Children's Alliance, Kentucky: Coding, Documentation, and Compliance Manual, 3rd Edition

Prepared Exclusively for: Children's Alliance, Kentucky

Date: June 2025

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Update History

ITEM	DATE
First Edition	September 2017
Second Edition	December 2020
CPT Code 90832: Coding Documentation Notes #1: Changed time range from 17-37 minutes to 16-37 minutes	December 2020
CPT Code 90833: Coding Documentation Notes #2: Clarified that 90833 is an add-on code used with E & M services	December 2020
CPT Code H2019: Who may perform this service: Added modifiers SA, AH, U1 and U4 to BHSO's	December 2020
CPT Code H2020: Who may perform this service: Added modifiers SA, AH, U1 and U4	December 2020
Third Edition: Entire manual reviewed and updated; Addition of CHW	June 2025
Changed H2023 to T2023 (Targeted Case Management) pg. 236	June 18, 2025

1. Coding & Documentation

PREFACE

Children's Alliance Members are committed to providing medically necessary, clinically appropriate and cost-effective behavioral health and substance use services to the community. Children's Alliance Members also strive to adhere to formal compliance program guidelines. This manual is a comprehensive coding, documentation and compliance program manual for a variety of behavioral health and substance use provider organizations in the Children's Alliance, Kentucky. This first part of this manual will address coding and documentation information and compliance for a variety of provider types in the state of Kentucky. The second part of this manual outlines a formal compliance program that may serve as the template to set up or improve current compliance program efforts.

Not every applicable CPT® or HCPCS code is included in this manual. The codes in this third edition came from the April 1, 2024 fee schedule published by Kentucky Department of Medicaid Services. Additional codes relevant to the behavioral health industry are also included.

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INTRODUCTION

The purpose of this coding and compliance manual is to demonstrate our commitment to providing high quality, standardized and comprehensive services to our client population. We strive to use a standardized systemic coding, diagnostic, and documentation approach throughout the organization. By standardizing our documentation, coding and billing processes, we can obtain an accurate estimate of service costs and compliance with state and federal regulatory requirements for our industry.

This manual will provide guidance in documenting and reporting covered services. There are several standardized coding systems that will be used and referenced in this manual. In addition, there are several references to resources that are publicly available and used regularly in the healthcare industry.

The clinical coding systems used in this manual are:

1. CPT®: A listing of descriptive terms and identifying service codes that healthcare providers perform. The purpose of CPT® codes is to provide a uniform language that will accurately reflect diagnostic and healthcare services delivered to clients. CPT® codes are copyrighted by the American Medical Association.

2. HCPCS: The HCPCS level II coding system is a comprehensive and standardized system that classifies similar products that are medical in nature into categories for efficient claims processing. For each alphanumeric HCPCS code, there is descriptive terminology that identifies a category of like items. These codes are used primarily for billing purposes. HCPCS is a system for identifying items and certain services. Certain H codes are used by those State Medicaid agencies that are mandated by State law to establish separate codes for identifying mental health services such as alcohol and drug treatment services.

3. ICD-10-CM: The 10th version of the ICD-10 is the International Classification of Diseases. It contains the diagnosis codes that we will submit on healthcare billing claims and assign to our clients.

Some organizations will use Modifiers. Modifiers are additional codes that are added to service codes that allow providers to more accurately describe the service that was provided. They are two-digit codes appended to the CPT® codes on a healthcare claim to indicate the procedure has been altered in some fashion, by some circumstance, but that it has not changed the inherent service code or delivery. Modifiers convey the following information: the service provided was increased/reduced; identification of the credentials of person delivering the service; whether the service is mandated; and, any unusual circumstance that impacts the service delivery.

Children's Alliance Members Coding Integrity Policy and Procedure

We have developed a Coding Integrity Policy for the following purpose: To comply with the requirements set forth by the state of Kentucky and the Federal False Claims Act to prevent fraud against federal, state and local governmental entities. The policy and procedure below outline the steps we will take to ensure coding and documentation compliance at our organization.

Policy Background and Statement: Government health care programs and private insurers use a series of coding rules for the submission of claims for payment. The process of coding requires the assignment of codes or numbers to represent clinical diagnostic information and the type of services rendered.

We are reimbursed based on the codes we submit to payers for payment. Coding for services that were not provided, coding for a higher level of service than was provided or coding with a less complex or lower cost procedure than was reported ("upcoding" or "downcoding") may result in an improper level of reimbursement and constitutes a false claim.

Codes for payment must correlate with the documentation in the client's medical record and comply with the rules associated with billing these codes. Claims should be submitted only when there is documentation available for review to support the codes billed.

Only those individuals who are licensed to assign mental health diagnoses may add, update, change, or assign diagnoses to clients. No one may change the diagnoses for any purposes unless they have authorization and the scope of practice to do so.

As part of our Coding Integrity Policy, we shall use the ICD-10-CM Official Guidelines for Coding and Reporting published by CMS, approved by: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), and National Center for Healthcare Statistics (NCHS). We recognize that the general healthcare industry typically utilizes Certified Professional Coders (CPC's); we, however, do not. Thus, we do not use an Encoder or the Alphabetical Index. Instead, we strive to adhere to the ICD-10-CM Official Guidelines for Coding and Reporting and the Tabular Index of the ICD-10-CM. We strive to assign all applicable codes for every client to convey the medical necessity, complexity of the case, and to reflect a comprehensive clinical representation of the client's condition.

Key Procedures and Provisions for the Coding Integrity Policy:

1. Clinicians will be sufficiently trained in coding techniques and current coding requirements to ensure that the codes selected accurately depict the service performed

2. Codes for payment must correlate with the documentation in the client's medical record and comply with the rules associated with billing these service codes
3. We strive to follow the ICD-10-CM Official Guidelines for Coding and Reporting
4. Each client record will contain sufficient documentation to support the treating diagnosis and service code
5. Each client record will minimally contain the following clinical information: service code, diagnosis documentation, pertinent history, treatment plan, progress made, response to treatment, recommendations and discharge status
6. Only authorized personnel, clinicians, may assign diagnosis codes based on provider documentation. Questions about a code assignment are addressed to the clinician responsible for the client
7. Codes will not be assigned, modified, or excluded solely for maximizing reimbursement. Clinical codes will not be changed or amended due to provider's or patient's requests to have services covered by payers.

Parties Responsible for Coding Assignments

Unless we retain a Certified Professional Coder (CPC) to our revenue cycle staff to review and assign service and diagnosis codes based on provider documentation, only the service provider may select and assign: service codes (CPT®, HCPCS) and diagnosis codes (ICD-10-CM).

Correcting Inaccurate Code Assignments and Claim Rejections

If we discover that a service code was mistakenly billed, or a code was inaccurately assigned, we will correct it as soon as possible. An amended claim shall be submitted to the payer per the payer policies for corrected claims. The provider responsible for the case will be consulted. At no time, will we amend the billing to reflect a service that was not provided, or for the sole purpose of obtaining reimbursement.

GUIDELINES FOR CODING AND BILLING

General Resources

We will use the following resources and guidelines for assigning diagnoses and service codes:

1. International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM). This is the table of all available diagnosis codes.
2. ICD-10-CM Official Guidelines for Coding and Reporting, developed by the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and the National Center for Health Statistics (NCHS)
3. Diagnostic and Statistical Manual of Mental Disorders, 5th Edition Text Revision (DSM-5-TR). Note: The DSM-5-TR is used for clinical diagnosis guidelines, not code numbers. The DSM-5-TR states that ICD-10-CM coding rules should be followed
4. Current Procedural Terminology, CPT® 2025
5. Centers for Medicare and Medicaid Services (CMS), Documentation Guidelines for Evaluation and Management Services, 1995 and 1997
6. Healthcare Common Procedure Coding System (HCPCS)
7. Looking forward to ICD-11: WHO's Clinical descriptions and diagnostic requirements for ICD-11 mental, behavioural and neurodevelopmental disorders WHO ICD 11 CDDG

Primary and Secondary Insurance Billing

Medicaid is by law always the payer of last resort. If a Medicaid recipient has coverage from a third-party source such as Medicare, an insurance plan, or some other third-party with a legal obligation to pay, then Medicaid payment is reduced by the amount of the third-party obligation.

907 KAR 1:005 is the regulation that sets forth the parameters for Medicaid payments. KAR 1:005 Section 2 states:

"(1) The department shall comply with 42 C.F.R. Part 433, Sub-part D, and consider any third-party liability as a resource.(2) A recipient shall cooperate with the department for third-party liability purposes in accordance with 42 U.S.C. 1396k, 42 C.F.R. 433.138, and 42 C.F.R. 433.145.(3) If payment for a covered service is due and payable from a third-party source such as Medicare, an insurance plan, or some other third-party with a legal obligation to pay, the amount payable by the cabinet shall be reduced by the amount of the third-party obligation."

For Department of Medicaid Services (DMS) recipients enrolled in Medicaid managed care (according to OPEN MINDS data, 89% of all Medicaid enrollees as of June 2024), contracted managed care companies (MCOs) administer the Kentucky Medicaid program and become the "payer of last resort" on all claims. Please refer to the next section for further information on coordinating benefits with the MCO's.

By-Pass Codes for Primary Insurance: Some MCO's have a list of service codes that they acknowledge will not be covered by the primary insurer. When a provider knows this ahead of claim submission (for a service code on the MCO's by-pass list), they can send the claim directly to the MCO and by-pass having to send the claim to the primary insurer. The list of "by-pass" codes is not consistent across the MCO's due to their own benefit and coverage guidelines and at least one MCO may not use "by-pass" codes. It is advisable to check with each MCO regarding their process for utilizing "by-pass" codes and which service codes are involved, keeping in mind the list may change from time to time.

Billing Guidance: When a client has more than one health insurance coverage policy:

1. Submit the initial claim to the other payer first
2. Obtain remittance, Explanation of Benefits (EOB), or EDI file*
3. Upon receipt of the information in #2, submit to Medicaid or to the Medicaid MCO
4. If your payer does not provide you with an EOB, please refer to your legal contract with the payer. Most contracts include payer obligations to issue an EOB for every clean claim submitted to them. Contact your contract representative at the payer and leverage your contract terms with them. Terms such as "breach of contract" or "contract violations" usually get the payers attention.

*Third-party Liability (TPL). There are times when a provider organization does not receive the remittance. If you have not received a remittance from the other health insurance within 120 days of filing the claim, Kentucky Medicaid has a Third-Party Liability Lead Form that you may fill out. Some MCO's have accepted this form, others have not. It is advisable to check with the MCO regarding how they will manage TPL forms for third party claims. Kentucky Medicaid instructions for their TPL form, to be used for Medicaid clients that are not assigned to an MCO are: "Write 'no response in 120 days' on either the TPL Lead Form or the claim form, attach it to the claim and submit it to Gainwell. Gainwell overrides the other health insurance edits and forwards a copy of the TPL Lead form to the TPL Unit. A member of the TPL staff contacts the insurance carrier to see why they have not paid their portion of liability." (Source: DMS Provider Billing Instructions Manuals).

Clients with Both Medicaid and Commercial Insurances

907 KAR 5:005: Health Insurance Premium Payment (HIPP) Program is the main regulatory reference to help understand this section.

If a Medicaid beneficiary is eligible to participate in a group health insurance plan, federal law authorizes the state to establish a health insurance premium payment, or HIPP, program to provide health insurance coverage outside of Medicaid to Medicaid enrollees, and any family member of Medicaid enrollees, if the state Medicaid department determines that HIPP program participation would be cost effective for the department.

Kentucky's program is called the Kentucky Integrated Health Insurance Premium Payment, or KI-HIPP, program. Under the KI-HIPP program, DMS purchases health insurance coverage for an individual by paying the individual's (and family members if applicable) health insurance premiums, deductibles and coinsurance.

For a Medicaid enrollee who is a KI-HIPP program participant, DMS pays all group health insurance plan premiums and deductibles, coinsurance and other cost-sharing obligations for items and services otherwise covered under Medicaid, up to the Medicaid allowed amount, minus any Medicaid cost-sharing that would normally be paid. The individual's group health insurance plan is the primary payer; and DMS is secondary (i.e., payer of last resort). In the case where a service to which a KI-HIPP participant would be entitled under Medicaid is not provided by the individual's group health insurance plan, DMS provides wrap-around coverage. DMS will reimburse the provider for the service in accordance with DMS' administrative regulation governing reimbursement for the given service. DMS currently does not terminate individuals for failure to participate with group health insurance.

Coordination of Benefits:
The term, "coordination of benefits" (COB) refers to situations where a client is covered by more than one health plan. COB allows plans that provide health coverage for a person to determine their respective payment responsibility—ie: to determine which insurance plan has the primary payment responsibility and the extent to which the other plans will contribute when an individual is covered by more than one plan.

Most payers, including the MCO's, have specific guidance in their Provider Manuals about processing of COB claims. If the Medicaid enrollee who is a KI-HPP program participant is enrolled in a Medicaid MCO program, the MCO's then become the "payer of last resort." All other insurance, including any health or casualty insurance, liability insurance and attorneys retained for tort action coverage, or other medical coverage, including Medicare, pays the member's claims before the MCOs. These other insurers are considered primary coverage. COB responsibilities are shifted to providers by MCOs as follows (as taken from current MCO provider manuals, March 2025):

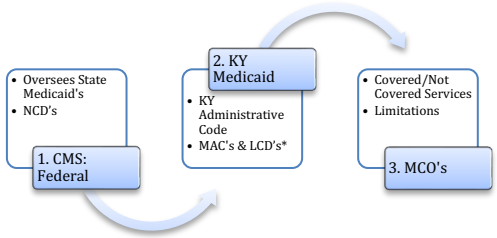
KY MCO	Coordination of Benefits (COB)	COB Exceptions
Aetna Better Health	Aetna Better Health shall be used as a source of payment for covered services by providers only after all other sources of payment have been exhausted	EPSDT Special Services Maternity claims through postpartum (except delivery) Preventative pediatric services Children having other insurance through Title IV Court Support Order
Humana Healthy Horizons	Humana collects COB information for members. This information helps Humana ensure that claims are paid appropriately and comply with federal regulations that Medicaid programs are the payer of last resort Claims involving COB will not be paid until an EOB/EOP or EDI payment information file is received, indicating the amount the primary carrier paid. Claims indicating the primary carrier paid in full (i.e., $0 balance) still must be submitted to Humana Healthy Horizons for processing due to regulatory requirements. Please see the Medicaid Bypass List for Medicare Non-covered Codes section of this provider manual for bypass code information.	
Passport by Molina Healthcare	Medicaid is always the payer of last resort and Providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Passport Members. If third party liability can be established, Providers must bill the primary payer and submit a primary explanation of benefits (EOB) to Passport for secondary Claim processing. In the event that coordination of benefts occurs, Provider shall be reimbursed based on the state regulatory COB methodology. Primary carrier payment information is required with the Claim submission. Providers can submit Claims with attachments, including EOB and other required documents. Passport will pay claims for prenatal care and preventive pediatric care (EPSDT) and then seek reimbursement from third parties. If services and payment have been rendered prior to establishing third party liability, an overpayment notification letter will be sent to the Provider requesting a refund including third party policy information required for billing.	
WellCare of Kentucky	Medicaid is the payor of last resort. Providers shall bill primary insurers for items and services they provide to an Enrollee before they submit claims for the same items or services to WellCare. Any balance due after receipt of payment from the primary payer should be submitted to WellCare for consideration and the claim must include information verifying the payment amount received from the primary plan.	

KY MCO	Coordination of Benefits (COB)	COB Exceptions
UnitedHealthcare	UnitedHealthcare Community Plan is the payer of last resort. Other coverage should be billed as the primary carrier. When billing UnitedHealthcare Community Plan, submit the primary payer's Explanation of Benefits or remittance advice with the claim.	

*DMS MCO's: Here

Billing for Multiple Services on the Same-Day

In the healthcare industry, the flow of policy guidance follows this path:



*MAC: Medicare Administrative Contractors retained by CMS by geographical region; LCD: Local Coverage Determination: regional guidance on how to bill certain codes

Written guidance in KAR's is limited regarding multiple services on the same day, and not every scenario is covered. Generally, entities will look to CMS or other regulatory authorities to help when making billing decisions. CMS works collaboratively with the authors of the CPT® and HCPCS coding systems, the American Medical Association. Coding edits are put into place by payers and CMS in their claims software to detect any billing abnormalities, overpayments or conflicts. CMS issues Medicare National Correct Coding Initiative (NCCI) guidelines for payers to mitigate Fraud, Waste and Abuse. Kentucky Medicaid does use NCCI coding edits to help determine what services are allowed to be billed together, or on the same day, or not.

Historically, the use of Modifier 59 was used to delineate that two services provided on the same date of service were separate and distinct from one another. An example of this is the provision of a 90834 Psychotherapy 45-minutes by one provider and the delivery of 90853, Group Psychotherapy by another provider on the same day, at different times. If audited, medical recordkeeping indicating the start and stop times, therapeutic modality, and different provider NPI's would substantiate that these were two separately distinct and identifiable services.

In 2015, additional modifiers were introduced to help further specify the utilization of Modifier 59 because it was discovered that Modifier 59 was being overutilized. The modifiers, collectively referred to as -X{EPSU} modifiers, define specific subsets of the -59 modifier.

Information from KAR's is intermittent within the regulations. Some limitations found regarding multiple services on the same date of service include:

- 907 KAR 15:020 Section 4: (3) The department shall not reimburse for both a screening provided pursuant to this administrative regulation and a screening, brief intervention and referral to treatment (SBIRT) provided to a recipient on the same date of service.
- 907 KAR 15:020: Section 5. No Duplication of Service. (1) The department shall not reimburse for a service provided to a recipient by more than one (1) provider of any program in which the service is covered, during the same time period. (2) For example, if a recipient is receiving a behavioral health service from an independent behavioral health provider, the department shall not reimburse for the same service provided to the same recipient during the same time period by a behavioral health services organization.

CMS MLN 1783722 (February 2025, PDF here) states, in part:

Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M [Evaluation/Management] services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session.....

Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.....

Modifiers XE, XP, XS, and XU are valid modifiers. These modifiers give greater reporting specificity in situations where you used modifier 59 previously. Use these modifiers instead of modifier 59 whenever possible. Only use modifier 59 if no other more specific modifier is appropriate.....

XE — "Separate encounter, a service that is distinct because it occurred during a separate encounter." Only use XE to describe separate encounters on the same DOS.

Direction was issued to the Medicare Administrative Contractors to enforce the new Modifier 59 specifiers, and this has then trickled down to State Medicaid agencies, and in this case, some of Kentucky's MCO's contracted to administer Kentucky Medicaid benefits. Below is some policy guidance found regarding modifiers 59, -X{EPSU}:

Source	Guidance
Kentucky Medicaid 907 KAR 15:20	Defines limitations on amount, duration, and scope of services (per day): • Individual therapy, family therapy and group therapy services are limited to a maximum of three (3) hours per day alone or in combination with any other outpatient therapy per recipient unless additional time is medically necessary • Collateral outpatient therapy is limited to recipients under age 21 • Intensive outpatient (IOP) services must be provided at least three (3) hours per day and at least three (3) days per week for adults and a minimum of six (6) hours per week for adolescents • Partial hospitalization is typically provided less than 24 hours per day; short-term is an average of 4-6 weeks • All services, including those without specific limitations, with the exception of crisis services, screening, assessment and peer support services for the engagement into substance use treatment within ED Bridge Clinics must be provided in accordance with a documented diagnosis and plan of treatment
Wellcare	When reviewing claim lines with modifier 59, or one of the X modifiers listed below, WellCare will be looking for documentation that supports "a different session, different procedure .....not ordinarily encountered or performed on the same day by the same individual."
Passport Health Plan (Molina) PDF here	The X(EPSU) modifiers, which include XE, XP, XS, and XU, collectively refer to specific subsets of modifier 59. These modifiers serve as more precise alternatives to modifier 59, indicating distinct or independent services under specific circumstances. It is essential to note that it is incorrect to use both modifier 59 and any of the X(EPSU) modifiers on the same line.

Billing Guidance:

1. DMS has indicated that they do allow billing for some therapies on the same day, provided the start/stop times clearly show separate services.
2. Using other "combinations" of codes for same-day billing: it is best to check with DMS prior to service delivery. The best way to reach them is to email: DMS.ISSUES@ky.gov and put in the subject line: BH and SU
3. Verify with the MCO how they would like for you to submit same-day services
4. Use start and stop times for all services rendered
5. Clearly document that the services were separate, distinct, and mutually exclusive
6. There are increased chances that the use of Modifiers 59 or -X{EPSU} will result in initial denials or requests for medical records; checking with DMS ahead of service delivery is strongly recommended.

Psycho-Educational Groups

The following definition of psycho-educational groups in Kentucky are taken from:

1. The Kentucky Cabinet for Health and Family Services: Here
2. The Kentucky Cabinet for Health and Family Services, Provider Letter dated November 1, 2024: Here
3. 907 KAR 15:010
4. 907 KAR 15:020
5. 907 KAR 15:022

Kentucky regulations have the same language across the different sections of the regulations. The language reads:

"During psycho-education, the recipient or recipient's family member shall be: a. Provided with knowledge regarding the recipient's diagnosis, the causes of the condition, and the reasons why a particular treatment might be effective for reducing symptoms; and b. Taught how to cope with the recipient's diagnosis or condition in a successful manner."

Since the above definition leaves room for interpretation, The Provider Letter dated November 1, 2024 offers additional guidance:

"Psychoeducation (H2027) is a direct, planned, and structured intervention that involves presenting or demonstrating information. Psychoeducation provides individuals diagnosed with a mental health, substance use, or co-occurring disorder and their families with pertinent information regarding the identified condition, treatment options to address the condition, and teaches problem-solving, communication, and coping skills to support recovery." HERE

Included in the letter was clear guidance about the content of the service including:

a. Understanding the nature of mental health and substance use conditions
b. recognizing warning signs of relapse
c. stress reduction techniques
d. and building a support network.

H2027 is not an add-on code. It is to be billed as a separate and distinct service. Limitations on H2027, whether provided individually, in a group or a combination thereof include:

a. No more than 12 recipients per group session
b. 8 units per day (2 hours)
c. 500 units per calendar year (125 hours)

A thorough research study was published in July 2022 called "The principles and practices of psychoeducation with alcohol and other drug use disorders: A review and brief guide" in the Journal of Substance Use Treatment (Vol. 126, 108442, July 2022). In it, the authors

outlined 9 principles and 21 best practices of psychoeducation. While most Children's Alliance members are behavioral health organizations, the principles and skills can be applied to both substance use and mental health disorders. The goal of psychoeducation is to be a collaborative approach to teaching where client engagement, understanding, and utilization of the information provided to the client.

When considering documentation to substantiate the provision of psychoeducation, the following tables of the 9 principles and 21 practices will help guide the clinician:

Principle	Description
1) *Psychoeducation is empowering*	Information is provided to empower clients to become central actors and collaborators in their treatment.
2) *Psychoeducation is well-informed*	When information is provided, it should be the best available information (e.g., grounded in high quality research).
3) *Psychoeducation is understandable*	When information is provided, every effort must be made to ensure that information is understood by the client.
4) *Psychoeducation is brief*	Brevity is important when providing information; not only for engagement, but also for retention.
5) *Psychoeducation is interactive*	Providing information in a dialogue facilitates client engagement with the material.
6) *Psychoeducation is tailored to individual needs*	The provider must match teaching to client learning style, cultural worldview, and/or attentional capacity in the moment.
7) *Psychoeducation may end with a goal*	While not necessary, often information is provided with the intent of setting a goal centered on the use of that information.
8) *Psychoeducation uses both facilitation and teaching skills*	The aims of information-giving in psychoeducation (e.g., empowerment, understanding, and often a goal) requires both facilitative-counseling and didactic-teaching skills.
9) *The psychoeducation provider is a charismatic, client-centered expert*	The psychoeducation provider must be an expert, while attending closely to both persuasion and connection.

Practice	Description
Transitioning and structuring	
Begin with permission to provide information	Provider asks permission to give information prior to giving information to the client.
Begin with a rationale for the information	Provider begins with a clear rationale for information, which should orient the client to the need for the information and promote expectancies around the value of the information.
Maintain focus on information with structure	Provider uses structure and time-management to ensure that attention to information is thorough.
Teaching	
Provide information using plain language	Provider always uses simple language, avoiding acronyms, jargon, or other specialized terminology when giving information to the client.
Provide information using client language	Where possible, the client's own words, symbols, and phrases should be used to communicate information.
Provide information at a moderate pace	Information should be communicated at a moderate and steady pace; the provider should never rush information.
Provide information in small, meaningful units	Information can be organized into small units to facilitate learning and retention.
Scaffold information with increasing difficulty	Information can be scaffolded such that later information builds on earlier information with increasing difficulty.
Tailoring	
Adjust teaching to learning needs	Provider must assess the client's learning needs and adjust their methods wherever possible.
Adjust teaching to language and culture needs	Provider should adjust to language and cultural needs, including language-appropriate teaching materials and incorporation of cultural meanings and symbols.

Adjust teaching to non-verbal indicators of attention	Provider should attend to indicators of waning attention, non-verbal or otherwise, and adjust their methods if it appears they are losing client engagement with the information.
Facilitating interaction	
Ask clients what they already know about the information	When providing information, it is vital to assess what information the client already has on a given topic.
Ask client to ask questions	When providing information, always ask "what questions" the client has about the information.
Ask client questions to check understanding of information	When providing information, always check for understanding with specific strategies such as requesting the information be repeated back or applied in a personal example.
Ask client questions to explore reaction to information	When providing information, questions can be used to explore how the client perceives the information and how they intend to use the information.
Ask client questions to explore possible action, following information	When providing information, questions can be used to explore how the client might apply the information to reach their health-related goals.
Facilitating retention	
Use repetition to promote comprehension and retention	Provider uses strategies, such as repetition of content, to make information understandable and memorable.
Use narrative methods to promote comprehension and retention	Provider uses stories to communicate information that is engaging, emotionally evocative, and memorable.
Use materials to promote comprehension and retention	Provider uses teaching materials such as a white broad, handouts, or worksheets; all materials function to vary educational methods and to make information more understandable and memorable.
Closing	
Affirm client capacity to use information	Provider is optimistic of the client's capacity to use the information to meet their goals.
End with a summary of information, and if applicable, action plan	Provider always ends psychoeducation with a summary of the content along with any stated goals and/or action steps.

HEALTHCARE COMPLIANCE PROGRAMS

We are committed to following all applicable federal and state healthcare laws and holding ourselves to the highest standards available. We are committed to integrity in all that we do. To hold ourselves accountable to the community, our stakeholders, and interested authorities, we have devised and implemented an effective compliance program, set forth by the Department of Health and Human Services, Office of the Inspector General (OIG).

A formal program has specific demonstrable elements and requirements and each organization is held accountable to maintaining and implementing such a program. The seven (7) elements of a compliance program are:

1. Written Code of Conduct, Standards, and Policies and Procedures

2. Compliance Program Administration
3. Education and Training
4. Reporting of Complaints
5. Investigations and Disciplinary Actions
6. Auditing and Monitoring
7. Risk Assessments and Mitigation

The second portion of this manual outlines, describes, and defines our formal compliance program.

MEDICAL RECORD DOCUMENTATION

The contents of a complete medical record are usually proscribed by a variety of regulatory and licensing bodies. We will adhere to the following medical record requirements put forth by:

- CMS
- State of Kentucky, Department of Medicaid Services (DMS)
- All applicable Kentucky Statutes, Regulations, and Health Licensing Boards
- Kentucky contracted MCO's chosen to administer Medicaid

Behavioral health services must meet specific requirements for reimbursement. Documented services must:

1. Meet Kentucky's Medicaid program rules
2. Reflect medical necessity and justify the treatment and clinical rationale (907 KAR 3:130)
3. Reflect active, individually focused treatment
4. Be complete, concise, and accurate, including the face-to-face time spent with the client
5. Be legible, signed, dated, authenticated
6. Be retained and available for review
7. Be coded correctly for billing and reimbursement purposes
8. Not be duplicated, cloned, or copy/pasted from another record entry in the client record.
9. Start/Stop Times for telehealth
10. Safety Plan documentation/reviews for telehealth, every session

CMS has issued guidance for what constitutes a complete medical record:

§482.24(c)(1) - All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.

Legible:
All entries in the medical record must be legible. Orders, progress notes, nursing notes, or other entries in the medical record that are not legible may be misread or misinterpreted and may lead to medical errors or other adverse patient events.

Complete:
All entries in the medical record must be complete. A medical record is considered complete if it contains sufficient information to identify the patient; support the diagnosis/condition; justify the care, treatment, and services; document the course and results of care, treatment, and services; and promote continuity of care among providers.

Other documentation elements will likely be required to support:

1. The mental health diagnosis or diagnoses, including the diagnostic criteria met
2. Medical necessity
3. Impairment or a probability of deterioration of treatment is not received
4. Level of Functioning
5. Symptoms, complications, manifestations
6. Clinical and treatment rationale
7. Severity, intensity, and frequency of symptoms and challenges
8. Integrated health concerns

TELEHEALTH SERVICES

Background

Telehealth is a viable and legitimate form of clinical service delivery with the right infrastructure in place. Telehealth reduces barriers and access to care problems and offers provider organizations an opportunity to reach clients that may not be able to travel to the organization. Understanding the compliance requirements is essential for effective service delivery and reimbursement justifications. "Telehealth" is the provision of services using telecommunication and electronic technologies where the two individuals are physically located in two different locations from each other. Telehealth in the behavioral health industry is "synchronous", meaning the client and provider are communicating in a two-way, real-time manner using audio and visual technology to remotely provide healthcare services and information. Store-and-forward technology is not allowed.

Telehealth, Telebehavioral Health, Telemental Health, Distance Counseling, and Telemedicine: These terms are frequently used interchangeably in the healthcare industry. They all describe the use of digital technologies to deliver healthcare services by connecting multiple users who are physically located in separate locations. Medical information is exchanged from one site to another via electronic communications to improve a client's health or medical status. An "Originating Site" is the location where the client is located at the time of service delivery. A "Distant Site" is the location where the health care provider is located at the time of service delivery.

Statutory Definitions
KRS 211.332 defines telehealth or digital health:

a. Means a mode of delivering healthcare services through the use of telecommunication technologies, including but not limited to synchronous and asynchronous technology, remote patient monitoring technology, and audio only encounters, by a health care provider to a patient or to another health care provider at a different location;
b. Shall not include:
    i. The delivery of health care services through electronic mail, text, chat, or facsimile unless a state agency authorized or required to promulgate administrative regulations relating to telehealth determines that health care services can be delivered via these modalities in ways that enhance recipient health and well-being and meet all clinical and technology guidelines for recipient safety and appropriate delivery of services; or
    ii. Basic communication between a health care provider and a patient, including but not limited to appointment scheduling, appointment reminders, voicemails, or any other similar communication intended to facilitate the actual provision of healthcare services either in-person or via telehealth; and

iii. Unless waived by the applicable federal authority, shall be delivered over a secure communications connection that complies with the federal Health Insurance Portability and Accountability Act.

KRS 205.510 (17) defines telehealth consultation as: a medical or health consultation, for purposes of patient diagnosis or treatment.

907 KAR 3:170, "Telehealth Service Coverage and Reimbursement" details the components of telehealth that are important for provider organizations to know. Specifically:

1. Medically Necessary: Telehealth services must meet medical necessity criteria in order to be reimbursed.
2. Equivalent Service: If the equivalent service in-person is not reimbursable, then the telehealth provision of that same service will also not be reimbursed.

Managed Care Organizations (MCO's) may add other layers of requirements such as verifying the member's identity before providing services or submitting a legal attestation that you are following certain policies. Please check the Provider Manuals and their Reimbursement Policies for each MCO to make sure you are meeting all the requirements.

Technology Platform

In accordance with Kentucky law, only HIPAA-secured platforms/technology may be used for the delivery of telehealth. This means that your organization has partnered with a software vendor that demonstrates it is "HIPAA-compliant" by issuing legal contract called a HIPAA Business Associate Agreement, or BAA. Verify that the company complies with all three (3) aspects of HIPAA, not just one (1): Privacy, Security, and the Breach Notification Rules. This document should be kept on file and renewed annually. Use of applications such as FaceTime or Skype are not proven to be HIPAA-compliant or secure and should never be used for healthcare service delivery.

Telehealth Providers

907 KAR 3:170, "Telehealth Service Coverage and Reimbursement" defines a "Telehealth Care provider" as someone who is actively enrolled as a Medicaid Provider who is "operating within the scope of the providers professional license AND operating within the providers scope of practice.

Provider "means an individual, company, corporation, association, facility, or institution which is providing or has been approved to provide medical services, goods, or assistance to recipients under the Medical Assistance Program." (see KRS 205.8451). Provider organizations who are approved will want to refer to the DMS Fee Schedules to verify what types of providers may deliver reimbursable services, such as individuals under supervision.

Documentation for Telehealth

Minimum documentation requirements in the medical record include:

1. All normal documentation requirements for a clinical service and ongoing delivery
2. Written consent for Telehealth Services
3. Documentation indicating that the "session was conducted via telehealth"
4. Start and stop times and length of session
5. For ongoing psychotherapy, include a plan for the return session
6. Re-assessments as needed
7. A documented safety plan with periodic updates or notations it was reviewed with the client

Elements to Establish an Effective Telehealth Program

1. Technology
    a. Obtain a contract with HIPAA-secured telehealth vendor
    b. Obtain the vendors HIPAA BAA and renew annually
    c. Procure the technology necessary to support the project such as headsets, camera's, speakers, larger monitors, and more
    d. Construct technical specification sheets for clients to ensure they have the technical capability to connect securely. You may consider including definitions of open versus secured wireless networks
2. Administrative Procedures
    a. Determine if you will offer the initial appointment by telehealth.
    b. Obtain consents, such as Consent to Treat Minors, regular agency forms, and collect the Intake Tool
    c. Obtain Intake Tool and consent for telehealth services for already-established clients who are moving to a telehealth platform
    d. Prepare a telehealth FAQ for clients to help them understand the technology you are using, including technical specifications for successful access via different devices
    e. Have the clinician evaluate the Intake Tool to determine if the client is appropriate for telehealth
    f. Perform regular revenue cycle tasks including insurance coverage
3. Compliance and Operations
    a. Establish your agencies telehealth policies and procedures. Include references to the types of services you deliver or the types of clients you will serve; lay out clinician responsibilities, documentation requirements for the medical record, emergency procedures, platform endorsed, and other relevant items
    b. Develop emergency protocols and safety plans
    c. Receive regular provider bulletins pertaining to telehealth services

4. Staff Training
    a. Create a training program on your agency's telehealth services, policies and procedures for your staff
    b. Verify licensing board requirements for additional training or ongoing continuing education mandates
5. Billing/Coding
    a. Verify which payers may require written attestations or other necessary documentation to bill for and receive reimbursement for telehealth service delivery
    b. Determine eligible provider types for telehealth services
    c. Confirm the electronic billing systems are prepared to accept and process telehealth claims
    d. Establish a workflow for the provider to indicate if a service was delivered in-person or via telehealth

Billing for Telehealth

Use the appropriate CPT®/HCPCS code and normal billing procedures should be followed. The only difference for a telehealth claim is the place of service code:

- Modifier: 95
- Use Place of Service Code: 02 for telehealth when the originating site is not the patient's home and POS 10 for telehealth services when the originating site is the patient's home.
- Some MCO's may want you to use modifier 95 or another indicator: please check with each payer
- Telehealth services are subject to the same cost-sharing in place for services provided face-to-face
- January 1, 2025: CMS has reinstated the guidance that the client must be in their home to receive telehealth services. Please check with each MCO for their requirements and downstream effects.

