Connecticut Medical Assistance Program Provider Bulletin 2016-35
Policy Transmittal 2016-12 June 2016

Roderick L. Bremby, Commissioner

Effective Date: July 1, 2016
Contact: Hector Massari @ (860) 424-5152

TO: **General Acute Care Hospitals, Psychiatric Hospitals and Chronic Disease Hospitals**

RE: **Outpatient Hospital Modernization – Behavioral Health Services**

Effective for dates of services July 1, 2016 and forward, outpatient hospital BH services will be reimbursed either by:

1. Fixed fee based on revenue center code (RCC) and Healthcare Common Procedure Code System (HCPCS) combination ; or
2. HCPCS/Current Procedural Terminology (CPT) based on a fee schedule.

The Department of Social Services (DSS) is modernizing its reimbursement methodology for outpatient hospital services under Connecticut's Outpatient Prospective Payment System (OPPS) effective for dates of services July 1, 2016 and forward.

Outpatient hospital Behavioral Health (BH) services will be modernized under OPPS, but will be carved out of the Ambulatory Payment Classification (APC) methodology. Based upon several differences in Medicare and Connecticut policies, outpatient hospital BH services are categorized as APC policy exclusions. This approach does not follow Medicare, however it does allow DSS to modernize payment for outpatient hospital BH services. Reimbursement will be based off the complexity of the service and therefore adds consistency to the CMAP BH program by reimbursing outpatient hospital services similar to those being delivered in outpatient free-standing BH clinic settings.

ROUTINE BEHAVIORAL HEALTH SERVICES

The following routine BH services must be billed with the applicable HCPCS/CPT and RCC combination. Hospitals will be reimbursed off of the Clinic and Outpatient Hospital Behavioral Health Fee Schedule:

RCC	Description	Billable CPT/HCPC
900	General Behavioral Health	90791, 90792, 90785
914	Individual Therapy	90832-90838
915	Group Therapy	90853
916	Family Therapy	90846, 90847, 90849
918	Psychiatric Testing	96101, 96116, 96118
919	Other BH – Med Management	99201 - 99205, 99211 - 99215

To determine reimbursement for routine BH services, an outpatient hospital will use the newly assigned rate type of outpatient mental health (**OMH)**. If a hospital has met the criteria to be designated as an Enhanced Care Clinic (ECC), the hospital will use the outpatient enhanced care (**OEC)** rate type. The above services should not be billed as part of an intermediate BH program such as intensive outpatient program (IOP) or partial hospitalization program (PHP).

Medication Management

Medication management is only allowed to be billed when performed by a physician and/or advanced practitioner registered nurse (APRN). The way in which the Hospital bills medication management is dependent on what other psychiatric services were performed on the same date of service. Medication management should be billed in one of the following ways:

1. When medication management is the only psychiatric service provided to the patient on the date of service, the hospital should bill RCC 919 with CPT codes 99201-99215. **Please refer to the medication management attachment - scenario 1 for example.**

2. When there is a medication management service (RCC 919) provided on the same date of service as a psychotherapy service (e.g. RCC 914-individual, RCC 915-group or RCC 916-family therapy) that is performed by a non-medical BH clinician (e.g. LCSW, LMFT etc.) the hospital should bill the following:

a. RCC 919 with CPT codes 99201-99215; and
b. The applicable RCC & CPT/HCPCS codes corresponding to the psychotherapy performed.

Please refer to the medication management attachment - scenario 2 for example.

3. When there is a medication management service (RCC 919) on the same date of service as an individual therapy service (RCC 914) and both are performed by the same physician/APRN, the hospital should bill the following:
   a. RCC 919 with CPT codes 99201-99215; and
   b. RCC 914 with CPT codes 90833 or 90836 or 90838 (note: CPT guidelines should be followed).

   Please refer to the medication management attachment - scenario 3 for example.

Note: If a patient is enrolled in a PHP or IOP the Hospital cannot bill separately for the medication management service. Only the PHP or IOP service should be billed.

INTERMEDIATE BEHAVIORAL HEALTH SERVICES

Intermediate Behavioral Health Services include Intensive Outpatient Programs (IOP), Partial Hospital Programs (PHP) and Extended Day Treatment (EDT). Intermediate behavioral health services are considered a bundled all-inclusive service for the day which may include a variety of individual, group or family therapies, medication management, and rehabilitative or psycho-educational services that are integrated into an intensive, coordinated and structured clinical program.

In order to receive reimbursement for intermediate BH services, the RCC must be billed in conjunction with the applicable HCPCS/CPT. To determine reimbursement for Intermediate BH services, an outpatient hospital will use the newly assigned rate type of **OMH** on the Clinic and Outpatient Hospital Behavioral Health Fee Schedule.

