2013 SA Billing Manual Questions

Updated 2/1/13

1) Pg. 7 and 8 – Family Counseling/Group Counseling - Under **SAS Reporting Combination Restrictions** the manual states "Cannot be billed in conjunction with any bundled services (MH, SA, or DD)." Does this mean that family/group counseling cannot be billed with ACT, Day Treatment, and In-Home services? This is also referenced on individual counseling as well. **Yes. If you are billing us a daily or hourly rate you cannot bill another service on the same hour or day.**

2) Pg. 8 – Group Counseling - The Maximum billable units is 6 hours/208 per year. Does this mean 6 hours/208 ***hours*** per year? **Corrected 6 until per day 208 per year.**

3) Pg. 14---Individual Counseling- Is the code 9908?
Not correct codes 90832, 90834, 90837

   a) *Is the rate correct? It appears that it was set up for 15 minute increments rather than the 20-30 minute unit.* ***Three different rates, three different codes only one can be billed per day.***
   b) *The new CPT codes effective January 1st, (90832, 90834, 90837) are based on time, so will the rates set here match the new CPT code times?* **Clarified in the Manual**
   c) Page 14 specifies that Individual Counseling cannot be billed in conjunction with any DMH bundled service as opposed to service ***restrictions on other pages*** that specify "any bundled" services. **Corrected it to say any bundled services.**

4) Pg.16 – Case Management –
   a) Under Non-Emergency Transportation there is a reference to Medicaid Clients. What is the purpose of this statement? **Medicaid is specific as to when you can bill for transportation. You can only bill Medicaid to transport to a Medicaid service.**
   b) Is case-management going ***to be*** covered by Medicaid chapter 105 or 106? **Yes, If SPA Target Case Management amendment IS APPROVED**

5) Pg. 31 - Treatment Plan Review-- Medicaid includes QSAP1 to provide this service. Is it the intent to allow QSAP I, II, and III to provide this service? **Corrected QSAP I, II III all licensed only.**

6) Pg. 32 - Oral Medication Administration –

   a) Are we going to be able to administer both oral and injectable medications? If so, we only have a service description for ORAL meds, is this an oversight? **Yes, *injectable Services have been added.***
   b) *The code listed for ORAL meds is the code for INJECTIBLE meds in the Medicaid State Plan Amendment documentation. The ORAL code in that documentation is 96372.* **The correct coeds are listed in the manual and match the current Medicaid manual.**
   c) Can the medication order come from the client's primary physician or does it have to come from the organization's physician? **Current Medicaid regulations state as "directed by a physician" and does not specific.**

7) Pg. 36- Peer Counseling--- Is there a maximum group size for this service type? **30 Maximum per peer counselor**

8) Some of the services in the manual only have codes for specific populations such as general and adolescent. However, there are other populations, such as special women, that will need these services. Are the codes/modifiers going to be included for these populations or should we only provide services to the populations covered by the codes listed? **Yes, see revisions to manual.**

9) One example of this is Behavioral Health Outreach - the codes/modifiers are for the General Population and adolescents. Are these the only populations to be provided this service? **See above**

10) Pg. 38 – Crisis Counseling – Under **SAS Reporting Combination Restrictions** the manual states "Cannot be billed in conjunction with in-home intervention or any bundled service. Does this mean that Crisis counseling cannot be billed with ACT, Day Treatment, and In-Home services? **See question 1.**

11) Pg. 39 – Basic Living Skills - Under **SAS Reporting Combination Restrictions** the manual states "Cannot be billed in conjunction with any bundled service." Does this mean that BLS cannot be billed with ACT, Day Treatment, and In-Home services? **See question 1** Also: Basic Living Skills "20 units per unit" should read "20 units per *day*". **Corrected**

12) Page 48 - Family Training and Counseling appears to have the wrong modifier, should it be HD to indicate this is to be paid under Special Women funding***? Corrected in the manual***

13) General Question: Should case management, behavioral outreach service, psycho-educational services, developmental delay prevention activities for dependent children, parenting skills development, and transportation are included on the treatment plan if being provided? **YES.**

14) General Question: Is this draft manual going to be updated by Jan. 1 to coincide with the new CPT codes that are effective for Jan. 1? (Intake Evaluation/Behavioral Health…Assessment and Individual Counseling are examples) ***YES***

