Frequently Asked Questions for Behavioral Health Providers

Jackson Care Connect™

Table of Contents

You asked, JCC's external consultant and expert, Dr. Derek Jones, answered.

About the Expert: Dr. Derek Jones is a Board-Certified Fraud Examiner (CFE), Forensic Consultant (CFC), and Medical Investigator (CMI-V). He is a member of the Advisory Council to the Association of Certified Fraud Examiners and is a Fellow of the American Board of Forensic Examiners. Dr. Jones holds a PhD in Forensic Psychology, specializing in behavioral analysis. Dr. Jones is the principal and co-founder at The Compliance Consortium www.TheComplianceConsortium.org. His experience includes conducting risk analyses, performing due diligence and leading internal investigations for large companies in healthcare and government. He consults directly to State Medicaid Authorities, Health Lawyers, Health Plans and provider trade associations. His publications include three recent books and dozens of articles in peer-reviewed journals.

Billing/Coding Definitions

Q - What is the CPT code for treatment planning? Can it be billed for on the same date of service (DOS) as a 90837/90834, as they often occur concurrently?

A - Initial service planning is a “process”, a service, that includes assigning certain providers and treatment to address specific client issues, as determined during a comprehensive assessment. Service planning also requires the participation of others, including the participation of the client and family. It is not anticipated that all the work of service planning be completed during a single encounter with the client, or family. As in the previous question, if both therapy and the face-to-face portion of service planning occurs on the same day, there’s 1 client and 1 session and your documentation should reflect this.

Q - What is the definition of case management and environmental intervention and when to use them. For example, what to use when a therapist is speaking to a teacher in a school-based setting?

A - 90882, environmental intervention, is often used as a “catch all” code for medical management interactions on a psychiatric patient's behalf with agencies, employers, or institutions. Typically, a discussion of medications is included. Oregon identifies case management/care coordination (CM/CC) at OAR 410-120-0000(39) with the following definitions: “case management services” means services provided to ensure that CCO members obtain health services necessary to maintain physical, mental, and emotional development and oral health.

Case management services include a comprehensive, ongoing assessment of medical, mental health, substance use disorder or dental needs plus the development and implementation of a plan to obtain or make referrals for needed medical, mental, chemical dependency, or dental services, referring members to community services and supports that may include referrals to allied agencies.

If you are an agency with a certificate of approval, an additional definition of case management is: (309-019-0105(16)): "Case management" means the services provided to assist individuals who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, entitlement, and other applicable services.

We suggest that one of the CM/CC codes will more closely describe this encounter with the teacher. The provider’s credential will determine the specific code.

Q - I need to know how to use emergency (90839) and the add-on codes for one or two additional 30-minutes—a total of 90 minutes or 120 minutes.

A- The first thing to remember is that this is a psychotherapy for crisis service and not a crisis intervention service such as h2011, s9484, or one of the other crisis codes that are often used. If the alphanumeric codes more accurately describe the service, they should be the first choice.

If indeed psychotherapy is needed for crisis, the process is to claim 90839 for the first 30-74 minutes, then 90840 for the next 30 minutes. So, in your example, a single claim for 90839 and 90840. Consider this: the alphanumeric codes are often more descriptive of the service and flexible with billable units. Take a close look at those codes. Of course, if it is psychotherapy you are providing, the answer is 90839 and appending 90840 (90840 should never be used alone).

Q- When is it appropriate to use the 02 telehealth place of service code and does the documentation need to explain why it is being used? For example, a phone session was done because the client couldn't get transportation or was feeling ill.

A- The telehealth site of service code (02) has a very specific definition and requirement, as defined by CMS. It does not refer to routine services as you describe in your example and it is not intended for telephonic services.

For a telehealth place of service code to be appropriate, the client would have to be in a healthcare professional shortage area (HPSA, as determined by the US Department of Health and Human Services) and a non-metropolitan statistical area, by a clinician delivering a covered service from a "distant" site (the location of the provider which has the correct telehealth equipment), and to a client in a facility that qualifies as an "originating" site (also defined by DHHS).

Phone calls to or from your office for a client who is temporarily unable to keep a regularly scheduled appointment, or who may need temporary crisis/emergency contact by phone would not qualify.

Consider this: using your typical place of service (POS) code (E.g. 11). Depending on the credential of the provider and the content of the call, there are generally or HCPCS codes your payer has agreed to reimburse when provided by phone. These will be payer-specific. On each occurrence, the documentation should describe the circumstance(s) necessitating the call, especially if the call replaces a face-to-face visit.

Q- What do the feds say about the minimum # of minutes of service that need to occur to justify a per occurrence CPT? HCPCS code? Is there is still a minimum amount of services needed to support a per occurrence code? For example, would a 2-minute service substantiate a per occurrence billing?

