Examples of States' Billing Codes for Mental Health Services, Publicly Funded (As of August 2007; revised October 2010)

Purpose and Background.

This collection of examples of successful codes that states use to bill for mental health services is the outgrowth of a collaborative Federal project. The three agencies working together on this project include SAMHSA, CMS and HRSA. The project began in 2005 as a response to the President's New Freedom Commission recommendations, and the ensuing Federal Action Agenda for carrying out those recommendations. One of the action steps was to address reimbursement barriers to payment of mental health services provided in primary care settings, particularly in the public sector. To that end, the three Federal agencies consulted with key informants, convened a Forum of experts, wrote a literature review, White Paper, and Final report on Reimbursement of Mental Health Services in Primary Care Settings (Kautz, C., Mauch, D., & Smith, S. A. *Reimbursement of mental health services in primary care settings* (HHS Pub. No.SMA-08-4324). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2008, publication pending). The Forum of experts suggested, among other things, that collecting examples of what States and providers do now to bill for mental health services, and sharing that information via a simple, accessible document for the use of providers and States, would be very helpful.

We hope you find this publication useful, and we welcome your feedback.

A brief orientation to HCPCS codes

In the public sector, both Medicare and Medicaid are billed using the Healthcare Common Procedure Coding System (HCPCS) codes. The HCPCS is primarily two separate and different sets of codes, referred to as Level I Current Procedural Terminology ("CPT codes"), and Level II (State codes). The Level I CPT codes were created and are maintained by the American Medicaid Association; while the Centers for Medicare and Medicaid Services maintains the Level II State codes.

The HCPCS (pronounced "HIC PICS") refers to both these Level I and II codes. There are some "Level III" codes, being phased out, which can be used in special situations, for infrequent local services that do not have a code, such as unanticipated emergency services in a unique situation like September 11 or Hurricane Katrina.

The HIPAA legislation of 1996 specified that all medical coding systems in the future should be uniform and standardized nationally, and it projected phase-in dates, by 2003, which have been extended more than once for some Level II codes. HIPAA also required use of the ICD-9-DM (International Classification of Diseases) medical manual for diagnoses, which includes mental disorders, rather than the use of the DSM (Diagnostic

and Statistical Manual of Mental Disorders) that mental health clinicians had previously used for mental diagnoses.

Introduction to Level I and Level II HCPCS Codes

Level I Codes are the Current Procedural Terminology or "CPT" codes and are owned and maintained by the American Medical Association, which initiated them in 1966. The CPT codes are 5-digit numbers, for example, 90806. These codes are often used by providers billing Medicare or private insurance companies. (Medicaid can also pay for some Level I CPT codes if the State decides to allow, as can State MH Agencies.)

Level II are nationally standardized State codes, determined by the Centers for Medicare and Medicaid Services (CMS), and applied by each State. These codes are often used by providers billing the State Medicaid agency for services rendered to Medicaid beneficiaries. Level II codes are 5-digit, and begin with a letter that is followed by a 4-digit number, e.g., H4006. Medicare also pays for Level II codes, but specifically excludes the codes beginning with "H" or "T," which includes most mental health and substance abuse screening and treatment services.

The Level II codes are used by many States and, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), are required to be standardized nationally. The codes beginning with A through V are nationally the same; however, the codes W – Z vary from State to State. States are trying to switch to use only nationally standardized codes.

HCPCS and the public sector: Medicare and Medicaid both use both Level I and II codes. Under Medicaid, the States specify what codes may be reimbursed. Each State is different. Under Medicare, the Level I CPT codes are most commonly used, but must be each approved by CMS for Medicare payment. Certain (but not all) Level II codes, the State codes, are allowed to be used under Medicare, and CMS is the decision maker for what codes are allowed in Medicare payment. Although HCPCS refers to both Level I and Level II codes, a point of confusion is that in common usage, often times the term "HCPCS" is used informally to refer principally to only Level II (State) codes rather than both Levels I and II.

Please see Table I for a summary of codes and payers.

More Specifics

Level I: Current Procedural Terminology

CPT level I codes fall into several categories that are relevant to mental health billing. Level I HCPCS codes used for mental health services are in the Evaluation and Management (EM) as well as the Medicine sections of the CPT manual. In the Medicine section, the two areas that apply specifically to mental health services are the Psychiatry

codes (90801 – 90899) and the Health Behavioral Assessment and Intervention (HBAI) codes (96150 – 96155).

