



QUEST Integration Supervision Requirements for Behavioral Health Providers in FQHCs and RHCs

AlohaCare is issuing this provider advisory to communicate billing and reimbursement guidelines for unlicensed behavioral health providers who are under the supervision of a licensed behavioral health provider in FQHCs and RHCs.

In January 2012, the Med-QUEST Division (MQD) issued a memo providing guidance regarding the reimbursement of unlicensed behavioral health providers in FQHCs and RHCs. A copy of this memo has been included with this advisory.

MQD provided the qualifications, supervisory requirements, and reimbursement guidelines in the 2012 memo. As a QUEST Integration Health Plan responsible for reimbursement, AlohaCare wanted to call attention to the reimbursement guidelines provided in the MQD memo.

Reimbursement to FQHC/RHCs

Services provided by an unlicensed behavioral health provider located at an FQHC/RHC are not eligible for Prospective Payment System (PPS) reimbursement. Services are eligible for reimbursement at 50% of the applicable AlohaCare plan fee schedule associated with the supervising provider. The following conditions must be met:

- The supervising provider must be either a psychologist or a psychiatrist in AlohaCare's network;
- The supervising provider is the provider of record of the service and must submit the FFS claims for therapy services with the modifier "HO";
- The supervising provider and/or the FQHC/RHC must provide AlohaCare with a listing of the unlicensed behavioral health providers and a copy of their master's degree;
- The therapy services covered will be limited to individual therapy in the clinic setting; and
- Only the following HCPCS codes will be covered:

**QUEST Integration
Supervision Requirements for Behavioral
Health Providers in FQHCs and RHCs**

2012 Code w Modifier	Active BH Code w Modifier	Description
90804 HO	90832 HO	Individual psychotherapy, insight orientated, behavior modifying and/or supportive, in an office or outpatient facility, approx. 20 to 30 minutes face-to-face with the patient.
90806 HO	90834 HO	Individual psychotherapy, insight orientated, behavior modifying and/or supportive, in an office or outpatient facility, approx. 45 to 50 minutes face-to-face with the patient.
90808 HO	90837 HO	Individual psychotherapy, insight orientated, behavior modifying and/or supportive, in an office or outpatient facility, approx. 75 to 80 minutes face-to-face with the patient.

Please note the 2012 MQD memo is still in effect; however, there were changes to the psychotherapy codes effective January 1, 2013. MQD issued a memo on March 8, 2013 to describe the crosswalk from the former codes to the new codes. A copy of this memo has been included with this advisory.

AlohaCare advises the FQHCs/RHCs who are using unlicensed behavioral health providers to ensure claims are submitted with the appropriate psychotherapy codes, with a modifier HO.

AlohaCare values the use of such providers to increase access to quality care, especially in our rural and remote communities.

Thank you for the services you provide to our members. Please contact AlohaCare’s Provider Relations Department at (808) 973-1650 or toll free at 1-800-434-1002 with questions.



**STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES**

Med-QUEST Division
Health Care Services Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

January 5, 2012

MEMORANDUM

QUEST MEMO

ACS-M12-01 [FFS]
ADM-1201 [QUEST]
ADMX-1201 [QExA]

TO: QUEST and QExA Health Plans
Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC)

FROM: Kenneth S. Fink, MD, MGA, MPH *KF*
Med-QUEST Division Administrator

SUBJECT: SUPERVISION REQUIREMENTS FOR BEHAVIORAL HEALTH
PROVIDERS IN FQHCs AND RHCs

The Med-QUEST Division (MQD) is issuing this memorandum to provide guidance regarding reimbursement for unlicensed behavioral health providers who are under the supervision of a licensed behavioral health provider in FQHCs and RHCs. In addition, supervisory requirements are being established to not only promote access to care, but to ensure that care is provided in a high quality manner. The use of unlicensed behavioral health providers is permissible in order to increase access to behavioral health services, especially in rural communities that have limited access. Health plans are not required to cover services provided by unlicensed behavioral health providers as long as their provider networks are sufficient to assure member access to necessary behavioral health services.

Qualifications

- The supervising provider is either the provider who is contracted with the health plan or the employee of a contracted provider if the contracted provider is not an individual. Since unlicensed behavioral health providers are providing care, the supervising requirements identified below must be met in order to assure quality of care.
- The supervising provider must be licensed in Hawaii and supervise no more than ten (10) unlicensed behavioral health providers in the State.

