moda HEALTH	Reimbursement Policy Manual	Policy #:	RPM058
Policy Title:	Behavioral Health Case Management & Care Coordination		
Section:	Behavioral Health	Subsection:	none

Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:

Companies: ☐ All Companies, subsidiaries, & affiliates ☒ Moda Health Plan, Inc. ☒ Moda Assurance Company ☐ Summit Health Plan, Inc. ☐ Eastern Oregon Coordinated Care Organization (EOCCO) ☐ OHSU Health IDS

Types of Business: ☐ All Types ☒ Commercial Group ☒ Commercial Individual ☒ Commercial Marketplace/Exchange ☒ Commercial Self-funded ☐ Medicaid ☐ Medicare Advantage ☒ Short Term ☐ Other: _____

States: ☒ All States ☐ Alaska ☐ Idaho ☐ Oregon ☐ Texas ☐ Washington

Claim forms: ☒ CMS1500 ☒ CMS1450/UB (or the electronic equivalent or successor forms)

Date: ☒ All dates for Oregon, Alaska, & Washington ☒ Specific date(s): For Texas: dates of service 10/1/2022 and following. ☐ Date of Service; For Facilities: ☐ n/a ☐ Facility admission ☐ Facility discharge ☐ Date of processing

Provider Contract Status: ☒ Contracted directly, any/all networks ☒ Contracted with a secondary network ☒ Out of Network

Originally Effective:	1/1/2018	Initially Published:	8/17/2018
Last Updated:	8/8/2024	Last Reviewed:	8/14/2024
Last update payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)?		No	
Last Update Effective Date for Texas:		8/14/2024	

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. These same benefits are allowed for plans in other states outside of the Oregon mandate.
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 or the state in which the program operates.
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 Coding requirements for specific types of providers.

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) "Choose the code closest to the actual time…Do not report psychotherapy of less than 16 minutes duration." [6]
         c) For the example set of codes 90832-90838 (when psychotherapy is not performed in addition to an evaluation and management service), 90832 = 30 minutes, 90834 = 45 minutes, 90837 = 60 minutes:
            1) Psychotherapy of 15 minutes or less is not eligible to be separately reported. See b) above. [6]
            2) For 16 – 37 minutes service documented, report 90832 x 1 unit.
            3) For 38 – 52 minutes service documented, report 90834 x 1 unit.
            4) For 53 -89 minutes service documented, report 90837 x 1 unit.
            5) For 90 – 134 minutes service documented, report 90837 x 1 unit only; no prolonged services code exists/may be reported.
            6) For 135 – 164 minutes service documented, report 90837 x 1 unit only; no prolonged services code exists/may be reported.
            7) For further questions about prolonged services, refer to your CPT book guidelines.
         d) When psychotherapy is performed in addition to an evaluation and management (E/M) service, the E/M service is coded as the primary service and add-on codes 90833, 90836, or 90838 are used to report the psychotherapy services.
            1) The separate time for the psychotherapy needs to be documented.
            2) The time spent performing the E/M service cannot be counted in the time for the psychotherapy service. Thus, the time documented for the psychotherapy services must be less than the total amount of time spent with the patient.
            3) Per CPT coding instructions, when psychotherapy services with E/M services (90833, 90836, 90838) are reported, time may not be used as the basis of E/M code selection and prolonged services may not be reported. The E/M service must be coded based upon medical decision making. [8, 9]

      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. (Note that this rule does not apply to E/M services. The time given in the E/M code description is the minimum required time when coding E/M services based upon time.)
         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 minutes" 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. [5]

e) When CPT guidelines for the use of a specific time-based code contain specific guidelines other than this, the specific code guidelines prevail.

iv. **Prolonged services.** With the January 1, 2023 E/M code changes, no prolonged services procedure code is available to be reported with psychotherapy procedure codes. [D]

a) Dr. Peter Hollmann, Co-Chair of the CPT/RUC Workgroup on E/M, explained the psychotherapy participants in the E/M Revision workgroup indicated a prolonged service code is not needed for psychotherapy services.[13]

b) Should providers disagree with this decision, they will need to work directly with their professional specialty society/association to have a request submitted to the AMA for a new procedure code to be created for this purpose.

