PURPOSE:

The purpose of this bulletin is to clarify policies regarding the authorization, when required, and delivery of Behavioral Health Rehabilitation Services (BHRS).

SCOPE:

This bulletin applies to HealthChoices Contractors, Behavioral Health Managed Care Organizations (BH-MCOs) and providers enrolled in the Medical Assistance (MA) Program to provide BHRS in the fee-for-service (FFS) and behavioral health managed care delivery systems. Enrolled providers are responsible for ensuring that any subcontractors comply with this bulletin.

BACKGROUND:

BHRS are individualized services which are based on the clinical needs of the child receiving the service. BHRS provide a child with specific behavioral health interventions, as set forth in the child’s treatment plan. The Department of Public Welfare’s (Department’s) experience with BHRS has evolved during the almost twenty years that the MA Program has paid for these services. As a result of this experience, the Department has been engaged in discussions with BH-MCOs, HealthChoices Contractors, and providers in an effort to ensure that the services that are being billed to the MA Program are behavioral health interventions. These discussions may have led to some confusion about when requests for prior authorization of BHRS should be approved and what services may properly be billed to the MA Program. The Department is issuing this bulletin to clarify some of the issues that have recently arisen regarding services that are on the MA Program Fee Schedule and services not on the MA Program Fee Schedule and to remind the BH-MCOs, HealthChoices Contractors and providers of the services that the Department is also issuing this bulletin to address issues that have previously been communicated through letters and policy clarifications.
To the extent that this bulletin is inconsistent with any previous guidance issued by the Department or a BH-MCO, this bulletin controls.

**DISCUSSION:**

Both federal and state law require that the MA Program pay for covered services if the services are medically necessary. A medically necessary service is defined in part as a “service . . . or level of care that is necessary for the proper treatment or management of an illness, injury or disability.” 55 Pa. Code § 1101.21. A service or level of care is necessary for proper treatment or management of an illness, injury or disability if it “will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability” or if it will “assist the recipient to achieve or maintain maximum functional capacity, taking into account both the functional capacity of the recipient and those functional capacities that are appropriate of recipients of the same age.” 55 Pa. Code §1101.21a. The medical necessity for BHRS is specific to the behavioral health needs of the child as demonstrated by a DSM diagnosis.

All requests for services, both initial and ongoing, are reviewed for medical necessity. A reduction in the level of services a child is receiving must not be arbitrary or based on length of time the child has been receiving services, but instead must be based on the clinical needs of the child.

To fulfill its responsibility to ensure that the MA Program pays only for services that are medically necessary, the Department requires that some services, including BHRS, be prior authorized, either by the Department or by the managed care organizations with which the Department or the county HealthChoices entity contracts. Consistent with the requirement that proper treatment take into account the functional capacity of the recipient, a prior authorization determination that any BHRS is medically necessary encompasses a review that the requested service is clinically appropriate and will best meet the individualized presenting needs of the child.

Because the above well-established principles have at times been applied inconsistently, the Department is reiterating and clarifying application of these principles in the contexts that follow.

**Informing Families of All Treatment Options**

BHRS are but one component of the continuum of care available to treat the behavioral health needs of children. It is the responsibility of the Department, its system partners such as the HealthChoices Contractors, BH-MCOs, and prescribers to inform families, including youth age 14 and older, of all available treatment options. To that end, it may be appropriate for a BH-MCO to reach out to a family or a prescriber to determine if the family or prescriber was informed of and has considered all treatment options that may be appropriate to treat the individualized needs of the child and family. The discussion of other services should not be limited to BHRS. Services other than BHRS such as
family-based mental health services, partial hospitalization, outpatient clinic-based services, or medication should be discussed and considered when appropriate. Discussions with the family, including youth age 14 and older, or prescriber about other treatment options should also occur if the expected benefits of treatment are not being realized. Services that are medically necessary may not, however, be denied because an alternative treatment is available.

