

Diagnostic Assessment and Updates

Policy Number: SC14P0004A3

Effective Date: May 1, 2012

Last Update: September 19, 2022

PAYMENT POLICY HISTORY

DATE	SUMMARY OF CHANGE
September 19, 2022	Information regarding code-specific procedure CPT® or HCPCS was removed.
November 29, 2021	Annual policy review was completed. No technical changes were made to the policy.
October 19, 2020	Annual policy review was completed. The definition of a brief diagnostic assessment was updated. The policy was moved to UCare’s new branded format. As a result, some of the information may have been reformatted.
August 30, 2019	Information regarding comparison to the DHS MH Procedure CPT® or HCPCS Codes and Rates Chart and UCare fee schedules was removed from the document. The UCare Provider Manual contains information regarding how and when UCare updates fee schedules. A link to the UCare Provider Manual continues to be available within the document.
June 19, 2019	Annual policy review completed. Replaced deleted CPT codes 96101, 96102, 96103 psychiatric testing codes with 96130 and 96131. Internal links and the UCare logo were updated.
May 1, 2018	Diagnostic Assessment and Updates policy is published by UCare.

APPLICABLE PRODUCTS

This policy applies to the products checked below:

UCARE PRODUCT	APPLIES TO
UCare MinnesotaCare	✓
UCare Minnesota Senior Care Plus (MSC+)	✓
UCare Prepaid Medical Assistance (PMAP)	✓
UCare Connect	✓
UCare Connect +Medicare (When MHCP is the primary payer)	✓
UCare Minnesota Senior Health Options (MSHO) (When MHCP is the primary payer)	✓

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PAYMENT POLICY INSTRUCTIONS

A payment policy assists in determining provider reimbursement for specific covered services. To receive payment, the provider must be in a contractual relationship with UCare and provide services to a member enrolled in one of UCare’s products. This payment policy is intended to provide a foundation for system configuration, work instructions, call scripts, and provider communications. A payment policy describes the rules for payment, which include applicable fee schedules, additional payment rules by regulatory bodies, and contractual terms. This policy is a general guideline and may be superseded by specific provider contract language.

PAYMENT POLICY OVERVIEW

A diagnostic assessment is written report that documents the functional and clinical face-to face evaluation that determines the need for mental health services, and typically includes the:

- Nature, severity, and impact of behavioral difficulties
- Functional impairment
- Subjective distress
- Strengths and resources

POLICY DEFINITIONS

TERM	NARRATIVE DESCRIPTION
Adult Diagnostic Assessment Update	Means an assessment for adults 18 years old or older, using an adult diagnostic assessment that revises a standard or extended diagnostic assessment that occurred: <ul style="list-style-type: none"> • Within the past twelve (12) months • Within the past twenty-four (24) months when a previous adult diagnostic assessment has occurred within the past twelve (12) months
Brief Diagnostic Assessment	Means an assessment that documents sufficient information to apply a clinical hypothesis that may be used to address the patient’s immediate needs or presenting problem, and typically includes information about the patient’s current life situation, including: <ul style="list-style-type: none"> • Age • Description of symptoms including reason for referral • A mental status examination • History of mental health treatment • Cultural influences • A clinical summary explaining the provisional diagnostic hypothesis

