

Billing Frequently Asked Questions

What are the general conditions which must be met in order to bill for a service?

All billed services except assessment must be medically necessary for the treatment of a covered mental health condition, specified in a treatment plan, and documented in the clinical record in a progress note. Services specified in a treatment plan must relate to the goals and objectives identified in the plan. For services that are not specifically included in the client's Treatment Plan, or exceed the scope of the plan, an explanation is required of how the services being billed relate to the Treatment Plan or meet an urgent or emergent client need.

Providers must bill at a rate, based upon reasonable and allowable costs of services not in excess of the Provider's usual and customary charge to the general public. Payment will be made at each Provider's usual and customary charge or WCHHS' reimbursement rates, whichever is less, minus payments received or due from other payors.

What is "Medically Necessary"

As discussed earlier, all services which are billable must meet the standard of medical necessity. This is defined by OAR as "a service [which] is required for the treatment of mental health conditions and is appropriate and consistent with the diagnosis; consistent with treating the symptoms of a mental illness or treatment of a mental condition; appropriate with regard to standards of good practice and generally recognized by the relevant scientific community as effective; not solely for the convenience of the client or provider of the service; and the most cost-effective of the alternative levels of medically appropriate services which can be safely and effectively provided to the client." "Treatment" means a planned, medically appropriate, individualized program of interactive medical, psychological, rehabilitative procedures, therapeutic interventions, experiences, and/or activities designed to rehabilitate, relieve or minimize mental or emotional disorders identified through a mental health assessment and provided by a QMHP or QMHA.

When can we bill for phone contacts?

Phone contacts can be billed using some codes, as identified in the Provider Code Guide, such as H0004 (Behavioral Health Counseling), T1016 (Case Management), Consultation (90882, 90887) and Screening (T1023, H0002) UNDER THE FOLLOWING CONDITIONS:

1. Phone contact is planned when medically necessary, clinically justified and included in the treatment plan.
2. Phone contact is unplanned, as in an urgent or emergent behavioral health event or crisis.

Phone calls can be an excellent means for maintaining contact with a client, checking in, problem-solving, maintaining contact with a guardian, checking on mental status or progress towards goals.

Can we bill for no-shows?

Neither WCHHS, nor the client may be billed for a missed appointment. A client missing an appointment may be phoned using an appropriate code if circumstances described previously are met. For example, when a client misses appointments regularly because his/her mental condition causes chronic disorganization, negative symptoms, or psychotic symptoms which interfere with the client's ability to keep scheduled appointments, it may be appropriate to include this as a need in the treatment plan addressed by interventions such as contact by phone or outreach visits.

Can we bill for writing reports or other paperwork tasks?

These activities are not included in most of the code descriptions. These are administrative costs occurring within the time clinicians are not providing "direct service". These costs should be considered in unit cost studies used to set an organization's fee schedule.

There are a couple of exceptions. Psychological Testing (96101) includes scoring and interpretation of test results and preparing a report. Psychiatric Diagnostic Interview (90801) includes time spent reviewing records or interviewing collateral sources for clinical information as does H0031, Mental Health Assessment..

When is Psychological Testing appropriate to bill?

Psychological testing is authorized as an exceptional needs request. These requests will be reviewed by a WCHHS Care Coordinator for medical necessity. Bills that are submitted without a specific authorization for Psychological Testing will be denied.

What codes do not require an above the line diagnosis?

All Assessment codes including 90801, 90802, H0031 and Screening codes H0002 and T1023 do not require a covered condition (above the line diagnosis).

Can we bill for scheduling client appointments?

No. Scheduling appointments is considered an administrative task, not a clinical intervention.

Can we bill for listening to voice mails from clients?

No, listening cannot be considered a clinical intervention. Leaving voice mails for a client also cannot be billed as there is no certainty that clients will receive the message..

Can we bill for E-mail contacts?

The State has indicated that Medicare and Medicaid standards do not allow Email encounters to be billed.

Can we bill for testifying in court?

Since testifying in court generally can't be considered a treatment intervention that would be listed in a treatment plan as a means to address a treatment goal or objective, most often it would not be considered a covered service. There may be exceptions to this however, for example in cases of commitment hearings or drug court. If court testimony is clearly an intervention, Washington County would support the use of 90882, environmental intervention on a psychiatric patient's behalf with agencies, employers or institutions.

Who can bill for 9080x series codes that don't include medication management?

As described in the Washington County Code Guide, 90801 and 90802 are assessment codes that are intended for Medicare-approved providers only, i.e. LMP's, Licensed Psychologists and Licensed Clinical Social Workers. The 9080x Individual Therapy codes (versus H0004), are restricted to Medicare-approved providers only, i.e. LMP's, Licensed Psychologists and Licensed Clinical Social Workers.

How can mental health assessments that are longer than 1 hour be billed?