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 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.[5]

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 (96156-96171, formerly 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 96156 – 96171 (formerly 96150-96155) 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), adaptive behavior services (97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0326T, 0373T) as well as health and behavior assessment/intervention (96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171), report the predominant service performed. Do not report 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171 in conjunction with 90785-90899 on the same date." [7]
        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. CM/CC services:

Code	Definition	Valid for:
G0177	Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)	All plans.

Code	Definition	Valid for:
G0323	Care management services for behavioral health conditions, at least 20 minutes of clinical psychologist or clinical social worker time, per calendar month. (These services include 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, coordination with and/or referral to physicians and practitioners who are authorized by Medicare to prescribe medications and furnish E/M services, counseling and/or psychiatric consultation; and continuity of care with a designated member of the care team)	Medicare Advantage & Commercial plans only. Not valid for Medicaid plans.
H0023	Behavioral health outreach service (planned approach to reach a targeted population)	Valid for Medicaid plans only. Per OHA fee schedule, may be used to report IIBHT or Alcohol and/or drug outreach.[18]
H0036	Community psychiatric supportive treatment, per 15 minutes	All plans.
H0039	Assertive community treatment, face-to-face, per 15 minutes	All plans.
H0040	Assertive community treatment program, per diem	All plans. DOS 1/1/2021 and after
H0046	Mental health services, not otherwise specified	All plans. Per OHA fee schedule, may be used to report Home Based and Behavioral Habilitation, 60 minutes. (OHA[18]) This description must be included on the claim for unlisted code H0046.
H2011	Crisis intervention service, per 15 minutes	All plans.
H2014	Skills training and development, per 15 minutes	All plans.
H2021	Community-based wrap-around services, per 15 minutes	Medicare Advantage & Commercial plans only.
T1013	Sign language or oral interpretive services, per 15 minutes	Medicaid plans only.

Code	Definition	Valid for:
T1016	Case management, each 15 minutes	All plans.
T1017	Targeted case management, each 15 minutes	All plans.

2. Qualified Mental Health Professional (QMHP) practicing under the auspices of a program appropriately licensed or certified by the Oregon Health Authority or the state in which the program operates. Reimbursable services include:
   a. Psychiatric Diagnostic Evaluation (90791)
   b. Psychotherapy (90832-90899)
   c. Health and Behavior Assessment/Intervention (96156-96171, formerly 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 96156-96171, (formerly 96150-96155) 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), adaptive behavior services (97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0326T, 0373T) as well as health and behavior assessment/intervention (96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171), report the predominant service performed. Do not report 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171 in conjunction with 90785-90899 on the same date." [7]
      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	Valid for:
G0177	Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)	All plans.
H0023	Behavioral health outreach service (planned approach to reach a targeted population)	Valid for Medicaid plans only. Per OHA fee schedule, may be used to report IIBHT or Alcohol and/or drug outreach. [18]
H0036	Community psychiatric supportive treatment, per 15 minutes	All plans.
H0039	Assertive community treatment, face-to-face, per 15 minutes	All plans.

Code	Definition	Valid for:
H0040	Assertive community treatment program, per diem (Note: For DOS 1/1/2021 and after)	Medicare Advantage & Commercial plans only.
H2011	Crisis intervention service, per 15 minutes	All plans.
H2014	Skills training and development, per 15 minutes	All plans.
H2021	Community-based wrap-around services, per 15 minutes	Medicare Advantage & Commercial plans only.
T1013	Sign language or oral interpretive services, per 15 minutes	Medicaid plans only.
T1016	Case management, each 15 minutes	All plans.
T1017	Targeted case management, each 15 minutes	Medicare Advantage & Commercial plans only.
90882	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions	All plans.

