

Description of the Initial Clinical Evaluation & Outpatient Authorization

The Division of MH/DD/SAS eliminated the behavioral health screening code (H0002), effective July 1, 2004. We appealed that decision but their decision was affirmed. Since the Diagnostic Assessment service definition, which was to be implemented July 1, has been delayed for at least a year, we are left with less flexibility. This document describes the new process for the initial assessment/authorization, which will be effective October 1, 2004.

All new consumers will be screened by the Western Highlands Network (WHN) Access Department. Consumers will be referred to a provider of their choice for an evaluation. The Access Department will directly authorize a maximum of 8 sessions for the provider to complete the evaluation and person-centered plan, as well as commence outpatient treatment as appropriate: 8 events of 90800 and 32 units of H0000. **Providers should use either the 90800 package or the H0000 package, depending on whether the staff member delivering the services may bill CPT codes**, which require professional licensure. If the staff member is eligible to deliver CPT code services, then the 90800 package must be used. Both packages should not be used, unless a mixture of staff (CPT code-eligible and non-CPT code-eligible) deliver the initial service. In these cases, the number of sessions for H0000 and 90800 should not exceed 8. After this initial package of services is used, additional services must be authorized through the WHN Services Management Department.

The initial authorization (as well as all authorizations) carries the contingency that consumers must have an IPRS target population which is valid for the service provided and billed for. If a consumer does not meet an IPRS Target Population, providers may bill for the evaluation using H0031 or H0001. 90801 should NOT be used.

Note: **Medicaid eligible consumers** do not require a valid target population which funds a particular service; Medicaid is an entitlement and as long as the medical necessity criteria are met for the service, the consumer does not have to meet a target population. The IPRS form still must be submitted.

A case is to be opened on the first contact, using either the 90801 code (Clinical Evaluation) or H0031 code (Mental Health Assessment). Only one event/session should be used; 90801 can be used a second time for the physician (psychiatric) evaluation (It may be on the same day as the psychosocial assessment.) The following elements are required to complete the case opening:

1. Assessment, with diagnosis (A concise assessment is permissible; the data elements in the Service Records Manual, however, must be present. If the assessment cannot be fully completed in the initial interview, it may be completed in a follow-up treatment session.)
2. Demographics
3. IPRS (requires the completion of the functional assessment: GAF, CAFAS, ASAM, SNAP)
4. PCP (At least a minimal plan must be completed; it may specify the need for additional evaluation.)

A case must be open and a plan completed in order for therapy services in the 90800/H0000 packages to be billed.

Note: H0002 authorizations issued prior to October 1 will be honored until their expiration (end) date.

Service Code	Service	Unit of Service	Amount of service authorized	Duration (time-frame that service can be provided in)
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90800 (authorization code only)	<u>Outpatient Services (CPT Code Billable)</u> These services will be authorized as a bundled service. Providers should bill the specific service code; the authorization will cover all the services denoted below which are billed under the specific service code.	event	8 events	90 days
90801 (billing code only)	Clinical Evaluation	event	1 event for psychosocial evaluation (for case opening event); 1 event for psychiatric evaluation if applicable	
90804 (billing code only)	Individual therapy 20-30 min.	event		
90805 (billing code only)	Individual therapy with medical evaluation and management services 20-30 min.	event	MD only	
90810 (billing code only)	Interactive individual therapy 20-30 min.	event	Non-verbal communication	
90806 (billing code only)	Individual therapy 45-50 min.	event		
90807 (billing code only)	Individual therapy with medical evaluation and management services 45-50 min.		MD only	
90812 (billing code only)	Interactive individual therapy 45-50 min.	event	Non-verbal communication	
90808 (billing code only)	Individual therapy 75+ min.	event		
90809 (billing code only)	Individual therapy with medical evaluation and management services 75+ min.		MD only	
90814 (billing code only)	Interactive individual therapy 75+ min.	event	Non-verbal communication	
90846 (billing code only)	Family therapy w/out patient	event		
90847 (billing code only)	Family therapy w/ patient	event		
90849 (billing code only)	Multi-family Group Therapy	event		
90853 (billing code only)	Group therapy	event		

Service Code	Service	Unit of Service	Amount of service authorized	Duration (time-frame that service can be provided in)
H0000 (authorization code only)	<u>Outpatient Services (Non-CPT Code Billable)</u> These services will be authorized as a bundled service. Providers should bill the specific service code; the authorization will cover all the services denoted below which are billed under the specific service code.	:15	32 units (in maximum of 8 sessions)	90 days
H0001 (billing code only)	Behavioral Health Assessment		To be used for drug/alcohol evaluations	
H0031 (billing code only)	Mental Health Assessment			
H0004 (billing code only)	Behavioral Health Counseling & Therapy			
H0004HQ (billing code only)	Group Therapy			
H0004HR (billing code only)	Family Therapy with Client			
H0004HS (billing code only)	Family Therapy w/out Client			

We received a memorandum from the Division of Medical Assistance on August 27, 2004 with new instructions for counting sessions. It is effective immediately. We cite it verbatim:

“In the 8 unmanaged visits the following codes are counted as ½ visit: 90846, 90847, 90849, 90853, 90857, H0004HQ, H0004HR, H0004HS and H0005.”

“Once the 8 visits have been used and prior approval is required, the following guidelines need to be followed: CPT codes 90846, 90847, 90849, 90853 and 90857 are counted as one unit and prior approval should be requested on that basis. H0004 with the above modifiers and H0005 are 15 minute units, therefore when requesting prior approval you need to request units accordingly. This will mean projecting the length of the visit, the number of visits and combing that information to request an adequate number of units. ValueOptions is adding a line to their OTR to accommodate this.”

The ½ visit is only applicable to adults. As a point of clarification, H0005 is a redundant code. It is not in the H0000 outpatient package. All non-CPT code-eligible providers, including substance abuse providers, should use H004HQ for group therapy.