



Manual: Reimbursement Policy

Policy Title: Behavioral Health Case Management & Care Coordination

Section: Behavioral Health

Subsection: none

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Scope

This policy applies to dates of service 1/1/2018 and following for Oregon insured Commercial medical benefit plans and any ASO plans which adopt the Oregon behavioral health Case Management and Care Coordination mandate.

This policy is intended to explain how Moda Health implements and applies ORS 743A.168 as amended by the Oregon Legislature in 2017 (HB 3091) and OAR 836-053-1403 for our company, plans, and claims.

Reimbursement Guidelines

A. General

1. Moda Health covers Behavioral Health Case Management and Care Coordination (CM/CC) in full compliance with ORS 743A.168 as amended by the Oregon Legislature in 2017 (HB 3091) and OAR 836-053-1403.
2. Case Management and Care Coordination services are reimbursable only when:
 - a. The service provided is within the rendering provider's scope of practice.
 - b. Correctly coded and billed, in accordance with the requirements of this policy.
 - c. Licensed providers (MD, DO, ND, PA, NP, LCSW, LPC, LMFT, Psychologist, etc.) may provide CM/CC services in any setting.
 - d. Certified (non-licensed) providers (QMHA, Peer Support, etc.) may provide CM/CC services under the auspices of a program appropriately licensed or certified by the Oregon Health Authority.
3. Behavioral Health Case Management and Care Coordination (CM/CC) services may be provided by a variety of provider types with different licensure and/or certification levels. However, not every procedure code may be reported by every provider type. Refer to section B.

4. Case Management and Care Coordination services are subject to standard correct coding and bundling guidelines. Refer to section C.

5. Time-based Services

a. **Procedure descriptions.** Time-based procedure codes have descriptions that specify an increment of time, such as “minutes” or “hours.”

i. **At least.** If a procedure code description says “at least 20 minutes of clinical staff time,” then the procedure code may not be reported if only 19 minutes of service time is documented.

ii. **Code selection.** When a procedure code is in a group of similar codes with different time ranges, then:

a) The lowest code may be reported when more than half of the time specified has been performed and documented.

b) The next procedure code may not be used until at least the amount of time listed in the description has been performed and documented.

c) For the example set of codes 90832 = 30 minutes, 90834 = 45 minutes, 90836 = 60 minutes:

1) For 16 – 44 minutes service documented, report 90832 x 1 unit.

2) For 45 – 59 minutes service documented, report 90834 x 1 unit.

3) For 60 minutes or more service documented, report 90836 x 1 unit.

iii. **Passing the mid-point.** When a procedure code description says “each 15 minutes” or “each hour” etc., then a unit of time is attained when the mid-point is passed.

a) The smallest unit of measurement acceptable is one minute. “7.5 minutes” or “30.5 minutes” is not acceptable.

b) For an each 15 minute code:

0-7 minutes = not reported

8-22 minutes = 1 unit

23-37 minutes = 2 units

Etc.

c) For an each hour code:

0-30 minutes = not reported

31-90 minutes = 1 unit

91-149 minutes = 2 units

Etc.

d) This is consistent with the Medicare “8-minute rule” and CPT book guidelines on reporting time-based services. (AMA⁵)

b. Time documentation.

For any time-based procedure codes (codes with descriptions that specify an increment of time such as minutes or hours) the duration of the service must be clearly documented in the medical record. If the duration of the time-based service is not clearly and properly documented in the medical record, then the service is not supported due to incomplete documentation; the procedure code will be denied as not documented.

i. Documentation in terms of “units” does not constitute documentation of time or duration. The actual number of minutes or begin-to-end times must be used.

