SERVICE CODE CLARIFICATIONS

Service Description	HCPCS Codes	Code Description	Explanation of Code Utilization
Assertive Community Treatment (ACT)	H0039 Modifier 95 Modifier TG	ACT	• Report only face-to-face encounters • Count one contact by team regardless of number of staff on team • ACT Services are not required to be unbundled to bill other insurance carriers; however unbundling is not prohibited (MDHHS memo dated 1/18/18) • Modifier 95 is used for ACT telepractice for psychiatric services only (see MPM BH/IDD 4.3 for additional information on Telepractice) • Modifier TG is used when pre-admission screen is completed as part of an ACT service.
Assisted Outpatient Treatment (AOT)	Modifier H9	AOT	• Purpose of Kevin's Law is to authorize courts and CMHSPs to use AOT programs for people who do not adhere to prescribed treatments or as a condition for release from hospital, jail or prison • AOT is provided in lieu of more restrictive treatment such as hospitalization (EDIT Update 6/1/17) • Use modifier on all services except inpatient regardless of funding source (EDIT meeting 9/21/17)
Health Services	T1002	RN services, up to 15 minutes	• Face-to-face with beneficiary • Health services are provided for purposes of improving the beneficiary's overall health and ability to care for health-related needs • Nursing services (per visit basis, not on-going hourly care) • May include maintenance of health and hygiene, care of minor injuries or first aid, recognizing early symptoms of illness and teaching the beneficiary to seek assistance in case of emergencies • Health services must be carefully coordinated with the beneficiary's health care plan so the PIHP does not provide services that are the responsibility of the MHP
Housing Assistance	T2038	Community Transition, per service	• Assistance with short-term, interim, or one-time-only expenses (not including room and board costs) for beneficiaries transitioning from restrictive settings and homelessness into more independent, integrated living arrangements while in process of securing other benefits or public programs that will become available to assume these obligations and provide needed assistance. • May <u>not</u> be used for Room and Board costs • May be used for items like security deposits, needed repairs, and other costs associated with transitioning to or being able to maintain independent living arrangements • Costs include only non-staff expenses associated with housing: assistance for utilities, home maintenance, insurance, and moving expenses • For more information, see MPM BH/IDD 17.3.F.

Intensive Crisis Stabilization	H2011 TJ (Child) H2011 HB (Adult - non-Geriatric) H2011 HC (Adult - Geriatric) S9484 (Adult only)	Crisis Intervention mental health services. Use for the MDHHS-approved program	• Effective 10/1/18, for Intensive Crisis Stabilization (ICSS) for Children, **code H2011 TJ must be used** – S9484 TJ will no longer be used because the one-hour time requirement does not accurately reflect the services being provided. • Effective 10/1/18, for Intensive Crisis Stabilization (ICSS) for Adults, code H2011 HB (Non-Geriatric – services for persons 18-64 years old) or H2011 HC (Geriatric – services for persons 65 years or older) may be used for ICSS services not meeting the one-hour minimum (required for code S9484). • If the ICS service meets the one-hour minimum requirement, S9484 may be used **for Adults only.** • H2011 code is billed in 15-minute units and must meet requirements according to General Rule for Reporting in the Encounter Code Chart. • **If using the H2011 codes, the Intensive Crisis Stabilization service must be initially reported at 30 minutes and in 15-minute increments thereafter.** • Programs must be enrolled by MDHHS to provide this mobile intensive crisis stabilization service for children or adults. • Refer to PIHP/CMHSP Encounter Reporting HCPCS and Revenue Codes List for additional information on Intensive Crisis Stabilization.
Medication Administration	96372	Therapeutic, Prophylactic or Diagnostic Injection	• Report procedure code only when provided as a separate service • Face-to-face with qualified provider • Physician, licensed physician's assistant, nurse practitioner, registered nurse, or licensed practical nurse assisting a physician.
Medication Review – Evaluation & Management Codes	99201 - 99215	Psychiatric Evaluation & Medication Management	• Guidance on E/M codes is found at the end of this document
Telemedicine	Modifier GT	Use with E & M codes	• GT modifier means that Telemedicine was provided via video-conferencing face-to-face with beneficiary. • Use Place of Service 02 for distant site (not where the patient is) • Use GT modifier both with service provided (E & M) from distant site and with Originating Site Facility Fee (Q3014) • For example, if a patient comes to the CMH office for a telemedicine service (medication review) and the psychiatrist (who is providing the med review) is offsite at a different location, the psychiatrist bills the service (99213) with the GT modifier and POS 02. The CMH office bills the Q3014 with GT modifier and POS 11.

Telemedicine Facility Fee	Q3014	Telehealth Originating Site Facility Fee, per service	• Use GT modifier to bill the site facility fee (Q3014) • Use POS appropriate for the business (e.g. office) – do not use POS 02 • Originating site = where the patient is. Patient home is not allowable originating site. (9/21/17 EDIT)
Telepractice	Modifier 95	Telepractice Modifier	• There are only three, non-ABA, approved telepractice codes that can occur and must include modifier 95. • Use Modifier 95 for Telepractice occurring with ACT services (H0039), Assessment by non-physician (H0031), Pre-Admission Screening (T1023) • Services shall occur through real-time interactions between beneficiaries and the designated staff person completing the service. • Refer to PIHP/CMHSP Encounter Reporting HCPCS and Revenue Codes List for additional information on Telepractice.
Treatment Planning	H0032	Mental Health service plan development by non-physician	• Activities associated with the development and periodic review of the plan of service, including all aspects of person-centered planning process, such as pre-meeting activities, and external facilitation of PCP. • Count independent facilitator and all professional staff participating in person-centered planning or plan review with the consumer • Case manager / supports coordinator do not report treatment planning as this is part of TCM / SCIncludes face-to-face monitoring of plan by professional staff (see H0032 TS for clinician monitoring of plan) • For more information see MPM BH/IDD 3.28
Treatment Plan Monitoring (by clinician)	H0032TS	Clinician monitoring of treatment plan	• Use modifier TS when clinician provides monitoring of the plan face-to-face with the consumer

Evaluation and Management (E/M) Services Guidelines

Within each category or subcategory of E/M service, there are three to five levels of E/M services available for reporting purposes. Levels of E/M service are not interchangeable among the different categories or subcategories of service. For example, the first level of E/M services in the subcategory of office visit, new patient, does not have the same definition as the first level of E/M services in the subcategory of office visit, established patient.

