



State of New Mexico
Medical Assistance Program Manual
Supplement



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TO: BEHAVIORAL HEALTH PROVIDERS

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**SUBJECT: I: BILLING FOR MEDICATION MONITORING BY RNs
II: GROUP THERAPY – SAME DAY BILLING
III: CLARIFICATION ON PROLONGED SERVICE
IV: ASSERTIVE COMMUNITY TREATMENT (ACT) UPDATES
V: THE USE OF PROVISIONAL DIAGNOSES FOR THE “TREAT FIRST” CLINICAL MODEL**

I: Billing For Medication Monitoring By Registered Nurses (RNs) and Physician Assistants (PAs) – Effective January 1, 2017

HCPCS code H2010, medication monitoring, is reimbursable for services provided by Registered Nurses with either behavioral health experience or a psychiatric-mental health nursing certification, Certified Nurse Specialists in Psychiatry, Certified Psychiatric Nurse Practitioners and Physicians Assistants to fee for service recipients and managed care members effective January 1, 2017 for practitioners enrolled in any of the below listed agencies. For H2010 without the U8 modifier the fee is currently \$15.65, and with the U8 modifier is \$30.00. All H2010 services, i.e. both with and without the U8 modifier, will be paid at \$30.00, effective January 1, 2017. Until further notice the U8 modifier can continue to be utilized for the Psychosocial Rehabilitation Program (PSR).

Other Payment arrangements may have been made with individual MCOs prior to January 1, 2017 and shall be honored.

H2010 service includes:

- medication assessment
- administration
- monitoring
- education

The target populations are children and adults diagnosed with a mental health and/or substance abuse disorder.

The following provider types are included when working within their scope of practice as delineated by the American Nurses Association (ANA), or the National Commission on Certification of Physician Assistants (NCCPA):

- RN, provider type 317, with either a specialty of 059, psychiatric RN, or 096, other RN. This includes those RNs grandfathered in by OHNM at the start of Centennial Care;
- CNP, provider type 316 with a specialty of 097 psychiatric;
- CNS, provider type 306; and
- PAs, provider type 305.

The above named providers must be working within one of the below named facilities in order to bill HCPCS code H2010:

- Indian Health Services or Tribal 638 Clinics
- Federally Qualified Health Centers (FQHC)
- Community Mental Health Centers (CMHC)
- Core Service Agencies (CSA)
- CareLink NM Health Home (CLNM)
- Behavioral Health Agencies (BHA)

Billing for CMHC, CSA, CLNM, and BHA: The rendering provider name and NPI are not currently a requirement for billing when the service is provided by an RN, but may be a CMS requirement in the future. The agency NPI, therefore, can be placed in the rendering field. RNs or PAs that are not currently enrolled and are affiliated with one of the above agencies are encouraged to enroll now. This entails an individual practitioner procuring an NPI if they don't already have one, and then applying to Xerox, the Medicaid fiscal agent for a Medicaid ID, and affiliating with the agency for which they are working. Refer to the attachment for information on enrolling as a Medicaid provider.

Once receiving this ID the practitioner is rostered with each of the applicable MCOs to be identified as a service provider within that agency. At this point the practitioner's name and NPI can be utilized in the rendering fields on a claim.

Physicians, prescribing psychologists, CNPs, CNSs, and PAs are to use the Evaluation and Management code that includes medication management, rather than H2010, unless medication management is the only service that is performed. When the medication management is provided separately from any other evaluation or therapy service, the code H2010 can then be billed by the physician, prescribing psychologist, PA, CNP or CNS.

Billing for FQHC, IHS and Tribal 638 facilities

Indian Health Service facilities, Tribal 638 facilities, and Federally Qualified Health Clinics may bill their encounter rates when this service is provided even if no other

medical or behavioral health service is being billed for that same day. If this service and another behavioral health service are performed on the same day, only one OMB rate or one FQHC encounter rate can be billed.

II: Group Therapy – Same Day Billing Effective 1/01/2017

The unit of service for CPT codes 90849 (multiple family group psychotherapy), and 90853 (Group psychotherapy (other than a multiple family group)) is the patient encounter even if it lasts longer than one hour. A practitioner may usually report only one unit of service on a single date of service for the same patient, however, there are some exceptions.

