Rules of
Department of Social Services
Division 70—MO HealthNet Division
Chapter 98—Behavioral Health Services

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 98—Behavioral Health Services

13 CSR 70-98.015 Behavioral Health Services Program Documentation

PURPOSE: This rule establishes the regulatory basis for the documentation requirements of services provided through the MO HealthNet behavioral health services. The Health Insurance Portability and Accountability Act (HIPAA) mandates that states allow providers to bill for services using the standard current procedural terminology (CPT) code sets, however, it does not require states to add coverage for services that it does not currently cover. The MO HealthNet Division (MHD) has not added coverage of services previously not covered; however, it is redefining limitations based on standard code definitions, and clarification to MO HealthNet policy.

PUBLISHER'S NOTE The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Administration. The MO HealthNet behavioral health services program shall be administered by the Department of Social Services, MO HealthNet Division (MHD). The services covered and not covered and the limitations under which services are covered shall be determined by MHD and shall be included in the *MO HealthNet Behavioral Health Services Provider Manual* and Section 13 of the *Physician's Provider Manual*, which are incorporated by reference in this rule and available through the Department of Social Services, MO HealthNet Division website at www.dss.mo.gov/mhd November 1, 2013. This rule does not incorporate any subsequent amendments or additions. Behavioral health services shall include only those which are clearly shown to be medically necessary.

(2) Persons Eligible. The MO HealthNet Program pays for approved MO HealthNet services for 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. It is the provider's responsibility to determine the coverage benefits for a participant based on their type of assistance as outlined in the provider program manual. The provider shall ascertain the patient's MO HealthNet and managed care or other lock-in status before any service is performed. The participant's eligibility shall be verified in accordance with methodology outlined in the provider program manual.

(3) Provider Participation. To be eligible for participation in the MO HealthNet behavioral health services program, a provider must meet the licensing criteria specified for his or her profession and be an enrolled MO HealthNet provider.

(A) The enrolled MO HealthNet provider shall comply with the following requirements:

1. Keep any records necessary to disclose the extent of services the provider furnishes to participants;

2. On request furnish to the MO HealthNet agency or State Medicaid Fraud Control Unit any information regarding payments claimed by the provider for furnishing services under the plan;

3. Limit MO HealthNet billable hours to a maximum of one hundred fifty (150) hours in a single calendar month. Services provided to MO HealthNet participants and participants who are both MO HealthNet and Medicare eligible are counted toward the monthly one hundred fifty (150)-hour limit; and

4. Refund payment for MO HealthNet services to the MO HealthNet Division when the provider has billed the MO HealthNet Division for more than one hundred fifty (150) hours in a single calendar month.

(4) Documentation Requirements for Behavioral Health Services. Documentation must be in narrative form, fully describing each session billed. A check-off list or pre-established form will not be accepted as sole documentation. Progress notes shall be written and maintained in the patient's medical record for each date of service for which a claim is filed. Progress notes for behavioral health services shall specify—

(A) First and last name of participant:

1. When family therapy is furnished, each member of the family included in the session must be identified. Description of immediate issue addressed in therapy, identification of underlying roles, conflicts or patterns, and description of therapist intervention;

2. When group therapy is furnished each service shall include the number of group members present, description of immediate issue addressed in therapy, identification of underlying roles, conflicts or patterns, and description of therapist intervention and progress towards goals;

(B) The specific service rendered;

(C) Name of person who provided service;

(D) The date (month/day/year) and actual begin and end time (e.g., 4:00–4:30 p.m.) for face-to-face services;

(E) The setting in which the service was rendered;

(F) Patient's report of recent symptoms and behaviors related to their diagnosis and treatment plan goals;

(G) Therapist interventions for that visit and patient's response;

(H) The pertinence of the service to the treatment plan; and

(I) The patient's progress toward one (1) or more goals stated in the treatment plan.

(5) A plan of treatment is a required document in the overall record of the patient.

(A) A treatment plan must be developed by the provider based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the participant's situation and reflects the need for behavioral health services. If the service is for a child who is in the legal custody of the Children's Division, a copy of the treatment plan shall be provided to the Children's Division in order for the provider to retain reimbursement for the covered service(s).

(B) The treatment plan shall be individualized to reflect the patient's unique needs and goals.

