Behavioral Health Redesign

2017 Overview and Billing Guide
Beginning on January 1, 2018, ODM is making significant changes to the management and administration of behavioral health services. These changes will impact all Ohio behavioral health providers, facilities and practitioners. It is critical for all providers to understand the changes and the actions required to ensure a smooth transition.
Behavioral Health Re-Design

• January 1, 2018 Re-Design Occurs
  – Behavioral Health (BH) providers must begin submitting claims utilizing correct CPT/HCPC/NDC/modifiers codes
  – MyCare Managed Care Plans (MCPs) will only accept claims using the above
  – ODM will only accept claims using above
Behavioral Health Re-Design

• What Is Changing?
  – Claim submission requirements will be changed.
  – Requires NDC codes for all medications along with J codes
  – Rendering providers must have a valid Medicaid Identification Number
  – Rendering providers must have an individual NPI number
    • To obtain an NPI go to: [https://nppes.cms.hhs.gov/webhelp/nppeshelp/MAIN%20PAGE.html](https://nppes.cms.hhs.gov/webhelp/nppeshelp/MAIN%20PAGE.html)
  – Rendering provider NPI must be included in all claims
  – Claims submitted without the required information will be rejected or denied
  – NOTE: Claims must be submitted to the Third Party Payor prior to submitting to Medicaid or the MCPs. Remember, Medicaid is the payor of last resort.
Behavioral Health Re-Design

Who is Affected?

- All providers who submit claims to ODM and or MCPs for MyCare/Medicaid in the MyCare Regions
Behavioral Health Re-Design

Provider Types

• Ohio Mental Health & Addiction Services (MHAS) - Provider Type 84
  – Must be or obtain certification by OhioMHAS as a provider of mental health
  – Then submit online application in the Ohio MH FFS Medicaid via MITS

• OhioMHAS-Provider Type 95
  – Must be or obtain certification by OhioMHAS as an Substance Use Disorder (SUD) treatment program
  – Then submit online application in the Ohio MH FFS Medicaid via MITS

*the above steps must be completed for a Type 84/95 to submit claims
Behavioral Health Re-Design

Provider Types

Rendering Practitioners-Effective Jan. 1, 2018

Physicians (MD/DO) Type 20
CNP Type 72
CNS Type 65
PA Type 24
RN Type 38-384
Licensed Pract. Nurse Type 38-385

Licensed Psychologists Type 42
Licensed Ind. Social Worker Type 37
Licensed Prof. Clinical Couns. Type 47
Licensed Ind. Marriage/Fam. Therap. Type 52
Licensed Ind. Chem. Dep. Couns. Type 54
Behavioral Health Re-Design

Provider Types
Rendering Practitioners-Effective Jan. 1, 2018

- Providers are required to enroll in Medicaid with their personal NPI. Claims must be submitted by using their NPI in the rendering field (Box 24J)
- Then visit the ODM Provider Enrollment page and enroll in Medicaid
- Each agency **MUST** ensure that each of its corresponding employed/contracted providers are affiliated or linked to their agency. This is completed in MITS.
Behavioral Health Re-Design

Provider Types

Rendering Practitioners Requiring Supervision-Effective July 1

- LSW Type 37-371
- Social Worker Train. Type 37-372
- Social Worker Assist. Type 37-373
- Psychology Train. Type 42-422
- Psychology Assist. Type 42/423
- Psychology Intern Type 42/424
- Chem. Dep. Couns II Type 54-541
- Chem. Dep. Couns III Type 54-542
- Licensed Prof. Couns. Type 47-471
- Couns. Train. Type 47-472
- Licensed Marriage/Fam Couns. Type 52-521
- Marriage/Fam Couns. Train. Type 52-522
- Qual. MH Specialist Type 96-960
- Qual. MH specialist 3 Type 96-961
- Care Management Spec. Type 96-962
- Peer Recovery Supporter type 96-963

* NPIs will be required in the rendering field effective for dates of service on and after July 1, 2018. Some modifiers that indicate practitioner will continue to be required. NOTE: for dates of service Jan. 1 thru June 30 practitioner modifiers are required on claims.
Behavioral Health Re-Design

Supervision

- Ohio Medicaid covers services provided by practitioners who, under state licensing, require supervision. The types of practitioners who may supervise is determined according to the appropriate licensing board.
  - General supervision – supervising practitioner must be available by telephone to provide assistance and direction if needed
  - Direct supervision – supervising practitioner must be “immediately available” and “interruptible” to provide assistance and direction throughout the performance of the procedure, however does not need to be present
Rendering Practitioners Requiring Supervision – Effective July 1
- Ohio Medicaid requires the above practitioners to practice under either direct or general supervision. Reporting supervising NPI on the claim will be optional with the implementation of the services and codes included in the ODM BH State Plan Services.
- Services will be paid at direct supervisor’s rate when supervisor NPI is included in the header of the claim. If the supervisor NPI is not included on the claim indicating the services are provided under general supervision the service will be paid at 72.25% of maximum fee.
Behavioral Health Re-Design

