



Dear Behavioral Health Services Provider:

Effective December 26, 2008, regulations were passed through the Department of Health and Social Services/Behavioral Health to increase the reimbursement rates for selected mental health and substance abuse treatment services. Attached are replacement pages for your *Behavioral Health Services* provider billing manual which reflect those changes.

The prior authorization/service authorization request forms and rate tables on these replacement pages have been updated to reflect both the former rates and the new, increased reimbursement rates. Please distribute this information to the appropriate staff within your agency and insert the updated pages into your billing manual to keep a current reference.

Please feel free to direct any questions to the ACS Provider Inquiry Unit at (907) 644-6800 (option 1) or (800) 770-5650 (toll-free in Alaska).

Attachments:

- Billing manual replacement pages I-31 through I-44
- Billing manual replacement pages I-53 through I-58

P.O. Box 240808  
Anchorage, AK 99524-0808  
907-644-6800

## Extension of Service Limits for “Clinic” Services

Service limitations for the following “clinic” services for **children** may be extended if the services requested meet program requirements, and are requested in compliance with program rules.

- H0031-Mental health assessment, by non-physician (Intake Assessment)
- 90801-Psy dx interview (Psychiatric assessment)
- 90802-Intac psy dx (Psychiatric assessment)
- CDBAQ-Psychological testing comprehensive assessment, each 15 minutes
- CDBAS-Neuropsychological testing, each 15 minutes
- S9484-Crisis intervention mental health services, per hour
- 90847-Family Psytx w/ patient
- 90849-Multiple-family group psytx
- 90853-Group psychotherapy
- 90804-Psytx, office, 20-30 min
- 90810-Intac psytx, off, 20-30 min
- 90862-Medication management

Service limitations for the following “clinic” services for **adults** may be extended if the services requested meet program requirements and are requested in compliance with program rules.

- H0031-Mental health assessment, by non-physician (Intake Assessment)
- 90801-Psy dx interview (Psychiatric assessment)
- 90802-Intac psy dx interview (Psychiatric assessment)
- CDBAQ-Psychological testing comprehensive assessment, each 15 minutes
- CDBAS-Neuropsychological testing, each 15 minutes
- S9484-Crisis intervention mental health services, per hour
- 90847-Family Psytx w/ patient
- 90849-Multiple-family group psytx
- 90853-Group psychotherapy
- 90804-Psytx, office, 20-30 min
- 90862-Medication management

**Note:** Please refer to service definitions and policy clarifications within this section of the manual for further information regarding limitations of services.

*Updated 06/09*

## Extension of Service Limits for “Rehabilitation” Services

Service limitations for the following “rehabilitation” services for **severely emotionally disturbed children** may be extended if the services requested meet program requirements and are requested in compliance with program rules.

- CDBAP-Psychological testing brief assessment each 15 minutes [*Functional assessment*]
- H0033-Oral medication administration, direct observation [*on-premises*]
- H0033 HK-Oral medication administration, direct observation [*off-premises*]
- T1016-Case management, each 15 minutes
- CDAEP-Social skills assistance individual each 15 minutes [*Individual skill development*]
- CDABF-Family-involvement training family each 15 minutes [*Family skill development*]
- CDAKQ-Social skills assessment group each 15 minutes [*Group skill development*]
- CDACM-Coping skills development assistance individual each 15 minutes [*Recipient support service*]

Service limitations for the following “rehabilitation” services for **severely emotionally disturbed adults or chronically mentally ill adults** may be extended if the services requested meet program requirements and are requested in compliance with program rules.

- CDBAP-Psychological testing brief assessment each 15 minutes [*Functional assessment*]
- H0033-Oral medication administration, direct observation [*on-premises*]
- H0033 HK-Oral medication administration, direct observation [*off-premises*]
- T1016-Case management, each 15 minutes
- CDAEP-Social skills assistance individual each 15 minutes [*Individual skill development*]
- CDAKQ-Social skills assistance group each 15 minutes [*Group skill development*]
- CDACM-Coping skills development assistance individual each 15 minutes [*Recipient support service*]

**Note:** Please see service definitions and policy clarifications within this section of the manual for more information regarding limitations of services. Complete service descriptions are also available at <http://www.hipaa.samhsa.gov/hipaacodes2.htm>.

Updated 06/09

## Obtaining Prior Authorization

Written approval is required for any services in excess of the annual service limitations specified in state regulations and this billing manual. A *Community Mental Health Clinic Prior Authorization Request* form is located later in this section. Any completed Prior Authorization Request form that is **not** for Recipient Support Services should be sent to:

Affiliated Computer Services, Inc.  
Prior Authorization Unit  
P.O. Box 240808  
Anchorage, AK 99524-0808

Any prior authorization request that contains Recipient Support Services, **with or without other services**, must be forwarded to the appropriate Division of Behavioral Health (DBH) regional administrator. Current DBH regions are listed below.

**Southeast** Regional CMHS Administrator  
P.O. Box 110620  
Juneau, AK 99803  
Phone: (907) 465-3370  
TDD: (907) 465-2225  
Fax: (907) 465-2677  
Toll Free: 1-800-465-4828

**Northern** Regional CMHS Administrator  
751 Old Richardson Highway, Suite #100-A  
Fairbanks, AK 99701  
Phone: (907) 451-5042  
TDD: (907) 451-5093  
Fax: (907) 451-5046  
Toll Free: 1-800-770-1672

**Anchorage** Regional CMHS Administrator  
3601 C Street, # 878  
Anchorage, AK 99503-7409  
Phone: (907) 269-3600  
TDD: (907) 269-3624  
Fax: (907) 269-3623  
Toll Free: 1-800-770-3930

**Southcentral** Regional CMHS Administrator  
3601 C Street, # 878  
Anchorage, AK 99503-7409  
Phone: (907) 269-3600  
TDD: (907) 269-3624  
Fax: (907) 269-3623  
Toll Free: 1-800-770-3930

For more regional contact information, visit the DBH web page:  
<http://www.hss.state.ak.us/dbh/mh/contacts.htm>

Updated 06/09



# COMMUNITY MENTAL HEALTH CLINIC PRIOR AUTHORIZATION REQUEST

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Effective 01/01/2010  
Page 1 of 2

### Provider Information

1. Request Date

2. Provider Name

3. Provider ID

4. Contact Name and Address  
(decision will be returned to this address)

5. Phone No.

6. Fax No.

7. E-Mail Address

### Recipient Information

8. Recipient Name

9. Date of Birth  10. Recipient ID

11. Gender  Male  Female

12. Recipient Address

a. Private Home  b. Foster Home

c. Office of Children's Services Rehabilitation Home

d. Transitional/Supported Living Home

e. Residential Substance Abuse Treatment Center

f. Homeless/Shelter  g. Other-Explain:

13. Type of Client:

a. ED Adult  b. SED Adult  c. CMI Adult

d. ED Child  e. SED Child

f. Other:

14. DSM: Axis I  Axis II  Axis III

15.  **New Request** Requested Dates: From:  Thru:

16.  **Update to existing PA** a. Update From:  Thru:  b. PA No.