A- Assuming "per occurrence" refers to any service you provide and get paid for that do not have time attached to them (as the psychotherapy and some others do), it's fairly simple: you get paid for what you do as required by the CPT/HCPCS I-ii or payer manuals for that specific service, and the description of which will reside in the medical record.

The time-based codes are self-explanatory: 30-minutes; per diem; per 15 minutes, etc.
Consider this: I've been at this for 40+ years and have defended many providers who got themselves in significant trouble with federal and/or state oversight bodies. Even with that experience, I would have a very hard time defending a provider who was delivering a 2-minute service.

Q- What CPT code to use for consultations with other providers without the patient present?

A- In this instance, the question does not contain enough info about what type of consultation is happening. We are not able to guess or cover all scenarios. The act of consultation is not in and of itself a covered service – the content of the consultation is what matters when billing for these services.

How do I bill, and when?

Q - I am providing therapy for a child, and both parents meet with me separately on the same day for the same member-- mom with the child for 45-50 minutes (without dad present), then dad with the child for 45-50 minutes (without mom present).

I have been billing for one session of family psychotherapy with client present, but I am wondering if it is okay to bill for two units of family psychotherapy with client present? --can one bill for two units of 90847 on the same day? Or would it be more appropriate to bill for two units of 90834, psychotherapy, 45 minutes with patient and/or family member?

A – In general, payers do not cover two family psychotherapy services with the patient present in one day. Try thinking of it this way: there is 1 client (the child); there isn't an upper limit time for billing 1 unit of the service (though some payers have a minimum); so, you are seeing the client for 90 minutes and bringing in one family member at a time. And, that's the way a payer or auditor would see it.

Q - A client was in crisis when she came in for her regular appointment. A second 60-minute session was scheduled with her the same day to utilize the crisis to move her forward in her therapy. How would the second hour be coded to get paid for it (90839 +90840 +90840)?

A - The CPT codes 90839 and 90840 are used for emergency sessions with patients who are in high distress and under complex or life-threatening circumstances that demand immediate attention. It's important to note that 90840 is an add-on code that must be used in conjunction with 90839.

In a crisis scenario, 90839 is billed for the first 60 minutes (though it can be used for 30-74-minute sessions), and 90840 is billed for each additional 30 minutes. Using both of these codes together requires that the session lasts 75 minutes or longer.

If you don't meet the time required to bill one or both of these two crisis codes, you can bill the standard CPT code for the session, such as 90832 (individual psychotherapy, 30 minutes). In this description, it seems as if the patient came for a regularly scheduled session of 1 hour during which the crisis situation was discovered.

The crisis necessitated a second one-hour encounter. The recommended coding is 90837 for the regularly scheduled hour (at which the crisis elements were prominent) and 90839 for the encounter prompted by the crisis. Due to national correct coding initiative (NCCI) auto-edits, it may be necessary to append the 90837 with the modifier -59.

Q - I have a provider that is seeing patients for an initial visit, plus a 60-min psychotherapy on the same day. Can he bill out a 90791 and a 90837? He's not a prescriber so can't bill e/m codes.

A - Billed without modifier, a psychotherapy by the same provider on the same day as a diagnostic visit is not allowable (wouldn't pass NCCI edits). The theory (the AMA, not me) is that 90791 has no minimum or maximum time attached, therefore is only content based, and that any counseling (or psychotherapy) provided adjunct to the visit is included in the time spent and payment.

I think the only way to be paid for this would be to add the modifier 59 to the 90791 and submit both services on the same claim. It's not clear how one would document the need for this immediate psychotherapy based on the outcome (one assumes) of a just completed diagnostic interview. It would certainly have to be an unusual occurrence and not a pattern of diagnostic visits followed by an hour of psychotherapy.

If the services are provided by two different providers, the 59 modifier would be appended and both claims would/should be paid whether on the same or different claims.

Consider this: if the patient's appointment is for a diagnostic interview (90791) and there is need for additional time due to challenges (for example, high anxiety, high reactivity, repeated questions, or disagreement), adding the code for interactive complexity (90785) may be more appropriate than adding modifiers and psychotherapy. And, you're much more likely to get paid.

Q - We are starting a weekly drop-in group facilitated by an LCSW for existing patients. The group will be art-focused, with an emphasis on interventions that reduce stress, improve emotion regulation, encourage problem-solving skills, and boost mood. During the group, patients will also have the opportunity to meet with a medical provider, and he will bill appropriately for those visits. We are hoping that this group will help patients access medical care promptly, and provide a therapeutic benefit in the process. For JCC members who attend this group, would it be appropriate for me to use g0176 (activity therapy)? Do you know whether g0176 requires a linked mental health assessment and treatment plan? Is it for Medicare only? I think the alternative is 96153.

A- The easy part, first: I think it would be very difficult to make the case that anything you are calling a "drop-in" service will meet the federal definition of psychotherapy. My 40 years of experience doing this leads me to believe that you can no longer order psychotherapy on a "PRN" or as needed basis – those days have long passed. Nearly every service beyond emergent care, or a very temporary change in modality, requires all the regulatory bells and whistles.