Helpful websites for further guidance on supervision:

• State of Ohio Medical Board – http://med.ohio.gov
• Ohio Nursing Board – http://www.nursing.ohio.gov
• Counselor, Social Worker and Marriage and Family Therapist Board – http://cswmft.ohio.gov/Home.aspx
• Ohio Chemical Dependency Professionals Board – http://ocdp.ohio.gov/
• Ohio Board of Psychology – http://psychology.ohio.gov/
Behavioral Health Re-Design

Specific Claim Submission Information

- Modifiers Usage
  - Must be used to identify Practitioner for dates of service
    - Jan. 1 thru June 30
    - General and Direct Supervision
  - Procedure Modifiers

- Place of Services
  - Most appropriate CMS POS code.
Behavioral Health Re-Design

Third Party Payor (TPP) Coordination of Benefits (COB)
- Effective January 1, 2018
- Federal Regulation requires states to deny Medicaid claims until after the application of available third party payor benefits since Medicaid is the payor of last resort.
- A claim that has been submitted to a TPP using a CPT code cannot be recoded to a HCPCS code to bill Ohio Medicaid.
Behavioral Health Carve-In

- July 1, 2018 Carve-In Occurs
  - All mental health benefits for Medicaid members will be managed by the MCPs
  - Behavioral Health Providers will submit all Medicaid claims to the MCPs
  - All coding and provider identification requirements will apply
Behavioral Health Provider Contracting

• Why Contract with Buckeye Health Plan
  – Non-par providers require prior authorization for all services and/or risk denied claims
  – External Provider Relations Representatives
    • Buckeye Health Plan is #1 in Provider Satisfaction
  – Prior Authorization is not required for most services when PAR
    • Refer to our QRG
  – No Single Case Agreement is required

• How to Join Buckeye Network
  – Go To www.BuckeyeHealthPlan.com/Provider
    • Click Join our Network
  – Call Buckeye Provider Relations 866-246-4356 - ext. 24291
  – PAR and Non PAR Providers please submit updated rosters of all providers that you will start submitting claims
Behavioral Health Testing

- Test your claims with us to see if you are ready for Re-design and Carve-In
- You Do Not need to be a Participating Provider to submit test claims
  - Testing
  - Create a 837I and or 837P file
  - Go to: https://sites.edifecs.com/index.jsp/centene
  - For further questions on testing contact EDIBA Help Desk at 800-225-2573

OR

- Call Buckeye Provider Relations and ask for the Rapid Response Team at 800-224-1991
Utilization Management

Prior Authorization

• Prior authorizations differ in each program that Buckeye offers
• Highlights
  – All out-of-network (non-par) services and providers require prior authorization, excluding emergency care, out-of-area urgent care
  – All inpatient stays
  – ACT-Assertive Community Treatment
  – IHBC-Intensive Home Based treatment
  – SUD Residential
• Please see the detailed list of services, codes and authorization requirements in this guide.
Care Management

- Accountable point of contact (care manager) identified who can help obtain medically necessary care, assist with health-related services and coordinate care needs. Multi-disciplinary team consisting of licensed individuals.
- Care management strategies: best-practice and evidence-based clinical guidelines; lower member/care manager ratios.
- Guidelines for frequency and intensity of contact with high-risk members.
- Expected outcomes include optimization of member’s health; improved continuity of care coordination; decreased overall medical costs; decreased IP admits and ED visits.
New Behavioral Health Redesign Services

Starting on January 1, 2018, a transformative initiative aimed at rebuilding Ohio’s community behavioral health system. Key proposals include adding new services for people that may need high intensity service and support needs along with aligning the procedure codes used by Ohio’s behavioral health providers to better integrate physical and behavioral healthcare. For additional information on the provider types, codes, practitioner and procedure modifiers and rates on the services listed below please refer to the ODM BH Redesign Manual link listed below.


Substance Use Disorder (SUD)

A diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to use of the substance. The diagnosis of a substance use disorder is based from criteria defined in the current ICD-10 diagnosis codes manual can be applied to all 10 classes of drugs including: alcohol; cannabis; hallucinogens; inhalants; opioids; sedatives, hypnotics, and anxiolytics; stimulants; tobacco; and other (or unknown) substances.