PSYCHOLOGICAL TESTING EVALUATION SERVICES

Background

Note: The terms psychological assessment and psychological testing are used interchangeably.

Psychological testing is a process where clients are given any number of "tests." The test results are gathered together with information from the client themselves in a clinical interview, or from collateral sources. Psychological testing or assessment typically look at the domains of mood, emotional and adaptive functioning, behaviors and interpersonal adjustment. The testing may consist of paper/pencil/computer tests, subjective tests, clinical interviews, and review of other medical records. Once all the information is compiled, the testing psychologist will then review everything and typically will write a report with recommendations on treatment, or the outcome of an assessment.

Psychological testing is different than neuro-psychological testing, which may also be referred to as neuro-cognitive testing. Neuro-psychological testing typically measures brain functioning such as IQ, the extent of a brain injury, central nervous system trauma and/or disorders, memory or cognitive declines such as in the elderly population. It can include brain scans or other medical information gathered to help the testing psychologist assess the extent of the diagnosis. Most Children's Alliance members will be conducting general psychological testing, not neuro-psychological testing.

While psychologists are generally the professional who do the clinical interviewing, interpreting the tests results, and write the reports, they can utilize assistants to administer some tests. Billing for the assistant's time is allowed under the CPT® rules. The assistants are referred to as "testing technicians" and must be supervised by the testing psychologist.

The process of psychological testing may also involve "mixed billing," meaning the psychologist may bill the psychological testing CPT® codes, but also use more traditional CPT® codes such as 90791 or 90837's. The rendering provider will know what CPT® code to bill for the service encounter.

CPT® Testing Codes

Commonly used psychological testing codes:

96130: Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and

interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour

+ 96131: each additional hour (List separately in addition to code for primary procedure)

96132: Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour

+ 96133: each additional hour (List separately in addition to code for primary procedure)

96136: Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes

+ 96137: each additional hour (List separately in addition to code for primary procedure)

96138: Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes

+ 96139: each additional hour (List separately in addition to code for primary procedure)

96146: Psychological or neuropsychological test administration, with single automated instrument via electronic platform, with automated result only

Who May Perform Psychological Testing

Psychological testing requires a qualified health professional or clinically trained technician for test administration and scoring. Psychological test interpretation and integration of test results with other relevant clinical data must be performed only by a qualified health professional, such as a clinical psychologist, with training, competency and expertise in psychological testing assessment. A psychological testing technician may also be used to help administer psychological testing.

Medical Necessity Rationales

Many third-party payers require a prior authorization to reimburse for psychological testing. It is always best to call the client's insurance company to verify their requirements and limitations on the scope of services delivered. Make sure to ask for timelines for how long the authorization is in effect.

When requesting the prior authorization, medical necessity reasons indicated by the qualified health professional can include any of the following:

1. Measure a psychological disorder and its severity and functional impairment to determine psychiatric diagnosis
2. Measure behavioral factors that impact disease management in scenarios that include but are not limited to: (a) pre-surgical evaluation to identify psychological factors that may potentially affect or complicate the outcome of surgical procedures and/or aftercare (e.g., spinal surgery, bariatric surgery); (b) assessment of emotional/personality factors impacting physical disease management and ability to comply with and benefit from medical interventions; (c) assessment of psychological factors in chronic pain patients
3. Measure functional capacity to delineate specific cognitive, emotional, or behavioral bases of functional complaints and/or disability, and/or to assess patient capacity for decision-making when impairment is suspected
4. Measure psychological barriers and strengths to aid in treatment planning
5. Measure risk factors needed to determine patients' risk of harm to self and/or others
6. Perform symptom measurement to objectively measure treatment effectiveness and/or determine the need to refer for pharmacological treatment or other medical evaluation
7. Measure and confirm or refute clinical impressions obtained from interactions with patients, particularly when malingering of disorder or denial of psychological difficulty is suspected
8. Evaluate primary symptoms of impaired attention and concentration that can occur in many neurological and psychiatric conditions

Documentation

Minimum documentation requirements in the medical record include:

1. The patient's medical record should contain documentation that supports the medical necessity for testing or other services performed, and examination results. When appropriate, documentation includes the following information:
    a. Referral question and referral diagnosis
    b. Relevant medical history
    c. Relevant psychosocial history
    d. Sources of information (e.g., patient interview, record review, behavioral observations)
    e. Procedures administered
    f. Clinical decision making
    g. Interpretation of test data and other clinical information (e.g., test results)
    h. Integration of sources of information (e.g., summary and impressions)
    i. Diagnosis
    j. Treatment planning and recommendations
2. The administration of psychological testing and/or neuropsychological testing must result in the generation of material that will be formulated into a report. All Testing

Evaluation services and Test Administration and Scoring services provided by the qualified health professional and technician must be documented in clearly understandable terms, and feedback provided for the benefit of referral sources and other reviewers.

3. These codes are timed codes. Therefore, the documentation should contain the total time spent rendering and interpreting the service, including the start and stop times of the testing.

Billing for Psychological Testing

Most psychological testing happens across multiple dates of service. When a service is spread out over multiple visits, the total cumulative time spent performing each type of service in the evaluation process should be reported at the completion of the entire testing process (i.e.: “batch billing”).

CPT® codes are reported based on the cumulative time spent performing each individual service category (i.e., clinical interview, testing evaluation services, and test administration and scoring) even if time occurs on the same or different dates of service. Time spent performing the activities associated with each service category is cumulative over the entire episode of care, but the activities in each service category do not necessarily happen chronologically.

For each service category provided, time is cumulated over the episode of care based on the time stated in the CPT® code descriptors.

- Test administration and scoring services are cumulated in 30-minute increments
- Neurobehavioral status exam and Testing evaluation services are cumulated in 60-minute increments
- Psychiatric diagnostic evaluation (90791) is an untimed procedure and can be billed only one time for the service provided during a single encounter

Cumulated time is then converted to units of CPT® codes reported. A single unit of a base code should be reported with multiple units (as needed) of the corresponding add-on code for the individual services performed.

The claim should contain:

1. Stand-alone codes that describe the primary or base service
2. List add-on codes, if applicable, for subsequent units/time, even if performed on separate dates of service. Add-on codes describe additional work and time associated with the primary/base service
3. Add-on codes are never reported as stand-alone codes and must be reported in conjunction with the primary or base service.

For case examples of billing for Psychological Testing, please see APA's 2024 Billing and Coding Guide: Here

COMPREHENSIVE COMMUNITY SUPPORT SERVICES (CCSS)

Background

908 KAR 2:250 and 907 KAR 15:020 are the main regulations describing Comprehensive Community Support Services (CCSS) in Kentucky.

The definition of CCSS includes:

1. Activities necessary to allow an individual to live with maximum independence in the community;
2. Are intended to ensure successful community living through the utilization of skills training as identified in the recipient's plan of care; and
3. Consist of using a variety of psychiatric or behavioral rehabilitation techniques to:
    a. Skills training, cueing, or supervision as identified in the client's individualized treatment plan
    b. Medication adherence and recognizing symptoms and side effects
    c. Non-clinical but therapeutic behavioral intervention, support, and skills training; (d) Assistance in accessing and utilizing community resources
    d. Improve daily living skills;
    e. Improve self-monitoring of symptoms and side effects
    f. Improve emotional regulation skills;
    g. Improve crisis coping skills;
    h. Develop and enhance interpersonal skills; and
    i. and be provided face-to-face.

Who are CCSS Clients?

1. An adult or child who has a primary mental health disorder diagnosis or a co-occurring disorder
2. Co-occurring disorder means the primary diagnosis of a mental health disorder and one (1) or more of the following:
    a. Substance use disorder;
    b. Intellectual disability; or
    c. Physical health disorder or condition.

Who Can Provide CCSS Services?

1. An approved behavioral health practitioner or an approved behavioral health practitioner under supervision. Staff must be authorized pursuant to 908 KAR 2:250 and to coordinate the provision of services among team members.
2. Community Support Associates (CSA's) under supervision of an approved behavioral health practitioner may also provide services. The CSA must meet with their supervisor no less than 1 time every two weeks.
3. Qualified CSA's will have completed the 10-hour certification training and maintain 6 hours/per year of continuing education on CCSS programming.
4. Qualified CSA Supervisors are: Physician, Psychiatrist, Advanced Practice Registered Nurse, Physician assistant, Licensed psychologist, Licensed psychological practitioner, Licensed clinical social worker, Licensed professional clinical counselor, Licensed marriage and family therapist, Certified psychologist, Certified psychologist with autonomous functioning, Licensed psychological associate, Marriage and family therapy associate, Certified social worker, Licensed professional counselor associate, Licensed professional art therapist, Professional equivalent, Certified alcohol and drug counselor, Psychiatric nurse, or Licensed board certified behavior analyst
5. Supervision of CSA's must be documented, dated, and signed by the supervisor for each supervision meeting. Please note that this documentation is subject to audit by the payer. The documentation must include:
    a. A description of the encounter(s) that specify the topics discussed
    b. Any specific actions to be taken
    c. An update for any issue previously discussed that required follow-up
    d. A plan for additional training needs if any were identified.

Examples of CCSS Services

1. Behavioral health prevention education services. This is the delivery of services with a target population to affect knowledge, attitude and/or behavior, for example a topic on "How to recognize signs of depression"
2. Services include skills training, cueing, medication adherence support, assistance with learning about recognizing symptoms, education regarding side effects of medication, assistance in accessing and utilizing community resources, emotional regulation skills, crisis management and crisis coping skills, developing and enhancing interpersonal skills, teaching parenting skills, teaching how to shop, and managing finances.
3. Use of psychiatric rehabilitation techniques to improve daily living skills such as personal hygiene and meal preparation
4. Non-clinical but therapeutic behavioral intervention, support and skills training
5. Supervision of the client as identified in the client's individualized treatment plan
6. Helping clients obtain stable and safe places to live independently, to support recovery
7. Helping clients establish relationships in the community to support them
8. Teaching clients about hope, recovery and resiliency skills, job-seeking skills
9. Development of system monitoring and management skills

Documentation Requirements for CCSS

CCSS activity must be coordinated within the context of a comprehensive individualized treatment plan which is developed through a person-centered process. CCSS must be identified on each client's treatment plan as a modality to address one or more goal/objective. Each service provided shall be documented in the client record. This documentation shall substantiate the service provided. Documentation shall include the type of service provided, the date of service, time of service, place of service and person providing the service. The documentation shall be signed by the person providing the service. Each CCSS service shall be directly related to each client's treatment plan and each service note shall reflect such.

CSA's who perform the CCSS services are defined in 907 KAR 15:005 as practitioners under supervision. 907 KAR 15.020, Section 6, 5c states: "Notes recorded by an approved behavioral health practitioner under supervision shall be co-signed and dated by the supervising professional within thirty (30) days." Additionally: "There shall be a monthly supervisory note recorded by the supervising professional reflecting consultations with the approved behavioral health practitioner under supervision concerning the: a. Case; and b. Supervising professional's evaluation of the services being provided to the recipient." These guidelines apply to all practitioners working under supervision.

UHC/Optum Guidance on CCSS

An excelled publication from Optum, dated January 2025, outlines the criteria for reimbursement of CCSS services. Of note are the explicit Admission Criteria, Continued Stay Criteria, Discharge Criteria, and Service Delivery. It is highly recommended that Alliance members read this document and use it to assist for programming and clinical documentation efforts to substantiate the billed codes. That publication can be found here: Click Here

Billing for CCSS

1. Code: H2015
    - If CCSS Service is delivered for ABA services, please use: 97152, 97153, 97154
2. Unit of Service: 15 minutes per 1 unit
3. For services rendered by a CSA, the modifier UC must be used to indicate that the LP/ARNP,LCSW,LPCC,LPP,LMFT/MD is billing for the service rendered by the CSA
4. These are one to one services, not provided in a group setting
5. Can be provided via telehealth

Note: Correspondence with DMS (February 2020) asking about CSA's billing for Treatment Team Meetings indicated, "Treatment team meetings are not billable by the CSA; the service plan development is the billable service." (source: Ann Hollen, MSW DMS, Division of Policy and Operations, Senior Behavioral Health Policy Advisor)

COMMUNITY HEALTH WORKER SERVICES

Background

Community Health Workers (CHW) help improve public health outcomes by serving as a bridge between systems of care and the communities they serve. They are often trusted members of the communities they work in and can provide culturally appropriate and linguistically accessible health services and information to individuals who may have limited access to traditional healthcare settings. Recipients of community health workers are high-risk individuals who may have challenges in seeking or obtaining in-person care. CHW's will typically provide services such as:

1. Providing support and advocacy to clients to help them achieve health goals
2. Address social determinants of health needs
3. Coach client in effectively managing their health conditions and self-care
4. Assist clients with understanding plans of care/care plans and instructions
5. Follow up with both clients and providers on treatment plans
6. Help clients find and utilize resources, including scheduling appointments and assisting with completing applications for programs for which they may be eligible

Billing Guidance

CHW's are a wonderful source of adjunct services for the mental health community. In 2023, a State Plan Amendment was approved in order to bill Medicaid for their services, several conditions of the CHW must be met:

1. Qualifications:
    a. Legal resident of the US
    b. Employed as a community health worker in the state of Kentucky
    c. Be at least 18 years old
    d. Meet and maintain CHW certification or recertification requirements.
2. Provider Types allowed to bill for services:
    a. Behavioral Health Services Organizations (BHSO) - 03
    b. Behavioral Health Multi-Specialty Group - 66
    c. Certified Community Behavioral Health Centers (CCBHC) - 16
3. Services must be delivered according to a plan of care and may include:
    a. Health system navigation
    b. Health promotion and coaching
    c. Preventative health training and assistance
    d. Health education and training.
4. Billing codes include:
    a. CPT 98960: 1 client; $22.53 per 30 minute increment
    b. CPT 98961: 2-4 clients; $10.88 per client, per 30 minute increment
    c. CPT 98962: 5-8 clients; $8.03 per client, per 30 minute increment
    d. Can be provided by telehealth (Modifier 95 with POS 02 if not in client's home or POS 10 if in the client's home)
5. Billing Limits and Guidelines:

a. No more than 104 units per calendar year
b. Provider Type/ Behavioral Health – 03, 16, 30, 66. These provider types equal one provider type. A total of 2 units per calendar week regardless of if billing provider type is 03, 16, 30, and 66. A total of 104 units per calendar year regardless of if billing provider type is 03, 16, 30, and 66
c. No POS limitations or restrictions on CHW services
d. You may bill for CHW services on the same day as you bill for other Provider services
e. Health Education Groups: No more than 8 participants per group
f. Mileage is not reimbursed

6. For CCBHC's:
    a. CCBHC's will not receive a wrap payment up to the daily Prospective Payment System (PPS) rate if this is the only service being billed. If it is the only service provided, it will be paid based on the fee schedule. If CHW services are provided on the same day as a service that does generate a wrap, then the CHW service will be bundled into the PPS rate.
7. If a provider receives federal, state, or private grant funding supporting a CHW, the provider cannot also bill Medicaid for services provided by that CHW for a Medicaid member. Provider must maintain records demonstrating no duplication of funding for the CHW and Medicaid reimbursement.

Documentation and Service Delivery

Documentation requirements:

1. An Order for the service by a qualified health provider (Physician, Physician Assistant, APRN/Nurse Practitioner, Certified Nurse Midwife, Dentist and Optometrist). As of the date of this manual, LCSW's and LPCC"s are not able to write Orders)
2. Clearly document the need for the service
3. Must be included in the Care Plan/Service Plan
4. Signed and documented by the CHW
5. Kept in the client medical record
6. NOTE: The official CPT Manual states that you should use a standardized curriculum; goal of the training should be to effectively manage the client's clinical condition; describe the type of education and training provided, the materials used and the reason the education was medically necessary.

Services considered in CHW scope of practice:

1. Services must be related to a medical intervention (medication management) that is outlined in the individuals care plan
2. Health system navigation and resource coordination, which may include:
    a. Helping a recipient find Medicaid providers to receive a covered service;
    b. Helping a recipient make an appointment for a Medicaid covered service;
    c. Arranging transportation to a medical appointment;
    d. Attending an appointment with the recipient for a covered service;

    e. Helping a recipient find other relevant community resources such as support groups.
3. Health promotion and coaching, which may include providing information or training to recipients that make positive contributions to their health status, such as:
    a. Cessation of tobacco use;
    b. Reduction in the misuse of alcohol or drugs;
    c. Improvement in nutrition;
    d. Improvement of physical fitness;
    e. Family planning;
    f. Control of stress;
    g. Pregnancy and infant care, including prevention of fetal alcohol syndrome.
4. Health education and training to train or promote to recipients' methods and measures that have been proven effective in avoiding illness or lessening its effects, including:
    a. Immunizations;
    b. Control of high blood pressure;
    c. Control of sexually transmittable disease;
    d. Prevention and control of diabetes;
    e. Control of toxic agents;
    f. Occupational safety and health;
    g. Accident prevention.
5. Additional Service ideas:
    a. Direct preventative services or services designed to slow the progression of chronic diseases, including screenings for basic human needs and referrals to appropriate services and agencies to meet those needs;
    b. Health promotion education to prevent illness or disease, including the promotion of healthy behaviors to increase awareness and prevent the development of illness or disease;
    c. Facilitation between a beneficiary and a provider when cultural factors, such as language, socioeconomic status, or health literacy, become a barrier to properly understanding treatment options or treatment plans;
    d. Diagnosis-related patient education regarding self-management of physical, dental, or mental health.

For more information on CHW's: CHW Medicaid Billing Best Practice- KY DPH

AUTISM SERVICES

Background

As of January 1, 2019 Autism Spectrum Disorder (ASD) coverage is mandated for all health plans (including those publicly funded) without reference to age and ends the maximum annual benefit limit, including any limits on the number of visits an individual may make to an autism services provider. Insurers do have the right to request a utilization review of that treatment not more than once every twelve (12) months (KRS Section 304.17A-142).

Services

Under state law, treatment for ASD includes the following care for an individual diagnosed with an autism spectrum disorder (KRS Section 304.17A-142):

1. Medical care services provided by a licensed physician, an advanced registered nurse practitioner, or other licensed health care provider;
2. Habilitative or rehabilitative care, including professional counseling and guidance services, therapy, and treatment programs, including applied behavior analysis, that are necessary to develop, maintain, and restore, to the maximum extent practicable, the functioning of an individual;
3. Pharmacy care, if covered by the plan, including medically necessary medications prescribed by a licensed physician or other health-care practitioner with prescribing authority and any medically necessary health-related services to determine the need or effectiveness of the medications;
4. Psychiatric care, including direct or consultative services, provided by a psychiatrist licensed in the state in which the psychiatrist practices;
5. Psychological care, including direct or consultative services, provided by an individual licensed by the Kentucky Board of Examiners of Psychology or by the appropriate licensing agency in the state in which the individual practices;
6. Therapeutic care services provided by licensed speech therapists, occupational therapists, or physical therapists; and
7. Applied behavior analysis (ABA) prescribed or ordered by a licensed health or allied health professional.

Kentucky's Medicaid state plan does not separate ABA services from other behavioral health services. Licensed behavioral analysts (LBAs) and Licensed assistant behavior analyst may provide services. LBAs may perform any of the following services:

1. Screening
2. Assessment
3. Crisis intervention
4. Mobile crisis
5. Residential crisis stabilization
6. Day treatment
7. Individual outpatient therapy
8. Group outpatient therapy
9. Collateral outpatient therapy
10. Partial hospitalization
11. Service planning
12. Assertive Community Treatment (mental health only)
13. Comprehensive community support services (mental health only)

LBAs are excluded under the Medicaid state plan from providing:

1. Psychological testing
2. Peer support
3. Intensive outpatient program
4. Family outpatient therapy
5. Residential services for SUD
6. SBIRT
7. Therapeutic rehabilitation program (mental health only)
8. Withdrawal management
9. Medication assisted treatment

Coding and Billing

DMS revised its guidance for billing ABA services in January 2019 to reflect CPT® adoption of eight permanent codes for billing of ABA services. There are no longer any add-on codes in use, and all codes use uniform time increments of 15-minutes.

ABA Billing Code	CPT® Descriptor
97151	Behavior identification assessment, administered by a physician or other qualified healthcare professional, each 15 minutes of the practitioner's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing finding and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan
97152	Behavior identification supporting assessment, administered by one technician under the direction of a physician or other qualified healthcare professional, face-to-face with the patient, each 15 minutes
97153	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified healthcare professional, face-to-face with one patient, each 15 minutes
97154	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified healthcare professional, face-to-face with two or more patients, each 15 minutes
97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes
97156	Family adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes
97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes

ABA Billing Code	CPT® Descriptor
97158	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional, face-to-face with multiple patients, each 15 minutes

Provider Billing Instructions for Licensed Behavior Analyst Provider Type - 63 : Click here

For Kentucky Medicaid, there are no limitations on State Plan ABA covered services for beneficiaries. There may be limitations on Participant Directed Services or Behavior Support if an individual is in a 1915c waiver. (Source: personal communication with Sherry Staley, MS, LPA, BH Supervisor DMS on April 17, 2025)
*2023 KY SPA

STATE-SPECIFIC BILLING AND CODING PROCEDURES AND INFORMATION

Kentucky Medicaid Managed Care Provider Billing & Coding Guidance Related to Behavioral Health, May 2025

Managed Care Organization	Online Provider Guidance & Updates
Aetna Better Health of Kentucky	1. 2025 Provider Manual: Here 2. Behavioral Health (August 2022): Here 3. Provider News: Here 4. Document Library: Here
Humana	1. 2024 Provider Manual: Here 2. Education & news: Here
Passport Molina	1. 2025 Provider Manual: Here 2. Provider Newsletters: Here
United Healthcare Community Plan of Kentucky	1. 2025 Provider Manual: Here 2. Optum Provider Express (Bulletins, Guidelines): Here
WellCare of Kentucky	1. 2024 Provider Manual, News, Bulletins, etc: Here

DMS Billing Limitations by Provider Types*
May 2025

1. Behavioral Health Service Organizations (BHSOs – Tiers I):

Service	DMS Billing Limitations Specific to BHSO I
General coverage requirements	1. Direct contact between a practitioner and a recipient shall be required for each service except for: ○ Collateral outpatient therapy for a child under the age of twenty-one (21) years if the collateral outpatient therapy is in the child's plan of care ○ Family outpatient service in which the corresponding CPT® code establishes that the recipient is not present; or ○ A psychological testing service comprised of interpreting or explaining results of an examination or data to family members or other kin if the corresponding CPT® code establishes that the recipient is not present. 2. A billable unit of service shall be actual time spent delivering a service in an encounter 3. Services covered may be provided for a: ○ Mental health disorder; or ○ Co-occurring disorders, if the: ▪ Substance use disorder diagnosis is secondary to a primary mental health diagnosis; and ▪ Services are provided by an independently licensed practitioner who could independently practice and provide treatment for a co-occurring disorder 4. Reimbursement shall not be available for services performed within a BHSO I by a: ○ A licensed clinical alcohol and drug counselor (LCADC); ○ A licensed clinical alcohol and drug counselor associate (LCADCA); ○ A certified alcohol and drug counselor (CADC); or ○ A substance use disorder peer support specialist
Screening	• Be face-to-face or via telehealth, as appropriate • DMS will not reimburse for both a screening and an SBIRT provided to a recipient on the same date of service.
Assessment	• Be face-to-face or via telehealth, as appropriate
Psychological testing	Provided face-to-face or via telehealth, as appropriate

Service	DMS Billing Limitations Specific to BHSO I
Crisis intervention	• Provided as an immediate relief to the presenting problem or threat • Provided in a one (1) on one (1) encounter between the provider and the recipient, which is delivered either face-to-face or as a comparable service provided via telehealth, as appropriate
Mobile crisis services	• Provided for a duration of less than 24 hours • Be provided via face-to-face contact by a multi-disciplinary team based intervention in a home or community setting that ensures access to mental health services and supports

Day treatment	• Non-residential, intensive treatment program for a child under the age of twenty-one (21) years who has:
	  ○ A mental health disorder
	  ○ A high risk of out-of-home placement due to a behavioral health issue
	• Provided face-to-face

Peer support	• Be provided face-to-face • Individuals providing peer support services to recipients to provide no more than thirty (30) hours per week of direct recipient contact; and • Peer support services provided to recipients in a group setting not exceed eight (8) individuals within any group at a time
Intensive outpatient program	• Involve a one (1) on one (1) encounter between the provider and recipient, which is delivered either face-to-face or provided via telehealth, as appropriate • Be provided at least three (3) days per week for adults • Be provided at least six (6) hours per week for adolescents
Individual outpatient therapy	• Delivered in a one (1) on one (1) encounter between the provider and recipient, which is delivered either face-to-face or provided via telehealth, as appropriate • Not exceed three (3) hours per day, alone or in combination with any other outpatient therapy per recipient, unless additional time is medically necessary
Group outpatient therapy	• Consist of a face-to-face behavioral health therapeutic intervention provided in accordance with the recipients plan of care • Not exceed twelve (12) nonrelated individuals except for multi-family group therapy in size • Not exceed three (3) hours per day, alone or in combination with any other outpatient therapy, per recipient unless additional time is medically necessary

Service	DMS Billing Limitations Specific to BHSO I
Family outpatient therapy	• Consist of a face-to-face behavioral health therapeutic intervention or occur via telehealth, as appropriate • Shall be billed as one service regardless of the number of individuals (including multiple members from one family) who participate in the session • Not exceed three (3) hours per day alone or in combination with any other outpatient therapy per recipient unless additional time is medically necessary
Collateral outpatient therapy	• Consist of a face-to-face behavioral health consultation or occur via telehealth, as appropriate • Not be reimbursable if the therapy is for a recipient who is at least twenty-one (21) years of age
Service planning	• Provided face-to-face • Signed by the recipient
SBIRT	• Must use a standardized tool and have it in the record • Cannot bill for SBIRT and screening same date of service
Substance use disorders	DMS will not reimburse for services provided for outpatient or residential substance use disorder treatment, except as permitted if the primary diagnosis is mental health
Assertive community treatment	• Provided face to face • Caseloads not to exceed 10 per staff member • Cannot bill same day for: an assessment, case management, individual outpatient and group outpatient therapy, peer support or mobile crisis services
Comprehensive community support	Provided face-to-face
Therapeutic rehabilitation program	• Provided face-to-face • Delivered individually or in a group
Partial hospitalization	• Provided face-to-face • Short term, less than 24 hours per day and at least 4 hours per day
Laboratory services	Limited to appropriate CLIA certification

Service	DMS Billing Limitations Specific to BHSO I
Coverage limitations (services or activities not covered)	1. Services or activities provided to: ○ A resident of: ▪ A nursing facility; or ▪ An intermediate care facility for individuals with an intellectual disability; ○ An inmate of a federal, local, or state: ▪ Jail; ▪ Detention center; or ▪ Prison ○ An individual with an intellectual disability without documentation of an additional psychiatric diagnosis 2. Psychiatric or psychological testing for another agency, including a court or school, that does not result in the individual receiving psychiatric intervention or behavioral health therapy from the provider; 3. Consultation or educational service provided to a recipient or to others; 4. Collateral therapy for an individual aged twenty-one (21) years or older; 5. A telephone call, an email, a text message, or other electronic contact that does not meet the requirements stated in the definition of "face-to-face"; 6. Travel time; 7. A field trip; 8. A recreational activity; 9. A social activity; or 10. A physical exercise activity group
Service duplication	DMS will not reimburse for a service provided to a recipient by more than one provider, of any program in which the service is covered, during the same time period

Source: 907 KAR 15:020. Coverage provisions and requirements regarding services provided by behavioral health services organizations for mental health treatment. Here

Service	DMS Billing Limitations Specific to BHSO II & III
General coverage requirements	1. Reimbursement shall not be available for services performed by a: ○ Licensed behavior analyst (LBA); ○ Licensed assistant behavior analyst (LABA); ○ Registered behavior technician (RBT); or ○ Community support associate (CSA) 2. Direct contact between a practitioner and a recipient shall be required for each service except for: ○ Collateral outpatient therapy for a child under the age of twenty-one (21) years if the collateral outpatient therapy is in the child's plan of care ○ Family outpatient service in which the corresponding CPT® code establishes that the recipient is not present; or ○ A psychological testing service comprised of interpreting or explaining results of an examination or data to family members or other kin if the corresponding CPT® code establishes that the recipient is not present. 3. A billable unit of service shall be actual time spent delivering a service in an encounter 4. Services covered may be provided for a: ○ Substance use disorder; or ○ Co-occurring disorders
Screening	• Can be provided face-to-face or via telehealth, as appropriate • DMS does not require that a diagnosis is made and documented in the recipient's medical record within three (3) visits
Assessment	• Can be provided face-to-face or via telehealth, as appropriate • DMS does not require that a diagnosis is made and documented in the recipient's medical record within three (3) visits
Psychological testing	Provided face-to-face or via telehealth, as appropriate
Crisis intervention	• Provided as an immediate relief to the presenting problem or threat • Provided in a one (1) on one (1) encounter between the provider and the recipient, which is delivered either face-to-face or via telehealth, if appropriate • DMS does not require that a diagnosis is made and documented in the recipient's medical record within three (3) visits
Mobile crisis services	• Provided for a duration of less than 24 hours • Be provided via face-to-face contact by a multi-disciplinary team based intervention in a home or community setting that ensures access to substance use disorder and co-occurring disorder services and supports

Service	DMS Billing Limitations Specific to BHSO II & III

Day treatment	• Non-residential, intensive treatment program for a child under the age of twenty-one (21) years who has:
	  ○ A substance use disorder or co-occurring disorders; and
	  ○ A high risk of out-of-home placement due to a behavioral health issue
	• Provided face-to-face

Peer support	1. DMS does not require that a diagnosis is made and documented in the recipient's medical record within three (3) visits 2. Be provided face-to-face 3. Individuals providing peer support services to recipients to provide no more than thirty (30) hours per week of direct recipient contact; and 4. Peer support services provided to recipients in a group setting not exceed eight (8) individuals within any group at one (1) time
Intensive outpatient program	• Be provided face-to-face • Be provided at least three (3) hours per day at least three (3) days per week for adults • Be provided at least six (6) hours per week for adolescents
Individual outpatient therapy	• Consist of a face-to-face encounter or via telehealth, as appropriate, that is a one (1) on one (1) encounter between the provider and recipient • Not exceed three (3) hours per day, alone or in combination with any other outpatient therapy per recipient, unless additional time is medically necessary
Group outpatient therapy	• Consist of a face-to-face behavioral health therapeutic intervention provided in accordance with the recipient's identified plan of care • Not exceed twelve (12) individuals in size • Not exceed three (3) hours per day, alone or in combination with any other outpatient therapy, per recipient unless additional time is medically necessary
Family outpatient therapy	• Consist of a face-to-face or appropriate telehealth behavioral health therapeutic intervention • Shall be billed as one service regardless of the number of individuals (including multiple members from one family) who participate in the session • Not exceed three (3) hours per day alone or in combination with any other outpatient therapy per recipient unless additional time is medically necessary
Collateral outpatient therapy	• Not be reimbursable if the therapy is for a recipient who is at least twenty-one (21) years of age • Consist of a face-to-face or appropriate telehealth behavioral health consultation

Service	DMS Billing Limitations Specific to BHSO II & III
Service planning	• Provided face-to-face • Provided for SUD services or co-occurring disorders • Signed by the recipient
SBIRT	• DMS will not reimburse for both a screening and an SBIRT provided to a recipient on the same date of service • SBIRT for a SUD can be provided face-to-face or via telehealth, as appropriate
Substance use disorders	• BHSO II shall provide services for outpatient substance use disorder services and co-occurring disorders • BHSO III shall provide services for residential substance use disorder services and co-occurring disorders
Withdrawal management (WDM)	• Provided face-to-face for recipients with a substance use disorder or co-occurring disorders • Can be provided in an outpatient setting
Medication assisted treatment (MAT)	• MAT with behavioral health therapies shall be co-located within the same practicing site or via telehealth, as appropriate • Can be provided in an outpatient behavioral health setting, including in a narcotic treatment program for SUD treatment with methadone
Partial hospitalization	• Short-term with an average of four (4) to six (6) weeks • Provided for at least four (4) hours per day, but less than twenty-four (24) hours each day • Provided face-to-face
Laboratory services	Limited to appropriate CLIA certificate

Service	DMS Billing Limitations Specific to BHSO II & III
Coverage limitations (services or activities not covered)	1. Services or activities provided to: ○ A resident of: ▪ A nursing facility; or ▪ An intermediate care facility for individuals with an intellectual disability; ○ An inmate of a federal, local, or state: ▪ Jail; ▪ Detention center; or ▪ Prison ○ An individual with an intellectual disability without documentation of an additional psychiatric diagnosis 2. Psychiatric or psychological testing for another agency, including a court or school, that does not result in the individual receiving psychiatric intervention or behavioral health therapy from the provider; 3. Consultation or educational service provided to a recipient or to others; 4. A telephone call, an email, a text message, or other electronic contact that does not meet the requirements stated in the definition of "face-to-face," unless permitted as a telehealth service; 5. Travel time; 6. A field trip; 7. A recreational activity; 8. A social activity; or 9. A physical exercise activity group
Service duplication	DMS will not reimburse for a service provided to a recipient by more than one provider, of any program in which the service is covered, during the same time period
Source: 907 KAR 15:022. Coverage provisions and requirements regarding services provided by behavioral health services organizations for substance use disorder treatment and co-occurring disorders. HERE	

2. Behavioral Health Practitioners, Behavioral Health Provider Groups, or Behavioral Health Multi-Specialty Groups

Service	DMS Billing Limitations Specific to Behavioral Health Multi-Specialty Groups*

General coverage	• Direct contact between a provider or practitioner and a recipient shall be required for each service except for:
	  ○ Collateral outpatient therapy for a child under the age of twenty-one (21) years if the collateral outpatient therapy is in the child's plan of care;
	  ○ A family outpatient therapy service in which the corresponding CPT® code establishes that the recipient is not present;
	  ○ A psychological testing service comprised of interpreting or explaining results of an examination or data to family members or others in which the corresponding CPT® code establishes that the recipient is not present; or
	  ○ A service planning activity in which the corresponding current procedural terminology code establishes that the recipient is not present
	• Billable unit of service shall be actual time spent delivering a service in an encounter

Screening	Provided face-to-face or via telehealth, as appropriate
Assessment	Provided face-to-face or via telehealth, as appropriate
Psychological testing	Provided face-to-face or via telehealth, as appropriate
Crisis intervention	Be a one-on-one encounter between the provider and the recipient, which is delivered either face-to-face or via telehealth, as appropriate
Service planning	Provided face-to-face
Individual outpatient	• Consist of a one-on-one encounter between the provider and the recipient, which is delivered either face-to-face or via telehealth, as appropriate • Not exceed three (3) hours per day alone or in combination with any other outpatient therapy per recipient unless additional time is medically necessary
Family outpatient therapy	• Face-to-face or appropriate telehealth • Billed as one (1) service regardless of the number of individuals (including multiple members from one (1) family) who participate in the session • Not exceed three (3) hours per day alone or in combination with any other outpatient therapy per individual unless additional time is medically necessary

Service	DMS Billing Limitations Specific to Behavioral Health Multi-Specialty Groups*

Group outpatient therapy	• Consist of a face-to-face behavioral health therapeutic intervention
	• Be provided to a recipient in a group setting:
	  ○ Of nonrelated individuals except for multi-family group therapy; and
	  ○ Not to exceed twelve (12) individuals in size
	• Not exceed three (3) hours per day alone or in combination with any other outpatient therapy per recipient unless additional time is medically necessary

Collateral outpatient therapy	• Consist of a face-to-face or appropriate telehealth behavioral health consultation • Not be reimbursable if the therapy is for a recipient who is at least twenty-one (21) years of age
SBIRT	• DSM shall not reimburse for both a screening and an SBIRT provided to a recipient on the same date of service • Provided face-to-face or via telehealth as appropriate

Day treatment	• Non-residential, intensive treatment program for a child under the age of twenty-one (21) years who has:
	  ○ A mental health disorder. substance use disorder or co-occurring disorders; and
	  ○ A high risk of out-of-home placement due to a behavioral health issue
	• Provided face-to-face

Comprehensive community support	Provided face-to-face

Peer support	1. Provided face-to-face
	2. Peer support shall only be covered if provided by a behavioral health:
	  ○ Provider group; or
	  ○ Multi-specialty group
	3. Individuals providing peer support services to recipients provide no more than 30 hours per week of direct recipient contact
	4. Peer support services provided to recipients in a group setting not exceed eight (8) individuals within any group at one (1) time

Service	DMS Billing Limitations Specific to Behavioral Health Multi-Specialty Groups*

Intensive outpatient program services	1. Provided face-to-face
	2. Intensive outpatient program services shall only be covered if provided by a behavioral health:
	  ○ Provider group; or
	  ○ Multi-specialty group
	3. Minimum staff ratio of ten (10) to one (1)
	4. Intensive outpatient programs providing services for SUD treatment should meet The ASAM Criteria including components for support systems, staffing, and therapies. SUD services must:
	5. Be provided at least three (3) hours per day at least three (3) days per week for adults;
	6. Be provided at least six (6) hours per week for adolescents

Therapeutic rehabilitation program	• Face-to-face, on-site, psychiatric rehabilitation and supports for an individual with:
	  ○ A severe and persistent mental illness; or
	  ○ Individual under the age of twenty-one (21) years who has a severe emotional disability
	• Services can be delivered either individually or in a group

Withdrawal management (WDM)	• Provided face-to-face for recipients with a SUD disorder or co-occurring disorder
	• Can be provided by:
	  ○ A behavioral health multi-specialty group;
	  ○ A behavioral health provider group; or
	  ○ An approved behavioral health practitioner or behavioral health practitioner under supervision with oversight by a physician, advanced practice registered nurse, or physician assistant

Medication assisted treatment (MAT)	May be provided in a behavioral health provider group or multi-specialty group
Applied Behavior Analysis	• Provided by: licensed behavioral analyst, licensed assistance behavior analyst, approved behavioral health practitioner with documented training in applied behavior analysis, an approved behavioral health practitioner under supervision with documented training in applied behavior analysis, or a registered behavior technician under supervision
Laboratory services	Reimbursable to behavioral health provider group or behavioral health multi-specialty group with appropriate CLIA certificate to perform laboratory testing

Service	DMS Billing Limitations Specific to Behavioral Health Multi-Specialty Groups*
Diagnosis	Unless a diagnosis is made and documented in the recipient's medical record within three (3) visits, services will not be covered except for: 1. Crisis intervention; 2. A screening; 3. An assessment; or 4. Peer support services for the engagement into substance use disorder treatment within an emergency department bridge clinic
Coverage limitations (services or activities not covered)	1. Services or activities provided to: ○ A resident of: ▪ A nursing facility; or ▪ An intermediate care facility for individuals with an intellectual disability; ○ An inmate of a federal, local, or state: ▪ Jail; ▪ Detention center; or ▪ Prison • An individual with an intellectual disability without documentation of an additional psychiatric diagnosis 2. Psychiatric or psychological testing for another agency, including a court or school, that does not result in the individual receiving psychiatric intervention or behavioral health therapy from the provider; 3. Consultation or educational service provided to a recipient or to others; 4. Collateral therapy for an individual aged twenty-one (21) years or older; 5. A telephone call, an email, a text message, or other electronic contact that does not meet the requirements stated in the definition of "face-to-face", unless the electronic contact is appropriate as a comparable telehealth service; 6. Travel time; 7. A field trip; 8. A recreational activity; 9. A social activity; or 10. A physical exercise activity group
Duplication of service	The department shall not reimburse for a service provided to a recipient by more than one (1) provider, of any program in which the service is covered, during the same time period.

