HEALTH SYSTEMS DIVISION)
Oregon Medicaid - Adult Services

Kate Brown, Governor

Oregon Health Authority

Memorandum

To: Oregon Supported Employment Center for Excellence (OSECE)

From: Chad Scott

Date: September 10, 2015

Subject: HCPCS H2023 and H2023TG frequently asked billing questions

Question 1	**Is supported employment a covered service for Substance Use Disorder conditions?**
Answer 1	Procedure code H2023 is a covered service on Oregon's prioritized list beginning on Line 7 and includes the following conditions. There are no substance use disorder diagnoses that pair with procedure code H2023. Condition: **MAJOR DEPRESSION, RECURRENT; MAJOR DEPRESSION, SINGLE EPISODE, SEVERE** ICD-9: 296.23-296.24,296.30-296.36,298.0 Condition: **SCHIZOPHRENIC DISORDERS** ICD-9: 295.00,295.01,295.02,295.03,295.04,295.05,295.10-295.95,298.4,299.10-299.11,299.90-299.91 Condition: **BIPOLAR DISORDERS** ICD-9: 296.00-296.16,296.40-296.89,301.13 Condition: **BORDERLINE PERSONALITY DISORDER** ICD-9: 301.83 http://www.oregon.gov/oha/herc/pages/prioritizedlist.aspx
Question 2	**Are Certified Peer Support Specialists an approved provider type for the supported employment code?**
Answer 2	Yes, Certified Peer Support Specialists are an approved provider type for the H2023 procedure code. The list of providers approved for the H2023 code can be found on the OHA behavioral health fee for service fee schedule located at: http://www.oregon.gov/oha/healthplan/pages/feeschedule.aspx
Question 3	**How do I claim for IPS supported employment services provided to ACT recipients?**
Answer 3	Supported employment or vocational services provided to enrolled ACT recipients by ACT members are billed using the ACT code (H0039). Supported employment provided

	to an enrolled ACT recipient by a non-ACT team provider are billed using the H2023 code.
Question 4	**What procedure code is used when claiming for supported education services?**
Answer 4	When claiming for supported employment services, providers should bill using code H2023 with a TG modifier.
Question 5	**What provider types of allowed to bill using the H2023 and H2023TG procedure codes?**
Answer 5	Providers approved to claim for services using the H2023 and H2023TG procedures codes are; Licensed Professional Counselor, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Psychologist, Unlicensed QMHP, QMHA, Certified Peer Support Specialist.
Question 6	**What are the billing limitations placed on use of the supported education code in terms of treatment planning requirements?**
Answer 6	OHA has OAR language defining a service as medically appropriate. The need for supported education services and associate interventions must be documented in the assessment and related to the deficits experienced due to the symptoms of a diagnosed behavioral health condition. Interventions recommended or prescribed in the treatment plan should be linked with the functional deficits identified in the assessment and appropriate to achieve the education or employment outcomes defined for the person. **OAR 410-172-0630** defines a service as medically appropriate as; *(1) In addition to the definition of medically appropriate in OAR 410-120-0000 for behavioral health services, "medically appropriate" means the services and supports required to diagnose, stabilize, care for, and treat a behavioral health condition.* *(2) The Division shall make payment for medically appropriate behavioral health services when the services or supports are:* *(a) Rendered by a provider whose training, credentials, or license is appropriate to treat the identified condition and deliver the service;* *(b) Based on the standards of evidence-based practice, and the services provided are appropriate and consistent with the diagnosis identified in the behavioral health assessment;* *(c) Provided in accordance with an individualized service plan and appropriate to achieve the specific and measurable goals identified in the service plan;* *(d) Not provided solely for the convenience of the recipient, the recipient's family, or the provider of the services or supplies;* *(e) Not provided solely for recreational purposes;* *(f) Not provided solely for research and data collection;* *(g) Not provided solely for the purpose of fulfilling a legal requirement placed on the recipient.*
Question 7	**Can the supported education or supported employment codes be claimed for interventions provided via e-mail or text?**
Answer 7	OHA has an OAR for telemedicine. H2023 and H2023TG can be billed using the GT (telemedicine modifier) when the service complies with **OAR 410-172-0850.** **410-172-0850** **Telemedicine for Behavioral Health** (1) Telemedicine encompasses different types of programs, services, and delivery mechanisms for medically appropriate covered services within the recipient's benefit package:

	(a) Patient consultations using telephone and online or electronic mail (e-mail) are covered when billed services comply with the practice guidelines set forth by the Health Evidence Review Commission and the applicable HERC-approved code requirements, delivered consistent with the HERC Evidence-Based Guidelines; (b) Patient consultations using videoconferencing, a synchronous (live two-way interactive) video transmission resulting in real time communication between a provider located in a distant site and the recipient being evaluated and located in an originating site, is covered when billed services comply with the billing requirements stated below. (2) Behavioral health services specifically identified as allowable for telephonic delivery are listed on the Behavioral Health Fee schedule published by the Authority. (3) Unless expressly authorized in OAR 410-120-1200 (Exclusions), other types of telecommunications are not covered such as images transmitted via facsimile machines and electronic mail when: (a) Those methods are not being used in lieu of videoconferencing, due to limited videoconferencing equipment access; or (b) Those methods and specific services are not specifically allowed pursuant to the Oregon Health Evidence Review Commission's Prioritized List of Health Services and Evidence Based Guidelines. (4) Providers billing for covered telemedicine services shall: (a) Comply with HIPAA and the Authority's Confidentiality and Privacy Rules and security protections for the patient in connection with the telemedicine communication and related records; (b) Obtain and maintain technology used in the telemedicine communication that is compliant with privacy and security standards in HIPAA and the Authority's Privacy and Confidentiality Rules set forth in OAR 943 division 14; (c) Ensure policies and procedures are in place to prevent a breach in privacy or exposure of patient health information or records (whether oral or recorded in any form or medium) to unauthorized individuals; (d) Comply with the relevant HERC evidence-based guidelines for telephone and e-mail consultation. Refer to the current prioritized list and evidence based guidelines at http://www.oregon.gov/oha/herc/Pages/PrioritizedList.aspx; (e) Maintain clinical and financial documentation related to telemedicine services as required in OAR 410-120-1360. (5) For purposes of behavioral health services, the Authority shall provide coverage for telemedicine services to the same extent that the services would be covered if they were provided in person.
Question 8	**Can I claim for job development or resource identification activities when the recipient is not present?**
Answer 8	Activities conducted to identify potential employers, education or training programs or to link the recipient with education or employment services are billable when the service is provided on behalf of a specific individual and the service or activity is identified in the treatment plan. General resource identification or employer outreach not provided on behalf of a specific individual cannot be billed using the H2023 or H2023TG procedure codes.
Question 9	**If a recipient has been referred and is coming onto the SE caseload. Can the individual therapist bill for the entire session under therapy and the SE specialist bill for SE for the portion of time that they are in the meeting? It is our understanding that both can bill as they are providing separate services.**
Answer 9	Two providers within the same agency can bill for services provided during the same period of time to a single recipient under the following circumstances:

	• When the services are not similar or duplicate • When the providers are a different provider type or have a different specialty • When the time is split between the two providers to reflect the time spent by each provider delivering the service
Question 10	**How important is it to have IPS on the assessment when the client starts services? Sometimes the annual update of the assessment is not due for a while.**
Answer 10	With the exception of emergent or crisis services, all services provided and claimed should be provided under prescription of a treatment plan based on needs identified in the assessment (see medical appropriateness rule). When the assessment does not support an intervention listed on the treatment plan, the assessment should be amended, reassessment should occur or the service should be removed from the treatment plan. **410-172-0620** **Documentation Standards** (1) OHP providers shall maintain records that fully support the extent of services for which payment has been requested and provide the records to the Division upon request. (2) All records shall document the specific service provided, the number of services comprising the service provided, the extent of the service provided, the dates on which the service was provided, and the individual who provided the service. (3) Clinical records shall document the recipient's diagnosis and the medical need for the service. (4) The record shall be annotated each time a service is provided and be signed or initialed by the individual providing the service. (5) Information contained in the record shall be appropriate in quality and quantity to meet the professional standards applicable to the provider and any additional standards for documentation found in these rules, other Division rules, and pertinent contracts. (6) For AMH certified providers, in addition to meeting the requirements in this rule, clinical documentation for behavioral health services shall also comply with the requirements in OAR 309-019-0135 through OAR 309-019-0140, and clinical documentation standards for substance use disorder services shall comply with OAR 309-018-0140 through OAR 309-018-0150.
Question 11	**Can I bill for time sitting in the car waiting for a client to complete their interview because they didn't want the employment specialist to be a part of the interview?**
Answer 11	No, time spent not providing a service or procedure listed on the treatment plan cannot be claimed.
Question 12	**Can multiple 1-5 minute brief interactions with a client add up to one billable unit of time? Can you round up time?**
Answer 12	When only one service is provided in a day, providers should not bill for services performed for less than 8 minutes. For any single timed CPT code in the same day measured in 15 minute units, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes. If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes through and including 37 minutes, then 2 units should be billed. Time intervals for 1 through 8 units are as follows:

	Units **Number of Minutes** 1 unit: ≥ 8 minutes through 22 minutes 2 units: ≥ 23 minutes through 37 minutes 3 units: ≥ 38 minutes through 52 minutes 4 units: ≥ 53 minutes through 67 minutes 5 units: ≥ 68 minutes through 82 minutes 6 units: ≥ 83 minutes through 97 minutes 7 units: ≥ 98 minutes through 112 minutes 8 units: ≥ 113 minutes through 127 minutes The pattern remains the same for treatment times in excess of 2 hours. If a service represented by a 15 minute timed code is performed in a single day for at least 15 minutes that service shall be billed for at least one unit. If the service is performed for at least 30 minutes, that service shall be billed for at least two units, etc. It is not appropriate to count all minutes of treatment in a day toward the units for one code if other services were performed for more than 15 minutes. When more than one service represented by 15 minute timed codes is performed in a single day, the total number of minutes of service (as noted on the chart above) determines the number of units billed. If any 15 minute timed service that is performed for 7 minutes or less than 7 minutes on the same day as another 15 minute timed service that was also performed for 7 minutes or less and the total time of the two is 8 minutes or greater than 8 minutes, then bill one unit for the service performed for the most minutes. This is correct because the total time is greater than the minimum time for one unit. The same logic is applied when three or more different services are provided for 7 minutes or less than 7 minutes.
Question 13	**How do I bill my service intervention if I am unable to avoid providing a service that is not IPS?**
Answer 13	Interventions that do not qualify as an IPS SE intervention should be billed with the procedure code appropriate to the service and your provider type. Refer to the BH fee schedule for available codes and information on approved providers.
Question 14	**If my client is an ACT client, and I am the employment specialist on the ACT team, do I bill ACT or IPS for the employment service?**
Answer 14	Supported employment or vocational services provided to enrolled ACT recipients by ACT members are billed using the ACT code (H0039). Supported employment provided to an enrolled ACT recipient by a non-ACT team provider are billed using the H2023 code.
Question 15	**Can certified peer support specialists who are not QMHAs or QMHPs bill for IPS services?**
Answer 15	Yes, Certified Peer Support specialist is an approved provider type for H2023 and H2023TG
Question 16	**How do we prove medical necessity for IPS supported employment?**
Answer 16	OHA has an OAR defining medical appropriateness (OAR 410-172-0630) . Generally, an assessment leading to diagnosis of a mental health condition and documentation of functional deficit(s) resulting from the onset or course of the condition is used to justify evidence based and appropriate interventions prescribed or recommended on the treatment plan. See answer 6.