OPTUM360™

Coding *and* Payment Guide for Behavioral Health Services

An essential coding, billing and reimbursement resource for psychiatrists, psychologists and clinical social workers

2016

Contents

http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt/category-iii-codes.page.

HCPCS Level II Codes

HCPCS Level II codes are commonly referred to as national codes or simply by the acronym HCPCS (Healthcare Common Procedure Coding System, pronounced hik piks). HCPCS codes are used to bill Medicare and Medicaid patients and are also used by some third-party payers.

HCPCS Level II codes, updated and published by CMS, are intended to supplement the CPT coding system by including codes for nonphysician services, durable medical equipment (DME), and office supplies. These Level II codes consist of one alphabetic character (A through V) followed by four numbers. Non-Medicare acceptance of HCPCS Level II codes is idiosyncratic. Providers should check with the payer before billing these codes. A complete list of the HCPCS Level II codes and the quarterly updates to this code set may be found at http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS_Quarterly_Update.html.

Claim Forms

Institutional (facility) providers use the UB-04 claim form, also known as the CMS-1450 or the electronic 837I format, to file a Medicare Part A claim to Medicare contractors.

Noninstitutional providers and suppliers (private practice or other health care provider's offices) use the CMS-1500 form or the 837P electronic format to submit claims to Medicare contractors for Medicare Part B covered services. Medicare Part A coverage includes inpatient hospital, skilled nursing facilities (SNF), hospice, and home health. Medicare Part B coverage provides payment for medical supplies, physician, and outpatient services.

Not all services rendered by a facility are inpatient services. Providers working in facilities routinely render services on an outpatient basis. Outpatient services are provided in settings that include rehabilitation centers, certified outpatient rehabilitation facilities, SNFs, and hospitals. Outpatient and partial hospitalization facility claims might be submitted on either a CMS-1500 or UB-04, depending on the payer.

For professional component billing, most claims are filed using ICD-9-CM diagnosis codes to indicate the reason for the service, CPT codes to identify the service provided, and HCPCS Level II codes to report supplies on the CMS-1500 paper claim or the 837P electronic format.

A step-by-step guide for completing the CMS-1500 and UB-04 claim forms and an explanation of the claims filing process can be found in the claims processing section.

Contents and Format of This Guide

The three chapters following this introduction provide information regarding the reimbursement process, documentation, and claim completion, respectively.

The fifth chapter, "Procedure Codes," contains a numeric listing of procedure codes. Each page identifies the information associated with that procedure including an explanation of the service, coding tips, and associated diagnoses. Please note that this list of associated ICD-9-CM codes is not all inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported. The procedure code page also contains related terms and the CMS Manual System references that designate the official references to the service, which is identified by the procedure code and found in the online manual system. The full excerpt from the online CMS Manual System pertaining to the reference is provided in the Medicare official regulatory information appendix. The full text of all of the Internet-Only Manuals (IOM) may be found at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html. The procedure code pages also have a list of codes from the official *Centers for Medicare and Medicaid Services National Correct Coding Policy Manual for Part B Medicare Contractors* that are considered to be an integral part of the comprehensive or mutually exclusive coding system and should not be reported separately. Please note that the CCI edits will be updated quarterly and posted on Optum's website at www.optumcoding.com/cciedits. Finally, all relative value information relevant to the code is listed at the bottom of the page.

Following this chapter are a procedure code index, a diagnosis code for behavioral health index, HCPCS Level II definitions and guidelines, an appendix that contains Medicare official regulatory information, and a glossary.

How to Use This Guide

The chapters: "The Reimbursement Process," "Documentation—An Overview," and "Claims Processing" may be read in their entirety and/or used as references. When using this *Coding and Payment Guide* for code assignment, follow these important steps to improve accuracy and experience fewer overlooked diagnoses and services:

- **Step 1.** Carefully read the medical record documentation that describes the patient's diagnosis and the service provided. Remember, more than one diagnosis or service may be documented.
- **Step 2.** Locate the main term for the procedure or service documented in the CPT index. This will identify the procedure code that may be used to report this service.
- **Step 3.** Locate the procedure code in the chapter titled "Procedure Codes." Read the explanation and determine if that is the procedure performed and supported by the medical record documentation. The Terms to Know section may be used to ensure appropriate code assignment.
- **Step 4.** At this time review the additional CPT coding information found in the coding tips, IOM references, and CCI sections or the Medicare physician fee schedule references.
- **Step 5.** Peruse the list of ICD-9-CM codes to determine if the condition documented in the medical record is listed and the code identified. If the condition is not listed refer to the ICD-9-CM index or ICD-9-CM manual to locate the appropriate code.

  Assessing the ICD-10-CM Code Crosswalks on October 1, 2015

  Optum will include the ICD-9-CM to ICD-10-CM crosswalk in the web-based http://www.MedicalCodeExpert.com. This

(80302)

80302 Drug screen, presumptive, single drug class from Drug Class List B, by immunoassay (eg, ELISA) or non-TLC chromatography without mass spectrometry (eg, GC, HPLC), each procedure

Explanation

This test may be requested as drug screen for single drug classes within Drug Class List B. Presumptive testing is analyzed by immunoassay, gas chromatography, or high performance liquid chromatography. Report this code for each procedure. This screening may be confirmed with a definitive test that designates drug. Specimen type varies.

Coding Tips

This code is new for 2015. It is a resequenced code and will not display in numeric order. This code is used to report those drugs contained in Drug Class List B of the CPT manual. This code is reported once for each drug class or procedure and, therefore, may be reported with more than one unit. To report definitive drug testing, see codes 80300-80377. To report therapeutic drug testing, see codes 80150-80299.