A behavioral provider, i.e., CMHC, CSA, CLNM, BHA, or group practice may report one unit of service for each separate and distinct family or group therapy session provided by a different practitioner or a different type of group for up to 3 separate encounters on the same day. Utilize the modifiers:

- XE Separate Encounter, a Service That Is Distinct Because It Occurred During a Separate Encounter
- XP Separate Practitioner, a Service That Is Distinct Because It Was Performed By a Different Practitioner

Note that FQHC, IHS or 638 tribal facilities may bill more than one encounter or OMB rate on the same day for completely different services, such as a behavioral health visit and eye exam. In the above description, these multiple behavioral health services are considered sufficiently different as to allow an encounter or OMB rate to be billed for each of the different services above.

III. Clarification On Prolonged Service: 99354 – 99357 Effective 1/01/2017

- a) 99354 – 99355 are used to report the total duration of face-to-face time spent by a physician or other qualified health care professional on a given date providing prolonged service in the office or other outpatient setting, even if the time spent on that date is not continuous. These codes are reported separately from the original E & M or psychotherapy session. Time spent performing separately reported services other than the E/M or psychotherapy service is not counted toward the prolonged services time.
- b) 99356 – 99357 are used to report the total duration of time spent by a physician or other qualified health care professional in an inpatient or nursing facility on delivering face-to-face service at the bedside and time spent on the patient's floor or unit on a given date providing prolonged service, even if the time spent on that date is

not continuous.

- c) 99354 or 99356 are used to report the first hour of prolonged service on a given date, depending on the place of service. They are to be listed separately from the original E & M or treatment code. 99355 or 99357 are used to report each additional 30 minutes. Either code may also be used to report the final 15-30 minutes on a given date. Prolonged service of less than 15 minutes beyond the first hour or beyond the final 30 minutes is not reported separately.
- d) Any prolonged service of less than 30 minutes total on the same day beyond the original session is not reported; it is considered included in the original session.

These codes can be reported by all licensed clinicians delivering psychotherapy within their scope of practice. The pricing will be incorporated in the next version of the Behavioral Health fee schedule.

IV: Assertive Community Treatment (ACT) Updates – Effective 1/01/17

The ACT program provides four levels of interaction with the participating individuals:

- 1. Face-to-face encounters
- 2. Collateral encounters designated as members of the recipient's family or household, or significant others who regularly interact with the recipient and are directly affected by or have the capability of affecting his or her condition, and are identified in the service plan as having a role in treatment.
- 3. Assertive outreach is defined as the ACT team being assertive in their knowledge of what is happening with an individual and acting quickly and decisively when action is called for, while increasing client independence.
- 4. Group encounters defined by the following types:
 - a) Basic living skills development
 - b) Psychosocial skills training
 - c) Peer groups
 - d) Wellness and recovery groups

Each ACT team shall include at least:

- 1. One team leader;
- 2. One board-certified or board eligible psychiatrist, OR psychiatric nurse practitioner, OR psychiatric clinical nurse specialist, OR prescribing psychologist under the supervision/consultation of an MD which may be provided via telehealth;
- 3. Two nurses, one of whom shall be a registered nurse;
- 4. One other licensed mental health professional;
- 5. One licensed substance abuse professional;
- 6. One employment specialist; and
- 7. One peer specialist or family specialist.

Note: For those existing ACT teams that have been utilizing a non-MD because of the scarcity of psychiatrists, this change will be considered a retroactive waiver.

Billing: Utilize the following modifiers when billing HCPCS code H0039 (ACT);

1. U1 – face to face
2. U2 – collateral encounter
3. U3 – assertive outreach
4. U4 – group encounters

V: The Use of Provisional Diagnoses for the “Treat First” Clinical Model - Effective 1/11/2016 For Designated Providers

Outpatient BH therapy and all specialty services can be initiated and billed before a psychiatric diagnostic evaluation has been completed. The specification of a diagnosis may be deferred until after the fourth (4th) session where upon a diagnosis will then be established and appropriately documented in the medical record and on all subsequent billed claims. There will always be a “provisional diagnosis” on any claim through the 4th encounter if the diagnostic evaluation has not yet been completed. This shall include all appropriate ICD 10 classified external causes of morbidity (V, X and Y diagnosis codes).