- The supervising provider must have policies and procedures to select and monitor the behavioral health providers he/she is supervising that must include but not be limited to:
 - Accurate, legible therapy notes that reflect the treatment goals of the member; and
 - Understanding and implementing State and Federal privacy, confidentiality, and security requirements and laws.

Supervisory Requirements

- The supervising provider complies with applicable State and Federal laws and regulations relating to supervision of unlicensed providers, including but not limited to Hawaii Administrative Rules §16-98-4 (Direction of an individual by a psychologist).
- The supervising provider and the unlicensed provider must work in the same physical setting or location. However, use of an alternate method of communication that has been approved by the supervising provider's specialty board (i.e., telehealth or video teleconference) is permitted provided the other requirements are met.
 - During utilization of an alternate method of communication (i.e., telehealth or video teleconference), the supervising provider must be readily available to the unlicensed behavioral health provider at all times. The telephone is not an acceptable method of communication for supervision. In addition, the licensed provider must conduct one face-to-face/in-person supervision session of the unlicensed behavioral health provider at least once every thirty (30) days.
- Supervision must be performed at a minimum frequency of weekly on the therapy the unlicensed behavioral health provider is providing to each individual patient. The supervision of each unlicensed behavioral health provider must be performed individually. Due to privacy and security requirements, it is not acceptable for therapy supervision to be conducted with a group of behavioral health providers. This supervision shall be documented in a supervisory note.
- The supervising provider must develop each member's plan of care with the unlicensed behavioral health provider. The plan of care must include all pertinent diagnoses and have appropriate short-term and long-term goals. The therapy that is provided must be directed towards the established goals.
- The unlicensed behavioral health provider being supervised must have at a minimum a Master's degree in psychology or a human services related field of study and have a minimum of three (3) years of experience in behavioral health that may include their practicum.
- At a minimum, the supervision must be documented as follows:
 - All of the documents must be legible and kept in the individual member's record.
 - The plan of care (including diagnoses and goals) must be signed by both the supervising behavioral health provider and the unlicensed behavioral health provider.

- A reassessment of the plan of care must be performed by the supervising behavioral health provider and the unlicensed behavioral health provider at a minimum of every six months. The reassessment should include any changes in diagnoses, short-term or long-term goals.
- Therapy notes must be signed by both the unlicensed behavioral health provider and the supervising behavioral health provider.
- All supervisory notes must be signed and dated by the supervising provider and included in the patient’s record.
- Upon request, the supervising provider must make all individual members’ clinical records available to the MQD and the Centers for Medicare & Medicaid Services (CMS) and their authorized agents.

Reimbursement to FQHC/RHCs

Services provided by an unlicensed behavioral health provider located at an FQHC/RHC or under the supervision of a supervisory provider located at an FQHC/RHC are not eligible for Prospective Payment System (PPS) reimbursement. Services are eligible for reimbursement at 50% of the Medicaid fee-for-service (FFS) rate, consistent with reimbursement for “incident to” services, for eligible individuals enrolled in the FFS program in the following circumstances:

- The supervising provider must be either a psychologist or a psychiatrist who is an active Hawaii Medicaid Provider;
- The supervising provider is the provider of record of the service and must submit the FFS claims for therapy services with the modifier “HO.” Reimbursement will be at 50% of the Medicaid rate for the code;
- The supervising provider and/or the FQHC/RHC must provide the MQD with a listing of the unlicensed behavioral health providers and a copy of their master’s degree. This listing must be updated when any change is made;
- The therapy services covered will be limited to individual therapy in the clinic setting; and
- Only the HCPCS codes listed below will be covered.

Code	Description
90804 HO	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient.
90806 HO	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient.
90808 HO	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient.

Services that are specifically excluded from being eligible for provision by an unlicensed behavioral health provider include but are not limited to the following:

- Psychiatric evaluations;
- Group therapy;
- Family therapy with/without the patient present; and
- Conjoint therapy.

If the service provider is not able to prescribe and medication is needed, care should be coordinated to get the patient seen by a provider who can prescribe. If the patient is seen at a FQHC/RHC by a provider who is unable to prescribe and on the same day is seen by a provider who can prescribe to treat the behavioral health condition, the FQHC/RHC shall submit a PPS claim for a behavioral health visit and the unlicensed behavioral health provider and supervising behavioral health provider shall not submit either a FFS or PPS claim.