Intensive Outpatient Program (IOP)

Depending on whether the predominant focus of the program is mental health or chemical dependence the hospital must bill **RCC 905**- *Intensive Outpatient Services-Psychiatric* or **RCC 906** - *Intensive Outpatient Services-Chemical Dependency*

IOP must include three (3) hours of structured programming for 2-5 days a week with a minimum of 2.5 hours of documented clinical services per day. IOP must be billed once per day with the following RCC/HCPC combination:

RCC	Description	Billable CPT/HCPC
905	Intensive Outpatient Services-Psychiatric	S9480
906	Intensive Outpatient Services-Chemical Dependency	H0015

Extended Day Treatment (EDT)

Hospitals must be licensed to provide EDT by the Department of Children and Families and cannot bill for EDT unless they have this licensure. EDT must include three (3) hours of structured programming for 2-5 days per week with a minimum of 2.5 hours of documented clinical services per day. EDT must be billed once per day with the following RCC/HCPC combination:

RCC	Description	Billable CPT/HCPC
907	Extended Day Treatment	H2012

Partial Hospital Program (PHP)

PHP must include least four (4) hours of structured programming 3-5 days per week with a minimum of 3.5 hours of documented clinical services per day. PHP must be billed once per day with the following RCC/HCPC combination:

RCC	Description	Billable CPT/HCPC
913	Partial Hospitalization-Intensive	H0035

Full & Partial Day Billing for Intermediate BH Services

Providers must schedule an individual for a full day of program participation. The Department's policy does recognize that there may be rare times when a member cannot attend the entire duration of an intermediate program on a particular day due to unforeseen circumstances which should be clearly documented in the medical record. For these situations, the provider may follow the guidelines below.

1. **Full Day Billing Policy:**

If the member is present for at least half of the intermediate level of care program day, but less than a full day and attends at least **two** individual, family or group sessions, the provider may bill the full day.

The minimum number of service hours required in order to bill a full day is as follows:

- **PHP:** 1.75 hours of documented clinical services.
- **IOP:** 1.25 hours of documented clinical services.
- **EDT:** 1.25 hours of documented clinical services.

2. **Partial Day Billing Policy:**

For intermediate behavioral health services that qualify for partial day billing, the hospital should submit the appropriate RCC with one of the applicable HCPC/CPT codes and append **modifier 52-Reduced Services**. The combination of the RCC, HCPC/CPT and modifier 52 on the claim will allow the claims system to reimburse 50% of the normal allowed amount for intermediate BH services. **Please note:** modifier 52 will only impact BH claims for partial day billing for intermediate care and will not impact other BH services. .

The minimum number of services required in order to bill for a partial day of an intermediate program are as follows:

- **PHP:** at least one full clinical service (individual, family or group session) for which the member is normally scheduled on that day.
- **IOP:** at least one full clinical service (individual, family or group session) for which the member is normally scheduled on that day.
- **EDT:** at least one full clinical service (individual, family or group session) for which the member is scheduled on that day.

If the member does not attend at least one full individual, group or family session the provider is not entitled to any payment from the Department.

OTHER BH SERVICES

1. **Electroshock Therapy:** Electroshock therapy (ECT) will continue to be reimbursed by RCC/procedure code at a fixed fee from the Outpatient Hospital fee schedule. Electroshock therapy must be billed with the applicable RCC/HCPC combination:

RCC	Description	Billable CPT/HCPC
901	Electroshock Therapy	90870

2. **Group Tobacco Cessation:** Group tobacco cessation will continue to be reimbursed by RCC/procedure code at a fixed fee from the Outpatient Hospital fee schedule. Please reference provider bulletin 2015-37-Tobacco Cessation Group Counseling Services for additional policy and billing guidance. Group tobacco cessation must be billed with the applicable RCC/HCPC combination:

RCC	Description	Billable CPT/HCPC
953	Group Tobacco Cessation	99412

AUTISM SERVICES

A forthcoming bulletin will be issued regarding autism services in an outpatient hospital setting.

ACCESSING THE FEE SCHEDULES

Fee schedules can be accessed and downloaded from the Connecticut Medical Assistance Web site: www.ctdssmap.com. From this Web page, go to "Provider", then to "Provider Fee Schedule Download". Click the "I accept" button and proceed to click on the CSV for the applicable fee schedule. Press the control key while clicking the CSV link, then select "Open".

