

**INSTRUCTIONS FOR PROVIDERS OF
MENTAL HEALTH TREATMENT
UNDER THE CRIME VICTIMS' COMPENSATION ACT**

MENTAL HEALTH FORM



CRIME VICTIMS' COMPENSATION PROGRAM
CRIME VICTIM SERVICES DIVISION
OFFICE *of the* ATTORNEY GENERAL

**Crime Victim Services Division
Crime Victims' Compensation Program**

INSTRUCTIONS FOR PROVIDERS OF MENTAL HEALTH SERVICES

Dear Mental Health Service Provider,

The purpose of the Crime Victims' Compensation Program (CVC) is to help victims of violent crime and to provide them with assistance to ease their financial burden during the recovery period. Providing financial help to crime victims who need mental health treatment is an integral part of their recovery process and is a service of the Crime Victims' Compensation Program. The CVC Program is also charged with protecting the fund to ensure that the services are related to the victimization and that they are necessary and reasonable. The primary goal of the CVC Program is to restore the victim to a level of functioning comparable with their level of functioning immediately prior to the victimization.

The counseling limit for each victim and/or eligible claimant is:

-\$3,000 per victim or claimant for dates of crimes after September 1, 1994,
or 60 sessions for dates of crimes after September 1, 2014.

If your client is eligible for Medicaid, CHIPS, and/or other private medical insurance, you must first file with the insurance available. The CVC Program statute requires a victim or claimant to use the health care benefits that are available to them. If the CVC Program determines that a crime victim has a private healthcare plan or is currently eligible for Medicaid, and the victim has not used their plan or used a network provider within the plan's network, the mental health therapy services may be denied. It is always best to call the Program if you have a question about the other third-party payers available.

The following instructions contains a general description of the process for requesting and obtaining authorization to provide services under the act. The following packet includes:

- I. A List of Eligible Provider Disciplines,
- II. Request for Authorization and Elements of the Treatment Plan,
- III. Treatment Progress Reports,
- IV. Eligible Services,
- V. Limitations on Covered Services, and
- VI. - IX. Procedures to Follow to Seek Payment for Services Rendered.

Please review the instructions carefully. If you have any questions or concerns, please call (512) 936-2952. Finally, these instructions have been developed to assist you in receiving payment for the critical services that you provide. It is the CVC Program's goal to make this a positive process. Thank you for your care and support of crime victims.

PLEASE MAIL COMPLETED FORMS TO:

**Office of the Attorney General
Crime Victims' Compensation Program
PO Box 12198
Austin, Texas 78711-2198**

SECTION I. ELIGIBLE PROVIDER DISCIPLINES

Eligible providers must be licensed practitioners limited to the disciplines listed on the OAG website at: <https://www.texasattorneygeneral.gov/cvs/mental-health-counseling-psychiatric-service>

SECTION II. REQUEST FOR AUTHORIZATION AND ELEMENTS OF THE TREATMENT PLAN

The therapist shall send to the Program the "Mental Health Form" **legibly completed**, 30 days after the initial evaluation session(s). It should contain all of the information that a therapist would properly obtain from the client during assessment. It should include the following:

- **Presenting Problem** - A clear and concise description of the problems the victim is experiencing and their relationship to the crime. This typically contains the precipitating event that brought the victim into therapy that may or may not be the crime but the event should be related to the crime in some way.
- **Preliminary Diagnoses** - Should be given with concrete, observable symptoms that meet the diagnostic criteria of the DSM-V stated explicitly and related to the crime.
- **Preliminary Treatment Plan** - should state clearly measurable goals which are clearly related to the presenting problem and its symptomatology.
- **Prognoses** - are necessary in order that the case manager can plan with the victim how their claim will be handled and to determine the progress of the victim. The prognoses should be specific, time limited estimates of the length of treatment based on the severity of the victim's condition.

SECTION III. TREATMENT PROGRESS REPORTS

Treatment progress reports are the update of the information contained in the initial authorization request (Mental Health Form) to the Program. However, progress should also describe the client's current symptom pattern, any changes in symptoms since the last report, progress toward each treatment goal, a list of the impediments to progress and a plan to address the impediments. A new MHF should be submitted every 6 months the victim/claimant is in therapy. Progress notes from individual sessions may be requested by CVC as a resource to indicate the progress being made.

