DATE: October 15, 2003

TO: All Interested Parties

FROM: Anita Miller
OMHAS, OHP Coordinator

RE: New Coding Standards for Mental Health and Chemical Dependency Treatment Services - Questions Received

OMHAS received many questions from managed care plans and providers regarding the new coding standards for the billing of mental health and chemical dependency treatment services for Medicaid clients. As staff reviewed the questions, it became apparent that the questions clustered around either technical or programmatic issues.

In the attached document, an attempt was made to answer as many questions as possible through some general policy statements. These policy statements broadly address many of the technical questions around upper payment limits, units of service, documentation of services, and other general coding and billing issues. Other programmatic issues will not be addressed in this document. We encourage provider billing staff and their clinical administrative leadership to sort through the internal billing and coding questions. We also recommend that providers raise questions they are not able to resolve internally with the managed care plans they work with.

OMHAS staff will provide technical assistance and continue to address questions that are received. We also acknowledge that there will be a number of issues and opportunities to explore as we work on this transition.
If you have questions, please contact Debra Scott at 503-945-5962 or Anita Miller at 503-945-9447.

Coding Standards for
Mental Health and Chemical Dependency Treatment Services
Effective October 1, 2003

A. General Policy Statements

1. Upper Payment Limits

Fee-for-service claims for mental health and chemical dependency treatment services for Medicaid-eligible clients are paid within the upper payment limitations established by OMHAS through the Oregon Medicaid Services Procedure Codes and Reimbursement Rates Schedules.

a. Providers must establish a fee schedule based upon reasonable and customary costs of services in accordance with a cost allocation plan, OMB Circular A-87 or A-122, or other applicable state and federal laws, rules and regulations, but not in excess of the Provider's usual and customary charge to the general public. Charges should reflect the cost of the service performed.
b. Payment will be made at each Provider's usual and customary charge or OMHAS upper payment limit, whichever is less.
c. Staff providing the services must meet applicable Oregon Administrative Rule requirements for the level of service provided.

2. Units of Service

a. The inclusion of 'time' in CPT or HCPCs was intended to assist Providers in selecting the most appropriate level of services. The CPT manual advises that it should be recognized that the specific times expressed in the codes are 'averages and therefore represent a range of times which may be higher or lower depending on actual clinical circumstances.'
b. For many codes, time is not a descriptive component in the national coding guidelines. Providers should develop a rate for services through a cost allocation plan.
c. OMHAS has established an upper payment limit for each CPT or HCPC based on either a 'per service' or 'per specified time' basis. Providers must indicate how many 'services per day' or how many 'units of the indicated time increments' they provide.

d. Some services may be provided in structured programs licensed or certified to provide an intensive level of care and will have an all-inclusive 'daily' or 'per diem' rate.

3. Coding and Billing

a. It is important that the Provider select the name of the procedure that accurately identifies the service performed. Coding and billing should be based on the service provided. When both CPT and HCPC codes share nearly identical narratives select the code with the narrative that better describes the service; generally the HCPC is more specific.
b. Every reasonable effort has been made by OMHAS to ensure that the information contained in the Oregon Medicaid Procedure Codes and Reimbursement Rates Schedule is consistent with the official CPT manual developed by the American Medical Association or the national HCPCs maintained by the HCPCs National Panel. There may be other interpretations of the CPT codes and the HCPCs contained in other 'unofficial' guidebooks available for coding and payment for behavioral health services.
c. While CPT codes predominately describe procedures performed by physicians, many behavioral health providers may use CPT codes when billing for their services. Behavioral health providers should choose the most appropriate code available for the service provided, whether CPT or HCPC.
d. Providers must indicate on the claim, the 'Place of Service' code that describes where the services were performed.
e. Modifiers provide the means to indicate that a service or procedure has been performed under some specific circumstance but not changed in definition or code. While the CPT and HCPCs national committees have developed many modifiers, modifiers have been used sparingly by OMHAS and only when necessary to differentiate when similar codes are being used for different types of programs. Providers may use modifiers only as indicated on the Oregon Medicaid Procedure Codes and Reimbursement Rates Schedule for specific codes and programs.
f. In general, most services require a 'face-to-face' contact. However, Oregon Administrative Rules (OAR) for certification or licensure through OMHAS may specify or require a “face to face” contact for some services. For crisis services, a telephonic contact may be

used to assess the urgency of the crisis and for immediate stabilization of the client. Circumstances surrounding the telephonic contact must be documented in the client's clinical record.

g. Frequency limitations for chemical dependency treatment services have been in place for several years. These limitations have been modified to reflect the changes in 'per service' or 'per time specified' components of CPTs and HCPCs. Providers must determine the scope and frequency of services provided to client's based on the placement and level of care criteria specified in the Oregon Administrative Rules and consistent with the client's individualized treatment plan.