PRIOR AUTHORIZATION/REGISTRATION

Prior authorization or registration will continue to be required for services specified by the Department. There will be no changes in prior

authorization or registration for behavioral health. Prior Authorization is required for all behavioral health outpatient treatment. Beacon Health Options needs to be notified of the initiation of a behavioral health outpatient hospital service which includes information regarding the evaluation findings and plan of care. Registration may serve in lieu of prior authorization as applicable, only if a service is specifically designated by Beacon Health Options as requiring registration.

For authorization of services contact Beacon Health Options at 1-877-552-8247 and for web registration go to www.CTBHP.com, click provider for online services.

PROFESSIONAL SERVICES

Outpatient hospital BH services are considered an all-inclusive rate and professional fees will not be reimbursed separately. The only time professional services may be billed separately is for RCC 901 (ECT) and behavioral health evaluations in Emergency Department by a physician, APRN, LPC or LCSW.

In order to receive payment for professional services, the hospital must enroll their practitioners into a professional group. Please see **Provider Bulletin 2016-06 – Hospital Based Practitioners-Outpatient Services** for further information on how to enroll a practitioner billing group.

DOCUMENTATION

There must be documentation maintained in the member's medical record to support the applicable service billed by the provider. Documentation should include, at a minimum, the actual time of day the member was in attendance and the duration of attendance at each group or session, the components of the program the member attended, progress notes for the day and a description of why the member's attendance was truncated. Failure to adequately document the services provided or failure to bill according to the guidelines identified in this bulletin may result in a post payment audit adjustment.

For additional documentation guidelines please see Section 17b-262-971 4(g) of the Regulations of Connecticut State Agencies.

PROVIDER BULLETINS

OPPS logic will take precedence over any previous provider bulletins; hospitals should follow CMAP's Addendum B and the new outpatient hospital regulation. Effective for dates of service July 1, 2016 and forward, the following BH related provider bulletins and policy transmittals will be rescinded for outpatient hospitals:

- **PB 2016-02** - Billing for Partial Payment for Behavioral Health Intermediate Level of Care
- **PB 2014-32-** Partial Day Billing for Behavioral Health Intermediate Levels of Care
- **PB 2013-11** - RCC Crosswalk to New Psychiatric Procedure Codes for 2013
- **PB 2012-01** - Transition from Revenue Center Code 513 to More Precise Coding for Hospital Outpatient Psychiatric Services

REGULATIONS CONCERNING OUTPATIENT HOSPITAL SERVICES

The draft regulation concerning Outpatient Hospital Services will be posted to the DSS Web site on or before July 1, 2016. DSS is implementing these policies and procedures in draft regulation form pending final adoption. Pursuant to Section 17b-239 of the Connecticut General Statutes, the provisions of these regulations will be operational and effective July 1, 2016.

To access the draft regulations from the DSS Web site, go to www.ct.gov/dss, and then select "Publications", then "Policies and Regulations", then "Notices of Intent, Operational Policies, and Proposed Regulations", and then "Regulations Concerning Outpatient Hospital Services".

The regulation will also be posted to the www.ctdssmap.com Web site. To access the regulation, go to "Information", then

"Publications", then "Provider Manuals Chapter 7", and then choose "Hospital Outpatient: NEW Requirements Eff. 7/1/16" from the drop down menu.

Posting Instructions: Policy transmittals can be downloaded from the Web site at www.ctdssmap.com

Distribution: This policy transmittal is being distributed to providers of the Connecticut

Medical Assistance Program by Hewlett Packard Enterprise.

Responsible Unit: DSS, Division of Health Services, Medical Policy and Regulations, Hector Massari, Integrated Care, at hector.massari@ct.gov or 860-424-5152

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Medication Management Scenarios

Scenario 1: When medication management is the only psychiatric service provided to the patient on the date of service

RCC/Description	Billable CPT/HCPCS	Allowed Clinician
919- Other BH-Med Management	99201-99205, 99211-99215	Physician or APRN

Scenario 2: When medication management service is provided on the same day as another psychotherapy service which is performed by a non-medical BH clinician.

RCC	Billable CPT/HCPCS	Allowed clinician		RCC	Billable CPT/HCPCS	Allowed clinician
919	99201-99205 99211-99215	Physician/ APRN	**Bill with either**	914	90832 or 90834 or 90837	e.g. LCSW, LMFT
				915	90853	
				916	90846 or 90847 or 90849	

Scenario 3: When there is a medication management service on the same day as an individual therapy service and both are performed by the same physician/APRN

RCC	Billable CPT/HCPCS	Allowed clinician		RCC	Billable CPT/HCPCS	Allowed clinician
919	99201-99205 99211-99215	Physician/ APRN	**Bill with**	914	90833 or 90836 or 90838	Same physician/APRN