TERM	NARRATIVE DESCRIPTION
	<p>Treatment sessions conducted under authorization of a brief assessment may be used to gather additional information necessary to complete a standard diagnostic assessment or an extended diagnostic assessment.</p> <p>A brief diagnostic assessment includes sufficient information for the professional or clinical trainee to document a provisional clinical hypothesis. The clinical hypothesis may be used to address the recipient’s immediate needs or presenting problem.</p>
Clinical Supervision	Means the oversight responsibility for individual treatment plans and individual mental health service delivery, including that provided by the case manager. Clinical supervision must be accomplished by full or part-time employment of or contracts with mental health professionals. Clinical supervision must be documented by the mental health professional cosigning individual treatment plans and by entries in the client's record regarding supervisory activities.
Clinical Trainee	Means a mental health practitioner who meets the qualifications specified in Minnesota Rules, part 9505.0371 , subpart 5, item C.
Diagnostic Assessment	Means functional face-to-face evaluation resulting in a complete written assessment that includes clinical considerations and severity of the client's general physical, developmental, family, social, psychiatric, and psychological history, and current condition. The Diagnostic Assessment will also note strengths, vulnerabilities, and needed mental health services.
Explanation of Findings	Means the explanation of a client's diagnostic assessment, psychological testing, treatment program, and consultation with culturally informed mental health consultants or other accumulated data and recommendations to the patient patient's family, primary caregiver, or other responsible persons.
Extended Diagnostic Assessment	<p>Means an assessment that includes all the components of a standard diagnostic assessment usually gathered over three or more appointments. The patient requires additional assessment time due to their complex needs, caused by:</p> <ul style="list-style-type: none"> • Acuity of psychotic disorder • Cognitive or neurocognitive impairment • Consideration of past diagnoses and determining their current applicability • Co-occurring substance abuse use disorder • Disruptive or changing environments • Communication barriers • Cultural considerations
Individual Treatment Plan	Means the person-centered process that focuses on developing a written plan that defines the course of treatment for the patient. The plan is focused on collaboratively determining real-life outcomes with a patient and developing a strategy to achieve those outcomes. The plan establishes goals, measurable objectives, target dates for achieving specific goals, identifies key participants in the process, and the responsible party for each treatment component. In addition, the plan outlines the recommended services based on the patient’s diagnostic

TERM	NARRATIVE DESCRIPTION
	assessment and other patient specific data needed to aid the patient in their recovery and enhance resiliency. An individual treatment plan should be completed before mental health service delivery begins.
Mental Health Practitioner	<p>Means a provider who are not eligible for enrollment, must be under clinical supervision of a mental health professional and must be qualified in <i>at least one</i> of the following five ways:</p> <ol style="list-style-type: none"> 1. Holds a bachelor’s degree in a behavioral science or a related field, from an accredited college or university and meets either a or b: <ol style="list-style-type: none"> a. Has at least 2,000 hours of supervised experience in the delivery of mental health services to patients with mental illness. b. Is fluent in a non-English language of a cultural group to which at least 50% of the practitioner’s patients belong, completes 40 hours of training in the delivery of services to patients with mental illness, and receives clinical supervision from a mental health professional at least once a week until the requirements of 2,000 hours of supervised experience are met. 2. Has at least 6,000 hours of supervised experience in the delivery of mental health services to patients with mental illness. Hours worked as a mental health behavioral aide I or II under Children’s Therapeutic Services and Supports (CTSS) may be included in the 6,000 hours of experience for child patients. 3. Is a graduate student in one of the mental health professional disciplines and an accredited college or university formally assigns the student to an agency or facility for clinical training. 4. Holds a masters or other graduate degree in one of the mental health professional disciplines from an accredited college or university. 5. Is a tribally certified mental health practitioner who is serving a federally recognized Indian tribe. <p>In addition to the above criteria:</p> <ul style="list-style-type: none"> • A mental health practitioner for a child patient must have training working with children. • A mental health practitioner for a child patient must have training working with children.
Prior Authorization	Means an approval by UCare or their delegates prior to the delivery of a specific service or treatment. Prior authorization requests require a clinical review by qualified, appropriate professionals to determine if the service or treatment is medically necessary. UCare requires certain services to be authorized before services begin. Services provided without an authorization will be denied. UCare does update its’ authorization, notification, and threshold requirements from time-to-time.

