ordering provider
18**	Hospitalization Dates	Leave blank
19	Reserved for Local Use	Providers may use this field for additional remarks/descriptions
20	Lab Work Performed Outside Office	Leave blank
21*	Diagnosis	Enter the complete International Classification of Diseases (ICD), current edition, diagnosis code(s). Enter the primary diagnosis under No. 1, the secondary diagnosis under No. 2, etc.
22	Medicaid Resubmission	Leave blank
24a*	Date of Service	Enter the date of service under “from” in month/day/year format, using six (6)-digit format in the unshaded area of the field. All line items must have a “from” date. Multiple dates of service cannot be billed on a single line of the claim form. Each date of service must be shown on a separate line of the claim form with no more than six (6) lines per claim form.
24b*	Place of Service	Enter the appropriate place of service (POS) code in the unshaded area of the claim. Reference Section 3.3 in this manual for Program Specific Place of Service Codes.
24c	EMG - Emergency	Leave blank

24d*	Procedure Code	Enter the appropriate procedure code and applicable modifiers, if any, corresponding to the service rendered in the unshaded area of this field
24e*	Diagnosis Code or Pointer	Enter 1, 2, 3, 4 or the actual diagnosis code(s) from Field 21 in the unshaded area of this field
24f*	Charges	Enter the provider's usual and customary charge for each line item in the unshaded area of this field. This should be the total charge when there are multiple units entered for a line item.
24g*	Days or Units	Enter the number of units of service provided for each detail line in the unshaded area of this field. The system automatically plugs a "1," if the field is left blank.
24h	EPSDT/HCY/Family Planning	If this service is a Healthy Children and Youth (HCY) screening or referral, enter an "E" in the unshaded area of this field
24i**	ID Qualifier	Enter the Provider Taxonomy qualifier ZZ in the shaded area if the rendering/performing provider is required to report a Provider Taxonomy Code to MHD
24j**	Rendering Provider ID #	If the provider Taxonomy qualifier was reported in 24i, enter the 10-digit Provider Taxonomy Code in the shaded area. Enter the 10-digit NPI number of the individual rendering/performing the service in the unshaded area. This field is only required if the billing provider is a clinic, FQHC, teaching institution, or a group practice.
25	SS#/Fed. Tax ID	Leave blank
26	Patient Account Number	For the provider's own information, a maximum of 12 alpha and/or numeric characters may be listed here
27	Assignment	Not required on MHD only claims
28*	Total Charge	Enter the sum of the line item charges
29	Amount Paid	Enter the total amount received by all other insurance resources. Previous MHD payments, Medicare payments, cost sharing and copay amounts are not to be entered in this field

30	Balance Due	Enter the difference between the total charge (Field 28) and the amount paid (Field 29)
31	Provider Signature	Not required
32**	Name and Address of Service Facility	If services were rendered in a facility other than the home or office, enter the name and location of the facility. This field is required if other than home or office.
32a**	NPI Number	Enter the 10-digit NPI number of the service facility location in Field 32
32b**	Other ID Number	Enter the Provider Taxonomy qualifier ZZ and the corresponding 10-digit Provider Taxonomy Code for the NPI number reported in 32a if the provider is required to report a Provider Taxonomy Code to MHD. Do not enter a space, hyphen or other separator between the qualifier and the number. A Provider Taxonomy Code must be reported if the provider has a one to many provider NPI.
33*	Billing Provider Info & Phone #	Enter the provider's name, address, and phone number
33a*	NPI Number	Enter the NPI number of the Billing Provider listed in field 33
33b**	Other ID#	Enter the Provider Taxonomy qualifier ZZ and the corresponding 10-digit Provider Taxonomy Code for the NPI number reported in 33a if the provider is required to report a Provider Taxonomy Code to MHD. Do not enter a space, hyphen or other separator between the qualifier and the number. A provider taxonomy code must be reported if the provider has a one to many provider NPI.

3.2 Billing Procedures for Medicare/MO HealthNet Claims

When a patient has both Medicare Part B and MO HealthNet coverage, a claim must be filed with Medicare first as the primary payer. If the patient has Medicare Part B but the service is not covered or the limits of coverage have been reached previously, an electronic claim must be submitted to MHD along with the Medicare Remittance Advice attached indicating the denial. Reference the [Medicare/Medicaid Claims Processing Provider Manual](#) for further information about billing Medicare/MO HealthNet claims.