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

Code	Definition	Valid for:
G0177	Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)	All plans.
H0023	Behavioral health outreach service (planned approach to reach a targeted population)	Valid for Medicaid plans only. Per OHA fee schedule, may be used to report IIBHT or Alcohol and/or drug outreach. [18]
H0039	Assertive community treatment, face-to-face, per 15 minutes	All plans.
H0046	Home Based and Behavioral Habilitation, 60 minutes	All plans.
H2011	Crisis Intervention Services, per 15 min	All plans.
H2014	Skills training and development, per 15 minutes	All plans.
T1013	Sign language or oral interpretive services, per 15 minutes	Medicaid plans only.
T1016	Case management, each 15 minutes	All plans.
T1017	Targeted case management, each 15 minutes	Medicare Advantage & Commercial plans only.

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 or the state in which the program operates. Reimbursable services include:

Code	Definition	Valid for:
G0177	Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)	All plans.
H0023	Behavioral health outreach service (planned approach to reach a targeted population)	Valid for Medicaid plans only. Per OHA fee schedule, may be used to report IIBHT or Alcohol and/or drug outreach. [18]
H0038	Self-help/Peer Services, per 15 minutes	All plans. DOS 1/1/2022 & after.
H0039	Assertive community treatment, face-to-face, per 15 minutes	All plans.
H0046	Home Based and Behavioral Habilitation, 60 minutes	All plans.
H2011	Crisis Intervention Services, per 15 min	All plans.
H2014	Skills training and development, per 15 minutes	All plans.
T1013	Sign language or oral interpretive services, per 15 minutes	Medicaid plans only.
T1016	Case management, each 15 minutes	All plans.
T1017	Targeted case management, each 15 minutes	Medicare Advantage & Commercial plans only.

5. Physicians (MD, DO, ND) and NPPs (PA, NP).
   a. Two types of care models exist for case management/care coordination services. A different set of codes are used depending upon which care model is used.
      i. Psychiatric Collaborative Care Model (CoCM):
         1) Behavioral Health Integration (BHI) services under this care model involve: A team of 3 individuals delivers CoCM: a behavioral health care manager, psychiatric consultant, and treating (billing) practitioner. This model enhances primary care by adding 2 key services to the primary care team:
            - Care management support for patients getting behavioral health treatment.
            - Regular psychiatric inter-specialty consultation.
         2) To bill CoCM services, the primary care physician reports CPT codes 99492–99494 and HCPCS code G2214.
      ii. Behavioral Health Integration using models of care other than CoCM:
         1) BHI services include elements such as:
            - Systemic assessment and monitoring.
            - Care plan revision for patients whose condition isn't improving adequately.
            - Continuous relationship with an appointed behavioral health care team member.

iii. To bill general BHI services, the primary care physician reports CPT codes 99483–99484, 99487, 99489-99491, G2064-G2065. (Note: The behavioral health team member will report G0323.)

b. Reimbursable services include:

i. Any of the procedure code listed in the table below, which are limited specifically to Physicians (MD, DO, ND) and NPPs (PA, NP) due to scope of license requirements for evaluation and management services ([E]) or the nature of the service represented by the HCPCS code.

ii. Physicians (MD, DO, ND) and NPPs (PA, NP) may also bill any of the procedure codes listed for licensed behavioral health professionals if:

1) The service is within the practitioner's scope of license, scope of practice, professional training, and competence.

2) There is not a more appropriate code listed in the table below.

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.	Use for Commercial, Medicare Advantage, Medicaid, and Medicare Supplement/crossover claims. * Do not report with E/M services, 90785, 90791, 90792, 96127, 96146, 96160, 96161, 99605, 99606, or 99607.
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: **.	Use for Commercial, Medicare Advantage, Medicaid, and Medicare Supplement/crossover claims. *Do not report 99484 in the same calendar month as 99492, 99493, 99494.
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. *Do not report 99490, G2058 in the same calendar month as 99487, 99489, 99491.
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. *Do not report 99490, G2058 in the same calendar month as 99487, 99489, 99491.