Source: 907 KAR 15:010. Coverage provisions and requirements regarding behavioral health services provided by individual approved behavioral health practitioners, behavioral health provider groups, and behavioral health multi-specialty groups. HERE

3. PRTF Level I and PRTF Level II

Service	DMS Billing Limitations Specific to Psychiatric Residential Treatment Facility Service, Level I and II*
Treatment plan (Level I and II)	A treatment plan shall specify: • The amount and frequency of services needed; and • The number of therapeutic pass days for a recipient, if the treatment plan includes any therapeutic pass days.
Services specified on the treatment plan: Level I	Provided as described in the recipient's current treatment plan, if included in the treatment plan

Services specified on the treatment plan: Level II	• Provided as described in the recipient's current treatment plan, if included in the treatment plan
	• Provided at least once a week:
	  ○ Unless the service is necessary twice a week, in which case the service shall be provided at least twice a week; or
	  ○ Except for diagnostic and assessment services which shall have no weekly minimum requirement

Determining patient status	• Level I PRTF shall complete a review of each recipient's treatment plan at least once every thirty (30) days
	  ○ If a recipient no longer meets Level I PRTF patient status criteria, DSM shall only reimburse through the last day of the individual's current approved stay
	• Level II PRTF shall complete by no later than the third (3rd) business day following an admission, an initial review of services and treatment provided
	  ○ For a recipient aged four (4) to five (5) years, a Level II PRTF shall complete a review of the recipient's treatment plan of care at least once every fourteen (14) days after the initial review
	  ○ For a recipient aged six (6) to twenty-two (22) years, a Level II PRTF shall complete a review of the recipient's treatment plan of care at least once every thirty (30) days after the initial review

Not covered as Level I or II PRTF services	1. Outpatient services (not behavioral health) 2. Pharmacy services 3. Durable medical equipment 4. Hospital emergency room services 5. Acute care hospital inpatient services 6. Laboratory and radiology services 7. Dental services 8. Hearing and vision services 9. Ambulance services

Service	DMS Billing Limitations Specific to Psychiatric Residential Treatment Facility Service, Level I and II*

Limitations in coverage	• No reimbursement for Level I or II PRTF services for a recipient if appropriate alternative services are available for the recipient in the community
	• No reimbursement for an admission that is not medically necessary; or
	• No reimbursement for services for an individual:
	  ○ With a major medical problem or minor symptoms;
	  ○ Who might only require a psychiatric consultation rather than an admission to a PRTF; or
	  ○ Who might need only adequate living accommodations, economic aid, or social support services

General coverage requirements	• Face-to-face contact between a practitioner and a recipient shall be required for each service except for:
	  ○ Collateral outpatient therapy for a recipient under the age of twenty-one (21) years if the collateral outpatient therapy is in the recipient's plan of care;
	  ○ A family outpatient therapy service in which the corresponding CPT® code establishes that the recipient is not present;
	  ○ A psychological testing service comprised of interpreting or explaining results of an examination or data to family members or others in which the corresponding CPT® code establishes that the recipient is not present; or
	  ○ A service planning activity in which the corresponding CPT® code establishes that the recipient is not present.
	• A billable unit of service shall be actual time spent delivering a service in a face-to-face encounter except for any component of service planning that does not require the presence of the recipient or recipient's representative

Service	DMS Billing Limitations Specific to Psychiatric Residential Treatment Facility Service, Level I and II*

Reserved bed coverage	• Annual bed reserve day limit per recipient shall be five (5) days per calendar year in aggregate for any combination of bed reserve days
	  ○ Bed reserve day count for each recipient shall begin at zero on January 1 of each calendar year
	• DMS shall cover a bed reserve day for an acute hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital for a recipient's absence from a Level I or II PRTF if the recipient:
	  ○ Is in Medicaid payment status in a Level I or II PRTF;
	  ○ Has been in the Level I or II PRTF overnight for at least one (1) night;
	  ○ Is reasonably expected to return requiring Level I or II PRTF care; and
	  ○ Has not exceeded the bed reserve day limit (unless exception)

Therapeutic pass coverage	• Annual therapeutic pass day limit per recipient shall be fourteen (14) days per calendar year
	  ○ Therapeutic pass day count for each recipient shall begin at zero on January 1 of each calendar year
	• DMS shall cover a therapeutic pass day for a recipient's absence from a Level I or II PRTF if the recipient:
	  ○ Is in Medicaid payment status in a Level I or II PRTF;
	  ○ Has been in the Level I or II PRTF overnight for at least one (1) night;
	  ○ Is reasonably expected to return requiring Level I or II PRTF care; and
	  ○ Has not exceeded the therapeutic pass day limit

Outpatient Services	Please refer to 907 KAR 9:015
PRTF Sources: 907 KAR 9:005. Non-outpatient level I and II psychiatric residential treatment facility service and coverage policies. HERE	

4. Intermediate Care Facility For Individuals With An Intellectual Disability Services (ICF/IID):

Service	DMS Billing Limitations Specific to ICF/IID*
Coverage	An ICF-IID shall receive payments for ICF-IID services only.
Reevaluation of Need for Service	• An individual's patient status shall be re-evaluated at least once every twelve (12) months. • Payment shall continue for ten (10) days to permit orderly discharge or transfer to an appropriate level of care

Reserve bed days	• Reserved bed days, per resident, are covered for:
	  ○ A maximum of forty-five (45) days within a calendar quarter; and
	  ○ Not exceed fifteen (15) calendar days per stay due to hospitalization; and
	• More than thirty (30) consecutive reserved bed days due to hospitalization plus leave of absence or due to leave of absence shall not be approved for coverage
	• Coverage due to hospitalization or due to leave of absence contingent upon whether:
	  ○ Individual is in Medicaid payment status in the level of care the individual is authorized to receive
	  ▪ If Medicaid is making Medicare coinsurance payments, the individual is not considered to have Medicaid payment status
	  ○ Been a resident of the facility at least overnight

Source: 907 KAR 1:022. Nursing facility services and intermediate care facility for individuals with an intellectual disability. HERE

5. Community Mental Health Center

Service	DMS Billing Limitations Specific to CMHC*
Duplication of service	The department shall not reimburse for a service provided to a recipient by more than one (1) provider, of any program in which the service is covered, on the same day of service
Units of service	A unit for a behavioral health service, a physician service, a physical therapy service, a speech-language pathology service, an occupational therapy service, a laboratory service, or a radiological service shall be the amount indicated for the corresponding: ○ CPT® code; or ○ Healthcare Common Procedure Coding System (HCPCS) code
CMHC Sources: 907 KAR 1:044. Coverage provisions and requirements regarding community mental health center behavioral health services. HERE 907 KAR 1:045. Reimbursement provisions and requirements regarding community mental health center services. HERE	

6. Supports for Community Living (SCL)

Service	DMS Billing Limitations Specific to Supports for Community Living*
Assessment service	• Conducted within seven (7) calendar days of receipt of request for assessment • Include at least one (1) face-to-face contact with the SCL recipient and, if appropriate, his or her family by the assessor in the SCL recipient's home • Not be reimbursable if the individual does not receive a level of care certification
Reassessment service	• Be performed at least every twelve (12) months; • Be conducted by a SCL case manager or support broker and submitted to the department no more than three (3) weeks prior to the expiration of the current level of care certification to ensure that certification is consecutive; • Not be reimbursable if conducted during a period that the SCL recipient is not covered by a valid level of care certification; and • Not be retroactive
Behavior support	Limited to ten (10) hours for an initial functional assessment and six (6) hours for the initial development of the behavior support plan and staff training
Case management	• Be initially developed within thirty (30) days of the initiation of the service using person-centered guiding principles • Annually reviewed • Monthly face-to-face contact with an SCL recipient
Community living supports	Limited to sixteen (16) hours per day alone or in combination with adult day training, children's day habilitation, and supported employment
Children's day habilitation	Limited to: • Individuals who are in school and up to sixteen (16) years of age; • Up to eight (8) hours per day, five (5) days per week; and • Up to sixteen (16) hours per day in combination with community living supports
Respite service	• Limited to 1,440 hours per calendar year • Provided only to an SCL recipient unable to independently administer self-care
Supported employment	Limited to forty (40) hours per week alone or in combination with adult day training

Service	DMS Billing Limitations Specific to Supports for Community Living*
Consumer Directed Option (CDO) services	• Reimbursement for a CDO service shall not exceed the department's allowed reimbursement for the same or a similar service provided in a non-CDO SCL setting • Consumer's budget shall not exceed the average per capita cost of services provided to individuals in an ICF-IID
Non-Consumer Directed Option (Non-CDO) covered services	• Be provided to recipients age twenty-two (22) or older; or to recipients age sixteen (16) to twenty-one (21) as a transition process from school to work or adult support services • Be limited to five (5) days per week, 255 days maximum per year; • Not exceed eight (8) hours per day, five (5) days per week; and • Not exceed sixteen (16) hours per day if provided in combination with community living supports or supported employment
Source: 907 KAR 1:145. Supports for community living services for an individual with an intellectual or developmental disability. HERE	

7. Autism Services

Service	• DMS Billing Limitations Specific to Autism Services
General coverage	• Coverage under this section shall not be subject to any maximum annual benefit limit, including any limits on the number of visits an individual may make to an autism services provider. • April 2025, DMS: There are no limitations on State Plan ABA covered services for beneficiaries. There *may be* limitations on Participant Directed Services or Behavior Support if an individual is in a 1915c waiver.** • Except for inpatient visits, an insurer shall have the right to request a utilization review of that treatment not more than once every twelve (12) months, unless deemed medically necessary by the care team
Applied Behavior Analysis	• Provided by: licensed behavioral analyst, licensed assistance behavior analyst, approved behavioral health practitioner with documented training in applied behavior analysis, an approved behavioral health practitioner under supervision with documented training in applied behavior analysis, or a registered behavior technician under supervision
Duplication of service	The department shall not reimburse for a service provided to a recipient by more than one (1) provider, of any program in which the service is covered, during the same time period.

Source: 304.17A-142, HERE
**Personal correspondence 4.17.25 with Sherri Staley, MS, LPA, Behavioral Health Supervisor at DMS

*Please note that Kentucky State Regulations are subject to change. Not all provider types are included in this manual.

CODES, DESCRIPTIONS, DEFINITIONS, MODIFIERS, AND DOCUMENTATION GUIDELINES

Sample Code Guide

The table below reflects the following codes that are delineated in this manual. This guide gives the reader the source of the information, or an explanation about what that line-item means.

CPT® Code	AMA's CPT®© 2025 Professional Code Book
CPT® Description	AMA's CPT®© 2025 Professional Code Book/AAPC Software
CPT® Notes	AMA's CPT®© 2025 Professional Code Book/AAPC Software
Documentation Requirements	Information in this section was sourced from the following: 1. Optum, Behavioral Health Services, 2025 2. CPT®© 2025 Professional Code Book 3. AAPC Software, CPT and HCPCS (2025) 4. CMS, Kentucky's MAC (CGS Medicare Contractor), LCD's 5. Kentucky MCO Provider Manuals
Who May Perform This Service in the State of Kentucky?	In addition to CMS, LCD's, and MAC's, Provider organizations are also required to follow their State Medicaid Office's rules and guidelines for billing and coding. These regulations may be in in addition to the LCD requirements, they can be different than the LCD requirements, or they can be stand-alone. State Medicaid offices do align with CMS and LCD's, but it is not always guaranteed. Information in this section came from the State of Kentucky Administrative Regulations, Cabinet for Health and Family Services — Department for Medicaid Services, KAR Title 907
Coding Documentation Notes	Additional information derived from the above resources

Medicare, Medicaid, MCO's and CPT® Code Differences: At times, Medicare, Medicaid and CPT® do not agree on the way in which a specific service, or group of services, should be reported. Medicare may produce HCPCS code(s) with specific guidance for Medicare contracted providers to follow. The same principle applies to Medicaid. When a provider is contracted with a payer, they must follow the guidelines and policies specific to the contract they have signed with the payer, whether or not it matches with the CPT® guidelines.

Modifier Table: BHSO Outpatient (Non-Facility)

BHSO Modifiers	Definition	Description
22	Increased Procedural Services	• When the work required to provide a service is substantially greater than typically required it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedures, severity of patient's condition, physical and mental effort required). • NOTE: This modifier should not be appended to an E/M service.
32	Mandated Services	Services related to mandated consultation and/or related services (e.g., third party payer, governmental, legislative or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.
52	Reduced Services	Used, in certain circumstances, to signify that a service or procedure is partially reduced or eliminated at the provider's discretion. This modifier provides a means for documenting and reporting reduced services or procedures without disturbing the identification of the basic procedure code. Documentation must support the service, and the reduction with a brief explanation or clarifying statement.
59	Distinct Procedural Service	Under certain circumstances, a provider may need to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same patient on the same day. CPT® modifier 59 is used to identify procedures/ services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. See , -X{EPSU} Modifiers Below

BHSO Modifiers	Definition	Description
95	Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System	• Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction.
AF	Psychiatrist	None
AH	Licensed Clinical Psychologist (LCP)	None
AJ	Licensed Clinical Social Worker (LCSW)	None
AM	Physician	MD or DO
HM	Prevention Specialist	Non-Bachelors-level
HN	Professional Equivalent	A PE is someone who has education and experience in a behavioral health field to provide behavioral health services under the billing supervision of a Licensed Approved Behavioral Health Practitioner, in a CMHC only.
HO	Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT), Licensed Professional Art Therapist (LPAT), Licensed Behavior Analyst (LBA)	None
SA	Advance Practice Registered Nurse (APRN)	None
UC	Community Support Associate (CSA) or Registered Behavior Technician (RBT)	• Works under supervision • For services rendered by a CSA or RBT, the modifier UC must be used to indicate that the LP/APRN/LCSW/LPCC/LPP/LMFT/MD is billing for the service rendered by the CSA or RBT
U1	Physician Assistant (PA)	Works under supervision

BHSO Modifiers	Definition	Description
U4	LP's associate (LP); LCSW's associate (CSW); LPCC's associate (LPCCA); LPAT's associate (LPATA); LMFT's associate (LMFTA); LABA's associate (LABAA)	• The U4 modifier must be used to indicate that the LP/LPCC/LMFT/LCSW/LPAT/LABA is billing for the service rendered by his/her associate.
U6	Certified Alcohol And Drug Counselor (CADC)	For services rendered by a CADC, the modifier U6 must be used to indicate that the LP/APRN/LCSW/LPCC/LPP/LMFT/MD is billing for the service rendered by the CADC.
UC	Community Support Associate	• For services rendered by a CSA, the modifier UC must be used to indicate that the LP/APRN/LCSW/LPCC/LPP/LMFT/MD is billing for the service rendered by the CSA.
U7	Peer Support Specialist (PSS)	• For services rendered by a Peer Support Specialist, the modifier U7 must be used to indicate that the LP/ARNP/LCSW/LPCC/LPP/LMFT/ MD is billing for the service rendered by the Peer Support Specialist. • Use additional modifier HQ if the Peer Support Service was provided to a group. • Use additional modifier HF if the Peer Support Specialist service was for Substance Use Disorder.
UB	Community Health Worker	• For services rendered by a Community Health Worker, the modifier UB must be used to indicate the rendering provider (Physician, APRN, or Physician Assistant) is overseeing/supervising the service.
NOTE: Procedure code T2023 is to be used for Targeted Case Management Services (TCM). TCM can be billed using modifiers below or alone, if applicable		
TG	Procedure code T2023	For use when providing TCM for individuals with Co-occurring Mental Health or Substance Use Disorders and Chronic or Complex Physical Health Issues
HF	Procedure code T2023	For use when providing TCM for Individuals with Substance Use Disorders
UA	Procedure code T2023	For use when providing TCM for Individuals with a Severe Emotional Disability
TG	Procedure code H0040	• Procedure code H0040 can be used with the TG modifier or alone • For use when providing TCM with the H0040 to denote a 10 person team. (No modifier is used for a 4-person team.)

Source: KY Medicaid Provider Billing Instructions for PT-03 v3.0, January 2025 Here

Modifier Table: Community Mental Health Center (CMHC)

CMHC Modifiers	Definition	Description
22	Increased Procedural Services	• When the work required to provide a service is substantially greater than typically required it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedures, severity of patient's condition, physical and mental effort required). • NOTE: This modifier should not be appended to an E/M service.
32	Mandated Services	Services related to mandated consultation and/or related services (e.g., third party payer, governmental, legislative or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.
52	Reduced Services	Used, in certain circumstances, to signify that a service or procedure is partially reduced or eliminated at the provider's discretion. This modifier provides a means for documenting and reporting reduced services or procedures without disturbing the identification of the basic procedure code. Documentation must support the service, and the reduction with a brief explanation or clarifying statement.
59	Distinct Procedural Service	Under certain circumstances, a provider may need to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same patient on the same day. CPT® modifier 59 is used to identify procedures/ services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. See , -X{EPSU} Modifiers Below

CMHC Modifiers	Definition	Description
95	Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System	• Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction.
AF	Psychiatrist	None
AH	Licensed Psychologist (LP)	None
AJ	Licensed Clinical Social Worker (LCSW)	None
AM	Physician	MD or DO
HN	Professional Equivalent	A PE is someone who has education and experience in a behavioral health field to provide behavioral health services under the billing supervision of a Licensed Approved Behavioral Health Practitioner, in a CMHC only.
HO	Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT), Licensed Professional Art Therapist (LPAT), Licensed Behavior Analyst (LBA), Licensed Clinical Alcohol Drug Counselors (LCADC)	None
HM	Prevention Specialist	
SA	Advance Practice Registered Nurse (APRN)	None
TD	Registered Nurse (RN)	None
UC	Community Support Associate (CSA)	• Works under supervision • For services rendered by a CSA, the modifier UC must be used to indicate that the LP/APRN/LCSW/LPCC/LPP/LMFT/MD is billing for the service rendered by the CSA
UD	Pregnant Woman Case Manager	None
U1	Physician Assistant (PA)	Works under supervision

CMHC Modifiers	Definition	Description
U2	Psychiatric Registered Nurse (Psy RN)	None
U3	Psychiatric Resident	None
U4	Certified Social Worker (CSW), Marriage and Family Therapy Associate (MFTA), Licensed Professional Counselor Associate (LPCA), Licensed Professional Art Therapist Associate (LPATA), Licensed Assistant Behavior Analyst (LABA), Licensed Clinical Alcohol Drug Counselor Associate (LCADCA); LPA, CPsy	Associate (under supervision) for services: • Rendered by the LCSW's associate (CSW); or Rendered by a LMFT's associate (MFTA); or services Rendered by a LPCC's associate (LPCA); or Rendered by a LPAT's associate (LPATA); or services Rendered by a LBA's associate (LABA); or Rendered by a LCADC's associate (LCADCA) • The U4 modifier must be used to indicate that the LCSW /LMFT/LPCC/LPAT/LBA/LCADC is billing for the service rendered by his/her associate.
U5	Mental Health Associate	A MHA is someone who has a minimum of a bachelor's degree in psychology, sociology, social work or human services under the billing supervision of a Licensed Approved Behavioral Health Practitioner.
U6	Certified Alcohol And Drug Counselor (CADC)	For services rendered by a CADC, the modifier U6 must be used to indicate that the LP/ARNP/LCSW/LPCC/LPP/LMFT/MD is billing for the service rendered by the CADC.
U7	Peer Support Specialist (PSS)	• Works under supervision • For services rendered by a Peer Support Specialist, the modifier HM must be used to indicate that the LP/ARNP/LCSW/LPCC/LPP/LMFT/MD is billing for the service rendered by the Peer Support Specialist.
UC	Community Support Specialist (CSA), Registered Behavior Technician (RBT)	
U8	Licensed Psychological Practitioner (LPP), CPsy w/Auto. Functionality	None
UK	Collateral Relationship	
U9	Per Diem	
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
XU	Unusual Non-Overlapping Service	The Use of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service

CMHC Modifiers	Definition	Description
NOTE: Procedure code T2023 is to be used for Targeted Case Management Services (TCM). TCM can be billed using modifiers below or alone, if applicable		
HE	Procedure code T2023	Targeted Case Management – individuals with Severe Mental Illness (SMI) as defined in 907 KAR 15:060E, per month
HF	Procedure code T2023	For use when providing TCM for individuals with Substance Use Disorder as defined in 907 KAR 15:040E, per month
TG	Procedure code T2023	Targeted Case Management – individuals with co-occurring Severe Mental Illness (SMI), Severe Emotional Disability (SED), or Substance Use Disorders and Chronic or Complex Physical Health Issues as defined in 907 KAR 15:050E, per month
UA	Procedure code T2023	For use when providing TCM for Individuals with a Severe Emotional Disability, 1 unit per member per month

Source: KY Medicaid Provider Billing Instructions for PT-30 v7.50, January 2025 Here

CPT® Code	90785
CPT® Description	Interactive complexity (List separately in addition to the code for primary procedure)
CPT® Notes	1. Code 90785 is an add-on code for interactive complexity to be reported in conjunction with codes for diagnostic psychiatric evaluation (90791, 90792), psychotherapy (90832, 90834, 90837), psychotherapy when performed with an evaluation and management service (90833, 90836, 90838, 99202-99255, 99304-99337, 99341-99350), and group psychotherapy (90853). 2. When provided in conjunction with the psychotherapy services (90832-90838), the amount of time spent by a physician or other qualified health care professional providing interactive complexity services should be reflected in the timed service code for psychotherapy (90832, 90834, 90837) or the psychotherapy add-in code performed with an evaluation and management service (90833, 90836, 90838) and must relate to the psychotherapy service only. 3. Do not report 90785 in conjunction with 90839, 90840, or in conjunction with E/M services when no psychotherapy service is also reported. 4. Do not report 90785 in conjunction with 90839, 90840, 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T

CPT® Code	90785
Documentation Requirements	Interactive complexity refers to specific communication factors that complicate the delivery of a psychiatric procedure. Common factors include more difficult communication with discordant or emotional family members and engagement of young and verbally undeveloped or impaired patients. Psychiatric procedures may be reported "with interactive complexity" when at least one of the following is present: 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 (e.g., 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 to communicate with the patient to overcome barriers to therapeutic or diagnostic interaction between the physician or other qualified health care professional and a patient who: ○ Is not fluent in the same language as the physician or other qualified health care professional, 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 qualified health care professional if he/she were to use typical language for communication. The medical record must reflect the elements outlined above and must be rendered by a qualified provider and must indicate that the person being evaluated does not have the ability to interact through normal verbal communicative channels. Additionally, the medical record must include adaptations utilized in the session and the rationale for employing these interactive techniques. If the patient is capable of ordinary verbal communication, this code should not be used. The medical record must include treatment recommendations.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA); CADC Modifier: U6
Coding Documentation Notes	Add-on code: Use in conjunction with codes for diagnostic psychiatric evaluation [90791, 90792], psychotherapy [90832, 90834, 90837], psychotherapy when performed with an E&M service [90833, 90836, 90838, 99203-90205, 99213-99215], and group psychotherapy [90853]

CPT® Code	90791
CPT® Description	Psychiatric diagnostic evaluation (without medical evaluation and management services)
CPT® Notes	1. Do not report 90785-90899 in conjunction with 90839, 90840, 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T 2. Do not report 90791-90899 in conjunction with 90839, 90840, 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T

CPT® Code	90791
Documentation Requirements	The medical record must reflect the elements outlined in the code's description and must be rendered by a qualified provider. Psychiatric diagnostic evaluation is an integrated biopsychosocial assessment, including history, mental status, and recommendations. The evaluation may include communication with family or other sources and review and ordering of diagnostic studies. Psychiatric diagnostic evaluation with medical services is an integrated biopsychosocial and medical assessment, including history, mental status, other physical examination elements as indicated, and recommendations. The evaluation may include communication with family or other sources, prescription of medications, and review and ordering of laboratory or other diagnostic studies. In certain circumstances one or more other informants (family members, guardians, or significant others) may be seen in lieu of the patient. Codes 90791, 90792 may be reported more than once for the patient when separate diagnostic evaluations are conducted with the patient and other informants. Report services as being provided to the patient and not the informant or other party in such circumstances. Codes 90791, 90792 may be reported once per day and not on the same day as an evaluation and management service performed by the same individual for the same patient. The psychiatric diagnostic evaluation may include interactive complexity services when factors exist that complicate the delivery of the psychiatric procedure. These services should be reported with add-on code 90785 used in conjunction with the diagnostic psychiatric evaluation codes 90791, 90792. Codes 90791, 90792 are used for the diagnostic assessment(s) or reassessment(s), if required, and do not include psychotherapeutic services. Psychotherapy services, including for crisis, may not be reported on the same day. This service may be covered once, at the outset of an illness or suspected illness. It may be utilized again for the same patient if a new episode of illness occurs after a hiatus or on admission or readmission to an inpatient status due to complications of the underlying condition. Certain patients, especially children, may require more than one visit for the completion of the initial diagnostic evaluation. The medical record must support the reason for more than one diagnostic interview.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA)

CPT® Code	90791
Coding Documentation Notes	1. Includes: history, mental status but elements may vary by payer 2. In some cases, family members, guardians or others may be consulted instead of patient 3. Do not use this code on same date-of-service as an E & M service (99xxx), psychotherapy or crisis service 4. Can be reported with a group psychotherapy code on same date if the time intervals are separate (i.e.: occur during different time slots and this is documented) 5. Use this code only once per day regardless of the number of sessions or time that the provider spends with the patient on the same day.

CPT® Code	90792
CPT® Description	Psychiatric diagnostic evaluation with medical services
CPT® Notes	1. Do not report 90791 or 90792 in conjunction with 98000-98016, 99202-99316, 99341-99350, 99366-99368, 99401, 99402, 99403, 99404, 99406, 99407, 99408, 99409, 99411, 99412, 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T 2. Use 90785 in conjunction with 90791, 90792 when the diagnostic evaluation includes interactive complexity services
Documentation Requirements	Documentation: Psychiatric diagnostic evaluation is an integrated biopsychosocial assessment, including history, mental status, and recommendations. The evaluation may include communication with family or other sources and review and ordering of diagnostic studies. Psychiatric diagnostic evaluation with medical services is an integrated biopsychosocial and medical assessment, including history, mental status, other physical examination elements as indicated, and recommendations. The evaluation may include communication with family or other sources, prescription of medications, and review and ordering of laboratory or other diagnostic studies. In certain circumstances one or more other informants (family members, guardians, or significant others) may be seen in lieu of the patient. Codes 90791, 90792 may be reported more than once for the patient when separate diagnostic evaluations are conducted with the patient and other informants. Report services as being provided to the patient and not the informant or other party in such circumstances. Codes 90791, 90792 may be reported once per day and not on the same day as an evaluation and management service performed by the same individual for the same patient. Codes 90791, 90792 are used for the diagnostic assessment(s) or reassessment(s), if required, and do not include psychotherapeutic services. Psychotherapy services, including for crisis, may not be reported on the same day.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; PA Modifier: U1
Coding Documentation Notes	Use this code only once per day regardless of the number of sessions or time that the provider spends with the patient on the same day.

CPT® Code	90832
CPT® Description	Psychotherapy, 30 minutes with patient
CPT® Notes	1. Psychotherapy codes 90832-90838 include ongoing assessment and adjustment of psychotherapeutic interventions, and may include involvement of informants in the treatment process. 2. Codes 90832, 90833, 90834, 90836, 90837, 90838 describe psychotherapy for the individual patient, although times are for face-to-face services with patient and may include informant(s). The patient must be present for all or a majority of the service. 3. In reporting, choose the code closest to the actual time (i.e., 16-37 minutes for 90832 and 90833, 38-52 minutes for 90834 and 90836, and 53 or more minutes for 90837 and 90838). Do not report psychotherapy of less than 16 minutes duration. 4. Psychotherapy provided to a patient in a crisis state is reported with codes 90839 and 90840 and cannot be reported in addition to the psychotherapy codes 90832-90838. 5. Code 90785 is an add-on code to report interactive complexity services when provided in conjunction with the psychotherapy codes 90832-90838. For family psychotherapy, see 90846, 90847. The amount of time spent by a physician or other qualified health care professional providing interactive complexity services should be reflected in the timed service code for psychotherapy (90832, 90834, 90837) or the psychotherapy add-on code performed with an evaluation and management service (90833, 90836, 90838). 6. Do not report 90785-90899 in conjunction with 90839, 90840, 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T.

CPT® Code	90832
Documentation Requirements	Psychotherapy is the treatment of mental illness and behavioral disturbances in which the physician or other qualified health care professional, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage personality growth and development. Psychotherapy includes the interactive process between the provider and the patient. See codes 90846, 90847 when utilizing family psychotherapy techniques, such as focusing on family dynamics. Do not report 90846, 90847 for family psychotherapy services less than 26 minutes. Codes 90832, 90833, 90834, 90836, 90837, 90838 may be reported on the same day as codes 90846, 90847, when the services are separate and distinct. The medical record must indicate the time spent in the psychotherapy encounter and the therapeutic maneuvers, such as behavior modification, supportive or interpretive interactions that were applied to produce a therapeutic change. Behavior modification is not a separate service, but is an adjunctive measure in psychotherapy. Additionally, a periodic summary of goals, progress toward goals, and an updated treatment plan must be included in the medical record. Prolonged periods of psychotherapy must be well-supported in the medical record describing the necessity for ongoing treatment. Medicare coverage of procedure codes 90832-90838 does not include teaching grooming skills, monitoring activities of daily living (ADL), recreational therapy (dance, art, play) or social interaction. Therefore, procedure codes 90832-90838 should not be used to bill for ADL training and/or teaching social interaction skills. A psychotherapy code should not be billed when the service is not primarily a psychotherapy service, that is, when the service could be more accurately described by an evaluation and management or other code.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA); CADC Modifier: U6
Coding Documentation Notes	1. Report 90832 for 16-37 minutes of face-to-face time with patient without E/M; 2. Document total time or start/stop times; 3. Document at least 1 technique to treat patients condition; 4. Document how patient benefited by therapy in reaching their goals; 5. Document if this is a single episode/recurrent, current degree of impairment, psychotic/not & symptoms, and remission status; 6. Psychotherapy that is palliative or to maintain functioning level will likely not be reimbursed

CPT® Code	90833
CPT® Description	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
CPT® Notes	1. Codes 90832-90838 include ongoing assessment and adjustment of psychotherapeutic interventions. 2. Because +90833 is an add–on code, payers will not reimburse you if you report it without an appropriate evaluation and management service code, such as 98000-98015, 99202–99255, 99304–99316, or 99341–99350. 3. Codes 90832, 90833, 90834, 90836, 90837, 90838 describe psychotherapy for the individual patient, although times are for face-to-face services with patient and may include informant(s). The patient must be present for all or a majority of the service. 4. In reporting, choose the code closest to the actual time (i.e., 16-37 minutes for 90832 and 90833, 38-52 minutes for 90834 and 90836, and 53 or more minutes for 90837 and 90838). Do not report psychotherapy of less than 16 minutes duration. 5. Psychotherapy provided to a patient in a crisis state is reported with codes 90839 and 90840 and cannot be reported in addition to the psychotherapy codes 90832-90833. 6. Code 90785 is an add-on code to report interactive complexity services when provided in conjunction with the psychotherapy codes 90832-90838. For family psychotherapy, see 90846, 90847. The amount of time spent by a physician or other qualified health care professional providing interactive complexity services should be reflected in the timed service code for psychotherapy (90832, 90834, 90837) or the psychotherapy add-on code performed with an evaluation and management service (90833, 90836, 90838). 7. (E/M) service on the same day as a psychotherapy service by the same physician or other qualified health care professional: To report both E/M and psychotherapy, the two services must be significant and separately identifiable. These services are reported by using codes specific for psychotherapy when performed with evaluation and management services (90833, 90836, 90838) as add-on codes to the evaluation and management service to report 90785-90899 in conjunction with 90839, 90840, 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T.