15) General Question: PMAT is not listed as a service in the draft manual. Is this an oversight? **Corrected in manual**

16) General Question: Now that we have unbundled ancillary services, is there a service category for child sitting while mother is in treatment? **NO**

17) Need to verify the Intake Assessment code, 90801 was deleted **YES**

18) Some service types (i.e. family counseling) restrict billing in conjunction with bundled services. If bundled services are **not** restricted, can we assume you can bill them in addition to the bundled rate? **YES**

19) Pg. 4 Behavioral Health Accommodation (BHA) Residential Treatment III.5 is not mentioned in BHA. Is an unbundled III.5 an eligible level of care for Behavioral Health Accommodation? **YES**

20) Pg. 6. Intake Evaluation Clarify the staff qualifications for eligible staff on this service. **Corrected**

21) Pg. 7. Family Counseling - There are multiple codes for this service. Is the maximum billing per SAS Reporting Code or combined codes? **Per code.**

22) Pg. 8. Group Counseling - The SAS reporting unit is 30 minutes however the maximum billing units is listed as hours. Please clarify. **Corrected**

23) Pg. 9. Diagnostic Testing - Does "physician" indicated on this service mean "psychiatrist"? **I means a "physician."**

24) Pg. 13. Non-emergency - Can non-emergency transportation be added to the case management plan vs the clinical service plan? **YES**

25) Pg. 14. Individual Counseling - Why was the 90804 code dropped and replaced with the new 90832, 9083, 90834 billing code? **Because of a federal law mandate.** If one (1) hour of individual counseling is provided, how is the service billed (three 20 min units or two 30 min units)? **Billed as one 60 minutes unit. Only one unit per day.** The total billing rate for one hour of service does not equal to the current $75.00 per hour rate. Was it the intent of the Department to reduce the rate for this critical service? **No. Clarified in new version.**

26) Pg. 29. Behavioral Health Outreach Service - Please provide examples of this service. **This is a contract and block requirement. There are three examples listed in the manual.** Is this service provided to active clients only? **This services is not billed per individual it is billed similar to prevention**

27) Pg. 31. Treatment Plan Review - MCD requires a QSAP I to provide this service. Is it the intent of the Dept to allow QSAP I, II, and III? **See Question 5**

28) Pg. 32. Oral Medication Administration- Can the medication order come from the client's physician, or does it have to be the organization's physician? **See Question 6**

29) Pg. 34 Peer Counseling - Is there a maximum group size for this service type? **30**

30) Pg. 36 Basic Living Skills - ("20 units per unit" needs to be corrected) **corrected**

31) If modifiers are not listed under the SAS Reporting Code will we be required to use modifiers? **Yes. Added modifiers to everything**

32) Pg. 4 Behavioral Health Accommodation and Residential Treatment (Level III.5)– can we still bill using this code and bill for individual services for Level III.5 (Level III.5 is not included in the eligible Levels of Care but all other Level III's are included) or do we have to bill the bundled Level III.5? **See Question 19**

33) Pg. 6 Intake Evaluation – the 2 episodes per year – does this include the updates that we have to do or is there an option to do update like on the old billing manual**? Revised: Updates are covered under H0031 – Mental Health and Substance Use Disorders Assessment**

34) Pg. 8 – do we bill in units or hours? Under maximum billable units it has 6 hours not units. **Corrected**

35) Pg. 13 – Individual Counseling – does a 40 plus minute session equal 2 units or 1 unit since it says 20-30 minute unit? **Corrected**

36) Pg. 15 - Case Management can all QSAP's provide case management? **Yes if trained.** Also, there are no drug court modifiers, can we still bill for case management for drug court clients? **Yes modifiers have been added.**

37) Pg. 28 – will there be a specific tool used? Is this done as the Updating Treatment Plan, when we have to update every 14 days or 90 days depending on level of care? **NO treatment plans are updated as they are needed not by certain dates or timelines.**

38) Pg. 29 – is this case staffing? Chart review as a part of clinical supervision? Since client is not present? **Billable purposes, it must be tied to a client.**

39) Pg. 30 – Definition says physician, PA or CRNP but in eligible staff has all listed as long as they have MAC training, does this mean in our residential program when we give out meds we can bill for this service for those who are given meds? **Under the direction of is not direct administration**

40) Pg. 34 – can peer support specialist be volunteers who come to our agency to provide this to residential clients, they are certified? **NO**