Code	**Definition** ***(** = Shortened description. See Code Definitions section later in policy for full description.)***	**Notes, Comments, & Instructions**
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. *Do not report 99490, G2058 in the same calendar month as 99487, 99489, 99491. *Requires 24/7 coverage. *Only report once per month, and only with unit of "1." *Requires co-morbidities.
99491	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. *Do not report 99490, G2058 in the same calendar month as 99487, 99489, 99491. *Requires 24/7 coverage. *Only report once per month, and only with unit of "1." *Requires co-morbidities.
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: **.	Use for Commercial, Medicare Advantage, Medicaid, and Medicare Supplement/crossover claims. See also G2214 for similar code, different time frame.
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: **.	Use for Commercial, Medicare Advantage, Medicaid, and Medicare Supplement/crossover claims.
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.	Use for Commercial, Medicare Advantage, Medicaid, and Medicare Supplement/crossover claims.

Code	**Definition** ***(** = Shortened description. See Code Definitions section later in policy for full description.)***	**Notes, Comments, & Instructions**
G0323	Care management services for behavioral health conditions, at least 20 minutes of clinical psychologist or clinical social worker time, per calendar month. (These services include 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, coordination with and/or referral to physicians and practitioners who are authorized by Medicare to prescribe medications and furnish E/M services, counseling and/or psychiatric consultation; and continuity of care with a designated member of the care team)	Billed by the clinical psychologist or clinical social worker for behavioral health integration services, when working in collaboration with a primary care physician.
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. Appropriate primary procedure codes (per CMS add-on code edit file) include 99202 – 99205, 99212 – 99215, 99217 – 99226, 99231 – 99236, 99238, 99241 – 99245, 99281 – 99285, 99304 – 99310, 99315, 99318, 99324 – 99328, 99334 – 99337, 99341 – 99350, 99441 – 99443, 99483, 99495 – 99496, G0402, G0438 - G0439.

Code	Definition *(** = Shortened description. See Code Definitions section later in policy for full description.)*	Notes, Comments, & Instructions
G2064	Comprehensive care management services for a single high-risk disease, e.g., principal care management, at least 30 minutes of physician or other qualified health care professional time per calendar month with the following elements: one complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities	Similar to 99487 – 99491, but with only one complex condition, and slightly different other requirements.
G2065	Comprehensive care management for a single high-risk disease services, e.g. principal care management, at least 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month with the following elements: **	Similar to 99487 – 99491, but with only one complex condition, and slightly different other requirements.
G2214	Initial or subsequent psychiatric collaborative care management, first 30 minutes in a 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.	Effective for dates of service beginning 1/1/2021. See also 99492 for different time frame.

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, G0506, G2064, G2065, and G2214:
   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 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:

1. Transitional Care Management procedure codes.
   a. Transitional Care Management (TCM) procedure codes (99495 and 99496) are only eligible for separate reimbursement when the member has primary Medicare coverage (Medicare Advantage plan or Original Medicare is primary and the Moda Health plan is secondary to Medicare).
   b. For all other plans, Transitional Care Management procedure codes (99495 and 99496) will be denied to provider write off. The denial explanation code will be:

      2M0 *Service/supply is considered bundled or incidental. Not eligible for separate payment. Always bundled into a related service.*

      835 CARC/RARC denial combination:

      CARC 97 (The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
      Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.)

      RARC M15 (Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.)

c. Claims for TCM services may be submitted using the following procedure codes:
    i. The face-to-face visit may be billed as usual under the appropriate evaluation and management service code for the place of service in which it occurs (e.g., hospital visit, subsequent office visit).
    ii. Non-face-to-face services:
        1) Any care plan oversight services may be reported under the appropriate Care Plan Oversight CPT codes (99339-99340, 99377-99378, or 99374-99380).
        2) Medical team conferences performed without face-to-face contact with the patient may be billed under 99367-99368.
        3) Additional non-face-to-face services are considered included in the discharge E/M or the subsequent office visit E/M.