In addition, a face-to-face encounter with the member by the licensed supervising provider is eligible for PPS reimbursement even if an unlicensed behavioral health provider or other health care team member provided information to support the face-to-face encounter so long as the licensed supervising provider was present for the key portions of the encounter and documents such. Any support work provided by the unlicensed behavioral health provider or other health care team member would then be considered included in the billing by the supervising provider and no separate claim should be submitted.

Please contact Patti Bazin via e-mail at pbazin@medicaid.dhs.state.hi.us or call her at 692-8083 should you have any questions.



**STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES**


Med-QUEST Division
Health Care Services Branch
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March 8, 2013

MEMORANDUM

MEMO NO.
ACS M13-02

TO: Behavioral Health Providers

FROM: Kenneth S. Fink, MD, MGA, MPH 
Med-QUEST Division Administrator

SUBJECT: CHANGES TO PSYCHOTHERAPY CODES FOR FEE-FOR-SERVICE (FFS)
REIMBURSEMENT EFFECTIVE JANUARY 1, 2013

The Med-QUEST Division (MQD) is sending this memo upon learning that providers may not be fully aware of the American Medical Association (AMA) update to the Current Procedural Terminology (CPT) codes for psychotherapy effective January 1, 2013. Attached is a chart that describes a crosswalk to former and revised reimbursement codes for psychotherapy services. In addition, included is an attachment on guidelines for use of Interactive Complexity code. Utilize these AMA revised psychotherapy codes for FFS Medicaid beneficiaries for services provided January 1, 2013 or later.

Xerox, the MQD fiscal intermediary, will deny all claims submitted using the former CPT codes that are billed for FFS beneficiaries. Please resubmit these claims using the revised codes.

Thank you for all of the services that you provide to our Medicaid beneficiaries. Please contact the Provider Hotline at 808-692-8099 should you have any questions.

Attachments

c: QUEST/QExA Health plans
Community Care Services (CCS)

Psychotherapy Codes – Effective January 1, 2013

The 2013 Current Procedural Terminology (CPT) replaces several of the former CPT codes for behavioral health services. Some of these new CPT codes allow the provider to use the interactive complexity code (90785) in addition to specific psychiatry codes for individuals that have specific communication factors that complicate the delivery of primary psychiatric procedures such as having a third party (i.e., parent or legal guardian) involved in their psychiatric care. Attachment A describes additional requirements for using interactive complexity code (90785). In addition, the 2013 CPT revised the definition of several psychotherapy codes to allow either a psychiatrist or advanced practice registered nurse (APRN) to separately report evaluation and management (E&M) services performed on the same day as psychotherapy. The 2012 CPT codes listed in the column “Former CPT Code” are the most commonly used psychotherapy codes. Inpatient Hospital, Partial Hospital or Residential Care Facility codes 90816-908922 and Interactive Psychotherapy codes 90823-90829 have been deleted from the 2013 CPT and should be crosswalked to 2013 codes. Please note that the therapy time of 2013 codes differs from the time in the 2012 CPT.

Qualified mental health providers are licensed behavioral health providers (psychiatrist, psychologist, APRN behavioral health, clinical social worker, mental health counselor, and marriage family therapist).

Former CPT Code	CPT Code	New Description	Rate	Comments
N/A	90785	Interactive complexity	\$4.77	<ul style="list-style-type: none"> List separately in addition to the specific codes listed below
90801	90791	Psychiatric diagnostic evaluation	\$104.43	<ul style="list-style-type: none"> May add 90785; Cannot code with E&M; Same rate for psychiatrist and psychologist; Residents okay; No telemedicine.
N/A	90792	Psychiatric diagnostic evaluation with medical services	\$104.43	Same as 90791
90804 20-30 min	90832	Psychotherapy, 30 min with patient and/or family member	\$46.62	<ul style="list-style-type: none"> May add 90785; Cannot code with E&M; Same rate for psychiatrist and psychologist; Other qualified mental health providers at 75% of rate; Residents okay; Telemedicine okay.