If a claim was submitted to Medicare indicating that the patient also had MO HealthNet and disposition of the claim is not received from MHD within 60 days of the Medicare Remittance Advice date (a reasonable period for transmission for Medicare and MHD processing), an electronic crossover claim must be submitted to MHD. Reference the [Medicare/Medicaid Claims Processing Provider Manual](#) for further information about billing Medicare/MO HealthNet claims. MO HealthNet enrolls the following practitioners that Medicare does not cover:

- Provisional licensed professional counselors
- Provisional licensed marital and family therapists
- Provisional licensed psychologists
- Licensed master social workers

Therefore, claims for services rendered by one of the above practitioners to participants who are dual eligible (Medicare and MO HealthNet) are not required to be filed with Medicare prior to submission to MHD or to the participant's MO HealthNet Managed Care Health Plan.

3.3 Place of Service Codes and Definition

Code	Description	Definition
02	Telehealth	The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology.
03	School	A facility whose primary purpose is education (e.g., public school).
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
05	Indian Health Service Free-standing Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do <i>not</i> require hospitalization.
06	Indian Health Service Provider-based Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians or Alaska Natives admitted as inpatients or outpatients.

07	Tribal 638 Free-standing Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 Provider-based Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
10	Telehealth Provided in Patient's Home	The location where health services and health related services are provided or received, through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology. *Effective 12/22/2024
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis. Services performed in a Head Start facility may use this place of service.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	Group Home	Congregate residential facility care setting for children and adolescents in state custody that provides some social, health care, and educational support services and that promotes rehabilitation and reintegration of residents into the community.

15	Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient Hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Room-Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A free-standing facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of newborn infants.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
27	Outreach Site/Street	A non-permanent location on the street or found environment, not described by any other POS code, where health professionals provide preventive, screening, diagnostic, and/or treatment services to unsheltered homeless individuals, including via telemedicine. *Effective 12/22/2024

31	Skilled Nursing Facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial Care Facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
46	Independent Clinic	A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by and under the supervision of a physician.
52	Psychiatric Facility Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-0 based or hospital-affiliated facility.

53	Community Mental Health Center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate Care Facility/Mentally Retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.

62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
65	End Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
71	Public Health Clinic	A facility maintained by either a state or local health department that provides ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
99	Other Place of Service	Other place of service not identified above (e.g., private school).

Section 4 - Diagnosis Codes

4.1 General Information

The diagnosis code(s) is a required field on claims, and the accuracy of the code that describes the participant's condition is important.

NOTE: The MO HealthNet claims processing system, [eMOMED](#), uses International Classification of Diseases (ICD), current edition, codes only. DSM-5-TR codes must not be used and are not recognized by [eMOMED](#).

The current edition ICD diagnosis code must be entered on the claim.

4.2 Healthy Children and Youth Screening Services

When billing for Healthy Children and Youth (HCY) screening services, reference the [HCY Provider Manual](#). The diagnosis code of Z00110, Z00111, Z00121, or Z00129 must appear as the primary diagnosis code on claims.

4.3 Behavioral Health Services Codes

For precertification, the diagnosis code must be a valid ICD, current edition, diagnosis code and must be mental health or substance use disorder related. This does not include developmental disabilities. Health and Behavior Assessment/Intervention services do not require precertification, and the diagnosis code on claims should reflect the physical condition that is impacted by psychological factors.

The four (4) autism spectrum disorder (ASD) diagnosis codes that can also be precertified for Applied Behavior Analysis (ABA) services are identified below.

ICD-10 Code	Description
F840	Autistic disorder
F843	Other childhood disintegrative disorder
F845	Asperger's syndrome
F848	Other pervasive developmental disorders

The following table lists valid codes for which psychotherapy/counseling services can be precertified.