CPT® Code	90832
Documentation Requirements	Psychotherapy is the treatment of mental illness and behavioral disturbances in which the physician or other qualified health care professional, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage personality growth and development. The medical record must indicate the time spent in the psychotherapy encounter and the therapeutic maneuvers, such as behavior modification, supportive or interpretive interactions that were applied to produce a therapeutic change. Behavior modification is not a separate service, but is an adjunctive measure in psychotherapy. Additionally, a periodic summary of goals, progress toward goals, and an updated treatment plan must be included in the medical record. Prolonged periods of psychotherapy must be well-supported in the medical record describing the necessity for ongoing treatment. Medicare coverage of procedure codes 90832-90838 does not include teaching grooming skills, monitoring activities of daily living (ADL), recreational therapy (dance, art, play) or social interaction. Therefore, procedure codes 90832-90838 should not be used to bill for ADL training and/or teaching social interaction skills. The psychotherapy service codes 90832-90833 include ongoing assessment and adjustment of psychotherapeutic interventions, and may include involvement of informants in the treatment process. Some psychiatric patients receive a medical evaluation and management (E/M) service on the same day as a psychotherapy service by the same physician or other qualified health care professional. To report both E/M and psychotherapy, the two services must be significant and separately identifiable. These services are reported by using codes specific for psychotherapy when performed with evaluation and management services (90833, 90836, 90838) as add-on codes to the evaluation and management service. Medical symptoms and disorders inform treatment choices of psychotherapeutic intervention, and data from therapeutic communication are used to evaluate the presence, type, and severity of medical symptoms and disorders. For the purposes of reporting, the medical and psychotherapeutic components of the service may be separately identified as follows: 1. The type and level of E/M service is selected first based upon the key components of history, examination, and medical decision-making. 2. Time associated with activities used to meet criteria for the E/M service is not included in the time used for reporting the psychotherapy service (i.e., time spent on history, examination and medical decision making when used for the E/M service is not psychotherapy time). Time may not be used as the basis of E/M code selection and Prolonged Services may not be reported when psychotherapy with E/M (90833, 90836, 90838) are reported. 3. A separate diagnosis is not required for the reporting of E/M and psychotherapy on the same date of service.

CPT® Code	90832
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1
Coding Documentation Notes	1. Add-on code: Use in conjunction with allowable E&M codes [99202-99205, 99213-99215] 2. Report 90833 for 16-37 minutes of face-to-face time as add-on to E/M. 3. Document total time or start/stop times; 4. Document at least 1 technique to treat patients' condition; 5. Document how patient benefited by therapy in reaching their goals; 6. Document if this is a single episode/recurrent, current degree of impairment, psychotic/not & symptoms, and remission status; 7. Psychotherapy that is palliative or to maintain functioning level will likely not be reimbursed

CPT® Code	90834
CPT® Description	Psychotherapy, 45 minutes with patient
CPT® Notes	1. Codes 90832-90838 include ongoing assessment and adjustment of psychotherapeutic interventions. 2. Codes 90832, 90833, 90834, 90836, 90837, 90838 describe psychotherapy for the individual patient, although times are for face-to-face services with patient and may include informant(s). The patient must be present for all or a majority of the service. 3. Codes 90832, 90833, 90834, 90836, 90837, 90838 may be reported on the same day as codes 90846, 90847, when the services are separate and distinct. 4. In reporting, choose the code closest to the actual time (i.e., 16-37 minutes for 90832 and 90833, 38-52 minutes for 90834 and 90836, and 53 or more minutes for 90837 and 90838). Do not report psychotherapy of less than 16 minutes duration. 5. Code 90785 is an add-on code to report interactive complexity services when provided in conjunction with the psychotherapy codes 90832-90838. For family psychotherapy, see 90846, 90847. The amount of time spent by a physician or other qualified health care professional providing interactive complexity services should be reflected in the timed service code for psychotherapy (90832, 90834, 90837) or the psychotherapy add-on code performed with an evaluation and management service (90833, 90836, 90838). 6. Do not report 90785-90899 in conjunction with 90839, 90840, 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T.

CPT® Code	90834
Documentation Requirements	Psychotherapy is the treatment of mental illness and behavioral disturbances in which the physician or other qualified health care professional, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage personality growth and development. The medical record must indicate the time spent in the psychotherapy encounter and the therapeutic maneuvers, such as behavior modification, supportive or interpretive interactions that were applied to produce a therapeutic change. Behavior modification is not a separate service, but is an adjunctive measure in psychotherapy. Additionally, a periodic summary of goals, progress toward goals, and an updated treatment plan must be included in the medical record. Prolonged periods of psychotherapy must be well-supported in the medical record describing the necessity for ongoing treatment. A psychotherapy code should not be billed when the service is not primarily a psychotherapy service, that is, when the service could be more accurately described by an evaluation and management or other code. Medicare coverage of procedure codes 90832-90838 does not include teaching grooming skills, monitoring activities of daily living (ADL), recreational therapy (dance, art, play) or social interaction. Therefore, procedure codes 90832-90838 should not be used to bill for ADL training and/or teaching social interaction skills. Some psychiatric patients receive a medical evaluation and management (E/M) service on the same day as a psychotherapy service by the same physician or other qualified health care professional. To report both E/M and psychotherapy, the two services must be significant and separately identifiable. These services are reported by using codes specific for psychotherapy when performed with evaluation and management services (90833, 90836, 90838) as add-on codes to the evaluation and management service.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA); CADC Modifier: U6
Coding Documentation Notes	1. Report 90834 for 38-52 minutes of face-to-face time without E/M; 2. Document total time or start/stop times; 3. Document at least 1 technique to treat patients condition; 4. Document how patient benefited by therapy in reaching their goals; 5. Document if this is a single episode/recurrent, current degree of impairment, psychotic/not & symptoms, and remission status; 6. Psychotherapy that is palliative or to maintain functioning level will likely not be reimbursed

CPT® Code	90836
CPT® Description	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
CPT® Notes	1. Codes 90832-90838 include ongoing assessment and adjustment of psychotherapeutic interventions, and may include involvement of informants in the treatment process. 2. Codes 90832, 90833, 90834, 90836, 90837, 90838 describe psychotherapy for the individual patient, although times are for face-to-face services with patient and may include informant(s). The patient must be present for all or a majority of the service. 3. Codes 90832, 90833, 90834, 90836, 90837, 90838 may be reported on the same day as codes 90846, 90847, when the services are separate and distinct. 4. In reporting, choose the code closest to the actual time (i.e., 16-37 minutes for 90832 and 90833, 38-52 minutes for 90834 and 90836, and 53 or more minutes for 90837 and 90838). Do not report psychotherapy of less than 16 minutes duration. 5. Use 90836 in conjunction with 99202-99255, 99304-99337, 99341-99350. 6. Code 90785 is an add-on code to report interactive complexity services when provided in conjunction with the psychotherapy codes 90832-90838. For family psychotherapy, see 90846, 90847. The amount of time spent by a physician or other qualified health care professional providing interactive complexity services should be reflected in the timed service code for psychotherapy (90832, 90834, 90837) or the psychotherapy add-on code performed with an evaluation and management service (90833, 90836, 90838). 7. Do not report 90785-90899 in conjunction with 90839, 90840, 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T 8. (E/M) service on the same day as a psychotherapy service by the same physician or other qualified health care professional: To report both E/M and psychotherapy, the two services must be significant and separately identifiable. These services are reported by using codes specific for psychotherapy when performed with evaluation and management services (90833, 90836, 90838) as add-on codes to the evaluation and management service.

CPT® Code	90834
Documentation Requirements	Psychotherapy is the treatment of mental illness and behavioral disturbances in which the physician or other qualified health care professional, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage personality growth and development. The medical record must indicate the time spent in the psychotherapy encounter and the therapeutic maneuvers, such as behavior modification, supportive or interpretive interactions that were applied to produce a therapeutic change. Behavior modification is not a separate service, but is an adjunctive measure in psychotherapy. Additionally, a periodic summary of goals, progress toward goals, and an updated treatment plan must be included in the medical record. Prolonged periods of psychotherapy must be well-supported in the medical record describing the necessity for ongoing treatment. A psychotherapy code should not be billed when the service is not primarily a psychotherapy service, that is, when the service could be more accurately described by an evaluation and management or other code. Medicare coverage of procedure codes 90832-90838 does not include teaching grooming skills, monitoring activities of daily living (ADL), recreational therapy (dance, art, play) or social interaction. Therefore, procedure codes 90832-90838 should not be used to bill for ADL training and/or teaching social interaction skills. Some psychiatric patients receive a medical evaluation and management (E/M) service on the same day as a psychotherapy service by the same physician or other qualified health care professional. To report both E/M and psychotherapy, the two services must be significant and separately identifiable. These services are reported by using codes specific for psychotherapy when performed with evaluation and management services (90833, 90836, 90838) as add-on codes to the evaluation and management service. Medical symptoms and disorders inform treatment choices of psychotherapeutic intervention, and data from therapeutic communication are used to evaluate the presence, type, and severity of medical symptoms and disorders. For the purposes of reporting, the medical and psychotherapeutic components of the service may be separately identified as follows: 1. The type and level of E/M service is selected first based upon the key components of history, examination, and medical decision-making. 2. Time associated with activities used to meet criteria for the E/M service is not included in the time used for reporting the psychotherapy service (i.e., time spent on history, examination and medical decision making when used for the E/M service is not psychotherapy time). Time may not be used as the basis of E/M code selection and Prolonged Services may not be reported when psychotherapy with E/M (90833, 90836, 90838) are reported. 3. A separate diagnosis is not required for the reporting of E/M and psychotherapy on the same date of service.

CPT® Code	90834
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1
Coding Documentation Notes	1. Add-on code: Use in conjunction with allowable E&M codes [99203-99205, 99213-99215] 2. Report 90836 for 38-52 minutes of face-to-face time without E/M; 3. Document total time or start/stop times; 4. Document at least 1 technique to treat patients condition; 5. Document how patient benefited by therapy in reaching their goals; 6. Document if this is a single episode/recurrent, current degree of impairment, psychotic/not & symptoms, and remission status; 7. Psychotherapy that is palliative or to maintain functioning level will likely not be reimbursed

CPT® Code	90837
CPT® Description	Psychotherapy, 60 minutes with patient
CPT® Notes	1. Codes 90832-90838 include ongoing assessment and adjustment of psychotherapeutic interventions, and may include involvement of informants in the treatment process. 2. Codes 90832, 90833, 90834, 90836, 90837, 90838 describe psychotherapy for the individual patient, although times are for face-to-face services with patient and may include informant(s). The patient must be present for all or a majority of the service. 3. Codes 90832, 90833, 90834, 90836, 90837, 90838 may be reported on the same day as codes 90846, 90847, when the services are separate and distinct. 4. In reporting, choose the code closest to the actual time (i.e., 16-37 minutes for 90832 and 90833, 38-52 minutes for 90834 and 90836, and 53 or more minutes for 90837 and 90838). Do not report psychotherapy of less than 16 minutes duration. 5. Codes 90839 and 90840 cannot be reported in addition to the psychotherapy codes 90832-90838. 6. Code 90785 is an add-on code to report interactive complexity services when provided in conjunction with the psychotherapy codes 90832-90838. For family psychotherapy, see 90846, 90847. The amount of time spent by a physician or other qualified health care professional providing interactive complexity services should be reflected in the timed service code for psychotherapy (90832, 90834, 90837) or the psychotherapy add-on code performed with an evaluation and management service (90833, 90836, 90838).

CPT® Code	90837
Documentation Requirements	Psychotherapy is the treatment of mental illness and behavioral disturbances in which the physician or other qualified health care professional, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage personality growth and development. The medical record must indicate the time spent in the psychotherapy encounter and the therapeutic maneuvers, such as behavior modification, supportive or interpretive interactions that were applied to produce a therapeutic change. Behavior modification is not a separate service, but is an adjunctive measure in psychotherapy. Additionally, a periodic summary of goals, progress toward goals, and an updated treatment plan must be included in the medical record. Prolonged periods of psychotherapy must be well-supported in the medical record describing the necessity for ongoing treatment. A psychotherapy code should not be billed when the service is not primarily a psychotherapy service, that is, when the service could be more accurately described by an evaluation and management or other code. Medicare coverage of procedure codes 90832-90838 does not include teaching grooming skills, monitoring activities of daily living (ADL), recreational therapy (dance, art, play) or social interaction. Therefore, procedure codes 90832-90838 should not be used to bill for ADL training and/or teaching social interaction skills. Use the appropriate prolonged services code [99356, 99357] for psychotherapy services not performed with an E/M service of 90 minutes or longer face-to-face with the patient.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA); CADC Modifier: U6
Coding Documentation Notes	1. Report 90837 for 53-plus minutes of face-to-face time with patient without E/M; 2. Document total time or start/stop times; 3. Document at least 1 technique to treat patients condition; 4. Document how patient benefited by therapy in reaching their goals; 5. Document if this is a single episode/recurrent, current degree of impairment, psychotic/not & symptoms, and remission status; 6. Psychotherapy that is palliative or to maintain functioning level will likely not be reimbursed

CPT® Code	90838
CPT® Description	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
CPT® Notes	1. Codes 90832-90838 include ongoing assessment and adjustment of psychotherapeutic interventions, and may include involvement of informants in the treatment process. 2. Codes 90832, 90833, 90834, 90836, 90837, 90838 describe psychotherapy for the individual patient, although times are for face-to-face services with patient and may include informant(s). The patient must be present for all or a majority of the service. 3. Codes 90832, 90833, 90834, 90836, 90837, 90838 may be reported on the same day as codes 90846, 90847, when the services are separate and distinct. 4. In reporting, choose the code closest to the actual time (i.e., 16-37 minutes for 90832 and 90833, 38-52 minutes for 90834 and 90836, and 53 or more minutes for 90837 and 90838). Do not report psychotherapy of less than 16 minutes duration. 5. Use 90838 in conjunction with 99202-99255, 99304-99337, 99341-99350. 6. Code 90785 is an add-on code to report interactive complexity services when provided in conjunction with the psychotherapy codes 90832-90838. For family psychotherapy, see 90846, 90847. The amount of time spent by a physician or other qualified health care professional providing interactive complexity services should be reflected in the timed service code for psychotherapy (90832, 90834, 90837) or the psychotherapy add-on code performed with an evaluation and management service (90833, 90836, 90838). 7. Do not report 90785-90899 in conjunction with 90839, 90840, 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T 8. (E/M) service on the same day as a psychotherapy service by the same physician or other qualified health care professional: To report both E/M and psychotherapy, the two services must be significant and separately identifiable. These services are reported by using codes specific for psychotherapy when performed with evaluation and management services (90833, 90836, 90838) as add-on codes to the evaluation and management service.

CPT® Code	90838
Documentation Requirements	Psychotherapy is the treatment of mental illness and behavioral disturbances in which the physician or other qualified health care professional, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage personality growth and development. The medical record must indicate the time spent in the psychotherapy encounter and the therapeutic maneuvers, such as behavior modification, supportive or interpretive interactions that were applied to produce a therapeutic change. Behavior modification is not a separate service, but is an adjunctive measure in psychotherapy. Additionally, a periodic summary of goals, progress toward goals, and an updated treatment plan must be included in the medical record. Prolonged periods of psychotherapy must be well-supported in the medical record describing the necessity for ongoing treatment. A psychotherapy code should not be billed when the service is not primarily a psychotherapy service, that is, when the service could be more accurately described by an evaluation and management or other code. Medicare coverage of procedure codes 90832-90838 does not include teaching grooming skills, monitoring activities of daily living (ADL), recreational therapy (dance, art, play) or social interaction. Therefore, procedure codes 90832-90838 should not be used to bill for ADL training and/or teaching social interaction skills. Some psychiatric patients receive a medical evaluation and management (E/M) service on the same day as a psychotherapy service by the same physician or other qualified health care professional. To report both E/M and psychotherapy, the two services must be significant and separately identifiable. These services are reported by using codes specific for psychotherapy when performed with evaluation and management services (90833, 90836, 90838) as add-on codes to the evaluation and management service. Medical symptoms and disorders inform treatment choices of psychotherapeutic intervention, and data from therapeutic communication are used to evaluate the presence, type, and severity of medical symptoms and disorders. For the purposes of reporting, the medical and psychotherapeutic components of the service may be separately identified as follows: 1. The type and level of E/M service is selected first based upon the key components of history, examination, and medical decision-making. 2. Time associated with activities used to meet criteria for the E/M service is not included in the time used for reporting the psychotherapy service (i.e., time spent on history, examination and medical decision making when used for the E/M service is not psychotherapy time). Time may not be used as the basis of E/M code selection and Prolonged Services may not be reported when psychotherapy with E/M (90833, 90836, 90838) are reported. 3. A separate diagnosis is not required for the reporting of E/M and psychotherapy on the same date of service.

CPT® Code	90838
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1
Coding Documentation Notes	1. Add-on code: Use in conjunction with allowable E&M codes (99203-99205, 99213-99215) 2. Report 90838 for 38-52 minutes of face-to-face time without E/M; 3. Document total time or start/stop times; 4. Document at least 1 technique to treat patients condition; 5. Document how patient benefited by therapy in reaching their goals; 6. Document if this is a single episode/recurrent, current degree of impairment, psychotic/not & symptoms, and remission status; 7. Psychotherapy that is palliative or to maintain functioning level will likely not be reimbursed

CPT® Code	90839
CPT® Description	Psychotherapy for crisis, first 60 minutes
CPT® Notes	1. Codes 90839, 90840 are used to report the total duration of time face-to-face with the patient and/or family spent by the physician or other qualified health care professional providing psychotherapy for crisis, even if the time spent on that date is not continuous. For any given period of time spent providing psychotherapy for crisis state, the physician or other qualified health care professional must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during the same time period. The patient must be present for all or some of the service. Do not report with 90791 or 90792. 2. Code 90839 is used to report the first 30-74 minutes of psychotherapy for crisis on a given date. It should be used only once per date even if the time spent by the physician or other health care professional is not continuous on that date. Psychotherapy for crisis of less than 30 minutes total duration on a given date should be reported with 90832 or 90833 (when provided with evaluation and management services). 3. Code 90840 is used to report additional block(s) of time, up to 30 minutes each beyond the first 74 minutes. 4. Do not report 90839, 90840 in conjunction with 90791, 90792, psychotherapy codes 90832-90838 or other psychiatric services, or 90785-90899. 5. Do not report 90785-90899 in conjunction with 90839, 90840, 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T.
Documentation Requirements	Psychotherapy for crisis is an urgent assessment and history of a crisis state, a mental status exam, and a disposition. The treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma. The presenting problem is typically life threatening or complex and requires immediate attention to a patient in high distress. The record must indicate that the guidelines under the "Description" and "Comments" sections were followed. Codes 90839, 90840 are used to report the total duration of time face-to-face with the patient and/or family spent by the physician or other qualified health care professional providing psychotherapy for crisis, even if the time spent on that date is not continuous. For any given period of time spent providing psychotherapy for crisis state, the physician or other qualified health care professional must devote his or her full attention to the patient and, therefore, cannot provide service to any other patient during the same time period. The patient must be present for all or some of the service.

CPT® Code	90839
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA); CADC Modifier: U6
Coding Documentation Notes	1. Must include: start and stop times; time does not have to be continuous; however, it must be face-face with patient, without distraction. If not continuous, start/stop times documented 2. Document at least 1 description of the techniques used to treat the condition, how the patient benefited by the therapy in reaching his/her goals. Major theme of the discussion should also be recorded with consideration to the patient's privacy 3. Must document: single versus recurrent episode, current degree of (depression), with or without psychotic features or symptoms, and remission status when applicable 4. Site of service does not affect this code (Place of Service) 5. Terms such as "urgent, mobilization of resources to defuse the crisis and restore safety, life threatening or complex, requiring immediate intervention" are key 6. You may not report 90839 more than once per day.

CPT® Code	90840
CPT® Description	Psychotherapy for crisis, each additional 30 minutes (List separately in addition to code for primary service)
CPT® Notes	1. Use 90840 in conjunction with 90839. 2. Codes 90839, 90840 are used to report the total duration of time face-to-face with the patient and/or family spent by the physician or other qualified health care professional providing psychotherapy for crisis, even if the time spent on that date is not continuous. For any given period of time spent providing psychotherapy for crisis state, the physician or other qualified health care professional must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during the same time period. The patient must be present for all or some of the service. Do not report with 90791 or 90792. 3. Code 90839 is used to report the first 30-74 minutes of psychotherapy for crisis on a given date. Code 90840 is used to report additional block(s) of time, up to 30 minutes each beyond the first 74 minutes. 4. Do not report 90839, 90840 in conjunction with 90791, 90792, psychotherapy codes 90832-90838 or other psychiatric services, or 90785-90899. 5. Do not report 90785-90899 in conjunction with 90839, 90840, 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T.
Documentation Requirements	Psychotherapy for crisis is an urgent assessment and history of a crisis state, a mental status exam, and a disposition. The treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma. The presenting problem is typically life threatening or complex and requires immediate attention to a patient in high distress. The record must indicate that the guidelines under the "Description" and "Comments" sections were followed. Codes 90839, 90840 are used to report the total duration of time face-to-face with the patient and/or family spent by the physician or other qualified health care professional providing psychotherapy for crisis, even if the time spent on that date is not continuous. For any given period of time spent providing psychotherapy for crisis state, the physician or other qualified health care professional must devote his or her full attention to the patient and, therefore, cannot provide service to any other patient during the same time period. The patient must be present for all or some of the service.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA); CADC Modifier: U6

CPT® Code	90840
Coding Documentation Notes	1. Add-on code: Use in conjunction with 90839 2. Must include: start and stop times; time does not have to be continuous; however, it must be face-face with patient, without distraction. If not continuous, start/stop times documented 3. Document at least 1 description of the techniques used to treat the condition, how the patient benefited by the therapy in reaching his/her goals. Major theme of the discussion should also be recorded with consideration to the patient's privacy 4. Must document: single versus recurrent episode, current degree of (depression), with or without psychotic features or symptoms, and remission status when applicable 5. Site of service does not affect this code (Place of Service) 6. Terms such as "urgent, mobilization of resources to defuse the crisis and restore safety, life threatening or complex, requiring immediate intervention" are key

CPT® Code	90845
CPT® Description	Psychoanalysis
CPT® Notes	1. Do not report 90785-90899 in conjunction with 90839, 90840, 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T. 2. 90845 refers to the practice of psychoanalysis, do not confuse this code with psychotherapy codes, 90832 to 90838, and 90846 to 90853. Report psychoanalysis per day.
Documentation Requirements	The provider uses an analytical technique to increase insight into a person's unconscious motivations and conflicts to effect a change in maladaptive actions. Psychoanalysis includes such work by the analyst as his review of related medical, legal, and administrative documentation, arrangement of all appointments as necessary to develop a trusting relationship with the patient; intently listening to and observing the patient to gain insight and identify issues; assessment of the patient's mental processes and experiences; use of analytical techniques, and questioning and patient feedback to facilitate the patient's introspection and self–understanding to overcome barriers and adapt change. Therapy sessions typically occur between one and four times a week and include monitoring and reassessment of any medications.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA)
Coding Documentation Notes	1. Medical necessity criteria must be documented for psychoanalysis; 2. Criteria for "who may perform" may vary across payers; may need certain certifications. Check Provider manuals for details

CPT® Code	90846
CPT® Description	Family psychotherapy (without the patient present), 50 minutes
CPT® Notes	1. Procedure codes 90846, 90847, 90849 describe the treatment of the family unit when maladaptive behaviors of family members are exacerbating the beneficiary's mental illness or interfering with the treatment, or to assist the family in addressing the maladaptive behaviors of the patient and to improve treatment compliance. 2. Code 90846 is used when the patient is not present. Code 90847 is used when the patient is present. Code 90849 is intended for group therapy sessions to support multiple families when similar dynamics are occurring due to common issues confronted in the family members under treatment. 3. Do not report 90846, 90847 for family psychotherapy services less than 26 minutes. 4. Do not report 90785-90899 in conjunction with 90839, 90840, 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T.
Documentation Requirements	The medical record must document the conditions described and comments relative to codes 90846, 90847, and 90849 The Medicare National Coverage Determinations Manual, Chapter 1, Section 70.1, states that family psychotherapy services are covered only where the primary purpose of such psychotherapy is the treatment of the patient's condition. Examples include: • When there is a need to observe and correct, through psychotherapeutic techniques, the patient's interaction with family members (90847). • Where there is a need to assess the conflicts or impediments within the family, and assist, through psychotherapy, the family members in the management of the patient (90846 or 90847). The term "family" may apply to traditional family members, live-in companions, or significant others involved in the care of the patient. Codes 90846 and 90847 are not timed but are typically 45 to 60 minutes in duration. Codes 90846 and 90847 do not pertain to consultation and interaction with paid staff members at an institution.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA); CADC Modifier: U6

CPT® Code	90846
Coding Documentation Notes	1. Document: patient's condition and impact on family, specific participation, contributions and reactions of each family member must be notes 2. Some payers require prior authorization for this service 3. Individual and group psychotherapy MAY be reported on the same date-of-service if the 2 services are performed during different time intervals. 4. Tip: record start/stop times 5. The provider supplies psychotherapy to the patient and his family, when individual psychotherapy sessions are not sufficient. This is done to evaluate the treatment plan and role of the family members in the treatment.

CPT® Code	90847
CPT® Description	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes
CPT® Notes	1. Procedure codes 90846, 90847, 90849 describe the treatment of the family unit when maladaptive behaviors of family members are exacerbating the beneficiary's mental illness or interfering with the treatment, or to assist the family in addressing the maladaptive behaviors of the patient and to improve treatment compliance. 2. Code 90846 is used when the patient is not present. Code 90847 is used when the patient is present. Code 90849 is intended for group therapy sessions to support multiple families when similar dynamics are occurring due to common issues confronted in the family members under treatment. 3. Do not report 90846, 90847 for family psychotherapy services less than 26 minutes 4. Do not report 90846, 90847 in conjunction with 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T. 5. For family psychotherapy services [90847] of 80 minutes or more, see the appropriate prolonged services code [99356, 99357.
Documentation Requirements	The medical record must document the conditions described and comments relative to codes 90846, 90847, and 90849. The Medicare National Coverage Determinations Manual, Chapter 1, Section 70.1, states that family psychotherapy services are covered only where the primary purpose of such psychotherapy is the treatment of the patient's condition. Examples include: • When there is a need to observe and correct, through psychotherapeutic techniques, the patient's interaction with family members (90847). • Where there is a need to assess the conflicts or impediments within the family, and assist, through psychotherapy, the family members in the management of the patient (90846 or 90847). The term "family" may apply to traditional family members, live-in companions, or significant others involved in the care of the patient. Codes 90846 and 90847 are not timed but are typically 45 to 60 minutes in duration. Codes 90846 and 90847 do not pertain to consultation and interaction with paid staff members at an institution.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA); CADC Modifier: U6

CPT® Code	90847
Coding Documentation Notes	1. Document: patient's condition and impact on family, specific participation, contributions and reactions of each family member must be notes 2. Some payers require prior authorization for this service 3. Individual and group psychotherapy MAY be reported on the same date-of-service if the 2 services are performed during different time intervals. 4. Tip: record start/stop times 5. The provider supplies psychotherapy to the patient and his family, when individual psychotherapy sessions are not sufficient. This is done to evaluate the treatment plan and role of the family members in the treatment.

CPT® Code	90849
CPT® Description	Multiple-family group psychotherapy
CPT® Notes	1. Procedure codes 90846, 90847, 90849 describe the treatment of the family unit when maladaptive behaviors of family members are exacerbating the beneficiary's mental illness or interfering with the treatment, or to assist the family in addressing the maladaptive behaviors of the patient and to improve treatment compliance. 2. Code 90846 is used when the patient is not present. Code 90847 is used when the patient is present. Code 90849 is intended for group therapy sessions to support multiple families when similar dynamics are occurring due to common issues confronted in the family members under treatment. 3. Do not report 90785-90899 in conjunction with 90839, 90840, 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T.
Documentation Requirements	The medical record must document the conditions described and comments relative to codes 90846, 90847, and 90849. Comments: The Medicare National Coverage Determinations Manual, Chapter 1, Section 70.1, states that family psychotherapy services are covered only where the primary purpose of such psychotherapy is the treatment of the patient's condition. Examples include: • When there is a need to observe and correct, through psychotherapeutic techniques, the patient's interaction with family members (90847). • Where there is a need to assess the conflicts or impediments within the family, and assist, through psychotherapy, the family members in the management of the patient (90846 or 90847). The term "family" may apply to traditional family members, live-in companions, or significant others involved in the care of the patient. Code 90849 represents multiple-family group psychotherapy and is generally non-covered by Medicare. Such group therapy is usually directed to the effects of the patient's condition on the family and its purpose is to support the affected family members. Therefore, code 90849 does not meet Medicare's standards of being a therapy primarily directed toward treating the beneficiary's condition. Claims for 90849 may be approved on an individual consideration basis.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA); CADC Modifier: U6

CPT® Code	90849
Coding Documentation Notes	1. Document: patient's condition and impact on family, specific participation, contributions and reactions of each family member must be notes 2. Some payers require prior authorization for this service 3. Individual and group psychotherapy MAY be reported on the same date-of-service if the 2 services are performed during different time intervals. 4. Tip: record start/stop times 5. Example: Multi-family DBT Skills Training Groups 6. Use this code once for each family group present, not for each family

CPT® Code	90853
CPT® Description	Group psychotherapy (other than of a multiple-family group)
CPT® Notes	1. Codes 90853 represent psychotherapy administered in a group setting, involving no more than 12 participants, facilitated by a trained therapist simultaneously providing therapy to these multiple patients. The group therapy session typically lasts 45 to 60 minutes. Personal and group dynamics are discussed and explored in a therapeutic setting allowing emotional catharsis, instruction, insight, and support. 2. The interactive complexity component code 90785 may be used in conjunction with codes for diagnostic psychiatric evaluation (90791, 90792) and psychotherapy (90832, 90834, 90837), psychotherapy when performed with an evaluation and management service (90833, 90836, 90838), and group psychotherapy (90853). 3. Use 90853 in conjunction with 90785 for the specified patient when group psychotherapy includes interactive complexity. 4. Do not report 90785-90899 in conjunction with 90839, 90840, 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T.
Documentation Requirements	Group therapy, since it involves psychotherapy, must be led by a person who is licensed or otherwise authorized by the state in which he or she practices to perform this service. This will usually mean a psychiatrist, psychologist, clinical social worker, clinical nurse specialist, or other person authorized by the state to perform this service. Registered nurses with special training, as described in the "Indications and Limitations of Coverage and/or Medical Necessity" section, may also be considered eligible for coverage. For Medicare coverage, group therapy does not include: socialization, music therapy, recreational activities, art classes, excursions, sensory stimulation or eating together, cognitive stimulation, or motion therapy, etc.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA); CADC Modifier: U6

CPT® Code	90853
Coding Documentation Notes	1. Group dynamics are explored. Emotional and rational cognitive interactions are facilitated and reported. Processes that help patients move towards emotional healing and modification of thought and behavior are used, such as facilitating improved interpersonal exchanges, group support. 2. Should be used for group psychotherapy with other patients and not members of the patient's families 3. Do not report this service with adaptive behavior treatments social skills group 4. Patient-specific documentation is required in each patient record: specific participation, contributions and reactions of each group member. 5. Individual psychotherapy and group psychotherapy may be reported on the same date of service if the 2 services are performed during separate time intervals (best to document start/stop times).

CPT® Code	90865
CPT® Description	Narcosynthesis for psychiatric diagnostic and therapeutic purposes (e.g., sodium amobarbital (Amytal) interview)
CPT® Notes	1. For electronic analysis with programming, when performed, of vagal nerve neurostimulators, see 95970, 95976, 95977. 2. Do not report 90785-90899 in conjunction with 90839, 90840, 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T.
Documentation Requirements	Narcosynthesis is a psychiatric treatment technique that involves administering a narcotic drug that allows the patient to release thoughts that might be suppressed or repressed. Amytal or sodium amobarbital is a sedative hypnotic that providers most commonly use for psychiatric diagnosis and treatment. An Amytal interview is a test in which the provider administers a small amount of the drug, by vein, every few minutes. Intravenous Amytal causes a feeling of relaxation, warmth, and closeness to the provider; while in this state, the provider questions the patient. The provider uses the interview to evaluate memory and to elicit information from a person who is voluntarily guarding against its revelation. Amytal interviews have a role in the assessment and initial management of catatonia and unexplained muteness as well as in distinguishing between depressive, schizophrenic, and organic stuporous states.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1
Coding Documentation Notes	Document set-up and preparation; indicate the types of medications used, the dosage administered and the findings during the examination.

CPT® Code	90870
CPT® Description	Electroconvulsive therapy (includes necessary monitoring)
CPT® Notes	1. For electronic analysis with programming, when performed, of vagal nerve neurostimulators, see 95970, 95976, 95977. 2. Do not report 90785-90899 in conjunction with 90839, 90840, 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T.
Documentation Requirements	Electroconvulsive therapy, or ECT, is a psychiatric treatment a provider performs on a patient for whom conventional lines of treatment, such as prescribed medications and other psychotherapy, are not working. ECT's primary use is for the treatment of depression, but the provider may also consider ECT for other conditions, such as persistent life–threatening psychoses when the patient is suicidal or homicidal, and there is a need for a rapid alleviation of symptoms. The code includes the psychiatrist evaluation prior to performing an ECT procedure; time the physician takes to monitor the patient during the convulsive phase including the management of the seizure time by electroencephalographic tracing, and observation, and monitoring during the recovery phase. Decision making regarding further treatment is part of the monitoring, as well.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM
Coding Documentation Notes	1. Report one unit of 90870 only once per session. 2. If the provider evaluates the patient for a significant and separately identifiable evaluation and management service, you can report it with the appropriate established patient E/M code. Append a modifier such as 25, Significant, separately identifiable evaluation and management services by the same physician or other qualified health care professional on the same day of the procedure or other service, to the E/M code that you are reporting for the service to override the edit. The exception is the psychodiagnostic evaluation code 90792, which you bundle with 90870. You cannot report these two codes together under any circumstances for physician services. Only 90870 is payable if you provide both services to the same patient on the same date.

CPT Code	90875
CPT® Code	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); 30 minutes
CPT® Description	1. For electronic analysis with programming, when performed, of vagal nerve neurostimulators, see 95970, 95976, 95977. 2. Do not report 90785-90899 in conjunction with 90839, 90840, 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T. 3. Use 90876 when the provider performs the session for 45 minutes.
Documentation Requirements	Psychophysiological therapy is a treatment technique that utilizes the relationship between physiological processes and thoughts, emotions, and behavior to treat psychiatric illness. In this service, the provider performs 30 minutes of psychophysiological therapy using biofeedback training along with psychotherapy to alter the behavior of the patient.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA)
Coding Documentation Notes	Document use of ancillary instrumentation, such as electrical sensors, computer-assisted guided imagery, or temperature readers. Specify whether this is a single episode or recurrent, the current degree of depression, the presence of psychotic features or symptoms, and remission status when applicable.

CPT® Code	90876
CPT® Description	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); 45 minutes
CPT® Notes	1. For electronic analysis with programming, when performed, of vagal nerve neurostimulators, see 95970, 95976, 95977. 2. Do not report 90785-90899 in conjunction with 90839, 90840, 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T. 3. Use 90875 when the provider performs the session for 30 minutes.
Documentation Requirements	Psychophysiological therapy is a treatment technique that utilizes the relationship between physiological processes and thoughts, emotions, and behavior to treat psychiatric illness. In this service, the provider performs 45 minutes of psychophysiological therapy using biofeedback training along with psychotherapy to alter the behavior of the patient.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA)
Coding Documentation Notes	Document use of ancillary instrumentation, such as electrical sensors, computer-assisted guided imagery, or temperature readers. Specify whether this is a single episode or recurrent, the current degree of depression, the presence of psychotic features or symptoms, and remission status when applicable.