(Required for PA updates only.)

Clinic Services	Code	Modifier	Unit	17. Units Requested
MH health assess by non-md [Intake assessment] .....	H0031 .....		15 min	<input type="text"/>
Psy dx interview [Psychiatric assessment] .....	90801 .....		1 assess.	<input type="text"/>
Intac psy dx interview [Psychiatric assessment] .....	90802 .....		1 assess.	<input type="text"/>
Psycho testing by psych/phys [15 minutes/unit] .....	96101 .....	U6 .....	15 min	<input type="text"/>
Neuropsych tst by psych/phys [15 minutes/unit] .....	96118 .....	U6 .....	15 min	<input type="text"/>
Crisis intervention per hour .....	S9484 .....		1 hour	<input type="text"/>
Group psychotherapy .....	90853 .....	U7 .....	30 min	<input type="text"/>
Family psytx w/patient .....	90847 .....	U7 .....	30 min	<input type="text"/>
Multiple family group psytx .....	90849 .....	U7 .....	30 min	<input type="text"/>
Psytx, office, 20-30 min .....	90804 .....		30 min	<input type="text"/>
Intac psytx, off, 20-30 min .....	90810 .....		30 min	<input type="text"/>
Medication management .....	90862 .....		1 visit	<input type="text"/>

**Pages 1 and 2 of this request must be completed. Requests without both pages cannot be processed.**

CPT codes and descriptions are copyright 2009, American Medical Association. All rights reserved. Applicable FARS/DFARS apply. CPT code descriptions are shortened to 28 characters or less to comply with copyright restrictions. For full descriptions, please refer to your CPT book. Effective 1/1/10 Dates of Service.



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# COMMUNITY MENTAL HEALTH CLINIC PRIOR AUTHORIZATION REQUEST

Page 2 of 2

Pages 1 and 2 of this request must be completed. Requests without both pages cannot be processed.

Provider Information		Recipient Information	
Provider Name	<input type="text"/>	Recipient Name	<input type="text"/>
Provider ID	<input type="text"/>	Recipient ID	<input type="text"/>

Rehabilitation Services, Adult and Child	Code	Modifier	Unit	18. Units Requested
Comp multidispln evaluation [Functional assessment]	H2000	U6	15 min	<input type="text"/>
Oral med adm, direct observe [on-premises]	H0033		1 day	<input type="text"/>
Oral med adm, direct observe [off-premises]	H0033	HK	1 day	<input type="text"/>
Skills train and dev [Group skill development]	H2014	HQ	15 min	<input type="text"/>
Skills train and dev [Individual skill development]	H2014		15 min	<input type="text"/>
Case management	T1016		15 min	<input type="text"/>

Rehabilitation Services, Child Only	Code	Modifier	Unit	19. Units Requested
Skills train and dev [Family skill development]	H2014	HR	15 min	<input type="text"/>

Recipient Support Services (RSS)	Code	Unit	20. Units Requested
Psyc soc rehab svc	H2017	15 min	<input type="text"/>
Current GAF Score	<input type="text"/>	(DBH review is required)	

Explanation (fully describe the justification for the requested RSS; attach a separate paper if necessary):

By submission of this form, the provider:

- Affirms the assessment of the recipient's symptomatology and current level of functionality is documented in the recipient's record and indicates the units and duration of services requested are medically necessary;
- Affirms the recipient's record includes documentation of the interdisciplinary team, physician, or mental health clinician recommendation of the requested services as medically necessary;
  - If the recipient is a severely emotionally disturbed child, the documentation must show that the interdisciplinary team reviewed the treatment plan and recommended the requested services as medically necessary.
  - If the recipient is a severely emotionally disturbed adult or a chronically mentally ill adult, the documentation must show that the recipient's mental health professional clinician or the recipient's physician reviewed the treatment plan and recommended the requested services as medically necessary; and
- Acknowledges the services are subject to post-payment review for medical necessity and completeness of documentation according to Medicaid/Denali KidCare program rules. The Department of Health and Social Services may recoup payment for any services that are not medically necessary, not properly documented, or not in compliance with Medicaid/Denali KidCare program rules.

21. Clinic Signature \_\_\_\_\_ Title \_\_\_\_\_

22. DBH Signature \_\_\_\_\_ Date \_\_\_\_\_



## Community Mental Health Clinic Prior Authorization Request Instructions

**Submission Requirements:** This prior authorization (PA) form must be completed to indicate the amount of services requested beyond the service limitations set out in the Provider Billing Manual and must bear the signature of a person authorized to bind the requesting clinic. Requests that include **Recipient Support Services must be submitted to the Division of Behavioral Health (DBH)** for its review. DBH will forward the form to Affiliated Computer Services, Inc. (ACS) after its review. **Submit all other requests directly to ACS.**

### Page 1:

1. **Request Date:** Enter the date that the authorization request is being submitted.
2. **Provider Name:** Enter the name of the enrolled mental health clinic.
3. **Provider ID No.:** Enter the Medical Assistance identification number assigned to the mental health clinic. If a clinic has multiple identification numbers, separate authorizations must be requested for each provider identification number (e.g., Day Treatment requests must be submitted on a separate form).
4. **Contact Name and Address:** Enter the name and address of the person ACS should contact regarding the authorization request. The authorization decision will be returned to the address entered here.
5. **Phone No.:** Enter the contact person's telephone number.
6. **Fax No.:** Enter the contact person's fax number, if applicable.
7. **E-Mail Address:** Enter the contact person's e-mail address, if applicable.
8. **Recipient Name:** Enter the name of the recipient for whom the authorization is being requested.
9. **Date of Birth:** Enter the recipient's date of birth.
10. **Recipient ID No.:** Enter the recipient's Medical Assistance identification number.
11. **Gender (recipient's):** Check appropriate box for male or female.
12. **Recipient Address:** Enter the recipient's address **and check the appropriate box** (a, b, c, d, e, f, or g).
13. **Type of Client:** Indicate by marking the appropriate designation for the client.
14. **DSM: Axis I**—Enter the primary DSM IV mental health disorder being treated. **Axis II**—Enter the DSM IV diagnosis being treated, if any. **Axis III**—Enter the medical condition, if applicable.
15. **New Request**—Mark this box if the prior authorization request is a request to initially exceed the annual service limits identified in the Provider Billing Manual. Enter the dates requested for the initial prior authorization. Prior authorization requests will be accepted if requested for periods not to exceed 6 months and not to extend beyond the end of a calendar year.
16. **Update to existing PA**—Mark this box when:
  - Requesting an update to add additional units of service to the existing PA record referred to in Field 16b.
  - Adding services not already included in the existing PA record referred to in Field 16b.
  - Extending the "thru" date of the authorization period for the existing PA record referred to in Field 16b.**a. Update**—Enter the "from" and "thru" dates for the authorization period being requested. Prior authorization requests will be accepted if requested for periods not to exceed 6 months and not to extend beyond the end of a calendar year.  
**b. PA Number**—Enter the number of the PA being updated.
17. **Units Requested (Clinic Services):** Enter the number of **additional units** of Clinic Services being requested. Always use the lowest unit size available when entering the Units Required.