ICD-10 Code	Description
F070	Personality change due to known physiological condition
F1010	Alcohol abuse, uncomplicated
F10120	Alcohol abuse with intoxication, uncomplicated
F10129	Alcohol abuse with intoxication, unspecified
F1013	Alcohol abuse, with withdrawal
F10130	Alcohol abuse with withdrawal, uncomplicated
F10131	Alcohol abuse with withdrawal delirium
F10132	Alcohol abuse with withdrawal with perceptual disturbance
F10139	Alcohol abuse with withdrawal, unspecified
F1020	Alcohol dependence, uncomplicated
F10259	Alcohol dependence w alcohol-induced psychotic disorder, unspecified
F1093	Alcohol use, unspecified with withdrawal

F10930	Alcohol use, unspecified with withdrawal, uncomplicated
F10931	Alcohol use, unspecified with withdrawal delirium
F10932	Alcohol use, unspecified with withdrawal with perceptual disturbance
F10939	Alcohol use, unspecified with withdrawal, unspecified
F1110	Opioid abuse, uncomplicated
F11120	Opioid abuse with intoxication, uncomplicated
F11129	Opioid abuse with intoxication, unspecified
F1113	Opioid abuse with withdrawal
F1120	Opioid dependence, uncomplicated
F11220	Opioid dependence with intoxication, uncomplicated
F11221	Opioid dependence with intoxication delirium
F11222	Opioid dependence with intoxication with perceptual disturbance
F11229	Opioid dependence with intoxication, unspecified
F1123	Opioid dependence with withdrawal
F1124	Opioid dependence with opioid-induced mood disorder
F11250	Opioid dependence with opioid-induced psychotic disorder with delusions
F11251	Opioid dependence with opioid-induced psychotic disorder with hallucinations
F11259	Opioid dependence with opioid-induced psychotic disorder, unspecified
F11281	Opioid dependence with opioid-induced sexual dysfunction
F11282	Opioid dependence with opioid-induced sleep disorder
F11288	Opioid dependence with other opioid-induced disorder
F1129	Opioid dependence with unspecified opioid-induced disorder
F1190	Opioid use, unspecified, uncomplicated
F1210	Cannabis abuse, uncomplicated
F1213	Cannabis abuse with withdrawal
F1220	Cannabis dependence, uncomplicated
F12220	Cannabis dependence with intoxication, uncomplicated

F12221	Cannabis dependence with intoxication delirium
F12222	Cannabis dependence with intoxication with perceptual disturbance
F12229	Cannabis dependence with intoxication, unspecified
F1223	Cannabis dependence with withdrawal
F12250	Cannabis dependence with psychotic disorder with delusions
F12251	Cannabis dependence with psychotic disorder with hallucinations
F12259	Cannabis dependence with psychotic disorder, unspecified
F12280	Cannabis dependence with cannabis-induced anxiety disorder
F12288	Cannabis dependence with other cannabis-induced disorder
F1229	Cannabis dependence with unspecified cannabis-induced disorder
F1290	Cannabis use, unspecified, uncomplicated
F1293	Cannabis use, unspecified with withdrawal
F1310	Sedative, hypnotic or anxiolytic abuse, uncomplicated
F13120	Sedative, hypnotic or anxiolytic abuse with intoxication, uncomplicated
F1313	Sedative, hypnotic or anxiolytic abuse with withdrawal
F13130	Sedative/hypnotic/anxiolytic abuse with withdrawal, uncomplicated
F13131	Sedative/hypnotic/anxiolytic abuse with withdrawal delirium
F13132	Sedative/hypnotic/anxiolytic abuse with withdrawal with perceptual disturbance
F13139	Sedative/hypnotic/anxiolytic abuse with withdrawal, unspecified
F1320	Sedative, hypnotic or anxiolytic dependence, uncomplicated
F13220	Sedative, hypnotic or anxiolytic dependence with intoxication, uncomplicated
F13221	Sedative, hypnotic or anxiolytic dependence with intoxication delirium
F13229	Sedative, hypnotic or anxiolytic dependence with intoxication, unspecified
F13230	Sedative, hypnotic or anxiolytic dependence with withdrawal, uncomplicated
F13231	Sedative, hypnotic or anxiolytic dependence with withdrawal delirium
F13232	Sedative, hypnotic or anxiolytic dependence with withdrawal with perceptual disturbance

