



**Mississippi Department of Mental Health**  
**Provider Bulletin**  
**Number PR0058**

**Subject:** New Documentation Requirements for HIV Early Intervention Purchase of Service Grant

**Issue Date:** April 4, 2016

**Effective Date:** April 4, 2016

**Scope**

All DMH Certified Providers receiving reimbursement for HIV Early Intervention Services through the HIV Early Intervention Purchase of Service Grant.

**Purpose**

Inform all DMH Certified Providers receiving reimbursement for HIV Early Intervention Services of new documentation requirements and provide guidance and forms required in order to receive reimbursement from DMH.

**Background**

The HIV Early Intervention Purchase of Service Grant requires monthly submission of cash requests in order for organizations to be reimbursed for eligible services. Recent changes and the expansion of services eligible for reimbursement have determined the need for the Bureau of Alcohol and Drug Services to make revisions to the current documentation, as well as add additional documentation to reflect these changes.

**Subject**

The revised *HIV Purchase of Service- SABG Fund (BADs-POS-1)* form and newly created *HIV/HEP/STD/TB Educational Services* form replace any earlier documentation and are now required to be submitted with each HIV Early Intervention Services Cash Request. The Bureau of Alcohol and Drug Services has also developed guidance documents for both forms to clarify implementation expectations.

**Providers are expected to utilize the attached billing forms in their entirety. Previous versions of DMH Form BADs-POS-1 will not be accepted.**

*End of Provider Bulletin*

# HIV POS Form Guidance

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## PROVIDER INFORMATION

<b>MISSISSIPPI DEPARTMENT OF MENTAL HEALTH</b>				
<b>BUREAU OF ALOCHOL AND DRUG SERVICES</b>				
<b>HIV PURCHASE OF SERVICE - SABG FUNDS</b>				
Name of Provider _____		Application _____ to _____		
Contract Number _____				
Month/Year _____				

**Name of Provider**

Please provide the name of the service provider.

**Contract Number**

Please indicate the contract number assigned to your grant.

**Application to**

Please indicate the application service period. (Example: 7/1/15 to 6/30/16)

**Month/Year**

Please indicate the month and year for reimbursement. Example: July 2015

*An Excel spreadsheet has been developed for the HIV Purchase of Services form in order to automatically calculate reimbursement totals.*

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HIV/HEP Service Categories	Unit Measures	Rate	Number of Units	Totals
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**Service Categories**

Indicate the HIV/HEP services that are eligible to be billed through this grant.

**Unit Measure**

Represent what quantity of that service will be used to calculate the cost of that service.

**Rate**

Dollar amount charged for each unit measure.

**Number of Units**

Total amount of units utilized by the service.

**Totals**

Total dollar amount calculated

When using this spreadsheet, enter the total number of units in the **Number of Units** column, and the totals will be calculated.

*\*Please note: deleting any information in the **Totals** column will delete the formulas used to make the calculations. Data should only be deleted in the **Number of Units** column when making changes to the form.*

**HIV/HEP SERVICE CATEGORIES**

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**THERAPEUTIC SERVICES**

HIV/HEP Service Categories		Unit Measures
<b>Therapeutic Services</b>		
1	<b>Pre-Test Individual Counseling</b> Master's Level	30 Minutes
2	<b>Pre-Test Individual Counseling</b> Bachelor's Level (Professional Certification Required)	30 Minutes
3	<b>Pre-Test Individual Counseling</b> Licensed Nurse	30 Minutes
4	<b>Pre-Test Individual Support</b> A Certified Peer Support Specialist may be used to provide support for clients	30 Minutes
5	<b>Post-Test Individual Counseling</b> Master's Level	*30 Minutes
6	<b>Post-Test Individual Counseling</b> Bachelor's Level (Professional Certification Required)	*30 Minutes
7	<b>Post-Test Individual Counseling</b> Licensed Nurse	*30 Minutes
8	<b>Post-Test Individual Support</b> Certified Peer Support Specialist (1 hour maximum)	*30 Minutes

*Pre-Test Individual Counseling*

**Item 1**

This is a service that is offered during the initial intake for a new or repeat client. It includes the risk assessment (if one has not been completed in the prior year) and any informational components used to

encourage the rapid testing. Indicate the number of units used by Master's Level Clinicians when providing Pre-Test Individual Counseling services.