(C) The plan shall include, but is not limited to, the following:

1. Measurable goals and outcomes;

2. Services, support, and actions to accomplish each goal/outcome. This includes services and supports and the staff member responsible, as well as action steps of the individual and other supports (family, social, peer, and other natural supports);

3. Involvement of family, when indicated;

4. Identification of other agencies working with the patient, plans for coordinating services with other agencies, or identification of medications, which have been prescribed, where applicable;

5. Services needed beyond the scope of the organization or program that are being addressed by referral or services at another community organization, where applicable;

6. Projected time frame for the completion of each goal/outcome; and

7. Estimated completion/discharge date for the level of care.

(D) The treatment plan shall be reviewed on a periodic basis to evaluate progress toward treatment goals and outcomes and to update the plan.

1. Each person shall directly participate in the review of his or her individualized treatment plan.

2. The frequency of treatment plan reviews shall be based on the individual's level of care or other applicable program rules. The occurrence of a crisis or significant clinical event may require a further review and modification of the treatment plan.

3. The individualized treatment plan shall be updated and changed as indicated.

4. Each treatment plan update shall include the therapist assessment of current symptoms and behaviors related to diagnosis, progress to treatment goals, justification of changed or new diagnosis, response to other concurrent treatments such as family or group therapy and medications.

5. The therapist's plan for continuing treatment and/or termination from therapy and aftercare shall be considerations expressed in each treatment plan update.

6. A diagnostic assessment from a MO HealthNet enrolled provider shall be documented in the patient's case record, which shall assist in ensuring an appropriate level of care, identifying necessary services, developing an individualized treatment plan, and documenting the following:

A. Statement of needs, goals, and treatment expectations from the individual requesting services. The family's perceptions are also obtained, when appropriate and available;

B. Presenting situations/problem and referral source;

C. History of previous psychiatric and/or substance abuse treatment including number and type of admissions;

D. Current medications and identifications of any medications allergies and adverse reactions;

E. Recent alcohol and drug use for at least the past thirty (30) days and, when indicated, a substance use history that includes duration, patterns, and consequences of use;

F. Current psychiatric symptoms;

G. Family, social, legal, and vocational/educational status and functioning. The collection and assessment of historical data is also required unless short-term crisis intervention or detoxification are the only services being provided;

H. Current use of resources and services from other community agencies;

I. Personal and social resources and strengths, including the availability and use of family, social, peer, and other natural supports; and

J. Multi-axis diagnosis or diagnostic impression in accordance with the current edition of the *Diagnostic and Statistical Manual* of the American Psychiatric Association or the *International Classification of Diseases*, (ICD). The ICD coding is required for billing purposes.

7. When interactive therapy is billed, the provider must document the need for this service and the equipment, devices, or other mechanism of equipment used.

8. When care is completed, the aftercare plan shall include, but is not limited to, the following:

A. Dates began and ended;

B. Frequency and duration of visits;

C. Target symptoms/behaviors addressed;

D. Interventions;

E. Progress to goals achieved;

F. Final diagnosis; and

G. Final recommendations including further services and providers, if needed, and activities recommended to promote further recovery.

(6) For all medically necessary covered services, a writing of all stipulated documentation elements referenced in this rule are an essential and integral part of the service itself. No service has been performed if documentation requirements are not met.

(7) Documentation required by MHD does not replace or negate documentation/reports required by the Children's Division for individuals in their care or custody. Providers are expected to comply with policies and procedures established by the Children's Division and MHD.

(8) Records Retention. 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 the MO HealthNet Program, and must furnish or make the records available for inspection or audit by the Department of Social Services or its representative upon request. Failure to furnish, reveal, and retain adequate documentation for services billed to the MO HealthNet Program may result in recovery of the payments for those services not adequately documented and may result in sanctions to the provider's participation in the MO HealthNet Program. 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.

(9) The requirement to document services and to release records to representatives of the Department of Social Services or the U.S. Department of Health and Human Services is also found in 13 CSR 70-3.020 and 13 CSR 70-3.030.