- ii. Time must be reported in full one-minute increments. Any fractions of less than one-minute will not be considered in the review.
- iii. If the time is documented with a range of time, only the lowest amount of time is considered to be supported in the record. Example: “Total time for performing exercises is 5 – 8 minutes.” Only five (5) minutes is supported by this documentation.
- iv. A unit of time is attained when the mid-point is passed. (This is consistent with the Medicare “8-minute rule” and CPT book guidelines on reporting time-based services. AMA⁵)
- v. If the amount of time the service was performed is less than 50% of the time described for the procedure code, then the service will not be separately reimbursable, but will be considered incidental to the other services performed on that date.

B. Coding requirements for specific types of providers

Various provider types report CM/CC services with specific procedure codes, as defined below.

(Procedure codes for other eligible services are also mentioned for context and perspective; these additional service codes are not intended to be a comprehensive list of additional service codes.)

1. Licensed behavioral health professionals (e.g., LCSW, LPC, LMFT, licensed Psychologist, licensed Psychologist Associate, etc.) may provide CM/CC services in any setting.

Reimbursable services include:

- a. Psychiatric Diagnostic Evaluation (90791)
- b. Psychotherapy (90832-90899)
- c. Health and Behavior Assessment/Intervention (96150-96155)
 - i. Health and behavior assessments will be requested by the medical provider managing a medical physical health condition, and are to be submitted with the diagnosis code to reflect that physical health condition for which the assessment was requested. These assessments intrinsically involve care coordination between the medical provider and the behavioral health provider for the benefit of the patient.
 - ii. CPT guidelines for 96150 – 96161 state:

“Health and behavior assessment procedures are used to identify the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment or management of physical health problems.

The focus of the assessment is not on mental health but on the biopsychosocial factors important to physical health problems and treatments.

...For patients that require psychiatric services (90785-90899) as well as health and behavior assessment/intervention (96150-96155), report the predominant service performed. Do not report 96150-96155 in conjunction with 90785-90899 on the same date.” (AMA¹)

- iii. Health and behavior assessments are not performed to evaluate or treat the mental health or behavioral conditions, and should not be submitted with a mental health diagnosis code.

d. CC/CM services:

Code	Definition
G0177	Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)
H0039	Assertive community treatment, face-to-face, per 15 minutes
H2011	Crisis intervention service, per 15 minutes
H2014	Skills training and development, per 15 minutes
H2021	Community-based wrap-around services, per 15 minutes
T1016	Case management, each 15 minutes
T1017	Targeted case management, each 15 minutes

2. Qualified Mental Health Professional (QMHP) practicing under the auspices of a program appropriately licensed or certified by the Oregon Health Authority. Reimbursable services include:

- a. Psychiatric Diagnostic Evaluation (90791)
- b. Psychotherapy (90832-90899)
- c. Health and Behavior Assessment/Intervention (96150-96155)
 - i. Health and behavior assessments will be requested by the medical provider managing a medical physical health condition, and are to be submitted with the diagnosis code to reflect that physical health condition for which the assessment was requested. These assessments intrinsically involve care coordination between the medical provider and the behavioral health provider for the benefit of the patient.
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...For patients that require psychiatric services (90785-90899) as well as health and behavior assessment/intervention (96150-96155), report the predominant service performed. Do not report 96150-96155 in conjunction with 90785-90899 on the same date.” (AMA¹)
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G0177	Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)
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H2011	Crisis intervention service, per 15 minutes
H2014	Skills training and development, per 15 minutes
H2021	Community-based wrap-around services, per 15 minutes
T1016	Case management, each 15 minutes
T1017	Targeted case management, each 15 minutes

3. Qualified Mental Health Associate (QMHA) practicing under the auspices of a program appropriately licensed or certified by the Oregon Health Authority. Reimbursable services include:

Code	Definition
G0177	Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)
H0039	Assertive community treatment, face-to-face, per 15 minutes
H2014	Skills training and development, per 15 minutes
T1016	Case management, each 15 minutes
T1017	Targeted case management, each 15 minutes