Consider this: regarding the G-code part of the question, what's the activity? What you describe is a care coordination model, with emergent/urgent medical care available. If that's an accurate understanding of what you've outlined, I'd be willing to bet the farm (probably yours, not mine) that we could work with JCC to "find a way" if this is truly doing as advertised.

Q - When counselors are required to appear in court after being subpoenaed, since there is no billable code to compensate for the time and the occasional stipend from the court does not cover costs, can the provider bill the attorney directly some fee that is more in line with the cost of the service and is there any rule (similar to not being able to bill a no-show fee) for OHP clients? Does it matter if it's a criminal case or permanency hearing? And, if attorneys are just being excessive and are unwilling to work with the provider (I.E. being ok with records and an affidavit versus having to actually appear in court), do they have any recourse? Wondering if there's just a general way to deter what seems to be developing into a growing issue and what our rights as agencies are within this process.

A- In most cases, it is either the state v our client, or, our client v the state. In some straight parent/parent or parent/family custody battles, it may be that we get pulled in via subpoena to testify for one side or the other. In the latter (straight custody) you may be able to negotiate some sort of appearance fee if you are willing to risk fighting a subpoena and the testimony is so valuable to one party, they consider paying you a fee. But, I would recommend you consider the impact this stance would have on opinions regarding the impartiality of your clinical practice.

The two caveats in this one: 1). I have been called in both civil and criminal cases as an expert witness and, in turn, been paid for my time. But, to be clear, that's not what we're talking about; 2). I'm not your lawyer.

In most cases, if you are handling the subpoena for records correctly, there is some negotiation room in the appearance factor. But, you should have someone else in your organization be arguing that for you and that's going to be very dependent on the lawyers. If you are in private practice, feel free to make

your own argument against appearance, but, it is not wise to refuse or to refuse unless you are compensated. In the eyes of the court, there is very little difference – you are simply in violation of the subpoena.

Consider this – have your own policy and process regarding how subpoenas for paper and appearance are handled. Make part of it that someone reaches out to the issuer of the subpoena. I think JCC made available some suggestions for how to respond to subpoena through the training sessions from last year. Check it out.
Most of the time clinicians are appearing for their clients, in one capacity or another, and get paid by an agency unless in private practice.
If you are in private practice, you can sometimes negotiate your way out of an appearance if they have the records. I don't know of an or prohibition about negotiating a fee, but, it's a subpoena.

In either case, entity or private practice, there are rules about charging for copies of the record.

Corrected Claims

Q - Is there compliance risk around submitting corrected claims for a modifier issue vs. just re-submitting the claim without flagging it as a corrected claim?

A- The simple answer is "yes". Without knowing the status of the original claim (paid, denied, pended, appealed, etc) any answer is general. But, you can't have two claim numbers in any system for the same service, even for a modifier issue.

The "proper" way of dealing with this (financial and billing systems aside) is to make sure the initial claim is fully adjudicated and not create a new claim until/unless instructed to do so by the payer. Complete adjudication may mean denial-appeal-payment/denial-whatever is next, or, payment (of the incorrect claim) and adjustment based on the payer's instructions.

Consider this: very good that you caught this and are dealing with it. Best practice is to learn how the "modifier issue" occurred and make whatever systemic changes you need to make to ensure it doesn't happen again. Turn an "issue" into a model for how well your compliance process works.

Billing Services

Q - Am I able to charge providers for my services as a billing company on a percent-based fee based off the provider's collections (patient, private insurance and Medicaid). OAR 410-12-0130 section (12) is rather gray and I want to make sure I am understanding it correctly. I have contacted the state directly and was told this OAR does not apply to the way I charge for my services, and only applies to billing for a rate that had been increased if a service was transferred to a collection agency, etc. For example: the provider bills a 90837 to Medicaid, I submit the claim and Medicaid then reimburses the provider directly the DMAP rate of $144.41. Are there any restrictions that prohibit me from charging a percent of the $144.41 collected for the services I provided in billing this for the provider?

A- I'm not immediately aware of any state restrictions on what a private company can charge for its services. There are many, many billing companies offering a variety of package services from claims-submission only all the way to providing one-stop shopping for everything from claims scrubbing to handling appeals. I'd look around at my colleagues/competition as a starting place.

Also, be aware there will be some common-sense rules related to what a provider will pay to have someone else file claims. That would be important information, too.
Consider this: the US Department of Health and Human Services, Office of the Inspector General (commonly referred to as the OIG) issued guidance for third party billing companies that deal with government healthcare programs (primarily Medicare and Medicaid) about 20 years ago. It may have been updated and you'd find that on the OIG compliance home page. Here's a link to the federal register guidance document: https://oig.Hhs.Gov/fraud/docs/complianceguidance/thirdparty.pdf.