

Bulletin

June 20, 2011

Minnesota Department of Human Services -- P.O. Box 64941 -- St. Paul, MN 55164-0941

OF INTEREST TO

- County Directors
- Tribal Directors
- Social Services Supervisors
- Managed Care Organizations
- Mental Health Case Management Providers
- State Operated Services
- Mental Health Advocacy Agencies
- Mental Health Providers

ACTION/DUE DATE

Please read for information and implement changes effective June 28, 2011

EXPIRATION DATE

June 27, 2013

DHS Updates Mental Health Clinical Services Administrative Rule

TOPIC

Mental Health Outpatient Services Administrative Rule

PURPOSE

Announcing policy changes for outpatient mental health services. The rules include standards for services and payment requirements that a vendor must meet to qualify for payment through the Medical Assistance program.

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Introduction

This bulletin informs mental health services providers, counties, tribal authorities, managed care organizations (MCOs), advocates and other stakeholders of:

- Significant changes to the Minnesota rules governing outpatient mental health services that are covered by Medicaid or MinnesotaCare under fee-for-service payment
- Components of each rule part in Minnesota Rules, parts 9505.0370, 9505.0371, and 9505.0372
- Repeal of obsolete rules
- New Outpatient Mental Health Service web page
- Rules where references to the old rule number will be deleted and replaced by new rule number reference.

Background

Administrative rules bring clarity to Minnesota's Statutes, to establish benefit coverage standards, and to provide understandable principles for providers. The Minnesota Department of Human Services (DHS) developed the rules in consultation with a broad stakeholder advisory committee. The advisory committee was composed of twenty-six people representing groups likely to be impacted by the rule or who are interested in mental health treatment issues; it included consumers and providers of mental health services, professional associations that represent individuals and companies that provide mental health care, insurance companies that pay for treatment, and academic staff who train and educate persons who will work in mental health treatment. The committee also used task forces and subcommittees from time-to-time to consider some topics more extensively and report back to the committee with ideas and policy suggestions. In addition, the committee meetings considered the input of any person who attended the meetings or sent written comments to DHS staff or committee members about a related topic. The [October 11, 2010 State Register](#) contained the proposed permanent rules relating to outpatient mental health services notice of hearing.

A public hearing was held on November 15, 2010 at which many members of the public provided testimony on the proposed rule language. Revisions to the proposed rule language were made and submitted to the administrative law judge for approval. The Notice to Adopt a Rule was published in the Minnesota State Register on June 20, 2011 and the new rules parts 9505.0370, 9505.0371, and 9505.0372 are officially adopted and implemented five days later on June 28, 2011. Concurrently, Minnesota Rule, part 9505.0323 is repealed.

Implementing the Rule

Providers need to take several actions prior to implementing the rule. They include:

- Review the rule
- Attend Information Session
- Attend Training Opportunities on:
 - Diagnostic Assessment
 - Clinical Supervision
 - Dialectical Behavior Therapy (DBT)
 - Neuropsychological Services

- Review this bulletin
- Complete provider enrollment requirements for clinical supervisor

Action Requested

Please read the information and implement changes. Please inform mental health consumers who might be impacted by changes noted. The bulletin is divided into two parts. The main body is a brief explanation of the significant and other changes. The attachment is done in a “question and answer” format. The main body and the attachment are both organized by the three rule parts (Minnesota Rule, parts 9505.0370; 9505.0371; and 9505.0372) and then by specific subparts consistent with the new administrative rule. In the main body you will see references to revisions even though these are new rules. Minnesota Rule, part 9505.0323 was used as the starting point for the development of the new rule. When the bulletin references “revision” it is talking about revisions that were made to language in the previous rule. When the bulletin states “new” it is describing something that was not in the previous rule.

Minnesota Rule, part 9505.0370 – Definitions

This rule contains new definitions and revised definitions. Under “Deleted Items” the bulletin identifies definitions that were not carried forward into the new rule and old definitions that were incorporated into revised definitions. A significant change to definitions (and other parts of the rule) is the inclusion of culture, cultural influences and cultural competency.

New Definitions

- Clinical summary
- Clinical supervisor
- Cultural competence or culturally competent
- Cultural influences
- Culture
- Dialectical behavior therapy
- Family
- Medication management
- Mental health practitioner
- Mental health professional
- Mental health telemedicine
- Multidisciplinary staff
- Neuropsychological assessment
- Neuropsychological testing
- Supervisee

Revised Definitions

- Clinical supervision
- Adult day treatment (previously day treatment)
- Diagnostic assessment
- Explanation of findings
- Psychotherapy

Deleted Definitions

- Biofeedback (incorporated into psychotherapy)
- Case management services (not an outpatient clinical service)
- Family psychotherapy (combined under psychotherapy)
- Group psychotherapy (combined under psychotherapy)
- Hypnotherapy (may be a component of psychotherapy)
- Individual psychotherapy (combined under psychotherapy)
- Mental health services (covered services added as distinct rule part)
- Multiple family group psychotherapy (combined under psychotherapy)
- Neurological examination
- Special mental health consultant

Minnesota Rule, part 9505.0371 – Coverage Requirement

This rule describes the requirements that outpatient mental health services must meet to receive medical assistance reimbursement. Even though the rule is specific to Medical Assistance coverage, providers must follow these same rules (Minnesota Rule parts 9505.0370 to 9505.0372) for services delivered to eligible clients under MinnesotaCare (see [MinnesotaCare covered services](#)).

