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ATTENTION: ALTERNATIVE BILLING CONCEPTS (ABC) CODES FOR BEHAVIORAL HEALTH SERVICES TO END AS OF 12/31/2009

Alaska Medical Assistance will transition from use of Alternative Billing Concepts (ABC) procedure codes. Revising the Behavioral Health billing codes from ABC codes to national standard codes has been a goal of the department for some time. This change will minimize problems providers encounter when billing other third parties or when programming systems to national standards. Because service limits are specified in calendar year limits, changing the code set at the beginning of the year should improve the providers' ability to manage PA requests and track service limit usage. Due to the delay in implementing the new MMIS, the department has recently determined that Affiliated Computer Services, Inc. (ACS) could proceed with implementing the changes in the current system at this time.

Effective with dates of service on and after January 1, 2010, claims and prior authorization requests for services rendered in 2010 must be reported using national standard codes.

The "old" ABC codes can only be used for billing claims for services rendered **on or before** December 31, 2009. The "new" national codes must be used for billing claims for services rendered **on or after** January 1, 2010.

The "new" prior authorization (PA) request form will be required for services provided on or after January 1, 2010 that exceed program service limits. ACS will assist providers with cross-walking the old ABC codes to the new national codes for any 2010 PA requests received on the old PA request form and received by ACS on or before December 15, 2009.

The enclosed packet contains the following information:

- A cover letter
- A crosswalk comparing the old ABC codes and the new national replacement codes
- A list of questions and answers for your reference regarding this code set transition effort
- New Prior Authorization (PA) request forms containing the new national codes
 - NOTE: These forms can be completed and saved using computer word processing software.

For your convenience, the enclosed crosswalk includes all the services covered by the Medicaid program for your provider type, whether the codes and descriptions have changed or not. These crosswalks replace the applicable procedure code tables in Section I of billing manuals for affected provider types as follows:

- Tables I-4 and I-5 for community mental health clinic providers
- Table I-7 for substance abuse providers
- Tables I-4 and I-5 for mental health physician clinic providers

Please contact the ACS Provider Inquiry Unit at (907) 644-6800 or (800) 770-5650 (toll-free in Alaska) if you need additional clarification regarding the information provided in this flyer, or have general inquiries regarding the Alaska Medicaid Program. Provider Inquiry staff is available to assist you Monday – Friday, 8:00 a.m. – 5:00 p.m.

QUESTIONS AND ANSWERS FOR BEHAVIORAL HEALTH PROVIDERS

Affiliated Computer Services (ACS), in conjunction with the Department of Health and Social Services, has developed these questions and answers to assist providers in filing claims and prior authorization requests with Alaska Medical Assistance. It is hoped that this information will be useful to providers as they transition from the use of current Alternative Billing Concepts (ABC) codes to national codes.

Question: Why is this change being implemented now?

Answer: Revising the Behavioral Health billing codes from ABC codes to national standard codes has been a goal of the department for some time. This change will minimize problems providers encounter when billing other third parties or when programming systems to national standards. Because service limits are specified in calendar year limits, changing the code set at the beginning of a calendar year should improve providers' ability to manage prior authorization requests and track service usage and limits. Due to the delay in implementing the new Medicaid Management Information System (MMIS), the department has recently determined that ACS could proceed with implementing the changes in the current system at this time.

Question: How are these behavioral health code cross-walks used?

Answer: The code crosswalks correlate the ABC codes with replacement national codes. Providers will continue to bill using ABC codes for dates of service on or before December 31, 2009 and will use the replacement national code for services provided on or after January 1, 2010.

Question: Which national code sources were used to choose the replacement codes for the alternative billing codes that are reflected in the crosswalks?

Answer: Replacement codes were chosen from comparable services included within the national coding systems: the American Medical Association's Current Procedural Terminology (CPT) and the Healthcare Common Procedure Coding System (HCPCS).

Question: Is there a "one-to-one" correlation between the ABC codes and the replacement national code?

Answer: Not always. Double-check the code and description columns of the new replacement national codes for accuracy when filing your claim. Some new national codes require the use of modifiers to describe the services.

Question: Have the time increments associated with the services changed?

Answer: For a few services, the time increment for the national replacement code is different. Ensure that you bill the correct number of units to identify the quantity of services actually rendered. Note that the time increment associated with family and group psychotherapy coded using codes 90847, 90849 and/or 90853 without a procedure code modifier has changed. When these codes are billed without modifiers for billing services rendered before 12/31/2009, the unit of time is 30 minutes; however, the time increment associated with these unmodified codes as of January 1, 2010 will be one hour. Providers will need to pay special attention to ensure the appropriate codes and/or modifiers are billed as well as the appropriate number of units of service when billing codes 90847, 90849, and 90853.

Question: Will the modifiers "1M" and "1H" change when the alternative billing codes change?