Institute for Mental Disease (IMD)

Medicaid recipients ages 21 through 64, who receive their Medicaid benefits through a managed care plan (MCP), to receive inpatient treatment in an Institution for Mental Disease (IMD).

As a result of this policy, Medicaid recipients, ages 21 through 64, enrolled and receiving their Medicaid services through an MCP, such as Buckeye Health Plan, will have access to medically necessary and reimbursable treatment in an IMD setting. It is Buckeye’s intent to contract with all Ohio IMD’s and cover medically necessary services rendered to our members.

Assertive Community Treatment (ACT)

Assertive community treatment (ACT) is a collaborative, multidisciplinary team approach that shall include, at a minimum, behavioral health counseling and therapy service, mental health assessment service, pharmacologic management service, community psychiatric supportive treatment (CPST) service, self-help/peer support service, mental health crisis response service, substance abuse services, and supported employment services.
**Intensive Home Base Treatment (IHBT)**

Services assist individuals in achieving their recovery and rehabilitation goals. The program aims to reduce psychiatric and addiction symptoms and to assist in developing community living skills. The services may include coordination of services, support during a crisis, development of system monitoring and management skills, monitoring medications, and help in developing independent living skills.

**Therapeutic Behavioral Services (TBS)**

Therapeutic Behavioral Services (TBS) is an intensive, individualized, one-to-one behavioral coaching program available to children/youth up to age 21 who are experiencing a current emotional or behavioral challenge or experiencing a stressful life transition.

**Psychosocial Rehabilitation (PSR)**

Restoration of community functioning and well-being of an individual diagnosed in mental health or mental or emotional disorder and who may be considered to have a psychiatric disability.

**Screen, Brief Intervention and Referral to Treatment (SBIRT)**

- Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment.
- Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.
- Referral to treatment provides those identified as needing more extensive treatment with access to specialty care.
Behavioral Health Covered Services & Authorization Guidelines
Ohio MyCare Medicare/Medicaid Program (MMP)

Please refer to your Provider Agreement with Buckeye Health Plan to identify additional services you are contracted and eligible to provide. Non-participating providers (those that are not contracted and credentialed with Buckeye Health Plan) require prior authorization, unless otherwise noted.

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Billable Provider Types</th>
<th>Billing Codes</th>
<th>Service Locations</th>
<th>Guidelines/Requirements</th>
<th>Prior Authorization Required</th>
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<td>Inpatient – Behavioral Health Facility</td>
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<td>Inpatient – Substance Use Disorder (SUD)</td>
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<td>21,51,55,56</td>
<td>1 per day</td>
<td>Yes</td>
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</table>
| Inpatient – Eating Disorder Facility   | Facility                | 120,130,140,150        | 21,51,55,56       | 1 per day
Must be billed w/ an eating disorder DX | Yes                          |
| Inpatient – Rehab Facility             | Facility                | 128                    | 21,51,55,56       | 1 per day                                                    | Yes                          |
| Behavioral Health Treatment Services   | CMHC billing as FACILITY| 900,904,906,907,911,912,913,671,1002 | 19,21,22,51,52,56,57 | 1 per day
Must be billed with appropriate CPT Code | No                           |
| Behavioral Health Treatment Services   | FACILITY                | 900,911,944,945        | 19,21,22,51,52,56,57 | 1 per day
Must be billed with appropriate CPT Code | No                           |
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<tr>
<th>Service Description</th>
<th>Facility and CMHC Facility</th>
<th>CPT Codes</th>
<th>Billing Requirement</th>
<th>Coverage</th>
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<td><strong>Outpatient Individual, group, or family therapy</strong></td>
<td>Facility and CMHC Facility</td>
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<td>Must be billed with appropriate CPT Code</td>
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<td><strong>Inpatient or Outpatient testing</strong></td>
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<td>Must be billed with appropriate CPT Code</td>
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<td>Facility and CMHC Facility</td>
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<td>1 Per Day up to 2 consecutive days Must be billed with appropriate CPT Code</td>
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<td><strong>Discharge Follow-Up</strong></td>
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<td>510,513</td>
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<td><strong>Anesthesia for ECT</strong></td>
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<td>Up to 4 per day</td>
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<td><strong>OUTPATIENT HOSPITAL SERVICES</strong></td>
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<td>Service Category</td>
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<td>Required Codes</td>
<td>Billing Notes</td>
<td>Limitation</td>
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<td>Outpatient Hospital Services CMHC Facility</td>
<td>90785 MODS = AH,AJ,AM,HE, SA,UA,UC,UD, U1,U2,U3,U4, U5,U6,U7,U9, UT</td>
<td>19,21,22,51,52,56,57</td>
<td>MUST BE BILLED WITH: 90791,90792,90832,90833, 90834,90836,90837,90838, 99201-99255,99304-99337,99341-99350,90853 CANNOT BE BILLED WITH: 90839,90841 1 PER DAY</td>
<td>No</td>
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<tr>
<td>Outpatient Hospital Services CMHC Facility</td>
<td>90791 MODS = AH,AJ,AM,HE, SA,UA,UC,UD, U1,U2,U3,U4, U5,U6,U7,U9, UT</td>
<td>19,21,22,51,52,56,57</td>
<td>CANNOT be billed with 90792,90832-90834, 90836-90840, 90845-90847, 90863, 90885, 99201-99205, 99211-99215, 99354, 99355 1 PER DAY LIMITED TO 1 PER YEAR</td>
<td>Prior Authorization required after the first service</td>
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<td>Outpatient Hospital Services CMHC Facility</td>
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<td>19,21,22,51,52,56,57</td>
<td>1 PER DAY</td>
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<td>Outpatient CMHC</td>
<td>90832, 90839, 90832</td>
<td>19,21,22,51,52</td>
<td>90832 = 1 PER DAY</td>
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<td>HOSPITAL SERVICES</td>
<td>Facility</td>
<td>90840, 90846, 90847, 90849, 90853, 99354, 99355</td>
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<td>MODS =</td>
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<td>U1, U2, U3, U4, U5, U6, U7, U9,</td>
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<td>2,</td>
<td>56, 57</td>
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| OUTPATIENT HOSPITAL SERVICES | CMHC Facility | H2034 MOD = HE                    | 19,21,22,51,52, 56, 57 | Prior Authorization is required after 30 consecutive days. Call for Authorization including medical necessity for continued stay or for additional stays. | Prior Authorization is required after the first 30 consecutive days. |