**Examples**

When reviewing a request for therapeutic staff support (TSS) services for a child with attention deficit hyperactivity disorder, the BH-MCO may ask the prescriber if the prescriber and family considered medication as an alternative to TSS or medication in concert with TSS. The BH-MCO may not, however, deny TSS services because the child is not on medication. The BH-MCO must review the request to determine whether TSS is medically necessary based on the child’s current clinical presentation.

When reviewing a request for TSS for a child and another child in the family is already receiving TSS, the BH-MCO may discuss with the prescriber and family if family-based services - i.e., family rather than individual modalities - would be appropriate to treat the needs of the children and family. A BH-MCO may not, however, refuse to consider a request for TSS or determine that TSS is not medically necessary because more than one child in the family is in need of behavioral health services.

When reviewing a request for BHRS, the BH-MCO may inquire whether the family or prescriber has considered outpatient therapy. The BH-MCO may not, however, determine that BHRS is not medically necessary because outpatient therapy is available.

**Services in School**

Information sharing and collaborative planning between behavioral health and educational staff is critical to assuring that a child’s treatment needs are being met. To ensure that services are delivered consistent with Child and Adolescent Service System Program (CASSP) principles, including coordination among service delivery systems, a representative from the school should participate in the Interagency Service Planning Team (ISPT) meeting when BHRS are provided in the school setting. However, formalized meetings such as the ISPT are only one means by which ongoing communication and collaboration take place. In addition to requesting input and participation for an ISPT meeting, behavioral health staff should have ongoing communication and collaboration with school personnel.

Requests for medically necessary behavioral health services, including BHRS, cannot be denied on the ground that the requested service should or could be provided by either the child’s school or early intervention program. The BH-MCO can, however, inquire whether the child is receiving the requested service from the child’s school or
early intervention program to determine if the child’s needs are already being met to avoid duplication of services. The BH-MCO cannot, however, require that a service be listed in a child’s Individual Education Plan (IEP), nor deny a request for medically necessary services because the service is listed in the IEP.

**Reduction in Level of Services During an Authorization Period**

As part of the ongoing care and treatment of a child the treatment team should regularly discuss the current needs, goals and progress of a child and review documentation to determine if treatment plan goals and objectives need to be modified and to assess the ongoing need for the service. During this ongoing review the treatment team may determine that services are working well and can be decreased during the current authorization period.

When a child is doing well the provider and family may determine that the child does not need to receive all authorized services and decide that a particular scheduled service does not need to be provided at a certain time. If the provider and family agree that a service should not be provided, the provider must document in the progress notes the reason that the service was not provided and the family must sign off on the reason that the service was not provided. The provider must also notify the BH-MCO that the provider and family have agreed that a service should not be provided. A reduction in the amount of services a child receives must never occur because the provider is unable to staff the authorized hours.

If it appears that a child no longer needs all of the hours of service that have been prior authorized, the treatment team should be convened to discuss if the number of hours services are provided should be reduced. If the child is in the FFS system, the specific procedure for decreasing the amount of service during an authorization period is set forth in MAB 08-04-06. If the child is enrolled in HealthChoices, the child’s BH-MCO should be consulted for the specific procedures for decreasing the amount of service during an authorization period.

**Billable Time for Services and Documentations of Services**

Concerns have arisen about the MA Program being billed for time that staff is not actively providing therapeutic interventions. The treatment plan should specify specific interventions to be used in order to reach the identified objectives and goals, specific to the environment within which the interventions will occur, identifying: the person performing the intervention(s), specific intervention(s) to be used, the setting where the intervention(s) should be used, and the specific intervention(s) planned to encourage child and family independence in the management of the behavioral health interventions. A provider may bill for the authorized units of service delivered by BHRS staff, as long as those units of service are delivered consistent with the goals and
interventions stated in the treatment plan and there is appropriate documentation that the services were provided.