Answer: Modifiers "1M" and "1H" will no longer be valid modifiers. The new modifiers that will be used by Alaska Medical Assistance are "U6" to indicate a quarter hour unit (15 minutes) and "U7" to indicate a half hour unit (30 minutes). In addition, the modifiers HR (representing family/couple) and HQ (representing group) will also be accepted.

Question: Have the service limitations and prior authorization requirements changed?

Answer: No, the service limitations and prior authorization requirements have not changed. Please ensure that prior authorization requests include the correct number of units and the correct codes on the appropriate prior authorization request form. Double-check the date of service, the old and new code descriptions, and the time increments associated with them. Also, please remember that prior authorization units must be requested and entered into the MMIS in the lowest time unit increment possible so in some cases, every procedure code/modifier combination will not be present on the PA request form but every procedure code/modifier combination can be used for billing claims.

Question: Will Third Party Liability (TPL) Avoidance for mental health rehabilitation services be continued for the new codes?

Answer: Yes, it is understood that most other insurance carriers do not cover mental health rehabilitation services, therefore, the Alaska MMIS will continue to ensure that editing related to billing third party insurance will be bypassed for all claim lines for which a mental health rehabilitation service is billed--whether the service is billed using ABC codes in calendar year 2009 or new national standard codes in calendar year 2010.

COMMUNITY MENTAL HEALTH CLINIC CROSSWALK

Table I-4(a). CPT¹ Procedure Codes: Children's Clinic Services/Community Mental Health Clinic (Replaces Table I-4(a). CPT Procedure Codes: Children's Clinic Services/Community Mental Health Clinic)							
Procedure Code for DOS thru 12/31/09	Modifier thru 12/31/09	Procedure Code Description for Coded Service	Reimbursement Rate for Coded Service	Procedure Code Effective 01/01/10	Modifier Effective 01/01/10	Procedure Code Description for Coded Service	Reimbursement Rate for Coded Service
90801	none	Psy dx interview <i>[Psychiatric assessment]</i>	\$230.00/Assessment (1 Unit = 1 Assessment)	90801	none	Psy dx interview <i>[Psychiatric assessment]</i>	\$230.00/Assessment (1 Unit = 1 Assessment)
90802	none	Intac psy dx interview <i>[Psychiatric assessment]</i>	\$230.00/Assessment (1 Unit = 1 Assessment)	90802	none	Intac psy dx interview <i>[Psychiatric assessment]</i>	\$230.00/Assessment (1 Unit = 1 Assessment)
90804	none	Psytx, office, 20-30 min	\$50.00/30 Minutes (1 Unit = 30 Minutes)	90804	none	Psytx, office, 20-30 min	\$50.00/30 Minutes (1 Unit = 30 Minutes)
				90806	none		\$100.00/One Hour (1 Unit = 1 Hour)
90810	none	Intac psytx, off, 20-30 min	\$50.00/30 Minutes (1 Unit = 30 Minutes)	90810	none	Intac psytx, off, 20-30 min	\$50.00/30 Minutes (1 Unit = 30 Minutes)
				90812	none		\$100.00/One Hour (1 Unit = 1 Hour)
90847	none	Family psytx w/patient	\$55.00/30 Minutes (1 Unit = 30 Minutes)	90847	none	Family psytx w/patient	\$110.00/One Hour (1 Unit = 1 Hour)
				90847	U7 (30 minute modifier)		\$55.00/30 Minutes (1 Unit = 30 Minutes)

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**Table I-4(a). CPT¹ Procedure Codes: Children's Clinic Services/Community Mental Health Clinic
(Replaces Table I-4(a). CPT Procedure Codes: Children's Clinic Services/Community Mental Health Clinic)**

Procedure Code for DOS thru 12/31/09	Modifier thru 12/31/09	Procedure Code Description for Coded Service	Reimbursement Rate for Coded Service	Procedure Code Effective 01/01/10	Modifier Effective 01/01/10	Procedure Code Description for Coded Service	Reimbursement Rate for Coded Service
90849	none	Multiple-family group psytx	\$28.00/30 Minutes (1 Unit = 30 Minutes)	90849	none	Multiple-family group psytx	\$56.00/One Hour (1 Unit = 1 Hour)
				90849	U7 (30-minute modifier)		\$28.00/30 Minutes (1 Unit = 30 Minutes)
90853	none	Group psychotherapy	\$28.00/30 Minutes (1 Unit = 30 Minutes)	90853	none	Group psychotherapy	\$56.00/One Hour (1 Unit = 1 Hour)
				90853	U7 (30-minute modifier)		\$28.00/30 Minutes (1 Unit = 30 Minutes)
90862	none	Medication management	\$75.00/Visit (1 Unit = 1 Visit)	90862	none	Medication management	\$75.00/Visit (1 Unit = 1 Visit)

- Psychiatric assessment (90801, 90802): Combined maximum of four assessments per calendar year
- Individual, Group, and Family Psychotherapy: Combined limit of 10 hours per calendar year
- Medication Management: No more than one visit per week during the initial month following entry to a program, then no more than one visit per month unless unusual reaction or more frequent monitoring is required.
- Psychological Testing and Evaluation: Maximum six hours per calendar year
- Neuropsychological Testing and Evaluation: Maximum 12 hours per calendar year
- Psychological Testing and Evaluation: Maximum six hours per calendar year
- Neuropsychological Testing and Evaluation: Maximum 12 hours per calendar year

Note: For complete definitions and guidelines for the above services, please refer to 2009/2010 American Medical Association's Current Procedural Terminology, Healthcare Common Procedure Coding System (HCPCS) and the ABC Coding Manual for Integrative Health care, as well as Alaska Medical Assistance regulations and provider billing manual. Complete service descriptions are also available at <http://www.hipaa.samhsa.gov/hipaacodes2.htm>.