F13239	Sedative, hypnotic or anxiolytic dependence with withdrawal, unspecified
F1324	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced mood disorder
F13250	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions
F13251	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations
F13259	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified
F1326	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting amnestic disorder
F1327	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting dementia
F13280	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced anxiety disorder
F13281	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sexual dysfunction
F13282	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sleep disorder
F13288	Sedative, hypnotic or anxiolytic dependence with other sedative, hypnotic or anxiolytic-induced disorder
F1329	Sedative, hypnotic or anxiolytic dependence with unspecified sedative, hypnotic or anxiolytic-induced disorder
F1390	Sedative, hypnotic, or anxiolytic use, unspecified, uncomplicated
F1410	Cocaine abuse, uncomplicated
F14120	Cocaine abuse with intoxication, uncomplicated
F1413	Cocaine abuse, unspecified with withdrawal
F1420	Cocaine dependence, uncomplicated
F14220	Cocaine dependence with intoxication, uncomplicated
F14221	Cocaine dependence with intoxication delirium
F14222	Cocaine dependence with intoxication with perceptual disturbance

F14229	Cocaine dependence with intoxication, unspecified
F1423	Cocaine dependence with withdrawal
F1424	Cocaine dependence with cocaine-induced mood disorder
F14250	Cocaine dependence with cocaine-induced psychotic disorder with delusions
F14251	Cocaine dependence with cocaine-induced psychotic disorder with hallucinations
F14259	Cocaine dependence with cocaine-induced psychotic disorder, unspecified
F14280	Cocaine dependence with cocaine-induced anxiety disorder
F14281	Cocaine dependence with cocaine-induced sexual dysfunction
F14282	Cocaine dependence with cocaine-induced sleep disorder
F14288	Cocaine dependence with other cocaine-induced disorder
F1429	Cocaine dependence with unspecified cocaine-induced disorder
F1490	Cocaine use, unspecified, uncomplicated
F1493	Cocaine use, unspecified with withdrawal
F1510	Other stimulant abuse, uncomplicated
F15120	Other stimulant abuse with intoxication, uncomplicated
F1513	Other stimulant abuse with withdrawal
F1520	Other stimulant dependence, uncomplicated
F15220	Other stimulant dependence with intoxication, uncomplicated
F15221	Other stimulant dependence with intoxication delirium
F15222	Other stimulant dependence with intoxication with perceptual disturbance
F15229	Other stimulant dependence with intoxication, unspecified
F1523	Other stimulant dependence with withdrawal
F1524	Other stimulant dependence with stimulant-induced mood disorder
F15250	Other stimulant dependence with stimulant-induced psychotic disorder with delusions
F15251	Other stimulant dependence with stimulant-induced psychotic disorder with hallucinations
F15259	Other stimulant dependence with stimulant-induced psychotic disorder, unspecified

F15280	Other stimulant dependence with stimulant-induced anxiety disorder
F15281	Other stimulant dependence with stimulant-induced sexual dysfunction
F15282	Other stimulant dependence with stimulant-induced sleep disorder
F15288	Other stimulant dependence with other stimulant-induced disorder
F1529	Other stimulant dependence with unspecified stimulant-induced disorder
F1590	Other stimulant use, unspecified, uncomplicated
F1610	Hallucinogen abuse, uncomplicated
F16120	Hallucinogen abuse with intoxication, uncomplicated
F1620	Hallucinogen dependence, uncomplicated
F16220	Hallucinogen dependence with intoxication, uncomplicated
F16221	Hallucinogen dependence with intoxication with delirium
F16229	Hallucinogen dependence with intoxication, unspecified
F1624	Hallucinogen dependence with hallucinogen-induced mood disorder
F16250	Hallucinogen dependence with hallucinogen-induced psychotic disorder with delusions
F16251	Hallucinogen dependence with hallucinogen-induced psychotic disorder with hallucinations
F16259	Hallucinogen dependence with hallucinogen-induced psychotic disorder, unspecified
F16280	Hallucinogen dependence with hallucinogen-induced anxiety disorder
F16283	Hallucinogen dependence with hallucinogen persisting perception disorder (flashbacks)
F16288	Hallucinogen dependence with other hallucinogen-induced disorder
F1629	Hallucinogen dependence with unspecified hallucinogen-induced disorder
F1690	Hallucinogen use, unspecified, uncomplicated
F17200	Nicotine dependence, unspecified, uncomplicated
F17201	Nicotine dependence, unspecified, in remission
F17203	Nicotine dependence unspecified, with withdrawal
F17208	Nicotine dependence, unspecified, with other nicotine-induced disorders