TERM	NARRATIVE DESCRIPTION
Standard Diagnostic Assessment	<p>Means an assessment conducted in the cultural context of the patient that includes all the components of a brief diagnostic assessment, and all the following additional components:</p> <ul style="list-style-type: none"> • The patient’s reason for the assessment, including the patient’s: <ul style="list-style-type: none"> ○ Perception of their condition ○ Description of symptoms, including the reason for the referral; • History of mental illness/treatment, including a review of the patient’s medical record; • Important developmental incidents; • Maltreatment, trauma, or abuse issues; • History of alcohol and drug usage and treatment; • Personal and family medical history, including physical, chemical, and mental health history; • Cultural influences and their impact on the patient; • An assessment of the patient’s needs based on: <ul style="list-style-type: none"> ○ Baseline measurements ○ Symptoms ○ Behavior ○ Skills ○ Abilities ○ Resources ○ Vulnerabilities ○ Safety; • Assessment methods and use of standardized assessment tools. • Clinical summary, including recommendations and prioritization of needed mental health or other services; and • Data sufficient to support findings in all axes of the current Diagnostic and Statistical Manual (DSM), and any differential diagnosis.

ENROLLEE ELIGIBILITY CRITERIA

THIS SECTION OF THE POLICY PROVIDES INFORMATION THAT IS SPECIFIC TO THE UCARE MEMBER, INCLUDING INFORMATION ABOUT THE CRITERIA THE MEMBER MUST MEET IN ORDER FOR THE SERVICE(S) IN THE POLICY TO BE ELIGIBLE FOR PAYMENT

An individual must be enrolled and eligible for coverage in an UCare MHCP product to eligible for this service.

ELIGIBLE PROVIDERS OR FACILITIES**OUTLINED BELOW IS THE SPECIFIC CRITERIA A PROVIDER MUST MEET IN ORDER FOR THE SERVICE(S) IN THIS POLICY TO BE ELIGIBLE FOR PAYMENT. THE SERVICE(S) IN THE POLICY TO BE ELIGIBLE FOR PAYMENT****Provider**

UCare recognizes the following mental health professionals as eligible to furnish a diagnostic assessment:

- Clinical Nurse Specialist (CNS-MH)
- Licensed Independent Clinical Social Worker (LICSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Psychologist (LP)
 - Psychiatric Nurse Practitioner (NP)
 - Psychiatrist
 - Mental health practitioners who qualify as clinical trainees

Standard Diagnostic Assessment

Diagnostic Assessments with medical services can be performed by:

- Psychiatrists
- Clinical Nurse Specialist – Mental Health (CNS-MH)
- Psychiatric Nurse Practitioner

Facility

Not applicable.

Other and/or Additional Information

Not applicable.

EXCLUDED PROVIDER TYPES**OUTLINED BELOW IS INFORMATION REGARDING PROVIDERS WHO ARE NOT ELIGIBLE TO FURNISH THE SERVICE(S) LISTED IN THIS POLICY.**

A diagnostic assessment cannot be performed by providers who are allied mental health professionals or adult mental health rehabilitation professionals.

MODIFIERS, CPT, HCPCS, AND REVENUE CODES

General Information

The Current Procedural Terminology (CPT®) HCPCS, and Revenue codes listed in this policy are for reference purposes only. Including information in this policy does not imply that the service described by a code is a covered or non-covered health service. The inclusion of a code does not imply any right to reimbursement or guarantee of claim payment.

Modifiers

The modifiers listed below are not intended to be a comprehensive list of all modifiers. Instead, the modifiers that are listed are those that must be appended to the CPT® / HCPCS codes listed below. Based on the service(s) provided, and the circumstances surrounding those services it may, based on correct coding, be appropriate to append an additional modifier(s) to the CPT® / HCPCS code.

When a service requires multiple modifiers, the modifiers must be submitted in the order listed below. If it is necessary to add additional modifiers they should be added after the modifiers listed below.

MODIFIER(S)	NARRATIVE DESCRIPTION
52	Brief Diagnostic Assessment (Reduced Services)
HN	For purposes of this policy, the –HN modifier indicates services were furnished by a Mental Health Practitioner or qualified Clinical Trainee when licensing and supervision requirements are met,
TG	Extended Diagnostic Update/Psychiatric Consultation Complex/Lengthy
TS	Adult Diagnostic Update

CPT and/or HCPCS Code(s)

CPT® AND/OR HCPCS CODE(S)	MODIFIER(S)	NARRATIVE DESCRIPTION
90791		Standard Diagnostic Assessment
90791	HN	Standard Diagnostic Assessment furnished by a clinical trainee
90971	52	Brief Diagnostic Assessment
90971	52, HN	Brief Diagnostic Assessment furnished by a qualified clinical trainee when licensing and supervision requirements are met
90791	TG	Extended Diagnostic Assessment