| OUTPATIENT HOSPITAL SERVICES | CMHC Facility | H2015 MODS = HE, AH, AJ, U5, U2   | 19,21,22,51,52, 56, 57 | Yes |

| OUTPATIENT HOSPITAL SERVICES | CMHC Facility | H2020 MODS = HE, AH, AJ, U5, U2, U4, U1, U9, U8, UA, U7, HO, HQ, UT, UK, HN | 19,21,22,51,52, 56, 57 | 1 PER DAY | No |

<p>| OUTPATIENT HOSPITAL SERVICES | CMHC Facility | H2012 MODS = HE, AH, AJ, U5, U2, U4, U1, U9, U8, UA, U7, HO, HQ, UT, UK, HN | 19,21,22,51,52, 56, 57 | 2 HOURS PER DAY | No |</p>
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<td>CMHC Facility</td>
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<td>90833, 90836, 90838, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350 MODS = HE,AM,SA,UC, UD</td>
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<td>OUTPATIENT HOSPITAL</td>
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<td>OUTPATIENT HOSPITAL SERVICES</td>
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<td>H0012</td>
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<td>Up to 30 consecutive days without Prior Authorization. Call for Authorization including medical necessity for continued stay or for additional stays.</td>
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<td>19,21,22,51,52, 56,57</td>
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<td>Service Description</td>
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<td>Allowed Locations</td>
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<tr>
<td>OUTPATIENT HOSPITAL SERVICES</td>
<td>CMHC Facility</td>
<td>H2019 MODS = HE, U1, U9, U8, UA, U7, HO, HQ, UT, TD, HN, UK</td>
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<tr>
<td>OUTPATIENT HOSPITAL SERVICES</td>
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<td>OUTPATIENT HOSPITAL SERVICES</td>
<td>CMHC Facility</td>
<td>H0001 MODS = HE, U1, U9, UA, U7</td>
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PROFESSIONAL BEHAVIORAL HEALTH SERVICES
FQHCs do not require AUTH