COMMUNITY MENTAL HEALTH CLINIC CROSSWALK

Table I-4(b). Children's Community Mental Health Clinic Services (Replaces Table I-4(b). HCPCS and ABC ¹ Procedure Codes: Children's Clinic Services/Community Mental Health Clinic)							
Procedure Code for DOS thru 12/31/09	Modifier thru 12/31/09	Procedure Code Description for Coded Service	Reimbursement Rate for Coded Service	Procedure Code Effective 01/01/10	Modifier Effective 01/01/10	Procedure Code Description for Coded Service	Reimbursement Rate for Coded Service
H0031	none	Mental health assessment, by non-physician <i>[Intake assessment]</i>	\$24.00/15 Minutes (1 Unit = 15 Minutes)	H0031	none	Mental health assessment, by non-physician <i>[Intake assessment]</i>	\$24.00/15 Minutes (1 Unit = 15 Minutes)
S9484	none	Crisis intervention mental health services, per hour	\$92.00/One Hour (1 Unit = 1 Hour)	S9484	none	Crisis intervention mental health services, per hour	\$92.00/One Hour (1 Unit = 1 Hour)
CDBAQ	none	Psychological testing comprehensive assessment, each 15 minutes	\$25.00/15 Minutes (1 Unit = 15 Minutes)	96101	none	Psycho testing by psych/phys	\$100.00/One Hour (1 Unit = 1 Hour)
				96101	U6 (15-minute modifier)		\$25.00/15 Minutes (1 Unit = 15 Minutes)
CDBAS	none	Neuropsychological testing, each 15 minutes	\$25.00/15 Minutes (1 Unit = 15 Minutes)	96118		Neuropsych tst by psych/phys	\$100.00/One Hour (1 Unit = 1 Hour)
				96118	U6 (15-minute modifier)		\$25.00/15 Minutes (1 Unit = 15 Minutes)

- Intake Assessment: Initial intake assessment – three hours per admission. Semiannual intake assessment – one hour, two times per year, per admission. Requires prior authorization to assess for medical necessity if exceeds five hours annually
- Crisis Intervention: Maximum of two hours per day for no more than 72 hours per psychiatric emergency; maximum 22 hours per calendar year
- Psychological Testing and Evaluation: Maximum six hours per calendar year
- Neuropsychological Testing and Evaluation: Maximum 12 hours per calendar year

Note: For complete definitions and guidelines for the above services, please refer to *2009/2010 American Medical Association's Current Procedural Terminology, Healthcare Common Procedure Coding System (HCPCS) and the ABC Coding Manual for Integrative Health care*, as well as Alaska Medical Assistance regulations and provider billing manual. Complete service descriptions are also available at <http://www.hipaa.samhsa.gov/hipaacodes2.htm>.

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COMMUNITY MENTAL HEALTH CLINIC CROSSWALK

Table I-4(c). Children's Rehabilitation Services/Community Mental Health Clinic (Replaces Table I-4(c). HCPCS and ABC¹ Procedure Codes: Children's Rehabilitation Services/Community Mental Health Clinic							
Procedure Code for DOS thru 12/31/09	Modifier thru 12/31/09	Procedure Code Description for Coded Service	Reimbursement Rate for Coded Service	Procedure Code Effective 01/01/10	Modifier Effective 01/01/10	Procedure Code Description for Coded Service	Reimbursement Rate for Coded Service
H0018	none	Behavioral health; short term residential (non-hospital residential treatment program) without room and board; per diem), [Daily Behavioral Health residential rehabilitation]	\$171.00/Day (1 Unit = 1 Day)	H0018	none	Behavioral health; short term residential (non-hospital residential treatment program) without room and board; per diem), [Daily Behavioral Health residential rehabilitation]	\$171.00/Day (1 Unit = 1 Day)
H0033	none	Oral medication administration direct observation [on premises]	\$20.00/Day (1 Unit = 1 Day)	H0033	none	Oral medication administration direct observation [on premises]	\$20.00/Day (1 Unit = 1 Day)
H0033	HK	Oral medication administration direct observation [off premises]	\$30.00 Day (1 Unit = 1 Day)	H0033	HK	Oral medication administration direct observation [off premises]	\$30.00 Day (1 Unit = 1 Day)
T1016	none	Case management, each 15 minutes	\$16.00/15 Minutes (1 Unit = 15 Minutes)	T1016	none	Case management, each 15 minutes	\$16.00/15 Minutes (1 Unit = 15 Minutes)
CDABF	none	Family-involvement training family, each 15 minutes [Family skill development for clients under the age of 21 years]	\$17.00/15 Minutes (1 Unit = 15 Minutes)	H2014	HR (Family/ couple with client present)	Skills training and development, per 15 minutes [Family skill development for clients under the age of 21 years]	\$17.00/15 Minutes (1 Unit = 15 Minutes)
CDAEP	none	Social skills assistance individual, each 15 minutes [Individual skill development]	\$17.00/15 Minutes (1 Unit = 15 Minutes)	H2014	none	Skills training and development, per 15 minutes [Individual skill development]	\$17.00/15 Minutes (1 Unit = 15 Minutes)