Attachment 1: Enrolling As a Medicaid Provider and Verifying Enrollment Status

To enroll as a provider, refer to the following website:

Web application process: <https://nmmedicaid.acs-inc.com/webportal/enrollOnline>

To verify current enrollment status, refer to the following on line “Look-Up” tool:

Provider Search: <https://nmmedicaid.acs-inc.com/webportal/providerSearch>

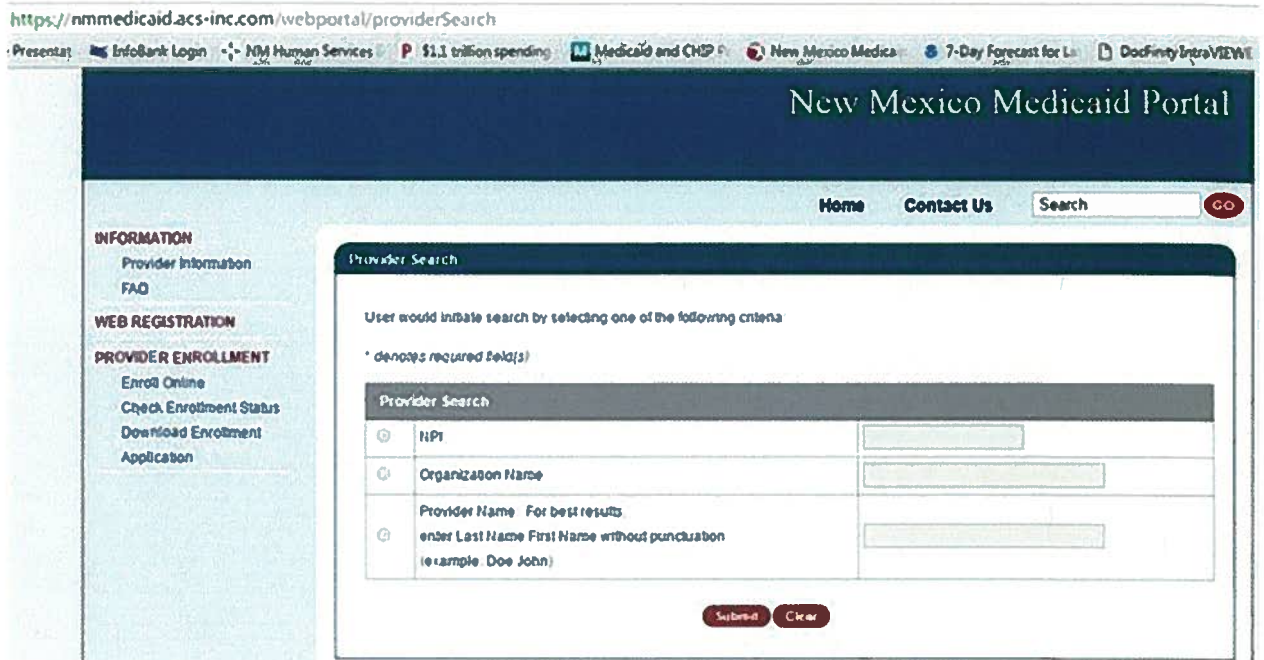
Click on the ‘Provider Search’ link on the left side of the screen (highlighted in yellow below)

The screenshot shows a web browser window with the URL <https://nmmedicaid.acs-inc.com/static/ProviderInformation.htm>. The browser's address bar and tabs are visible at the top. The website header includes the text "New Mexico". On the left side, there is a navigation menu with the following items: HOME, PROVIDER, Provider Login, Provider Information, FAQ, E-News and Notices, Links, Contact Us, and Provider Search (highlighted in yellow). The main content area is titled "Provider Information" and contains several sections: "1095 Information", "Electronic Data Exchange (EDI)", and "Downloading Tips". Under the "1095 Information" section, there is a table with the following content:

Topic	Wor
Questions and Answers about Health Care Information Forms for Individuals (Forms 1095-A, 1095-B, and 1095-C)	Not

Under the "Electronic Data Exchange (EDI)" section, there is a sub-section titled "What's new with EDI" with a "Wor" status.

Then you can do a search by NPI, organization name or provider name:



- If you do not get any results, re-check the information entered.
- You can search for an organization even by just putting part of the organization's name in the search field.

If the searches above do not locate the provider, it is likely that the provider is not enrolled as a Medicaid provider.

If you need additional help determining whether a provider is already enrolled, you may contact the fiscal agent, Xerox, at:

Provider Relations - HIPPA Helpdesk

Local
Toll Free
Email

505-246-0710 option 6
1-800-299-7304 option 6 then option 4
HIPPA.Desk.NM@xerox.com