****New Services outlined by the state no Authorization required 7/1/2018

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Billable Provider Types</th>
<th>Billing Codes</th>
<th>Allowed Locations</th>
<th>Guidelines/Requirements</th>
<th>Prior Authorization Required</th>
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<tr>
<td>Service Description</td>
<td>Provider Types</td>
<td>Area Code</td>
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<tr>
<td>Drug Screenings</td>
<td>MD/DO</td>
<td>80305, 80306, 80307</td>
<td>ALL</td>
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<tr>
<td>Psychiatric Diagnostic Evaluation</td>
<td>MD, PA, PhD, CNP, CNS, LMFT, LISW, LPC</td>
<td>90791</td>
<td>03, 04, 11, 12, 19, 20, 21, 22, 23, 31, 32, 49, 50, 51, 52, 55, 56, 57, 61, 71, 72, 99</td>
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<td>No</td>
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<tr>
<td>Diagnostic Evaluation, Interactive</td>
<td>MD, APN</td>
<td>90792</td>
<td>03, 04, 11, 12, 19, 20, 21, 22, 23, 31, 32, 49, 50, 51, 52, 55, 56, 57, 61, 71, 72, 99</td>
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<tr>
<td>Psychotherapy Individual and Family</td>
<td>MD, PA, PhD, CNP, CNS, LMFT, LISW, LPC</td>
<td>90832, 90834, 90837</td>
<td>03, 04, 11, 12, 19, 20, 21, 22, 23, 31, 32, 49, 50, 51, 52, 55, 56, 57, 61, 71, 72, 99</td>
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<tr>
<td>Psychotherapy Crisis</td>
<td>MD, PA, PhD, CNP, CNS, LMFT, LISW, LPC</td>
<td>90839, 90840</td>
<td>11, 12, 19, 22, 23, 31, 32, 50, 53</td>
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<tr>
<td>Psychotherapy Family and Group</td>
<td>MD, PA, PhD, CNP, CNS, LMFT, LISW, LPC</td>
<td>90845, 90846, 90847, 90849</td>
<td>03, 04, 11, 12, 19, 20, 21, 22, 23, 31, 32, 49, 50, 51, 52, 55, 56, 57, 61, 71, 72, 99</td>
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<td>Group Psychotherapy</td>
<td>MD, PA, PhD, CNP, APN, CNS, LMFT, LISW, LPC</td>
<td>90853</td>
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<tr>
<td>Pharmacological Management</td>
<td>MD, PA, PhD, CNP, CNS, LMFT, LISW, LPC</td>
<td>90863</td>
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<tr>
<td>Service Description</td>
<td>Required Documentation</td>
<td>Allowable Codes</td>
<td>Limitations</td>
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<tr>
<td>Therapeutic Repetitive Transcranial Magnetic Stimulation Treatment</td>
<td>FACILITY: 90867, 90868</td>
<td>19, 20, 21, 22, 23</td>
<td>1 per day for 90867</td>
<td>Yes</td>
<td>No Limit for 90868</td>
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<tr>
<td>Unlisted Psychiatric Service</td>
<td>FACILITY: 90899</td>
<td>19, 22</td>
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<tr>
<td>Electroconvulsive Therapy (ECT)</td>
<td>MD, FACILITY: 90870</td>
<td>21, 22</td>
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<tr>
<td>Individual Psychotherapy with medication management</td>
<td>MD, PA, CNP, APN</td>
<td>99201-99205, 99211-99215</td>
<td>1 per day</td>
<td>No</td>
<td>With or without: 90833/90785, 90836/90785, 90838/90785</td>
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<tr>
<td>Home Visits</td>
<td>MD, CNP, CNS, PA, APN</td>
<td>99311-99350</td>
<td></td>
<td>No</td>
<td></td>
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<tr>
<td>Psych Testing Per Hour = 1 Unit</td>
<td>MD, PhD</td>
<td>96101</td>
<td>8 hours per year</td>
<td>Yes</td>
<td></td>
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</table>