One Unit is equal to 30 minute session, and each client receives one 30 minute Pre-Test Individual Counseling session. The 30 minute Pre-Test Counseling Session must include the Risk Assessment if one hasn't been previously conducted.

**Item 2**

This is a service that is offered during the initial intake for a new or repeat client. It includes the risk assessment (if one has not been completed in the prior year) and any informational components used to encourage the rapid testing. Indicate the number of units used by Bachelor's Level Clinicians (MAAP Certification required) when providing Pre-Test Individual Counseling services.

One Unit is equal to 30 minute session, and each client receives one 30 minute Pre-Test Individual Counseling session. The 30 minute Pre-Test Counseling Session must include the Risk Assessment if one hasn't been previously conducted.

**Item 3**

This is a service that is offered during the initial intake for a new or repeat client. It includes the risk assessment (if one has not been completed in the prior year) and any informational components used to encourage the rapid testing. Indicate the number of units used by Licensed Nurses, an LPN or greater, when providing Pre-Test Individual Counseling/Education services.

One Unit is equal to 30 minute session, and each client receives one 30 minute Pre-Test Individual Counseling session. The 30 minute Pre-Test Counseling Session must include the Risk Assessment if one hasn't been previously conducted.

**Item 4**

This is offered during the initial intake to encourage rapid testing. Peer support must have firsthand experience in the process in order to relate to the unique position of the potential recipient. The Peer Support staff may share their experience and talk about the benefits of knowing your status. Report the number of units used by a Certified Peer Support Specialist providing Pre-Test Individual Counseling. A Certified Peer Support Specialist may be used to provide these services once the CPSS has completed a DMH approved training course.

This is a complementary service to pre-test counseling and can be billed in conjunction with items 1, 2, or 3. One Unit is equal to 15 minutes; however 30 minutes of Pre-Test Individual Support should be utilized.

The 30 minute Pre-Test Support Session must include the Risk Assessment if one hasn't been previously conducted.

*Post-Test Individual Counseling/Education*

**Item 5**

Post-test counseling is available to anyone who receives a rapid test. Post-test counseling is limited to 30 minutes for negative rapid screen results and 1 hour is reserved for individuals with a preliminary positive

screen. Indicate the number of units used by Master's Level Clinicians when providing Post-Test Individual Counseling services.

One Unit is equal to 30 minute session, and each client receives one 30 minute post-test counseling session. 60 or more minutes of Post-Test Individual Counseling is required for individuals who have a reactive test ("test positive").

**Item 6**

Post-test counseling is available to anyone who receives a rapid test. Post-test counseling is limited to 30 minutes for negative rapid screen results and 1 hour is reserved for individuals with a preliminary positive screen. Indicate the number of units used by Bachelor's Level Clinicians (MAAP Certification required) when providing Post-Test Individual Counseling services.

One Unit is equal to 30 minute session, and each client receives one 30 minute post-test counseling session. 60 or more minutes of Post-Test Individual Counseling is required for individuals who have a reactive test ("test positive").

**Item 7**

Post-test counseling is available to anyone who receives a rapid test. Post-test counseling is limited to 30 minutes for negative rapid screen results and 1 hour is reserved for individuals with a preliminary positive screen. Indicate the number of units used by Licensed Nurses (LPN or greater) when providing Post-Test Individual Counseling services.

One Unit is equal to 30 minute session, and each client receives one 30 minute pre-test counseling session. 60 or more minutes of Post-Test Individual Counseling is required for individuals who have a reactive test ("test positive").