2. Other procedure codes.

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.
H0006	Alcohol and/or drug services; case management	Does not specify amount of time; higher level of specificity needed. T1016 may be appropriate instead.
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	<u>For dates of service 12/31/2021 and prior:</u> Does not specify activity/service provided. H2014, T1016, G0177 or H0039 may be appropriate instead. <u>For dates of service 1/1/2022 & following:</u> H0038 accepted for processing.
H0040	Assertive community treatment program, per diem	<u>For dates of service 12/31/2020 and prior:</u> Not eligible for separate reimbursement. Use H0039 instead with appropriate number of units.

Code	Description	Reason
H2022	Community-based wrap-around services, per diem	Use H2021 instead with appropriate number of units.
H2023	Supported Employment, per 15 min	Vocational service, not medical service. Tends to be a General Exclusion (non-covered) for most member plans.
H2027	Psychoeducational service, per 15 minutes	Higher level of specificity needed.

E. Conversations/Consultations Between Therapist and PCP

When a behavioral health therapist (clinician) of any type of licensure holds a conversation with a medical primary care provider (PCP) regarding a patient that both are treating for the purpose of both treating the patient appropriately, ensuring that medications are managed appropriately, and to coordinate care, the conversation/consultation is reported as follows:

1. Depending upon the time and extent of other care management activities by the primary care provider providing medical care, the PCP reports either:
    a. General Behavioral Health Integration Care Management (99484) [10]
        i. Service must include the following required elements:
            1) Initial assessment or follow-up monitoring, including the use of applicable validated rating scales.
            2) Behavioral health care planning/revision in relation to behavioral/psychiatric health problems.
            3) Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation.
            4) Continuity of care with a designated member of the care team.
            5) A minimum of 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month.
        ii. Services less than 20 minutes/calendar month are not reported separately.
    b. Psychiatric Collaborative Care Management Services (99492-99494) [11, 12]
        i. Services less than 36 minutes may qualify for reporting under General Behavioral Health Integration Care Management (99484).
        ii. For the PCP to report 99492-99494, the service must include the following required elements:
            1) Outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional.
            2) Initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan.

3) Review by the psychiatric consultant with modifications of the plan if recommended.

4) 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.

5) Provision of brief interventions using evidence-based techniques.

iii. If the above requirements are fully met, the PCP reporting 99492-99494 includes the services of the behavioral health care manager and the psychiatric consultant. [12]

c. The PCP may not report a separate procedure code if the full requirements for the above codes are not met.

2. The therapist/behavioral health clinician does not report a separate procedure code for this conversation with the PCP. [12]

3. Note, the conversation between the PCP and the therapist only involves two disciplines (primary care/family care and behavioral health/psychiatry). Therefore, it may not be reported as an interdisciplinary team conference (99366-99368) because those procedure codes require the participation of individuals from three separate specialties or disciplines.

Codes, Terms, and Definitions

Acronyms Defined

Acronym	Definition
AMA	American Medical Association
ASO	Administrative Services Only
BHI	Behavioral Health Integration
CCI	Correct Coding Initiative (see also NCCI)
CM/CC	Case Management and Care Coordination
CMS	Centers for Medicare and Medicaid Services
CoCM	Psychiatric Collaborative Care Model (a specific type of Behavioral Health Integration services)
CPT	Current Procedural Terminology
DCBS	Department of Consumer and Business Services
DO	Doctor of Osteopathic Medicine
DOS	Date of Service
E/M	Evaluation and Management (Sometimes also listed by the AMA as E&M)
HCPCS	Healthcare Common Procedure Coding System
IIBHT	Intensive In-Home Behavioral Health Treatment Services (OHA[18])
MD	Medical Doctor
NCCI	National Correct Coding Initiative (aka CCI)
ND	Naturopathic Doctor
NP	Nurse Practitioner
NPP	Nonphysician provider
OAR	Oregon Administrative Rules

Acronym	Definition
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 (* = notes and comments not part of the 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
96156	Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)
96158	Health behavior intervention, individual, face-to-face; initial 30 minutes
96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
96160	Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument
96161	Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument
96164	Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes
96165	Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
96167	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes

Code	Code Description (* = notes and comments not part of the code description)
96168	Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
96170	Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes
96171	Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
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: 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.
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: 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.
99487	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.
99489	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.

