Billing for Behavioral Health Services

According to the DHMH Non-Chargeable List for Fiscal Year 2021 the following Addiction Services <u>cannot</u> be billed:

• Court-Based Screening
• General Education or Prevention Services
• In Prison/Detention Center Services
• Education, Prevention provided to adolescents in a school setting

What are Diagnosis Codes?

Diagnoses are reported to both public and private insurance carriers using the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) which provides a classification system for diseases and injuries, including Behavioral Health diagnoses.

Behavioral health services are reported by using a standardized code set called Healthcare Common Procedure Coding System (HCPCS). HCPCS codes fall into three categories:

Level I or **CPT-4** – Five-digit codes with descriptors that matches up with a procedure or service.

Level II or **HCPCS** – Five character alphanumeric codes used for reporting and billing of equipment, medication and specific supplies. Also used to report services not in Level I CPT codes.

Level III – Provisional/temporary codes for new and developing procedures/technology, used only if a more suitable code does not exist in Level I or II.

What are CPT (Level I) codes?

CPT codes are developed, maintained and copyrighted by the American Medical Association. In the U.S., all healthcare providers and facilities use CPT codes. They are a standardized set of 5-digit numbers (sometimes alphanumeric) used to report services provided by a medical practitioner including medical, surgical, lab and diagnostic services. Insurers use CPT codes reported to them on medical claims to determine the amount of reimbursement a practitioner or facility will receive for providing these services.

What are HCPCS (Level II) codes?

Medicare and Medicaid use HCPCS codes and are monitored by the Centers for Medicare and Medicaid Services (CMS). Of the three levels of HCPCS codes, Level I and II are relevant to mental health billing. Both Medicaid and Medicare use some of both Level I and Level II. Medicare more often uses Level I codes while Medicaid more often uses Level II codes. Each State determines the specific HCPCS codes they will use for Medicaid (often Level II codes) for reimbursement. They include the H and T codes which are for mental health and substance abuse. A list of Maryland's specific mental health and behavioral health codes is included in this manual.

Medical Record Documentation

Effective medical record documentation improves success in billing. The general principles of medical record documentation for reporting of mental health services include:

- Medical records should be complete and legible;
- Documentation of each patient encounter should include: Reason for encounter and relevant history;
- Physical examination findings and prior diagnostic test results;
- Assessment, clinical impression, and diagnosis;
- Plan for care; and
- Date and legible identity of observer;
- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred;
- Past and present diagnoses should be accessible for treating and/or consulting physician;
- Appropriate health risk factors should be identified;
- Patient's progress, response to changes in treatment, and revision of diagnosis should be documented;
- CPT and ICD-10-CM codes reported on the health insurance claim should be supported by documentation in the medical record. Additional Resources:

CPTCodes:

https://www.ama-assn.org/practice-management/cpt/need-coding-resources

HCPCS codes:

https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/HCPCS-Coding-Decisions