F17209	Nicotine dependence, unspecified, with unspecified nicotine-induced disorders
F17210	Nicotine dependence, cigarettes, uncomplicated
F17211	Nicotine dependence, cigarettes, in remission
F17213	Nicotine dependence, cigarettes, with withdrawal
F17218	Nicotine dependence, cigarettes, with other nicotine-induced disorders
F17219	Nicotine dependence, cigarettes, with unspecified nicotine-induced disorders
F17220	Nicotine dependence, chewing tobacco, uncomplicated
F17221	Nicotine dependence, chewing tobacco, in remission
F17223	Nicotine dependence, chewing tobacco, with withdrawal
F17228	Nicotine dependence, chewing tobacco, with other nicotine-induced disorders
F17229	Nicotine dependence, chewing tobacco, with unspecified nicotine-induced disorders
F17290	Nicotine dependence, other tobacco product, uncomplicated
F17291	Nicotine dependence, other tobacco product, in remission
F17293	Nicotine dependence, other tobacco product, with withdrawal
F17298	Nicotine dependence, other tobacco product, with other nicotine-induced disorders
F17299	Nicotine dependence, other tobacco product, with unspecified nicotine-induced disorders
F1810	Inhalant abuse, uncomplicated
F18120	Inhalant abuse with intoxication, uncomplicated
F1820	Inhalant dependence, uncomplicated
F18220	Inhalant dependence with intoxication, uncomplicated
F18221	Inhalant dependence with intoxication delirium
F18229	Inhalant dependence with intoxication, unspecified
F1824	Inhalant dependence with inhalant-induced mood disorder
F18250	Inhalant dependence with inhalant-induced psychotic disorder with delusions
F18251	Inhalant dependence with inhalant-induced psychotic disorder with hallucinations
F18259	Inhalant dependence with inhalant-induced psychotic disorder, unspecified

F1827	Inhalant dependence with inhalant-induced dementia
F18280	Inhalant dependence with inhalant-induced anxiety disorder
F18288	Inhalant dependence with other inhalant-induced disorder
F1829	Inhalant dependence with unspecified inhalant-induced disorder
F1890	Inhalant use, unspecified, uncomplicated
F1913	Other psychoactive substance abuse with withdrawal
F19130	Other psychoactive substance abuse with withdrawal, uncomplicated
F19131	Other psychoactive substance abuse with withdrawal delirium
F19132	Other psychoactive substance abuse with withdrawal w perceptual disturbance
F19139	Other psychoactive substance abuse with withdrawal, unspecified
F1920	Other psychoactive substance dependence, uncomplicated
F19220	Other psychoactive substance dependence with intoxication, uncomplicated
F19221	Other psychoactive substance dependence with intoxication delirium
F19222	Other psychoactive substance dependence with intoxication with perceptual disturbance
F19229	Other psychoactive substance dependence with intoxication, unspecified
F19230	Other psychoactive substance dependence with withdrawal, uncomplicated
F19231	Other psychoactive substance dependence with withdrawal delirium
F19232	Other psychoactive substance dependence with withdrawal with perceptual disturbance
F19239	Other psychoactive substance dependence with withdrawal, unspecified
F1924	Other psychoactive substance dependence with psychoactive substance-induced mood disorder
F19250	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with delusions
F19251	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with hallucinations
F19259	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder, unspecified

F1926	Other psychoactive substance dependence with psychoactive substance-induced persisting amnestic disorder
F1927	Other psychoactive substance dependence with psychoactive substance-induced persisting dementia
F19280	Other psychoactive substance dependence with psychoactive substance-induced anxiety disorder
F19281	Other psychoactive substance dependence with psychoactive substance-induced sexual dysfunction
F19282	Other psychoactive substance dependence with psychoactive substance-induced sleep disorder
F19288	Other psychoactive substance dependence with other psychoactive substance-induced disorder
F1929	Other psychoactive substance dependence with unspecified psychoactive substance-induced disorder
F200	Paranoid schizophrenia
F201	Disorganized schizophrenia
F202	Catatonic schizophrenia
F203	Undifferentiated schizophrenia
F205	Residual schizophrenia
F2081	Schizophreniform disorder
F209	Schizophrenia, unspecified
F21	Schizotypal disorder
F22	Delusional disorders
F23	Brief psychotic disorder
F24	Shared psychotic disorder
F250	Schizoaffective disorder, bipolar type
F251	Schizoaffective disorder, depressive type
F258	Other schizoaffective disorders
F259	Schizoaffective disorder, unspecified