Code	Code Description (* = notes and comments not part of the 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)
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 (* = notes and comments not part of the code description)
G2064	Comprehensive care management services for a single high-risk disease, e.g., principal care management, at least 30 minutes of physician or other qualified health care professional time per calendar month with the following elements: one complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities
G2065	Comprehensive care management for a single high-risk disease services, e.g. principal care management, at least 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month with the following elements: one complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities
G2214	Initial or subsequent psychiatric collaborative care management, first 30 minutes in a 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. (*Effective for dates of service 1/1/2021 and following.)
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 (*Accepted for processing for dates of service 1/1/2022 & following.)
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 Description & Definition
Modifier 59	**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. **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.
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." [2]

"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)." [3]

"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." [4]

"Some psychiatric patients receive a medical evaluation and management (E/M) service on the same day as a psychotherapy service by the same physician or other qualified health care professional. To report both E/M and psychotherapy, the two services must be significant and separately identifiable. These services are reported by using codes specific for psychotherapy when performed with evaluation and management services (90833, 90836, 90838) as add-on codes to the evaluation and management service.

Medical symptoms and disorders inform treatment choices of 22psychotherapeutic interventions, and data from therapeutic communication are used to evaluate the presence, type, and severity of medical symptoms and disorders. For the purposes of reporting, the medial and psychotherapeutic components of the service may be separately identified as follows:

1. The type and level of E/M service is selected based on medical decision making.

2. Time spent on the activities of the E/M service is not included in the time used for reporting the psychotherapy service. Time may not be used as the basis of E/M code selection and prolonged services may not be reported when psychotherapy with E/M (90833, 90836, 90838) are reported.
3. A separate diagnosis is not required for the reporting of E/M and psychotherapy on the same date of service." [8]

"Questions and Answers: Evaluation and Management (E/M): E/M Services Guidelines
Medicine: Psychiatry

Question: What is the current guidance for reporting E/M services with psychotherapy codes 90833, 90836, and 90838? Per CPT coding conventions, time is not an allowable component for E/M code selection in this situation because psychotherapy services are time-based codes. Both services cannot be assigned based on time. However, the psychotherapy subsection guidelines do not reflect the 2021 changes to the criteria for E/M office visit code selection (medical decision making [MDM] or time). If health care professionals follow the 2021 guidelines for level selection for E/M services, they must use MDM to assign the E/M level of service. If they are allowed to follow the CMS 1995/1997 Documentation Guidelines for Evaluation and Management Services, they may use history, examination, and MDM. What is the correct criterion to use for E/M code selection?

Answer: MDM is the correct criterion for E/M level selection when E/M services are performed in conjunction with psychotherapy codes 90833, Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure), 90836, Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure), and 90838, Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure). Note that the instructions in the code descriptors for all these codes were reviewed by the CPT Editorial Panel at the February 2022 CPT Editorial Panel Meeting. Therefore, updates to the referenced language, if approved, will be included in the CPT 2023 code set." [9]

"Because psychiatric problems are recognized as common and disabling health conditions that could benefit from collaborative care management services, the Centers for Medicare & Medicaid Services (CMS) and the American Psychiatric Association (APA) worked together to develop coding structures that could facilitate the appropriate valuation of these psychiatric collaborative care management services for different patient populations. As a result, three CPT codes (99492, 99493, 99494) have been developed for the general population, and three Healthcare Common Procedural Coding System (HCPCS) codes (00502, 00503, 00504) have been created specifically for the Medicare population to report the monthly services furnished using the psychiatric collaborative care model (CoCM). The CMS psychiatric CoCM is defined as evidence-based psychiatric services that ensure patients seen in primary care settings, who are diagnosed with a mental health or substance use disorder have access to psychiatric services through their primary care provider, including access to nonface-to-face psychiatric consultation and collaborative psychiatric care management.

