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**Rules of**  
**Department of Social Services**  
**Division 70—Division of Medical Services**  
**Chapter 98—Psychiatric/Psychology/Counseling/Clinical**  
**Social Work Program**

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**Title 13—DEPARTMENT OF  
SOCIAL SERVICES**

**Division 70—Division of Medical  
Services**

**Chapter 98—Psychiatric/Psychology/  
Counseling/Clinical Social Work  
Program**

**13 CSR 70-98.015 Psychiatric/Psychology/  
Counseling/Clinical Social Work Program  
Documentation**

*PURPOSE: This rule establishes the regulatory basis for the documentation requirements of services provided through the Medicaid psychiatric/psychology/counseling/clinical social work program. 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 Division of Medical Services (DMS) has not added coverage of services previously not covered, however, it is redefining limitations based on standard code definitions, and clarification to Medicaid 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. Therefore, the material which is so incorporated is on file with the agency who filed this rule, and with the Office of the Secretary of State. Any interested person may view this material at either agency's headquarters or the same will be made available at the Office of the Secretary of State at a cost not to exceed actual cost of copy reproduction. The entire text of the rule is printed here. This note refers only to the incorporated by reference material.*

(1) Administration. The Missouri Medicaid psychiatric/psychology/counseling/clinical social work program shall be administered by the Department of Social Services, Division of Medical Services (DMS). 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 DMS and shall be included in the Medicaid *Psychology/Counseling Provider Manual* and Section 13.57 of the *Physician's Provider Manual*, which are incorporated by reference in this rule and available through the Department of Social Services, Division of Medical

Services website at [www.dss.mo.gov/dms](http://www.dss.mo.gov/dms). Psychiatric/psychology/counseling/clinical social work services shall include only those which are clearly shown to be medically necessary. The division reserves the right to affect changes in services, limitations, and fees with notification to providers.

(2) Persons Eligible. The Missouri Medicaid Program pays for approved Medicaid services for psychiatric/psychology/counseling/clinical social work services when furnished within the provider's scope of practice. The recipient must be eligible on the date the service is furnished. Recipients may have specific limitations for psychiatric/psychology/counseling/clinical social work 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 recipient based on their type of assistance as outlined in the provider program manual. The provider shall ascertain the patient's Medicaid/MC+ and managed care or other lock-in status before any service is performed. The recipient'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 Missouri Medicaid psychiatric/psychology/counseling/clinical social work program, a provider must meet the licensing criteria specified for his or her profession and be an enrolled Medicaid provider.

(A) The enrolled Medicaid provider shall agree to:

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

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

(4) Documentation Requirements for Psychiatric/Psychology/Counseling/Clinical Social Work 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 psychiatric/psychology/counseling/clinical social work services shall specify:

(A) First and last name of recipient:

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/date/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 recipient's situation and reflects the need for psychiatric/psychological/counseling/clinical social work services. If the service is for a child who is in the legal custody of the Children's Division (formerly known as Division of Family Services, Children's Services section), 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 Medicaid 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*, Ninth Revision, Clinical Modification (ICD9-CM). The ICD9-CM 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 DMS 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 (formerly known as Division of Family Services, Children's Services section) and DMS.

(8) Records Retention. Medicaid 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 Medicaid 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 Medicaid 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 Medicaid Program. This policy continues to apply in the event of the provider's discontinuance as an actively participating Medicaid 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 2000.\* Original rule filed Nov. 14, 2003, effective June 30, 2004.*

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

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

*PURPOSE: This rule establishes the process by which non-pharmaceutical mental health services will be prior authorized in order to be reimbursable by the Missouri Medicaid 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 Missouri Medicaid recipients.*

*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. Therefore, the material which is so incorporated is on file with the agency who filed this rule, and with the Office of the Secretary of State. Any interested person may view this material at either agency's headquarters or the same will be made available at the Office of the Secretary of State at a cost not to exceed actual cost of copy reproduction. The entire text of the rule is printed here. This note refers only to the incorporated by reference material.*



(1) This rule establishes a Medicaid non-pharmaceutical mental health services prior authorization advisory committee in the Department of Social Services, Division of Medical Services. 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 Division of Medical Services out of appropriations made for that purpose.

(2) All persons eligible for medical assistance benefits shall have access to non-pharmaceutical mental health services when they are determined medically necessary when using diagnostic criteria from the Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition (DSM-IV), published by the American Psychiatric Association, or the most currently published version of the DSM manual. 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 Division of Medical Services and shall be included in the Medicaid Psychology/Counseling Provider Manual and Section 13 of the Physician Provider Manual, which are incorporated by reference in this rule and available through the Department of Social Services, Division of Medical Services website at [www.dss.mo.gov/dms](http://www.dss.mo.gov/dms). The Medicaid non-pharmaceutical mental health services prior authorization advisory committee shall review and make recommendations regarding the prior authorization process to the Division of Medical Services. The Medicaid non-pharmaceutical mental 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 mental health services prior authorization advisory committee shall be provided to the Division of Medical Services, in writing, prior to the division making a final determination. The policy requirements regarding the prior authorization process for non-pharmaceutical mental health services shall be available through the Department of Social Services, Division of Medical Services website at [www.dss.mo.gov/dms](http://www.dss.mo.gov/dms).

(3) The prior authorization requirements shall be reviewed at least every twelve (12) months by the non-pharmaceutical mental 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 2000.\* Original rule filed Jan. 15, 2004, effective Aug. 30, 2004.*

*\*Original authority: 208.201, RSMo 1987.*