CPT 5-digit numeric codes include:

- Psychiatric codes (90801 – 90899),
- Health Behavioral Assessment & Intervention ("HBAI" codes 96150 – 96155)

- Evaluation & Management ("EM" codes—5 categories):

  - Office: 99201 – 99215;
  - Consultation: 99241 – 99255 (CMS discontinued 2010);
  - Home care: 99324 – 99340; and
  - Preventive: 99381 – 99429 (99230 – 99440 are exclusively for newborn treatment).
  - Telehealth 99441 – 99444 for MDs; 98966 – 98969 for non MDs

Psychiatry codes, 90801 – 90899

According to Medicare, the "psychiatry" CPT procedure codes 90801-90899 may be used by mental health specialists: physicians, physician extenders (such as nurse practitioners, clinical nurse specialists, or physician assistants), and nonphysicians, such as clinical social workers (CSW) licensed by the State; and clinical psychologists, licensed by and subject to State criteria, operating within the scope of their practice as defined by the State. This range of Psychiatry procedure codes 90801-90899 can be used to treat patients with primary mental disorders that are identified by ICD-9-CM diagnosis codes 290-319. When submitting claims for outpatient mental health services under the Medicare program, the claim must contain an appropriate diagnosis code, procedure code and a place of service code.

State Medicaid offices specify what type of provider may use the Psychiatry codes; many states limit reimbursement for these codes to mental health specialists such as psychiatrists, advanced practice psychiatric nurses, clinical social workers, or psychologists. Although Medicare does not limit psychiatry CPT codes to be used only by physicians who are specialized in mental health, Medicare does, however, direct carriers billing for Medicare payment to evaluate the providers' qualifications and licensure or certification to perform mental health services, and to evaluate whether the physician is operating within the State scope of practice and the services are reasonable/ necessary. This may be a source of variable interpretation and payment variability, in that states may vary in specificity of provider type that they authorize to deliver specialized mental health services.

HBAI and EM codes

The use of HBAI CPT Codes requires a primary medical diagnosis from the ICD-9-CM. The mental symptoms are a result of the physical or medical primary problem. HBAI codes used for a beneficiary with a mental health problem due to a primary physical illness are to be used by non-physicians such as clinical psychologists or MH specialists; however, CSWs may not bill Medicare using HBAI or EM codes.

E/M services codes can be used with a primary diagnosis of either a physical or mental illness. E/M codes are most successfully used by physicians such as primary care MDs or physician extenders. E/M codes are not recommended for use under Medicare by clinical psychologists. NOTE: As of January 1, 2010, the Centers for Medicare and Medicaid Services no longer recognize the E/M Consultation codes, except for telehealth consultation G codes and the 99441- series. CMS states to use E/M Office visit codes instead. They issued a CMS Manual System Pub 100-04 Claims Processing for Medicare guidance, Transmittal #1875 downloadable at: http://www.cms.gov/transmittals/downloads/R1875CP.pdf.

When billing Medicare, local carriers or fiscal sometimes reject a claim from a primary care provider using a mental diagnosis. Even when approved, Medicare reimbursement for a mental diagnosis may be at the 50% level, rather than the reimbursement level of 80% for primary non-mental physical illness.

If billing Medicaid using an E/M procedure code, many states report that they allow use of mental disorders 290 – 319 from the ICD-9-CM, such as 311 Depressive disorder, 300.00 Anxiety disorder, or 300.02 Generalized Anxiety Disorder. E/M Office Visit codes (CPT # 99201-99215) are still recognized under Medicare and in fact the Relative Value Units (RVUs) for New or Established patients may be increased with the 2010 rules. One can check CPT code viability at the AMA website: https://catalog.ama-assn.org/Catalog/cpt/cpt_search.jsp?locality=MD. CMS states that all E/M services shall follow the E/M documentation guidelines available on http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp.

Telephone E/M provided by physician CPT codes as of 2008 include # 99441 – 99444; the same services given by qualified non-physicians are CPT # 98966 – 98969. (downloaded 10/19/2010 at: http://www.cms.gov/Transmittals/downloads/R1423CP.pdf)

Level II: State Codes

Level II HCPCS codes beginning with letters A through V are national codes; however, there are certain codes that Medicare does not pay for, such as the H and T (Mental Health and Substance Abuse codes); however, most Medicaid programs do allow many H and T codes. In addition, S-codes are not recognized by Medicare; however, they are used by other third party payers (e.g., Aetna, Blue Cross/Blue Shield, Department of Defense, Humana, etc.).

Level II codes beginning with W, X, Y and Z are local State codes, and may vary from State to State. States may specify which nationally standardized codes they allow (the A

– V codes); some states also use some W – Z codes, such as Maine, which are specific to that individual state only.

Newer codes: As of January 1, 2007, two "H" codes were approved and effective under Medicaid: H0049 (alcohol and /or drug screening) and H0050 (alcohol and/ or drug brief intervention, per 15 minutes), and so far, states are exploring use of them.

As of January 1, 2008, Medicare will pay for the two new "G" codes, for assessment and brief intervention for alcohol and/or drug abuse services. G0396 (15 minutes) and G0397 (same services for 30 minutes) are the two new billable codes under Medicare, and they replicate the new Level I CPT codes numbering 99408 and 99409 for private insurers.

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Shelagh Smith, MPH
SAMHSA