4. Peer Support, Family Support, Peer Wellness or Youth Support Specialists practicing under the auspices of a program appropriately licensed or certified by the Oregon Health Authority. Reimbursable services include:

Code	Definition
G0177	Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)
H0039	Assertive community treatment, face-to-face, per 15 minutes
H2014	Skills training and development, per 15 minutes
T1016	Case management, each 15 minutes
T1017	Targeted case management, each 15 minutes

5. Physicians (MD, DO, ND) and NPPs (PA, NP). Reimbursable services include:

Code	Definition (** = Shortened description. See Code Definitions section later in policy for full description.)	Notes, Comments, & Instructions
99483	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements:** Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver.	See also G0505. For Medicare Advantage, Medicaid, and Medicare Supplement/crossover claims, use G0505. For all other Commercial claims, use either 99483 or G0505.
99484	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements: **.	See also G0507. For Medicare Advantage, Medicaid, and Medicare Supplement/crossover claims, use G0507. For all other Commercial claims, use either 99484 or G0507.
99487	Complex chronic care management services, with the following required elements: **; 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month	Use for Commercial, Medicare Advantage, Medicaid, and Medicare Supplement/crossover claims.
99489	Complex chronic care management services, with the following required elements: **; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)	Use for Commercial, Medicare Advantage, Medicaid, and Medicare Supplement/crossover claims.
99490	Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: **.	*Reportable by physicians and NPP eligible to report E/M services. *Not reportable with 99487/99489. *Requires 24/7 coverage. *Only report once per month, and only with unit of "1." *Requires co-morbidities.

Code	Definition (* = Shortened description. See Code Definitions section later in policy for full description.)	Notes, Comments, & Instructions
99492	Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: **.	See also G0502. For Medicare Advantage, Medicaid, and Medicare Supplement/crossover claims, use G0502. For all other Commercial claims, use either 99492 or G0502.
99493	Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: **.	See also G0503. For Medicare Advantage, Medicaid, and Medicare Supplement/crossover claims, use G0503. For all other Commercial claims, use either 99493 or G0503.
99494	Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional.	See also G0504. For Medicare Advantage, Medicaid, and Medicare Supplement/crossover claims, use G0504. For all other Commercial claims, use either 99494 or G0504.
G0502	Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: **.	See also 99492. For Medicare Advantage, Medicaid, and Medicare Supplement/crossover claims, use G0502. For all other Commercial claims, use either 99492 or G0502.
G0503	Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: **.	See also 99493. For Medicare Advantage, Medicaid, and Medicare Supplement/crossover claims, use G0503. For all other Commercial claims, use either 99493 or G0503.

Code	Definition (* = Shortened description. See Code Definitions section later in policy for full description.)	Notes, Comments, & Instructions
G0504	Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional.	See also 99494. For Medicare Advantage, Medicaid, and Medicare Supplement/crossover claims, use G0504. For all other Commercial claims, use either 99494 or G0504.
G0505	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: **. Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver.	See also 99483. For Medicare Advantage, Medicaid, and Medicare Supplement/crossover claims, use G0505. For all other Commercial claims, use either 99483 or G0505.
G0506	Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service)	Do not use in combination with or as add-on code to 99483 or 99485.
G0507	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements: **.	See also 99484. For Medicare Advantage, Medicaid, and Medicare Supplement/crossover claims, use G0507. For all other Commercial claims, use either 99484 or G0507.

C. Reimbursement and Bundling.

1. Case Management and Care Coordination (CM/CC) services are reimbursed in accordance with coding definitions, standard correct coding guidelines, documentation requirements, and correct billing practices.
2. CM/CC is denied as a separately billed service when provided by the employee (QMHP, QMHA, Certified Peer Support, Family Support, Peer Wellness or Youth Support Specialist) of an inpatient program or intensive outpatient partial hospitalization program being reimbursed under a per diem rate, unless the service is specifically carved out from the per diem.