Fractions (every 6 minutes = 0.1 unit) 24 hours per SFY - adults

Yellow Shading Indicates New Covered Services
<table>
<thead>
<tr>
<th>Service Description</th>
<th>Type</th>
<th>Code(s)</th>
<th>Provider(s)</th>
<th>Allowed Times</th>
<th>Hours per Year</th>
<th>Covered?</th>
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<tbody>
<tr>
<td>Developmental Screening/Testing</td>
<td>MD, PhD</td>
<td>96110-96111</td>
<td>11, 19, 21, 22</td>
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<td>8 hours per year</td>
<td>Yes</td>
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<tr>
<td>Neurobehavioral Status Exam / Neuropsychological Testing</td>
<td>MD, PhD</td>
<td>96116-96118</td>
<td>11, 19, 21, 22, 31, 32</td>
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<td>8 hours per year</td>
<td>Yes</td>
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<tr>
<td>Emergency Department Services</td>
<td>MD, APN</td>
<td>99281-99285</td>
<td>23</td>
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<tr>
<td>Initial Observation Care</td>
<td>MD, PA, CNP, APN</td>
<td>99217-99220</td>
<td>21, 19, 22, 23, 51, 52, 61</td>
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<td>1 per day</td>
<td>No</td>
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<tr>
<td>Initial Facility Care</td>
<td>MD, PA, CNP, APN</td>
<td>99221-99226</td>
<td>21, 19, 22, 23, 51, 52, 61</td>
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<td>1 per day</td>
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<tr>
<td>Subsequent Facility Care</td>
<td>MD, PA, CNP, APN</td>
<td>99231-99236</td>
<td>21, 51, 61</td>
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<td>1 per day</td>
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<tr>
<td>Facility Discharge Management</td>
<td>MD, PA, CNP, APN</td>
<td>99238-99239</td>
<td>21, 31, 32, 51, 55, 56,</td>
<td></td>
<td>1 per day</td>
<td>No</td>
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<tr>
<td>Office Consults</td>
<td>MD, PA, CNP, APN</td>
<td>99241-99245</td>
<td>11, 19, 20, 22, 32, 49, 50, 52, 53, 56, 57, 71, 72, 99</td>
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<td>1 per day</td>
<td>No</td>
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<tr>
<td>Inpatient Consults</td>
<td>MD, PA, CNP, APN</td>
<td>99251-99255</td>
<td>21, 51</td>
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<td>1 per day</td>
<td>No</td>
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<tr>
<td>Service Description</td>
<td>Provider Types</td>
<td>Code Range</td>
<td>Days Covered</td>
<td>Frequency</td>
<td>Covered?</td>
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<tr>
<td>Initial Nursing Facility - Coordination of Care Counseling</td>
<td>MD, PA, CNP, APN</td>
<td>99304-99306</td>
<td>31, 32, 33</td>
<td>1 per day</td>
<td>No</td>
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<tr>
<td>Subsequent Nursing Facility - Coordination of Care Counseling</td>
<td>MD, PA, CNP, APN</td>
<td>99307-99310</td>
<td>31, 32, 33</td>
<td>1 per day</td>
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<tr>
<td>Therapeutic, Prophylactic or Diagnostic Injection</td>
<td>MD, PA, CNP, APN</td>
<td>96372</td>
<td>All Locations</td>
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<td>No</td>
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<tr>
<td>Telepsychiatry Originating Site Fee</td>
<td>MD/DO, FACILITY, FQHC</td>
<td>Q3014</td>
<td>11, 19, 22, 50, 53, 72</td>
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<tr>
<td>OPIOID Treatment</td>
<td>MD/DO, PA, CNS, CNP, LPN, RN</td>
<td>H0020 MODS – HF, TV, UB, TS, HG</td>
<td>ALL EXCLUDE = 12</td>
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<td>No</td>
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<tr>
<td>OPIOID Treatment</td>
<td>MD/DO, PA, CNS, CNP, LPN, RN</td>
<td>T1502 MODS – HF, TV, UB, TS, HG</td>
<td>ALL EXCLUDE = 12</td>
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<tr>
<td>OPIOID Treatment</td>
<td>MD/DO, PA, CNS, CNP, LPN, RN</td>
<td>36415</td>
<td>ALL EXCLUDE = 12</td>
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</table>
SBIRT – Screening, Brief Intervention, and Referral to Treatment

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Billable Provider Types</th>
<th>Billing Codes</th>
<th>Allowed Locations</th>
<th>Guidelines/Requirements</th>
<th>Prior Authorization Required</th>
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<tbody>
<tr>
<td>E/M New Patient</td>
<td>MD/DO, CNS, CNP, PA</td>
<td>99201-99205 MOD GT, NONE</td>
<td>11, 13, 31, 32, 53, 57</td>
<td>1 Per Day</td>
<td>No</td>
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<tr>
<td>E/M Established Patient</td>
<td>MD/DO, CNS, CNP, PA, RN, LPN</td>
<td>99212-99215 MOD GT, NONE</td>
<td>11, 13, 31, 32, 53, 57</td>
<td>1 Per Day</td>
<td>No</td>
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</table>