**Item 8**

Post-test support is offered to individuals who receive a rapid test. Peer support must have firsthand experience in the process in order to relate to the unique position of the potential recipient. This support can be utilized in conjunction with items 5, 6, or 7. This support can be used in innovative ways such as accompanying individuals for confirmatory testing or any other needed supports. Indicate the number of units delivered by a Certified Peer Support Specialist providing Post-Test Individual Support. A Certified Peer Support Specialist may be used to provide these services once the CPSS has completed a DMH approved training course.

Unit Measures for CPSS's are in 15 minute increments, however up to 30 minutes of Post-Test Individual Support should be utilized for every individual tested. 60 or more minutes of Post-Test Individual Support is required for individuals who have a reactive test ("test positive").

## EDUCATIONAL GROUP SERVICES

<b>Educational Group Services</b> May bill a combined maximum of 2 hrs for HIV/STD/Hepatitis/TB education		
9	<b>Individual/Group Education</b> Master's Level	60 Minutes
10	<b>Individual/Group Education</b> Bachelor's Level (Professional Certification Required)	60 Minutes
11	<b>Individual/Group Education</b> <b>Licensed</b> Nurse	60 Minutes
12	<b>Individual/Group Education</b> Certified Peer Support Specialist (DMH Approved Training Course Required)	60 Minutes

### *Individual/Group Education*

#### **Item 9**

Educational services are structured to offer information in a psychoeducational approach. These services may be offered to individuals who have completed an intake and have been admitted into the program. No individual may be billed over 2 hours annually in the same program educational group services. Services may be offered in individual or group settings. Indicate the number of units used by Master's Level Clinicians when providing individual and/or group HIV, Hepatitis, STD, and/or TB education services.

#### **Item 10**

Educational services are structured to offer information in a psychoeducational approach. These services may be offered to individuals who have completed an intake and have been admitted into the program. No individual may be billed over 2 hours annually in the same program educational group services. Services may be offered in individual or group settings. Indicate the number of units used by Bachelor's Level Clinicians (MAAP Certification required) when providing individual and/or group HIV, Hepatitis, STD, and/or TB education services.

#### **Item 11**

Educational services are structured to offer information in a psychoeducational approach. These services may be offered to individuals who have completed an intake and have been admitted into the program. No individual may be billed over 2 hours annually in the same program educational group services. Services may be offered in individual or group settings. Indicate the number of units used by Licensed Nurses (LPN or greater) when providing individual and/or group HIV, Hepatitis, STD, and/or TB education services.

#### **Item 12**

Educational services are structured to offer information in a psychoeducational approach. These services may be offered to individuals who have completed an intake and have been admitted into the program. No individual may be billed over 2 hours annually in the same program educational group services. Services may be offered in individual or group settings. Indicate the number of units used by Certified Peer Support Specialists when providing individual and/or group HIV, Hepatitis, STD, and/or TB education services. A Certified Peer Support Specialist may be used to provide these educational services once the CPSS has completed a DMH approved training course.

## HIV/HEP Service Categories

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HIV/HEP Service Categories		Unit Measure
<b>Rapid Testing</b>		
13	<b>HIV RAPID TESTING</b> Completed by individual trained to administer	Per Service
14	<b>HCV RAPID TESTING</b> Completed by individual trained to administer	Per Service
15	<b>HEPATITIS PANEL:</b> If completed on site or through formal agreement with other agency	Per Service

### **RAPID TESTING**

#### **Item 13**

Indicate total number of HIV Rapid tests administered.

#### **Item 14**

Indicate total number of HCV Rapid tests administered.

#### **Item 15**

Indicate the total number of HEP panels completed (if completed on site or through a formal agreement with another agency). Hepatitis panel can only be paid if the individual has a confirmed positive screen.

### **TESTING SUPPLIES**

Testing Supplies		
16	<b>HIV RAPID TEST</b>	Per Unit
17	<b>HCV RAPID TEST</b>	Per Unit

#### **Item 16**

Testing supplies should be covered through memorandum of agreement with the Mississippi Department of Health. If this is not indicated, then grant funds can be used to purchase these kits. Indicate total number of HIV Rapid test kits administered.