F28	Other psychotic disorder not due to a substance or known physiological condition
F29	Unspecified psychosis not due to a substance or known physiological condition
F3010	Manic episode without psychotic symptoms, unspecified
F3011	Manic episode without psychotic symptoms, mild
F3012	Manic episode without psychotic symptoms, moderate
F3013	Manic episode, severe, without psychotic symptoms
F302	Manic episode, severe with psychotic symptoms
F303	Manic episode in partial remission
F304	Manic episode in full remission
F309	Manic episode, unspecified
F310	Bipolar disorder, current episode hypomanic
F3110	Bipolar disorder, current episode manic without psychotic features, unspecified
F3111	Bipolar disorder, current episode manic without psychotic features, mild
F3112	Bipolar disorder, current episode manic without psychotic features, moderate
F3113	Bipolar disorder, current episode manic without psychotic features, severe
F312	Bipolar disorder, current episode manic severe with psychotic features
F3130	Bipolar disorder, current episode depressed, mild or moderate severity, unspecified
F3131	Bipolar disorder, current episode depressed, mild
F3132	Bipolar disorder, current episode depressed, moderate
F314	Bipolar disorder, current episode depressed, severe, without psychotic features
F315	Bipolar disorder, current episode depressed, severe, with psychotic features
F3160	Bipolar disorder, current episode mixed, unspecified
F3161	Bipolar disorder, current episode mixed, mild
F3162	Bipolar disorder, current episode mixed, moderate
F3163	Bipolar disorder, current episode mixed, severe, without psychotic features
F3164	Bipolar disorder, current episode mixed, severe, with psychotic features
F3170	Bipolar disorder, currently in remission, most recent episode unspecified

F3171	Bipolar disorder, in partial remission, most recent episode hypomanic
F3172	Bipolar disorder, in full remission, most recent episode hypomanic
F3173	Bipolar disorder, in partial remission, most recent episode manic
F3174	Bipolar disorder, in full remission, most recent episode manic
F3175	Bipolar disorder, in partial remission, most recent episode depressed
F3176	Bipolar disorder, in full remission, most recent episode depressed
F3177	Bipolar disorder, in partial remission, most recent episode mixed
F3178	Bipolar disorder, in full remission, most recent episode mixed
F3181	Bipolar II disorder
F3189	Other bipolar disorder
F319	Bipolar disorder, unspecified
F320	Major depressive disorder, single episode, mild
F321	Major depressive disorder, single episode, moderate
F322	Major depressive disorder, single episode, severe without psychotic features
F323	Major depressive disorder, single episode, severe with psychotic features
F324	Major depressive disorder, single episode, in partial remission
F325	Major depressive disorder, single episode, in full remission
F329	Major depressive disorder, single episode, unspecified
F32A	Depression, unspecified
F330	Major depressive disorder, recurrent, mild
F331	Major depressive disorder, recurrent, moderate
F332	Major depressive disorder, recurrent severe without psychotic features
F333	Major depressive disorder, recurrent, severe with psychotic symptoms
F3340	Major depressive disorder, recurrent, in remission, unspecified
F3341	Major depressive disorder, recurrent, in partial remission
F3342	Major depressive disorder, recurrent, in full remission
F339	Major depressive disorder, recurrent, unspecified

F340	Cyclothymic disorder
F341	Dysthymic disorder
F3481	Disruptive mood dysregulation disorder
F39	Unspecified mood [affective] disorder
F4000	Agoraphobia, unspecified
F4001	Agoraphobia with panic disorder
F4002	Agoraphobia without panic disorder
F4010	Social phobia, unspecified
F4011	Social phobia, generalized
F40210	Arachnophobia
F40218	Other animal type phobia
F40220	Fear of thunderstorms
F40228	Other natural environment type phobia
F40230	Fear of blood
F40231	Fear of injections and transfusions
F40232	Fear of other medical care
F40233	Fear of injury
F40240	Claustrophobia
F40241	Acrophobia
F40242	Fear of bridges
F40243	Fear of flying
F40248	Other situational type phobia
F40290	Androphobia
F40291	Gynephobia
F40298	Other specified phobia
F408	Other phobic anxiety disorders
F410	Panic disorder [episodic paroxysmal anxiety] without agoraphobia