CPT® Code	90887
CPT® Description	Collateral Therapy Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist the patient.
CPT® Notes	1. Do not report 90785-90899 in conjunction with 90839, 90840, 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T. 2. For electronic analysis with programming, when performed, of vagal nerve neurostimulators, see 95970, 95976, 95977.
Documentation Requirements	90887 is used when the treatment of the patient may require explanations to the family, employers, or other involved persons for their support in the therapy process. This may include reporting of examinations, procedures, and other accumulated data. Codes 90885, 90887, and 90889 represent administrative services that do not involve face to face contact with the patient and are not covered by Medicare.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA); CADC Modifier: U6
Coding Documentation Notes	1. Documentation should clearly identify all evaluated data, as well as the provider's interpretation of the data evaluation. All entries to the medical record should be dated and authenticated. 2. Few payers provide coverage for this service 3. Purpose of interpretation is to obtain the responsible parties participation and support in the treatment of the patient 4. Do not report this service with adaptive behavior treatment with protocol modification, family adaptive behavior treatment guidance or multiple-family group adaptive behavior treatment guidance. 5. The provider fives the family advice and guidance on how to help the patient manage his disease and how to work with the patients to improve his condition.

CPT® Code	90899
CPT® Description	Unlisted psychiatric service or procedure Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for individuals, agencies, or insurance carriers.
CPT® Notes	1. Do not report 90785-90899 in conjunction with 90839, 90840, 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T. 2. For electronic analysis with programming, when performed, of vagal nerve neurostimulators, see 95970, 95976, 95977
Documentation Requirements	Use 90899 to report psychiatric services or procedures that do not have a specific code. When reporting a procedure with an unlisted code, submit a cover letter explaining the reason for choosing the unlisted code instead of a defined, active code. Include one or more similar codes and compare your service to those codes to justify the claim amount you are billing. Also include the operative notes or other relevant documentation to strengthen the claim and to avoid a possible denial. Your payers will consider claims with unlisted procedure codes on a case by case basis, and they will determine payment based on the documentation you provide.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA)
Coding Documentation Notes	This code will vary by payer: Check with individual payers: some may use this code for one service while another may use the same code for another service

CPT® Code	96105
CPT® Description	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g., by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour
CPT® Notes	Do not report assessment of aphasia and cognitive performance testing services [96105, 96125], developmental/behavioral screening and testing services [96110, 96112, 96113, 96127], and psychological/neuropsychological testing services [96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146] in conjunction with 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T)
Documentation Requirements	This testing is typically performed once during treatment and the medical necessity for such testing should be documented. Repeat testing should only be done if there is a significant change in the patient's aphasic condition. Included in the code are the administration of the test, scoring the test, interpretation of the various findings, formulating a diagnosis, and developing treatment guidelines. A requirement of testing services (96105, 96125, 96112, 96113, 96130, 96131, 96132, 96133, 96146) is that there is an interpretation and report when performed by a qualified health care professional, or a result when generated by automation. These services follow standard CPT® time definitions (ie, a minimum of 16 minutes for 30 minutes codes and 31 minutes for 1-hour codes must be provided to report any per hour code). Report the total time at the completion of the entire episode of evaluation.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA)
Coding Documentation Notes	Verify with payer if MD orders are needed to perform this service

CPT® Code	96110
CPT® Description	Developmental screening (e.g., developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument
CPT® Notes	1. For an emotional/behavioral assessment, use 96127 2. Developmental/behavioral testing services, which include interpretation and report, are described by 96112, 96113. 3. Do not report assessment of aphasia and cognitive performance testing services [96105, 96125], developmental/behavioral screening and testing services [96110, 96112, 96113, 96127], and psychological/neuropsychological testing services [96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146] in conjunction with 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T.
Documentation Requirements	The provider uses a standardized form to analyze the presence of any developmental disorder, typically during infancy or adolescence, any delay in a child's developmental milestones, and age appropriate maturity of speech and language, using the measurable parameters of the standardized instrument. Practitioners who can provide services vary per service, but include behavioral health professionals who are licensed to practice independently as well as behavioral health professionals who must work under supervision. Append modifier 59 to each additional 96110 if the provider employs two or more separate standardized tests during the same visit. Report the total time at the completion of the entire episode of evaluation.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA)
Coding Documentation Notes	These codes are NOT time-based. Information obtained through the assessment testing is interpreted and a written report is generated. Interpretation and written report are included in the service. Developmental screening includes screening for conditions such as autism and behavioral and emotional disorders. Developmental testing includes the assessment of motor, language, social, adaptive, and/or cognitive functioning. For neuro-psychological testing, use codes range 96118-96120. To report an emotional/behavioral assessment, use 96127. Coverage guidelines vary by payer.

CPT® Code	96112
CPT® Description	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour
CPT® Notes	1. For an emotional/behavioral assessment, use 96127 2. Developmental/behavioral testing services, which include interpretation and report, are described by 96112, 96113. 3. When you report 96112 in conjunction with an E/M service, do not count the time and effort to perform the developmental test toward the key components, history, physical, medical decision–making, or time for selecting the appropriate E/M code. You may append modifier 59 to 96112 to differentiate the developmental testing services at the same visit from the E/M services. 4. For each additional 30 minutes of developmental testing, see 96113. 5. Do not report assessment of aphasia and cognitive performance testing services [96105, 96125], developmental/behavioral screening and testing services [96110, 96112, 96113, 96127], and psychological/neuropsychological testing services [96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146] in conjunction with 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T.
Documentation Requirements	The provider administers various standardized tests to diagnose developmental problems in children. He interprets the results and prepares a report. Report this code for the first hour of test administration. A requirement of testing services (96105, 96125, 96112, 96113, 96130, 96131, 96132, 96133, 96146) is that there is an interpretation and report when performed by a qualified health care professional, or a result when generated by automation. These services follow standard CPT® time definitions (i.e., a minimum of 16 minutes for 30 minutes codes and 31 minutes for 1-hour codes must be provided to report any per hour code). Report the total time at the completion of the entire episode of evaluation.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA)
Coding Documentation Notes	1. Use this code only once per date of service. 2. Before reporting 96112, verify that supporting documentation includes test interpretation, score, and discussion. The provider must use a standardized test or tool and score the report as normal or abnormal on the patient's chart. He must review and discuss the results with the patient or a family member. 3. Keep a copy of the actual questionnaire in the patient's record for future reference.

CPT® Code	96113
CPT® Description	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes (List separately in addition to code for primary procedure)
CPT® Notes	1. For an emotional/behavioral assessment, use 96127 2. When you report 96112 in conjunction with an E/M service, do not count the time and effort to perform the developmental test toward the key components, history, physical, medical decision–making, or time for selecting the appropriate E/M code. You may append modifier 59 to 96112 to differentiate the developmental testing services at the same visit from the E/M services. 3. For each additional 30 minutes of developmental testing, see 96113. 4. Do not report assessment of aphasia and cognitive performance testing services [96105, 96125], developmental/behavioral screening and testing services [96110, 96112, 96113, 96127], and psychological/neuropsychological testing services [96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146] in conjunction with 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T.
Documentation Requirements	Developmental/behavioral testing services, which include interpretation and report, are described by 96112, 96113. The provider administers various standardized tests to diagnose developmental problems in children. He interprets the results and prepares a report. For the first hour of developmental testing, see 96112. Use these codes only once per date of service. Verify that supporting documentation includes test interpretation, score, and discussion. The provider must use a standardized test or tool and score the report as normal or abnormal on the patient's chart. He must review and discuss the results with the patient or a family member. Keep a copy of the actual questionnaire in the patient's record for future reference. A requirement of testing services (96105, 96125, 96112, 96113, 96130, 96131, 96132, 96133, 96146) is that there is an interpretation and report when performed by a qualified health care professional, or a result when generated by automation. These services follow standard CPT® time definitions (i.e., a minimum of 16 minutes for 30 minutes codes and 31 minutes for 1-hour codes must be provided to report any per hour code). Report the total time at the completion of the entire episode of evaluation.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA)

CPT® Code	96113
Coding Documentation Notes	1. Add-on code: Use in conjunction with 96112 2. Use this code only once per date of service. 3. Keep a copy of the actual questionnaire in the patient's record for future reference.

CPT® Code	96116
CPT® Description	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour
CPT® Notes	1. To report neuropsychological testing evaluation and administration and scoring services, see 96132, 96133, 96136, 96137, 96138, 96139, 96146). 2. To report psychological test administration using a single automated instrument, use 96146. 3. To report an E/M service with 96116, make sure that the neurobehavioral status exam is separate and distinct from the key components of the E/M service. When you report 96116 in conjunction with an E/M service, do not count the time and effort to perform the developmental test toward the key components, history, physical, medical decision–making, or time for selecting the appropriate E/M code. Append modifier 59 to 96116 to differentiate the developmental testing services at the same visit from the E/M services. 4. Do not report assessment of aphasia and cognitive performance testing services [96105, 96125], developmental/behavioral screening and testing services [96110, 96112, 96113, 96127], and psychological/neuropsychological testing services [96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146] in conjunction with 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T.
Documentation Requirements	Neurobehavioral status examination: a clinical assessment of cognitive functions and behavior, and may include an interview with the patient, other informant(s), and/or staff, as well as integration of prior history and other sources of clinical data with clinical decision making, further assessment and/or treatment planning and report. Evaluation domains may include acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities. The service includes face–to–face time with the patient, as well as time to interpret test results and document the findings in a report. This service is reportable per hour of the provider's time. Neurobehavioral status examination, which includes interpretation and report, is described by 96116, 96121. The time reported in 96116, 96121, 96130, 96131, 96132, 96133, 96125 is the face-to-face time with the patient and the time spent integrating and interpreting data. Report the total time at the completion of the entire episode of evaluation.

CPT® Code	96116
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC)
Coding Documentation Notes	Document the total time at the completion of the entire episode of evaluation, including start and stop times of testing.

CPT® Code	96121
CPT® Description	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour (List separately in addition to code for primary procedure)
CPT® Notes	1. 96121 is an add-on code. Use 96121 in conjunction with 96116. 2. To report neuropsychological testing evaluation and administration and scoring services, see 96132, 96133, 96136, 96137, 96138, 96139, 96146). 3. To report psychological test administration using a single automated instrument, use 96146. 4. Do not report assessment of aphasia and cognitive performance testing services [96105, 96125], developmental/behavioral screening and testing services [96110, 96112, 96113, 96127], and psychological/neuropsychological testing services [96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146] in conjunction with 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T.
Documentation Requirements	Neurobehavioral status examination, which includes interpretation and report, is described by 96116, 96121. Neurobehavioral status examination is a clinical assessment of cognitive functions and behavior, and may include an interview with the patient, other informant(s), and/or staff, as well as integration of prior history and other sources of clinical data with clinical decision making, further assessment and/or treatment planning and report. Evaluation domains may include acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities. The service includes face–to–face time with the patient, as well as time to interpret test results and document the findings in a report. This service is reportable per hour of the provider's time. The time reported in 96116, 96121, 96130, 96131, 96132, 96133, 96125 is the face-to-face time with the patient and the time spent integrating and interpreting data. Report the total time at the completion of the entire episode of evaluation.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC)
Coding Documentation Notes	96121 is an add-on code. Use 96121 in conjunction with 96116. Document the total time spent rendering and interpreting the service, including start and stop times of testing.

CPT® Code	96125
CPT® Description	Standardized cognitive performance testing (e.g., Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report
CPT® Notes	1. To report neuropsychological testing evaluation and administration and scoring services, see 96132, 96133, 96136, 96137, 96138, 96139, 96146 2. To report psychological test administration using a single automated instrument, use 96146. 3. Do not report assessment of aphasia and cognitive performance testing services [96105, 96125], developmental/behavioral screening and testing services [96110, 96112, 96113, 96127], and psychological/neuropsychological testing services [96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146] in conjunction with 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T.
Documentation Requirements	Cognitive performance testing assesses the patient's ability to complete specific functional tasks applicable to the patient's environment in order to identify or quantify specific cognitive deficits. The results are used to determine impairments and develop therapeutic goals and objectives. A requirement of testing services (96105, 96125, 96112, 96113, 96130, 96131, 96132, 96133, 96146) is that there is an interpretation and report when performed by a qualified health care professional, or a result when generated by automation. These services follow standard CPT® time definitions (i.e., a minimum of 16 minutes for 30 minutes codes and 31 minutes for 1-hour codes must be provided to report any per hour code). The time reported in 96116, 96121, 96130, 96131, 96132, 96133, 96125 is the face-to-face time with the patient and the time spent integrating and interpreting data. Report the total time at the completion of the entire episode of evaluation.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA)
Coding Documentation Notes	Report this code for each hour of the performing qualified health care professional's face-to-face time with the patient and time interpreting the result and preparing the report. A written report must be generated.

CPT® Code	96127
CPT® Description	Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument
CPT® Notes	1. For developmental screening, use 96110 2. Report this code for each instrument used for assessing the emotional state and behavior of the patient. 3. Do not report assessment of aphasia and cognitive performance testing services [96105, 96125], developmental/behavioral screening and testing services [96110, 96112, 96113, 96127], and psychological/neuropsychological testing services [96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146] in conjunction with 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T.
Documentation Requirements	The physician or healthcare professional performs a brief assessment of the patient's emotions and behaviors associated with conditions such as depression or ADHD using an inventory or scale method. The screening is used to determine whether the patient requires additional work up or treatment. This code includes scoring and documentation by standardized instrument.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: **AF**; Physician (MD or DO) Modifier: **AM**; APRN Modifier: **SA**; Licensed Clinical Psychologist Modifier: **AH**; PA Modifier: **U1**; Licensed Masters-level (Supervisor) Modifiers: **U8** (LPP, CPsy w/Auto. Funct.), **AJ** (LCSW), **HO** (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: **U4** (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA)
Coding Documentation Notes	1. To report a mini-mental status exam, see the appropriate level of E & M service. 2. To report developmental screening, use 96110. 3. Documentation may include the completion of standardized tools that include scoring.

CPT® Code	H0031
CPT® Description	Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument
CPT® Notes	4. For developmental screening, use 96110 5. Report this code for each instrument used for assessing the emotional state and behavior of the patient. 6. Do not report assessment of aphasia and cognitive performance testing services [96105, 96125], developmental/behavioral screening and testing services [96110, 96112, 96113, 96127], and psychological/neuropsychological testing services [96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146] in conjunction with 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T.
Documentation Requirements	The physician or healthcare professional performs a brief assessment of the patient's emotions and behaviors associated with conditions such as depression or ADHD using an inventory or scale method. The screening is used to determine whether the patient requires additional work up or treatment. This code includes scoring and documentation by standardized instrument.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA)
Coding Documentation Notes	4. To report a mini-mental status exam, see the appropriate level of E & M service. 5. To report developmental screening, use 96110. 6. Documentation may include the completion of standardized tools that include scoring. 7. Different MCO's may have different clinical documentation requirements.

CPT® Code	96130
CPT® Description	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
CPT® Notes	1. Psychological and neuropsychological test evaluation services, which include integration of patient data, interpretation of test results and clinical data, treatment planning and report, and interactive feedback, are described by 96130, 96131, 96132, 96133. 2. Time for evaluation services (e.g., integration of patient data or interpretation of test results) is included with psychological and neuropsychological test evaluation services (96130, 96131, 96132, 96133). 3. Psychological/neuropsychological testing evaluation services (96130, 96131, 96132, 96133) may be reported with psychological/neuropsychological test administration and scoring services (96136, 96137, 96138, 96139). 4. See 96131 for each additional hour of this same psychological testing service. 5. To report psychological test administration using a single automated instrument, use 96146. 6. Do not report assessment of aphasia and cognitive performance testing services [96105, 96125], developmental/behavioral screening and testing services [96110, 96112, 96113, 96127], and psychological/neuropsychological testing services [96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146] in conjunction with 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T.

CPT® Code	96130
Documentation Requirements	Psychological testing evaluation services typically include integration of patient data with other sources of clinical data, interpretation, clinical decision making, and treatment planning and report. It may include interactive feedback to the patient, family member(s) or caregiver(s) when performed. Evaluation domains for psychological evaluation may include emotional and interpersonal functioning, intellectual function, thought processes, personality, and psychopathology. This code covers up to the first hour of psychological testing, interpretation of results, and preparing a report. It also includes arriving at a diagnosis and course of treatment. The provider may discuss the test results, diagnosis and treatment plan with the patient and/or parents or guardian. A requirement of testing services (96105, 96125, 96112, 96113, 96130, 96131, 96132, 96133, 96146) is that there is an interpretation and report when performed by a qualified health care professional, or a result when generated by automation. These services follow standard CPT® time definitions (i.e., a minimum of 16 minutes for 30 minutes codes and 31 minutes for 1-hour codes must be provided to report any per hour code). The time reported in 96116, 96121, 96130, 96131, 96132, 96133, 96125 is the face-to-face time with the patient and the time spent integrating and interpreting data. Report the total time at the completion of the entire episode of evaluation.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA)
Coding Documentation Notes	See Psychological Testing section of this manual

CPT® Code	96131
CPT® Description	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)
CPT® Notes	1. Psychological and neuropsychological test evaluation services, which include integration of patient data, interpretation of test results and clinical data, treatment planning and report, and interactive feedback, are described by 96130, 96131, 96132, 96133. 2. Time for evaluation services (e.g., integration of patient data or interpretation of test results) is included with psychological and neuropsychological test evaluation services (96130, 96131, 96132, 96133). 3. Psychological/neuropsychological testing evaluation services (96130, 96131, 96132, 96133) may be reported with psychological/neuropsychological test administration and scoring services (96136, 96137, 96138, 96139). 4. To report psychological test administration using a single automated instrument, use 96146. 5. Do not report assessment of aphasia and cognitive performance testing services [96105, 96125], developmental/behavioral screening and testing services [96110, 96112, 96113, 96127], and psychological/neuropsychological testing services [96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146] in conjunction with 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T.
Documentation Requirements	Psychological testing evaluation services typically include integration of patient data with other sources of clinical data, interpretation, clinical decision making, and treatment planning and report. It may include interactive feedback to the patient, family member(s) or caregiver(s) when performed. Evaluation domains for psychological evaluation may include emotional and interpersonal functioning, intellectual function, thought processes, personality, and psychopathology. Report this code for each additional hour of psychological testing with the primary code (96130) for the first hour of service. A requirement of testing services (96105, 96125, 96112, 96113, 96130, 96131, 96132, 96133, 96146) is that there is an interpretation and report when performed by a qualified health care professional, or a result when generated by automation. These services follow standard CPT® time definitions (i.e., a minimum of 16 minutes for 30 minutes codes and 31 minutes for 1-hour codes must be provided to report any per hour code). The time reported in 96116, 96121, 96130, 96131, 96132, 96133, 96125 is the face-to-face time with the patient and the time spent integrating and interpreting data. Report the total time at the completion of the entire episode of evaluation.

CPT® Code	96131
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.); Modifier: U4 (LPA, CPsy only)
Coding Documentation Notes	Add-on code: Use in conjunction with 96132. See Psychological Testing section of this manual

CPT® Code	96132
CPT® Description	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
CPT® Notes	1. Psychological and neuropsychological test evaluation services, which include integration of patient data, interpretation of test results and clinical data, treatment planning and report, and interactive feedback, are described by 96130, 96131, 96132, 96133. 2. Time for evaluation services (e.g., integration of patient data or interpretation of test results) is included with psychological and neuropsychological test evaluation services (96130, 96131, 96132, 96133). 3. See 96133 for each additional hour spent in neuropsychological testing. 4. Psychological/neuropsychological testing evaluation services (96130, 96131, 96132, 96133) may be reported with psychological/neuropsychological test administration and scoring services (96136, 96137, 96138, 96139). 5. To report psychological test administration using a single automated instrument, use 96146. 6. Do not report assessment of aphasia and cognitive performance testing services [96105, 96125], developmental/behavioral screening and testing services [96110, 96112, 96113, 96127], and psychological/neuropsychological testing services [96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146] in conjunction with 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T.

CPT® Code	96132
Documentation Requirements	Neuropsychological testing evaluation services typically include integration of patient data with other sources of clinical data, interpretation, clinical decision making, and treatment planning and report. It may include interactive feedback to the patient, family member(s) or caregiver(s), when performed. Evaluation domains for neuropsychological evaluation may include intellectual function, attention, executive function, language and communication, memory, visual-spatial function, sensorimotor function, emotional and personality features, and adaptive behavior. The provider, a physician or other qualified healthcare professional, spends up to one hour administering neuropsychological tests, which includes time spent face–to–face with the patient in performing the tests, interpretation of the outcome, and preparation of the report. The code includes time spent in discussion of the outcome with the patient and family members or caregivers. A requirement of testing services (96105, 96125, 96112, 96113, 96130, 96131, 96132, 96133, 96146) is that there is an interpretation and report when performed by a qualified health care professional, or a result when generated by automation. These services follow standard CPT® time definitions (i.e., a minimum of 16 minutes for 30 minutes codes and 31 minutes for 1-hour codes must be provided to report any per hour code). The time reported in 96116, 96121, 96130, 96131, 96132, 96133, 96125 is the face-to-face time with the patient and the time spent integrating and interpreting data. Report the total time at the completion of the entire episode of evaluation.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC)
Coding Documentation Notes	See Psychological Testing section of this manual

CPT® Code	96133
CPT® Description	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)
CPT® Notes	1. Psychological and neuropsychological test evaluation services, which include integration of patient data, interpretation of test results and clinical data, treatment planning and report, and interactive feedback, are described by 96130, 96131, 96132, 96133. 2. Time for evaluation services (e.g., integration of patient data or interpretation of test results) is included with psychological and neuropsychological test evaluation services (96130, 96131, 96132, 96133). 3. Psychological/neuropsychological testing evaluation services (96130, 96131, 96132, 96133) may be reported with psychological/neuropsychological test administration and scoring services (96136, 96137, 96138, 96139). 4. To report psychological test administration using a single automated instrument, use 96146. 5. Do not report assessment of aphasia and cognitive performance testing services [96105, 96125], developmental/behavioral screening and testing services [96110, 96112, 96113, 96127], and psychological/neuropsychological testing services [96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146] in conjunction with 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T.

CPT® Code	96133
Documentation Requirements	Neuropsychological testing evaluation services typically include integration of patient data with other sources of clinical data, interpretation, clinical decision making, and treatment planning and report. It may include interactive feedback to the patient, family member(s) or caregiver(s), when performed. Evaluation domains for neuropsychological evaluation may include intellectual function, attention, executive function, language and communication, memory, visual-spatial function, sensorimotor function, emotional and personality features, and adaptive behavior. The provider, a physician or other qualified healthcare professional, administers neuropsychological tests, face–to–face with the patient. Report this code in addition to the primary code (96132) for each additional hour the provider spends administering the tests, interpreting the results, and preparing the report, including time spent in discussion with the patient and family members or caregivers. A requirement of testing services (96105, 96125, 96112, 96113, 96130, 96131, 96132, 96133, 96146) is that there is an interpretation and report when performed by a qualified health care professional, or a result when generated by automation. These services follow standard CPT® time definitions (i.e., a minimum of 16 minutes for 30 minutes codes and 31 minutes for 1-hour codes must be provided to report any per hour code). The time reported in 96116, 96121, 96130, 96131, 96132, 96133, 96125 is the face-to-face time with the patient and the time spent integrating and interpreting data. Report the total time at the completion of the entire episode of evaluation.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.)
Coding Documentation Notes	Add-on code: Use in conjunction with 96132. See Psychological Testing section of this manual

CPT® Code	96136
CPT® Description	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes
CPT® Notes	1. To report psychological testing evaluation and administration and scoring services, see 96130, 96131, 96136, 96137, 96138, 96139, 96146. 2. Psychological/neuropsychological testing evaluation services (96130, 96131, 96132, 96133) may be reported with psychological/neuropsychological test administration and scoring services (96136, 96137, 96138, 96139). 3. To report psychological test administration using a single automated instrument, use 96146. 4. Report 96137 with the primary code (96136) for each additional 30 minutes of administration and scoring of psychological or neuropsychological tests. 5. For 96136, 96137, 96138, 96139, do not include time for evaluation services [e.g., integration of patient data or interpretation of test results]. This time is included in 96130, 96131, 96132, 96133. 6. Do not report assessment of aphasia and cognitive performance testing services [96105, 96125], developmental/behavioral screening and testing services [96110, 96112, 96113, 96127], and psychological/neuropsychological testing services [96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146] in conjunction with 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T.
Documentation Requirements	Neuropsychological testing evaluation services typically include integration of patient data with other sources of clinical data, interpretation, clinical decision making, and treatment planning and report. It may include interactive feedback to the patient, family member(s) or caregiver(s), when performed. Evaluation domains for neuropsychological evaluation may include intellectual function, attention, executive function, language and communication, memory, visual-spatial function, sensorimotor function, emotional and personality features, and adaptive behavior. Psychological testing evaluation services: typically include integration of patient data with other sources of clinical data, interpretation, clinical decision making, and treatment planning and report. It may include interactive feedback to the patient, family member(s) or caregiver(s) when performed. Evaluation domains for psychological evaluation may include emotional and interpersonal functioning, intellectual function, thought processes, personality, and psychopathology. Testing and administration services (96136, 96137) are performed by a physician or other qualified health care professional.

CPT® Code	96136
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA)
Coding Documentation Notes	See Psychological Testing section of this manual

CPT® Code	96137
CPT® Description	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)
CPT® Notes	1. To report psychological testing evaluation and administration and scoring services, see 96130, 96131, 96136, 96137, 96138, 96139, 96146. 2. Psychological/neuropsychological testing evaluation services (96130, 96131, 96132, 96133) may be reported with psychological/neuropsychological test administration and scoring services (96136, 96137, 96138, 96139). 3. To report psychological test administration using a single automated instrument, use 96146. 4. Report 96137 with the primary code (96136) for each additional 30 minutes of administration and scoring of psychological or neuropsychological tests. 5. For 96136, 96137, 96138, 96139, do not include time for evaluation services [e.g., integration of patient data or interpretation of test results]. This time is included in 96130, 96131, 96132, 96133 6. Do not report assessment of aphasia and cognitive performance testing services [96105, 96125], developmental/behavioral screening and testing services [96110, 96112, 96113, 96127], and psychological/neuropsychological testing services [96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146] in conjunction with 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T.
Documentation Requirements	The provider, a physician or other qualified healthcare professional, administers two or more psychological or neuropsychological tests and scores them requiring an additional 30 minutes beyond the initial 30 minutes. Testing and administration services (96136, 96137) are performed by a physician or other qualified health care professional.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy only)
Coding Documentation Notes	Add-on code: 96137 may be reported in conjunction with 96130, 96131, 96132, 96133 on the same or different days. See Psychological Testing section of this manual

CPT® Code	96138
CPT® Description	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes
CPT® Notes	1. To report psychological testing evaluation and administration and scoring services, see 96130, 96131, 96136, 96137, 96138, 96139, 96146. 2. Psychological/neuropsychological testing evaluation services (96130, 96131, 96132, 96133) may be reported with psychological/neuropsychological test administration and scoring services (96136, 96137, 96138, 96139). 3. To report psychological test administration using a single automated instrument, use 96146. 4. For 96136, 96137, 96138, 96139, do not include time for evaluation services [e.g., integration of patient data or interpretation of test results]. This time is included in 96130, 96131, 96132, 96133 5. Report 96139 each additional 30 minutes in addition to the primary code 96138. 6. Do not report assessment of aphasia and cognitive performance testing services [96105, 96125], developmental/behavioral screening and testing services [96110, 96112, 96113, 96127], and psychological/neuropsychological testing services [96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146] in conjunction with 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T.
Documentation Requirements	A technician administers two or more psychological or neuropsychological tests and scores them. Report this code for the first 30 minutes of administration and scoring by any method. The tests selected, test administration and method of testing and scoring are the same, regardless whether the testing is performed by a physician, other qualified health care professional, or a technician, for 96136, 96137, 96138, 96139.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA)
Coding Documentation Notes	See Psychological Testing section of this manual

CPT® Code	96139
CPT® Description	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)
CPT® Notes	1. To report psychological testing evaluation and administration and scoring services, see 96130, 96131, 96136, 96137, 96138, 96139, 96146. 2. Psychological/neuropsychological testing evaluation services (96130, 96131, 96132, 96133) may be reported with psychological/neuropsychological test administration and scoring services (96136, 96137, 96138, 96139). 3. To report psychological test administration using a single automated instrument, use 96146. 4. For 96136, 96137, 96138, 96139, do not include time for evaluation services [e.g., integration of patient data or interpretation of test results]. This time is included in 96130, 96131, 96132, 96133. 5. Do not report assessment of aphasia and cognitive performance testing services [96105, 96125], developmental/behavioral screening and testing services [96110, 96112, 96113, 96127], and psychological/neuropsychological testing services [96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146] in conjunction with 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T.
Documentation Requirements	A technician administers two or more psychological or neuropsychological tests and scores them requiring an additional 30 minutes beyond the initial 30 minutes. The tests selected, test administration and method of testing and scoring are the same, regardless whether the testing is performed by a physician, other qualified health care professional, or a technician, for 96136, 96137, 96138, 96139.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA)
Coding Documentation Notes	1. Add-on code: 96139 may be reported in conjunction with 96130, 96131, 96132, 96133 on the same or different days. 2. Report +96139 with primary code 96138 for each additional 30 minutes of administration and scoring of psychological or neuropsychological tests by any method by a technician. See Psychological Testing section of this manual

CPT® Code	96146
CPT® Description	Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only
CPT® Notes	1. To report psychological test administration using a single automated instrument, use 96146. 2. If test is administered by physician, other qualified health care professional, or technician, do not report 96146. To report, see 96127, 96136, 96137, 96138, 96139. 3. Do not report assessment of aphasia and cognitive performance testing services [96105, 96125], developmental/behavioral screening and testing services [96110, 96112, 96113, 96127], and psychological/neuropsychological testing services [96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146] in conjunction with 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T.
Documentation Requirements	Automated testing and result code 96146 describes testing performed by a single automated instrument with an automated result. The patient is administered a single, standardized psychological or neuropsychological test using an electronic platform such as a computer, which scores the test on completion. A requirement of testing services (96105, 96125, 96112, 96113, 96130, 96131, 96132, 96133, 96146) is that there is an interpretation and report when performed by a qualified health care professional, or a result when generated by automation. These services follow standard CPT® time definitions (i.e., a minimum of 16 minutes for 30 minutes codes and 31 minutes for 1-hour codes must be provided to report any per hour code). Report the total time at the completion of the entire episode of evaluation.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.); Modifier: U4 (LPA, CPsy, only)
Coding Documentation Notes	See Psychological Testing section of this manual

CPT® Code	96156
CPT® Description	Health behavior assessment, or re-assessment (i.e., health-focused clinical interview, behavioral observations, clinical decision making)
CPT® Notes	1. For patients that require psychiatric services (90785-90899), adaptive behavior services (97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T) as well as health behavior assessment and intervention (96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171), report the predominant service performed. 2. Do not report 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171 in conjunction with 90785-90899 on the same date. 3. Evaluation and management services codes (including counseling risk factor reduction and behavior change intervention [99401-99412]) should not be reported on the same day as health behavior assessment and intervention codes 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171 by the same provider. 4. Do not report 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171 in conjunction with 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T.

CPT® Code	96156
Documentation Requirements	Health and behavior assessment procedures are used to identify the psychological, behavioral, emotional, cognitive, and interpersonal factors important to the assessment, treatment, or management of physical health problems. Health behavior assessment: includes evaluation of the patients' responses to disease, illness or injury, outlook, coping strategies, motivation, and adherence to medical treatment. Includes promotion of functional improvement, minimizing psychological and/or psychosocial barriers to recovery and management of and improvied coping with medical conditions. Report 96156 for an initial assessment or reassessment of a patient to identify and address the psychosocial, behavioral, emotional, and intellectual factors important to the treatment and management of physical health problems. HBA includes a health-focused clinical interview, behavioral observations, and clinical decision-making. Codes 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171 describe services offered to patients who present with primary physical illnesses, diagnoses, or symptoms and may benefit from assessments and interventions that focus on the psychological and/or psychosocial factors related to the patient's health status. These services do not represent preventive medicine counseling and risk factor reduction interventions. Health behavior assessment and intervention services (96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171) can occur and be reported on the same date of service as evaluation and management services (including counseling risk factor reduction and behavior change intervention [99401, 99402, 99403, 99404, 99406, 99407, 99408, 99409, 99411, 99412]), as long as the health behavior assessment and intervention service is reported by a physician or other qualified health care professional and the evaluation and management service is performed by a physician or other qualified health care professional who may report evaluation and management services.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; PA Modifier: U1; Licensed Clinical Psychologist Modifier: AH;
Coding Documentation Notes	Physical health issues, including patient adherence to medical treatment, symptom management, health-promoting behaviors, health-related risk-taking behaviors and overall adjustment to physical illness. Example: TMJ Disorder and referral by dentist or a patient who is combative due to painful medical treatments or a patient in constant pain.

CPT® Code	97151
CPT® Description	Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan
CPT® Notes	1. Codes 97152, 0362T may be reported separately with 97151 based on the time that the patient is face-to-face with one or more technician(s). Only count the time of one technician when two or more are present. 2. 97151, 97152, 0362T may be repeated on the same or different days until the behavior identification assessment [97151] and, if necessary, supporting assessment[s] [97152, 0362T], is complete) 3. For behavior identification-supporting assessment with four required components, use 0362T.
Documentation Requirements	Behavior identification assessment (97151) is conducted by the physician or other qualified health care professional and may include analysis of pertinent past data (including medical diagnosis), a detailed behavioral history, patient observation, administration of standardized and/or non-standardized instruments and procedures, functional behavior assessment, functional analysis, and/or guardian/caregiver interview to identify and describe deficient adaptive behaviors, maladaptive behaviors, and other impaired functioning secondary to deficient adaptive or maladaptive behaviors. Code 97151 includes the physician's or other qualified health care professional's scoring of assessments, interpretation of results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), preparation of report, and development of plan of care, which may include behavior identification supporting assessment (97152) or behavior identification-supporting assessment with four required components (0362T). For psychiatric diagnostic evaluation, see 90791, 90792 For speech evaluations, see 92521, 92522, 92523, 92524 For occupational therapy evaluation, see 97165, 97166, 97167, 97168 For medical team conference, see 99366, 99367, 99368 For health and behavior assessment/intervention, see 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171 For neurobehavioral status exam, see 96116, 96121 For neuropsychological testing, see 96132, 96133, 96136, 96137, 96138, 96139, 96146

CPT® Code	96156
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA)
Coding Documentation Notes	Report 97151 for each 15 minutes that a physician or other qualified healthcare professional spends administering, scoring, and interpreting assessments, analyzing past data, and preparing a report and/or treatment plan. The time spent includes face-to-face time discussing findings and recommendations with a patient and/or guardian or caregiver and non-face-to-face time performing the other services. The provider may administer several different types of tests to identify the patient's adaptive or maladaptive behaviors. This new code can be reported for each 15 minutes that the provider is engaged in performing these services.