CPT® AND/OR HCPCS CODE(S)	MODIFIER(S)	NARRATIVE DESCRIPTION
90791	TG, HN	Extended Diagnostic Assessment furnished by a qualified clinical trainee when licensing and supervision requirements are met
90791	TS	Adult Update Diagnostic Assessment
90791	TS, HN	Adult Update Diagnostic Assessment furnished by a qualified clinical trainee when licensing and supervision requirements are met
90792		Standard Diagnostic Assessment (with medical service)
90792	HN	Standard Diagnostic Assessment (with medical service) furnished by a qualified clinical trainee when licensing and supervision requirements are met.
90792	52	Brief Standard Diagnostic Assessment (with medical service)
90792	52, HN	Brief Standard Diagnostic Assessment (with medical service) furnished by a qualified clinical trainee when licensing and supervision requirements are met.
90792	TG	Extended Diagnostic Assessment
90792	TG, HN	Extended Diagnostic Assessment (with medical service) furnished by a clinical trainee when licensing and supervision requirements are met.
90792	TS	Adult Update Diagnostic Assessment
90792	TS, HN	Adult Update Diagnostic Assessment (with medical service) furnished by a qualified clinical trainee when licensing and supervision requirements are met.
90785		Interactive Complexity (When appropriate bill in addition to 90791 or 90792)
90887		Explanation of Findings
90887	HN	Explanation of Findings furnished by a qualified clinical trainee when licensing and supervision requirements are met.
96130		Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
96131		Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)

CPT® AND/OR HCPCS CODE(S)	MODIFIER(S)	NARRATIVE DESCRIPTION
90785		Interactive complexity (When appropriate bill in addition to 90791 or 90792)

CPT® is a registered trademark of the American Medical Association.

Revenue Codes

Not applicable.

PAYMENT INFORMATION

Covered Services

To be eligible for payment, a diagnostic assessment must:

- Specify the mental health diagnosis(s) of the patient and outline the recommended services, or determine that the patient does not meet the criteria for a mental health disorder;
- Include a face-to-face interview with the patient and a written evaluation; and
- Meet the conditions of one of the following diagnostic assessments:
 - Standard Diagnostic Assessment
 - Extended Diagnostic Assessment
 - Adult Diagnostic Assessment Update
- Brief Diagnostic Assessment. If a diagnostic assessment does not result in a diagnosis of mental illness or emotional disturbance, the provider can provide and bill for the following if performed:
 - 90887- **One** Explanation of Findings session
 - 96130, 96131 - **Psychological** Testing
- Do not bill for diagnostic assessment on the same day as:
 - E/M services provided by the same provider
 - Psychotherapy services (any type)
- A new patient may receive up to three sessions of a combination of individual or family psychotherapy, or family psychoeducation prior to completing the diagnostic assessment.

Payment Increases and Reductions

Based on MHCP guidelines when certain mental services are furnished by a Masters prepared provider a twenty percent (20%) reduction is applied to the allowed amount. Masters prepared providers are:

- Clinical Nurse Specialist (CNS-MH)

- Licensed Independent Clinical Social Worker (LICSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Psychologist (LP) Master's Level
- Psychiatric Nurse Practitioner
- Master's Level enrolled provider

Masters level reductions are not applied to mental health services when they are furnished:

- In a Community Mental Health Center (CMHC)
- By a Mental Health Practitioner qualified to work as a clinical trainee.

BILLING REQUIREMENTS AND DIRECTIONS

Assessment Requirements

Children

Standard Diagnostic Assessment and Extended Diagnostic Assessment

A new standard diagnostic assessment must be completed:

- At least annually following the initial diagnostic assessment if additional services are needed.
- When the criteria for a brief or extended diagnostic assessment is no longer being met.
- When the mental health condition has changed markedly since the most recent diagnostic assessment was furnished.