Former CPT Code	CPT Code	New Description	Rate	Comments
90806 45-50 min	90834	Psychotherapy, 45min with patient and/or family member	\$75.00	Same as 90832
90808 75-80 min	90837	Psychotherapy, 60 min with patient and/or family member	\$110.09	Same as 90832
90805 20-30 min	90833	Psychotherapy, 30 min with patient and/or family member when performed with an E&M service	\$42.15	<ul style="list-style-type: none"> • May add 90785; • May code with E&M as long as added separately in addition to primary procedure code; • For psychiatrist; APRN paid at 75% • Residents okay; • Telemedicine okay.
90807 45-50 min	90836	Psychotherapy, 45 min with patient and/or family member when performed with an E&M service	\$68.43	Same as 90833
90809 75-80 min	90838	Psychotherapy, 60 min with patient and/or family member when performed with an E&M service	\$110.68	Same as 90833
90862	N/A	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services	N/A	Medication management services should be billed by a physician with an E&M code.
90845	90845	Psychoanalysis	\$65.82	<ul style="list-style-type: none"> • Cannot code with 90785; • Same rate for psychiatrist and psychologist; • Other qualified mental health providers at 75% of rate; • Residents okay; • Telemedicine okay.
90846	90846	Family psychotherapy (without patient present)	\$71.55	<ul style="list-style-type: none"> • Cannot code with 90785; • Cannot code with E&M; • Same rate for psychiatrist and psychologist; • Other qualified mental health providers at 75% of rate; • Residents okay; • No telemedicine.

Former CPT Code	CPT Code	New Description	Rate	Comments
90847	90847	Family psychotherapy (conjoint psychotherapy) (with patient present)	\$82.73	<ul style="list-style-type: none"> • Cannot code with 90785; • May code with E&M as long as added separately in addition to primary procedure code; • Same rate for psychiatrist and psychologist; • Other qualified mental health providers at 75% of rate; • Residents okay; • No telemedicine.
90849	90849	Multiple-family group psychotherapy	\$25.38	<ul style="list-style-type: none"> • Cannot code with 90785; • Cannot code with E&M; • Same rate for psychiatrist and psychologist; • Other qualified mental health providers at 75% of rate; • Residents okay; • No telemedicine.
90853	90853	Group psychotherapy	\$24.71	<ul style="list-style-type: none"> • May add 90785; • Group psychotherapy must include interactive complexity; • Same rate for psychiatrist and psychologist; • Other qualified mental health providers at 75% of rate; • Residents okay; • No telemedicine.

Attachment A

Interactive Complexity – Guidelines for use

Definition:	Interactive complexity is a code that is used to identify communication issues that make treatment of the individual more complicated when related to several psychotherapy procedures. The CPT add-on code for interactive complexity is 90785. Add-on codes may be reported in conjunction with several identified procedure codes. Add- on codes may not be used alone.
Individuals who this code may be used:	Those who have third parties, such as parents, guardians, other family members, interpreters, language translators, agencies, court officers, or schools involved in their psychiatric care. These factors are typically present with patients who: <ul style="list-style-type: none"> • Have other individuals legally responsible for their care, such as minors or adults with guardians, or • Request others to be involved in their care during the visit, such as adults accompanied by one or more participating family members or interpreter or language translator, or • Require the involvement of other their parties, such as child welfare agencies, parole or probation officers, or schools.
Use when at least one of the following is present:	<ol style="list-style-type: none"> 1. The need to manage maladaptive communication (related to e.g., high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicates delivery of care. 2. Caregiver emotions or behavior that interferes with the caregiver’s understanding and ability to assist in the implementation of the treatment plan. 3. Evidence or disclosure of a sentinel event and mandated report to third party (eg, abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants. 4. Use of play equipment, other physical devices, interpreter, or translator to communicate with the patient to overcome barriers to therapeutic or diagnostic interaction between the physician or other qualified health care professional (QHCP) and a patient who: <ul style="list-style-type: none"> ▪ Is not fluent in the same language as the physician or other QHCP, or ▪ Has not developed, or has lost, either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the physician or other QHCP if he/she were to use typical language for communication.
Able to use with the following codes:	The following psychiatric “primary” procedure codes: <ul style="list-style-type: none"> • Psychiatric diagnostic evaluation, 90791, 90792. • Psychotherapy, 90832, 90834, 90837. • Psychotherapy add-on codes, 90833, 90836, 90838 WHEN reported with E/M. • Group psychotherapy , 90853
May not be used with the following codes:	<ul style="list-style-type: none"> • Psychotherapy for crisis (90839, 90840) • Evaluation and Management (E/M) alone. This code cannot be used if the E/M code is not reported in conjunction with a psychotherapy code. • Family psychotherapy (90846, 90847, 90849).
Unit code only:	Used as one (1) unit only. No time allotment is used with this code.

Guidelines are adapted from 2013 Current Procedural Terminology (CPT) coding from American Medical Association (AMA) Interactive Complexity section.