**Item 17**

Testing supplies should be covered through memorandum of agreement with the Mississippi Department of Health. If this is not indicated, then grant funds can be used to purchase these kits. Indicate total number of HCV Rapid test kits administered.

**TREATMENT/CONSULTATION**

Treatment/Consultation		
18	Post-Test Recovery Support (1 hour maximum)	Per Unit

**Item 18**

Indicate total number of units a Certified Peer Support Specialist is utilized for travel with the individual for consultation with health provider after HIV/HCV positive confirmatory result.

(1 hour maximum)

**CONFIRMATION TESTING**

Confirmation Testing		Total Tested	Total Confirmations
19	HIV	0	
20	HEPATITIS	0	

**Item 19 - HIV**

**Number Tested-** This item is to indicate the total number of individuals tested for HIV. The number of individuals tested will be automatically calculated when the number of units for Item 13-HIV Rapid Testing is entered. Please be sure to not delete this number, as the formula will be deleted also.

**Number Confirmed-** Indicate the total number of individuals who have received a confirmatory test from the Dept. of Health. There is no formula for this item, so please enter this data based on client data.

**Item 20 - HCV**

**Number Tested-** This item is to indicate the total number of individuals tested for HCV. The number of individuals tested will be automatically calculated when the number of units for Item 14-HCV Rapid Testing is entered. Please be sure to not delete this number, as the formula will be deleted also.



**Number Confirmed-** Indicate the total number of individuals who have received a confirmatory test from the Dept. of Health. There is no formula for this item, so please enter this data based on client data.

**Important:**

**All service unit costs are based on Medicaid reimbursement rates**

***\*60 or more minutes of post-test counseling is required for individuals who have a reactive HIV test ("tests positive")***

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Medicaid Reimbursement Rates-** Service costs were determined using the current fee schedules and rates of Mississippi Division of Medicaid. These rates are subject to change at any time. Do not exceed the current rate.

**Signature/Date-** The billing form must be signed and dated in order to be valid. Missing information in either field will not be accepted until a signed/dated form is returned.

**MISSISSIPPI DEPARTMENT OF MENTAL HEALTH  
BUREAU OF ALOCHOL AND DRUG SERVICES  
HIV PURCHASE OF SERVICE - SABG FUNDS**

Name of Provider \_\_\_\_\_

Contract Number \_\_\_\_\_

Month/Year \_\_\_\_\_

Application \_\_\_\_\_ to \_\_\_\_\_

<b>HIV/HEP Service Categories</b>		<b>Unit Measures</b>	<b>Rate</b>	<b>Number of Units</b>	<b>Totals</b>
<b>Therapeutic Services</b>					
1	<b>Pre-Test Individual Counseling</b> Master's Level	30 Minutes	\$ 55.93		\$ -
2	<b>Pre-Test Individual Counseling</b> Bachelor's Level (Professional Certification Required)	30 Minutes	\$ 29.76		\$ -
3	<b>Pre-Test Individual Counseling</b> Licensed Nurse	30 Minutes	\$ 29.76		\$ -
4	<b>Pre-Test Individual Support</b> A Certified Peer Support Specialist may be used to provide support for clients	30 Minutes	\$ 14.78		\$ -
5	<b>Post-Test Individual Counseling</b> Master's Level	*30 Minutes	\$ 55.93		\$ -
6	<b>Post-Test Individual Counseling</b> Bachelor's Level (Professional Certification Required)	*30 Minutes	\$ 29.76		\$ -
7	<b>Post-Test Individual Counseling</b> Licensed Nurse	*30 Minutes	\$ 29.76		\$ -
8	<b>Post-Test Individual Support</b> Certified Peer Support Specialist (1 hour maximum)	*30 Minutes	\$ 14.78		\$ -
<b>Educational Group Services</b>					
May bill a combined maximum of 2 hrs for HIV/STD/Hepatitis/TB education					
9	<b>Individual/Group Education</b> Master's Level	60 Minutes	\$ 22.44		\$ -
10	<b>Individual/Group Education</b> Bachelor's Level (Professional Certification Required)	60 Minutes	\$ 15.48		\$ -
11	<b>Individual/Group Education</b> Licensed Nurse	60 Minutes	\$ 22.44		\$ -
12	<b>Individual/Group Education</b> Certified Peer Support Specialist (DMH Approved Training Course Required)	60 Minutes	\$ 14.78		\$ -

