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

NEWSLETTER

Volume 26 No. 15 **November 2016**

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

SUBJECT: Clarification of Intake Assessment and the Use of Evaluation and Management Codes for Behavioral Health Services

EFFECTIVE: Claims with service dates on or after July 1, 2016

PURPOSE: To clarify new and existing policy, billing procedures and rates for mental health and substance use disorder (SUD) treatment for fee-for-service billing of behavioral health services.

BACKGROUND: The Division of Mental Health and Addiction Services (DMHAS) recently completed a rate study and rate setting process to establish new rates for multiple behavioral health services. These services included existing mental health services as well as newly covered Substance Use Disorder (SUD) services. Effective July 1, 2016, the Division of Medical Assistance and Health Services began covering a variety of SUD services for individuals, 18 years or older, with plan "A" or "ABP". The volume and magnitude of these changes resulted in many questions and concerns. This newsletter contains corrections and/or clarification of policy that resulted from provider input.

ACTION: The Division of Mental Health and Addiction Services (DMHAS) re-evaluated its current policy regarding coverage and reimbursement for Medication Assisted Treatment (MAT) delivered by an Opioid Treatment Program (OTP). For claims with service dates on or after July 1, 2016, DMHAS has established new weekly bundled rates designed to cover MAT services delivered in an OTP.

- H0020 HF 26 Methadone Medication in a licensed OTP: 1 unit =7 days
- H0033 HF 26 Medication other than Methadone in a licensed OTP: 1 unit=7 days

When billing for these codes, please remember that the service unit for these codes are defined as covering 7 days. Each week of service should be listed on one line of the bill with the service dates "from" and "through" listed as the first date of the 7 day span. Think of it as asking for one unit of service that you are only allowed to bill once every 7 days. Therefore, you would enter 9/5/2016 through 9/5/2016; **not** 9/5/2016 through 9/11/2016. The next period of service would list 9/12/2016 through 9/12/2016. The 7 day span always begins with the actual first date of service provided. Service can begin on any day of the week.

The bundled rate will reimburse OTPs for costs related to weekly MAT services provided to consumers. A weekly bundled rate applies to Methadone and non-Methadone opioid treatment services including but not limited to buprenorphine/buprenorphine-naloxone. MAT services included in the weekly bundled rate include: Medication dispensing, drug costs, individual or group counseling session(s), a case management session, and medication monitoring related to MAT. The bundled rate does not include transportation, intensive outpatient, specimen collection, intake or psychiatric evaluation. The same weekly bundled rates apply to Phase I-VI. Those services not included in the MAT bundled rate may be billed separately. Methadone Intensive Outpatient (IOP) requires a separate prior authorization.

Medicaid/NJ FamilyCare Billing Considerations

- Providers must enroll or re-enroll in the NJ FamilyCare program to receive Medicaid/NJFC payments or State funds for eligible behavioral health consumers. Prospective applicants may download an independent clinic provider application by visiting www.njmmis.com. Providers may also learn more about the provider re-enrollment process by visiting www.njmmis.com and accessing the Medicaid newsletter Volume 24 No. 04.

- The provider is responsible for ensuring that the NJ FamilyCare Fee-For-Service (FFS) program is billed first for covered behavioral health services provided to eligible beneficiary prior to requesting State or County funding.

- Certain SUD services must be prior authorized by the Interim Management Entity (IME) under contract with DMHAS. Additional information regarding IME procedures may be found in the July, 2016 Newsletter Vol 26 No. 06 which is posted on www.njmmis.com.

- **Effective July 1, 2016**, providers are required to bill the NJ FamilyCare FFS program for clients who have not yet attained the age of 21 years or consumers 65 years of age or older, for providing short term residential and a detox level of care in a setting of more than 16 beds. If a client was receiving services prior to turning 21, they may continue to receive services until the end of that admission or until they turn 22 years old.

- For mental health and substance use disorder outpatient services, there is an allowable spend of $6,000 for those services provided by the same provider to the same client over one year. Services provided that exceed $6,000 per year requires prior authorization to receive payment. The prior authorization requirement has a rolling look-back of 1 year and does not reset annually. For every claim submitted, the system looks back one year for claims for this one client with this one provider. For independent clinics, prior authorization may be requested from the IME. For independent community practitioners, prior authorization is requested from the Office of Behavioral Health and Customer Service at 609-631-4641.

Program Intake Assessments

Medicaid will reimburse an independent clinic, hospital or other provider type who is required to complete a comprehensive biopsychosocial assessment or intake in order to determine if a client is appropriate for admission to their program. Medicaid covers one assessment per admission. There are two codes utilized for this purpose:

- **90791** when the biopsychosocial assessment is completed by a clinician and **does not** require the participation of a physician or APN
- **90792** when the biopsychosocial assessment requires the participation of a physician or APN including a history and physical, establishment of a diagnosis and certification that the client is appropriate for participation in the selected program

The full biopsychosocial assessment shall be completed prior to billing for the procedure. If regulations allow additional time for the physician or APN to complete their portion of the assessment, billing should not be submitted until their documentation is complete. Please note that if this occurs, you cannot bill for any other behavioral health service on the same date you bill for 90792/90791.

