



State of New Jersey
Department of Human Services
Division of Medical Assistance & Health Services

NEWSLETTER

Volume 26 No. 10

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TO: Providers of Behavioral Health Services - For Action
Health Maintenance Organizations - For Information Only

SUBJECT: Fiscal Year 2017 Behavioral Health Rate and Coding Changes

EFFECTIVE: Immediately

PURPOSE: Clarification of Provider Billing Questions

BACKGROUND: For claims with service dates on or after July 1, 2016, New Jersey FamilyCare (NJFC) fee-for-service providers of behavioral health services received new reimbursement rates for mental health and substance use disorder (SUD) treatment services. Providers were also provided updated billing procedures.

The Newsletter Volume 26 No. 05 was distributed to inform providers of these changes. Multiple providers raised questions that require clarification.

ACTION: The first area of concern is found on Page 4 of Newsletter Volume 26 No. 05. Under "Hospital Based Services", individual therapy is described as 60 minutes and the new rate is listed as \$68.21. Revenue code 914 is billable as two 30 minute units (total of 60 minutes) and each unit pays \$68.21. If two units are billed, the payment would be \$136.42.

The second area of concern is on page 8 under SUD-Residential. "Detoxification ambulatory or residential" should not have used the term "ambulatory". New Jersey Medicaid does not currently cover ambulatory withdrawal services outside of a residential setting. H0010HF is meant for use with residential detoxification. This service description should read "Residential Detoxification Level III.7".

The third area identified for clarification concerns the use of assessment codes for SUD and mental health. The CPT code 90791 is described as a psychiatric diagnostic evaluation without medical services. This code is used by a provider to bill for any assessment required to determine the need for further treatment that is completed or approved by a licensed clinician whose license allows them to assess and develop a treatment plan. The plan does not require physician participation or approval.

The code 90792 is a psychiatric diagnostic evaluation with medical services. This code is intended for use when the intake assessment requires physician participation to complete. Physician participation may include the physician completing a history and physical as well as reviewing and approving the treatment plan if the client is accepted into the program for treatment. If the physician agrees to manage their treatment outside of the program including medication management, the program may also bill with an additional evaluation and management code for a service above and beyond completing the intake assessment.

Evaluation and management (E/M) codes may be billed by any independent clinic when a physician or APN provides medical services that are outside of the program requirements. For example, once a client is admitted into a partial care program, the psychiatrist or psychiatric APN is required to review and approve treatment plans. As a program requirement, this is not billable. However, partial care regulations do not require a physician or APN to evaluate clients for medication management. The program may bill for the appropriate E/M code as described in the CPT manual. The physician/APN is required to document the problem or focus of the examination, the decision outcome of the exam and the length of time spent with the client.

When a program bills for an E/M code during partial care program hours, that time may not also be counted toward the therapeutic services requirement for partial care billing. If a client leaves a partial care group that runs for 45 minutes to see the physician or APN, the therapeutic time counted toward partial care billing is equal to the 45 minutes minus the amount of time spent with the physician/APN.

If you have any questions concerning this Newsletter, please contact The DMAHS Office of Customer Service at 609-631-4641.

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