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Table I-4(c). Children's Rehabilitation Services/Community Mental Health Clinic
(Replaces Table I-4(c). HCPCS and ABC¹ Procedure Codes: Children's Rehabilitation Services/Community Mental Health Clinic)

Procedure Code for DOS thru 12/31/09	Modifier thru 12/31/09	Procedure Code Description for Coded Service	Reimbursement Rate for Coded Service	Procedure Code Effective 01/01/10	Modifier Effective 01/01/10	Procedure Code Description for Coded Service	Reimbursement Rate for Coded Service
CDAKQ	none	Social skills assistance, group, each 15 minutes <i>[Group skill development]</i>	\$9.00/15 Minutes (1 Unit = 15 Minutes)	H2014	HQ (Group setting)	Skills training and development, per 15 minutes <i>[Group skill development]</i>	\$9.00/15 Minutes (1 Unit = 15 Minutes)
CDACM	none	Coping skills development assistance, individual, each 15 minutes <i>[Recipient support services]</i>	\$8.75/15 Minutes (1 Unit = 15 Minutes)	H2017	none	Psychosocial rehabilitation services, per 15 minutes <i>[Recipient support services]</i>	\$8.75/15 Minutes (1 Unit = 15 Minutes)
CDBAP	none	Psychological testing comprehensive assessment, each 15 minutes <i>[Functional assessment]</i>	\$17.00/15 Minutes (1 Unit = 15 Minutes)	H2000	U6 (15-minute modifier)	Comprehensive multidisciplinary evaluation <i>[Functional assessment]</i>	\$17.00/15 Minutes (1 Unit = 15 Minutes)

- Medication Administration: To be billed, medication administration must be rendered at least once on a given date and may be rendered multiple times during that day. Reimbursement is based on a daily rate code.
- Case Management: Maximum of 180 hours per calendar year
- Skill Development: **Family** Skill Development—maximum 180 hours per calendar year; **Individual** Skill Development—maximum 100 hours per calendar year; **Group** Skill Development—maximum 140 hours per calendar year
- Recipient Support Services: Maximum of sixteen 15-minute units, 4 hours per day, 1460 hours per calendar year
- Functional Assessment: Maximum six hours per calendar year. **Initial** functional assessment: four hours. **Semiannual** functional assessment: one hour, two times per year.

Note: For complete definitions and guidelines for the above services, please refer to *2009/2010 American Medical Association's Current Procedural Terminology, Healthcare Common Procedure Coding System (HCPCS) and the ABC Coding Manual for Integrative Health care*, as well as Alaska Medical Assistance regulations and provider billing manual. Complete service descriptions are also available at <http://www.hipaa.samhsa.gov/hipaacodes2.htm>.

COMMUNITY MENTAL HEALTH CLINIC CROSSWALK

Table I-5(a). CPT¹ Procedure Codes: Adult's Clinic Services/Community Mental Health Clinic (Replaces Table I-5(a). CPT Procedure Codes: Adult's Clinic Services/Community Mental Health Clinic)							
Current Procedure Code for DOS thru 12/31/09	Current Modifier thru 12/31/09	Procedure Code Description for Coded Service	Reimbursement Rate for Coded Service	Procedure Code Effective 01/01/10	Modifier Effective 01/01/10	Procedure Code Description for Coded Service	Reimbursement Rate for Coded Service
90801	none	Psy dx interview <i>[Psychiatric assessment]</i>	\$230.00/Assessment (1 Unit = 1 Assessment)	90801	none	Psy dx interview <i>[Psychiatric assessment]</i>	\$230.00/Assessment (1 Unit = 1 Assessment)
90802	none	Intac psy dx interview <i>[Psychiatric assessment]</i>	\$230.00/Assessment (1 Unit = 1 Assessment)	90802	none	Intac psy dx interview <i>[Psychiatric assessment]</i>	\$230.00/Assessment (1 Unit = 1 Assessment)
90804	none	Psytx, office, 20-30 min	\$50.00/30 Minutes (1 Unit = 30 Minutes)	90804	none	Psytx, office, 20-30 min	\$50.00/30 Minutes (1 Unit = 30 Minutes)
				90806	none		\$100.00/One Hour (1 Unit = 1 Hour)
90847	none	Family psytx w/patient	\$55.00/30 Minutes (1 Unit = 30 Minutes)	90847	none	Family psytx w/patient	\$110.00/One Hour (1 Unit = 1 Hour)
				90847	U7 (30-minute modifier)		\$55.00/30 Minutes (1 Unit = 30 Minutes)
90849	none	Multiple-family group psytx	\$28.00/30 Minutes (1 Unit = 30 Minutes)	90849	none	Multiple-family group psytx	\$56.00/One Hour (1 Unit = 1 Hour)
				90849	U7 (30-minute modifier)		\$28.00/30 Minutes (1 Unit = 30 Minutes)