**Page 2:** Enter the request date, Provider name and ID number, Contact person and phone number, recipient name, and ID number as entered on page 1. **If you do not enter this information, ACS may not be able to process your authorization.**

18. **Units Requested (Rehab. Services-Adult & Child):** Enter the number of **additional** units of Child or Adult Rehabilitation Services being requested. Always use the lowest unit size available when entering the Units Required. Always use the lowest unit size available when entering the Units Required.
19. **Units Requested (Rehab. Services-Child Only):** Enter the number of **additional** units of Child-only Rehabilitation Services being requested. Always use the lowest unit size available when entering the Units Required. Always use the lowest unit size available when entering the Units Required.
20. **Units Requested:** Enter the number of **additional** units of Recipient Support Services (RSS) being requested. Enter the client's current (past 7 days) GAF score. Your explanation must give 1) the specific staff involvement to be provided as RSS and 2) the symptoms and behaviors that support the GAF score. Always use the lowest unit size available for Units Requested.
21. **Clinic Signature:** The signature must be by a person authorized to bind the clinic to the completed form as accurate and subject to Medical Assistance program rules. Please include the title of the person signing the prior authorization request form.
22. **DBH Signature:** The DBH signature indicates DBH reviewed the form and may have discussed the request with the clinic staff for clarification. The signature does not indicate acceptance of the requested services or units as medically necessary. Medical necessity may be determined during a post-payment review according to Medical Assistance program rules. The division may recoup payment for any services that are not medically necessary, not properly documented, or not in compliance with Medical Assistance program rules.

## Billing Mental Health Rehabilitation Services

Third-party insurance carriers may cover mental health rehabilitation services provided by clinic staff meeting the Alaska Medical Assistance definition of a mental health professional clinician. Therefore, Alaska Medical Assistance has adopted the following guidelines for billing these services.

**Important:** The clinical records must document the credentials of the rendering clinic staff and be supported in the claims billing through the appropriate use of procedure code modifiers.

### Rehabilitation Services Performed by Mental Health Clinical Associates

It is not necessary to bill third-party carriers for services provided by mental health clinical associates. All services provided by these staff members are on TPL Avoidance (refer to *Third Party Liability (TPL) Avoidance* in *Section I-E* for additional information); you do not have to bill other insurance before billing Alaska Medical Assistance. When billing Alaska Medical Assistance, use the procedure codes/modifier as listed in *Tables I-4* and *I-5*. Most services (except oral medication administration, direct observation [*off-premises*], HCPC code H0033-HK) performed by mental health clinical associates will be billed to Alaska Medical Assistance *without procedure code modifiers*.

### Rehabilitation Services Performed by Mental Health Professional Clinicians

All mental health rehabilitation services (except oral medication administration, direct observation [*off-premises*], HCPC code H0033-HK) performed by mental health professional clinicians must be billed to third-party carriers before billing Alaska Medical Assistance. After you have received an Explanation of Benefits (EOB) showing payment or denial from the third-party carrier, bill Alaska Medical Assistance (*using the appropriate modifier as listed below*) and attach the EOB to the claim.

**Note:** Although most third-party carriers do not recognize the ABC code set currently, they may still cover and reimburse some rehabilitation services rendered by mental health professional clinicians. The Division of Behavioral Health suggests that you use CPT code 90899 (unlisted psychiatric service) to bill third-party carriers for those services for which Alaska Medical Assistance uses ABC codes. You should include a description of the service and the credentials of the clinic staff member with the claim. If you cannot use the ABC codes when billing third-party carriers, make sure you change to the ABC codes when you bill Alaska Medical Assistance.

#### Modifiers for HCPCS Codes

(five-character code that begins with a letter followed by 4 numbers)

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HO	Master's degree
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HP	Doctoral degree
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#### Modifiers for ABC Codes<sup>3</sup>

(five-letter code)

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1M	Medical Doctor (all specialties) [ <i>Licensed Medical Doctor</i> ]
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1H	Nurse Practitioner (all specialties) [ <i>Licensed Advanced Nurse Practitioner</i> ]
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Updated 07/07

<sup>3</sup> ABC codes are copyright protected by Alternative Link, Inc., 2009, all rights reserved. Previous editions copyrighted 1999-2004.

## Procedure Codes

Use specific procedure codes when completing the forms. Enter the appropriate code from the following tables in Field 24D of the CMS-1500.

**Table I-4(a). CPT<sup>4</sup> Procedure Codes: Children’s Clinic Services/Community Mental Health Clinic**

<b>CPT Code</b>	<b>CPT Brief Description</b>	<b>Maximum Allowable Before 12/26/2008</b>	<b>Maximum Allowable Effective 12/26/2008</b>
90801 <sup>^</sup>	Psy dx interview [ <i>Psychiatric assessment</i> ]	\$230.00/Assessment (1 Unit = 1 Assessment)	\$230.00/Assessment (1 Unit = 1 Assessment)
90802 <sup>^</sup>	Intac psy dx interview [ <i>Psychiatric assessment</i> ]	\$230.00/Assessment (1 Unit = 1 Assessment)	\$230.00/Assessment (1 Unit = 1 Assessment)
90804 <sup>*</sup>	Psytx, office, 20-30 min	\$40.00/30 Minutes (1 Unit = 30 Minutes)	\$50.00/30 Minutes (1 Unit = 30 Minutes)
90810 <sup>*</sup>	Intac psytx, off, 20-30 min (must be under the age of 21 years)	\$40.00/30 Minutes (1 Unit = 30 Minutes)	\$50.00/30 Minutes (1 Unit = 30 Minutes)
90847 <sup>*</sup>	Family psytx w/patient	\$40.00/30 Minutes (1 Unit = 30 Minutes)	\$55.00/30 Minutes (1 Unit = 30 Minutes)
90849 <sup>*</sup>	Multiple family group psytx	\$22.50/30 Minutes (1 Unit = 30 Minutes)	\$28.00/30 Minutes (1 Unit = 30 Minutes)
90853 <sup>*</sup>	Group psychotherapy (per recipient)	\$22.50/30 Minutes (1 Unit = 30 Minutes)	\$28.00/30 Minutes (1 Unit = 30 Minutes)
90862 <sup>+</sup>	Medication management	\$75.00/Visit (1 Unit = 1 Visit)	\$75.00/Visit (1 Unit = 1 Visit)

<sup>^</sup> Psychiatric assessment (90801, 90802): Combined maximum of four assessments per calendar year

<sup>\*</sup> Individual, Group, and Family Psychotherapy: Combined limit of 10 hours per calendar year

<sup>+</sup> Pharmacologic Management: No more than one visit per week during the initial month following entry to a program, then no more than one visit per month unless there is an unusual reaction or if more frequent monitoring is required.