When providing services, staff attention must be focused on the child, whether or not the child is in need of active intervention in a particular moment. It is not the role of TSS staff to sit by idly, awaiting the need for intervention. It is the role of the TSS worker to monitor the child’s behaviors related to the treatment goals and document both the positive and negative behaviors of a child as well as the triggers for both positive and negative behaviors and the interventions provided to address negative behaviors and the outcome of the interventions. The documentation should account for all of the time the TSS worker spent with a child and provide an accurate picture of activities during each unit of service being billed. Each 15 minute unit of TSS service provided must be reflected in the documentation in increments no greater than 30 minutes. For example, if a TSS provides 60 minutes of TSS, there must be at least two time periods differentiated in the progress note for the day, but 2 separate progress notes are not necessary.

**Appropriate BHRS Interventions**

**Prompting and Cueing**

Prompting and cueing can be used as effective interventions to help achieve behavioral health goals as specified in the child’s treatment plan. Prompting and cueing can also be used as effective interventions to achieve academic goals and performance and other goals that are unrelated to behavioral health needs. The MA Program may be billed for BHRS only when behavioral health staff provides prompting and cueing specific to behavioral health needs.

**Activities of Daily Living (ADL)**

Although assistance with ADLs, such as bathing, brushing teeth, and toileting, is not considered a BHRS, there may be circumstances where the need for assistance with ADLs is the result of a behavioral health need and a BHRS is medically necessary to address the behavioral components associated with an ADL(s). The child’s treatment plan should identify the specific behavioral health interventions that should be used.

If a child is at an age where the performance of ADLs is developmentally appropriate but because of a cognitive or physical disability the child is not able to perform ADLs, the MA Program may not be billed for time spent by BHRS staff assisting with ADLs. Home health aide services can be requested outside of the behavioral health system, including through the MA program, to assist the child with ADLs.
Recreation

A typical part of childhood is having time to play, participate in community activities, and spend time with friends. Children receiving BHRS also need these things in addition to breaks from school and treatment time.

Behavioral health staff may utilize various forms of play, recreation, community activities and social opportunities as part of the treatment process to facilitate the acquisition of a skill(s) provided those activities meet behavioral health needs and are included in the child’s treatment plan. The MA Program may not, however, be billed for time behavioral health staff spend doing, attending, or participating in purely recreational activities, nor may it be billed for the time spent supervising children while they are engaged in a recreational activity outside of the identified treatment process. Specific interventions should be detailed in a child’s treatment plan, including identification of therapeutic goal(s) and how the interventions are anticipated to achieve these goal(s). The staff person providing the BHRS should document the behavioral health interventions provided and the outcome of the intervention.

Role of Parents and Natural Supports

BHRS cannot be used in place of child care or as a substitute for natural supports. The absence of the supports, such as the unavailability of an after-school program or summer camp, does not alone justify the provision of BHRS.

Involvement of the child’s parents, other caregivers, or natural supports during the delivery of BHRS is critical because one component of these services is often to facilitate the transfer of skills to the parents, other caregivers, or natural supports. However, BHRS staff may provide services in the home or community without the involvement of the child’s parents, other caregivers, or natural supports when the need for such intervention is identified in the child’s treatment plan to meet specific treatment goals or objectives for the child. The treatment plan must also include interventions directed toward the transfer of skills to the parents or natural supports, unless the goal is the transfer of skills to the child.
PAYMENT FOR SERVICES:

The following activities may not be billed as part of BHRS:

- Time spent doing, attending or participating in purely recreational activities
- Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher’s aide or an academic tutor
- Habilitation Services
- Services provided as a substitute for the parent and other adults responsible for providing care
- Personal care services
- Respite care
- Services that have not been rendered
- Services not identified on the child’s treatment plan
- Services not in compliance with Chapters 1101 and 1150
- Services provided to parents, siblings, or others to address issues not directly related to the child’s issues and not listed on the child’s treatment plan
- Services provided that are not within the provider’s scope of practice
- Anything not included in the provider’s approved service description
- Changes made to a BHRS program that do not follow the requirements outlined in MA Bulletin 01-96-11 “Procedures for Service Descriptions”