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**Table I-5(a). CPT¹ Procedure Codes: Adult's Clinic Services/Community Mental Health Clinic
(Replaces Table I-5(a). CPT Procedure Codes: Adult's Clinic Services/Community Mental Health Clinic)**

Current Procedure Code for DOS thru 12/31/09	Current Modifier thru 12/31/09	Procedure Code Description for Coded Service	Reimbursement Rate for Coded Service	Procedure Code Effective 01/01/10	Modifier Effective 01/01/10	Procedure Code Description for Coded Service	Reimbursement Rate for Coded Service
90853	none	Group psychotherapy	\$28.00/30 Minutes (1 Unit = 30 Minutes)	90853	none	Group psychotherapy	\$56.00/One Hour (1 Unit = 1 Hour)
				90853	U7 (30-minute modifier)		\$28.00/30 Minutes (1 Unit = 30 Minutes)
90862	none	Medication management	\$75.00/Visit (1 Unit = 1 Visit)	90862	none	Medication management	\$75.00/Visit (1 Unit = 1 Visit)

- Psychiatric assessment (90801, 90802): Combined maximum of four assessments per calendar year
- Individual, Group, and Family Psychotherapy: Combined limit of 10 hours per calendar year
- Medication Management: No more than one visit per week during the initial month following entry to a program, then no more than one visit per month unless unusual reaction or more frequent monitoring is required.
- Psychological Testing and Evaluation: Maximum six hours per calendar year
- Neuropsychological Testing and Evaluation: Maximum 12 hours per calendar year

Note: For complete definitions and guidelines for the above services, please refer to *2009/2010 American Medical Association's Current Procedural Terminology, Healthcare Common Procedure Coding System (HCPCS) and the ABC Coding Manual for Integrative Health care*, as well as Alaska Medical Assistance regulations and provider billing manual. Complete service descriptions are also available at <http://www.hipaa.samhsa.gov/hipaacodes2.htm>.

COMMUNITY MENTAL HEALTH CLINIC CROSSWALK

Table I-5(b). Adult's Community Mental Health Clinic Services

(Replaces Table I-5(b). HCPCS and ABC¹ Procedure Codes: Adult's Clinic Services/Community Mental Health Clinic)

Procedure Code for DOS thru 12/31/09	Modifier thru 12/31/09	Procedure Code Description for Coded Service	Reimbursement Rate for Coded Service	Procedure Code Effective 01/01/10	Modifier Effective 01/01/10	Procedure Code Description for Coded Service	Reimbursement Rate for Coded Service
H0031	none	Mental health assessment, by non-physician <i>[Intake assessment]</i>	\$24.00/15 Minutes (1 Unit = 15 Minutes)	H0031	none	Mental health assessment, by non-physician <i>[Intake assessment]</i>	\$24.00/15 Minutes (1 Unit = 15 Minutes)
S9484	none	Crisis intervention mental health services, per hour	\$92.00/One Hour (1 Unit = 1 Hour)	S9484	none	Crisis intervention mental health services, per hour	\$92.00/One Hour (1 Unit = 1 Hour)
CDBAQ	none	Psychological testing comprehensive assessment, each 15 minutes	\$25.00/15 Minutes (1 Unit = 15 Minutes)	96101	none	Psycho testing by psych/phys	\$100.00/One Hour (1 Unit = 1 Hour)
				96101	U6 (15-minute modifier)		\$25.00/15 Minutes (1 Unit = 15 Minutes)
CDBAS	none	Neuropsychological testing, each 15 minutes	\$25.00/15 Minutes (1 Unit = 15 Minutes)	96118		Neuropsych testing by psych/phys	\$100.00/One Hour (1 Unit = 1 Hour)
				96118	U6 (15-minute modifier)		\$25.00/15 Minutes (1 Unit = 15 Minutes)

- Intake Assessment: Initial intake assessment – three hours per admission. Semiannual intake assessment – one hour, two times per year, per admission. Requires prior authorization to assess for medical necessity if exceeds five hours annually
- Crisis Intervention: Maximum of two hours per day for no more than 72 hours per psychiatric emergency; maximum 22 hours per calendar year
- Psychological Testing and Evaluation: Maximum six hours per calendar year
- Neuropsychological Testing and Evaluation: Maximum 12 hours per calendar year

Note: For complete definitions and guidelines for the above services, please refer to *2009/2010 American Medical Association's Current Procedural Terminology, Healthcare Common Procedure Coding System (HCPCS) and the ABC Coding Manual for Integrative Health care*, as well as Alaska Medical Assistance regulations and provider billing manual. Complete service descriptions are also available at <http://www.hipaa.samhsa.gov/hipaacodes2.htm>.

