

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 11-53-03 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 11-53-03 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 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.