**Note:** For complete definitions and guidelines for the above services, refer to the *American Medical Association Current Procedural Terminology*, previous subsections of this manual, and Alaska Medical Assistance regulations. Complete service descriptions are also available at <http://www.hipaa.samhsa.gov/hipaacodes2.htm>.

Updated 06/09

<sup>4</sup> CPT Codes and descriptions only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply. Coverage and rates are subject to change.

**Table I-4(b). HCPCS and ABC<sup>5</sup> Procedure Codes:  
Children's Clinic Services/Community Mental Health Clinic**

<b>Code</b>	<b>Description</b>	<b>Maximum Allowable Before 12/26/2008</b>	<b>Maximum Allowable Effective 12/26/2008</b>
H0031 <sup>^</sup>	Mental health assessment, by non-physician <i>[Intake assessment]</i>	\$21.25/15 Minutes (1 Unit = 15 Minutes)	\$24.00/15 Minutes (1 Unit = 15 Minutes)
S9484 <sup>*</sup>	Crisis intervention mental health services, per hour	\$75.00/1 Hour (1 Unit = 1 Hour)	\$92.00/1 Hour (1 Unit = 1 Hour)
CDBAQ <sup>#</sup>	Psychological testing comprehensive assessment, each 15 minutes	\$21.25/15 Minutes (1 Unit = 15 Minutes)	\$25.00/15 Minutes (1 Unit = 15 Minutes)
CDBAS <sup>+</sup>	Neuropsychological testing, each 15 minutes	\$21.25/15 Minutes (1 Unit = 15 Minutes)	\$25.00/15 Minutes (1 Unit = 15 Minutes)

<sup>^</sup> Intake Assessment: Initial intake assessment – three hours per admission. Semiannual intake assessment – one hour, two times per year, per admission. Requires prior authorization to assess for medical necessity if exceeds five hours annually

<sup>\*</sup> Crisis Intervention: Maximum of two hours per day for no more than 72 hours per psychiatric emergency; maximum 22 hours per calendar year

<sup>#</sup> Psychological Testing and Evaluation: Maximum six hours per calendar year

<sup>+</sup> Neuropsychological Testing and Evaluation: Maximum 12 hours per calendar year

**Note:** For complete definitions and guidelines for the above services, refer to *Healthcare Common Procedure Coding System (HCPCS)* and the *ABC Coding Manual for Integrative Healthcare*, as well as this section of the manual and Alaska Medical Assistance regulations. Complete service descriptions are also available at <http://www.hipaa.samhsa.gov/hipaacodes2.htm>.

Updated 06/09

<sup>5</sup> ABC codes are copyright protected by Alternative Link, Inc., 2009, all rights reserved. Previous editions copyrighted 1999-2004.

**Table I-4(c). HCPCS and ABC<sup>6</sup> Procedure Codes:  
Children's Rehabilitation Services/Community Mental Health Clinic**

Code	Modifier	Description	Maximum Allowable Before 12/26/2008	Maximum Allowable Effective 12/26/2008
H0018		Behavioral health; short term residential (non-hospital residential treatment program) without room and board, per diem <i>[Daily Behavioral Health residential rehabilitation]</i>	\$171.00/Day (1 Unit = 1 Day)	\$171.00/Day (1 Unit = 1 Day)
H0033*		Oral medication administration, direct observation <i>[on-premises]</i>	\$20.00/Day (1 Unit = 1 Day)	\$20.00/Day (1 Unit = 1 Day)
H0033*	HK	Oral medication administration, direct observation <i>[off-premises]</i>	\$30.00/Day (1 Unit = 1 Day)	\$30.00/Day (1 Unit = 1 Day)
T1016 <sup>^</sup>		Case Management, each 15 minutes	\$12.50/15 Minutes (1 Unit = 15 Minutes)	\$16.00/15 Minutes (1 Unit = 15 Minutes)
CDABF <sup>+</sup>		Family-involvement training family, each 15 minutes <i>[Family skill development for clients under the age of 21]</i>	\$12.50/15 Minutes (1 Unit = 15 Minutes)	\$17.00/15 Minutes (1 Unit = 15 Minutes)
CDAEP <sup>+</sup>		Social skills assistance, individual, each 15 minutes <i>[Individual skill development]</i>	\$12.50/15 Minutes (1 Unit = 15 Minutes)	\$17.00/15 Minutes (1 Unit = 15 Minutes)
CDAKQ <sup>+</sup>		Social skills assistance, group, each 15 minutes <i>[Group skill development]</i>	\$7.50/15 Minutes (1 Unit = 15 Minutes)	\$9.00/15 Minutes (1 Unit = 15 Minutes)
CDACM <sup>#</sup>		Coping skills development assistance, individual, each 15 minutes <i>[Recipient support services]</i>	\$5.00/15 Minutes (1 Unit = 15 Minutes)	\$8.75/15 Minutes (1 Unit = 15 Minutes)
CDBAP <sup>‡</sup>		Psychological testing brief assessment, each 15-minutes <i>[Functional assessment]</i>	\$12.50/15 Minutes (1 Unit = 15 Minutes)	\$17.00/15 Minutes (1 Unit = 15 Minutes)

\* Medication Administration: To be billed, medication administration must be rendered at least once on a given date and may be rendered multiple times during that day. Reimbursement is based on a daily rate code.

<sup>^</sup> Case Management: Maximum of 180 hours per calendar year

<sup>+</sup> Skill Development: Family Skill Development—maximum 180 hours per calendar year;  
Individual Skill Development—maximum 100 hours per calendar year;  
Group Skill Development—maximum 140 hours per calendar year

<sup>#</sup> Recipient Support Services: Maximum of sixteen 15-minute units hours per day, 1460 hours per calendar year

<sup>‡</sup> Functional Assessment: Maximum six hours per calendar year. Initial functional assessment—four hours.  
Semiannual functional assessment—one hour, two times per year.

