# ORIENTATION & TRAINING

## MEDICAID

Medicaid/AHCA is our primary funding-source. Their fiscal year runs July 1 to June 30. Medicaid pays for mostly face-to-face interactions with clients. Clinicians cannot bill phone calls or emails and there is no double billing allowed (to avoid double billing, it is essential that clinicians ensure there is not another therapist in the home billing Medicaid).

Medicaid is composed of straight Medicaid plans, and their MMA plans, which are Sunshine, Molina, Beacon, Simply, United etc. Those are part of Medicaid, and receive the money from Medicaid, although they are allowed to run as a separate insurance plan.

Intakes consist of usually 3 items: the biopsychosocial, the CFARS, and the master treatment plan. If you are not licensed and doing an intake, there are special procedures to follow, because some of the documents must be done before others, so please pay attention to that (explained later on). You can also do and bill for an individual therapy session after your intake.

Every year you can do another bio-psychosocial or in-depth assessment if the conditions warrant doing so.

For weekly counseling sessions, Medicaid approves clients for IT (Individual Therapy) or TBOS (Therapeutic Behavioral Onsite Services). It is the clinician's responsibility to know how many units he or she has left-over. Though you and we will both track the units used, it does not mean that the number that we have is accurate > If a client was seen by another agency in the start of the fiscal year, then came to us, Medicaid does not inform us how many units remain.

Each Medicaid case requires "authorization" from Medicaid to provide services, that's why it's crucial to wait for the office to let you know what you are authorized for, for each particular case.

The initial approved services will be in the assignment email sent by your account manager or referral coordinator. Please keep track the number of units remaining in your spreadsheet.

Please be aware - if a client has been seen by another agency in the same fiscal year, Medicaid does not inform us how many units remain. Please ask your client if they received services prior to coming to Lukas Counseling to best measure how many remaining sessions they have available.

- Individual Therapy 104 units per fiscal year
- TBOS / PSR / TCM by authorization, usually 30-90 units per 3 months

**Individual/Family Therapy**

- Most funders allow 104 units of IT per fiscal year / 1 unit = 15 minutes.
- Typically, funders approve 16 units/month (4 units/week for 6 months).
- Does not allow for more than 4 units per session, per day.
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### Case Managers

**Some plans will REQUIRE you to have an Auth. Please plan ahead, and keep track of your units and deadlines so that you don't bill for sessions that are not covered by the Auth.** Lisa will help you complete any Auths - please reach out to her with questions (lisap@lukascounseling.org)

### TBOS Therapy

TBOS will allow clinicians to see the client for 8 units per week. Many insurance companies require a clinician to apply for TBOS units by justifying the clinical necessity for more intensive services.

TBOS is rendered onsite either in school or in the home for adults and children under the age of 21.

These units are separate from IT and are to be used in lieu (instead) of IT. You cannot bill both TBOS and IT. TBOS gives more units to work with the client so that the clinician can stabilize the client quickly. With TBOS, clinicians can bill up to 36 units per month.

It is approved by the Medicaid plans on a case-by-case basis, and all units must be used if approved. Certain plans require two months of IT before applying for TBOS

## PUTTING A CLIENT ON TBOS

If you are requesting TBOS/PSR, you MUST wait until the office gives you the OK in order to start billing these.

If you are putting someone on TBOS, please remember that you need to complete two things:

- # 1 AUTHORIZE TBOS **CLINICALLY** - Complete a Treatment Plan Addendum to authorize TBOS (if it's close enough that you are about to do a Treatment Plan Review instead, then do a Review instead of an addendum). Part of the treatment plan is to complete the TBOS Certification Form.

This is the checklist you'll complete in the Tx Plan Review:

**In order to receive therapeutic behavioral on-site services, a recipient must meet one of the following eligibility criteria:**

**Under the age of 2 years and meets ONE of the following criteria:**

- ☐ Exhibiting symptoms of an emotional or behavioral nature that are atypical for the recipient's age and development that interferes with social interaction and relationship development.
- ☐ Failure to thrive (due to emotional or psychosocial causes, not solely medical issues).

**Ages 2 years through 5 years and meets BOTH of the following criteria:**

- ☐ Exhibiting symptoms of an emotional or behavioral nature that are atypical for the recipient's age and development.
- ☐ Score in at least the moderate impairment range on a behavior and functional rating scale developed for the specific age group.

**Ages 6 years through 17 years and meets ONE of the following criteria:**

- ☐ Have an emotional disturbance.
- ☐ Have a serious emotional disturbance.
- ☐ Have a substance use disorder.

**Ages 18 years through 20 years, but...**

- ☐ otherwise meets the criteria for an emotional disturbance or a serious emotional.

- # 2 AUTHORIZE TBOS **VIA INSURANCE** - A form must be faxed to the insurance company. Different insurances have different needs. Once the form comes back approved, we will let you know.