Client Eligibility

The rule revised language that allows a client to receive limited services prior to completing an initial diagnostic assessment. The revised language clarifies the number of each service a client may receive and further specifies that any modality of psychotherapy except multifamily group is allowed before the initial diagnostic is completed. A client may receive:

- One explanation of findings
- Either one family psychotherapy session or one group psychotherapy session or one individual psychotherapy unit most appropriate for client situation (e.g. CPT[®] 90804 or 90806)
- One psychological testing

The rule allows clients who enter the mental health system as a result of a crisis to access outpatient mental health services without going through a brief, standard, or extended diagnostic assessment if the clients' crisis assessment meets the criteria specified in Minnesota Statutes, section 256B.0944 or 256B.0624, and was conducted within 60 days before the outpatient mental health service. This allows individuals who are experiencing short term psychiatric crises an opportunity to receive up to 10 mental health services within a 12-month period. If the crisis assessment identifies a need for intensive mental health services, a standard or extended diagnostic assessment should be conducted.

The rule identifies circumstances under which various diagnostic assessments may or may not be used to receive mental health services.

A Brief Diagnostic Assessment may be used for:

- A new client

- An existing client who had fewer than 10 sessions of psychotherapy in the previous 12 months and is anticipated to need ten or fewer psychotherapy sessions in the next 12 months
- An existing client who needs medication management only
- A subsequent annual assessment if, based upon the client's treatment history and the provider's clinical judgment, the client will need ten or fewer mental health sessions in the next 12 months

A brief diagnostic assessment must not be used:

- When a client or client's family requires a language interpreter to participate in the assessment unless the client is:
 - an existing client who needs medication management only
 - an existing client who has had less than 10 sessions of psychotherapy in the previous 12 months and is anticipated to need ten or fewer psychotherapy sessions in the next 12 months
 - a subsequent annual assessment if, based upon the client's treatment history and the provider's clinical judgment, the client will need ten or fewer mental health sessions in the next 12 months
- When an ongoing client is expected to need more than ten sessions of mental health services in a 12 month period.

A new Standard or Extended diagnostic assessment must be completed for a child:

- Who requires an initial diagnostic assessment and does not meet the criteria for a brief diagnostic assessment
- At least annually, following the initial diagnostic assessment, if:
 - Additional services are needed; and
 - The child does not meet the criteria for a Brief diagnostic assessment
- When the child's mental health condition has changed markedly since the child's most recent diagnostic assessment
- When the child's current mental health condition does not meet criteria of the child's current diagnosis.

A new Standard or Extended diagnostic assessment must be completed for an adult:

- Who requires an initial diagnostic assessment and does not meet the criteria for a brief diagnostic assessment
- At least every three years following the initial diagnostic assessment for an adult who has been receiving services
- When the adult's mental health condition has changed markedly since the adult's most recent diagnostic assessment
- When the adult's current mental health condition does not meet criteria of the adult's current diagnosis

An adult diagnostic assessment Update must be completed at least annually unless a new standard or extended diagnostic assessment is performed. The adult diagnostic assessment update must include an update of the most recent standard or extended diagnostic assessment and

any recent adult diagnostic assessment updates that have occurred since the last standard or extended diagnostic assessment.

Adult Diagnostic Assessment Update

- Adults age 18 and older
- Updates the most recent diagnostic assessment
- Reviews recipient's life situation: updates significant new or changed information, documents where there has not been significant change
- Screens for substance use, abuse, or dependency
- Mental status exam
- Assesses recipient's needs based on baseline measurements, symptoms, behavior, skills, abilities, resources, vulnerabilities, safety needs
- Includes a clinical summary
- Includes recommendations and prioritization of needed mental health, ancillary, or other services
- Includes involvement of recipient and recipient's family in assessment and service preferences and referrals to services
- Includes diagnosis on all axes of the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM)

Note: An adult diagnostic assessment update can only be an update of a standard or extended diagnostic assessment. An adult diagnostic assessment update must be an update of a standard or extended diagnostic assessment that has occurred within the past 12 months; or an update of a standard or extended diagnostic assessment that has occurred within the past 24 months and an adult diagnostic assessment that has occurred within the past 12 months.

Note: CTSS requires an annual diagnostic assessment for children up to age 18 (CTSS annual DA exception). For adolescents age 18-21 only annual updating is required, unless the mental health status has changed.

Authorization for Mental Health Services

This subpart allows DHS to establish thresholds, medical review standards, and criteria in accordance with Minnesota Statutes, section 256B.0625, subdivision 25. This statutory authority allows DHS to place limits on health care services based on medical necessity or utilization control.

Clinical Supervision

Changes made to the rule pertaining to clinical supervision were made with the intent to provide a structure around the supervision session. All Mental Health Practitioners (qualified under Minnesota Statutes, section 245.4871, subdivision 26, or section 245.462, subdivision 17) who are providing services defined in this rule must be under the clinical supervision of a qualified clinical supervisor. Mental health practitioners fit into two groups:

- Practitioners conducting diagnostic assessments, psychotherapy or explanation of findings as part of a legitimate internship or on an approved licensure track to be a Mental Health Professional or

- Practitioners working within day treatment, or dialectical behavior therapy or partial hospitalization programs who are not conducting diagnostic assessments or psychotherapy services.

Clinical supervision can be done either individually or in a group. The rule implements a group size maximum. Group supervision cannot exceed six supervisees. Face-to-face individual or group supervision can be by telemedicine. The interactive video equipment and connection must comply with Medicare standards that are in effect at the time of the service.

A new requirement for clinical supervision is the development and maintenance of an individual clinical supervision plan for each individual under clinical supervision. Clinical supervision must be based on each supervisee's written supervision plan and must:

- promote professional knowledge, skills, and values development
- model ethical standards of practice
- promote cultural competency
- recognize that the client's family has knowledge about the client and encourage the families' participation in treatment planning where possible
- Monitor, evaluate, and document the supervisee's performance of assessment, treatment planning and service delivery

The clinical supervision plan must be developed by the supervisor and supervisee, and reviewed and updated at least annually. The supervision plan must include:

- supervisee name and qualifications and name of agency where clinical supervision occurred
- name, licensure, and qualifications of the supervisor
- number of individual and group supervision hours and whether those hours will be face-to-face or by some other method approved by commissioner
- policy and method that the supervisee must use to contact the clinical supervisor during service provision to a supervisee
- procedures the supervisee must use to respond to client emergencies
- authorized scope of practice, including:
 - description of the supervisee's service responsibilities
 - description of client population
 - Treatment methods and modalities

Documentation of the supervision session needs to be made in the supervision record of the supervisee. The record must include:

- Date and duration of supervision
- Type of supervision (individual or group)
- Name of clinical supervisor
- Subsequent actions supervisee must take
- Date and signature of clinical supervisor

Clinical supervision documentation pertinent to client treatment changes must be recorded by a case notation in the client chart.