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COMMUNITY MENTAL HEALTH CLINIC CROSSWALK

Table I-5(c). Adult's Rehabilitation Services/Community Mental Health Clinic (Replaces Table I-5(c). HCPCS and ABC¹ Procedure Codes: Adult's Rehabilitation Services/Community Mental Health Clinic)							
Procedure Code for DOS thru 12/31/09	Modifier thru 12/31/09	Procedure Code Description for Coded Service	Reimbursement Rate for Coded Service	Procedure Code Effective 01/01/10	Modifier Effective 01/01/10	Procedure Code Description for Coded Service	Reimbursement Rate for Coded Service
H0033	none	Oral medication administration direct observation [<i>on premises</i>]	\$20.00/Day (1 Unit = 1 Day)	H0033	none	Oral medication administration direct observation [<i>on premises</i>]	\$20.00/Day (1 Unit = 1 Day)
H0033	HK	Oral medication administration direct observation [<i>off premises</i>]	\$30.00 Day (1 Unit = 1 Day)	H0033	HK	Oral medication administration direct observation [<i>off premises</i>]	\$30.00 Day (1 Unit = 1 Day)
T1016	none	Case management, each 15 minutes	\$16.00/15 Minutes (1 Unit = 15 Minutes)	T1016	none	Case management, each 15 minutes	\$16.00/15 Minutes (1 Unit = 15 Minutes)
CDAEP	none	Social skills assistance individual, each 15 minutes [<i>Individual skill development</i>]	\$17.00/15 Minutes (1 Unit = 15 Minutes)	H2014	none	Skills training and development, per 15 minutes [<i>Individual skill development</i>]	\$17.00/15 Minutes (1 Unit = 15 Minutes)
CDAKQ	none	Social skills assistance, group, each 15 minutes [<i>Group skill development</i>]	\$9.00/15 Minutes (1 Unit = 15 Minutes)	H2014	HQ (Group setting)	Skills training and development, per 15 minutes [<i>Group skill development</i>]	\$9.00/15 Minutes (1 Unit = 15 Minutes)
CDACM	none	Coping skills development assistance, individual, each 15 minutes [<i>Recipient support services</i>]	\$8.75/15 Minutes (1 Unit = 15 Minutes)	H2017	none	Psychosocial rehabilitation services, per 15 minutes [<i>Recipient support services</i>]	\$8.75/15 Minutes (1 Unit = 15 Minutes)

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Table I-5(c). Adult's Rehabilitation Services/Community Mental Health Clinic

(Replaces Table I-5(c). HCPCS and ABC¹ Procedure Codes: Adult's Rehabilitation Services/Community Mental Health Clinic)

Procedure Code for DOS thru 12/31/09	Modifier thru 12/31/09	Procedure Code Description for Coded Service	Reimbursement Rate for Coded Service	Procedure Code Effective 01/01/10	Modifier Effective 01/01/10	Procedure Code Description for Coded Service	Reimbursement Rate for Coded Service
CDBAP	none	Psychological testing comprehensive assessment, each 15 minutes [Functional assessment]	\$17.00/15 Minutes (1 Unit = 15 Minutes)	H2000	U6 (15-minute modifier)	Comprehensive multidisciplinary evaluation [Functional assessment]	\$17.00/15 Minutes (1 Unit = 15 Minutes)

- Medication Administration: To be billed, medication administration must be rendered at least once on a given date and may be rendered multiple times during that day. Reimbursement is based on a daily rate code.
- Case Management: Maximum of 180 hours per calendar year
- Skill Development: **Family** Skill Development—maximum 180 hours per calendar year; **Individual** Skill Development—maximum 100 hours per calendar year; **Group** Skill Development—maximum 140 hours per calendar year
- Recipient Support Services: Maximum of sixteen 15-minute units, 4 hours per day, 1460 hours per calendar year
- Functional Assessment: Maximum six hours per calendar year. **Initial** functional assessment: four hours. **Semiannual** functional assessment: one hour, two times per year.

Note: For complete definitions and guidelines for the above services, please refer to 2009/2010 American Medical Association's Current Procedural Terminology, Healthcare Common Procedure Coding System (HCPCS) and the ABC Coding Manual for Integrative Health care, as well as Alaska Medical Assistance regulations and provider billing manual. Complete service descriptions are also available at <http://www.hipaa.samhsa.gov/hipaacodes2.htm>.