4. Documentation

a. Providers must follow clinical documentation guidelines as defined in the applicable Oregon Administrative Rules for the level of care provided, or other applicable state or federal laws, rules or regulations.
b. Clinical documentation serves as the method for:
    1. tracking a client's treatment history and ongoing care;
    2. the legal document that is the basis for determining quality and quantity of services, as well as the medical appropriateness of services; and
    3. the method by which payers can review paid claims against the information recorded at the time of service.
c. Codes submitted for billing should reflect the documentation in the clinical record.

B. Specific Questions

1. 90882/90887

- 90882 – Environmental intervention. Time spent by a provider on the client's behalf with providers, state agencies, employers, or institutions.

- 90887 – Interpretation or explanation of results. Time spent by a provider discussing a client's care and treatment with family or other persons involved in the client's care.
- Mental Health providers may utilize both codes when billing for services. Chemical Dependency providers should utilize 90887 when billing for services.

2. H2023 – Supported Employment - Can supported employment services be provided by a QMHP? If so, why is there only a QMHA rate?

   - Supported employment is an evidence-based service to promote rehabilitation and return to productive employment for persons with severe and persistent mental illness. Persons performing this service may be responsible for activities such as carrying out vocational services from intake to follow-along and contacts may occur in the home, at the job site, or in the community. The goal of these services is to assist the client to obtain and maintain employment. Performance of this service does not require a QMHP level therapist and as such, the upper payment limit is based on a QMHA level of staff. This issue may be reassessed as OMHAS develops a work plan to expand the implementation of evidence based practices.

3. G0176/G0177 – Activity Therapy and Training/Education Services - What does "45 minutes or more" mean?

   - National coding guidelines indicate that the service duration of this activity is '45 minutes or more'. Providers must identify the types of therapeutic activities to improve functioning capacity (G0176) or activities to restore or develop skills necessary for daily living (G0177) and indicate the number of those services performed per day. Each activity may vary in duration but must be at least 45 minutes in duration.

4. 96100 - Psychological Testing - Is this still an hour unit?

   - Yes. CPT coding guidelines indicate that this code applies to each hour of testing. Interpretation and report on the

information obtained through the assessment testing is included.

5. T1005 - Respite Care Services - what does “up to 15 min “ mean?

   - HCPC coding guidelines indicate the service duration for each unit is 'up to 15 minutes'. Providers should indicate how many units of this service they provide.

6. Intake coordinator is using a flex code “FF663” to record the services she provided. Will this code go away after 10/1/2003? Is so, what code does she use?

   - FF663 is not a code recognized by OMHAS for the billing of mental health services. It is important that the Intake Coordinator identifies the type of service provided and chooses the most appropriate CPT or HCPC code available. If the function of the Intake Coordinator is to gather and triage information prior to a client's entry into treatment, the services may be considered 'administrative' in nature and not a billable service. H0002 is the encounter code available for a screening that is needed to determine a person's immediate treatment needs and may result in a provisional diagnosis for the purpose of referral.

7. Is the definition of "interactive diagnostic" interview really supposed to include a language translator as well as things like play therapy?

   - Interactive therapies typically involve the use of physical devices or other mechanisms of non-verbal communication to overcome barriers to a clinical interaction for a client who has not yet developed, or has lost expressive communication skills or lacks the receptive communication skills to understand the clinician.

   - For clients with hearing impairments or limited English speaking skills, providers may use T1013 for sign language or oral interpreter services, in conjunction with the therapeutic service. Whenever feasible, clients should receive services from staff

who are able to provide sign and/or oral interpretive services. When treatment staff are bilingual or trained in sign language, no additional interpreter services may be billed.

8. H0002-Behavioral Health Screening - is this for QMHP or for QMHA also?

   - The service criteria for this code indicates the purpose of this service is to: assess a client's immediate treatment needs to establish a provisional diagnosis for referral. QMHAs do not meet the educational qualifications as described in the Oregon Administrative Rules to conduct an assessment for the purpose of establishing a diagnosis.