**Note:** For complete definitions and guidelines for the above services, refer to *Healthcare Common Procedure Coding System (HCPCS)* and the *ABC Coding Manual for Integrative Healthcare*, as well as this section of the manual and Alaska Medical Assistance regulations. Complete service descriptions are also available at <http://www.hipa.samhsa.gov/hipaacodes2.htm>.

Updated 06/09

<sup>6</sup> ABC codes are copyright protected by Alternative Link, Inc., 2009, all rights reserved. Previous editions copyrighted 1999-2004.

**Table I-5(a). CPT<sup>7</sup> Procedure Codes:  
Adult's Clinic Services/Community Mental Health Clinic**

<b>CPT Code</b>	<b>CPT Brief Description</b>	<b>Maximum Allowable Before 12/26/2008</b>	<b>Maximum Allowable Effective 12/26/2008</b>
90801 <sup>^</sup>	Psy dx interview [Psychiatric assessment]	\$230.00/Assessment (1 Unit = 1 Assessment)	\$230.00/Assessment (1 Unit = 1 Assessment)
90802 <sup>^</sup>	Intac psy dx interview [Psychiatric assessment]	\$230.00/Assessment (1 Unit = 1 Assessment)	\$230.00/Assessment (1 Unit = 1 Assessment)
90804 <sup>*</sup>	Psytx, office, 20-30 min	\$40.00/30 Minutes (1 Unit = 30 Minutes)	\$50.00/30 Minutes (1 Unit = 30 Minutes)
90847 <sup>*</sup>	Family psytx w/patient	\$40.00/30 Minutes (1 Unit = 30 Minutes)	\$55.00/30 Minutes (1 Unit = 30 Minutes)
90849 <sup>*</sup>	Multiple family group psytx	\$22.50/30 Minutes (1 Unit = 30 Minutes)	\$28.00/30 Minutes (1 Unit = 30 Minutes)
90853 <sup>*</sup>	Group psychotherapy (per recipient)	\$22.50/30 Minutes (1 Unit = 30 Minutes)	\$28.00/30 Minutes (1 Unit = 30 Minutes)
90862 <sup>+</sup>	Medication management	\$75.00/Visit (1 Unit = 1 Visit)	\$75.00/Visit (1 Unit = 1 Visit)

<sup>^</sup> Psychiatric assessment (90801, 90802): Combined maximum of four assessments per calendar year

<sup>\*</sup> Individual, Group, and Family Psychotherapy: Combined limit of 10 hours per calendar year

<sup>+</sup> Pharmacologic Management: No more than one visit per week during the initial month following entry to a program, then no more than one visit per month unless there is an unusual reaction or if more frequent monitoring is required.

**Note:** For complete definitions and guidelines for the above services, please refer to the *American Medical Association Current Procedural Terminology*, previous subsections of this manual, and Alaska Medical Assistance regulations. Complete service descriptions are also available at <http://www.hipaa.samhsa.gov/hipaacodes2.htm>.

Updated 06/09

<sup>7</sup> CPT Codes and descriptions only are copyright 2009, American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply. Coverage and rates are subject to change.

**Table I-5(b). HCPCS and ABC<sup>8</sup> Procedure Codes:  
Adult's Clinic Services/Community Mental Health Clinic**

<b>Code</b>	<b>Description</b>	<b>Maximum Allowable Before 12/26/2008</b>	<b>Maximum Allowable Effective 12/26/2008</b>
H0031 <sup>^</sup>	Mental health assessment, by non-physician [Intake assessment]	\$21.25/15 Minutes (1 Unit = 15 Minutes)	\$24.00/15 Minutes (1 Unit = 15 Minutes)
S9484 <sup>*</sup>	Crisis intervention mental health services, per hour	\$75.00/1 Hour (1 Unit = 1 Hour)	\$92.00/1 Hour (1 Unit = 1 Hour)
CDBAQ <sup>#</sup>	Psychological testing comprehensive assessment, each 15 minutes	\$21.25/15 Minutes (1 Unit = 15 Minutes)	\$25.00/15 Minutes (1 Unit = 15 Minutes)
CDBAS <sup>+</sup>	Neuropsychological testing, each 15 minutes	\$21.25/15 Minutes (1 Unit = 15 Minutes)	\$25.00/15 Minutes (1 Unit = 15 Minutes)

<sup>^</sup> Intake Assessment: Initial intake assessment – three hours per admission. Semiannual intake assessment – one hour, two times per year, per admission. Requires prior authorization to assess for medical necessity if exceeds five hours annually

<sup>\*</sup> Crisis Intervention: Maximum of two hours per day for no more than 72 hours per psychiatric emergency; maximum 22 hours per calendar year

<sup>#</sup> Psychological Testing and Evaluation: Maximum six hours per calendar year

<sup>+</sup> Neuropsychological Testing and Evaluation: Maximum 12 hours per calendar year

**Note:** For complete definitions and guidelines for the above services, refer to *Healthcare Common Procedure Coding System (HCPCS)* and the *ABC Coding Manual for Integrative Healthcare*, as well as this section of the manual and Alaska Medical Assistance regulations. Complete service descriptions are also available at <http://www.hipaa.samhsa.gov/hipaacodes2.htm>.

Updated 06/09

<sup>8</sup> ABC codes are copyright protected by Alternative Link, Inc., 2009, all rights reserved. Previous editions copyrighted 1999-2004.

**Table I-5(c). HCPCS and ABC<sup>9</sup> Procedure Codes:  
Adult's Rehabilitation Services/Community Mental Health Clinic**

<b>Code</b>	<b>Modifier</b>	<b>Description</b>	<b>Maximum Allowable Before 12/26/2008</b>	<b>Maximum Allowable Effective 12/26/2008</b>
H0033*		Oral medication administration, direct observation [ <i>on-premises</i> ]	\$20.00/Day (1 Unit = 1 Day)	\$20.00/Day (1 Unit = 1 Day)
H0033*	HK	Oral medication administration, direct observation [ <i>off-premises</i> ]	\$30.00/Day (1 Unit = 1 Day)	\$30.00/Day (1 Unit = 1 Day)
T1016 <sup>^</sup>		Case Management, each 15 minutes	\$12.50/15 Minutes (1 Unit = 15 Minutes)	\$16.00/15 Minutes (1 Unit = 15 Minutes)
CDAEP <sup>+</sup>		Social skills assistance individual, each 15 minutes [ <i>Individual skill development</i> ]	\$12.50/15 Minutes (1 Unit = 15 Minutes)	\$17.00/15 Minutes (1 Unit = 15 Minutes)
CDAKQ <sup>+</sup>		Social skills assistance, group, each 15 minutes [ <i>Group skill development</i> ]	\$7.50/15 Minutes (1 Unit = 15 Minutes)	\$9.00/15 Minutes (1 Unit = 15 Minutes)
CDACM <sup>#</sup>		Coping skills development assistance, individual, each 15 minutes [ <i>Recipient support services</i> ]	\$5.00/15 Minutes (1 Unit = 15 Minutes)	\$8.75/15 Minutes (1 Unit = 15 Minutes)
CDBAP <sup>‡</sup>		Psychological testing brief assessment, each 15 minutes [ <i>Functional assessment</i> ]	\$12.50/15 Minutes (1 Unit = 15 Minutes)	\$17.00/15 Minutes (1 Unit = 15 Minutes)

\* Medication Administration: To be billed, medication administration must be rendered at least once on a given date and may be rendered multiple times during that day. Reimbursement is based on a daily rate code.