Qualified Providers

The rule consolidates various other rule and statute citations into a cohesive description of mental health professionals who are licensed to practice independently in Minnesota and enroll with Minnesota Health Care Programs (MHCP). [Under Minnesota Statutes, section 256B.02, subd. 7](#), a federally-recognized Minnesota tribe may license or credential health care providers using standards adopted by its governing body. Providers credentialed this way may also enroll as MHCP providers. Licensure and enrollment criteria for each mental health professional can be viewed in the MHCP Provider Manual under the Mental Health Professional Certification and Enrollment table. See the MHCP Provider manual for a list of mental health practitioner requirements.

The rule now considers mental health practitioners working as clinical trainees. A mental health practitioner must have training to work with the population (child or adult) they are delivering services to and must be qualified in at least one of the following ways. The practitioner must:

- hold a master's or other graduate degree in one of the mental health professional disciplines (as defined in Minnesota Rule, part 9505.0371, subp. 5, item A)
- be a student in one of the mental health professional disciplines (as defined in Minnesota Rule, part 9505.0371, subp. 5, item A) and be formally assigned by an accredited college or university to an agency or facility for clinical training

Under Medical Assistance Fee For Service (FFS), the clinical trainee may conduct a diagnostic assessment, provide an explanation of findings, and render psychotherapy when under the clinical supervision of a qualified supervisor as defined by the outpatient mental health clinical services rule.

A significant change is the addition of specific criteria an enrolled mental health professional must meet as a clinical supervisor. Although the rule delineates specific requirements and duties for a clinical supervisor, many are duties clinical supervisors already meet or are doing as quality assurance components of their clinical responsibilities. A clinical supervisor:

- Is a licensed mental health professional
- Holds a license without restrictions, in good standing for at least one year, and has performed at least 1,000 hours clinical practice;
- Is approved, certified, or in some other manner recognized as a qualified clinical supervisor by the individual's professional licensing board where required
- Is competent, as demonstrated by experience and graduate-level training, in the area of practice and the activities being supervised
- Is not the supervisee's blood or legal relative or cohabitant, or someone who has acted as the supervisee's therapist in the past two years;
- Has experience and skills that are informed by advanced training, years of experience, and mastery of a range of competencies
 - capacity to provide services that incorporate best practice;
 - ability to recognize and evaluate competencies in supervisees;
 - ability to review assessments and treatment plans for accuracy and

- appropriateness;
- ability to give clear direction to mental health staff related to alternative strategies when a client is struggling with progress toward recovery; and
- ability to coach, teach, and practice skills with supervisees
- Accept full professional liability for the supervisee's direction of clients' mental health services
- Instructs supervisee, oversees quality and outcome of supervisee's work
- Review, approve, and sign the diagnostic assessment, individual treatment plan (ITP) and ITP reviews created by supervisee
- Review and approve the progress notes according to the supervisee's supervision plan
- Be employed by or under contract with the same agency as the supervisee
- develop a clinical supervision plan for each supervisee
- ensure that each supervisee receives the guidance and support needed to provide treatment services in areas where the supervisee practices and promote cultural competence
- establish an evaluation process that identifies the performance and competence of each supervisee

Release of information

Rather than specifying requirements for release of information, the rule follows Minnesota Data Practices Act and Health Insurance Portability and Accountability Act (HIPAA) standards. An addition to the rule is a requirement that providers need to share information with other providers without undue delay when client consent is given.

Individual Treatment Plan

No substantial change is made to individual treatment plan requirements. See MHCP Provider Manual Mental Health Overview for more information.

Documentation

Changes are minimal for this subpart. For each occurrence of service, providers are now required to record the date of documentation and start and stop times in client records. Providers are also required to document the date treatment begins and ends plus reasons for discontinuing service.

Service Coordination

Coordination between providers is an expectation. Of course it needs to be done with the permission of the individual receiving the services. Service coordination needs to be documented in the client's mental health record.

Providers must:

- Coordinate with services delivered by other mental health providers services and ensure services are provided efficiently to achieve maximum benefit for the recipient
- Coordinate with recipient's physical health care provider
- Coordinate with any other provider or service the recipient is receiving when permission is granted by the individual

Telemedicine

The outpatient mental health services may be conducted via telemedicine and reimbursed just as they would if the person and the provider were face to face in the same room. Telemedicine means that the services are provided using two-way interactive video technology that is secure and meets HIPAA requirements for privacy. The use of telemedicine technology must be appropriate to the recipient's condition and needs. Services that would not be covered using telemedicine are found under Telemedicine on the Mental Health Overview page in MHCP Provider Manual.

Minnesota Rule, part 9505.0372 – Covered Services

Diagnostic Assessment

Significant changes were made to this covered service, one of which is the creation of four diagnostic assessment types. They are: brief diagnostic assessment; standard diagnostic assessment; extended diagnostic assessment; and adult diagnostic assessment update. When the clinician chooses the type of diagnostic assessment based on their client's need, the clinician must follow the specific criteria for that assessment. As clinicians implement these different options they will begin to see that the components of the standard lay the framework for the other assessments.

