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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.

MENTAL HEALTH PHYSICIAN CLINIC CROSSWALK

CPT[1] Procedure Codes: Children's/Adult's/Mental Health Physician Clinic Services
(Replaces Tables I-4(a) and (b) and I-5(a) and (b).)

Current Procedure Code for DOS thru 12/31/09	Modifier thru 12/31/09	Procedure Code Description for Coded Service	Current 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 ***[Psychiatric assessment]***	$230.00/Assessment (1 Unit = 1 Assessment)	90801	none	Psy dx interview ***[Psychiatric assessment]***	$230.00/Assessment (1 Unit = 1 Assessment)
90802	none	Intac psy dx interview ***[Psychiatric assessment]***	$230.00/Assessment (1 Unit = 1 Assessment)	90802	none	Intac psy dx interview ***[Psychiatric assessment]***	$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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CPT[1] Procedure Codes: Children's/Adult's/Mental Health Physician Clinic Services (Replaces Tables I-4(a) and (b) and I-5(a) and (b).)							
Current Procedure Code for DOS thru 12/31/09	**Modifier thru 12/31/09**	**Procedure Code Description for Coded Service**	**Current 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)
H0031	none	Mental health assessment, by non-physician ***[Intake assessment]***	$24.00/15 Minutes (1 Unit = 15 Minutes)	H0031	none	Mental health assessment, by non-physician ***[Intake assessment]***	$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)**

CPT[1] Procedure Codes: Children's/Adult's/Mental Health Physician Clinic Services (Replaces Tables I-4(a) and (b) and I-5(a) and (b).)							
Current Procedure Code for DOS thru 12/31/09	**Modifier thru 12/31/09**	**Procedure Code Description for Coded Service**	**Current 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**
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)**

- 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.*

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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.

MENTAL HEALTH PHYSICIAN CLINIC PRIOR AUTHORIZATION REQUEST

Effective 01/01/2010

(See instructions on reverse side)

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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

13. ☐ **New Request** Requested Dates: From: Thru:
14. ☐ **Update to existing PA** a. Update From: Thru: b. PA No.
    (Required for PA updates only.)

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

By submission of this form the provider:

- Affirms the assessment of the recipient's symptomatology and current level of functioning 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 physician or mental health clinician recommendation of 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.

16. Signature_____ Title_____

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Mental Health Physician Clinic Prior Authorization Request Instructions

Submission Requirements: This prior authorization form is completed to indicate the amount of services requested beyond the service limitations set out in the Provider Billing Manual. Signature required is that of the person authorized to bind the requesting clinic. **Submit all requests directly to Affiliated Computer Services, Inc. (ACS).**

1. **Request Date:** Enter the date that the authorization request is being submitted.
2. **Provider Name:** Enter the name of the enrolled mental health physician clinic.
3. **Provider ID No.:** Enter the Medical Assistance identification number assigned to the mental health physician clinic.
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 recipient's address.
13. **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 exceed beyond the end of a calendar year.
14. **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 14b
    - Adding services not already included in the existing PA record referred to in Field 14b
    - Extending the "thru" date of the authorization period for the existing PA record referred to in Field 14b

    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 record being updated.
15. **Units Requested:** Enter the number of **additional units** of service being requested. Always use the lowest unit size available when entering the Units Required.
16. **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.