CPT® Code	97152
CPT® Description	Behavior identification-supporting assessment, administered by one technician under the direction of a physician or other qualified health care professional, face-to-face with the patient, each 15 minutes
CPT® Notes	1. Codes 97152, 0362T may be reported separately with 97151 based on the time that the patient is face-to-face with one or more technician(s). Only count the time of one technician when two or more are present. 2. 97151, 97152, 0362T may be repeated on the same or different days until the behavior identification assessment [97151] and, if necessary, supporting assessment[s] [97152, 0362T], is complete. 4. For behavior identification-supporting assessment with four required components, use 0362T.
Documentation Requirements	Behavior identification supporting assessment (97152) is administered by a technician under the direction of a physician or other qualified health care professional. The physician or other qualified health care professional may or may not be on site during the face-to-face assessment process. Code 97152 includes the physician's or other qualified health care professional's interpretation of results and may include functional behavior assessment, functional analysis, and other structured observations and/or standardized and/or non-standardized instruments and procedures to determine levels of adaptive and maladaptive behavior. For psychiatric diagnostic evaluation, see 90791, 90792 For speech evaluations, see 92521, 92522, 92523, 92524 For occupational therapy evaluation, see 97165, 97166, 97167, 97168 For medical team conference, see 99366, 99367, 99368 For health and behavior assessment/intervention, see 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171 For neurobehavioral status exam, see 96116, 96121 For neuropsychological testing, see 96132, 96133, 96136, 96137, 96138, 96139, 96146
Who May Perform This Service in the State of Kentucky?	Limited to Physician, LBA, LABA, Technician, or other qualified healthcare professional as listed: U7 UC

CPT® Code	97152
Coding Documentation Notes	Report 97152 for each 15 minutes that a technician spends face-to-face with the patient administering a behavior identification-supporting assessment under the direction of a physician or other qualified healthcare professional. The technician administers test(s) to confirm the results of prior tests that were used to identify a patient's adaptive or maladaptive behaviors. Because this new code can be reported for each 15 minutes that the technician is engaged in performing these services, no add-on code is required to report additional time.

CPT® Code	97153
CPT® Description	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes
CPT® Notes	1. Do not report 97153 in conjunction with 90785-90899, 92507, 96105-96171, 97129 2. For adaptive behavior treatment with protocol modification with four required components, use 0373T.
Documentation Requirements	Adaptive behavior treatment codes 97153, 97154, 97155, 97156, 97157, 97158, 0373T describe services that address specific treatment targets and goals based on results of previous assessments (see 97151, 97152, 0362T), and include ongoing assessment and adjustment of treatment protocols, targets, and goals. Adaptive behavior treatment by protocol (97153) and group adaptive behavior treatment by protocol (97154) are administered by a technician under the direction of a physician or other qualified health care professional, utilizing a treatment protocol designed in advance by the physician or other qualified health care professional, who may or may not provide direction during the treatment. Code 97153 describes face-to-face services with one patient and code 97154 describes face-to-face services with two or more patients. Do not report 97154 if the group is larger than eight patients.
Who May Perform This Service in the State of Kentucky?	Limited to Physician, LBA, LABA, Technician, or other qualified healthcare professional as listed: U7 UC
Coding Documentation Notes	1. Report 97153 for each 15 minutes that a technician spends face-to-face with a single patient administering treatment that targets conditions such as developmental disabilities like impaired social and communication skills associated with adaptive or maladaptive behaviors, under the direction of a physician or other qualified healthcare professional. Because this new code can be reported for each 15 minutes that the technician is engaged in performing these services, no add-on code is required to report additional time. 2. Report this code for each 15 minutes that a technician performs this service face–to–face with one patient.

CPT® Code	97154
CPT® Description	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes
CPT® Notes	1. Do not report 97154 if the group has more than 8 patients. 2. Do not report 97154 in conjunction with 90785-90899, 92508, 96105-96171, 97150. 3. For adaptive behavior treatment with protocol modification with four required components, use 0373T.
Documentation Requirements	Adaptive behavior treatment codes 97153, 97154, 97155, 97156, 97157, 97158, 0373T describe services that address specific treatment targets and goals based on results of previous assessments (see 97151, 97152, 0362T), and include ongoing assessment and adjustment of treatment protocols, targets, and goals. Adaptive behavior treatment by protocol (97153) and group adaptive behavior treatment by protocol (97154) are administered by a technician under the direction of a physician or other qualified health care professional, utilizing a treatment protocol designed in advance by the physician or other qualified health care professional, who may or may not provide direction during the treatment. Code 97153 describes face-to-face services with one patient and code 97154 describes face-to-face services with two or more patients. Do not report 97154 if the group is larger than eight patients.
Who May Perform This Service in the State of Kentucky?	Limited to Physician, LBA, LABA, Technician, or other qualified healthcare professional as listed: U7 UC
Coding Documentation Notes	1. Report 97154 for each 15 minutes that a technician spends face-to-face with two or more patients administering treatment that targets conditions such as developmental disabilities like impaired social and communication skills associated with adaptive or maladaptive behaviors, under the direction of a physician or other qualified healthcare professional. Because this new code can be reported for each 15 minutes that the technician is engaged in performing these services, no add-on code is required to report additional time. 2. Report this code for each 15 minutes that a technician performs this service face–to–face with two or more patients.

CPT® Code	97155
CPT® Description	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes
CPT® Notes	1. Do not report 97155 in conjunction with 90785-90899, 92507, 96105-96171, 97129. 2. For adaptive behavior treatment with protocol modification with four required components, use 0373T.
Documentation Requirements	Adaptive behavior treatment codes 97153, 97154, 97155, 97156, 97157, 97158, 0373T describe services that address specific treatment targets and goals based on results of previous assessments (see 97151, 97152, 0362T), and include ongoing assessment and adjustment of treatment protocols, targets, and goals. Adaptive behavior treatment with protocol modification (97155) is administered by a physician or other qualified health care professional face-to-face with a single patient. The physician or other qualified health care professional resolves one or more problems with the protocol and may simultaneously direct a technician in administering the modified protocol while the patient is present. Physician or other qualified health care professional direction to the technician without the patient present is not reported separately.
Who May Perform This Service in the State of Kentucky?	Limited to Physician, LBA, LABA, Technician, or other qualified healthcare professional as listed: AF, AM, SA, AH, U1, U8, AJ, HO, U4
Coding Documentation Notes	1. Report 97155 for each 15 minutes that a physician or other qualified healthcare professional spends face-to-face with a single patient administering a modified treatment protocol that targets adaptive or maladaptive behaviors, which may include simultaneous direction of a technician. Because this new code can be reported for each 15 minutes that the provider is engaged in performing these services, no add-on code is required to report additional time. 2. Report this code for each 15 minutes of this service.

CPT® Code	97156
CPT® Description	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes
CPT® Notes	1. Do not report 97156 in conjunction with 90785-90899, 96105-96171. 2. For adaptive behavior treatment with protocol modification with four required components, use 0373T.
Documentation Requirements	Adaptive behavior treatment codes 97153, 97154, 97155, 97156, 97157, 97158, 0373T describe services that address specific treatment targets and goals based on results of previous assessments (see 97151, 97152, 0362T), and include ongoing assessment and adjustment of treatment protocols, targets, and goals. Family adaptive behavior treatment guidance and multiple-family group adaptive behavior treatment guidance (97156, 97157) are administered by a physician or other qualified health care professional face-to-face with guardian(s)/caregiver(s) and involve identifying potential treatment targets and training guardian(s)/caregiver(s) of one patient (97156) or multiple patients (97157) to implement treatment protocols designed to address deficient adaptive or maladaptive behaviors. Services described by 97156 may be performed with or without the patient present. Services described by 97157 are performed without the patient present. Do not report 97157 if the group has more than eight patients' guardian(s)/caretaker(s).
Who May Perform This Service in the State of Kentucky?	Limited to Physician, LBA, LABA, Technician, or other qualified healthcare professional as listed: AF, AM, SA, AH, U1, U8, AJ, HO, U4
Coding Documentation Notes	1. Report 97156 for each 15 minutes that a physician or other qualified healthcare professional provides guidance to a guardian or caregiver, face-to-face, on treatment that targets adaptive or maladaptive behaviors of a patient, with or without the patient present. Because this new code can be reported for each 15 minutes that the provider is engaged in performing these services, no add-on code is required to report additional time. 2. Report this code for each 15 minutes of this service.

CPT® Code	97157
CPT® Description	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes
CPT® Notes	1. Do not report 97157 if the group has more than 8 families. 2. Do not report 97157 in conjunction with 90785-90899, 96105-96171. 3. For adaptive behavior treatment with protocol modification with four required components, use 0373T.
Documentation Requirements	Adaptive behavior treatment codes 97153, 97154, 97155, 97156, 97157, 97158, 0373T describe services that address specific treatment targets and goals based on results of previous assessments (see 97151, 97152, 0362T), and include ongoing assessment and adjustment of treatment protocols, targets, and goals. Family adaptive behavior treatment guidance and multiple-family group adaptive behavior treatment guidance (97156, 97157) are administered by a physician or other qualified health care professional face-to-face with guardian(s)/caregiver(s) and involve identifying potential treatment targets and training guardian(s)/caregiver(s) of one patient (97156) or multiple patients (97157) to implement treatment protocols designed to address deficient adaptive or maladaptive behaviors. Services described by 97156 may be performed with or without the patient present. Services described by 97157 are performed without the patient present. Do not report 97157 if the group has more than eight patients' guardian(s)/caretaker(s).
Who May Perform This Service in the State of Kentucky?	Limited to Physician, LBA, LABA, Technician, or other qualified healthcare professional as listed: AF, AM, SA, AH, U1, U8, AJ, HO, U4
Coding Documentation Notes	1. Report 97157 for each 15 minutes that a physician or other qualified healthcare professional provides guidance to a multiple sets of guardians or caregivers, face-to-face, on treatment that targets adaptive or maladaptive behaviors of a patient, without the patient present. Because this new code can be reported for each 15 minutes that the provider is engaged in performing these services, no add-on code is required to report additional time. 2. Report this code for each 15 minutes that the provider spends face–to–face with multiple sets of guardians or caregivers.

CPT® Code	97158
CPT® Description	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes
CPT® Notes	1. Do not report 97158 if the group has more than 8 patients. 2. Do not report 97158 in conjunction with 90785-90899, 96105-96171, 92508, 97150. 3. For adaptive behavior treatment with protocol modification with four required components, use 0373T.
Documentation Requirements	Adaptive behavior treatment codes 97153, 97154, 97155, 97156, 97157, 97158, 0373T describe services that address specific treatment targets and goals based on results of previous assessments (see 97151, 97152, 0362T), and include ongoing assessment and adjustment of treatment protocols, targets, and goals. Group adaptive behavior treatment with protocol modification (97158) is administered by a physician or other qualified health care professional face-to-face with multiple patients. The physician or other qualified health care professional monitors the needs of individual patients and adjusts the treatment techniques during the group sessions, as needed. In contrast to group adaptive behavior treatment by protocol (97154), protocol adjustments are made in real time rather than for a subsequent service. Do not report 97158 if the group has more than eight patients. Report this code for each 15 minutes that the provider spends face–to–face with multiple patients in a group setting.
Who May Perform This Service in the State of Kentucky?	Limited to Physician, LBA, LABA, Technician, or other qualified healthcare professional as listed: AF, AM, SA, AH, U1, U8, AJ, HO, U4
Coding Documentation Notes	Report 97158 for each 15 minutes that a physician or other qualified healthcare professional spends face-to-face with two or more patients administering a modified treatment protocol that targets conditions such as developmental disabilities like impaired social and communication skills associated with adaptive or maladaptive behaviors. This new code can be reported for each 15 minutes that the provider is engaged in performing these services.

CPT® Code	98960
CPT® Description	Education and training for patient self-management by a non-physician qualified health care professional using standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient.
CPT® Notes	1. For health and behavior assessment and intervention that is not part of a standardized curriculum, see 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171.
Documentation Requirements	A nonphysician qualified healthcare professional (QHP) provides education and training prescribed by a physician or other QHP. The nonphysician QHP uses a standardized curriculum for the service, which relates to treatment and self–management of the patient's condition or delaying comorbidities, which are additional health conditions or diseases occurring simultaneously with a primary condition. The curriculum must be standardized, but it may be modified based on the patient's clinical requirements, culture, and ability to obtain, understand, and use health information to make informed decisions about their health. This may be an initial service, or this service may be to reinforce the training or to discuss adjustments because of changes in the patient's health and treatment. The provider and training program must meet qualification requirements consistent with the relevant professional association or similar source. This code represents each 30 minutes the provider spends with an individual patient and possibly their caregiver or family.
Who May Perform This Service in the State of Kentucky?	Limited to Physician, LBA, LABA, Technician, or other qualified healthcare professional as listed: AF, AM, SA, AH, U1, U8, AJ, HO, U4
Coding Documentation Notes	1. DMS allows the use of standing orders for CHS's where appropriate 2. See CHW section of this manual for more information

CPT® Code	99202
CPT® Description	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.
CPT® Notes	1. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs 2. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.
Documentation Requirements	The provider spends approximately 15 minutes face-to-face with a new patient and/or the patient's family in the provider's office or in another outpatient setting to evaluate and manage the patient's medical problems, which are usually of low to moderate severity. The provider's evaluation consists of all three of these components: an expanded problem–focused history, an expanded problem–focused physical examination, and straightforward medical decision making. She may provide additional services, including counseling or coordination of care with other healthcare professionals or agencies, if necessary.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; PA Modifier: U1; AH NOTE: Service can be provided/billed by an enrolled Narcotic Treatment Program (Provider Type 03-BHSO Tier II NTP)
Coding Documentation Notes	1. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded. 2. CPT 2024 revises 99202 as part of a larger revision. The update replaces the previous time ranges with a minimum time to use when selecting a code based on total time spent on the date of the encounter.

CPT® Code	99203
CPT® Description	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making.
CPT® Notes	1. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs 2. Usually the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
Documentation Requirements	The provider spends approximately 30 minutes face-to-face with a new patient and/or the patient's family in the provider's office or in another outpatient setting to evaluate and manage the patient's medical problems, which are usually of moderate severity. The provider's evaluation consists of all three of these components: a detailed history, a detailed physical examination, and medical decision making of low complexity. She may provide additional services, including counseling or coordination of care with other healthcare professionals or agencies, if necessary.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; PA Modifier: U1; AH NOTE: Service can be provided/billed by an enrolled Narcotic Treatment Program (Provider Type 03-BHSO Tier II NTP
Coding Documentation Notes	1. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded. 2. CPT 2024 revises 99203 as part of a larger revision. The update replaces the previous time ranges with a minimum time to use when selecting a code based on total time spent on the date of the encounter.

CPT® Code	99204
CPT® Description	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.
CPT® Notes	1. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs 2. Usually the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.
Documentation Requirements	The provider spends approximately 45 minutes face–to–face with a new patient and/or the patient's family in the provider's office or in another outpatient setting to evaluate and manage the patient's medical problems, which are usually of moderate to high severity. The provider's evaluation consists of all three of these components: a comprehensive history, a comprehensive physical examination, and medical decision making of moderate complexity. She may provide additional services, including counseling or coordination of care with other healthcare professionals or agencies, if necessary.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; PA Modifier: U1; AH NOTE: Service can be provided/billed by an enrolled Narcotic Treatment Program (Provider Type 03-BHSO Tier II NTP
Coding Documentation Notes	1. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded. 2. CPT 2024 revises 99204 as part of a larger revision. The update replaces the previous time ranges with a minimum time to use when selecting a code based on total time spent on the date of the encounter.

CPT® Code	99205
CPT® Description	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making.
CPT® Notes	1. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs 2. Usually the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.
Documentation Requirements	The provider spends approximately 60 minutes face–to–face with a new patient and/or the patient's family in the provider's office or in another outpatient setting to evaluate and manage the patient's medical problems, which are usually of moderate to high severity. The provider's evaluation consists of all three of these components: a comprehensive history, a comprehensive physical examination, and medical decision making of high complexity. She may provide additional services, including counseling or coordination of care with other healthcare professionals or agencies, if necessary.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; PA Modifier: U1 NOTE: Service can be provided/billed by an enrolled Narcotic Treatment Program (Provider Type 03-BHSO Tier II NTP
Coding Documentation Notes	1. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded. 2. CPT 2024 revises 99205 as part of a larger revision. The update replaces the previous time ranges with a minimum time to use when selecting a code based on total time spent on the date of the encounter.

CPT® Code	99213
CPT® Description	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making.
CPT® Notes	1. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. 2. Usually, the presenting problem(s) are low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family. 3. Report a separate and significant E/M service, including outpatient visits with CPT® codes 99202–99215, on the same day as another service or procedure. In most of these cases it is appropriate to append a modifier to the E/M service code.
Documentation Requirements	Report CPT® 99213 if the physician spends 20 minutes of face–to face time with the patient and/or family.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; PA Modifier: U1; AH NOTE: Service can be provided/billed by an enrolled Narcotic Treatment Program (Provider Type 03-BHSO Tier II NTP
Coding Documentation Notes	1. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded. 2. CPT 2024 revises 99213 as part of a larger revision. The update replaces the previous time ranges with a minimum time to use when selecting a code based on total time spent on the date of the encounter.

CPT® Code	99214
CPT® Description	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.
CPT® Notes	1. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. 2. Usually, the presenting problem(s) are low to moderate to high severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
Documentation Requirements	Report CPT® 99214 if the physician spends 30 minutes of face–to face time with the patient and/or family. Report a separate and significant E/M service, including outpatient visits with CPT® codes 99202–99215, on the same day as another service or procedure. In most of these cases it is appropriate to append a modifier to the E/M service code.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; PA Modifier: U1 NOTE: Service can be provided/billed by an enrolled Narcotic Treatment Program (Provider Type 03-BHSO Tier II NTP
Coding Documentation Notes	1. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded. 2. CPT 2024 revises 99214 as part of a larger revision. The update replaces the previous time ranges with a minimum time to use when selecting a code based on total time spent on the date of the encounter.

CPT® Code	99215
CPT® Description	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making.
CPT® Notes	1. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. 2. Usually, the presenting problem(s) are low to moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.
Documentation Requirements	For CPT® code 99215, the provider spends an average of 40 minutes face–to–face with an established patient. A patient is considered to be established if the same physician or qualified healthcare practitioner, or any physician or qualified healthcare practitioner in the group practice (or any physician or practitioner of the same specialty who is billing under the same group number), has seen the patient for a face–to–face service within the past 36 months.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; PA Modifier: U1; AH NOTE: Service can be provided/billed by an enrolled Narcotic Treatment Program (Provider Type 03-BHSO Tier II NTP
Coding Documentation Notes	1. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded. 2. CPT 2024 revises 99214 as part of a larger revision. The update replaces the previous time ranges with a minimum time to use when selecting a code based on total time spent on the date of the encounter.

CPT® Code	99406
CPT® Description	Smoking and tobacco use cessation counseling visit, intermediate, greater than 3 minutes up to 10 minutes
CPT® Notes	1. Health behavior assessment and intervention services (96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171) should not be reported on the same day as codes 99401-99412. 2. Do not report 99407 in conjunction with 99406 3. For counseling groups of patients with symptoms or established illness, use 99078
Documentation Requirements	These codes are used to report services provided face-to-face by a physician or other qualified health care professional for the purpose of promoting health and preventing illness or injury. They are distinct from evaluation and management (E/M) services that may be reported separately with modifier 25 when performed. Risk factor reduction services are used for persons without a specific illness for which the counseling might otherwise be used as part of treatment. Behavior change interventions are for persons who have a behavior that is often considered an illness itself, such as tobacco use and addiction, substance abuse/misuse, or obesity. Behavior change services may be reported when performed as part of the treatment of condition(s) related to or potentially exacerbated by the behavior or when performed to change the harmful behavior that has not yet resulted in illness. Any E/M services reported on the same day must be distinct and reported with modifier 25, and time spent providing these services may not be used as a basis for the E/M code selection. Behavior change services involve specific validated interventions of assessing readiness for change and barriers to change, advising a change in behavior, assisting by providing specific suggested actions and motivational counseling, and arranging for services and follow-up.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA); CADC Modifier: U6
Coding Documentation Notes	Document behavior change services including: assessing readiness for change and barriers to change; advising a change in behavior, assisting by providing specific suggested actions and motivational counseling, and arranging for services and follow-up. Document steps given to stop tobacco product use.

CPT® Code	99407
CPT® Description	Smoking and tobacco use cessation counseling visit, intensive, greater than 10 minutes
CPT® Notes	1. Health behavior assessment and intervention services (96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171) should not be reported on the same day as codes 99401-99412. 2. Do not report 99407 in conjunction with 99406 3. For counseling groups of patients with symptoms or established illness, use 99078
Documentation Requirements	These codes are used to report services provided face-to-face by a physician or other qualified health care professional for the purpose of promoting health and preventing illness or injury. They are distinct from evaluation and management (E/M) services that may be reported separately with modifier 25 when performed. Risk factor reduction services are used for persons without a specific illness for which the counseling might otherwise be used as part of treatment. Behavior change interventions are for persons who have a behavior that is often considered an illness itself, such as tobacco use and addiction, substance abuse/misuse, or obesity. Behavior change services may be reported when performed as part of the treatment of condition(s) related to or potentially exacerbated by the behavior or when performed to change the harmful behavior that has not yet resulted in illness. Any E/M services reported on the same day must be distinct and reported with modifier 25, and time spent providing these services may not be used as a basis for the E/M code selection. Behavior change services involve specific validated interventions of assessing readiness for change and barriers to change, advising a change in behavior, assisting by providing specific suggested actions and motivational counseling, and arranging for services and follow-up.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA); CADC Modifier: U6
Coding Documentation Notes	Document behavior change services including: assessing readiness for change and barriers to change; advising a change in behavior, assisting by providing specific suggested actions and motivational counseling, and arranging for services and follow-up. Document steps given to stop tobacco use.

CPT® Code	99408
CPT® Description	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes; AKA: SBIRT Code
CPT® Notes	1. Health behavior assessment and intervention services (96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171) should not be reported on the same day as codes 99401-99412. 2. Do not report services of less than 15 minutes with 99408. 3. Do not report 99408, 99409 in conjunction with 96160, 96161. 4. Use 99408, 99409 only for initial screening and brief intervention. 5. For counseling groups of patients with symptoms or established illness, use 99078.
Documentation Requirements	These codes are used to report services provided face-to-face by a physician or other qualified health care professional for the purpose of promoting health and preventing illness or injury. They are distinct from evaluation and management (E/M) services that may be reported separately with modifier 25 when performed. Risk factor reduction services are used for persons without a specific illness for which the counseling might otherwise be used as part of treatment. Behavior change interventions are for persons who have a behavior that is often considered an illness itself, such as tobacco use and addiction, substance abuse/misuse, or obesity. Behavior change services may be reported when performed as part of the treatment of condition(s) related to or potentially exacerbated by the behavior or when performed to change the harmful behavior that has not yet resulted in illness. Any E/M services reported on the same day must be distinct and reported with modifier 25, and time spent providing these services may not be used as a basis for the E/M code selection. Behavior change services involve specific validated interventions of assessing readiness for change and barriers to change, advising a change in behavior, assisting by providing specific suggested actions and motivational counseling, and arranging for services and follow-up.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA); CADC Modifier: U6
Coding Documentation Notes	Document behavior change services including: assessing readiness for change and barriers to change; advising a change in behavior, assisting by providing specific suggested actions and motivational counseling, and arranging for services and follow-up.

CPT® Code	99409
CPT® Description	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes; AKA: SBIRT Code
CPT® Notes	1. Health behavior assessment and intervention services (96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171) should not be reported on the same day as codes 99401-99412. 2. Do not report 99409 in conjunction with 99408 3. Do not report 99408, 99409 in conjunction with 96160, 96161 4. Use 99408, 99409 only for initial screening and brief intervention. 5. For counseling groups of patients with symptoms or established illness, use 99078.
KY LCD Documentation Requirements	These codes are used to report services provided face-to-face by a physician or other qualified health care professional for the purpose of promoting health and preventing illness or injury. They are distinct from evaluation and management (E/M) services that may be reported separately with modifier 25 when performed. Risk factor reduction services are used for persons without a specific illness for which the counseling might otherwise be used as part of treatment. Behavior change interventions are for persons who have a behavior that is often considered an illness itself, such as tobacco use and addiction, substance abuse/misuse, or obesity. Behavior change services may be reported when performed as part of the treatment of condition(s) related to or potentially exacerbated by the behavior or when performed to change the harmful behavior that has not yet resulted in illness. Any E/M services reported on the same day must be distinct and reported with modifier 25, and time spent providing these services may not be used as a basis for the E/M code selection. Behavior change services involve specific validated interventions of assessing readiness for change and barriers to change, advising a change in behavior, assisting by providing specific suggested actions and motivational counseling, and arranging for services and follow-up.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA); CADC Modifier: U6
Coding Documentation Notes	Document behavior change services including: assessing readiness for change and barriers to change; advising a change in behavior, assisting by providing specific suggested actions and motivational counseling, and arranging for services and follow-up.

CPT Code	99417	
CPT Description	Prolonged outpatient evaluation and management service(s) times with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes to total time.	
CPT Notes	1. List separately in addition to the code of the outpatient E & M service 2. Use 99417 in conjunction with 98003, 98007, 98011, 98015, 99215, 99245, 99345, 99350, 99483. 3. The initial time unit of 15 minutes may be added once the time threshold required for the primary E/M code has been surpassed by 15 minutes. 4. Do not report 99417, 99418 for any time of less than 15 minutes.	
Who May Perform This Service in the State of Kentucky?	AF, AM ,U3, SA, AH, AJ, U8, HO, U4, U1, U2, TD, HN, U5, U6	
Children's Alliance Notes	1. Add On code only	

HCPCS Code	T1007
HCPCS Description	Service Planning for Substance Use Alcohol and/or substance abuse services, treatment plan development and/or modification
HCPCS Notes	1. T codes are for use by state Medicaid agencies and some private insurers to report items for which there are no permanent national codes and for which codes are necessary to meet a national Medicaid program operating need.
Who May Perform This Service in the State of Kentucky?	AF, AM ,U3, SA, AH, AJ, U8, HO, U4, U1, U2, TD, HN, U5, U6
Children's Alliance Notes	This code serves a dual purpose. Providers use it for the initial development of a treatment plan for an individual with drug, alcohol, or drug and alcohol problems. They also use it for a reevaluation of the treatment plan on a periodic basis. Use HCPCS Modifier TS to indicate a reevaluation or modification to the original treatment plan.

HCPCS Code	T2023
HCPCS Description	Targeted case management (TCM); per month
HCPCS Notes	1. Services furnished to assist a recipient in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance: • Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. • Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment. • Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services. • Monitoring and follow-up activities. 2. Unit of service: one (1) unit per member, per month 3. DMS regulations limit an agency's TCM caseload to a total of 25 clients regardless of services being provided. The only services that may be provided and not counted toward the caseload include crisis services and screenings. 4. If a client is actively participating in one of the Kentucky Medicaid Waiver Programs, TCM services cannot be provided in addition to waiver case management.
Who May Perform This Service in the State of Kentucky?	Targeted case manager

HCPCS Code	T2023
Children's Alliance Notes	1. TCM SED (UA modifier): A unit of service shall be one month. For a billable service to have occurred, at least 4 service contacts shall have occurred. Two of the contacts shall be face-to-face with the client; at least one of these contacts shall be with the child and the other shall be with the family, parent(s), or person in custodial control. The other two contacts may be face-to-face or by telephone with or on behalf of the child. 2. TCM SMI (HE Modifier) 3. TCM SUD (HF modifier): A unit of service shall be one month; for a billable service to have occurred, at least 4 service contacts shall have occurred. Two of the contacts shall be face-to-face with the client. The other two contacts may be face-to-face or by telephone with or on behalf of the client. The is a special case to this rule found in the reimbursement regulation; if the recipient is under the age of eighteen, contacts shall include one face-to-face with the recipient and one face-to-face with the recipient's parent or legal guardian. 4. TCM Co-occurring MH or Substance Use and complex Physical Health Issue (TG modifier)*: A unit of service shall be one month. For a billable service to have occurred, at least 5 service contacts shall have occurred. Three of the contacts shall be face-to-face with the client. The other two contacts may be face-to-face or by telephone with or on behalf of the client. When used with clients under age 18 having SED, two contacts shall be face-to-face with the client, two contacts shall be face-to-face with parent or guardian and one face-to-face or by telephone with or on behalf of the child. This shall be delivered in accordance with the current Kentucky State Plan Amendment and Reimbursement Regulations. 5. * BHSO Tier II providers must also include the Modifier HF

	H0001
HCPCS Description	Alcohol and/or drug assessment
HCPCS Notes	Report this code for alcohol and drug assessment services, also known as drug assessment or chemical health assessment. This assessment determines the patient's level and extent of addiction and the impact of addiction on the individual. The service also assists with treatment development.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA); CADC Modifier: U6
Children's Alliance Notes	Kentucky may have a standardized form or format to use for documenting this code. Notate any screening tools used and documental collateral information.

HCPCS Code	H0002
HCPCS Description	Behavioral health screening to determine eligibility for admission to treatment program
HCPCS Notes	Report this code for a behavioral health screening to evaluate a patient for eligibility for a treatment program. The provider screens the patient with a focus on biological, psychological, and social factors. This initial screening may assist with planning treatment for the patient.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA)
Children's Alliance Notes	To determine eligibility for admission to a treatment program, performing an assessment and referring/recommending a more intensive treatment program. Document in accordance with Kentucky formats, notate any screening tools used or collateral information obtained.

HCPCS Code	H0004
HCPCS Description	Behavioral health counseling and therapy, per 15 minutes
HCPCS Notes	Must be billed on same day as 90837
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA); CADC U6H
Children's Alliance Notes	Limited to 8 units max per client per date of service Kentucky DMS uses this code for Prolonged Services ((Here)

HCPCS Code	H0006
HCPCS Description	Alcohol and/or drug services; case management
HCPCS Notes	Report this code for case management for alcohol and drug abuse patients. The provider or case manager motivates and assists the patient, along with determining the needs and coordinating the care of the patient.
Who May Perform This Service in the State of Kentucky?	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U1, U2, TD, HM, U6, HN, U5,UD
Children's Alliance Notes	Unit of service: 15 minutes Notate other references/sources contacted.

HCPCS Code	H0011
HCPCS Description	Alcohol and/or drug services; acute detoxification (Kentucky Medicaid: residential addiction program for ASAM Level of Care 3.5, Without Room and Board)
HCPCS Notes	• Report this code for detoxification services for alcohol and drugs in which a licensed provider monitors, observes, and provides a residential inpatient addiction program to the patient under medical supervision for acute withdrawal symptoms of alcohol or drug abuse. • Per Diem
Who May Perform This Service in the State of Kentucky?	To be used by Residential SUD programs that have received Provisional Certification by DMS or CARF/ASAM Level of Care 3.5 Certification
Children's Alliance Notes	Document medical services if applicable.

HCPCS Code	H0012
HCPCS Description	Alcohol and/or drug services; sub-acute detoxification (residential addiction program outpatient)
HCPCS Notes	Report this code for detoxification services for alcohol and drugs in which a licensed provider monitors, observes, and provides outpatient services through a residential addiction program to the patient under medical supervision for subacute withdrawal symptoms of alcohol or drug abuse.
Who May Perform This Service in the State of Kentucky?	AF, AM, U3, SA
Children's Alliance Notes	Document medical services if applicable.

HCPCS Code	H0015
HCPCS Description	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education Note: Kentucky Medicaid describes this HCPCS code as: Alcohol and/or Drug Services IOP
HCPCS Notes	Report this code for alcohol services, drug services, or both in which the patient participates in an intensive outpatient treatment program for at least three hours a day and three days a week based on the patient's needs and treatment plan.
Who May Perform This Service in the State of Kentucky?	Service must be provided within a practitioner's scope of licensure, practice, and employment. Practitioners must adhere to behavioral health regulations for their provider type with regard to the services they are permitted to perform.
Children's Alliance Notes	Unit of service is per diem

HCPCS Code	H0016
HCPCS Description	Buprenorphine or Methadone Induction
HCPCS Notes	Requires HF Modifier
Who May Perform This Service in the State of Kentucky?	Licensed Narcotic Treatment Program only
Children's Alliance Notes	Limit 4 events per year

HCPCS Code	H0018
HCPCS Description	Behavioral health; short-term residential (non-hospital residential treatment program), without room and board, per diem
HCPCS Notes	A residential treatment program provides residential treatment for behavioral, or mental, health issues in a nonhospital residential treatment program setting. The duration of stay for this treatment program is generally less than 30 days and provides treatment to the patient for 24 hour per day. This code covers rehabilitation care and treatment, but it does not include room and board. Report this code once per day. The stay is short term, typically less than 30 days.
Who May Perform This Service in the State of Kentucky?	Service must be provided within a practitioner's scope of licensure, practice, and employment. Practitioners must adhere to behavioral health regulations for their provider type with regard to the services they are permitted to perform.
Children's Alliance Notes	Bill for Room and Board separately

HCPCS Code	H0019
HCPCS Description	Behavioral health; long-term residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem
HCPCS Notes	A residential treatment provides treatment for behavioral, or mental, health issues that do not require medical care or acute care. The duration of stay for this treatment program is generally more than 30 days. Report this code per day. For long term residential treatment for behavioral health, report H0019, Behavioral health; long term residential, nonmedical, nonacute care in a residential treatment program where stay is typically longer than 30 days, without room and board, per diem.
Who May Perform This Service in the State of Kentucky?	Service must be provided within a practitioner's scope of licensure, practice, and employment. Practitioners must adhere to behavioral health regulations for their provider type with regard to the services they are permitted to perform.
Children's Alliance Notes	Bill for Room and Board separately

HCPCS Code	H0020
HCPCS Description	Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program) Note: Kentucky Medicaid describes this code as follows: Methadone MAT Bundle, weekly (Narcotic Treatment Program only)
HCPCS Notes	Report this code for supply of methadone by an alcohol or drug program that is a licensed program.
Who May Perform This Service in the State of Kentucky?	Licensed Narcotic Treatment Program only
Children's Alliance Notes	1. Requires HF modifier 2. H0020 is a bundled rate code. The following codes are included in the weekly bundled rate and may not be billed outside this bundled code: 80305, 80306, 90785, 90832, 90834, 90837, 90838, 90840, 90853, and H0015. 3. Unit of service is weekly

HCPCS Code	H0024
HCPCS Description	Behavioral health prevention information dissemination service (one-way direct or non-direct contact with service audiences to affect knowledge and attitude)
HCPCS Notes	The provider uses one way or indirect contact methods, such as speeches or media campaigns, to spread information related to prevention of behavioral health issues. For behavioral health prevention education services, report code 99, Behavioral health prevention education service, delivery of services with target population to affect knowledge, attitude and or behavior.
Who May Perform This Service in the State of Kentucky?	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U1, U2, TD, HN, U5, U6, HM
Children's Alliance Notes	The approach is represented by one way communication from the source to a targeted individual, with limited contact between the two. Examples include health fairs, health promotions, newsletters, media campaigns, etc.

HCPCS Code	H0025
HCPCS Description	Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)
HCPCS Notes	The provider educates a target population by two-way communication with the intent of affecting their knowledge, attitude, and behaviors related to behavioral health issues.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA); CADC Modifier: U6
Children's Alliance Notes	Typically used by school personnel, court workers, CPS, and others. An event code, not timed which means a flat reimbursement is paid regardless of time spent on the service. See CCSS section of this manual. Possible educational activities include classroom education, small group sessions, and services for children with a family member with substance use disorders.

HCPCS Code	H0031
HCPCS Description	Mental health assessment, by non-physician
HCPCS Notes	Report this code when an individual other than a physician provides a mental health assessment. For instance, a skilled staff member or non-physician multidisciplinary team may provide the assessment.
Who May Perform This Service in the State of Kentucky?	APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA); CADC U6
Children's Alliance Notes	1. There is no length or time associated with this code. 2. HCPCS 2024 Definition: "Use H codes to identify mental health services, such as alcohol and drug treatment. State Medicaid agencies may require use of these codes, and each state may define its own rules for proper reporting." 3. Each MCO may have different guidelines for utilization of this code.