All of the assessment codes are per occurrence. This means that you may bill only one unit on a particular date of service. The Washington County rates for these codes are generally based on an assumptions of a one hour contact. For any per occurrence code type, organizations should take care in insuring billed charges submitted reflect one of the following approaches: 1) An agency-wide average for length of the service and provider type or 2) variable charges for each unit of service billed based on the length of that particular episode or provider type. For example, if service was provided by a Master's Level clinician for one hour, an agency might submit charges of \$100. Another episode provided for 2 hours might be submitted for \$200.

Additional bills for services described by other code definitions on the same date of service may be submitted. For example, individual therapy provided subsequent to an assessment may be billed using a different code.

How can psychiatric evaluations that are longer than 1 hour be billed?

The "Community Standard" for initial child psychiatric evaluations is lengthier and more complex than the same service provided for adults. In adult psychiatry, medication evaluation is typically included in the 90801 coding, whereas in child psychiatry it is not unusual to code these services separately to reflect the lengthier and more complicated

evaluation process. This is a practice Washington County does allow in the case of initial child psychiatric assessments only. In these cases, 90801 and 90862 may be billed by the same medical provider on the same date of service. The CPT code manual does not specifically prohibit this practice because the service code definitions do not overlap. The definition for 90801 is clearly an assessment and diagnostic interview and does not specifically include pharmacologic therapy. 90862 has in its definition "1) prescribing medication, 2) monitoring the effect of medication and its side effects, and adjusting the dosage. Any psychotherapy provided is minimal and is usually supportive in nature."

Can we bill for consulting with other staff in our organization?

No. Consultation between employed or contracted staff within a single organization is not billable. The cost of these activities should be considered in unit cost studies used to set an organization's fee schedule.

Can we bill for attending treatment planning meetings at hospitals or other community facilities? What if more than one of our staff attend?

Yes. Case management or consultation (90882) codes may be used. Multiple staff from a single organization cannot bill for the same service on the same date without being considered double billing with potential fraud exposure. Therefore only a single staff person may bill for the time spent in the meeting.

Can we bill for travel time?

No. Like other non-direct service costs, these are considered overhead costs and should be considered in unit cost studies used to set an organization's fee schedule.

WCHHS has considered travel time in setting the rate for the code Community-Based Wraparound (H2021) since the code definition is exclusively for services conducted out of the office. As with all codes, H2021 should only be billed for the number of units reflected by face-to-face contact.

When must we bill Medicare or another Third Party first?

OAR's and contracts require that providers must pursue potential third-party payments from Medicare, private health insurance, or other sources that may cover services rendered. We have the expectation/legal obligation that Medicare or other third party resources will be billed first. However, we recognize that reimbursement from these sources is reliant on a number of difficult issues, hence Washington County's expectations:

1. To ensure maximum Medicare reimbursement, agencies must apply for Individual Provider Identification Numbers for all Medicare/Private Insurance qualified staff. Qualified staff include, MD's, NP's, Licensed Psychologists and LCSW's and in the case of private insurance, LPC's.

2. We assume that all medication services are provided by Medicare approved providers. Additionally, it is our expectation that to the extent possible, non-medical services to Medicare/Private Insurance clients will be provided by staff approved by the payor. That said, we recognize that this will be impractical in many cases and that licensed staff will likely be prioritized first for Medicare/Private Insurance ONLY (vs. dually eligible) clients.
3. The following codes will be required to have an EOB from the primary payor before WCHHS will pay as secondary payor: 90801, 90805, 90807, 90809, and 90862 . Washington County will pay the patient responsibility identified in the EOB for these services.
4. We will not require the primary insurance to be billed first for any other approved codes . These claims may be submitted directly to PhTech . However if an eligible service not listed above was provided by an approved provider, the primary insurance must be billed first.

If two staff persons provide a service such as group therapy, can both of them bill?

No, claims with duplicate line items will be rejected as double billings.

What does “per occurrence” really mean in time spent?

In setting our rates, Washington County has made certain assumptions about unit cost for all per occurrence codes. These assumptions vary based on the code's service definition. As with all unit cost assumptions, these should be discussed from time to time to assure they reflect real world business. As discussed earlier, for any per occurrence code type, organizations should take care in insuring billed charges submitted reflect one of the following approaches: 1) An agency-wide average for length of the service and provider type or 2) variable charges for each unit of service billed based on the length of that particular episode or provider type. For example, if service was provided by a Master's Level clinician for one hour, an agency might submit charges of \$100. Another episode provided for 2 hours might be submitted for \$200.

What if case managers sit in on psychiatric appointments?

It is not possible to bill for two different services provided to a client with the same time frame without it being considered double billing and potential fraud exposure.

Why is important to include more than one diagnosis on a claim?

Capitation rate setting includes diagnostic risk adjustment. Some of these risk adjustments are higher for combinations of disorders such as a major mental illness along with chemical dependency. To the extent that diagnoses coded on claims accurately

reflects the client's real constellation of problems, the risk adjustment will be more fair. There is great benefit in insuring diagnostic coding on claims is as accurate as possible.

Can an axis II diagnosis be considered "primary"?