3. CM/CC services billed with G0177, H0039, H2011, H2014, H2021, T1016, and/or T1017 are eligible for separate reimbursement in addition to other assessment or treatment services provided when all of the following requirements are met:
 - a. The CM/CC is a distinct and separate service performed during a separate time period (not necessarily a separate patient encounter).
 - b. The CM/CC is billed with an NCCI-associated modifier appended.
 - c. The time for each separate service is clearly documented to not overlap. Any time, effort, and items in the medical records documentation cannot be counted towards more than one service or procedure code.
4. CM/CC services billed with 99483, 99484, 99487, 99489, 99490, 99492, 99493, 99494, G0502, G0503, G0504, G0505, G0506, and G0507:
 - a. Are never eligible to be reported on the same date of service as psychotherapy services, psychoanalysis, narcosynthesis, hypnotherapy, moderate sedation, a variety of other E/M codes, and any other services listed with a CCI PTP edit with modifier indicator of "0."
 - b. Are sometimes eligible to be reported on the same day as certain E/M services or other procedures with CCI PTP edits with modifier indicator of "1", but only if all of the following requirements are met:
 - i. The CM/CC is a distinct and separate service performed during a separate time period (not necessarily a separate patient encounter).
 - ii. The CM/CC is billed with an NCCI-associated modifier appended.
 - iii. The time for each separate service is clearly documented to not overlap. Any time, effort, and items in the medical records documentation cannot be counted towards more than one service or procedure code.

D. Procedure codes not eligible for separate reimbursement include:

Code	Description	Reason
90885	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes	Status "B" code. This work is always included in the related service.
90889	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other individuals, agencies, or insurance carriers	Status "B" code. This work is always included in the related service. Administrative, not clinical function.
99495	Transitional Care Management Services	Bundled with related E/M codes
99496	Transitional Care Management Services	Bundled with related E/M codes
H0006	Alcohol and/or drug services; case management	Does not specify amount of time; higher level of specificity needed. T1016 may be appropriate instead.

Code	Description	Reason
H0007	Alcohol and/or drug services; crisis intervention (outpatient)	Does not specify amount of time; higher level of specificity needed. H2011 may be appropriate instead.
H0038	Self-help/Peer Services, per 15 minutes	Does not specify activity/service provided. H2014, T1016, G0177 or H0039 may be appropriate instead.
H0040	Assertive community treatment program, per diem	Use H0039 instead with appropriate number of units.
H2022	Community-based wrap-around services, per diem	Use H2021 instead with appropriate number of units.
H2023	Supported Employment, per 15 min	Vocational, not medical service.
H2027	Psychoeducational service, per 15 minutes	Higher level of specificity needed.

Background Information

The 2017 Oregon legislature passed companion bills HB 3090 and HB 3091 to improve care for Oregonians experiencing a behavioral health crisis. HB 3091 requires Coordinated Care Organizations and commercial insurers to cover medically necessary treatment including “Coordinated care and case management as defined by the Department of Consumer and Business Services [DCBS] by rule.”

DCBS subsequently issued OAR 836-053-1403 effective 3/1/18 with the following definitions:

(3) “Case management” means the management of services that are provided to assist an individual in accessing medical and behavioral health care, social and educational services, public assistance and medical assistance and other needed community services identified in the individual’s patient-centered care plan.

(4) “Coordination of care” means the process of coordinating patient care activities as well as the facilitation of ongoing communication and collaboration with lay caregivers by community resource providers, health care providers, and agencies to meet the multiple needs of a patient by:

- (a) Organizing and participating in team meetings; and
- (b) Ensuring continuity of care during each transition of care.

Neither the law nor the rule contains specific instructions regarding coding. The CPT codeset offers limited options for coding behavioral health case management services. Moda Health allows certain HCPCS codes created for Medicaid which offer additional options for reporting these services. Moda Health follows established practices and principles, including bundling and subset procedures, such that certain codes may not be separately allowable when billed with other more comprehensive codes.