Note 1: Telepsychiatry Distant Site providers must be a medical doctor, doctor of osteopathic medicine, a licensed psychologist, or a federally qualified health center. The Originating Site is the location where the member receiving the telepsychiatry service is located. The Distant Site is the site where the provider rendering the telehealth service is located and must be billed with the GT Modifier.
<table>
<thead>
<tr>
<th>Service Description</th>
<th>Provider Types</th>
<th>Modifiers</th>
<th>Code Range</th>
<th>Frequency</th>
<th>Prior Authorization Required</th>
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<tr>
<td>E/M Established Patient</td>
<td>MD/DO, CNS, CNP, PA, RN, LPN</td>
<td>99211 MOD GT, NONE</td>
<td>11, 13, 31, 32, 53, 57</td>
<td>1 Per Day</td>
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<tr>
<td>E/M Home Visit New Patient</td>
<td>MD/DO, CNS, CNP, PA</td>
<td>99341-99345</td>
<td>04, 12, 16</td>
<td>1 Par Day</td>
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<tr>
<td>E/M Home Visit Established Patient</td>
<td>MD/DO, CNS, CNP, PA</td>
<td>99347-99350</td>
<td>04, 12, 16</td>
<td>1 Par Day</td>
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<tr>
<td>Prolonged Visit – First 60 Minutes</td>
<td>MD/DO, CNS, CNP, PA, PSY, LISW, LIMFT, LPCC, LICDC, Lic School Psy</td>
<td>+99354 (Add On Code) MOD GT, NONE</td>
<td>Same As Base Code</td>
<td>1 Per Day</td>
<td>No</td>
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<tr>
<td>Prolonged Visit – Each Additional 30 Minutes</td>
<td>MD/DO, CNS, CNP, PA, PSY, LISW, LIMFT, LPCC, LICDC, Lic School Psy</td>
<td>+99355 (Add On Code) MOD GT, NONE</td>
<td>Same as Base Code</td>
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<td>No</td>
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<tr>
<td>Psychiatric Diagnostic Evaluation W/O Medical</td>
<td>MD/DO, PSY, CNS, CNP, PA; ISW, LIMFT, LPCC, LICDC, Lic school Psy</td>
<td>90791 MOD GT, NONE</td>
<td>03, 04, 11, 12, 13, 14, 16, 18, 31, 32, 53, 57, 99</td>
<td>1 Per Year</td>
<td>Prior authorization is required after the first service. combined with 90792</td>
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<tr>
<td>Psychiatric Diagnostic Evaluation w/ Medical</td>
<td>MD/DO, CNS, CNP, PA</td>
<td>90792 MOD GT, NONE</td>
<td>03, 04, 11, 12, 13, 14, 16, 18, 31, 32, 53, 57, 99</td>
<td>1 Per Year</td>
<td>Prior authorization is required after the first</td>
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<td>Description</td>
<td>Provider</td>
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<td>Service Note</td>
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<tr>
<td>Electrocardiogram at least 12 leads w/ interpretation and report</td>
<td>MD/DO, CNS, CNP</td>
<td>93000</td>
<td>11, 53, 57</td>
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<td>Electrocardiogram tracing only w/o interpretation and report</td>
<td>MD/DO, CNS, CNP</td>
<td>93005</td>
<td>11, 53, 57</td>
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<td>Electrocardiogram interpretation and report only</td>
<td>MD/DO, CNS, CNP</td>
<td>93010</td>
<td>11, 53, 57</td>
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<tr>
<td>Other Medication Administration</td>
<td>MD/DO, CNS, CNP, PA, RN/LPN</td>
<td>96372</td>
<td>03, 04, 11, 12, 14, 16, 18, 53</td>
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<tr>
<td>Psychotherapy for Crisis – 60 Minutes</td>
<td>MD/DO, PSY, CNS, CNP, PA, LISW, LIMFT, LPCC, LICDC, Lic school Psy</td>
<td>90839  +90840 (Add On)</td>
<td>01, 03, 04, 11, 12, 13, 14, 15, 16, 17, 18, 20, 23, 24, 25, 31, 32, 33, 34, 41, 42, 53, 57, 99</td>
<td>90839 – 1 Per Day 90840 – 3 Per Day No</td>
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<tr>
<td>Individual Psychotherapy</td>
<td>MD/DO, PSY, CNS, CNP, PA, LISW, LIMFT, LPCC, LICDC, Lic school PSY</td>
<td>90832 – 30 Min MOD KX, GT, NONE 90834 – 45 Min 90837 –</td>
<td>03, 04, 11, 12, 13, 14, 16, 18, 31, 32, 34, 53, 57, 99</td>
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<tr>
<td>Service Description</td>
<td>Provider Types</td>
<td>Additional Codes</td>
<td>Allowed Days</td>
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<tr>
<td><strong>Individual Psychotherapy w/ E/M Service (Add On Code)</strong></td>
<td>MD/DO, CNS, CNP, PA</td>
<td>+90833 +90836 +90838</td>
<td>03, 04, 11, 12, 13, 14, 16, 18, 23, 31, 32, 34, 53, 57, 99</td>
<td>1 Per Day</td>
<td>No</td>
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<tr>
<td><strong>Family Psychotherapy – W/O Patient</strong></td>
<td>MD/DO, PSY, CNS, CNP, PA, LISW, LIMFT, LPCC, LICDC, Lic school Psy</td>
<td>90846 – 50 Min 90847 – 50 Min 90849 – Group</td>
<td>03, 04, 11, 12, 13, 14, 16, 31, 32, 34, 53, 57, 99</td>
<td>1 Per Day</td>
<td>No</td>
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<tr>
<td><strong>Group Psychotherapy</strong></td>
<td>MD/DO, PSY, CNS, CNP, PA, LISW, LIMFT, LPCC, LICDC, Lic school Psy</td>
<td>90853</td>
<td>03, 04, 11, 12, 13, 14, 16, 18, 31, 32, 34, 53, 57, 99</td>
<td>1 Per Day</td>
<td>No</td>
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<tr>
<td><strong>Interactive Complexity</strong></td>
<td>MD/DO, PSY, CNS, CNP, PA, LISW, LIMFT, LPCC, LICDC, Lic school Psy</td>
<td>+90785</td>
<td>Same as base code</td>
<td>1 Per Day</td>
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<tr>
<td><strong>Psychological Testing</strong></td>
<td>MD/DO, PSY, PS, CNS, CNP,</td>
<td>96101 MODS GT,</td>
<td>03, 04, 11, 12, 13, 14, 16, 31,</td>
<td>Limited to 12 Per Year combined with 96111 and Prior Authorization</td>
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<tr>
<td>Service Type</td>
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<td>MODS GT, NONE</td>
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<td>Prior Authorization Required After First Service</td>
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<tr>
<td>Developmental Testing</td>
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<td>96111</td>
<td>03, 04, 11, 12, 13, 14, 16, 31, 53, 57</td>
<td>Limited to 12 Per Year combined with 96101 and 96116</td>
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<tr>
<td>Neurobehavioral Status Exam</td>
<td>MD/DO, PA, PSY, CNS, CNP</td>
<td>96116</td>
<td>03, 04, 11, 12, 13, 14, 16, 31, 53, 57</td>
<td>Limited to 12 Per Year combined with 96101 and 96111</td>
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<tr>
<td>Neuropsychological Testing</td>
<td>MD/DO, PA, PSY, CNS, CNP</td>
<td>96118</td>
<td>03, 04, 11, 12, 13, 14, 16, 31, 53, 57</td>
<td>8 Per Year</td>
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<tr>
<td>Nursing Services – Individual / Group</td>
<td>RN</td>
<td>H2019</td>
<td>03, 04, 11, 12, 13, 14, 16, 18, 23, 31, 32, 34, 53, 99</td>
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<tr>
<td>Nursing Services – Individual</td>
<td>LPN</td>
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<td>03, 04, 11, 12, 13, 14, 16, 18, 23, 31, 32, 34, 53, 99</td>
<td>No</td>
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<tr>
<td>Screening, Brief Intervention and Referral Treatment (SBIRT)</td>
<td>MD/DO, CNS, CNP, PA, PSY, RN, LPN, LISW, LIMFT, LPCC, Lic School PSY</td>
<td>G0396, G0397</td>
<td>03, 04, 11, 12, 13, 14, 16, 31, 32, 53</td>
<td>1 Per Day</td>
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</table>