The following is a list of expectations that a clinician needs to follow in order to be in compliance with MHCP billing practices:

- There must be a written report: Please remember that the diagnostic assessment process is not complete with the interview or review of record alone; a written report must be generated.
- Identify a mental health diagnosis or include a finding that the client does not meet the criteria for a mental health disorder. At the end of the written report, a 5 axis diagnosis must be listed describing whether or not the individual meets criteria for a diagnosis. Not all assessments lead to the substantiation of a diagnosis.
- Include recommendations for mental health services that are medically necessary. The goal is to recommend all services that the client needs including those not offered by the diagnosing provider. Future providers may use this assessment
- All clients need to have a new diagnostic assessment each year to maintain eligibility and services, however adults may receive updates on years 2 and 3 of the service delivery
- Treatment plans are based from the diagnostic assessment: therefore a report should indicate what services and primary treatment goals are needed.
- Include screenings used to determine the likelihood of substance use, abuse or dependency. Recommended screening tools:
 - CAGE-AID (validated for ages 12+)
 - GAIN-SS (validated for ages 10+)
 - Please see DHS website for further details
http://www.dhs.state.mn.us/main/groups/disabilities/documents/pub/dhs16_145318.pdf
- Include assessment methods and describe use of standardized assessment tools:

- ECSII (if under the age of 6)
- CASII and
- SDQ (if between the ages of 3 and 18)

Note: the LOCUS for adults is not required at this time

- Include in the Clinical Summary
 - Clinical conceptualization of cause of client's mental health symptoms, prognosis, and likely consequences of the symptoms
 - How client meets criteria for the diagnosis
 - Analysis of strengths, functional impairment and how the diagnosis interacts/impacts with client's life
 - Explain rule outs, provisional diagnosis and why alternative diagnoses that were considered and ruled out
- Cultural influences MUST be addressed:
 - Racial or ethnic self-identification
 - Experience of cultural bias as a stressor
 - Immigration history and status
 - Level of acculturation
 - Time orientation
 - Social orientation
 - Verbal communication style
 - Locus of control
 - Spiritual beliefs
 - Health beliefs and engagement in culturally specific healing practices

Current licensed mental health professionals (licensed psychologists, licensed marriage and family therapists, licensed independent clinical social workers, licensed professional clinical counselors, licensed psychiatric nurse practitioners, psychiatrists and tribally approved mental health care professionals) may continue to conduct diagnostic assessment sessions and seek MHCP fee for service reimbursement once the report has been written.

The rule allows certain mental health practitioners to conduct diagnostic assessment sessions and seek MHCP fee for service reimbursement once the report has been written and the practitioner receives appropriate clinical supervision. These practitioners are:

- complying with requirements for licensure or board certification as an approved mental health professional (such as a Licensed Graduate Social Worker (LGSW), a Licensed Professional Counselor (LPC), a Licensed Associate Marriage and Family Therapist (LAMFT) or a post-doctoral candidate in psychology) or
- students in a bona fide field placement or internship under a program leading to completion of the requirements for licensure as a mental health professional,

Training on the diagnostic assessment standards will be offered. See at http://www.dhs.state.mn.us/dhs16_160315 for additional information on training.

Neuropsychological Assessment

The rule defines who is eligible to receive an assessment, defines assessment requirements, and defines who is qualified to conduct a neuropsychological assessment. Although the previous rule did not include any of this detail, the majority of the standards are recognized community standards.

As a result of the hearing process qualifications for conducting a neuropsychological assessment were made. There are four ways to be qualified. An assessor must have:

1. Received a diploma from one of the following boards or academies:
 - i. American Board of Clinical Neuropsychology (ABCN)
 - ii. American Board of Professional Neuropsychology (ABPN), or
 - iii. American Academy of Pediatric Neuropsychology (AAPN)
2. Earned a doctoral degree in psychology from an accredited university training program and
 - i. Completed an internship or its equivalent, in a clinically relevant area of professional psychology
 - ii. Completed the equivalent of two full-time years of experience and specialized training, at least one which is at the post-doctoral level, in the study and practices of clinical neuropsychology and related neurosciences supervised by a clinical neuropsychologist and
 - iii. Holds a current license to practice psychology independently in accordance with Minnesota Statutes, sections 148.88 – 148.98
3. Been licensed or credentialed by another state's board of psychology examiners in the specialty of neuropsychology using requirements equivalent to requirements specified by one of the boards named earlier
4. Been approved by the commissioner as an eligible provider of neuropsychological assessment prior to December 31, 2010, (enrolled in MHCP with neuropsychology specialty)

For detailed information about neuropsychological assessment see MHCP Provider Manual and attend Neuropsychological Assessment and Neuropsychological Testing training.

Neuropsychological Testing

There is no change to payment policy. See the MHCP Provider Manual and attend Neuropsychological Assessment and Neuropsychological Testing training.

Psychological Testing

There are no major changes to this area. Specific language was added indicating that in addition to licensed psychologist, a mental health practitioner working as a psychological clinical trainee can conduct psychological testing and write the report.

Explanation of finding

Clarified who may be part of this service. No change to payment policy.

Psychotherapy

Three changes to psychotherapy include:

- Changing the minimum size of group from 4 to 3 for group psychotherapy
- eliminating a 10 week limitation for multiple family group psychotherapy
- adding the ability to exclude the identified client from multiple family group psychotherapy if reason for the exclusion is documented

Medication Management

No Changes.

Adult Day Treatment

The rule updates and clarifies current payment policy. As a result of the hearing process, DHS changed language from the previously published proposed rule. Changes include eliminating two words, “short-term” and “cognitive” from the originally proposed language. See MHCP Provider Manual Adult Day Treatment.

Partial Hospitalization Program

Language is unchanged from Minnesota Rule, part 9505.0323.

Dialectical Behavior Therapy

Dialectical Behavior Therapy (DBT) has been added to the covered services. DBT is an effective treatment for persons with chronic suicidality and severe emotional and behavioral dysregulation. The treatment is a combination of clinical and rehabilitative interventions.

The review of DBT programs for certification is through an application submitted to the Adult Mental Health Division (AMHD) and reviewed for annual certification. Applications are reviewed by the AMHD on an ongoing basis. The certification application is available at http://www.dhs.state.mn.us/dhs16_158231.doc.