ICD-9-CM Diagnostic Codes

304.01 Opioid type dependence, continuous
304.02 Opioid type dependence, episodic
304.11 Sedative, hypnotic or anxiolytic dependence, continuous
304.12 Sedative, hypnotic or anxiolytic dependence, episodic
304.41 Amphetamine and other psychostimulant dependence, continuous
304.42 Amphetamine and other psychostimulant dependence, episodic
305.1 Nondependent tobacco use disorder
305.91 Other, mixed, or unspecified nondependent drug abuse, continuous
305.92 Other, mixed, or unspecified nondependent drug abuse, episodic
V70.4 Examination for medicolegal reason — (Use additional code(s) to identify any special screening examination(s) performed: V73.0-V82.9)
V72.69 Other laboratory examination

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

	Work Value	Non-Fac PE	Fac PE	Malpractice	Non-Fac Total	Fac Total
80302	0.00	0.00	0.00	0.00	0.00	0.00

Official ICD-9-CM Guidelines for Coding and Reporting

CMS and the National Center for Health Statistics (NCHS), two departments within the Department of Health and Human Services (HHS) provide official guidelines for coding and reporting using the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). The guidelines are considered a companion document to the official version of the ICD-9-CM as published on CD-ROM by the U.S. Government Printing Office (GPO).

The guidelines have been approved by four organizations constitute the cooperating parties for the ICD-9-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS. The guidelines are included on the official government version of ICD-9-CM, and are featured in the *AHA Coding Clinic for ICD-9-CM*, published by the AHA.

The guidelines are considered a set of rules which accompany and complement the official conventions and instructions provided within the ICD-9-CM text. The guidelines are based on coding and sequencing instructions in the ICD-9-CM text, but provide additional instruction. The Health Insurance Portability and Accountability Act (HIPAA) requires adherence to these guidelines, and reporting of diagnosis codes (volumes 1 and 2) for all health care settings.

The guidelines are organized into four main sections. Section I includes structure, conventions, general guidelines that apply to the entire classification, and chapter-specific guidelines that correspond to each distinct chapter. Section II includes guidelines for selection of principal diagnosis for nonoutpatient settings. Section III includes guidelines for reporting additional diagnoses in nonoutpatient settings. Section IV includes guidelines for outpatient coding and reporting.

Diagnostic Coding and Reporting Guidelines for Outpatient Services (Hospital-Based and Physician Office)

These coding guidelines for outpatient diagnoses have been approved for use by hospitals/ providers in coding and reporting hospital-based outpatient services and provider-based office visits.

Information about the use of certain abbreviations, punctuation, symbols, and other conventions used in the ICD-9-CM tabular list (code numbers and titles), can be found in section IA of these guidelines, under "Conventions Used in the Tabular List." Information about the correct sequence to use in finding a code is also described in Section I.

The terms "encounter" and "visit" are often used interchangeably in describing outpatient service contacts and, therefore, appear together in these guidelines without distinguishing one from the other.

Though the conventions and general guidelines apply to all settings, coding guidelines for outpatient and provider reporting of diagnoses will vary in a number of instances from those for inpatient diagnoses, recognizing that:

- The Uniform Hospital Discharge Data Set (UHDDS) definition of principal diagnosis applies only to inpatients in acute, short-term, long-term care and psychiatric hospitals.
- Coding guidelines for inconclusive diagnoses (probable, suspected, rule out, etc.) were developed for inpatient reporting and do not apply to outpatients.

A. Selection of first-listed condition

In the outpatient setting, the term "first-listed" diagnosis is used in lieu of principal diagnosis.

In determining the first-listed diagnosis the coding conventions of ICD-9-CM, as well as the general and disease specific guidelines take precedence over the outpatient guidelines.

Diagnoses often are not established at the time of the initial encounter/visit. It may take two or more visits before the diagnosis is confirmed.

The most critical rule involves beginning the search for the correct code assignment through the alphabetic index. Never begin searching initially in the tabular list as this will lead to coding errors.

1. **Outpatient surgery**
   When a patient presents for outpatient surgery, code the reason for the surgery as the first-listed diagnosis (reason for the encounter), even if the surgery is not performed due to a contraindication.
2. **Observation stay**
   When a patient is admitted for observation for a medical condition, assign a code for the medical condition as the first-listed diagnosis.

   When a patient presents for outpatient surgery and develops complications requiring admission to observation, code the reason for the surgery as the first reported diagnosis (reason for the encounter), followed by codes for the complications as secondary diagnoses.

B. Codes from 001.0 through V91.99

The appropriate code or codes from 001.0 through V91.99 must be used to identify diagnoses, symptoms, conditions, problems, complaints, or other reason(s) for the encounter/visit.

C. Accurate reporting of ICD-9-CM diagnosis codes

For accurate reporting of ICD-9-CM diagnosis codes, the documentation should describe the patient's condition, using terminology which includes specific diagnoses as well as symptoms, problems, or reasons for the encounter. There are ICD-9-CM codes to describe all of these.

D. Selection of codes 001.0 through 999.9

The selection of codes 001.0 through 999.9 will frequently be used to describe the reason for the encounter. These codes are from the section of ICD-9-CM for the classification of diseases and injuries (e.g., infectious and parasitic diseases; neoplasms; symptoms, signs, and ill-defined conditions, etc.).

E. Codes that describe symptoms and signs

Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a diagnosis has not been established (confirmed) by the provider. Chapter 16 of ICD-9-CM, "Symptoms, Signs, and Ill-Defined Conditions" (codes 780.0–799.9) contain many, but not all codes for symptoms.

F. Encounters for circumstances other than a disease or injury

ICD-9-CM provides codes to deal with encounters for