SECTION IV. ELIGIBLE SERVICES

The following treatment modalities will be considered to be eligible services:

- **Outpatient Psychotherapy Services** - provided by a licensed practitioner as listed in "Section I -- Eligible Provider Disciplines" in a variety of settings, including: crisis intervention, individual therapy, group therapy, family therapy, play therapy or EMDR.
 - For clients seen an average of once per week or less, the Mental Health Form should be submitted every 6 months.
 - For clients in crisis who are seen twice a week or

more, the Mental Health Form **and** progress notes/reports should be submitted, beginning with the first date of treatment.

- For clients in Family counseling, charges will be applied toward each family member's counseling limit. Progress notes indicating names of participants will be required.
- **Inpatient Psychiatric Services or Residential Treatment Facilities** - when prescribed by a physician and when facility is licensed or accredited.
 - Treatment Progress Reports should be submitted on a weekly basis.
 - There is a 30 day limit for inpatient and RTC services and allowable rate based upon Medical Fee Guideline.

(ALL REQUESTS FOR INPATIENT SERVICES MUST BE PRE-AUTHORIZED.)

SECTION V. LIMITATIONS ON COVERED SERVICES

The following services may not be approved for payment and should not be billed to the program:

- **Missed Appointments** -- if a client does not attend a scheduled session, the payment for that session is the client's responsibility.
- **Court Appearances or Evaluations**--when the therapist is required to appear in any court or prepare evaluations requested by a court.
- **Client Contacts** - services provided by **telephone** or outside of the office (e.g., victim's home), **Equestrian, Nutritional, Art, and Music Therapies** are not normally covered services. The Program recommends that the therapist discuss these contacts in advance to avoid the denial of a bill

SECTION VI. BILLING PROCEDURES

Therapists must submit their bills for services on the CMS (previously HCFA). The CMS 1500 must be complete or the bill will be returned to be corrected. The Program contracts with a private vendor to conduct utilization review and cost containment of all medical bills. The CVC Program statute requires that payments for health care services be made according to the medical fee guidelines prescribed by Subtitle A, Title 5, Labor Code (Workers' Compensation Law). Therapists may find their billing reduced to the amount prescribed under the law. When this occurs, therapists will be informed by an "Explanation of Benefits" (EOB) form attached to the check. If a therapist has any question concerning payment, they should call the CVC- vendor, at the phone number listed on the Explanation of Benefits.

The CVC Program provides, in part, that the program may only make an award for "pecuniary loss" incurred by a victim or claimant. The Program pays only for financial losses for which the provider will hold the victim responsible. If a sliding fee scale is used by the provider or their employing agency then that fee must be determined and no more than that amount billed to CVC. Under no conditions will CVC reimburse for services provided by grant funding from the Victims of Crime Act

or any other grants which underwrite the salary or fee of the provider.

The CVC- Program statute also specifies that a health care provider who accepts a payment by the CVC Program is considered payment in full. The act further specifies that neither the Office of the Attorney General nor the client are responsible for the difference between the billed amount and the amount authorized by law (Workers' Compensation Medical Fee Guideline).

Providers should include the victim's claim number (VC#) on all correspondence. Charges for the provision of mental health services should be sent to:

Office of the Attorney General
Crime Victims' Compensation Program
PO Box 12198
Austin, TX 78711-2198

Reimbursement for the completion of this mental health form shall be reimbursed according to TAC RULE §61.502 at the allowable medical fee guidelines. For consideration of payment, please submit an itemized bill to CVC along with the mental health form.

SECTION VII. THIRD-PARTY PAYERS (Collateral Sources)

The CVC Program differs from other third-party payers. The Program statute requires a victim to use the health care benefits that are readily available to them first. Medicaid and any other public health care benefits are included. **Therapists should be sure to ask** their crime victim clients **if they have** a source readily available to either provide or pay for these services such as **insurance or**

Medicaid. If the Program determines that a crime victim has a **private healthcare** plan or is currently eligible for **Medicaid**, and the victim has **not used** their particular plan, the **payment** for the therapy services may be **denied**. It is always best to call the Program to obtain approval, if there may be other third-party payers available.