AUTHORITY: sections 208.152, 208.153, and 208.201, RSMo Supp. 2013. Original rule filed Nov. 14, 2003, effective June 30, 2004. Amended: Filed Oct. 30, 2007, effective April 30, 2008. Amended: Filed June 2, 2008, effective Nov. 30, 2008. Amended: Filed Oct. 31, 2008, effective May 30, 2009. Amended: Filed Sept. 26, 2013, effective March 30, 2014.*

**Original authority: 208.152, RSMo 1967, amended 1969, 1971, 1972, 1973, 1975, 1977, 1978, 1978, 1981, 1986, 1988, 1990, 1992, 1993, 2004, 2005, 2007; 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007; and 208.201, RSMo 1987, amended 2007.*

13 CSR 70-98.020 Prior Authorization Process for Non-Pharmaceutical Behavioral Health Services

PURPOSE: This rule establishes the process by which non-pharmaceutical behavioral health services will be prior authorized in order to be reimbursable by the MO HealthNet Program. The prior authorization process will serve as a utilization management measure allowing payment only for this treatment and services (interventions) that are medically necessary, appropriate and cost-effective, and to reduce over-utilization or abuse of services without compromising the quality of care to MO HealthNet participants.

PUBLISHER'S NOTE The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) This rule establishes a MO HealthNet non-pharmaceutical behavioral health services prior authorization advisory committee

in the Department of Social Services, MO HealthNet Division. The advisory committee shall be composed of practicing clinicians who are also licensed in their respective fields. The advisory committee shall be composed of three (3) practicing psychiatrists, three (3) practicing psychologists, three (3) practicing licensed clinical social workers (LCSW), and three (3) practicing licensed professional counselors (LPC). All members shall be appointed by the director of the Department of Social Services. The members of the committee shall represent a broad spectrum of practice including, but not limited to, those providing services to adults, children, children in custody, the geriatric population, and Department of Mental Health clients. The members shall serve for a term of four (4) years, except that of the members first appointed, three (3) shall be appointed for one (1) year, three (3) shall be appointed for two (2) years, three (3) shall be appointed for three (3) years, and three (3) shall be appointed for four (4) years. Members of the committee shall receive no compensation for their services but shall be reimbursed for their actual and necessary expenses incurred related to participation on the committee, as approved by the MO HealthNet Division out of appropriations made for that purpose.

(2) All persons eligible for MO HealthNet benefits shall have access to non-pharmaceutical behavioral health services when they are determined medically necessary when using diagnostic criteria from the current edition of the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association. The services covered and not covered, the limitations under which services are covered, and the maximum allowable fees for all covered services shall be determined by the MO HealthNet Division and shall be included in the MO HealthNet Behavioral Health Services Provider Manual and Section 13 of the Physician Provider Manual, which are incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, on its website www.dss.mo.gov/mhd, November 15, 2013. This rule does not incorporate any subsequent amendments or additions. The MO HealthNet non-pharmaceutical behavioral health services prior authorization advisory committee shall review and make recommendations regarding the prior authorization process to the MO HealthNet Division. The MO HealthNet non-pharmaceutical behavioral health services prior authorization advisory committee shall hold a public hearing in order to make recommendations to the department prior to any final decisions by the division on the prior authorization process. The recommendations of the non-pharmaceutical behavioral health services prior authorization advisory committee shall be provided to the MO HealthNet Division, in writing, prior to the division making a final determination. The policy requirements regarding the prior authorization process for non-pharmaceutical behavioral health services shall be available through the Department of Social Services, MO HealthNet Division website at www.dss.mo.gov/mhd.

(3) The prior authorization requirements shall be reviewed at least every twelve (12) months by the non-pharmaceutical behavioral health services prior authorization committee.

(4) The prior authorization process will not apply to emergency and inpatient hospital interventions.

(5) The provider may bill for up to four (4) hours of service for diagnosis and testing without prior authorization. If additional services are needed the provider shall initiate the prior authorization process for up to an additional ten (10) to twenty (20) hours of service dependent on the diagnosis and type of service. The first prior authorization does not require an assessment treatment plan, or progress notes. After the first aggregate fourteen (14) to twenty-four (24) hours of service an additional prior authorization with appropriate documentation is required. The prior authorization request can be phoned, faxed, or mailed to the division designee.

AUTHORITY: section 208.201, RSMo Supp. 2013. Original rule filed Jan. 15, 2004, effective Aug. 30, 2004. Amended: Filed Oct. 30, 2007, effective April 30, 2008. Amended: Filed Oct. 10, 2013, effective April 30, 2014.*

**Original authority: 208.201, RSMo 1987, amended 2007.*

13 CSR 70-98.030 Applied Behavior Analysis Services

PURPOSE: This rule establishes the regulatory basis for coverage and reimbursement for applied behavior analysis services under the Medicaid state plan.

