Colorado Behavioral Health Coding Manual

Uniform Service Coding Standards (USCS)

Healthcare Common Procedure Coding System (HCPCS)

HIPAA (1996)

HIPAA required the Secretary of the Department of Health and Human Services (DHHS) to adopt standards for coding systems that are used for reporting health care transactions. Regulations were published in the Federal Register on August 17, 2000 (65 FR 50312), to implement standardized coding systems under HIPAA. These regulations provided for the elimination of “local codes” by December 31, 2003.

AMA/CMS

The Secretary of DHHS has delegated authority under HIPAA to the AMA and CMS to maintain and distribute annually.

Level I - Current Procedural Terminology (CPT), a uniform coding system consisting of descriptive terms and codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. [AMA controls]

Level II is a standardized coding system that is used primarily to identify drugs, biologicals and non-drug and non-biological items, supplies, and services not included in the CPT code set jurisdiction, when used outside a physician's office. [CMS controls]

State Medicaid

CMS releases its decisions on all coding actions on a quarterly basis and updates its coding manual annually. Each payer effectuates the changes to the code sets on its own timeframes. States have the authority to “open” codes at their discretion. But parameters of open codes should align with published details.

History of the Colorado USCS Manual

Medicaid Behavioral Health services are operated under a Managed Care Program

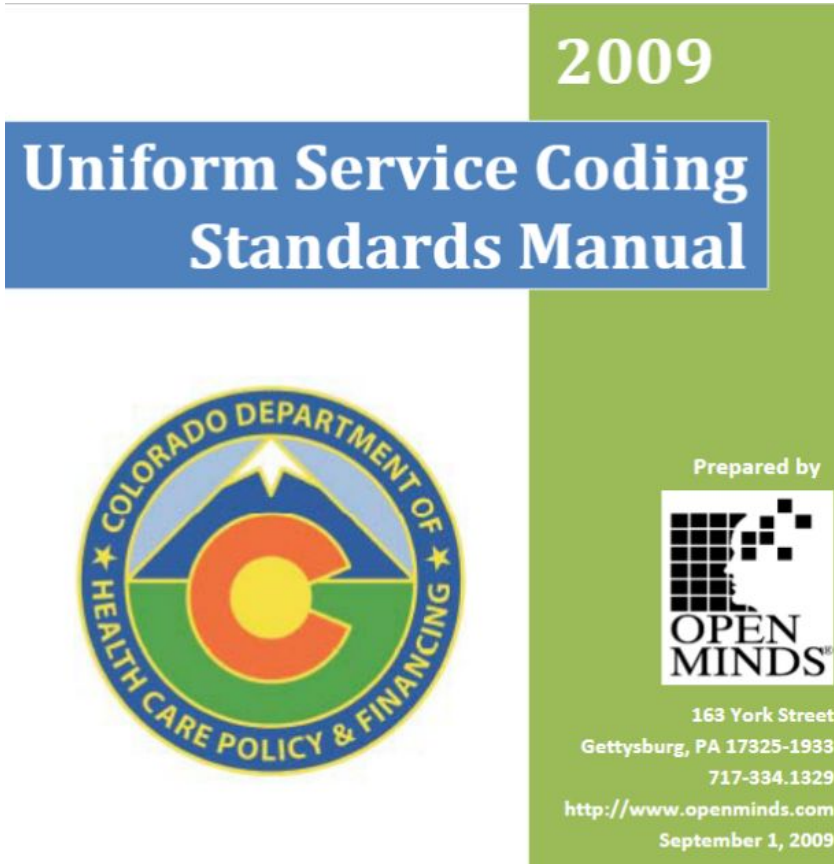
- The Colorado Medicaid Mental Health Capitation and Managed Care Program was implemented in 1995 in 51 counties and was expanded in 1998 to the remaining 12 counties of the state. The state was divided into five (5) specific geographic areas and one contractor, the Behavioral Health Organization, administered the program in each area. In 2004, program operations were transferred from the Department of Human Services to the HCPF, allowing for more cohesive management of the program.
- A 1915 B3 Waiver gives us authority to operate our managed care system
- Savings from managing care can be used to pay for alternative services
- "Alternative services" (i.e. B3 services) are services that are alternatives to inpatient care.

Historically the Community Mental Health Centers managed the Coding Manual, then the BHOs

- First Manual created in 2009
- These were the primary service providers of B3 services.
- ACC 2 saw significant changes in the role of CMHCs/BHO and expansion of our IPN – This has driven significant reform of the coding manual to meet the needs of a broader audience of providers

July 1, 2023 will reflect the next significant shift to include substantial content from the BHA and their role/scope of services.

- Merged OBH/Medicaid coding pages to align standards for providers
- BHA is primarily contract based (not claims based)
- MMIS reforms (R23) is working to bring BHA "claims" into the interchange (parallel system)