*Note: MODS KX, HQ, NONE is required after the first service.*
<table>
<thead>
<tr>
<th>Service Description</th>
<th>Provider</th>
<th>Mod Code</th>
<th>Covered Dates</th>
<th>Frequency</th>
<th>Authorization Required</th>
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<tbody>
<tr>
<td>Community Psychiatric Supportive Treatment (CPST)</td>
<td>MD/DO, CNS, CNP, PA, PSY, LISW, LIMFT, LPCC, Lic school PSY</td>
<td>H0036 MODS GT, HQ, NONE</td>
<td>03, 04, 11, 12, 13, 14, 16, 18, 23, 31, 32, 33, 34, 53, 99</td>
<td>No</td>
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<tr>
<td>Assertive Community Treatment (ACT)</td>
<td>MD/DO, CNP, CNS, PA</td>
<td>H0040 MODS AM, UC, SA</td>
<td>03, 04, 11, 12, 13, 14, 16, 17, 18, 20, 53, 99</td>
<td>1 Per Month</td>
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<td>Intensive Home Based Treatment (IHBT)</td>
<td>PSY, LISW, LIMFT, LPCC</td>
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<td>MD/DO, CNS / CNP, PA, PSY, LISW, LIMFT, LPCC, LICDC</td>
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<td>Urine Drug Screening – Collection, handling and point of service testing</td>
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<td>Prolonged Visit – First 60 Minutes</td>
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<td>Psychiatric Diagnostic Evaluation W/O Medical</td>
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<td>Psychotherapy for Crisis – 60 Minutes</td>
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<td>Screening, Brief Intervention and Referral Treatment (SBIRT)</td>
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<td>CMHC</td>
<td>H0010</td>
<td>55 Per Day</td>
<td>No</td>
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