The services represented by the O-codes are almost identical to the services reported by the CPT codes, however, they have been created specifically for Medicare payment purposes. The goal of CoCM is to enhance routine primary care by adding the components of care management support for patients receiving behavioral health treatment, and regular psychiatric inter-specialty consultation to the primary care team, particularly for patients whose conditions may not be improving." [11]

"These [Psychiatric Collaborative Care Management] services are reported by the treating physician or other qualified health care professional and include the services of the treating physician or other qualified health care professional, the behavioral health care manager (see definition below), and the psychiatric consultant (see definition below), who has contracted directly with the treating physician or other qualified health care professional to provide consultation." [12]

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.

D. "2021 & 2023 Updates to Evaluation and Management (E/M) Visits and Prolonged Services." Moda Health Reimbursement Policy Manual, RPM076.

E. "Scope Of License For Evaluation & Management Codes." Moda Health Reimbursement Policy Manual, RPM080.

F. "Evaluation and Management (E/M) Services With Psychotherapy Services." Moda Health Reimbursement Policy Manual, RPM081.

References & Resources

1. American Medical Association (AMA). "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.
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14. CMS. "Behavioral Health Integration Services." Medicare Learning Network. MLN909432. Last updated May 2023; Last accessed August 23, 2023.
15. CMS. "Frequently Asked Questions about Billing Medicare for Behavioral Health Integration (BHI) Services." Last updated April 17, 2018; Last accessed August 23, 2023. https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/downloads/behavioral-health-integration-faqs.pdf .
16. CMS. "Requirements for a Provider Direct Mailing and Education & Outreach for Behavioral Health Initiatives." CMS Transmittal 12285. Last updated October 5, 2023; Last accessed November 3, 2023.
17. Oregon Health Authority. "Behavioral Health Peer-Delivered Services Fee-for-Service (Open Card) Billing Guide." Last updated June 2024; Last accessed August 2, 2024. https://www.oregon.gov/oha/HSD/OHP/Tools/Peer-Support-Billing-Guide.pdf .
18. Oregon Health Authority. "Behavioral Health Fee Schedule, July 2024." Last updated July 1, 2024. Last accessed August 6, 2024. https://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/bh-fee-schedule-0724.xlsx.

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." HB 3091 made amendments to ORS 743A.168 which were effective 1/1/2018.

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.

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to 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] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
8/14/2024	Updated procedure code lists/tables based on updated OHA behavioral health fee schedule & billing guide. Updated Acronyms, Cross References, and References & Resources. Formatting updates. No policy changes.
11/8/2023	G0323 added as valid for licensed behavioral health professionals. Clarified major types of BHI care models for context. Acronyms & References updated.
8/15/2023	Updated for 2023 E/M coding updates, no psychotherapy services prolonged services codes. Updated References & Resources. Formatting updated. No policy changes.
8/9/2023	Clarified conversations/consultations between therapist and PCP. Updated procedure codes, Coding Guidelines, and References & Resources.
6/14/2023	Clarified E/M services with psychotherapy. Updated Coding Guidelines and References & resources.
4/12/2023	Clarified E/M coding based on time versus MDM. Updated Cross References. Formatting updated. No policy changes.

Date	Summary of Update
10/12/2022	Idaho added to policy scope; not subject to 28 TAC. Formatting & Acronym table updated.
5/11/2022	Alaska & Texas added to policy scope. Policy change for H0038. Clarified status of 99495, 99496, and H2023. Updated code lists. Formatting updates.
8/10/2018	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
1/1/2018	Original Effective Date. Policy based on Oregon 2017 HB3091 changes to ORS 743A.168. Also OAR 836-053-1403.