The rule also allows teams to be certified by DHS if the program is accredited by a nationally-recognized body approved by the commissioner. Providers must contact the AMHD for further instruction if they wish to be certified under this provision.

Once certified, DBT programs will have access to procedures codes for billing claims for DBT services.

Certified Programs must:

- Treat Eligible Recipients
 - Determine Treatment Readiness/Appropriateness
 - Determine Medical Necessity
 - Submit Prior Authorization Form for each recipient (<https://edocs.dhs.state.mn.us/lfservlet/Public/DHS-6322-ENG>)
- Offer Comprehensive Treatment, including:
 - Individual Therapy

- Group Skills Training
- Phone Coaching
- Team Consultation
- Have qualified staff, including:
 - Mental Health Professionals (Team Leader)
 - MH Practitioners in clinical training
 - Mental Health Practitioners
- Report Outcomes
 - Collect client-level information
 - Report data to DHS

Legal References

Minnesota Rules, parts 9505.0370 to 9505.0372

Minnesota Statutes, section 256B.04, subdivision 4

Minnesota Statutes, section 256B.0625

Minnesota Statutes, sections 245.461 to 245.4889

Minnesota Statutes, section 62J.536

Minnesota Statutes, section 14.388, subdivision 1

Code of Federal Regulations, Title 42, section 431.10 (42 CFR 431.10)

Americans with Disabilities Act (ADA) Advisory

This information is available in alternative formats to individuals with disabilities by calling (651) 431-2225 (voice). TTY users can call through Minnesota Relay at (800) 627-3529. For Speech-to-Speech, call (877) 627-3848. For additional assistance with legal rights and protections for equal access to human services programs, contact your agency's ADA coordinator.

Attachment

Questions and Answers Minnesota Rule, parts 9505.0370 to 9505.0372

9505.0370 Definitions:

1. Question: Is there anything that changed in this part?

1. Answer: Yes, see bulletin pages 3 and 4 plus the rule.

9505.0371 Coverage Requirements:

9505.0371 Subp. 2. Client Eligibility

1. Question: What is meant by “client eligibility?”

1. Answer: A client must meet certain criteria to qualify for reimbursable ongoing outpatient mental health services. Medical assistance pays for a health service only if the service is medically necessary and appropriate for the client. Medical necessity and appropriateness are documented by the information in a good written diagnostic assessment. The diagnostic assessment identifies whether the client has a mental illness that meets criteria listed in DSM-IV. If the recipient does not meet the DSM-IV (or for young children DC:0-3R) criteria then there is not a need for additional mental health services. The diagnostic assessment also determines which mental health services are medically necessary for the client.

2. Question: Do you need to have a complete diagnostic assessment before a client can receive ongoing outpatient mental health services?

2. Answer: Yes. An exception to this is for clients new to mental health services. Providers can conduct and get reimbursed for: one explanation of findings, one psychological testing encounter and either one individual psychotherapy or one family psychotherapy or one group psychotherapy prior to the completion of a client’s INITIAL diagnostic assessment.

3. Question: For a client who had a crisis assessment what do I do if a client needs more services than 10 sessions in a 12 month period?

3. Answer: The client needs to receive either a standard or extended diagnostic assessment.

4. Question: What if I do a brief diagnostic assessment because the referral information and the face-to-face interview doesn’t lead me to believe the client will need more less than 10 session but when we get to about the 7th session the client shares more information which changes my opinion?

4. Answer: Conduct a standard or extended diagnostic assessment.

9505.0371 Subp. 4. Clinical Supervision

1. Question: Where can I find more information on clinical supervision?

1. Answer: See bulletin pages 6 and 7 plus the rule.

2. Question: Who is required to receive clinical supervision?

2. Answer: All mental health practitioners that provide services under this rule. These specifically include mental health practitioners that are clinical trainees and completing DA's and psychotherapy (including psychotherapy under CTSS), as well as mental health practitioners that work within day treatment, partial hospitalization programs or Dialectical Behavior Therapy programs.

9505.0371 Subp. 5. Qualified Providers

1. Question: I am an LGSW and my agency wants me to be a clinical supervisor for billing MHCP in outpatient services. Can I be a clinical supervisor once I receive my LICSW license?

1. Answer: No, you must first complete 1000 hours of direct service and comply with any additional clinical supervisor requirements of the MN Board of Social Work.

2. Question: My agency is a Rule 29 clinic. I am a mental health practitioner, currently qualified as an LISW and work under the clinical supervision of a mental health professional. My agency previously received half of my clinical supervisor's rate when I conducted a diagnostic assessment or psychotherapy. My understanding of the new rule is that now my agency will receive 100% of my clinical supervisor's rate. Is this true?

2. Answer: Yes when claim coding instructions are followed and the rendering (treating provider) is enrolled with MHCP as qualified mental health professional clinical supervisor. The mental health professional must complete and submit DHS-6330 [MHCP Qualified Mental Health Professional Clinical Supervision Assurance Statement](#) to DHS Provider Enrollment.

Your agency should submit claims for the services you provide at the agency's usual and customary rate, regardless of the rate that is reimbursed under MHCP

9505.0372 – Covered Services

9505.0372 Subp. 1. Diagnostic Assessment (DA)

1. Question: Where can the reimbursement rates for diagnostic assessment be found?

1. Answer: [Diagnostic assessment rates](#) are located on Outpatient Mental Health Services web page.

2. Question: How does a diagnostician decide which diagnostic assessment type to use?

2. Answer: With the new rule, we are encouraging clinicians to use their clinical judgment to determine the best assessment type for their client's needs. However, there are particular situations where a Brief diagnostic assessment may be used (the client is new to mental health services, the client has been seen previously and it is anticipated they will need fewer than 10 psychotherapy sessions, etc.). There are also particular situations in which an Extended may be used (like the client has complex needs, is under the age of 5, or has co-occurring substance abuse disorders and there is a need for at least 3 diagnostic assessment appointments in order to conduct a thorough assessment).