41) New Levels of Certification when is it going to happen? **Is happening now.**

42) Is travel to and from AA/NA meeting a billable expense: **NO**

43) Why are some of the codes different? **See link**
http://www.thenationalcouncil.org/galleries/policy-file/CPT%202013%20Changes%20Fact%20Sheet.pdf

44) Will there be some training around special women's auxiliary services: **New Women's Coordinator will provide will be informed of this need.**

45) The Table of Contents pages does not match the contents. **FIXED**

46) Has the rate for Special Women's gone from $88.31 to $120? **Yes**

47) When presenters from outside the facility come in to present on a topic, can we bill for their services if they meet the QSAP requirements for that delivery? **If your staff is present and have the qualification and provide the proper documentation.**

48) If we send clients out to receive services (i.e. 'Parenting') can we bill for that service, if it is presented by a person who meets the QSAP requirements? **No. You will only be able to bill for services your agency provides.**

49) Pg. 4 – B. Behavioral Health Accommodation is misspelled…. (Ditto for it on the 'Table of Contents' – or Table of Content, as written… **Corrected**

50) Pg. 4 C. - Did they mean to say… "the individual's active treatment…' , or …"the individual active treatment plan…" ? **the individual's active treatment**

51) Pg. 5 – B. – Did they mean to say 'reasonably' as opposed to 'reasonable'? **Corrected Reasonably**

52) The below is a quoted excerpt; my question / statement follows the bold segment. "Page 6 Intake Evaluation – the 2 episodes per year – does this include the updates that we have to do or is there an option to do update like on the old billing manual? Revised: Updates are covered under H0031 – Mental Health and Substance Use Disorders Assessment". I cannot find 'H0031' on the current Procedure Code Sheet, but I DO see it in the new Billing Manual. Do we have a new Procedure Code Sheet? **New Sheet is being created.**

53) Pg. 11 Would administering a Tuberculosis skin test qualify as 'injecting medicine'? **NO**

54) Pg. 10 & 12 – Dx Testing Administered – Would administering the URICA, The Beck Depression Inventory, or career tests, or Jung Personality Test, or the 'DAST' (Drug Abuse Screening Test) apply here? **NO**

55) Pg. 41 Olivia's House is L III.1 and Special Women's programming – are you saying here that our program is going to be cut to 90 days (It is currently 4 – 12 months) **No. Exceptions require monthly continued stay justifications in the client record.**

56) Pg. 46 - What is an episode here**? Same unit as assessment.**

57) MCD came out with a 105 update in January with the following codes for individual counseling - 90832 (16-37 mins), 90834 (38-52 mins), and 90837 (53 mins or greater). The ADMH contract billing manual uses the same codes but are based on 30,45 and 60 minutes and are not clearly tied to the times. Will this be revised in the billing manual? Also, do you know when the new billing codes will be active in ASAIS? **Clarified in updated manual.**

58) For clients billed thru ASAIS are we restricted to charging the rates supplied in the Contract Billing Manual? **The rates in the contract billing manual have nothing to do with what you charge the clients. You are required by contract to have a sliding fee scale.** Do we bill the client based on sliding fee scale and the balance up to the contract rate to ASAIS or do we bill the client based on the sliding fee scale and bill the contract the full contract rate? **Neither. Contract providers are required to bill clients on a sliding fee scale and use their DMH contract as a payor of last resort. If a contract provider does bill DMH, they cannot also bill the client for the same service. However, providers are allowed to collect a surcharge or co-pay from the client to cover the cost of treatment, as long as it does not create a barrier to access treatment.**

59) For residential programs, do we get “bed and board” as well as the SAS contract billing rate, i.e. $37.42/day plus the $$90 for a III.3? **No, bed, board and protection cannot be billed with bundled residential rates.**

60) III.5 level indicates that length of stay is 14-21 days and III.1 is 90 days but there is no time restriction on the III.3, which is what we are planning to contract for…the standards also do not indicate a length of stay. What are our guidelines for a III.2 level? **This is a clinical treatment question and has been sent to Mr. Wynn to respond.**

61) There are 2 SAS codes for group counseling. 90853 & H0015. I cannot see the functional difference so am not sure which program should use which code? H0015 IOP services**. This code will go away when the new SPA is approved. We encourage you to bill what you are actually doing such psychoeducation., groups, individual etc.**