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New Prior Authorization Form Instructions

The Prior Authorization forms were created as a Word document to offer providers the ability to download, fill in, and save on office computers, however; due to various security settings on individual computer systems, some providers may experience difficulty. It is hoped that the following step-by-step instructions will be of assistance to providers using the new form.

Go to <http://medicaidalaska.com/providers/forms.shtml>.

Scroll down the page and choose the appropriate form under the heading OTHER forms.

Save as a Word document to your Desktop.

Open the document file.

Go to the TOOLS on your tool bar and select OPTIONS.

Click on the SECURITY TAB and select MACRO SECURITY.

Select the MEDIUM security and select OK.

Close the document.

Reopen the document and **enable the macros, then** you should be able to type in the fields. Save the completed form.

**COMMUNITY MENTAL HEALTH CLINIC
PRIOR AUTHORIZATION REQUEST**

Effective 01/01/2010
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Provider Information

1. Request Date

2. Provider Name

3. Provider ID No.

4. Contact Name and Address
(decision will be returned to this address)

5. Phone No.

6. Fax No.

7. E-Mail Address

Recipient Information

8. Recipient Name

9. Date of Birth 10. Recipient ID No.

11. Gender: Male Female

12. Recipient Address

a. Private Home b. Foster Home

c. Office of Children's Services Rehabilitation Home

d. Transitional/Supported Living Home

e. Residential Substance Abuse Treatment Center

f. Homeless/Shelter g. Other-Explain:

13. Type of Client:

a. ED Adult b. SED Adult c. CMI Adult

d. ED Child e. SED Child f. Other:

14. DSM: Axis I Axis II Axis III

15. **New Request** Requested Dates: From: Thru:

16. **Update to existing PA** a. Update From: Thru: b. PA No.

(Required for PA updates only.)

Clinic Services	Code	Modifier	Unit	17. Units Requested
Mental health assessment by non-physician [Intake assessment].....	H0031.....		15 min	<input type="text"/>
Psy dx interview [Psychiatric assessment].....	90801.....		1 assess.	<input type="text"/>
Intac psy dx interview [Psychiatric assessment]	90802.....		1 assess.	<input type="text"/>
Psycho testing by psych/phys [15 minutes/unit].....	96101.....	U6.....	15 min	<input type="text"/>
Neuropsych tst by psych/phys [15 minutes/unit]	96118.....	U6.....	15 min	<input type="text"/>
Crisis intervention per hour.....	S9484.....		1 hour	<input type="text"/>
Group psychotherapy	90853.....	U7.....	30 min	<input type="text"/>
Family psytx w/patient.....	90847.....	U7.....	30 min	<input type="text"/>
Multiple-family group psytx	90849.....	U7.....	30 min	<input type="text"/>
Psytx, office, 20-30 min	90804.....		30 min	<input type="text"/>
Intac psytx, off, 20-30 min.....	90810.....		30 min	<input type="text"/>
Medication management	90862.....		1 visit	<input type="text"/>

Pages 1 and 2 of this request must be completed. Requests without both pages cannot be processed.

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**COMMUNITY MENTAL HEALTH CLINIC
PRIOR AUTHORIZATION REQUEST**

Page 2 of 2



expertise in action

Pages 1 and 2 of this request must be completed. Requests without both pages cannot be processed.

Provider Information

Request Date _____

Provider Name _____

Provider ID No. _____

Contact Name _____

Contact Phone No. _____

Recipient Information

Recipient Name _____

Recipient ID No. _____

Rehabilitation Services, Adult and Child	Code	Modifier	Unit	18. Units Requested
Comprehensive multidisciplinary evaluation [<i>Functional assessment</i>]	H2000	U6	15 min	_____
Oral medication administration, direct observe [<i>on-premises</i>]	H0033		1 day	_____
Oral medication administration, direct observe [<i>off-premises</i>]	H0033	HK	1 day	_____
Skills training and development [<i>Group skill development</i>]	H2014	HQ	15 min	_____
Skills training and development [<i>Individual skill development</i>]	H2014		15 min	_____
Case management	T1016		15 min	_____

Rehabilitation Services, Child Only	Code	Modifier	Unit	19. Units Requested
Skills training and development [<i>Family skill development</i>]	H2014	HR	15 min	_____

Recipient Support Services	Code	Unit	20. Units Requested
Psychosocial rehabilitation services [<i>recipient support services</i>]	H2017	15 min	_____
Current GAF Score _____ (<i>DBH review is required</i>)			
Explanation: _____			

By submission of this form, the provider:

- Affirms the assessment of the recipient's symptomatology and current level of functionality is documented in the recipient's record and indicates the units and duration of services requested are medically necessary;
- Affirms the recipient's record includes documentation of the interdisciplinary team, physician, or mental health clinician recommendation of the requested services as medically necessary;
 - If the recipient is a severely emotionally disturbed child, the documentation must show that the interdisciplinary team reviewed the treatment plan and recommended the requested services as medically necessary.
 - If the recipient is a severely emotionally disturbed adult or a chronically mentally ill adult, the documentation must show that the recipient's mental health professional clinician or the recipient's physician reviewed the treatment plan and recommended the requested services as medically necessary; and
- Acknowledges the services are subject to post-payment review for medical necessity and completeness of documentation according to Medicaid/Denali KidCare program rules. The Department of Health and Social Services may recoup payment for any services that are not medically necessary, not properly documented, or not in compliance with Medicaid/Denali KidCare program rules.