Yes. Severe personality disorders, autism and other developmental disorders, are often primary and may be the only diagnosis. In the case of Borderline Personality Disorder, for example, if this is coded on a claim as primary, it gives us "credit" towards a higher risk adjustment.

What is the difference between Eligibility Determination and Behavioral Health Screening? How do I bill for these?

T1023, Eligibility Determination, is primarily directed at determining a client's appropriateness for a given program and may be performed by a QMHA or AMHP. Behavioral Health Screening includes the establishment of a provisional diagnosis and may only be performed by a QMHP.

What is the difference between Mental Health Assessment and Psychiatric Diagnostic Interview?

Though the service definitions are somewhat different, administrative rules define the elements of a comprehensive assessment. The choice in the use of these two codes is most often based on the practitioner rather than the service definition. 90801 requires MD, PMHNP, Licensed Psychologist or LCSW credentials.

Why does H2010 get denied? What should be billed instead?

Unfortunately H2010, Comprehensive Medication Services, has not been paired with diagnoses on the Prioritized List by the Health Services Commission. As of this writing, AMH has agreed to put forward a package recommending this code be paired. Once approved by HSC, bills for the service will be accepted. Meanwhile, agencies may bill H0034 Medication Training and Support.

If an LMP is providing a service not described by any med management codes, how can we be adequately reimbursed? For example, signing star card or disability applications or making phone calls to family members or pharmacists.

Unfortunately, since the codes whose service definitions are consistent with these kinds of activities are provided primarily by non-medical staff, the unit cost assumptions which have been used in setting rates for these codes reflect these costs and would not adequately reimburse for the higher costs of medical staff. That said, it is possible for medical staff to bill using these codes and receive reimbursement at the existing rates. Additionally, as with all services, any uncompensated time should be considered as non-direct service in unit cost studies for the purpose of developing agency fee schedules. Washington County also uses assumptions about uncompensated time in the development of our reimbursement rates.

Can services provided by non-traditional providers such as mentors, family partners, or consumer peers be billed?

A non-traditional provider is defined as an individual who has the ability, skills or training to provide a needed service directed at treating a covered mental health disorder, but who is not employed by a mental health organization, or otherwise certified, credentialled or licensed to provide mental health services. An example might be a family's neighbor who is able to provide respite care for a child. The service to be provided must be part of a client's mental health treatment plan and clearly related to the amelioration of symptoms of the covered mental health disorder. Agencies with a Medicaid provider number must act as the provider organization through which claims can be generated and the required clinical documentation can occur. The agency is responsible for assuring that the non-traditional provider completes a credentialling process, which minimally includes a criminal background check and documentation attesting that the individual has the skills, training, experience and supervision necessary to provide the service. The agency can then submit claims for the services utilizing the appropriate codes. Any codes not requiring a credential may be used. These include S9125 In-home Respite care, T1005 Respite Care services, H0045 Respite Care not in the Home, H2021 Community-Based Wraparound, H2027 Psychoeducational Services and H0038 Self-Help/Peer Support. A progress note must be completed by the non-traditional provider for each service provided. A QMHP with the associated provider must review and co-sign the completed progress notes.

Can masters-level graduate student interns deliver QMHP-level services under the direct supervision of a QMHP?

No, unless a graduate student meets criteria as a QMHP, then the person cannot bill service codes requiring the QMHP credential. Graduate students are likely to meet the QMHA credential however and may bill using QMHA codes. Sometimes a student may have other credentials that would qualify him or her as a QMHP, such as a person pursuing a PhD or PsyD after already being awarded a master's degree, but these are relatively rare circumstances. Although it rarely happens, it is possible that a graduate student could receive a variance to function as a QMHP under prescribed circumstances. For example, graduate students in rural areas where other QMHPs are not available or if the student has a needed skill set (e.g., bilingual) that is otherwise unavailable.

Can services be provided without being listed on the client's treatment plan?

Any appropriate service can be provided during the period of time before a formal treatment plan has been developed. In addition, services provided in a crisis or urgent situation that are by definition "unplanned" may be billed and need not be listed on the client's treatment plan. The service provided should be justified in the progress note.

What is included in Case Management? Can we bill time on things such as finding a resource for a client, finding information about specific healthcare conditions, filling out the paperwork to use a resource, etc.?

All services provided must meet the definition we have for the Case Management code: "Services provided to a consumer who requires access to benefits and services from local, regional or state allied agencies or other service providers, advocating for the consumer's treatment needs, providing assistance in obtaining entitlements, accessing housing or residential programs, coordinating services including mental health treatment, educational or vocational activities, and arranging alternatives to inpatient hospital services, assistance in applying for benefits to which the consumer is entitled; helping the consumer complete and update a personal crisis plan or a declaration for mental health treatment; outreach services; symptom-management efforts; linkages to work-related services; make contact when admitted to a hospital, State Hospital or non-hospital facility and be actively involved with discharge planning; and monitor health and safety needs for consumers who reside in community settings." It is hard to answer generally but if any particular activity meets this definition, it is billable.