3. Question: Are there limits on how many DA's can be reimbursed during a calendar year before prior authorization is needed?

3. Answer: Yes, up to two DAs, of any type can be completed and reimbursed within a 12 month period without the need for the clinician to receive prior authorization. A provider may seek authorization for a third diagnostic assessment in a twelve month period. See the MHCP Provider Manual for information regarding the process to seek authorization for additional services.

4. Question: Can psychotherapy sessions be reimbursed before a DA is completed?

4. Answer: Prior to the initial diagnostic assessment a client is eligible for one psychotherapy session (individual, family or group).

5. Question: Completion of a "brief" DA permits the provision/reimbursement for some amounts and types of mental health services. Could more clarity be provided about this? Amounts and types?

5. Answer: The rule states that a brief diagnostic assessment may be used to allow up to 10 sessions of mental health services in part 9505.0372. Services listed in part 9505.0372 "Covered Services" include: Diagnostic Assessment, Neuropsychological Assessment, Neuropsychological Testing, Psychological Testing, Explanation of Findings, Psychotherapy (Individual, Family, Group, Multiple-family Group), Medication Management, Adult Day Treatment, Partial Hospitalization, and Dialectical Behavioral Therapy. While all of these services can be accessed from the Brief Diagnostic Assessment, clinically Adult Day Treatment, Partial Hospitalization and DBT require more than the Brief level of assessment to medically justify that level of intensive service. See MHCP Provider Manual and rule for further information.

6. Question: If the diagnosis is unclear in the brief diagnostic assessment, should the diagnosis be "deferred" or be labeled as "provisional" other label?

6. Answer: It is recommended that a "provisional" diagnosis be made, rather than "deferring" a diagnosis. A provisional diagnostic hypothesis is allowed for the brief diagnostic assessment and can be listed as such on the diagnostic material. Provisional or deferred may only be utilized when conducting a standard or an extended diagnostic assessment after at least one diagnosis is

substantiated (example: Axis I: 296.23 Depressive Disorder, Single Episode, Moderate Severity; provisional 309.81 Post Traumatic Stress Disorder).

7. Question: How long does a clinician have to officially determine if a client meets criteria for a diagnosis that is recorded as a “rule out” on the DA?

7. Answer: The clinician should continue the evaluation of the potential rule-out in client file through the progress notes. The diagnosis should be officially ruled in or out at the next assessment, if not before.

8. Question: To implement this new rule correctly, must new standard or extended DA’s that are consistent with the new administrative rule standards be completed immediately on all clients?

8. Answer: No, if a client has a valid diagnostic assessment in their file that authorizes current services, a new diagnostic does not need to be done. If, however, the diagnostic for a child is over a year old, a brief, standard or extended diagnostic should be done based on the client’s current situation or need. See answer 9 for information on adult criteria.

9. Question: Concerning Adult DA Updates, if there is a valid DA within the past year, or within the past two years with an adult DA update that has been completed within the past year (under the old rule standards), is it sufficient to do an Adult DA Update in the coming year; or must a new standard or extended DA be completed first as the basis for future Adult DA Updates.

9. Answer: Implementation of this new administrative rule does not require the immediate completion of new DAs just to comply with the new standards. If there is a valid DA within the past year, or within the past two years with a DA update that has been completed within the past year (under the old rule standards), is it sufficient to do an Adult DA Update in the coming year. Again, these are the minimum frequencies for completion of DAs. The need to complete new DAs or complete Adult DA Updates is also determined by the individual’s situation and changes in symptoms and/or functioning.

10. Question: Does the diagnostician really have to address all of the areas/items list in the rule as relates to assessing cultural influences?

10. Answer: The rule states that the diagnostic assessment needs to discuss cultural influences that “are relevant to the client” which may include the list identified. However, while a clinician need only document in the record the cultural influences that are relevant to the client, it is still incumbent on the clinician to ask about all of them to determine relevance. The DHS expectation is that there will be documentation of specific culturally relevant influences on each DA. It is not acceptable to state that there are no cultural influences that are relevant / applicable for an individual.

11. Question: Must the DC:0-3R diagnostic system (tool) be used when completing DA for children under age 5?

11. Answer: No the clinician can conduct a standard diagnostic assessment without using the DC:0-3R diagnostic system. It is highly recommended, though not required, that mental health clinicians who have attended a DC:0-3R training utilize the DC:0-3R process for diagnosing children under the age of five. As this process is quite extensive, the extended diagnostic assessment is the best choice for conducting this process and the DC:0-3R diagnostic system is one of the components of an extended DA for children under age 5.

12. Question: Can DA be completed via videoconferencing?

12. Answer: Yes. A diagnostic assessment can be completed face-to-face or by using mental health telemedicine which is defined in Minnesota Statutes, section 256B.0625, subdivision 46 which states: “Effective January 1, 2006, and subject to federal approval, mental health services that are otherwise covered by medical assistance as direct face-to-face services may be provided via two-way interactive video. Use of two-way interactive video must be medically appropriate to the condition and needs of the person being served. Reimbursement is at the same rates and under the same conditions that would otherwise apply to the service. The interactive video equipment and connection must comply with Medicare standards in effect at the time the service is provided.

13. Question: Why is there a new emphasis on a “clinical summary”? How long does it have to be?

13. Answer: A clinical summary is the most important part of the diagnostic assessment; it is where a clinician is able to connect all the data into a synthesized diagnostic hypothesis. There is no specific length of space that a clinical summary should occupy in the diagnostic assessment, but it should be complete and comprehensive in explaining how this particular client’s symptoms meet the diagnostic code listed. See definition in rule for content specifics.

14. Question: The rule states that “screenings are to be used to determine the client’s substance use, abuse or dependency and other screening instruments determined by the commissioner”. What are those screening instruments and where can they be found?