21. Clinic Signature _____ Title _____

22. DBH Signature _____ Date _____

Community Mental Health Clinic Prior Authorization Request Instructions

Submission Requirements: This prior authorization (PA) form must be completed to indicate the amount of services requested beyond the service limitations set out in the Provider Billing Manual and must bear the signature of a person authorized to bind the requesting clinic. Requests that include **Recipient Support Services must be submitted to the Division of Behavioral Health (DBH)** for its review. DBH will forward the form to Affiliated Computer Services, Inc. (ACS) after its review. **Submit all other requests directly to ACS.**

Page 1:

1. **Request Date:** Enter the date that the authorization request is being submitted.
2. **Provider Name:** Enter the name of the enrolled mental health clinic.
3. **Provider ID No.:** Enter the Medical Assistance identification number assigned to the mental health clinic. If a clinic has multiple identification numbers, separate authorizations must be requested for each provider identification number (e.g., Day Treatment requests must be submitted on a separate form).
4. **Contact Name and Address:** Enter the name and address of the person ACS should contact regarding the authorization request. The authorization decision will be returned to the address entered here.
5. **Phone No.:** Enter the contact person's telephone number.
6. **Fax No.:** Enter the contact person's fax number, if applicable.
7. **E-Mail Address:** Enter the contact person's e-mail address, if applicable.
8. **Recipient Name:** Enter the name of the recipient for whom the authorization is being requested.
9. **Date of Birth:** Enter the recipient's date of birth.
10. **Recipient ID No.:** Enter the recipient's Medical Assistance identification number.
11. **Gender (recipient's):** Check appropriate box for male or female.
12. **Recipient Address:** Enter the recipient's address **and check the appropriate box** (a, b, c, d, e, f, or g).
13. **Type of Client:** Indicate by marking the appropriate designation for the client.
14. **DSM: Axis I**—Enter the primary DSM IV mental health disorder being treated. **Axis II**—Enter the DSM IV diagnosis being treated, if any. **Axis III**—Enter the medical condition, if applicable.
15. **New Request**—Mark this box if the prior authorization request is a request to initially exceed the annual service limits identified in the Provider Billing Manual. Enter the dates requested for the initial prior authorization. Prior authorization requests will be accepted if requested for periods not to exceed 6 months and not to extend beyond the end of a calendar year.
16. **Update to existing PA**—Mark this box when:
 - Requesting an update to add additional units of service to the existing PA record referred to in Field 16b.
 - Adding services not already included in the existing PA record referred to in Field 16b.
 - Extending the "thru" date of the authorization period for the existing PA record referred to in Field 16b.

a. Update—Enter the "from" and "thru" dates for the authorization period being requested. Prior authorization requests will be accepted if requested for periods not to exceed 6 months and not to extend beyond the end of a calendar year.

b. PA Number—Enter the number of the PA being updated.
17. **Units Requested (Clinic Services):** Enter the number of **additional units** of Clinic Services being requested. Always use the lowest unit size available when entering the Units Required.

Page 2: Enter the request date, Provider name and ID number, Contact person and phone number, recipient name, and ID number as entered on page 1. **If you do not enter this information, ACS may not be able to process your authorization.**

18. **Units Requested (Rehab. Services-Adult & Child):** Enter the number of **additional** units of Child or Adult Rehabilitation Services being requested. Always use the lowest unit size available when entering the Units Required. Always use the lowest unit size available when entering the Units Required.
19. **Units Requested (Rehab. Services-Child Only):** Enter the number of **additional** units of Child-only Rehabilitation Services being requested. Always use the lowest unit size available when entering the Units Required. Always use the lowest unit size available when entering the Units Required.
20. **Units Requested:** Enter the number of **additional** units of Recipient Support Services (RSS) being requested. Enter the client's current (past 7 days) GAF score. Your explanation must give 1) the specific staff involvement to be provided as RSS and 2) the symptoms and behaviors that support the GAF score. Always use the lowest unit size available when entering the Units Required.
21. **Clinic Signature:** The signature must be by a person authorized to bind the clinic to the completed form as accurate and subject to Medical Assistance program rules. Please include the title of the person signing the prior authorization request form.
22. **DBH Signature:** The DBH signature indicates DBH reviewed the form and may have discussed the request with the clinic staff for clarification. The signature does not indicate acceptance of the requested services or units as medically necessary. Medical necessity may be determined during a post-payment review according to Medical Assistance program rules. The division may recoup payment for any services that are not medically necessary, not properly documented, or not in compliance with Medical Assistance program rules.