HCPCS Code	H0032
HCPCS Description	Mental health service plan development by non-physician
HCPCS Notes	Report this code when a skilled staff member, other than a physician, develops a plan to provide mental health services to a patient.
Who May Perform This Service in the State of Kentucky?	APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA); CADC U6
Children's Alliance Notes	There is no length of time on this code.

HCPCS Code	H0033
HCPCS Description	Oral medication administration, direct observation Note: Kentucky Medicaid uses this description for this code: Methadone Induction, limit 4 per calendar year per individual
HCPCS Notes	Report this code when a skilled medical staff member directly observes the patient during the administration of oral medication.
Who May Perform This Service in the State of Kentucky?	Billable by a licensed Narcotic Treatment Program only
Children's Alliance Notes	• Limit of 4 events per calendar year, per client • Requires HF modifier

HCPCS Code	H0035
HCPCS Description	Mental health partial hospitalization, treatment, less than 24 hours Note: Kentucky Medicaid uses this description for this code: Partial hospitalization, under 24 hours
HCPCS Notes	Report this code for partial hospitalization, lasting fewer than 24 hours, as part of a structured mental health treatment program.
Who May Perform This Service in the State of Kentucky?	Licensed organization only; must be billed by provider type 03 (BHSO)
Children's Alliance Notes	None

HCPCS Code	H0038
HCPCS Description	Self-help/peer services, individual, per 15 minutes
HCPCS Notes	A trained individual provides self- help or peer mental health services. Report one unit for each 15 minutes.
Who May Perform This Service in the State of Kentucky?	U7 (PSS) only
Children's Alliance Notes	1. January, 2025: H0038 limited to the following maximum units whether provided individually, in a group, or a combination thereof: 8 units per day (2 hours) or 800 units (200 hours) per calendar. These limits apply to both the managed care and FFS populations. They may be exceeded for an individual based on medical necessity if prior authorized. (Source: DMS Letter to Providers)

HCPCS Code	H0038 HQ
HCPCS Description	Self-help/peer services, group, per 15 minutes
HCPCS Notes	Must use HQ modifier to designate group service. Limit group size to 8 clients maximum per group, Limit of 8 units per group.
Who May Perform This Service in the State of Kentucky?	U7 (PSS) only
Children's Alliance Notes	None

HCPCS Code	H0040
HCPCS Description	Assertive community treatment program Note: Kentucky Medicaid describes this HCPCS code as: Assertive Community Treatment program, 4 professional team
HCPCS Notes	A multidisciplinary team, combining several separate branches of expertise, provides assertive community treatment. Assertive treatment helps the patient gain self- assurance in social and daily living situations. Report this code once per day.
Who May Perform This Service in the State of Kentucky?	Licensed organization only; must be billed by provider type 03 (BHSO) Assertive Community Treatment team must be led by an approved behavioral health services practitioner; and be comprised of at least four (4) full-time equivalents including a prescriber, a nurse, an approved behavioral health services practitioner, or a case manager; have adequate staffing to ensure that a team's caseload size shall not exceed ten (10) participants per team member.
Children's Alliance Notes	Unit of service is monthly

HCPCS Code	H0040 UB
HCPCS Description	Assertive community treatment program Note: Kentucky Medicaid describes this HCPCS code as: Assertive Community Treatment program, 10 professional team
HCPCS Notes	A multidisciplinary team, combining several separate branches of expertise, provides assertive community treatment. Assertive treatment helps the patient gain self- assurance in social and daily living situations. Report this code once per day.
Who May Perform This Service in the State of Kentucky?	Licensed organization only; must be billed by provider type 03 (BHSO) Assertive Community Treatment team must be led by an approved behavioral health services practitioner; and be comprised of at least ten (10) full-time equivalents including a prescriber, a nurse, an approved behavioral health services practitioner, or a case manager; have adequate staffing to ensure that a team's caseload size shall not exceed ten (10) participants per team member.
Children's Alliance Notes	Unit of service is monthly

HCPCS Code	H0046
HCPCS Description	Mental health services, not otherwise specified
HCPCS Notes	The provider performs mental health services, not described by another code, for an individual.
Who May Perform This Service in the State of Kentucky?	AF, AM, U3, SA, AH, AJ, U8, HO, U4, U2, HN, U5
Children's Alliance Notes	None

HCPCS Code	H0049
HCPCS Description	Alcohol and/or other drug abuse services, not otherwise specified Note: Kentucky Medicaid describes this HCPCS service code as: Alcohol and/or Drug Screening, & Brief Intervention, less than 15 minutes
HCPCS Notes	The provider performs alcohol or other drug abuse related services that another code does not describe.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA); CADC Modifier: U6
Children's Alliance Notes	None

HCPCS Code	H2011
HCPCS Description	Crisis intervention service, per 15 minutes
HCPCS Notes	The provider reports this code for each 15 minutes of crisis intervention services he provides to a patient. Crisis intervention is a period in which an individual requires continuous short term care for as much as 24 hours to achieve palliation, or management of acute medical, mental, or physical symptoms.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA); CADC Modifier: U6
Children's Alliance Notes	None

HCPCS Code	H2012
HCPCS Description	Behavioral health day treatment, per hour
HCPCS Notes	The provider reports this code for each hour of behavioral health day treatment he renders to a patient. For this service, the provider helps the patient to improve their independent living skills and offer support in developing healthy coping skills.
Who May Perform This Service in the State of Kentucky?	APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA); CADC Modifier: U6
Children's Alliance Notes	None

HCPCS Code	H2015
HCPCS Description	Comprehensive community support services, per 15 minutes
HCPCS Notes	This is a timed code of 15 minutes. The provider reports this code for each 15 minutes of comprehensive community support services he renders to a patient. This includes providing support to the patient to live independently in the community.
Who May Perform This Service in the State of Kentucky?	APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA); Other Non-Bachelors-level Modifiers: U7 (PSS); UC (CSA RBT)
Children's Alliance Notes	• February 2020: DMS indicated that CCSS services are 1-1 individual only, not to be applied to group settings.

HCPCS Code	H2019
HCPCS Description	Therapeutic behavioral services, per 15 minutes
HCPCS Notes	• The provider reports this code for each 15 minutes of therapeutic behavioral services, or TBS, he gives to a patient. • For programs that are one to three hours in duration • Not payable by Medicare
Who May Perform This Service in the State of Kentucky?	• CMHCs: AF; AM; U3; SA; AH; AJ; U8; HO; U4; U1; U2; TD; HN; U5; U6 • BHSOs: U8; AJ; HO; SA; AH; U1; U4
Children's Alliance Notes	Limit of 12 units per day per client (3 hours of service or less) per individual, per day

HCPCS Code	H2020
HCPCS Description	Therapeutic behavioral health services, per diem (>3 hours of services per day)
HCPCS Notes	• Report this code when a provider renders per diem therapeutic behavioral services, or TBS to a patient. A per diem service is payment for the day for all the services the provider supplies to a patient during that day. • For programs that are over three hours in duration • No payable by Medicare
Who May Perform This Service in the State of Kentucky?	U8; AJ; HO; U8; AJ; HO; SA; AH; U1; U4
Children's Alliance Notes	Unit of service: Over 3 service hours

HCPCS Code	H2024
HCPCS Description	Supported employment, per diem
HCPCS Notes	• The employment consultant supports a mentally ill individual in acquiring an occupation. Report this code once per day. • Not payable by Medicare
Who May Perform This Service in the State of Kentucky?	Service must be provided within a practitioner's scope of licensure, practice, and employment. Practitioners must adhere to behavioral health regulations for their provider type with regard to the services they are permitted to perform.
Children's Alliance Notes	Unit of service: A minimum of 5 service hours

HCPCS Code	H2027
HCPCS Description	Psychoeducational service, per 15 minutes
HCPCS Notes	The provider reports this code for each 15 minute increment of time he spends with a patient performing psychoeducational services. This individualized assessment can provide the patient, family and or school with information regarding the patient's learning disabilities, processing deficits, current functioning levels, and provide all involved the skills to deal with them.
Who May Perform This Service in the State of Kentucky?	Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA); CADC Modifier: U6; Other Non-Bachelors-level Modifiers: U7 (PSS); UC (CSA RBT)
Children's Alliance Notes	1. Psychoeducation (H2027) is a direct, planned, and structured intervention that involves presenting or demonstrating information. Psychoeducation sessions may cover topics such as understanding the nature of mental health and substance use conditions, recognizing warning signs of relapse, stress reduction techniques, and building a support network. Psychoeducation is a component of day treatment, therapeutic rehabilitation program (TRP), intensive outpatient program (IOP), partial hospitalization program (PHP), and residential services. It is included in the per diem rate for those services, and should never be billed on the same day. In addition, providers should never unbundle to separately bill for services that are bundled in the appropriate level of care. H2027 provided to a group of individuals should include a HQ modifier. H2027 with HQ modifier may not exceed 12 recipients per group, and multiple groups may not be provided at the same time. H2027 is limited to the following maximum units, whether provided individually, in a group, or a combination thereof: • 8 units per day (2 hours) • 500 units per calendar year (125 hours) (Source: DMS Letter to Providers)

HCPCS Code	H2034	
HCPCS Description	Behavioral Health, Residential Treatment Program	
HCPCS Notes	State of Kentucky may define this differently than CPT 2024.	
Who May Perform This Service in the State of Kentucky?	For SUD programs that have received Provisional Certification by DMS of CARDS/ASAM LOC 3.1 Certification, without room and board	
Children's Alliance Notes	Per Diem	

HCPCS Code	H2036
HCPCS Description	Alcohol and/or Drug Treatment Program
HCPCS Notes	• Report this code for services the provider renders on a per diem, or per day basis
Who May Perform This Service in the State of Kentucky?	Service must be provided within a practitioner's scope of licensure, practice, and employment. Practitioners must adhere to behavioral health regulations for their provider type with regard to the services they are permitted to perform.
Children's Alliance Notes	To be used by Residential Crisis Stabilization Units treating Substance Use Disorder or Chemical Dependency Treatment Centers, ASAM LOC 3.7

HCPCS Code	S9480
HCPCS Description	Intensive Outpatient psychiatric services, per diem
HCPCS Notes	Kentucky Medicaid defines this HCPCS code differently than CPT 2024
Who May Perform This Service in the State of Kentucky?	Qualified provider organizations
Children's Alliance Notes	S codes represent drugs, services, and supplies that do not have a permanent national code.

HCPCS Code	S9484
HCPCS Description	Crisis intervention mental health services, per hour Kentucky Medicaid describes this HCPCS code as: Mobile Crisis Service
HCPCS Notes	Use this code to report each hour of a patient's participation in crisis intervention mental health services.
Who May Perform This Service in the State of Kentucky?	Licensed Organization only; must be billed by provider type 03 (BHSO): • Psychiatrist Modifier: AF; Physician (MD or DO) Modifier: AM; APRN Modifier: SA; Licensed Clinical Psychologist Modifier: AH; PA Modifier: U1; Licensed Masters-level (Supervisor) Modifiers: U8 (LPP, CPsy w/Auto. Funct.), AJ (LCSW), HO (LPCC, LMFT, LPAT, LBA, LCADC); Associate (under Supervision) Modifier: U4 (LPA, CPsy, CSW, LPCA, MFTA, LPATA, LABA, LCADCA); CADC Modifier: U6
Children's Alliance Notes	Unit of service: One hour

HCPCS Code	S9485
HCPCS Description	Crisis intervention mental health service (CSU), per diem
HCPCS Notes	Mental health professionals or other qualified practitioners intervene in a crisis situation resulting from an individual's mental distress or problems.
Who May Perform This Service in the State of Kentucky?	Licensed Residential Crisis Stabilization Unit only; must be billed by provider type 26
Children's Alliance Notes	None

2. Compliance for Behavioral Health: Establishing and Running an Effective Compliance Program

Preface

The following pages describe our agency's formal Compliance Program. The Manual is written from the perspective of a Chief Compliance Officer and the senior leadership team of a health and human service organization.

Introduction

Our Compliance Program is a formalized process within our healthcare business that seeks to hold ourselves to the highest standards available. In addition to being required by law to have a formal compliance program, we recognize that by having an active, formal compliance program we will be able to:

1. Concretely demonstrate to the community at large our commitment to integrity, best practices and honesty;
2. Reinforce our employee's innate sense of right and wrong;
3. Recognize a compliance program is cost-effective;
4. Improve our quality of care to our clients and stakeholders;
5. Have appropriate expectations of employee and contractor behavior;
6. Have procedures to promptly identify risks and misconduct;
7. Hopefully mitigate any sanctions and reduce penalties;
8. Prove that we are proactively voluntarily and actively implementing a plan, not reacting when a corrective action plan is imposed;
9. Protect corporate directors from liability.

The Society for Corporate Compliance and Ethics is the lead organization in the United States for guiding Compliance Programs across industries, including our industry, healthcare. The information and guidance in this manual are sourced by two leading organizations in the USA: The Society for Corporate Compliance and Ethics (SCCE) and the Health Care Compliance Association (HCCA). Both have guidelines, definitions, program components, tools, resources, and a clear path to designing, implementing, and maintaining a formal Compliance Program.

There are programs in the USA that offer an accredited Graduate Certificate in Corporate Compliance, a rigorous program of study. After completion of this course of study, a

candidate is eligible to sit for the Compliance Certification Board Exam (CCB). Our facility has engaged professionals in this industry to help implement, maintain, and guide our Corporate Compliance Program at our agency.

Key to any effective compliance program are the concepts of ethics, compliance, and culture. While ethics is the term used to appeal to one's innate sense of morals and values, compliance conveys the legal-oriented standards to behavior, expectations, and standards. Most individuals need some sort of guidance, or standards, to help them navigate difficult situations. This is where compliance becomes essential. And for compliance to be effective and demonstrable, there must be a tone in the organization, or culture, that supports and articulates the expected standards of behavior. Organizations that have employees who seek out compliance guidance, recognizing this as the most productive way of performing their jobs, have effectively created a culture and environment where predictability, accountability, and candor are embedded.

In other words, organizations utilizing their compliance programs to engender a culture and tone of integrity throughout the organization is a successful one. It is the best insurance policy an organization can have at reducing the risk of bad things happening. Senior leaders, executives, and even the President/CEO must support a culture of compliance, or, "tone at the top." Ethics and compliance complement each other. A fantastic culture is one where employees want to do the right thing and seek ways to improve the organization. Employees taking part in a work environment that is not fear-based are more engaging and ultimately, successful. The return on the investment in a formal compliance program is clear: an ethical culture provides a positive workplace and improved performance. After all, we want nothing but the best for our clients at our agency!

Please feel free to contact the designated Compliance Officer or our CEO, should you have any questions about this manual.

A Compliance Program Defined

A *formal program is required* by the Department of Health and Human Services, Office of the Inspector General. In fact, any healthcare entity who receives funding in full, or even part, from the Medicare and/or State Medicaid programs is required to have a formal compliance program. Most third-party payers, regulatory agencies, and accreditation bodies also require a formal compliance program as a part of their contracting process.

Some healthcare entities think that having an informal compliance or quality assurance program meets the requirements for a formal program. However, many entities are not aware that a formal program has specific demonstrable elements and requirements to the program and each organization is held accountable to maintaining and implementing such a program. Because we are a healthcare entity, we have additional regulations we must follow, specifically: Health Information Portability and Accountability Act (HIPAA), Anti-

Stark Laws, and Anti-Kick-Backs Laws. Effective Compliance Programs safeguard the organization's legal responsibility to abide by applicable laws and regulations.

The seven (7) elements of a compliance program are:

1. Written Code of Conduct, Standards and Policies and Procedures
2. Compliance Program Administration
3. Education and Training
4. Reporting of Complaints
5. Investigations and Disciplinary Actions
6. Auditing and Monitoring
7. Risk Assessments and Mitigation

We recognize that Compliance Programs are scalable. Our program is considered a small behavioral health entity with revenues less that 10 million. Because of this, we have staffing and resourcing constraints for our Compliance program. Some accommodations we have made to adapt a formal compliance program to our clinic are to:

- Have a designated compliance contact at all times;
- Maintain an internal disclosure policy and process for all staff;
- Perform regular risk assessments;
- Ensure we monitor communications regarding any federal and state healthcare program guidance.

The rest of this manual will describe and outline the seven elements and our plan for implementing a formal compliance program.

COMPLIANCE PROGRAM MANUAL, ELEMENT 1: WRITTEN CODE AND STANDARDS OF CONDUCT

Introduction

The Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services has issued several policy statements and program guidance reports for healthcare organizations developing effective compliance programs. Referring to the US Federal Register Compliance Program Guidance documents:

"At a minimum, comprehensive compliance programs should include…the development and distribution of written standards of conduct, as well as written policies and procedures that promote the [organization's] commitment to compliance and that address specific areas of potential fraud, such as claims development and submission processes, code gaming, and financial relationships with physicians and other health care professionals."

A Code of Conduct, sometimes referred to as the Standards of Conduct, are separate than an organizations Policy and Procedure manual. The Code of Conduct demonstrates an organization's culture and attitude towards compliance matters and a commitment to applicable laws and regulations. The Code is a values statement to the employees that the organization emphasizes a culture of compliance to help meet the organizations requirements and goals. The Code of Conduct can, and does, empower employees.

A Code of Conduct is meant to be consulted and used as a resource guide to help everyone at the organization be successful. Our Code of Conduct represents the values we have as an organization as well as our expectations for everyone's behavior. Specifically, the Code's purpose is to:

1. Present specific guidelines for employees to follow and consult
2. Provide us a process for proper decision-making
3. Highlight the standards and policies to which we are committed
4. Be a resource outlining our values for everyone within our organization.

How can you, our staff and associates, help us achieve and continually strive for excellence in all that we do for our clients, customers, and for the community we live in? Do not worry, we will help you understand how you can help us continue to grow and maintain our reputation in the following pages!

CEO Vision Statement for Excellence, Mission, and Responsibility

ABC Agency seeks excellence in all that we do. We are defined by our attitude, culture, and ability to deliver clinical excellence and long-term relationships with the community around us. Our vision is that our clients, community, stakeholders, and employees are at the center of our actions. By using the highest standards of clinical excellence and care, we help individuals transform their lives to find meaning, purpose, and joy.

Personal transformation is hard. That is why everyone at ABC Agency places a high regard to respecting everyone where they are in their journey in recovery. Integrity, honesty, transparency, compassion, and openness are among our core values. These values facilitate growth in our clients and in our professional delivery of services at ABC Agency.

I am proud to be a visionary leader of ABC Agency. Driven by passion and our desire to help the underserved and disadvantaged, everyone deserves dignity, excellent clinical care. We promise to hold ourselves accountable to you, the community-at-large, and to continually improve our processes.

We welcome you to ABC Agency. You will clearly see our values in action when you are here. We take full ownership of our commitment to excellence, compliance, health and healing.

Sincerely,

NAME

CEO ABC Agency

Integrity, Accountability, and Values in Healthcare

What do you do when you see or hear something that concerns you, or that you feel might put our organization's reputation at risk?

Your actions affect all of us and shape the way our clients and customers view us. As a healthcare entity, we are committed to:

- Reducing fraud, waste and abuse
- Providing high-quality healthcare service delivery with respect, confidentiality, and best practices
- Maintaining integrity and honesty in all that we do

What to Do If You Have a Concern: Non-Retaliation Promise

We will be open and receptive to all concerns brought to our attention. In fact, we recognize that it can take courage to report problems or concerns. To ensure you feel as comfortable as possible when bringing forth your concerns, we have developed and will strictly enforce our Non-Retaliation Policy. As part of that policy, we promise to enforce disciplinary action for anyone who retaliates against another employee for reporting concerns to us. This applies to everyone: from the CEO, direct service staff to facility management services.

Our Non-Retaliation Policy

We expressly forbid anyone to take any form of retaliatory action against any member of our organizational community who, in good faith, voices concerns, seeks advise, files a grievance or complaint, seeks the intervention of Human Resources, the compliance department, or other such entity in the pursuit of upholding our organizational values. Those who testify or participate in investigations, proceedings or hearings are also protected by this policy.

All employees, contractors, clients, customers, and those whom we conduct business with are covered by this policy. The rationale is clear: we have a strong interest in the reporting of wrongdoing (or possible wrongdoing). Those who wish to report must feel supported and confident in our efforts to protect them from the fear of retaliation. We have a duty to protect those we work with from unlawful retaliation and we clearly have established that retaliation in any form will not be tolerated.

Formal Retaliation Examples: Bad performance review, lack of promotion/raise
Informal Retaliation Examples: Exclusion from group events, social outings

Both formal and informal retaliation are prohibited!

What to Do If You Have a Concern About Misconduct

Sometimes, concerns are a simple misunderstanding or a result of poor communication. Therefore, the first step is to:

1. Raise the concern to your immediate supervisor. If the concern is about your immediate supervisor, you may report directly to: Human Resources, the hotline, and/or the Compliance or Operations Department.

2. Your concern will be reported to the office who handles investigations. They will then work with you to determine the nature of the concern and gather initial information about the report. It is possible that a formal investigation will subsequently be opened.

3. We are committed to taking your report of misconduct seriously and we will take active steps to investigate, and stop, any misconduct.

4. Information obtained during a report, or investigation, will be shared on a need-to-know basis to preserve confidentiality and integrity.

5. Knowingly making a false report is a matter we take very seriously. Engagement in this behavior will result in adverse consequences.

6. Yes, you can make an anonymous report! Your case will be assigned an anonymous ticket number. There may be times, however, when your identity may be known. This is especially true of smaller organizations such as ours. Sometimes, additional information is needed to complete an investigation. If you choose to remain anonymous and are not able to provide additional information, the investigation may have to be closed. Human resource, or employee relations issues, cannot be handled anonymously.

7. Not every report will have the outcome you think it should! We will investigate the concern, the outcome may/may not be reported back to you, and sometimes the outcome will need to remain confidential. Your participation and facilitation of the information and investigation however, will always be appreciated.

We will not offer, or give any bribe, payment, gift, or thing of value to any person or entity with whom the business has or is seeking any business or regulatory relationship except for gifts of a nominal value which are legal and given in the ordinary course of business.

We will not have a financial or personal interest in a transaction between the agency and other vendors, suppliers, providers, or customers.

We will be respectful to everyone and honor all laws and regulations regarding client confidentiality.

We will be completely honest in all dealings with government agencies and representatives.

We will not submit any false bills, claims or documents to payers.

We will keep all financial records in accordance with generally accepted accounting and security standards.

We will maintain all clinical records in accordance with applicable regulations.

We will maintain the confidentiality of all recipient information in accordance with 42 CFR, state regulations, and HIPAA.

We will follow safe work practices and comply with safety standards and health regulations.

We will ensure that the work environment is free of discrimination or harassment due to age, race, gender, gender identity, religion, disability, sexual orientation.

We will provide exemplary services to our clients, in accordance with best clinical practices.

Any employee of ABC Agency who becomes aware of any violation of this code or illegal activity shall promptly report the violation to the CEO and follow up with a report to the (State) Department of Human Services or other applicable governing bodies.

We will fully and honestly cooperate with government investigations and may do so with an attorney present.

We will post this code of conduct in a visible area where all clients can see it.

Major Policy Topic Areas in Our Organization

1. Non-Discrimination and Non-Retaliation
2. Privacy, Security, and Confidentiality
3. Client Protection, Rights, and Safety
4. Personnel Management
5. Compliance Program

ABC Agency has (two or three) manuals that outline operations, compliance, procedures, and expectations. Please refer to these manuals for specific information:

1. The ABC Agency Policy and Procedure Manual
2. The ABC Agency Compliance Program Manual
3. The ABC Agency HIPAA Policy and Procedure Manual

COMPLIANCE PROGRAM MANUAL, ELEMENT 2: COMPLIANCE PROGRAM ADMINISTRATION

Introduction

An effective compliance program is deemed a mandatory regulatory activity by any healthcare entity in the United States who receives funding from the Federal government, or through State Medicaid offices. While a mandated program, we see an effective compliance program as essential to our professional health and accountability to our clients. We view an effective compliance program as essential to the provision of quality healthcare service delivery and to demonstrate our values to our employees, stakeholders, the community, and most importantly, our clients.

The compliance program at ABC Agency will be an evolving, dynamic and proactive long-term initiative that engages in continuous quality improvement and demonstrable outcomes and metrics. Specifically, an effective compliance program will consist of the following program oversight and management elements:

1. An active, engaged, and committed Board of Directors (owners and stakeholders)
2. An appointed compliance committee or contact, leader for the compliance program, and dedicated funds to support the program
3. An organized compliance plan, processes, and assessments of the program
4. A focus on a culture of compliance through staff engagement, incentives, and performance evaluations
5. Continual evaluation of risk, risk assessments, risk mitigation improvements and subsequent work plans.

Described below is the infrastructure ABC Agency has put in place to support a growing, and robust effective Compliance Program.

Administration Elements Critical for Success

Support, buy-in and commitment are critical to having an effective Compliance Program. Commitment breeds effectiveness and all individuals within the organization play a role in supporting, building, and improving the culture of compliance at ABC Agency.

Board Support*: As ABC Agency's governing authority, the Board of Directors must be fully supportive of an effective Compliance Program. It is the Board that officially recognizes the program, authorizes its launch and implementation, and monitors its progress and growth over time. There must be unqualified support from the Board of Directors for a program to be successful. Ongoing, visible support from the Board of Directors is critical. The Board of

Directors will see the Compliance Program as a good long-term investment for the organization, and themselves. In fact, due to the Caremark case decision, Boards of Directors are now responsible for implementation of a system to gather information on the organizations efforts to prevent and detect fraud and abuse. In other words, the Board of Directors is liable for the Compliance Program of ABC Agency.

*Substitute the word Owner and Compliance Contact for Board of Directors if needed.

Compliance Officer or Compliance Contact

ABC Agency is a small-medium size healthcare entity. The compliance officer/contact at our agency may serve in another role, such as the Owner, Chief Operations or Clinic Officer. The main role of the compliance officer is to develop, maintain and support the effective implementation of the compliance program. The Compliance Contact may delegate some these activities to another entity or staff. Some of the duties that the compliance officer will be engaged in are:

1. Development of an annual compliance plan
2. Operational and educational activities and responsibilities
3. Conduct and oversee review and audit activities
4. Investigation and Remediation activities
5. Maintain an objective and independent perspective while performing job related duties.
6. Ensures the company complies with its outside regulatory requirements and its own internal policies
7. Reporting on a regular basis to the governing body, CEO, and compliance committee/owner
8. Developing, coordinating, and participating in a multifaceted educational and training program
9. Ensuring independent contractors, agents, and employees are not sanctioned individuals
10. Assisting with internal compliance reviews and monitoring activities
11. Independently, and objectively, investigating complaints, and acting on matters related to compliance.

These duties, as outlined by the Office of the Inspector General (OIG), will reinforce our commitment to compliance. The compliance officer will also be a steward of public trust, engender employee trust and respect, and thus must maintain the highest degree of integrity, professionalism and competence. The compliance position is an outreach position, so good interpersonal skills are vital. The compliance officer should be unflappable and have the capacity to work with a wide range of personality types. Compliance is also about behavior change, so the compliance officer must be someone who can motivate staff, and deal with the unhappiness that sometimes comes with the position. Finally, the ability to be an effective educator and trainer is critical to this position as education is the first, and best, line of defense in an effective compliance program.

To do all the above-named duties and to support ABC Agency's compliance program, the compliance officer must have assistance. An effective Compliance program also has active involvement from the Board of Directors and has a formal Compliance committee.

Compliance Committee*

*If this is a very small organization, an internal Compliance Committee is not needed.

ABC Agency shall maintain an active Compliance Committee to ensure that there is an effective Compliance Program in place at the organization. The committee will support the compliance officer, assist in the development and maintenance of the compliance program, and assist in the resolution of any compliance-related investigations. The compliance office may delegate duties to the committee as he or she deem appropriate.

Committee members will be comprised of individuals with the authority to execute policies and procedures as well as consist of individuals with the experience and the capability of monitoring and executing the compliance program. Committee members will be representative of the various departments within the organization and be influential, or high-level members of their departments.

Duties of the Compliance Committee will encompass the following:

1. Be responsible for the execution of ABC Agency's Compliance Plan
2. Oversee policies and procedures
3. Actively track and monitor compliance-related activities including training and education
4. Ensure that federal and state laws are being followed by ABC Agency
5. Be available and accessible to ABC Agency staff, stakeholders, and others
6. Encourage all stakeholders to express concerns freely with any member of the committee, evidenced by an open-door policy. Employees may choose to remain completely anonymous and are protected against acts of retribution
7. Maintain confidentiality
8. Ensure the reporting process is effective
9. Have the authority to sanction individual members of the workforce
10. Have a direct line of communication with the CEO and the Board of Directors

At a minimum and on an annual basis, the Compliance Committee and/or Officer shall produce a report of the activities, goals, and accomplishments performed by the committee that will be presented to the Board of Directors.

Staff, Management, and Professional Support

To engender and promote a culture of compliance at ABC Agency, we believe that it is everyone's responsibility to contribute to the tone and process of the compliance program. No one is perfect and mistakes are made. ABC Agency wants a culture of accountability,

trust, and integrity to prevail when there are concerns and problems. We will therefore strictly enforce the No Retaliation policy of the organization and require that everyone (regardless of title or job position) participate in the compliance program at our agency.

We also seek dedicated advocates for the compliance program who can:

1. Build trust through involvement with the compliance program
2. Encourage early adopters and other enthusiasts
3. Contribute to and support compliance activities and improvements
4. Keep an open eye on operational and fiscal improvements gained through the compliance program.

With everyone's help and willing participation, the culture of compliance at our agency will demonstrate our excellence in standards through our behaviors to stakeholders, clients, and the community.

Financial Support

ABC Agency recognizes that having an effective Compliance Program means investing money into staffing, training, and ongoing support to meet regulatory requirements and standards of care. A reasonable budget will be developed by the leadership of our agency to support a trim, but a demonstrably effective Compliance Program. Considerations for the budgetary items will be:

- Staffing to include a compliance officer position, as-needed auditors, analysts, monitoring and investigations capabilities, and educational training initiatives of the program
- Ongoing operational expenses will be items such as outsourcing certain activities, communications, educational materials (printed, web-based or video), printing costs of the policies and procedures and code of conduct, computer support and training for security, professional journals, newsletters, and as-needed legal counsel.

Initial Compliance Program Activities

Any new formal compliance program will have the same set of objectives in the beginning stages of operation: conducting a baseline risk assessment, developing its mission and goals, and setting up the program for continuous effective assessments and improvements.

The initial Risk Assessment will provide ABC Agency with a snapshot of the potential and actual risks of the operations from a compliance perspective. An action plan is developed which will define the scope of the assessment, identify types of items to be reviewed,

personnel to be interviewed and a realistic timetable for completion. Previous problem areas will be placed at the beginning of the risk assessment, reviews of previous audits, and a review of the existing policies and procedures will transpire.

Based on the findings of the risk assessment, and the prioritized areas for addressable items, a plan will be constructed to begin the work of an effective Compliance Program. Additionally, this initial risk assessment will be the benchmark for us and a critical document to begin to measure the growth and improvements the organization makes as they move through engaging in the program.

Among typical mission and goal statements of compliance programs are:

- Develop and maintain clear lines of communication with key personnel throughout the organization
- Provide diverse educational opportunities to meet the demands of ABC Agency
- Create and provide quality resources that will optimize compliance activities

Development of the compliance programs overarching mission statement and its annual goals will be a key task for the compliance officer within the first few months of their tenure.

Ongoing Quality Strategy

The ongoing strategy at ABC Agency for quality and continual improvement in both compliance and clinical areas is the well-known "PDCA Approach: Plan, Do, Check, Act." It is also known as the iterative Deming Cycle:

1. Plan: Recognize an opportunity and plan a change
2. Do: Test the change. Carry out a small-scale study to measure effectiveness
3. Check: Review the test, analyze the results and identify what you have learned
4. Act: Take action based on what you learned in the study step. If the change did not work, go through the cycle again with a different plan. If the change did work, incorporate what you learned from the test into wider changes.

We are a healthcare entity that is committed to continual quality improvement and compliance. The implementation of the administrative elements outlined above will clearly demonstrate our commitment to an effective, and demonstrable compliance program.

COMPLIANCE PROGRAM MANUAL, ELEMENT 3: TRAINING AND EDUCATION

Introduction

At the heart of an organizations effective Compliance Program is the Training and Education of all stakeholders. It is, without doubt, the first line of defense for any healthcare entity, not to mention it is considered best practice in the industry. Stakeholders include the Board of Directors, staff, contractors, affiliates, and business associates. Some of these stakeholder groups will just need an overview of what ABC Agency is doing for the program while others will need ongoing, regular training opportunities. It is the job of the Compliance Program to provide meaningful, demonstrable, and effective training for the staff.

The Department of Justice, Federal Sentencing Guidelines, and the Office of the Inspector General have all declared that "conducting effective compliance training" is a key mitigating factor when considering penalties for organization who are in non-compliance. The general thinking in the field is that the amount of training needs to be proportionate to the level of risk an organization faces. In healthcare, and especially in mental health/substance use facilities, the risks are significant.

For healthcare entities, there are targeted areas for training that are considered very basic topics:

1. Privacy, Security, and Confidentiality (this includes HIPAA)
2. CMS's Fraud, Waste, Abuse Training: The False Claims Act
3. Ethics and Standards of Conduct
4. High Risk Topics

Compliance program duties include monitoring the topics that come up throughout the year and update the trainings as new risks emerge. Emphasizing the organizations expectations of the staff person during these trainings cannot be underestimated.

Training and Education at Our Agency

For education and training to be effective, a combination of two approaches are necessary: a hybrid of a "rules-based" and "values-based" approach has been determined to be the most successful. Staff need to know what the rules and policies are so that in difficult situations, they have organizational guidelines to fall back on. This also gives them a sense of support from the organization when their decisions might be challenged by clients. Staff also need to use their innate sense of judgment, right and wrong so that they feel good about themselves and their workplace.

Education and training must contain the following elements to be considered effective:

1. Assume a proactive stance, not a reactive one
2. Be user-friendly, understandable and easily comprehensive to all levels of education
3. Convey the values, mission and culture of the organization towards compliance
4. Emphasize that ethics, values and mission matter, including WHY they matter
5. Reassurance that by reporting concerns, a strict non-retaliation policy will be followed.

There are a variety of education and training formats to choose from: live and in-person, web or computer-based, video or toolbox-based. While any of these formats is technically acceptable, the Department of Justice and research has shown that in-person training is the most effective. The rationale for this is that there is an opportunity to ask questions, get answers, and it gives the trainer and management an opportunity to get to know their staff. In addition, real life examples or situations are best talked through in a group format. This is because staff many encounter difficult situations but may be too afraid to ask or speak up. Yet another staff person in the live training may ask the question that someone else is too anxious to bring up.

Our Training and Education Plan

Many organizations conduct a single Annual Compliance Training. ABC Agency believes in making compliance a part of the every-day culture of its workforce. We are committed to an ongoing, ever-present educational program to help all stakeholders remain mindful of the opportunities for improvement. To achieve this objective, we will engage in the following educational activities year-round:

- Ongoing marketing campaigns with educational and promotional resources to increase awareness of various compliance topics
- Periodic lunch-n-learn sessions: 15-30 minute sessions on hot topics
- Incentive programming to encourage staff to go above and beyond the expectations
    - For a compliance program to be effective, it needs to affect the behavior of those acting for the organization: Rewards and incentives clearly do this, and need to be included in any program
    - Yes, incentive programming is ethical and in fact, it is supported by the Federal Sentencing Guidelines. Where and how will we use incentives? Personnel evaluations, bonus evaluations, input into promotions, and spot and reward recognitions are examples of how an incentive program can operate.