SECTION VIII. REVIEW AND APPROVAL

The "Mental Health Form" will be reviewed by a Utilization Review Nurse. The review criteria include the CVC Program statute, the Administrative Rules and the Policy of the Program. When the UR Nurse approves the request, the therapist will be notified (telephone, FAX, or a letter confirming the approval). The therapist is then authorized to provide the services as approved. There may be occasions when the therapist and the Program disagree on therapy matters ranging from the necessity of treatment to reductions in amounts or denial of bills for technical reasons. If a reviewer denies the request, the reviewer will inform the therapist of the denial and the detailed reasons for the denial. Under extenuating circumstances an exception to the limit can be requested by the victim/claimant/provider of service along with supporting documentation. See appeals section for the procedure to ask for a review of the decision.

Please be advised, the attorney general may reconsider any prior decision to make or deny an award, especially based upon newly discovered evidence. When CVC makes this payment for these services, the victim or claimant cannot be held liable for charges left as a result of our fair and reasonable rate adjustment. However, if CVC subsequently denies an award and makes no payment for these services, the financially responsible party will remain liable for any services actually rendered.

SECTION IX. APPEAL PROCESS

If the therapist disagrees with the determination of the CVC Program, the first step is to call or write the medical review staff to discuss the differences. If the matter is not settled at that stage, only the adult victim or claimant can request an appeal. The CVC Program may appoint persons to serve as a peer review to resolve the matter. As a dispute moves through the process, the therapist may be required to submit additional supporting information, such as progress or session notes or other medical evaluations.

SECTION X. CONFIDENTIALITY

An informed consent to release confidential information is on file in this office and can be faxed or mailed to you upon your request. The release is critical to the therapist and the CVC Program in order to allow discussions about benefits and clinical issues.

Revised 8/30/16

**Crime Victim Services Division
Crime Victims' Compensation Program**

Mental Health Form

Date: _____

Claim Number: _____

Date of Crime: _____

CLIENT INFORMATION

Name: FN MI LN	Date of Birth:	Last 4 Digits of Social Security Number:
Parent / Legal Guardian:		Date of First Treatment:

ELEMENTS OF THE TREATMENT PLAN

Please describe the crime for which you are providing treatment including details provided to you:

DSM-V DIAGNOSES (Indicate both the diagnosis and corresponding code.)

Principal Diagnosis:

Additional Diagnosis:

PRESENTING PROBLEM AND ITS RELATIONSHIP TO THE CRIME

Describe, in detail, the problems for which the patient is seeking treatment including observable cognitive, behavioral and emotional symptoms displayed by the victim. *Note: You must inform CVC Program if this is court ordered evaluation or treatment.*

TREATMENT GOALS AND THE PROGNOSIS

A. Describe the Short-Term Treatment Goals (less than three months):

B. Describe the Long-Term Treatment Goals (longer than three months):

C. Describe the Prognosis, and Anticipated Termination Date:

Anticipated Termination Date (must enter date): _____

THIRD-PARTY PAYERS (Collateral Sources)

Does the patient have a health care plan? Yes No

If the patient has a health care plan, complete the following:

Name of Carrier:	Carrier Address:
Policy Number:	Group Number:

Is the patient currently on Medicaid or any other public insurance plan?
(CVC does not need this form if Medicaid is payer). Yes No

Medicaid Provider Number _____

Is the patient/client receiving counseling under a grant, free counseling, or reduced fee reimbursement (such as a sliding scale). If so, explain:

PROVIDER INFORMATION

Name:		Name of Agency:	
Address, City, State, Zip Code:		Telephone Number: ()	
		Fax Number: ()	
License Number:	Discipline/Title:	(If licensed Intern) List	
Expiration Date:		Supervisor / License Number:	
		Board-Approved Supervisor / License Number:	

Signature: _____ **Date:** _____

Reviewed 8/30/16