F411	Generalized anxiety disorder
F419	Anxiety disorder, unspecified
F42	Obsessive-compulsive disorder
F422	Mixed obsessional thoughts and acts
F423	Hoarding disorder
F424	Excoriation (skin-picking) disorder
F428	Other obsessive-compulsive disorder
F429	Obsessive-compulsive disorder, unspecified
F430	Acute stress reaction
F4310	Post-traumatic stress disorder, unspecified
F4311	Post-traumatic stress disorder, acute
F4312	Post-traumatic stress disorder, chronic
F4320	Adjustment disorder, unspecified
F4321	Adjustment disorder with depressed mood
F4322	Adjustment disorder with anxiety
F4323	Adjustment disorder with mixed anxiety and depressed mood
F4324	Adjustment disorder with disturbance of conduct
F4325	Adjustment disorder with mixed disturbance of emotions and conduct
F439	Reaction to severe stress, unspecified
F440	Dissociative amnesia
F441	Dissociative fugue
F442	Dissociative stupor
F444	Conversion disorder with motor symptom or deficit
F445	Conversion disorder with seizures or convulsions
F446	Conversion disorder with sensory symptom or deficit
F447	Conversion disorder with mixed symptom presentation
F4481	Dissociative identity disorder

F4489	Other dissociative and conversion disorders
F449	Dissociative and conversion disorder, unspecified
F450	Somatization disorder
F451	Undifferentiated somatoform disorder
F4520	Hypochondriacal disorder, unspecified
F4521	Hypochondriasis
F4522	Body dysmorphic disorder
F4529	Other hypochondriacal disorders
F4541	Pain disorder exclusively related to psychological factors
F4542	Pain disorder with related psychological factors
F459	Somatoform disorder, unspecified
F481	Depersonalization-derealization syndrome
F489	Nonpsychotic mental disorder, unspecified
F5000	Anorexia nervosa, unspecified
F5001	Anorexia nervosa, restricting type
F5002	Anorexia nervosa, binge eating/purging type
F502	Bulimia nervosa
F508	Other eating disorders
F5081	Binge eating disorder
F5082	Avoidant/restrictive food intake disorder
F5089	Other specified eating disorder
F509	Eating disorder, unspecified
F515	Nightmare disorder
F520	Hypoactive sexual desire disorder
F521	Sexual aversion disorder
F5221	Male erectile disorder
F5222	Female sexual arousal disorder

F5231	Female orgasmic disorder
F5232	Male orgasmic disorder
F524	Premature ejaculation
F525	Vaginismus not due to a substance or known physiological condition
F526	Dyspareunia not due to a substance or known physiological condition
F528	Other sexual dysfunction not due to a substance or known physiological condition
F529	Unspecified sexual dysfunction not due to a substance or known physiological condition
F530	Postpartum depression
F550	Abuse of antacids
F551	Abuse of herbal or folk remedies
F552	Abuse of laxatives
F553	Abuse of steroids or hormones
F554	Abuse of vitamins
F558	Abuse of other non-psychoactive substances
F600	Paranoid personality disorder
F601	Schizoid personality disorder
F602	Antisocial personality disorder
F603	Borderline personality disorder
F604	Histrionic personality disorder
F605	Obsessive-compulsive personality disorder
F606	Avoidant personality disorder
F607	Dependent personality disorder
F6081	Narcissistic personality disorder
F609	Personality disorder, unspecified
F630	Pathological gambling
F631	Pyromania

F632	Kleptomania
F633	Trichotillomania
F6381	Intermittent explosive disorder
F6389	Other impulse disorders
F639	Impulse disorder, unspecified
F640	Transsexualism
F641	Gender identity disorder in adolescence and adulthood
F642	Gender identity disorder of childhood
F648	Other gender identity disorders
F649	Gender identity disorder, unspecified
F650	Fetishism
F651	Transvestic fetishism
F652	Exhibitionism
F653	Voyeurism
F654	Pedophilia
F6550	Sadomasochism, unspecified
F6551	Sexual masochism
F6552	Sexual sadism
F6581	Frotteurism
F6589	Other paraphilias
F659	Paraphilia, unspecified
F66	Other sexual disorders
F6811	Factitious disorder with predominantly psychological signs and symptoms
F6813	Factitious disorder with combined psychological and physical signs and symptoms
F688	Other specified disorders of adult personality and behavior
F69	Unspecified disorder of adult personality and behavior
F840	Autistic disorder