Codes, Terms, and Definitions

Acronyms Defined

Acronym		Definition
AMA	=	American Medical Association
ASO	=	Administrative Services Only
CCI	=	Correct Coding Initiative (see also NCCI)
CM/CC	=	Case Management and Care Coordination
CMS	=	Centers for Medicare and Medicaid Services
CPT	=	Current Procedural Terminology
DO	=	Doctor of Osteopathic Medicine
E/M	=	Evaluation and Management (Sometimes also listed by the AMA as E&M)
EOCCO	=	Eastern Oregon Coordinated Care Organization
HCPCS	=	Healthcare Common Procedure Coding System
MD	=	Medical Doctor
NCCI	=	National Correct Coding Initiative (aka CCI)
ND	=	Naturopathic Doctor
NP	=	Nurse Practitioner
NPP	=	Nonphysician provider
OAR	=	Oregon Administrative Rules
ORS	=	Oregon Revised Statute
PA	=	Physician Assistant
PTP	=	Procedure-to-procedure (a specific type of NCCI edit)
QMHA	=	Qualified Mental Health Associate
QMHP	=	Qualified Mental Health Professional

Definition of Terms

Term	Definition
Peer Support Specialist	“Peer support specialist” means a Peer Wellness Specialist or a Peer Support Specialist, including Family Support Specialist and Youth Support Specialist, as defined in ORS 414.025 and 414.665 and certified under OAR 410-180-0310 to 410-180-0312.
Family Support Specialist	“Family support specialist” means an individual certified as a Family Support Specialist under OAR 410-180-0310 to 410-180-0312.
Peer Wellness Specialist	“Peer Wellness Specialist” means an individual certified as a Peer Wellness Specialist under OAR 410-180-0310 to 410-180-0312.
Youth Support Specialist	“Youth Support Specialist” means an individual certified as a Youth Support Specialist under OAR 410-180-0310 to 410-180-0312.
NPP/Nonphysician practitioner	For purposes of this policy, NPP shall specifically refer to a nonphysician practitioner who is eligible to perform and bill for evaluation and management (E/M) services. (In the broadest sense, NPP or “nonphysician practitioner” could refer to any professional provider who is not a physician (MD, DO, ND, DC). That broad usage shall not apply within this policy.)

Procedure codes (CPT & HCPCS):

Code	Code Description
90885	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes
90889	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other individuals, agencies, or insurance carriers

Code	Code Description
99483	<p>Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination; Medical decision making of moderate or high complexity; Functional assessment (e.g., Basic and Instrumental Activities of Daily Living), including decision-making capacity; Use of standardized instruments for staging of dementia (e.g., Functional Assessment Staging Test [FAST], Clinical Dementia Rating [CDR]); Medication reconciliation and review for high-risk medications; Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s); Evaluation of safety (e.g., home), including motor vehicle operation; Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; Development, updating or revision, or review of an Advance Care Plan; Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (e.g., rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver.</p>
99484	<p>Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements: Initial assessment or follow-up monitoring, including the use of applicable validated rating scales; Behavioral health care planning in relation to behavioral/ psychiatric health problems, including revision for patients who are not progressing or whose status changes; Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and Continuity of care with a designated member of the care team.</p>
99487	<p>Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment or substantial revision of a comprehensive care plan, moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.</p>
99489	<p>Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment or substantial revision of a comprehensive care plan, moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.</p>

Code	Code Description
99490	Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment or substantial revision of a comprehensive care plan, moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.
99492	Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: Outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional; initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan; review by the psychiatric consultant with modifications of the plan if recommended; entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.
99493	Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: Tracking patient follow-up and progress using the registry, with appropriate documentation; participation in weekly caseload consultation with the psychiatric consultant; ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers; additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant; provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies; monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.
99494	Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional.
99495	Transitional Care Management Services
99496	Transitional Care Management Services
G0177	Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)