For substance use disorder (SUD) providers, there are occasions where an individual has been evaluated for SUD services by a physician who refers the client to a psychiatrist for evaluation of an identified mental health issue. Providers can only bill for one intake assessment (90791 or 90792). Since a psychiatric evaluation is not included in the required services of the SUD program, in addition to the intake assessment (90792), the SUD program may bill for an additional psychiatric evaluation using an evaluation and management code. This service should be provided and billed on a separate date of service.

Evaluation and Management Codes

When the provision of a medical service is not a part of a bundled service provided by a behavioral health program, those services may be eligible for reimbursement using an Evaluation and Management (E/M) code. E/M codes are listed in the Current Procedural Terminology (CPT) book and include a description of the service including requirements necessary for billing. It is the responsibility of all providers to bill for the appropriate code for the appropriate service. Documentation should include the type of evaluation, identified problem, length of the evaluation and the evaluation's key components.

Independent clinic and outpatient hospital providers can bill CPT evaluation and management codes listed under the section "Office or Other Outpatient Services". The allowable codes are 99201 through 99205 for new clients, or 99211 through 99215 for established clients. In the example of an SUD provider providing a psychiatric evaluation in addition to an SUD intake evaluation, the appropriate billing series would be for a new client (99201-99205). Since an initial psychiatric evaluation usually involves complex issues and requires a history and physical evaluation, the provider should bill for 99204 if the evaluation is approximately 45 minutes spent face-to-face with the client and/or family member or 99205 if the evaluation requires approximately 60 minutes or more.

E/M codes are medical codes and are not behavioral health codes. They should be used for the provision of medical services by a physician, Advance Practice Nurse (APN) or a Physician Assistant (PA). Clinics and outpatient hospital programs may bill for services provided by APNs and PAs as long as the services are allowed by their licensing boards and they practice within their scope of practice.

The CPT manual allows billing for 99211 for visits that may not require the presence of a physician. The presenting problem must be minimal and typically only five minutes are spent performing or supervising the service. The code 99211 is the only code that allows a provision of a service by a non-physician (including APNs and PAs). There is no documentation requirement for a history or physical exam or the complexity of the medical decision-making. The visit can be for a minimal problem such as the administration of depot antipsychotics by a registered nurse or licensed practical nurse. While the physician or APN does not need to be present during this visit, they should be on the premises or available for consultation.

New Clients

99201 Requires a problem focused history, a problem focused examination, and straightforward medical decision making. Presenting problems are usually self-limited and the physician spends approximately 10 minutes face-to-face with the client/family.

99202 Requires an expanded problem focused history, an expanded problem focused examination and straightforward medical decision making. The presenting problems are low to moderate severity and the physician typically spends approximately 20 minutes face-to-face with the client/family.

99203 Requires a detailed history, a detailed examination and medical decision is low complexity. The presenting problems are of moderate severity and the physician typically spends 30 minutes face-to-face with the client/family.

99204 Requires a comprehensive history, comprehensive examination and medical decision making is of moderate complexity. The presenting problems are moderate to high severity and the physician typically spends 45 minutes face-to-face with the client/family.

99205 Requires a comprehensive history, comprehensive examination and medical decision making is of high complexity. Usually the presenting problems are moderate to high and the physician typically spends 60 minutes face-to-face with the client/family.

Established Clients

99211 May not require the presence of a physician. The presenting problems are usually minimal and the provider spends 5 minutes performing or supervising a service.

99212 Requires at least two of the following: a problem focused history, a problem focused examination or a straightforward medical decision-making. The presenting problems are usually self-limited or minor and the physician spends 10 minutes face-to-face with the client/family.

99213 Requires at least two of the following: an expanded problem focused history, an expanded problem focused examination, or medical decision-making of low complexity. The presenting problems are of low to moderate severity and the physician typically spends 15 minutes face-to-face with the client/family.

99214 Requires at least two of the following: a detailed history, a detailed examination or medical decision-making of moderate complexity. The presenting problems are of moderate to high severity and the physician typically spends 25 minutes face-to-face with the client/family.

99215 Requires at least two of the following: a comprehensive history, a comprehensive examination or medical decision-making of high complexity. The presenting problems are of moderate to high severity and the physician will typically spend 40 minutes face-to-face with the client/family.

A sample note for an E/M visit billing 99213:

History: F/U visit for a 30 y.o. female with history of depression. C/O difficulty concentrating at work but describes positive coping. Review of symptoms reveals no signs of sadness, minimal irritability.

Exam: appropriately dressed, well groomed, alert. Speech was normal rate. No suicidal ideation. Oriented x3, associations intact. Mood appropriate. Judgement and insight intact.

Medical decision-making: Depression stable, renew Wellbutrin. Next visit 1 month.

Visit: 15 minutes

If you have any questions concerning this Newsletter, please contact the NJ FamilyCare Office of Behavioral Health and Customer Service at 609-631-4641.

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