(1) The following definitions will be used in administering this rule:

(A) Applied Behavior Analysis (ABA)—the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationships between environment and behavior. ABA does not include psychological testing, personality assessment, intellectual assessment, neuropsychological assessment, psychotherapy, cognitive therapy, sex therapy, psychoanalysis, hypnotherapy, family therapy, or counseling;

(B) Autism Spectrum Disorder (ASD)—as defined in the most recent edition of *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association;

(C) Best practice guidelines—guidelines described in the Missouri Autism Guidelines Initiative's publications entitled *Autism Spectrum Disorders: Missouri Best Practice Guidelines for Screening, Diagnosis, and Assessment* and *Autism Spectrum Disorders: Guide to Evidence-Based Interventions*;

(D) Diagnostic evaluation—evaluation conducted according to best practice guidelines in order to determine if an ASD is present;

(E) Licensed Behavior Analyst (LBA)—an individual who is currently licensed by the Missouri Behavior Analyst Advisory Board to practice ABA independently;

(F) ABA qualified Licensed Psychologist (LP)—an individual who is currently licensed by Missouri to practice psychology and who has ABA in the scope of his/her education, training, and competence;

(G) Licensed Assistant Behavior Analyst (LABA)—an individual who is currently licensed by Missouri to practice applied behavior analysis under the supervision of an LBA;

(H) Technician—an individual who is credentialed by the Behavior Analyst Certification Board (BACB) as a Registered Behavior Technician™ (RBT™);

(I) ABA Assessment for Intervention Planning—assessment that is conducted according to best practice guidelines and considers the individual's specific strengths and concerns to inform the intervention planning process; and

(J) ABA intervention—involves directly and objectively measuring potential target behaviors and environmental events that influence them; constructing detailed, individualized behavior analytic treatment plans; using reinforcement and other scientifically validated procedures to build functional skills and reduce behaviors that jeopardize health, safety, and independent functioning; managing treatment environments to maximize client progress; implementing treatment protocols repeatedly, frequently, and consistently; measuring target behaviors directly and frequently; and adjusting treatment protocols

based on data.

(2) Recipient Criteria.

(A) In order to qualify for and receive ABA services, a MO HealthNet participant must meet all of the following criteria. The participant must—

1. Be under 21 years of age;

2. Exhibit the presence of excesses and/or deficits of behaviors that significantly interfere with home or community activities (examples include, but are not limited to, aggression, self-injury, elopement);

3. 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.

(3) Provider Criteria.

(A) To direct, supervise, and render ABA services, a professional shall meet the following specifications:

1. Be currently licensed by Missouri as an LBA or LP;

2. Be covered by professional liability insurance to limits of one (1) million dollars per occurrence, three (3) million dollars aggregate;

3. Have no sanctions or disciplinary actions by the applicable state licensing board or the BACB;

4. Have no current overpayment(s) due MO HealthNet and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and

5. Be currently enrolled with MO HealthNet as a provider.

(B) Assistant behavior analysts who render or supervise ABA services shall meet the following qualifications:

1. Be currently licensed by Missouri as an LABA;

2. Be currently supervised by a Missouri LBA;

A. The supervisory relationship must be documented in writing;

3. Be covered by professional liability insurance to limits of one (1) million dollars per occurrence, three (3) million dollars aggregate;

4. Have no sanctions or disciplinary actions by the state licensing board or BACB;

5. Have no current overpayment(s) due MO HealthNet and no Medicaid or Medicare sanctions or exclusions from participation in federally funded programs; and

6. Be currently enrolled with MO HealthNet as a provider.

(C) Technicians who render ABA services shall—

1. Be credentialed by the BACB as an RBT;

2. Work under the supervision of an LBA, LP (if officially granted supervisory privileges by the BACB), or LABA to the extent allowed for holders of the latter credential and at the discretion of the supervising LBA. RBTs are required by the BACB to be supervised by LBAs who are also Board Certified Behavior Analysts, Board Certified Behavior Analysts-Doctoral, Board Certified Assistant Behavior Analysts, or members of a professional group officially granted supervisory privileges by the BACB;

A. The supervisory relationship must be documented in writing; and

3. Have no current overpayment(s) due MO HealthNet and no Medicaid or Medicare sanctions or exclusions from participation in federally funded programs.

(4) Covered Services and Limitations.