14. Answer The AMH and CMH Division published a [paper](#) that indicates the current recommended screening tools. The use of a valid, reliable screening tool determines the likelihood of a substance abuse or dependency diagnoses and the need for further assessment. The CAGE-AID is validated for ages 12 and up and the GAIN-SS is validated for ages 10 and up. Youth above the age of 10 should be screened for substance use.

15. Question: The rule states that “assessment methods and use of standardized assessment tools by the provider as determined and periodically updated by the commissioner” are to be used. What are these tools and where can they be found?

15. Answer: The Children’s Mental Health Division published a bulletin “DHS Updates

Requirement for Standardized Outcome Measures for Children's Mental Health" (11-53-02 http://www.dhs.state.mn.us/main/groups/publications/documents/pub/dhs16_161561.pdf) which describes the current approved tools by the commissioner (the CASII, ECSII and SDQ). The Adult Mental Health Division recommends using the LOCUS but does not currently have a required tool at this time.

16. Question: The rule states that the diagnostic assessment needs to include information about health history and family health history... What happens if the client refuses to share the information or sign a release of information with the doctor?

16. Answer: The request and client reason for refusal should be noted in the client file. Consequences of not having this information should be discussed with the client. Future attempts should be made and documented to discuss this topic and to obtain needed releases of information, however, a clinician cannot be held accountable for information that has not been provided.

17. Question: Who is a good fit for an "extended" diagnostic assessment?

17. Answer: An extended diagnostic is a good assessment type to use with clients who are under the age of 5, clients who have complex needs that are caused by acuity of psychotic disorder, cognitive or neurocognitive impairment; clients with an extensive diagnostic history that needs to be determined current applicability, co-occurring substance abuse disorders, and/or disruptive or changing environments; clients who have significant communication barriers (client and clinician primary language is not the same), and/or cultural considerations as documented in the assessment.

18. Question: When doing the "extended" diagnostic assessment, does the clinician have to leave the office?

18. Answer: The clinician does not have to leave the office but does need to conduct 3 separate appointments in order to gather sufficient data to complete an extended diagnostic assessment. However, one of the intentions of the extended DA is to encourage observations and contacts in non-office settings when significant assessment information can be obtained that will contribute to the diagnostic formulation.

19. Question: Extended DA's require at least three different appointments with the client to complete. Can the appointment occur on the same day?

19. Answer: Each appointment should be a separate event. By definition, extended DA is determined to be necessary, in part, because of the need to observe/assess the client in multiple settings (i.e. 1 appointment with parents, 1 appointment just with the client and 1 appointment observing the child at school) and/or factors that make the completion of the DA inefficient or inadequate to do in a single time period. Booking three appointments back-to-back in the clinician's office is not the intent of the extended DA option.

20. Question: The extended DA requires at least three appointments with the client to complete.

Can the diagnostician obtain partial reimbursement for a partial DA, if the client does not show up for the second or third appointment?

20. Answer: A clinician may seek reimbursement for the end diagnostic assessment product – a complete DA. MHCP does not compensate for time attempted to create the product, just the product itself. The clinician should produce the diagnostic assessment report for which she has sufficient information.

21. Question: Who is a good fit for a “brief” diagnostic assessment?

21. Answer: Clients who have never received services before or whose presenting problem indicates that they will need fewer than 10 sessions are a good fit for a brief diagnostic assessment.

22. Question: When writing an Adult DA Update, how does the clinician indicate that nothing has changed in a given area of functioning or assessment? And does the client need one if the previous assessment still applies?

22. Answer: The rule language addresses this in 9505.0372 Subpart 1. E. The rule identifies the 7 areas where updates are needed. If there is an area or subarea where there is not significant change since the last DA or adult DA update, then document “the area was reviewed and no significant changes are noted.” A new mental health status examination must be completed and documented. Required screening must be repeated and documented with the frequency required for the screening tool. The clinical summary must be updated to include significant findings, changes in functioning since the previous DA baseline functioning assessment domains, updated recommendation and prioritization of need services, client and family participation and preferences, and recommended services.

23. Question: Does this new rule change the requirement that DA’s for mental health targeted case management services clients only have to be completed every three years?

23. Answer: This rule covers eligibility for services within this rule. Targeted case management eligibility is not covered within this rule, however, in order for the client to maintain eligibility for other services like day treatment or psychotherapy a diagnostic assessment needs to be completed every year and a copy should be shared with the case manager, with client consent.

24. Question: What happens if records are requested but do not arrive before the clinician needs to complete the diagnostic assessment?

24. Answer: Significant delays in obtaining requested records do not prevent the clinician from completing the DA if the clinician believes an adequate assessment has been produced. A clinician should review the records when they arrive and make note of the review in the client’s chart. A diagnostic assessment report can then be updated with the information at that time. This time should be considered part of the diagnostic assessment and will not be reimbursed separately.

25. Question: What type of documentation does a clinician need to provide to meet eligibility requirements for an extended diagnostic assessment?

25. Answer: The clinician should make a standard “progress note” entry into the client file for each appointment and document the rationale for the decision to use the extended diagnostic assessment option. That rationale should explain how the client meets one or more of the rule categories. See question 17.

9505.0372 Subparts 4., 5., 6., 7 Psychological Testing, Explanations of Findings, Psychotherapy, Medication Management

1. Question: Did anything change in the description of Explanation of Findings?

1. Answer: The premise of explanation of findings remains the same, this rule, however, includes the client as an eligible recipient of the service.

2. Question: When doing family psychotherapy, who should be the identified client?

2. Answer: The identified client should be the person who has a diagnosable mental health condition that requires mental health treatment, specifically family psychotherapy.

3. Question: How many people can participate in group psychotherapy?

3. Answer: Participant number depends on how many professional(s) or practitioner(s) working as clinical trainee are available for the group. If there is 1 professional or clinical trainee there may be 3 to 8 clients in group psychotherapy, if there are 2 professionals or 2 clinical trainees or 1 professional and one clinical trainee then the group may be from 9 to 12 clients.