62) Could special women's be billed unbundled with the III.3 at A Woman's Place despite the fact that children would only be on the premises for weekly Family Counseling? **The children do not have to be on the premises. It does not impact whether you bill bundled or unbundled.**

63) For the programs where we run more than 1.5 hours group (90853 will only allow 1.5hours) we can no longer do that? All groups have to 1.5 or less? **Doing more than 1.5 hours of groups counseling is really not appropriate. Look at what you are doing you are probably doing psycho education, family etc.**

64) Are the maximum billing units going to be calculated per provider or per client? (e.g. a client exhausted his maximum billing units of group therapy in one program but then had to be transferred to another program)
Per client

65) In the past, the Dept. has allowed a staffer to provide case management services while they are awaiting an upcoming case management training program. Can we provide peer counseling while we are waiting on Peer Support Specialist training? **Yes but you need to make sure you have a clear supervision log.**

66) Interestingly they kept the SA group treatment at 6 units per day in the crosswalk and renamed it SA intensive outpatient services (H0015). In the billing manual it is listed as Outpatient Group Counseling - Adult. I wonder if this means they will keep this service in and allow the 6 hours per day negating the issue of the other code entitled Group Counseling (90853) which limited group to 1.5 hours per day. Maybe H0015 can be used for Level II.1 services and 90853 can be used for Level I services which would make sense to me. Or do they still plan to delete H0015 when the new Medicaid amendment plan is approved. The crosswalk that Kim sent out is the revised fee schedule with Medicaid. The only changes in that fee schedule are the CPT changes that were mandated (i.e. Assessment and Individual Counseling).

H0015 is a bundled Intensive Outpatient service. Chapter 105:

Definition
A **combination** of **time limited**, goal oriented rehabilitative services designed to assist clients in reaching and maintaining a drug and alcohol free lifestyle.

Key service functions include the following:

- Initial screening to evaluate the appropriateness of the client's participation in the program
- Development of an individualized program plan
- Medical services including prescription of medication and medication management
- Group and family counseling
- Substance abuse education
- Pre-discharge planning
- Family therapy focusing on client and family education regarding substance abuse and community support
- Linkage to community resources

It is capped at 6 hours a day, but that never should have meant any client was subjected to six hours of **group counseling** in a day. It is not equivalent to 90853 (Group Counseling). The

Group Counseling code is capped at 1.5 hours per day. The expectation is you are doing the other services…Psychoeducational services, individual counseling, case management, basic living skills, etc. in lieu of billing six hours of H0015. We are trying to move away from IOP as a bundled service, but it will remain as an eligible billing code as long as it is billable at Medicaid.

February 1, 2013 Updates

(67) Can a person who is in recovery and holds a CADC go through the peer support training and conduct peer support groups? If he is certified as a peer special he can do the services.

(68) Level III.5 our CRC/TIOP program, we do 5.5 hours of services during the day and an additional 2 hours of groups 3 evenings a week. We are changing everything to make sure we are not over the maximum allowed time and seeking ways to provide much needed peer support services to them. I have a part-time therapist who is a CADC but also in recovery hence the question above. If he cannot provide this service, we will need to find another way to provide this service, if we collaborate with an agency that provides peer support, how do we bill for this? You can not,.

(69) Since Activity Therapy is a core service requirement in Adolescent and Special Women's Programs, how should this service be billed and documented? Cant bill for that in the current bill manual. You would need to look and see if it is educational or therapy and bill according. Should be documented just like any other service you provide.

(70) Question about reimbursement: In the past, if a client was assessed and did not have an SA diagnosis (V code), we could not bill DMH for the Assessment service. Since referrals to Early Intervention services are for clients without an SA diagnosis, will we now be able to get reimbursement for the SA Assessment that leads to a V code/no SA diagnosis? Programs have always been reimbursed for assessment regardless of diagnostic code. If you are certified for Early Intervention you can get reimbursed for assessments, individual family and psychoeducational services.

(71) Page 37 – Mental Health Consults – there are codes for adults but not adolescents. Is this intentional? Are we not able to bill mental health consults for adolescents? Since it specified adults, I would not assume that it would be the same for both? Corrected

(72) Page 40 – Psychoeducational services – again there are codes for adults but not adolescents; however in the Maximum group size it mentions the limitations for adolescent groups. Should there be another code. Corrected