Finally, all trainings and educational opportunities will be conducted in a respectful, non-judgmental, and open manner. We subscribe to an environment of embracing transparency, humility, and an acknowledgment that there will always be room for improvement and growth. We take compliance matters seriously and at the same time acknowledge that we are not immune to problems or challenges. What makes the difference in how challenges are perceived and handled is how we manage the issue: we

can do so from a position of integrity, compassion, and professionalism, or we can be punitive and covert. ABC Agency chooses honesty and transparency while maintaining appropriate professional boundaries.

COMPLIANCE PROGRAM MANUAL, ELEMENT 4: REPORTING PROCESSES

Introduction

To help meet the mission of ABC Agency, we are:

1. Committed to meeting the highest standards of healthcare practice and business ethics
2. Recognize that regardless of payer source, appropriate, medically necessary services will be delivered in the most efficient manner and meet or exceed all applicable state, local, and federal laws and guidelines
3. Intolerant of fraud, waste, and abuse and violations of such guidelines and regulations
4. Committed to providing excellent clinical care, education, monitoring, oversight to ensure that all staff, volunteers, trainees, contractors and other persons whose conduct reflects on ABC Agency is fully informed and committed to these standards, and,
5. Fully supportive and engaged in an open work environment of transparency so that all individuals feel free to openly communicate on any matter of concern.

Every organization needs to have a mechanism or process for reporting concerns. Open lines for communicating concerns are essential in a healthcare facility and all stakeholders should know what the process is for these reports. CMS and the OIG emphasize the necessity of having reporting mechanisms in place to help prevent fraud, waste, and abuse in the healthcare industry. Having a clear and demonstrable processes in place is also an indication that the organization is supportive of its staff, and that it is responsive to all identified concerns.

For a reporting process to work effectively, the organization must take a clear stand and support the No Retaliation Policy it has established. If reporters suspect there could be retaliation, then no one will come forward. This could pose life-threatening situations that no organization wants to have happen. This is why there is so much empirical evidence that collaborative, supportive and ethical cultures within workplaces are successful. Making it the daily normal to act ethically, with integrity, and with support is crucial for success.

How will reporting mechanisms at ABC Agency work? To whom do staff turn to when they feel like they need to report a concern? We will describe how reporting works at our agency and the process for which those concerns are responded to and vetted.

Reporting Mechanism: Our Hotline System

It is hoped that staff will report concerns as they arise. To do this, staff must be assured that their concerns will be taken seriously, there will be no retaliation for a report, and that their report will be handled with confidentiality. A hotline system should be deployed as one of many tools an organization uses to combat fraud, waste and abuse. While not primary, or even an initial means of prevention or detection of illegal, unsafe or detrimental practices, hotlines are considered “best practices” in organizations effort to uncover unethical or illegal behavior.

Implementing a confidential effective hotline is just one way we can underscore our commitment to ethical behavior and a culture of compliance. Confidentiality is key: Without confidentiality and a strongly-enforced no retaliation policy, the effectiveness of a hotline system for reporting concerns will not be realized. For some organizations, it is hoped that the reporting “hierarchy” will consist of first turning to one’s immediate supervisor, then to Human Resources or another higher-level staff member of management. Another option for reporting may be a hotline or an email-based solution. This option is designated to support and complement the overall existing strategy of awareness and compliance within the organization. Anyone on staff may use this option at any time.

ABC Agency is a small-sized, healthcare facility within a limited geographical region of the XYZ area. We may contract with an outside entity to manage compliance program operations, including the element of reporting. Or, we may have an internal reporting process where the compliance contract is the first in line to receive a report. We are governed by State and Federal healthcare industry regulatory requirements that include, but are not limited to:

1. Corruption, theft, fraud, waste, and abuse
2. Health and safety, or environmental concerns
3. Privacy, confidentiality, or other HIPAA-related concerns
4. Ethics, compliance, policy or procedure concerns
5. Security

It is also known that many concerns reported in any form are approximately 80% human resource related, not compliance matters. Examples of this may include reports of harassment, perceived unfair treatment by a supervisor, or interpersonal conflicts with co-workers. Because of the size of our agency, and that most reports will likely be human resource-related, we will establish an internal reporting process that consists of a confidential hotline and/or email access for all staff 24/7 (i.e.: hotline system). The reports shall go directly to the Compliance Officer for ABC Agency who will evaluate the concern and possibly initiate the investigation process for the reported concern.

It is imperative that the existence of the hotline and reporting mechanism (hotline system) be communicated throughout the organization. Regular ongoing communication about the hotline system is another form of education that reiterates our commitment to compliance

and can facilitate the prevention, detection, and resolution of problems. Nonconformance to ABC Agency policies and procedures, as well as behavior that is not sanctioned by law or industry regulation are examples of items that can be reported via the hotline system. Publicity about the reporting mechanism needs to be clear, concise, and frequent. It is important that any education or reminder about the hotline system is coupled with a statement about non-retaliation and confidentiality. It is also critical that staff are made aware that they are expected to use the hotline and their participation is vital to making the program work.

An important area for an effective hotline is determining how to best support the desire for transparency during the time of inquiry and through resolution. After all, staff need to know that their concerns are taken seriously for the program to work. Reporters need feedback they have been heard and that the compliance officer is committed to consistent enforcement of professional, and timely responsiveness. An effective compliance officer will have excellent interpersonal skills and will be able to convey validation to the reporter for taking a positive step forward, while maintaining professionalism and confidentiality.

Process for Reporting Concerns

This section will detail the process for reporting concerns and what reporters can expect when they submit a concern.

Anonymity refers to protecting the identity of the individual who reported the concern. Confidentiality relates to the protection of the reported information. It is important to make sure that those who make reports understand that while their names will be treated with anonymity, the information they give could potentially be the basis for which an action is taken. This can be confusing, but a solid education and awareness campaign will help staff know the importance of both anonymity AND confidentiality.

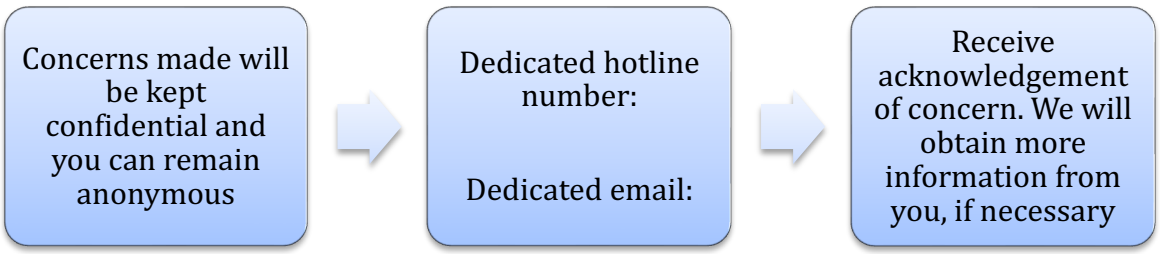
The purpose of the compliance hotline is critical to convey through training and education. A clear statement of purpose must be communicated to staff:

The purpose of the compliance hotline is to provide you with an alternative method of reporting concerns, compliance violations of any federal or state law, or ABC Agency's policies and procedures. The hotline is a dedicated number and the compliance office will make no attempts to trace the call or figure out who made the call. Should you choose to leave your contact information, that is up to you.

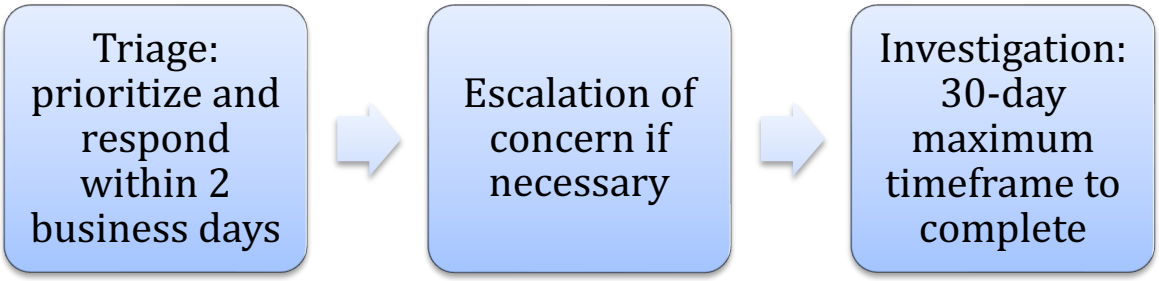
Training of managers and supervisors is also critical in the reporting process. It is likely that a staff member will first turn to their supervisor or manager, unless the object of the concern is that individual. Training managers and supervisors on how to handle concerns, and the process for escalating concerns is important. But more important is the notion that managers and supervisors understand that retribution or retaliation are never permitted in

the organization. Any form of harassment directed against an employee for reporting a compliance concern will not be tolerated.

For Those Who Wish to Make a Report:



Compliance Officer's Response to a Report:



Keeping in mind that many reports are unsubstantiated and reflect bias or an emotional response by the author, it is important that the nature of the concern is what drives the initial response. For example, if the concern relates to an interpersonal conflict with a co-worker versus a patient safety issue, then the patient safety concern will clearly require a more immediate response. For ABC Agency, the initial evaluation report to the hotline will be triaged as follows:

1. Every report will be received and initially vetted by the compliance officer within 2 business days of receipt;
2. Concerns will be evaluated per actionable responses and potential liability issues related to the allegations
3. Determine what rule or policy was violated: is the suspected activity a violation of our policies, a state or federal law, or industry standards (safety)? If so, which one and what is the impact this may have on the staff and organization?
4. If the concern is deemed critical*, it may warrant immediate disclosure to a duly authorized authority or law enforcement agency. This determination needs to be made swiftly and documented quickly. Failure to report a critical item to the appropriate authorities may result in an accusation that the organization is trying to cover up the concern.

5. Delaying in responding to a concern is considered a decision in itself. In other words, if ABC Agency delays making a decision about an actionable item, we will take the position that the decision was made, de facto, by indecision. Further, if the delay results in the complainant becoming the subject of retaliation, new liabilities will then require investigation.
6. Thorough evaluation of all reported concerns, their disposition, and the action/decision made about the next steps must be made promptly. The documentation of the rationale for a decision will be critical if other parties become involved (such as law enforcement).

*Samples of Critical Concerns

1. Theft of $500 or more
2. Fraud, alteration, destruction of or falsified documentation mandated to be kept under applicable governing laws
3. Actual or potential violation of law
4. Employee misconduct during a government inquiry or investigation, or intentional misrepresentation
5. Allegations of improper payments made to any official
6. Child Abuse, maltreatment, or a situation involving a vulnerable adult

Escalation Clause and Data Retention

If it is determined that a reported concern needs to be escalated, the matter will be brought to the CEO, Board of Directors, or General Council for the facility. These individuals are considered key personnel who bear an equal amount of responsibility for reported concerns as the compliance officer.

Most cases of reported concerns will be resolved quickly, sometimes within one day. Others may take some time to resolve and it is important to establish a set of stages so that the resolution process can be designated and attended to in a reasonable time frame.

When a case is closed, it is critical that how the case was closed, and the outcomes, are documented. Rationale for closure, steps taken, and necessary data points to validate the decision to close the case are important to document. All reported concerns, and the compliance officer's response to them shall be documented and retained for the requisite period.

COMPLIANCE PROGRAM MANUAL, ELEMENT 5: INVESTIGATIONS AND DISCIPLINARY ACTIONS

Introduction

Three pillars of excellent governance, Prevention, Detection, and Remediation are all central components of the Investigations and Disciplinary Action section of an effective compliance program. Having a structured, consistent investigation process in place will help an organization maintain its commitment to promoting a culture of efficiency, fairness, and compliance. While compliance programs aim to prevent acts that can harm the organization and its stakeholders, no organization is 100% bullet-proof. Compliant intake processes and investigations are an organization's first line of detection that something may be going awry and having a strategy to manage the process is critical for ABC Agency.

After establishing methods for reporting concerns, staff will begin to use the hotline and email processes to report concerns. This may be the first sign of a potential problem for us, but why? Many times, during litigation, the questions, "What did you know and when did you know it?" will be asked. Detecting a problem and being proactive with an investigation can make or break a legal case against the organization. Complaint and reporting concerns and processes are not as much as about creating a liability shield. Rather, having these processes in place helps an organization cut down on risks at an early stage is preferable than letting problems become more complicated over time. This next section of the manual will detail how to establish an effective investigations program within the organization.

Key to the Investigations and Disciplinary Process within any organization is the establishment of a standardized and consistent structure to the investigations process. This is important to not only know what to do, but how to perform the investigation. Investigations are fact-finding endeavors in which personal feelings, bias, or conflict-of-interests must be either removed or greatly minimized to be successful and impartial. To standardize the organizational investigations program ABC Agency will need to:

1. Identify information sources. This could include: employees, vendors, consultants, hotlines, workplace rumors, audit reviews, expense report incongruities, calls, emails, letters either by name or anonymous, exit interviews, information from the Employee Assistance Program, and general liability trends in the industry or recent litigation outcomes
2. Identify the investigator(s). Conduct a skills assessment of those who could perform the investigation. Remove conflict-of-interest variables by considering outside entities
3. Determine appropriate methods and means for conducting investigations, type of investigation program you will have, investigation phases, and what standardized responsive action will be taken, if any

4. Consider the rights and expectations of the witnesses, the implicated and investigators
5. Identify a process for developing any new policies and procedures determined as necessary during the investigation; identifying a change management approval strategy is also very important.

ABC Agency will take a semi-centralized approach to investigations. This means that the compliance office will likely perform the investigation, but depending on the nature of the allegation, it may be more appropriate for another individual (outside of compliance) to conduct the investigation. Our agency also takes the stance that until a determination is made, the outcome is not presumed ("innocent until proven otherwise" will be the motto). It is critical for a successful investigations program to take a stand that the implicated will always have the opportunity to respond, clarify, and explain.

A written policy and procedure about investigations will be developed that addresses the definition, process, confidentiality, and the rights and expectations for all parties involved. Maintaining confidentiality is critically important for the success of the program, and for the organization overall. Staff need to know they will be treated with due process, respect and professionalism. Finally, there will be a written record for investigations in which the types, length, and outcomes of an investigation can be documented for benchmarking or other statistical purposes. ABC Agency understands that any documentation may be discoverable in the court of law.

Goals of an Investigation

The purpose of an investigation is to seek facts about an allegation and to not engage in improper processes that could be perceived as harassment of an implicated individual. We want to know what happened any why, so that we can continuously improve the organization. Information developed from an investigation will maximize options for those individuals who are in a decision-making role, such as the CEO or supervisors.

Four Objectives of an Investigation:

1. Document incidents of actual or suspected misconduct to maintain a permanent record of their occurrence
2. Identify the root cause of the misconduct
3. Identify the persons involved in the incident
4. Compile the information that proves or disproves an allegation

Possible Outcomes of an Investigation:

1. Corrective Action: Steps taken to fix the system to reduce likelihood of future incidents. Examples include: establishing, changing or augmenting policies and procedures or implementing internal controls
2. Remedial Action: If harm has occurred, determine the extent of this harm and make a best-effort to restore the system to its original state, or make the situation "whole" again
3. Disciplinary Action: Any action short of criminal prosecution taken against the person found to have engaged in the wrongdoing. Examples could be: reprimand, suspension, demotion, corrective action, written warning, or termination.

Determining When to Investigate

Just because there is a reported concern or an allegation does not mean that a formal investigation will follow. Once a concern becomes known, a process of determining whether to conduct a formal investigation must happen. During this time, five elements must be discovered: Who, What, When, Where, and Why. Best practice is to thoroughly understand the five elements first, understand what the complaint consists of, and make a thoughtful decision about launching an investigation. The question to answer through discernment is, "Is this a valid claim and do we have a duty to investigate?"

There are benefits to investigations including the organizations credibility and to mitigate risk and liability. However, there are also consequences including time, resources, and the possible (negative) results of the investigation. There are also times when an investigation is clearly not necessary, i.e.: if there was a misunderstanding of an organizational policy or a lack of communication between two individuals. In this case, offering guidance, education or facilitating interpersonal communication might be a sufficient remedy.

Those making a report are voluntarily presenting information and there needs to be a strong organizational culture that there will be no retaliation against that person. This is where the organizations No Retaliation Policy must be strictly enforced. Those who report can be told whether an investigation will take place and what the outcome is, but at no time should the implicated person's confidentiality or rights be violated.

The Investigation Process

A formal investigation shall be commenced after the above steps are taken, should the initial report and discovery give the investigator probable cause to believe that misconduct has occurred. The scope of the investigation needs to be determined to ensure fairness and to protect the innocent. Making a list of documents, witnesses, and having an overview of the strategy for the investigation is important to establish at the beginning. An investigations plan should be developed, and serve as an outline for the findings and report. An investigation must gather evidence and separate out the facts from fiction.

After preliminary inquiries are made, conducting the interview(s) is next. Obtaining additional records or other sources of information is also critical to help complete the investigation. Examples of this could be: employee badges with time stamps of entering/leaving the building, policies and procedures, expense reports, etc. After analyzing the evidence, the interviews and the quality of the materials, it is the job of the investigator to make a concrete determination, conclusion, or recommendation. Keep in mind the investigators role is to also determine the root cause of the violation and make recommendations to correct any deficiency to prevent the likelihood that this will happen again. Investigations should be not considered reactionary; rather, they are also preventative in nature and be a part of an organizations continual quality improvement processes.

Conclusion

An investigative report should be written after the investigation. The investigation itself is only as good as the report. Distribution of the report should be very limited, given only to those who “need to know.” It is also critical to pay attention to the dynamics within the workplace after an investigation takes place: potential retaliation reports by witnesses or other participants in the investigation should be looked into immediately. The best tool to protect against and prevent possible retaliation is limiting the amount of information about the investigation that is ultimately distributed.

Having a clear process, with definitions, a structure, and a plan is critical for an effective workplace investigations process. Clear roles and responsibilities, coupled with fact-finding and non-judgmental strategies are key to success and overall organizational improvement.

COMPLIANCE PROGRAM MANUAL, ELEMENT 6: AUDITING AND MONITORING

Introduction

Auditing and monitoring are two key elements to an ongoing effective compliance program. They are also two distinctly different processes or tasks but depend on the other for success. Auditing is considered a time-limited, formalized method with a defined scope for assessing the condition of a certain target item, such as accounting, medical record reviews, etc. Audits can be independent of management or conducted internally. Audits can also be conducted by third-parties with a vested interest in the organization. Audit findings are documented and organizational management then develops an action plan to work to assure that the observations noted are resolved. Monitoring is an ongoing, iterative process of identifying how operational aspects of compliance might be occurring. In other words, monitoring is a way of ensuring ongoing effectiveness, efficiency, assurance, and consistency of operations and the internal controls put into place by the organization.

Auditing and Monitoring Plan

The first step in devising an Auditing and Monitoring Plan for the organization begins with a baseline Risk Assessment to identify and prioritize the risks that should be put into the plan. The auditing and monitoring plan is dynamic and changes per needs and priorities. Topics for auditing and monitoring are somewhat predictable in a healthcare facility due to the regulatory nature of the healthcare industry. For example, healthcare facilities are externally audited for safety and formal compliance issues, evidence-based protocol implementation, fraud-waste-abuse prevention and detection, HIPAA compliance, and anti-kickback schemes. Having an internal auditing and monitoring plan in place, with monitoring controls that are readily auditable and verifiable will proactively position ABC Agency.

Auditing Process at ABC Agency

There are essentially two types of audits, retrospective and concurrent audits. Baseline audits are a systemic inspection process with a goal to establish a benchmark comparison for future audits. In a sense, these audits are done for the first time and used as a template for future audits and improvements. They could be performed as retrospective audits. Retrospective audits involve reviewing entire records or operations and itemizing the things that need corrections, or fixes. The challenge with retrospective audits is that if you uncover any items that require corrective action, then you must remedy those actions. This sometimes will involve paybacks if overpayments are discovered or other forms of self-reporting.

Concurrent audits are ongoing, regular reviews of the medical records and position the healthcare entity in a "proactive" position rather than a reactive state. For example, regular ongoing peer reviews or concurrent audits will identify areas needed for improvement, not "corrective action." These areas for improvement or alteration are then brought to the clinician's attention and can therefore be learning opportunities to improve record keeping. This is sometimes also referred to as a "continuous quality improvement" initiative.

The Compliance Program at ABC Agency will consist of regularly auditing and monitoring in the following basic areas:

1. Safety: Training and Implementation
    a. Dissemination of standards, safety protocols, education materials to staff
    b. Verification of Annual Safety Training Attestations
    c. Identification of Deficiencies and Remedies
2. HIPAA: Privacy, Security and Administrative Adherence
    a. Security Risk Assessment Work Plan Progress
    b. Annual HIPAA Training Attestation
    c. Dissemination of Standards, Expectations and policies
3. Conflicts of Interest
    a. Verification that each staff has received the Conflict of Interest Policy
    b. Obtain an annual updated Conflict of Interest form from each staff member
4. Fraud, Waste and Abuse: Training and Monitoring
    a. Annual Required Training and attestation of completion per staff member
    b. Clinical documentation, coding and chart audits per licensure schedule

Methods for auditing and monitoring can consist of interviewing employees, conducting physical walk-throughs of the facility, questionnaires, review of written materials or complaints, or posing questions during exit interviews. A variety of auditing tools may also be used to help guide internal audits. When possible, state, federal, or payer audit templates will be used.

Results of the auditing and monitoring will be used to engage in a continual quality improvement process for our agency. New areas for auditing or monitored will be added as regulatory requirements are developed.

COMPLIANCE PROGRAM MANUAL, ELEMENT 7: RISK ASSESSMENTS AND MITIGATION

Introduction

Risk assessments and risk management are the final components to an effective compliance program. Like auditing and monitoring, these are two separate but interlinked activities. An organization must be aware of, and measure, their exposure to risk on an ongoing basis. A risk assessment is essentially the baseline assessment of risk to the organization and its mission. It also lays the foundation upon which a compliance program is established and directed. Risk is defined as the uncertainty of an event occurring that could have an impact on the achievement (and reputation) of the organization. A risk assessment is the systemic process for identifying and evaluating these risks. Failure to look at risks carefully, proactively, regularly, and objectively is in itself a risk!

The performance of risk assessment is essential. In fact, the US Sentencing Commission, along with other federal agencies such as the Office of the Inspector General, require the performance of a risk assessment and ongoing risk management as an explicit component of an effective compliance program:

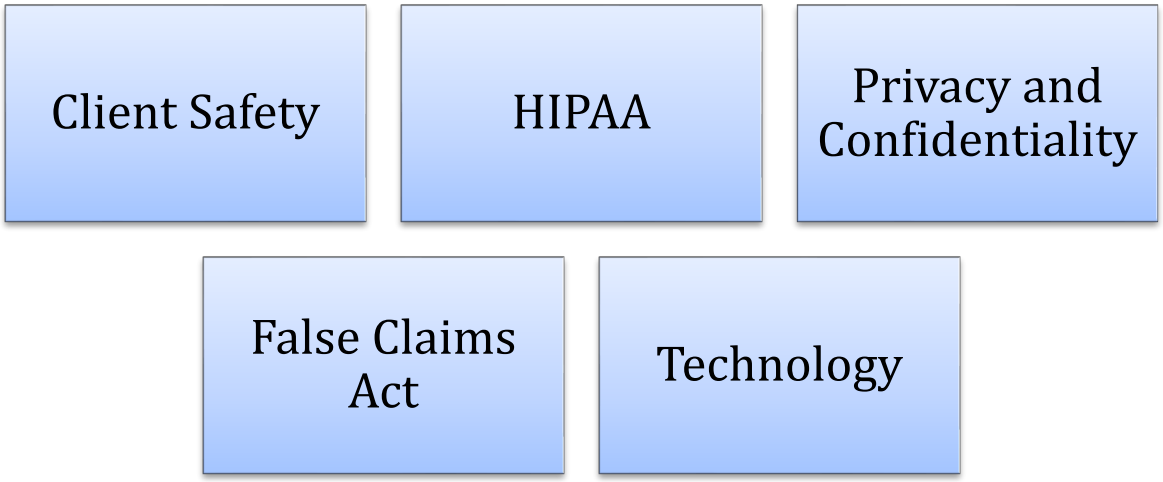
"Risk assessments need to be made at all stages of the development, testing, and implementation of a compliance program to ensure that compliance efforts are properly focused and effective....the organization shall periodically assess the risk of criminal conduct and shall take appropriate steps to design, implement, or modify each component of an effective compliance program to reduce the risk of misconduct..."

Risk Assessment Considerations

What is a Risk Assessment for purposes of setting up and running an effective compliance program? A risk assessment is a methodical evaluation of the criminal and civil liabilities, and the regulatory exposures the organization faces. It is not an audit or investigation, a financial or operational audit, and it is not a review of the compliance program itself. Rather, a risk assessment involves the identification and evaluation of compliance and ethics-type risks. Risk assessments categorize their weight and significance based on the likelihood and consequence of an adverse event occurring, while keeping in mind the current and desired levels of control and harm to the organization.

One crucial question to ask leadership when conducting a risk assessment and assessing an organizations tolerance for risk is, "How much risk is acceptable given what we know about the consequences?" In other words, what is the organization's "risk appetite" knowing that exposure to risk is inevitable for all organizations. Risk can take the form of losing the public or community's trust, being perceived as not having transparency, or

having the perception that the organization is unable to self-regulate and govern itself effectively. For healthcare entities, specific areas are more prone to risk and have a higher likelihood of a negative impact than others:



When there is a crisis within a healthcare organization, it is usually due in part to the organization not looking at risk at all. A baseline risk assessment is critical to set the foundation for a risk action plan for ongoing risk mitigation. Risk mitigation and management are defined as the process for prioritizing, evaluating, and implementing the appropriate risk-controls or counter-measures recommended to reduce the impact and likelihood of adverse risk events from occurring. Completing a periodic risk assessment is in fact, a part of the risk management and mitigation process.

Performing a Risk Assessment

A risk assessment should be able to answer the following five questions:

1. What can go wrong?
2. How can it go wrong?
3. What is the potential harm?
4. What can be done about it?
5. How can we stop it from happening again?

Once a risk assessment has been formalized and designed for the organization, completing the assessment is important to identify the Threats, Vulnerabilities, Likelihood and Impact of the identified risk factors to the organization. Only then can the leaders make decisions about their risk appetite by accepting, rejecting, transferring or mitigating

the identified risk. The risk assessment should cover the five areas noted above (Client Safety, HIPAA, Privacy and Confidentiality, False Claims Act, and Technology).

Staff interviews and survey's, documentation reviews, prior documentation of risks or regulatory concerns, reports and findings are all elements of a risk assessment. Current trends and known threats in the healthcare industry, made known through organizations such as the Health Care Compliance Association, should also be assessed. Developing a rating matrix for the identified risks is critical to develop next steps for mitigation. Finally, for information technology risks, the NIST Publication 800-30 serves as a template for conducting the information systems risk assessment for an organization. The NIST publication is the standard in the healthcare industry and is recommended for all healthcare entities who are conducting risk assessments.

Once a risk assessment has been completed, and the risks have been prioritized, an Action Plan is then set-up to help guide the risk mitigation component of the compliance program. Identifying, developing, and refining internal control processes is key to a risk management plan.

Strategies for Risk Mitigation

How is risk mitigated within an organization? What happens once risk is brought to the attention of leadership and what steps can the organization take to reduce the likelihood of a significant negative impact to the organization?

Key strategies for risk mitigation and management involve: auditing, monitoring, and internal controls. For the Department of Justice to take risk management efforts into consideration during sentencing, the risk strategies used within an organization must be demonstrable and measurable. Organizations can measure the strategies in several ways. Some examples are:

1. Utilization of the Compliance Hotline, number of complaints, investigations, calls
2. Money spent on fines, repairs
3. Audit and inspection results, findings and corrective action plans
4. Adherence to internal policies and procedures
5. Approval processes and procedures
6. The existence (or not) of a formal compliance program and their annual activities
7. Steps taken regarding technology and information systems
8. Separation of Duties among officers and fiscal staff
9. HIPAA Compliance Steps

Once internal controls have been established, the threshold that the Department of Justice will look for is the demonstration that the controls are effective. In other words, are the internal controls doing what they are supposed to be doing, mitigating risk for the

organization? An effective compliance program will be able to answer this question affirmatively, with the caveat that risk mitigation and management is an iterative, quality improvement process that never ends.

Conclusion

This manual has outlined the necessary steps ABC Agency is taking to establish and maintain an effective compliance program. While a compliance program is a required part of a healthcare business, ABC Agency views an effective, dynamic, and robust compliance program as an iterative quality improvement process that will benefit every stakeholder of the organization.

If you have any questions regarding the contents of this manual, please contact the CEO or the ABC Agency Chief Compliance Officer.

Updates	Date	Responsible party

APPENDIX A: QUICK REFERENCE OF FREQUENTLY USED CODES

CPT® Code	Description	Key Elements
90785	Interactive complexity (List separately in addition to the code for primary procedure)	1. Add on code for interactive complexity 2. Can be billed with any psychotherapy CPT® code (90791,90792, 90832-90838) 3. Is not a factor in selection of an E/M 4. Do not use with Crisis Codes or E & < with no psychotherapy service 5. Documentation should support communication factors that complicate delivery of psychiatric care
90791	Psychiatric diagnostic evaluation (without medical E/M services)	• In some cases family members, guardians or others may be consulted instead of patient • Do not use this code on same date-of-service as an E & M service (99xxx), psychotherapy or crisis service • Can be reported with a group psychotherapy code on same date if the time intervals are separate
90832	Psychotherapy, 30 minutes with patient	1. 16-37 minutes of face-to-face time; 2. Document total time or start/stop times; 3. Document at least 1 technique to treat patients condition; 4. Document how patient benefited by therapy in reaching their goals; 5. Document if this is a single episode/recurrent, current degree of impairment, psychotic/not & symptoms, and remission status
90834	Psychotherapy, 45 minutes with patient	1. 38-52 minutes of face-to-face time; 2. Document total time or start/stop times; 3. Document at least 1 technique to treat patients condition; 4. Document how patient benefited by therapy in reaching their goals; 5. Document if this is a single episode/recurrent, current degree of impairment, psychotic/not & symptoms, and remission status

CPT® Code	Description	Key Elements
90837	Psychotherapy, 60 minutes with patient	1. 53-plus minutes of face-to-face time; 2. Document total time or start/stop times; 3. Document at least 1 technique to treat patients condition; 4. Document how patient benefited by therapy in reaching their goals; 5. Document if this is a single episode/recurrent, current degree of impairment, psychotic/not & symptoms, and remission status
90839	Psychotherapy for crisis, first 60 minutes	1. Must include: start and stop times; time does not have to be continuous; however, it must be face-face with patient, without distraction. If not continuous, start/stop times documented. Patient present for all or some of the service. 2. Document at least 1 description of the techniques used to treat the condition, how the patient benefited by the therapy in reaching his/her goals. Major theme of the discussion should also be recorded with consideration to the patient's privacy 3. Must document: single versus recurrent episode, current degree of (depression), with or without psychotic features or symptoms, and remission status when applicable 4. Terms such as "urgent, mobilization of resources to defuse the crisis and restore safety, life threatening or complex, requiring immediate intervention" are key
90840	Psychotherapy for crisis, each additional 30 minutes (List separately in addition to code for primary service)	

CPT® Code	Description	Key Elements
90846	Family psychotherapy (without the patient present), 50 minutes	• Procedure codes 90846, 90847, 90849 describe the treatment of the family unit when maladaptive behaviors of family members are exacerbating the beneficiary's mental illness or interfering with the treatment, or to assist the family in addressing the maladaptive behaviors of the patient and to improve treatment compliance. • Code 90846 is used when the patient is not present. Code 90847 is used when the patient is present. Code 90849 is intended for group therapy sessions to support multiple families when similar dynamics are occurring due to common issues confronted in the family members under treatment. • Do not report 90846, 90847 for family psychotherapy services less than 26 minutes.
90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	• Procedure codes 90846, 90847, 90849 describe the treatment of the family unit when maladaptive behaviors of family members are exacerbating the beneficiary's mental illness or interfering with the treatment, or to assist the family in addressing the maladaptive behaviors of the patient and to improve treatment compliance. • Code 90846 is used when the patient is not present. Code 90847 is used when the patient is present. Code 90849 is intended for group therapy sessions to support multiple families when similar dynamics are occurring due to common issues confronted in the family members under treatment. • Do not report 90846, 90847 for family psychotherapy services less than 26 minutes.

CPT® Code	Description	Key Elements
90849	Multiple-family group psychotherapy	• Code 90849 is intended for group therapy sessions to support multiple families when similar dynamics are occurring due to common issues confronted in the family members under treatment. • Codes 90853 represent psychotherapy administered in a group setting, involving no more than 12 participants, facilitated by a trained therapist simultaneously providing therapy to these multiple patients. The group therapy session typically lasts 45 to 60 minutes. Personal and group dynamics are discussed and explored in a therapeutic setting allowing emotional catharsis, instruction, insight, and support.
90853	Group psychotherapy (other than of a multiple-family group)	
90887	Collateral Therapy (KY DMS 2025)	• Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient • Clearly identify all evaluated data • Objective is to obtain the responsilble parties participation and support in the treatment of the patient
90889	Unlisted Psychiatric Service or Procedure (KY DMS 2025)	• Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other individuals, agencies, or insurance carriers
96156	Health and behavioral assessment	• Health and behavior assessment • AF, AM. APRN, SA, AH or U1 only • procedures are used to identify the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems.
99408	Smoking, Brief Intervention, and Referral to Treatment (SBIRT), 15-30 minutes	• Do not report services less than 15 minutes • Only the initial screening and brief intervention • Document the standardized instrument used (AUDIT, DAST) • Document the behavior change, assessing readiness to change and barriers to change

CPT® Code	Description	Key Elements
99409	Smoking, Brief Intervention, and Referral to Treatment (SBIRT), greater than 30 minutes	• Only the initial screening and brief intervention • Document the standardized instrument used (AUDIT, DAST) • Document the behavior change, assessing readiness to change and barriers to change
H0004	Prolonged Therapy (KY DMS 2023)	• Used per 15-minute unit of service • Must be used in conjunction with 90837 • Limit of 8 units per date of service
T2023	Targeted Case Management	• 907 KAR 3:170 defines in-person as "not via telehealth" so direct contact between provider and client is required • Clients must be SED or SMI • Modifier UA will designate SED; HE will designate SMI
H2027	Psychoeducational Service, per 15 minutes	• A direct, planned, and structured intervention that involves presenting or demonstrating information. Psychoeducation sessions may cover topics such as understanding the nature of mental health and substance use conditions, recognizing warning signs of relapse, stress reduction techniques, and building a support network. • H2027 provided to a group of individuals should include a HQ modifier. H2027 with HQ modifier may not exceed 12 recipients per group, and multiple groups may not be provided at the same time. • Limited to the following maximum units, whether provided individually, in a group, or a combination thereof: • 8 units per day (2 hours) • 500 units per calendar year (125 hours)

APPENDIX B: E & M CODING INFORMATION

IN 2025, the E & M code changes included a significantly higher reliance on the Medical Decision Making (MDM) documentation and process of the provider. Time and the extent of the history and examination are considered important factors, but they are no longer the defining factors for the E & M codes. Documentation tips include:

1. Document the history in the context of the medical decision making
2. Indicate if the client's current condition has a direct impact on the clinical decision-making
3. MDM elements will take into consideration the number and complexity of the Problems addressed
4. The complexity and amount of other documentation reviewed will also contribute to supporting the code (ie: labs, medication history, collateral information)
5. Any risk of complications, morbidity or mortality associated with the patients condition will also support the code used.

References for E & M codes are:

1. American Medical Association, Practice Management, CPT® section
2. American Academy of Child and Adolescent Psychiatry