4. Question: Who needs to be present for multiple-family group psychotherapy?

4. Answer: There must be 2 but not more than 5 families present for multiple-group psychotherapy. If the identified client (with the diagnosable mental health disorder) or a member of the family is not present, the mental health professional or clinical trainee providing the service must document the reason for the exclusion.

5. Question: What is the difference between psychotherapy and counseling?

5. Answer: Psychotherapy is a medical service that is used to treat a diagnosed mental health disorder. Counseling is not a medical service and can be provided for anyone; counseling is not a reimbursable service in MHCP.

9505.0372 Subp. 8. Adult day treatment

1. Question: Has there been a change regarding who can provide psychotherapy within a day

treatment program?

1. Answer: Clarification has been made that clearly states that only a mental health professional or a mental health practitioner that qualifies as a clinical trainee can provide the psychotherapy components of an adult day treatment program.

2. Question: Is day treatment a short-term service?

2. Answer: Participants in adult day treatment must meet the admission or continuing stay criteria as stated in the MHCP provider manual. This is not a change to adult day treatment policy. Adult day treatment services are designed to be short-term, intensive interventions as determined medically necessary for each individual on a case by case basis.

3. Question: What are the changes around the documentation of treatment planning and the provision of services with regards to adult day treatment?

3. Answer: There have been changes as they relate to treatment planning and documentation:

- a.) There must be a treatment plan in place prior to the first day of treatment
- b.) The progress of the recipient as measured by the functional assessment (FA) and LOCUS and updates to the treatment plan must be updated every 30 days.
- c.) Interventions provided throughout the treatment day must be documented daily, including start and stop times. Although not specified in the rule, the daily documentation needs to include interventions offered within each group that occurred throughout the day.

9505.0372 Subp. 10. Dialectical Behavior Therapy

1. Question: What is the status of the proposed rule change for DBT programming, billing codes and reimbursement? Do you know when we will be able to start using the new billing codes?

1. Answer: By submitting evidence of meeting rule standards programs will be certified and authorized to bill using the DBT-specific procedure codes.

2. Question: What are the specific codes for Dialectical Behavior Therapy?

2. Answer: All DBT covered services require prior authorization. See [rates page](#) on mental health codes and maximum adjusted fee-for-service rate.

Code	Mod	Brief Description	Units	Service Limitation
H2019	U1	Individual DBT Therapy	15 min	Up to 26 hours (104 units) per six months
H2019	U1 HQ	Group DBT Skills Training	15 min	Up to 78 hours (312 units) per six month

3. Question: I am in private practice, but remain a part of a DBT team, including attending weekly consultation team with staff from a clinic. I also provide 24 hour coaching calls and skills training. Can I be a part of a certified team?

3. Answer: It is possible for an individual therapist to be part of a certified team even if they don't work for the same agency just as long as the therapist is considered an affiliated member of the team. Individual clinicians in private practice must be contracted or affiliated with a certified DBT program. At the time of applying for certification a DBT program should delineate all qualified staff considered to be a part of the DBT treating team whether employed by, contracted by or otherwise affiliated with the program. All team members of a certified team are required to follow all standards within this rule part. Once a team is certified all members who are enrolled Minnesota Healthcare Programs providers will be assigned a DBT specialty code on their provider profile.

4. Question: If individual therapists do not have to be employed within the same clinic as the certified team will individual clinicians in private practice be able to bill directly for covered services (assuming certification criteria are met)?

4. Answer: An individual DBT therapist can be considered part of a DBT team or program and bill directly for covered services provided outside of the clinic or entity certified. The provision of both individual DBT therapy and group skills training requires prior authorization. Provider names and national provider identification number (NPI) for each service (individual DBT and group skills training) must be designated at the time of prior authorization in order for those providers to use DBT procedure codes.

5. Question: In order for a team to be considered for certification will clinicians have certain training requirements?

5. Answer: All team members must have or obtain competencies and working knowledge of DBT principles and be able to apply the principles and practices consistent with the evidence-based practice within the first six months of working on a DBT team. Competencies can be obtained through multiple routes such as classroom training, workshops, DBT study group, team consultation and supervision.

6. Question: Will a DBT group designed for people with Developmental Disabilities who need a more concrete approach at a slower pace be considered for certification? We are wondering if this would fit under the new billing and what, if any, accommodations are put into the rule for this type of situation?

6. Answer: Individuals receiving the covered service of DBT must meet established eligibility criteria. There is a requirement that individuals understand and be cognitively capable of participating in DBT as an intensive therapy program. If an individual has a low IQ, a diagnosed TBI or other cognitive disability a program must demonstrate and describe on each individual's prior authorization form any adaptations to teaching style and behavioral interventions to be able to effectively provide the covered services.

7. Question: I have several Medicare/Medicaid DBT clients, so I want to make sure I understand the billing process for bypassing Medicare. Where is DHS in this process?

7. Answer: Please note that the above codes are not Medicare reimbursable. Bill DHS directly for dual eligibles.

8. Question: Will MCO's cover DBT?

8. Answer: All individuals that meet the criteria for DBT who are covered by a Minnesota Health Care Program will be eligible for DBT coverage. Individuals on MinnesotaCare, depending on sub-program, will have coverage that includes DBT. The rates listed on the DHS rates chart are for fee-for-service recipients. The rates can vary for enrollees in health plans. Most MinnesotaCare recipients and some MA recipients are enrolled in a health plan.

9. Question: Will I be able to bill the DBT codes for the time I spend completing the diagnostic assessment, functional assessment and determination of appropriate fit for DBT?

9. Answer: No. The DBT codes are for Individual DBT Therapy and for DBT Group Skills Training. The reimbursement rate accounts for the non-face-to-face time providing DBT treatment. Codes can be billed once the determination of medical necessity has been met. Completing the diagnostic assessment is billable under Diagnostic Assessment codes and Functional Assessment is not a separately billable service.