The levels of E/M services include examinations, evaluations, treatments, conferences with or concerning patients, preventive pediatric and adult health supervision, and similar medical services, such as the determination of the need and/or location for appropriate care. Medical screening includes the history, examination, and medical decision-making required to determine the need and/or location for appropriate care and treatment of the patient (e.g. office and other outpatient setting, emergency department, nursing facility). The levels of E/M services encompass the wide variations in skill, effort, time, responsibility, and medical knowledge required for the prevention or diagnosis and treatment of illness or injury and the promotion of optimal health. Each level of E/M services may be used by all physicians or other qualified health care professionals.

Instruction for Selecting a Level of E/M Service

Review the Level of E/M Service Descriptors and Examples in the Selected Category or Subcategory

The descriptors for the levels of E/M services recognize seven components, six of which are used in defining the levels of E/M services. These components are:

1) History
2) Examination
3) Medical decision making (MDM)
4) Counseling
5) Coordination of care
6) Nature of presenting problem
7) Time

The first three components (history, examination, medical decision making) should be considered the **key** components in selecting a level of E/M services. An exception to this rule is in the case of visits that consist predominantly of counseling or coordination of care. (See below)

The nature of the presenting problem and time are provided in some levels to assist the physician in determining the appropriate level of E/M service.

Determine the Extent of History Obtained

The extent of history is dependent upon clinical judgment and on the nature of the presenting problem(s). The levels of E/M services recognize four types of history that are defined as follows:

Problem focused: Chief compliant; brief history of present illness or problem.

Expanded problem focused: Chief complaint; brief history of present illness; problem pertinent system review.

Detailed: Chief complaint; extended history of present illness; problem pertinent system review extended to include a review of a limited number of additional systems; **pertinent** past, family and/or social history **directly related to the patient's problems.**

Comprehensive: Chief complaint; extended history of present illness; review of systems that is directly related to the problem(s) identified in the history of the present illness plus a review of all additional body systems; **complete** past, family and/or social history.

Determine the Extent of Examination Performed

The extent of the examination performed is dependent on clinical judgment and on the nature of the presenting problem(s). The levels of E/M services recognize four types of examination that are defined as follows:

Problem focused: A limited examination of the affected body area or organ system.

Expanded problem focused: A limited examination of the affected body are or organ system and other symptomatic or related organ system(s).

Detailed: An extended examination of the affected body area(s) and other symptomatic or related organ system(s).

Comprehensive: A general multisystem examination or a complete examination of a single organ system.

Determine the Complexity of Medical Decision Making

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- The number of possible diagnoses and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed
- The risk of significant complications, morbidity, and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options.

Four types of medical decision making are recognized: straightforward, low complexity, moderate complexity, and high complexity. To qualify for a given type of decision making, two of the three elements in the table below must be met or exceeded.

Number of Diagnoses or Management Options	Amount and/or Complexity of Data to be Reviewed	Risk of Complications and/or Morbidity or Mortality	Type of Decision Making
Minimal	Minimal or none	Minimal	**Straightforward**
Limited	Limited	Low	**Low complexity**
Multiple	Moderate	Moderate	**Moderate complexity**
Extensive	Extensive	High	**High complexity**

Select the Appropriate Level of E/M Services Based on the Following

For the purpose of distinguishing between new and established patients, a new patient is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty who belongs to the same group practice, within the past three years. **All of the key components** (history, examination, and medical decision making) must meet or exceed the stated requirements to qualify for a particular level of E/M service for new patients in an office setting.

New Patient				
CPT Code	**History**	**Examination**	**Medical Decision Making**	**Typical Time**
99201	Problem focused	Problem focused	Straightforward	10
99202	Expanded problem focused	Expanded problem focused	Straightforward	20
99203	Detailed	Detailed	Low complexity	30
99204	Comprehensive	Comprehensive	Moderate complexity	45
99205	Comprehensive	Comprehensive	High complexity	60

An established patient is one who has received professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty who belongs to the same group practice, within the past three years. In the instance where a physician/qualified health care professional is on call for or covering for another physician/qualified health care professional, the patient's encounter will be classified as it would have been by the physician/qualified health care professional who is not available. For established patients in an office setting, **two of the three key components** (history, examination, medical decision making) must meet or exceed the stated requirements to qualify for a particular level of E/M service.

Established Patient				
CPT Code	**History**	**Examination**	**Medical Decision Making**	**Typical Time**
99211	None	None	None	5
99212	Problem focused	Problem focused	Straightforward	10
99213	Expanded problem focused	Expanded problem focused	Low complexity	15
99214	Detailed	Detailed	Moderate complexity	25
99215	Comprehensive	Comprehensive	High complexity	40

When counseling and/or coordination of care dominates (more than 50%) the encounter with the patient and/or family (face-to-face time in the office or other outpatient setting), then **time** shall be considered the key or controlling factor to qualify for a particular level of E/M services. **The extent of the counseling and/or coordination of care must be documented in the medical record.**