F843	Other childhood disintegrative disorder
F845	Asperger's syndrome
F848	Other pervasive developmental disorders
F900	Attention-deficit hyperactivity disorder, predominantly inattentive type
F901	Attention-deficit hyperactivity disorder, predominantly hyperactive type
F902	Attention-deficit hyperactivity disorder, combined type
F908	Attention-deficit hyperactivity disorder, other type
F909	Attention-deficit hyperactivity disorder, unspecified type
F910	Conduct disorder confined to family context
F911	Conduct disorder, childhood-onset type
F912	Conduct disorder, adolescent-onset type
F913	Oppositional defiant disorder
F918	Other conduct disorders
F919	Conduct disorder, unspecified
F930	Separation anxiety disorder of childhood
F938	Other childhood emotional disorders
F939	Childhood emotional disorder, unspecified
F940	Selective mutism
F941	Reactive attachment disorder of childhood
F942	Disinhibited attachment disorder of childhood
F948	Other childhood disorders of social functioning
F949	Childhood disorder of social functioning, unspecified
F952	Tourette's disorder
F980	Enuresis not due to a substance or known physiological condition
F981	Encopresis not due to a substance or known physiological condition
F9821	Rumination disorder of infancy
F9829	Other feeding disorders of infancy and early childhood

F983	Pica of infancy and childhood
F988	Other specified behavioral and emotional disorders with onset usually occurring in childhood and adolescence
F989	Unspecified behavioral and emotional disorders with onset usually occurring in childhood and adolescence
F99	Mental disorder, not otherwise specified
R37	Sexual dysfunction, unspecified
R4183	Borderline intellectual functioning
R451	Restlessness and agitation
R452	Unhappiness
R455	Hostility
R456	Violent behavior
R4581	Low self-esteem
R4582	Worries
R45850	Homicidal ideations
R45851	Suicidal ideations
Z600	Problems of adjustment to life-cycle transitions
Z603	Acculturation difficulty
Z604	Social exclusion and rejection
Z605	Target of (perceived) adverse discrimination and persecution
Z608	Other problems related to social environment
Z609	Problem related to social environment, unspecified
Z620	Inadequate parental supervision and control
Z621	Parental overprotection
Z6222	Institutional upbringing
Z6229	Other upbringing away from parents
Z623	Hostility towards and scapegoating of child
Z626	Inappropriate (excessive) parental pressure

Z62810	Personal history of physical and sexual abuse in childhood
Z62811	Personal history of psychological abuse in childhood
Z62812	Personal history of neglect in childhood
Z62813	Personal history of forced labor or sexual exploitation in childhood
Z62819	Personal history of unspecified abuse in childhood
Z62820	Parent-biological child conflict
Z62821	Parent-adopted child conflict
Z62822	Parent-foster child conflict
Z62890	Parent-child estrangement NEC
Z6332	Other absence of family member
Z634	Disappearance and death of family member
Z635	Disruption of family by separation and divorce
Z636	Dependent relative needing care at home
Z6372	Alcoholism and drug addiction in family
Z6379	Other stressful life events affecting family and household
Z638	Other specified problems related to primary support group
Z644	Discord with counselors
Z654	Victim of crime and terrorism
Z658	Other specified problems related to psychosocial circumstances
Z69010	Encounter for mental health services for victim of parental child abuse
Z69020	Encounter for mental health services for victim of non-parental child abuse
Z69021	Encounter for mental health services for perpetrator of non-parental child abuse
Z6911	Encounter for mental health services for victim of spousal or partner abuse
Z6982	Encounter for mental health services for perpetrator of other abuse
Z7189	Other specified counseling
Z72810	Child and adolescent antisocial behavior
Z72811	Adult antisocial behavior

Z734	Inadequate social skills, not elsewhere classified
Z735	Social role conflict, not elsewhere classified
Z736	Limitation of activities due to disability
Z8651	Personal history of combat and operational stress reaction
Z91410	Personal history of adult physical and sexual abuse
Z91411	Personal history of adult psychological abuse
Z91412	Personal history of adult neglect
Z9151	Personal history of suicidal behavior
Z9152	Personal history of nonsuicidal self-harm