**MISSISSIPPI DEPARTMENT OF MENTAL HEALTH  
BUREAU OF ALOCHOL AND DRUG SERVICES  
HIV PURCHASE OF SERVICES - SABG FUNDS**

HIV/HEP Service Categories		Unit Measure	Rate	Number of Units	Totals
<b>Rapid Testing</b>					
13	<b>HIV RAPID TESTING</b> Completed by individual trained to administer	Per Service	\$ 16.79		\$ -
14	<b>HCV RAPID TESTING</b> Completed by individual trained to administer	Per Service	\$ 14.28		\$ -
15	<b>HEPATITIS PANEL:</b> If completed on site or through formal agreement with other agency	Per Service	\$ 50.42		\$ -
<b>Testing Supplies</b>					
16	<b>HIV RAPID TEST</b>	Per Unit			\$ -
17	<b>HCV RAPID TEST</b>	Per Unit			\$ -
<b>Treatment/Consultation</b>					
18	<b>Post-Test Recovery Support</b> (1 hour maximum)	Per Unit	\$7.39		\$ -
<b>Total HIV/HCV/STD Reimbursement Request</b>					\$ -

Confirmation Testing		Total Tested	Total Confirmations
19	<b>HIV</b>	0	
20	<b>HEPATITIS</b>	0	

**Important:**

All service unit costs are based on Medicaid reimbursement rates

*\*60 or more minutes of post-test counseling is required for individuals who have a reactive HIV test ("tests positive")*

Signature \_\_\_\_\_ Date \_\_\_\_\_

**DMH Form BADS-POS-1 (Rev 03/9/2016)**

# HIV/HEP/STD/TB Educational Services Form Guidance

An Excel spreadsheet has been developed to record the total number of education hours for each individual billed per month.

Individual Identification		Dates of Service	Units	Service Area -Select from Drop Down Options
1				
2				
3				
4				

### Individual Identification

List the individual's file or case number. Please do not list any personally identifiable information for the individual receiving services.

### Dates of Service

Indicate the date(s) the HIV/HEP/STD/TB education hours were completed.

### Units

Indicate the number of units used when providing individual and/or group HIV, Hepatitis, STD, and/or TB education services. The number of units must correspond with the units entered on lines 9, 10, 11, or 12 on the HIV Billing Sheet.

### Service Area

Indicate the specific service area and which clinician/specialist was utilized by the individual by selecting the options from the drop down box. (Please see example below)

Units	Service Area -Select from Drop Down Options
	<div style="border: 1px solid black; padding: 2px;"> <div style="background-color: #e1f5fe; padding: 2px;">Indiv/Group Ed-Master's</div> <div style="padding: 2px;">Indiv/Group Ed-Bachelor's</div> <div style="padding: 2px;">Indiv/Group Ed-Nurse</div> <div style="padding: 2px;">Indiv/Group Ed-CPSS</div> </div>

**MISSISSIPPI DEPARTMENT OF MENTAL HEALTH  
BUREAU OF ALOCHOL AND DRUG SERVICES  
HIV/HEP/STD/TB Educational Services**

Name of Provider \_\_\_\_\_  
 Contract Number \_\_\_\_\_  
 Month/Year \_\_\_\_\_

Application \_\_\_\_\_ to \_\_\_\_\_

	Individual Identification	Date of Service	Units	Service Area -Select from Drop Down Options
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
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