<sup>^</sup> Case Management: Maximum of 180 hours per calendar year

<sup>+</sup> Skill Development: Individual Skill Development—maximum 240 hours per calendar year;  
Group Skill Development—maximum 140 hours per calendar year.

<sup>#</sup> Recipient Support Services: Maximum of sixteen, 15-minute units per day, 1460 hours per calendar year

<sup>‡</sup> Functional Assessment: Maximum six hours per calendar year (initial functional assessment: four hours; semiannual functional assessment: one hour, two times per year)

**Note:** For complete definitions and guidelines for the above services, refer to *Healthcare Common Procedure Coding System (HCPCS)* and the *ABC Coding Manual for Integrative Healthcare*, as well as this section of the manual and Alaska Medical Assistance regulations. Complete service descriptions are also available at <http://www.hipaa.samhsa.gov/hipaacodes2.htm>.

Updated 06/09

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## Part B: Substance Abuse Services

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### Provider Participation Requirements

#### General

Eligible providers who enroll with the Division of Health Care Services (DHCS) can provide medically necessary services to Medical Assistance recipients. Enrolled providers are subject to the limits of Alaska state policy and must provide services within the guidelines and restrictions of the Medical Assistance program. *Section III* of this manual has additional general enrollment requirements.

*Updated 02/05*

#### Policy Clarifications

1. It is not envisioned that a physician provider is eligible to provide substance abuse rehabilitative services. Multiple office visits provided by a physician or physician collaborator for recipients presenting with substance abuse as a primary diagnosis are not reimbursable, where the office visits would otherwise constitute substance abuse rehabilitation services.
2. Any reimbursement for substance abuse rehabilitative services is made directly to the substance abuse rehabilitation treatment provider, rather than to a contracting entity, even if the contracting entity is approved by the Division of Behavioral Health to provide the service. (02/05)
3. Single date of service billing is required of all providers. "Single date of billing" means the procedure code billed represents no more than a single calendar day.

*Updated 07/07*

#### Substance Abuse Treatment Center

A nonprofit agency may enroll as a Substance Abuse Treatment Center when it has been approved by the Alaska Division of Behavioral Health to provide Substance Abuse Rehabilitative Services and has received grant funds from the Alaska Division of Behavioral Health. Providers must have the appropriate Clinical Laboratory Improvement Amendments (CLIA) certificate to be reimbursed for urinalysis procedures and diagnostic laboratory services.

*Updated 02/05*

#### Certified Contractors

A certified contractor rendering services for the Substance Abuse Treatment Center will not be directly reimbursed by Alaska Medical Assistance, even if the contractor is separately enrolled as a Medical Assistance provider.

For the Division of Health Care Services (DHCS) to reimburse a Substance Abuse Treatment Center for services contracted out, the contractor must:

- Be approved by the Alaska Division of Behavioral Health
- Be licensed as a medical professional in Alaska
- Perform the services within the scope of his/her licensure
- Meet the licensure requirement specified in Alaska state regulation under 7 AAC 43.746.

*Updated 02/05*



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### SUBSTANCE ABUSE TREATMENT SERVICES PRIOR AUTHORIZATION REQUEST

Effective 01/01/2010  
Page 1 of 2

#### Provider Information

1. Request Date

2. Provider Name

3. Provider ID

4. Contact Name and Address  
(decision will be returned to this address)

5. Phone No.

6. Fax No.

7. E-Mail Address

#### Recipient Information

8. Recipient Name

9. Date of Birth  10. Recipient ID

11. Gender:  Male  Female

12. Recipient Address

a. Private Home  b. Foster Home

c. Office of Children's Services Rehabilitation Home

d. Transitional/Supported Living Home

e. Residential Substance Abuse Treatment Center

f. Homeless/Shelter  g. Other-Explain:

13.  **New Request** Requested Dates: From:  Thru:

14.  **Update to existing PA** a. Update From:  Thru:  b. PA No.

(Required for PA updates only.)

#### Alcohol and/or Drug (Substance Abuse) Program or Treatment Services

Services	Code	Modifier	Unit	15. Units Req.	Rate	16. \$ Req.
Drug screen, qualitative/multi [Multiple drug].....	80100		1 screening	<input type="text"/>	+	<input type="text"/>
Medication management .....	90862		1 visit.....	<input type="text"/>	X \$75.00	<input type="text"/>
<i>Alcohol/drug/substance abuse treatment/ program/service...</i>						
• Individual substance abuse counseling .....	H2035	U6.....	15 min .....	<input type="text"/>	X \$17.00	<input type="text"/>
• Assessment [and diagnosis by substance abuse counselor].....	H0001		1 session.....	<input type="text"/>	X \$100.00	<input type="text"/>
• Group counseling by a clinician.....	H0005		15 min .....	<input type="text"/>	X \$9.00	<input type="text"/>
• Case management [care coordination].....	H0006		15 min .....	<input type="text"/>	X \$16.00	<input type="text"/>
• Acute detoxification [residential addiction program, outpatient].....	H0013		1 day .....	<input type="text"/>	X \$300.00	<input type="text"/>
• Intensive outpatient.....	H0015		15 min .....	<input type="text"/>	X \$17.00	<input type="text"/>
• Intervention service [intermediate service].....	H0022		15 min .....	<input type="text"/>	X \$17.00	<input type="text"/>
• Family/Couple counseling [family counseling].....	T1006		15 min .....	<input type="text"/>	X \$17.00	<input type="text"/>
• Skills development [rehabilitation treatment services].....	T1012		15 min .....	<input type="text"/>	X \$17.00	<input type="text"/>
17. Total \$ Requested						<input type="text"/>

Pages 1 and 2 of this request must be completed. Requests without both pages cannot be processed.

\*Per Medicare fee schedule.