(A) MO HealthNet covered ABA services (ABA assessment for intervention planning and ABA intervention) must be—

1. Medically necessary;

2. Precertified by MO HealthNet or its designee;

3. Delivered in accordance with the recipient's treatment plan; and

4. Overseen and delivered by providers who meet criteria specified herein.

(B) Medical necessity for ABA assessment for intervention planning shall be determined based on a diagnostic evaluation. Medical necessity for ABA intervention shall be determined based on an ABA assessment for intervention planning for initial intervention. Medical necessity for continued ABA intervention beyond the initial precertification period shall be determined based upon requested documentation including, but not limited to, updated treatment plan and progress graphs.

(C) ABA intervention services may be precertified for a time period not to exceed one hundred-eighty (180) days. Services provided without precertification shall not be considered for reimbursement, except in the case of retroactive MO HealthNet eligibility.

(D) Service Limitations.

1. Services shall be based upon the individual needs of the child and must give consideration to the child's age, school attendance requirements, and other daily activities as documented in the treatment plan.

2. Services must be delivered in a clinically appropriate setting for the behavior being treated.

(5) Not Medically Necessary/Non-Covered Services. The following services do not meet medically necessity criteria, nor qualify as MO HealthNet covered ABA services:

(A) Intervention services rendered when measureable functional improvement is not expected and services are not necessary to maintain function or prevent deterioration;

(B) Services that are solely educational are not covered. ABA treatment goals, objectives, and procedures that may be related in some way to educational activities but are medically necessary to address the deficits and symptoms of ASD in an individual are covered;

(C) Educational services provided under an individualized family service plan (IFSP) or an individualized educational program (IEP), as required under the federal Individuals with Disabilities Education Act (IDEA);

(D) Services that are solely vocational or recreational are not covered. ABA treatment goals, objectives, and procedures that may be related in some way to vocational or recreational activities but are medically necessary to address the deficits and symptoms of ASD in an individual are covered; and

(E) Custodial care is not an ABA service and is not covered as part of this benefit. Developing, restoring, or maintaining self-help, daily living, or safety skills as part of an ABA treatment plan does not constitute custodial care and are covered.

(6) ABA Treatment Plan.

(A) ABA intervention services shall be rendered in accordance with the individual's treatment plan. The treatment plan shall—

1. Be person centered and individualized;

2. Be developed by an LBA or LP;

3. Be based on the ABA assessment for intervention planning

4. Delineate the baseline levels of target behaviors;

5. Specify long- and short-term objectives that are defined in observable, measureable, behavioral terms;

6. Specify the criteria that will be used to determine achievement of objectives;

7. Include assessment and treatment protocols for addressing each of the target behaviors;

8. Clearly identify the schedule of services planned and the individuals responsible for delivering the services, including frequent review of data on target behaviors and adjustments in the treatment plan and/or protocols by the LBA or LP as needed;

9. Include training to enable LABAs and RBTs to implement assessment and treatment protocols.

10. Include training and support to enable parents and other caregivers to participate in treatment planning and treatment plan implementation;

11. Include care coordination involving the parents or caregiver(s), school, state disability programs, and others as applicable; and

12. Be consistent with applicable professional standards and guidelines relating to the practice of ABA as well as state Medicaid laws and regulations and applicable Missouri licensure laws and regulations.

(7) Reimbursement Methodology.

(A) MO HealthNet shall provide reimbursement for ABA services to enrolled LBAs or LPs who are currently licensed and in good standing with the state. Payment for services rendered by LABAs shall be made to the LBA supervising and employing these personnel. Payment for services rendered by technicians shall be made to the LBA or LP supervising and employing these personnel. If the LBA or LP operates through an agency or corporate entity, payment may be made to that agency or entity. Reimbursement for ABA services shall not be made to or for services rendered by a parent, a legal guardian, or other legally responsible person.

(B) Reimbursement for ABA services is made on a fee-for-services basis. The maximum allowable fee for a unit of service has been determined by the MO HealthNet 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. Reimbursement shall only be made for services authorized by the Medicaid agency or its designee.

(C) The fee schedule and any annual/periodic adjustments to the fee schedule are published at http://www.dss.mo.gov/mhd/providers/index.htm.

AUTHORITY: section 208.201, RSMo Supp. 2013. Original rule filed Dec. 14, 2015, effective July 30, 2016.*

**Original authority: 208.201, RSMo 1987, amended 2007.*