Code	Code Description
G0502	Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment or substantial revision of a comprehensive care plan, moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
G0503	Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: Tracking patient follow-up and progress using the registry, with appropriate documentation; participation in weekly caseload consultation with the psychiatric consultant; ongoing collaboration with and coordination of the patient’s mental health care with the treating physician or other qualified health care professional and any other treating mental health providers; additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant; provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies; monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.
G0504	Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional.
G0505	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination; Medical decision making of moderate or high complexity; Functional assessment (e.g., Basic and Instrumental Activities of Daily Living), including decision-making capacity; Use of standardized instruments for staging of dementia (e.g., Functional Assessment Staging Test [FAST], Clinical Dementia Rating [CDR]); Medication reconciliation and review for high-risk medications; Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s); Evaluation of safety (e.g., home), including motor vehicle operation; Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; Development, updating or revision, or review of an Advance Care Plan; Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (e.g., rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver.
G0506	Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service)

Code	Code Description
G0507	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements: Initial assessment or follow-up monitoring, including the use of applicable validated rating scales; Behavioral health care planning in relation to behavioral/ psychiatric health problems, including revision for patients who are not progressing or whose status changes; Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and Continuity of care with a designated member of the care team.
H0006	Alcohol and/or drug services; case management
H0007	Alcohol and/or drug services; crisis intervention (outpatient)
H0038	Self-help/Peer Services, per 15 minutes
H0039	Assertive community treatment, face-to-face, per 15 minutes
H0040	Assertive community treatment program, per diem
H2011	Crisis intervention service, per 15 minutes
H2014	Skills training and development, per 15 minutes
H2021	Community-based wrap-around services, per 15 minutes
H2022	Community-based wrap-around services, per diem
H2023	Supported Employment, per 15 min
H2027	Psychoeducational service, per 15 minutes
T1016	Case management, each 15 minutes
T1017	Targeted case management, each 15 minutes

Modifier Definitions:

Modifier	Modifier Definition
Modifier 59	<p>Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.</p> <p>Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same day, see modifier 25.</p>

Modifier	Modifier Definition
Modifier AF	Specialty physician
Modifier AG	Primary physician
Modifier AH	Clinical psychologist
Modifier AJ	Clinical social worker
Modifier AK	Nonparticipating physician
Modifier AQ	Physician providing a service in an unlisted health professional shortage area (HPSA)
Modifier AR	Physician provider services in a physician scarcity area
Modifier GF	Nonphysician (e.g., nurse practitioner (NP), certified registered nurse anesthetist (CRNA), certified registered nurse (CRN), clinical nurse specialist (CNS), physician assistant (PA)) services in a critical access hospital
Modifier HN	Bachelor's degree level
Modifier HO	Master's degree level
Modifier HP	Doctoral level
Modifier SA	Nurse practitioner rendering service in collaboration with a physician
Modifier XE	Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter
Modifier XP	Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner
Modifier XS	Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure
Modifier XU	Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

Note: *The following NCCI Policy Manual reference does not specifically discuss the behavioral health Case Management and Care Coordination (CM/CC) procedure codes listed in this policy. It has been included here because it speaks to several other CM/CC procedure codes and provides some perspective and foundational principles on how case management services in general overlap or do not overlap E/M and/or other services.*

“HCPCS codes G0396 and G0397 describe alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services. These codes shall not be reported separately with an evaluation and management (E&M), psychiatric diagnostic, or psychotherapy service code for the same work/time. If the E&M, psychiatric diagnostic, or psychotherapy service would normally include assessment and/or intervention of alcohol or substance abuse based on the patient’s clinical presentation, HCPCS G0396 or G0397 shall not be additionally reported. If a physician reports either of these G codes with an E&M, psychiatric diagnostic, or psychotherapy code utilizing an NCCI-associated modifier, the physician is certifying that the G code service is a distinct and separate service performed during a separate time period (not necessarily a separate patient encounter) than the E&M, psychiatric diagnostic, or

psychotherapy service and is a service that is not included in the E&M, psychiatric diagnostic, or psychotherapy service based on the clinical reason for the E&M, psychiatric diagnostic, or psychotherapy service.

