Service Name: Psychiatric Treatment

Service Definition

The provision of specialized medical and/or psychiatric services that include, but are not limited to:

a) Psychotherapeutic services with medical evaluation and management including evaluation and assessment of physiological phenomena (including comorbidity between behavioral and physical health care issues);
b) Assessment and monitoring of an individual's status in relation to treatment with medication;
c) Assessment of the appropriateness of initiating or continuing services.

Youth must receive appropriate medical interventions as prescribed and provided by members of the medical staff pursuant to the Medical Practice Act of 2009, Subsection 43-34-23 Delegation of Authority to Nurse and Physician Assistant that shall support the individualized goals of recovery as identified by the individual and their parent/guardians and their Individualized Recovery Plan (within the parameters of the youth/family's informed consent).

Note: For the purposes of this manual, Psychiatric Treatment is sometimes referred to as "physician assessment" or "physician assessment and care."

Admission Criteria

1. Individual is determined to be in need of psychotherapy services and has confounding medical issues which interact with behavioral health diagnosis, requiring medical oversight; or
2. Individual has been prescribed medications as a part of the treatment array.

Continuing Stay Criteria

1. Individual continues to meet the admission criteria; or
2. Individual exhibits acute disabling conditions of sufficient severity to bring about a significant impairment in day-to-day functioning; or
3. Individual continues to present symptoms that are likely to respond to pharmacological interventions; or
4. Individual continues to demonstrate symptoms that are likely to respond or are responding to medical interventions; or
5. Individual continues to require management of pharmacological treatment in order to maintain symptom remission.

Discharge Criteria

1. An adequate continuing care plan has been established; and one or more of the following:
2. Individual has withdrawn or been discharged from service; or
3. Individual no longer demonstrates symptoms that need pharmacological interventions.

Service Exclusions

1. Not offered in conjunction with ACT.
2. Supervision time is not billable.
3. Time spent on documentation is not billable.

Clinical Exclusions

Services defined as a part of ACT.

Required Components

When providing psychiatric services to individuals who are deaf, deaf-blind, and/or hard of hearing, psychiatrists shall demonstrate training, supervision, or consultation with a qualified professional as approved by DBHDD Office of Deaf Services.

Clinical Operations

1. In accordance with recovery philosophy, it is expected that individuals will be treated as full partners in the treatment regimen/services planned and received. As such, it is expected that practitioners will fully discuss treatment options with individuals and allow for individual choice when possible. Discussion of treatment options should include a full disclosure of the pros and cons of each option (e.g., full disclosure of medication/treatment regimen potential side effects, potential adverse reactions - including potential adverse reaction from not taking medication as prescribed and expected benefits). If such full discussion/disclosure is not possible or advisable according to the clinical judgment of the practitioner, this should be documented in the individual's chart (including the specific information that was not discussed and a compelling rationale for lack of discussion/disclosure).
2. Assistive tools, technologies, worksheets, etc. can be used by the served individual to facilitate communication about treatment, symptoms, improvements, etc. with the treating practitioner. If this work falls into the scope of Interactive Complexity, it is noted in accordance with that definition.
3. This service may be provided with Individual Counseling codes 90833 and 90836, but the two services must be separately identifiable.
4. For purposes of this definition, a "new patient" is an individual who has not received an E/M code service from that agency within the past three (3) years. If an individual has engaged with the agency and has seen a non-physician for a BH Assessment, they are still considered a "new patient" until after the first E/M service is completed.

Service Accessibility

This service may be provided via telemedicine to any individual/family who consents to this modality. This consent should be documented in the individual's record. The use of telemedicine should not be driven by the practitioner's/agency's convenience or preference.

Additional Medicaid Requirements

1. The daily maximum within a CSU for E/M is 1 unit/day.
2. Even if a physician also has his/her own Medicaid number, the physician providing behavioral health treatment and care through this code should bill via the approved provider agency's Medicaid number through the Medicaid Category of Service (COS) 440.

Billing & Reporting Requirements

1. Within this service group, a second unit with a U1 modifier may be used in the event that a Telemedicine Psychiatric Treatment unit is provided and it indicates a need for a face-to-face assessment (e.g. 99213GTU1 is billed and it is clinically indicated that a face-to-face by an on-site physician needs to immediately follow based upon clinical indicators during the first intervention, then 99213U1, can also be billed in the same day).
2. Within this service group, there is an allowance for when a U2 practitioner conducts an intervention and, because of clinical indicators presenting during this intervention, a U1 practitioner needs to provide another unit due to the concern of the U2 supervisee (e.g., Physician's Assistant provides and bills 90805U2U6 and because of concerns, requests U1 intervention following his/her billing of U2 intervention). The use of this practice should be rare and will be subject to additional utilization review scrutiny.
3. These E/M codes are based upon Time (even though recent CPT guidance allows the option of using either Medical Decision Making or Time). The Georgia Medicaid State Plan is priced on time increments and therefore time will remain the basis of justification for the selection of codes above for the near term.
4. If a Medicaid claim for this service denies for a Procedure-to-Procedure edit, a modifier (25) can be added to the claim and resubmitted to the MMIS for payment.
5. Despite recent CPT guidance, this service may not be billed for all time spent on an individual's case in a single day (i.e. pre- and post-appointment work that is not direct individual assessment and/or care), because this indirect time is already included in the service rate.