The entire process can be completed here in one step > LINK TO AUTHS

## PSR - PSYCHOSOCIAL REHAB SERVICES

PSR services are appropriate for clients showing psychiatric, behavioral, or cognitive symptoms, additive behaviors, or clinical conditions of sufficient severity to bring about impairment in day-to-day personal, social, vocational, and educational functioning. PSR services are designed to assist the client in strengthening or regaining interpersonal skills; psychosocial therapy targeted towards rehabilitation; and development of environmental supports necessary to thrive in the community.

PSR services combines daily medication use, independent living skills, social skills training, pre-vocational and transitional employment rehabilitation training, social support, and structured activities to lower tendencies towards isolation and withdrawal. PSR just like TBOS, must be authorized in the treatment plan with a special checklist (see website - homepage) - PSR can be done individually on in groups of up to 12 clients.

PSR must be authorized in a treatment plan (or review). **Select 20 units of PSR in the service grid,** and then a special PSR Authorization section populates, where you can indicate WHY the client would benefit from this.

**If someone else is doing your intake assessment, and you know you will want PSR, please email that person, so that he/she can put PSR goals and objectives in the Master Tx Plan (otherwise, you will have to do a Tx Review to add them)**

**Units Allowed**
1. Always check w Shere, Taylor, or Max to make sure the client doesn't need a special pre-auth (some insurances do).
2. You will be allowed either = 12 units per week, or 16, or 20.

**Payment -** $16.00 per hour, per client (or $4.00 per unit) - You can do PSR in groups up to 12. Both Therapists and Case Managers can do PSR.

## PUTTING A CLIENT ON PSR

If you are requesting TBOS/PSR, you MUST wait until the office gives you the OK in order to start billing these.
If you are putting someone on PSR, please remember that you need to complete two things:

- # 1 AUTHORIZE PSR **CLINICALLY** - Complete a Treatment Plan Addendum to authorize PSR (if it's close enough that you are about to do a Treatment Plan Review instead, then do a Review instead of an addendum). Part of the treatment plan is to complete the PSR Certification Form.

This is the checklist you'll complete in the Tx Plan Review:

***PSR services are appropriate for clients showing psychiatric, behavioral, or cognitive symptoms, additive behaviors, or clinical conditions of sufficient severity to bring about impairment in day-to-day personal, social, vocational, and educational functioning.***

***PSR services are designed to assist the client in strengthening or regaining interpersonal skills; psychosocial therapy targeted towards rehabilitation; and development of environmental supports necessary to thrive in the community. PSR services combines daily medication use, independent living skills, social skills training, pre-vocational and transitional employment rehabilitation training, social support, and structured activities to lower tendencies towards isolation and withdrawal.***

**Must meet all 4 criteria below for PSR to be medically necessary:**

- [ ] Client's meets criteria for PSR (the goal of PSR is to restore the client's skills and abilities essential for independent living).
- [ ] Client's diagnosis is NOT Adjustment Disorder.
- [ ] At least 1 PSR-related goal (with objectives) is listed in the Treatment Plan
- [ ] Client is age 12+, and needs rehabilitation in TWO or more of the following:

**Which TWO or more areas does client need with help with?**

- [ ] Pre-vocational, job training, matching, and/or support
- [ ] Budgeting and money management
- [ ] Maintenance of the living environment
- [ ] Training in appropriate use of community services
- [ ] Structured activities
- [ ] Social skills training
- [ ] Symptom management, medication management, and treatment options
- [ ] Food planning and preparation
- [ ] Transportation
- [ ] Daily living skills
- [ ] Establishing social supports
- [ ] Reducing isolation and withdrawal tendencies

- # 2 AUTHORIZE PSR **VIA INSURANCE** - A form must be faxed to the insurance company. Different insurances have different needs. Once the form comes back approved, we will let you know.

The entire process can be completed here in one step > LINK TO AUTHS

## ELIGIBILITY

Although most Medicaid clients will not change their plans from month to month, a small percentage will change, or their coverage will become inactive.

 **It is your responsibility to know these changes.** After all, you really don't want to go see a client, spend the time, and then realize that the client was inactive (if the client changed plans, it's usually not a big deal, but if they became inactive, that stinks!) Every month we at the office will check the client's eligibility for you and email you. However, we might not get results for the first few days of the month, so it's important during the first week of every month, to check with your clients if their insurance has changed.

Always ask the parent/client each month... "is your insurance still good this month?"... sometimes they know... but beware, they might say yes, and in reality their plan turned inactive without them knowing.

If Inactive --- If that happens, immediately cease services and call the parent within 7 days of the email to let them know that the client's Medicaid is not active and we cannot deliver services under Medicaid until it is re-instated.

Please note that you cannot bill for services once a client is "inactive"; but if the note goes through anyway, it will be denied by the insurance company, so it doesn't matter.