Managing the Colorado Coding Manual

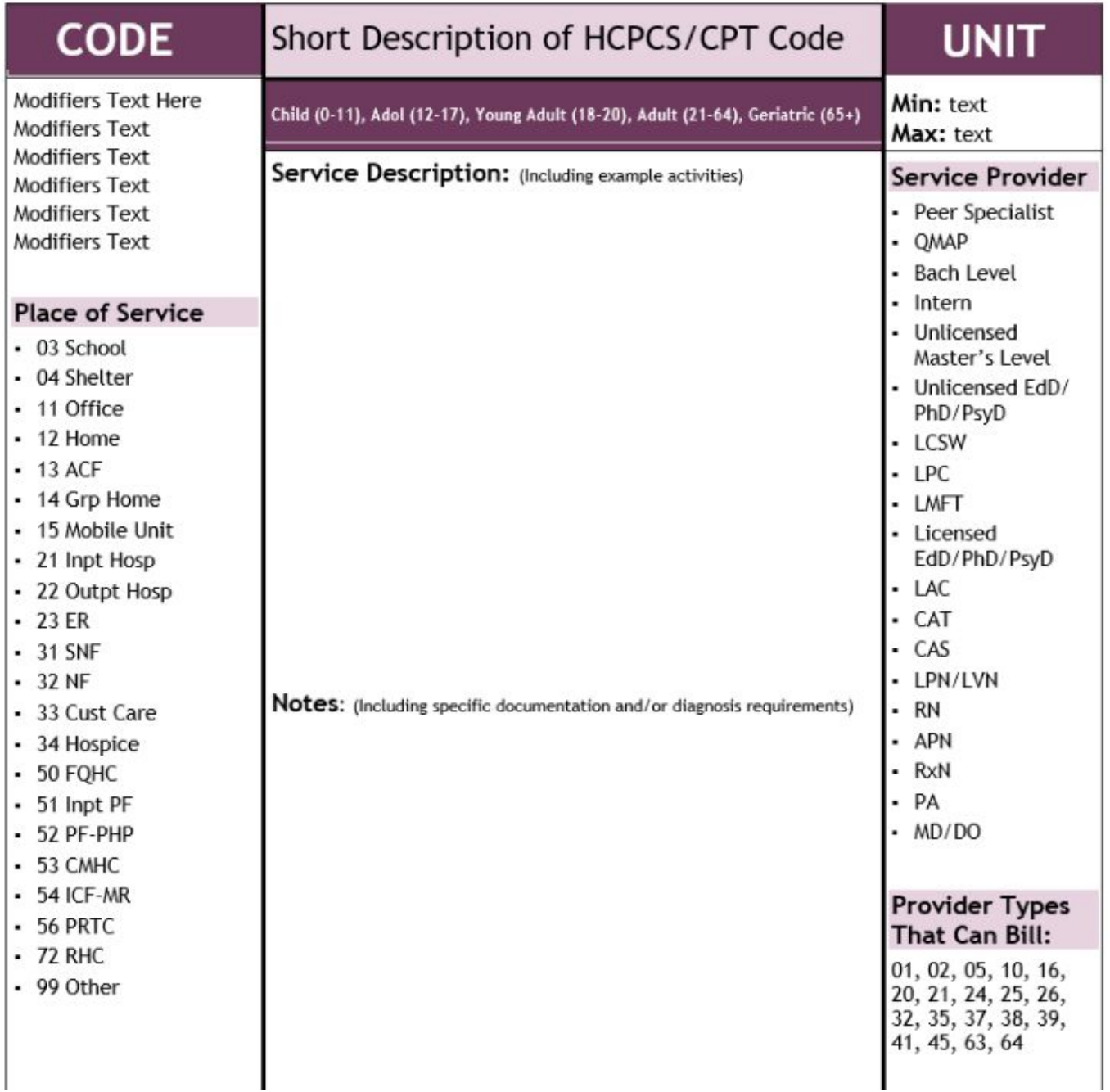
- HCPF is the final authority (we “own” it, approve any changes, etc.)
- Questions can be submitted anytime: hcpf_bhcoding@state.co.us
- A Coding Committee meets quarterly to discuss questions, address policy issues/implications, review changes
  - Representatives from RAEs, CMHCs, State, providers
  - RAEs are the key points of contact to bring change requests
- Proposed changes are reviewed by appropriate staff (rates, coding SME, policy SME, clinical, systems, etc.)
- New editions can be made quarterly as needed (Jan, April, July, Oct)
- Changes Tracking Log is published with each new edition of manual https://hcpf.colorado.gov/accountable-care-collaborative-phase-ii-provider-and-stakeholder-resource-center

Key Facts

- Details “covered services” under the Capitated Behavioral Health Benefit
  - 152 Codes [includes 56 E/M Codes, 50 B3 Codes]
- 10 Service Categories (each code has a primary category per CMS)
  - Prevention/Early Intervention Services • Crisis • Screening • Assessment • Treatment Services • Evaluation and Management (E/M) • Residential Services • Respite Care Services • Peer Support/Recovery Services • Support Service
- Includes “spans” of covered diagnoses (Mental Health and SUD)
- Includes definition of Medical Necessity, Third Party Liability, etc.
- Contains policy guidance for telemedicine, supervision, no-shows, claiming, documentation, etc.
- Appendices provide additional resources (i.e. Peer Services, Psych Testing, etc.)
- Aligns with RAE Contract and interChange (changes made to all)
  - Open codes, add diagnosis, billing providers, etc.
- The USCS Manual is shared with the BHA

Coding Page Template

- Gives information about the service and details related to proper billing/"coding"
- These details are built into RAE claims systems and HCPF interchange
- Appendices for most sections
- Referenced during audits and any review of services (by RAEs, HSAG, PI, etc.)
- Some components are determined by CMS (Description, Unit, Time, etc.)
- Some components HCPF has discretion to determine (Modifiers, Place of Service, Providers, etc.)
- Distinction between Service Provider and Provider Types that can bill
- Documentation Standards found in "Guidance Pages"



You can use the Colorado Coding Manual…

If there are questions about:

- Overall structure of Medicaid
- BH Diagnoses covered by the RAEs
- BH Services covered by the RAEs
- The definition of Medical Necessity
- Information about a specific code/service

If you are a:

- Provider - to understand Colorado Medicaid
- Provider - to understand details of a specific code/service
- Provider - to correct a billing error (modifier, time frame, code, etc.)
- RAE/MCE - to verify billing/coding design for their claims system
- RAE/MCE - to coach providers on best practice, documentation standards, etc.

Questions?

About:

Capitated Behavioral Health Benefit?

Medicaid Managed Care Structure?

Coding Procedures/Practice?