When the patient's current mental health condition no longer matches the diagnosis and criteria outlined in the current diagnostic assessment, an updated assessment must be completed

Adults

New Standard Diagnostic Assessment

A new standard diagnostic assessment must be completed:

- At least every three years following the initial standard or extended assessment when that patient continues to receive services
- When the criteria for a brief or extended diagnostic assessment is no longer being met
- When the mental health condition has changed markedly since the most recent diagnostic assessment was furnished

When the patient's current mental health condition no longer matches the diagnosis and criteria outlined in the current diagnostic assessment, an updated assessment must be completed.

Adult Diagnostic Assessment Update

For adults eighteen (18) year of age or older, use an adult diagnostic assessment update to revise a standard or extended diagnostic assessment has occurred within the past:

- Twelve (12) months
- Twenty-four (24) months when a previous adult diagnostic assessment has occurred within the past twelve (12) months.

Billing Guidelines

When submitting claims for a diagnostic assessment, follow the guidelines outlined below:

- Claims should be submitted using MN-ITS 837P (Professional) format or the electronic equivalent;
- The date of service entered on the claim is the date the written diagnostic assessment was completed;
- Enter the NPI number on each claim line;
- Append appropriate modifiers to the service(s) furnished, when applicable;
- Services provided by a Clinical Trainee must be submitted by the supervising provider, and be appended with the –HN modifier;
- A diagnostic assessment cannot be billed when performed on the same day as:
 - An Evaluation and Management service furnished by the same provider
 - Any type of psychotherapy service; and
- All components of the diagnostic assessment must be completed to bill UCare.

PRIOR AUTHORIZATION, NOTIFICATION AND THRESHOLD INFORMATION

Prior Authorization and Notification Requirements

An authorization is required for a diagnostic assessment that exceeds the allowed 4 sessions per calendar year. UCare does update its' authorization, notification, and threshold requirements from time-to-time. The most current prior authorization requirements can be found [here](#).

Threshold Information

UCare allows 4 sessions per calendar year.

RELATED PAYMENT POLICY INFORMATION

OUTLINED BELOW ARE OTHER POLICIES THAT MAY RELATE TO THIS POLICY AND/OR MAY HAVE AN IMPACT ON THIS POLICY.

POLICY NUMBER	POLICY TITLE

UCare payment policies are updated from time to time. The most current UCare payment policies can be found [here](#).

SOURCE DOCUMENTS AND REGULATORY REFENCES

LISTED BELOW ARE LINKS TO CMS, MHCP, AND STATUTORY AND REGULATORY REFERENCES USED TO CREATE THIS POLICY

[MHCP Provider Manual, Mental Health Services, Diagnostic Assessment](#)

[Minnesota Rules 9505.0370, 9505.0371, 9505.0372](#) Mental Health Services

[Minnesota Department of Health](#) Definition of Essential Community Providers

DISCLAIMER

“Payment Policies assist in administering payment for UCare benefits under UCare’s health benefit Plans. Payment Policies are intended to serve only as a general reference resource regarding UCare’s administration of health benefits and are not intended to address all issues related to payment for health care services provided to UCare members. When submitting claims, all providers must first identify member eligibility, federal and state legislation, or regulatory guidance regarding claims submission, UCare provider participation agreement contract terms, and the member-specific Evidence of Coverage (EOC) or other benefit document. In the event of a conflict, these sources supersede the Payment Policies. Payment Policies are provided for informational purposes and do not constitute coding or compliance advice. Providers are responsible for submission of accurate and compliant claims. In addition to Payment Policies, UCare also uses tools developed by third parties, such as the Current Procedural Terminology (CPT®*), InterQual guidelines, Centers for Medicare, and Medicaid Services (CMS), the Minnesota Department of Human Services (DHS), or other coding guidelines, to assist in administering health benefits. References to CPT® or other sources in UCare Payment Policies are for definitional purposes only and do not imply any right to payment. Other UCare Policies and

Coverage Determination Guidelines may also apply. UCare reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary and to administer payments in a manner other than as described by UCare Payment Policies when necessitated by operational considerations.”