\*CPT codes and descriptions are copyright 2009, American Medical Association. All rights reserved. Applicable FARS/DFARS apply. CPT code descriptions are shortened to 28 characters or less to comply with copyright restrictions. For full descriptions, please refer to your CPT book. Effective 1/1/10 Dates of Service.

**Pages 1 and 2 of this request must be completed. Requests without both pages cannot be processed.**

Provider Information	
Request Date	<input type="text"/>
Provider Name	<input type="text"/>

Recipient Information	
Recipient Name	<input type="text"/>
Recipient ID No.	<input type="text"/>

18. Client meets American Society of Addiction Medicine (ASAM) criteria for medical necessity as evidenced by:

ASAM Dimension	Level of Care	Criteria
1.	<input type="text"/>	<input type="text"/>
2.	<input type="text"/>	<input type="text"/>
3.	<input type="text"/>	<input type="text"/>
4.	<input type="text"/>	<input type="text"/>
5.	<input type="text"/>	<input type="text"/>
6.	<input type="text"/>	<input type="text"/>

By submission of this form, the provider:

- Affirms the assessment of the recipient's symptomatology and current level of functionality is documented in the recipient's record and indicates the units and duration of services requested are medically necessary,
- Affirms the recipient's record includes documentation of the clinical team recommendation of the requested services as medically necessary, and
- Acknowledges the services are subject to post-payment review for medical necessity and completeness of documentation according to Medicaid/Denali KidCare program rules.

The Department of Health and Social Services may recoup payment for any services that are not medically necessary, not properly documented, or not in compliance with Medicaid/Denali KidCare program rules.

19. Signature \_\_\_\_\_ Title \_\_\_\_\_

If this form requests more than \$10,000 of services in field 17, it must be approved by the Division of Behavioral Health (DBH) Treatment & Recovery staff before it is submitted to Affiliated Computer Services, Inc.

20. DBH Signature \_\_\_\_\_ Date \_\_\_\_\_



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## Substance Abuse Prior Authorization Request Instructions

**Submission Requirements:** This prior authorization (PA) form must be completed to indicate the amount of services requested beyond the service limitations set out in the Provider Billing Manual and must bear the signature of a person authorized to bind the requesting facility. **If field 17 (Total \$ Requested) is less than \$10,000, submit the request directly to Affiliated Computer Services, Inc. (ACS). If field 17 is \$10,000 or more, submit the request to your DBH Treatment and Recovery Regional Office.**

### Page 1:

1. **Request Date:** Enter the date that the authorization request is being submitted.
2. **Provider Name:** Enter the name of the enrolled substance abuse facility.
3. **Provider ID No.:** Enter the Medical Assistance identification number assigned to the substance abuse facility.
4. **Contact Name and Address:** Enter the name and address of the person ACS should contact regarding the authorization request. The authorization decision will be returned to the address entered here.
5. **Phone No.:** Enter the contact person's telephone number.
6. **Fax No.:** Enter the contact person's fax number, if applicable.
7. **E-Mail Address:** Enter the contact person's e-mail address, if applicable.
8. **Recipient Name:** Enter the name of the recipient for whom the authorization is being requested.
9. **Date of Birth:** Enter the recipient's date of birth.
10. **Recipient ID No.:** Enter the recipient's Medical Assistance identification number.
11. **Gender (recipient's):** Check appropriate box for male or female.
12. **Recipient Address:** Enter the recipient's address **and check the appropriate box** (a, b, c, d, e, f, or g).
13. **New Request:** Mark this box if the prior authorization request is a request to initially exceed the annual service limits identified in the Provider Billing Manual. Enter the dates requested for the initial prior authorization. Prior authorization requests will be accepted if requested for periods not to exceed 6 months and not to extend beyond the end of a calendar year.
14. **Update to existing PA:** Mark this box when:
  - Requesting an update to add additional units of service to the existing PA record referred to in Field 14b.
  - Adding services not already included in the existing PA record referred to in Field 14b.
  - Extending the "thru" date of the authorization period for the existing PA record referred to in Field 14b.
    - a. **Update:** Enter the "from" and "thru" dates for the authorization period being requested. Prior authorization requests will be accepted if requested for periods not to exceed 6 months and not to extend beyond the end of a calendar year.
    - b. **PA Number:** Enter the number of the PA record being updated.
15. **Units Req:** Enter the number of **additional units** of services being requested. Always use the lowest unit size available when entering the Units Required.
16. **\$ Req:** Multiply the units requested (field 15) by the maximum allowed dollar amount (Max \$).
17. **Total \$ Requested:** Enter the sum of the \$ Req column (field 16).

**Page 2:** Enter the request date, Provider name and ID number, Contact person and phone number, recipient name and ID number as entered on page 1. **If you do not enter this information, ACS may not be able to process your authorization.**

18. **Client meets American Society of Addiction Medicine (ASAM) criteria for medical necessity as evidenced by:** Indicate the clinical justification for the extension.
19. **Signature:** The signature must be by a person authorized to bind the facility to the completed form as accurate and subject to Medical Assistance program rules. Please include the title of the person signing the prior authorization request form.
20. **DBH Signature:** The DBH signature indicates DBH reviewed the form and may have discussed the request with the clinic staff for clarification. The signature does not indicate acceptance of the requested services or units as medically necessary. Medical necessity may be determined during a post-payment review according to Medical Assistance program rules. The division may recoup payment for any services that are not medically necessary, not properly documented, or not in compliance with Medical Assistance program rules.

## Transportation Authorization for Eligible Patients Needing Substance Abuse Treatment Services

All medically necessary non-emergency travel must be approved in advance and booked through the State Travel Office at 1-800-514-7123.

Transportation is a covered benefit for recipients in need of treatment for substance abuse if the services are not available in his or her home community and the need has been documented by a **referring agency**. In addition, treatment must be provided by a substance abuse treatment provider enrolled as a Medicaid provider (**receiving agency**).

Upon documenting the need for travel, the **referring agency** initiates the travel process:

1. The **referring agency** completes the Division of Behavioral Health (DBH) form entitled “Division of Behavioral-Medicaid Services-Travel Approval for Substance Abuse Patients” and faxes it to the designated Behavioral Health Specialist at (907) 465-2185. The name and fax number of the **receiving agency** must be included.
2. Upon authorization from the Division of Behavioral Health, the approved travel form is signed and faxed to Affiliated Computer Services, Inc. (ACS), to the **receiving agency**, and to the **referring agency**.
3. The **referring agency** calls ACS to complete the Medicaid Transportation Authorization & Invoice (AK-04).
4. The referring agency calls the State Travel Office at **1-800-514-7123** to book authorized travel.