CPT codes 99408 and 99409 describe services which are similar to those described by HCPCS codes G0396 and G0397, but are “screening” services which are not covered under the Medicare program. Where CPT codes 99408 and 99409 are covered by State Medicaid programs, the policies explained in the previous paragraph for G0396/G0397 also apply to 99408/99409.

The same principles apply to separate reporting of E&M services with other screening, intervention, or counseling service HCPCS codes (e.g., G0442 (annual alcohol misuse screening, 15 minutes), G0443 (brief face-to-face behavioral counseling for alcohol misuse, 15 minutes), and G0444 (annual depression screening, 15 minutes). If an E&M, psychiatric diagnostic, or psychotherapy service is related to a problem which would normally require evaluation and management duplicative of the HCPCS code, the HCPCS code is not separately reportable. For example, if a patient presents with symptoms suggestive of depression, the provider shall not report G0444 in addition to the E&M, psychiatric diagnostic, or psychotherapy service code. The time and work effort devoted to the HCPCS code screening, intervention, or counseling service must be distinct and separate from the time and work of the E&M, psychiatric diagnostic, or psychotherapy service. Both services may occur at the same patient encounter.” (CMS²)

“Time spent by the behavioral health care manager on activities for services reported separately could not be included in the time applied to any BHI service code (in other words, time and effort cannot be counted more than once).” (CMS³)

“Codes 99487 – 99490 are reported only once per calendar month and may only be reported by the single physician or other qualified health care professional who assumes the care management role with a particular patient for the calendar month.” (AMA⁴)

Cross References

- A. “Modifiers XE, XS, XP, XU, and 59 - Distinct Procedural Service.” Moda Health Reimbursement Policy Manual, RPM027.
- B. “Medical Records Documentation Standards.” Moda Health Reimbursement Policy Manual, RPM039.
- C. “Medically Unlikely Edits (MUEs).” Moda Health Reimbursement Policy Manual, RPM056.

References & Resources

1. American Medical Association. “Health and Behavior Assessment/Intervention Guidelines.” *CPT Book, Professional Edition*. Chicago: AMA Press, 2018, p. 676.

2. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 12 Supplemental Services HCPCS A0000-V999, § C.16.
3. CMS. "Frequently Asked Questions about Billing Medicare for Behavioral Health Integration (BHI) Services." April 17, 2018: May 1, 2018. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Behavioral-Health-Integration-FAQs.pdf> .
4. American Medical Association. "Coding Update: Care Management Services." *CPT Assistant*. Chicago: AMA Press, October 2014, pp. 3-5.
5. American Medical Association. "Time." *Current Procedural Terminology (CPT), Introduction*. Chicago: AMA Press.

IMPORTANT STATEMENT

The purpose of Moda Health Reimbursement Policy (formerly ODS Health Plan, Inc.) is to document payment policy for covered medical and surgical services and supplies. Health care providers (facilities, physicians and other professionals) are expected to exercise independent medical judgment in providing care to members. Reimbursement policy is not intended to impact care decisions or medical practice.

Providers are responsible for accurately, completely, and legibly documenting the services performed. The billing office is expected to submit claims for services rendered using valid codes from HIPAA-approved code sets. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI/NCCI) Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the applicable member contract language. To the extent there are any conflicts between the Moda Health Reimbursement Policy and the member contract language, the member contract language will prevail, to the extent of any inconsistency. Fee determinations will be based on the applicable provider contract language and Moda Health reimbursement policy. To the extent there are any conflicts between Reimbursement Policy and the provider contract language, the provider contract language will prevail.