If a child is accompanying a mother needing treatment, the Medical Assistance Program will pay for the mother’s transportation only. The child’s travel costs must be paid for from other sources, such as the DBH Travel Fund. (Forms for requesting DBH Travel Funds may be requested by calling the Behavioral Health Specialist at (907) 465-3370.)

The initial travel approval is for one-way travel only. When treatment has been completed, the **receiving agency** calls ACS for authorization for the patient to return home. **DBH approval for the patient to return home is NOT required.**

**Note:** If the patient does not travel, the referring counselor should notify ACS.

*Updated 06/09*

## Procedure Codes

Specific procedure codes must be used in completing the claim forms. See *Table I-7(a) and (b)* below.

**Table I-7(a) CPT Procedure Codes: Substance Abuse Rehabilitative Services**

Code	Description	Maximum Allowable Before 12/26/2008	Maximum Allowable Effective 12/26/2008
80100 <sup>12</sup>	Drug screen, qualitative/multi <i>[Multiple Drug]</i>	Medicare Fee Schedule	Medicare Fee Schedule (1 Unit = 1 drug screen)
90862 <sup>12</sup>	Medication management	\$35.00/Visit	\$75.00/Visit (1 Unit = 1 Visit)

**Note:** For complete definitions and guidelines for the above services, refer to the *American Medical Association Current Procedural Terminology*, previous subsections of this manual, and Alaska Medical Assistance regulations. Complete service descriptions are also available at <http://www.hipaa.samhsa.gov/hipaacodes2.htm>.

Updated 6/09

**Table I-7(b) HCPCS and ABC Procedure Codes: Substance Abuse Rehabilitative Services**

Code	Modifier	Description	Maximum Allowable Before 12/26/2008	Maximum Allowable Effective 12/26/2008
CDADK		Substance abuse treatment, individual, per 15 minutes <i>[Individual substance abuse counseling]</i> Combined maximum of 40 hours or 160 units per consecutive 12-month period for Individual, Group, and Family Counseling <sup>13</sup>	\$12.50/15 Minutes	\$17.00/15 Minutes (1 Unit = 15 Minutes)
H0001		Alcohol and/or drug assessment <i>[Assessment/Diagnosis by substance abuse counselor]</i> Maximum of 2 per consecutive 12-month period	\$50.00/Session	\$100.00/Session (1 Unit = 1 Session)
H0002		Behavioral health screening, to determine eligibility for admission to treatment program <i>[Medical Intake physical for non-methadone recipient]</i>	\$150.00	\$300.00/Visit (1 Unit = 1 Visit)
H0002	HF	Behavioral health screening to determine eligibility for admission to treatment program <i>[Medical evaluation for admission into methadone treatment]</i>	\$300.00	\$397.71/Visit (1 Unit = 1 Visit)
H0005		Alcohol and/or drug services; group counseling by a clinician <i>[Group substance abuse counseling]</i> Combined maximum of 40 hours or 160 units per consecutive 12-month period for Individual, Group, and Family Counseling <sup>13</sup>	\$5.00/15 Minutes	\$9.00/15 Minutes (1 Unit = 15 Minutes)
H0006		Alcohol and/or drug services; case management <i>[Care Coordination]</i> Each reimbursable contact must be at least 20 minutes in length and is limited to maximum of 8 hours in any consecutive 6-month period <sup>13</sup>	\$7.50/15 Minutes	\$16.00/15 Minutes (1 Unit = 15 Minutes)

<sup>12</sup>CPT codes and descriptions are copyright 2008, American Medical Association. All rights reserved. Applicable FARS/DFARS apply. CPT code descriptions are shortened to 28 characters or less to comply with copyright restrictions. For full descriptions, please refer to your CPT book. Complete service descriptions are also available at <http://www.hipaa.samhsa.gov/hipaacodes2.htm>.

<sup>13</sup>Counseling, care coordination, or rehabilitation treatment services are not reimbursable when rendered at the same time as intensive outpatient services or intermediate services.

Code	Modifier	Description	Maximum Allowable Before 12/26/2008	Maximum Allowable Effective 12/26/2008
H0013		Alcohol and/or drug services; acute detoxification ( <i>residential addiction program outpatient</i> ) <i>Immediate physiological stabilization - diagnosis and treatment for intoxication /withdrawal</i> . Stay must not be less than a 24 hour period and there can be no more than 12 admissions in consecutive 12-month period.	\$150.00 per Day	\$300.00/Day (1 Unit = 1 Day)
H0015		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 individual treatment plan, including assessment, counseling, crisis intervention, and activity therapies or education. <i>Intensive outpatient includes individual, family and group counseling, care coordination and rehabilitation treatment services.</i> ) Minimum 3 days or evenings/week, 8 to 12 hours or 32 to 48 units a week; not to exceed 8 consecutive weeks per consecutive 12-month period.	\$11.25/15 Minutes	\$17.00/15 Minutes (1 Unit = 15 Minutes)
H0020		Alcohol and/or drug services; methadone administration and/or service. <i>[Must be conducted by a physician, advanced nurse practitioner, physician's assistant, registered nurse or licensed practical nurse.]</i>	\$10.00/Visit	\$12.50/Visit (1 Unit = 1 Visit)
H0022		Alcohol and/or drug intervention service (planned facilitation) <i>[Intermediate Service includes individual, family and group counseling, care coordination, rehabilitation, and treatment services in a residential setting]</i> Maximum of 20 hours or 80 units per week; 8 weeks or 640 units per consecutive 12-month period <sup>13</sup>	\$12.50/15 minutes	\$17.00/15 Minutes (1 Unit = 15 Minutes)
T1006		Alcohol and/or substance abuse services, family/couple counseling <i>[Family substance abuse counseling]</i> Combined maximum of 40 hours or 160 units per consecutive 12-month period for Individual, Group, and Family Counseling <sup>13</sup>	\$11.25/15 Minutes	\$17.00/15 Minutes (1 Unit = 15 Minutes)
T1007		Alcohol and/or substance abuse services, treatment plan development and/or modification <i>[Treatment plan review for methadone recipient]</i>	\$30.00	\$75.00/Session (1 Unit = 1 Session)
T1012		Alcohol and/or substance abuse services, skills development <i>[Rehabilitation Treatment]</i> Maximum of 10 hours or 40 units per week; 40 hours or 160 units per consecutive 12-month period <sup>13</sup>	\$10.00/15 Minutes	\$17.00/15 Minutes (1 Unit = 15 Minutes)

**Note:** For complete definitions and guidelines for the above services, refer to *Healthcare Common Procedure Coding System (HCPCS)* and the *ABC Coding Manual for Integrative Healthcare* as well as this section of the manual and Alaska Medical Assistance regulations. Complete service descriptions are also available at <http://www.hipaa.samhsa.gov/hipaacodes2.htm>.

Updated 06/09