Provider Reference Guide

Appropriate Billing for HCPCS Code T1016 – Case Management

Overview

According to the **AHCCCS Covered Behavioral Health Services Guide**, HCPCS Code **T1016 - *Case management, each 15 minutes,*** is a supportive service to provide oversight and/or enhance and assist a member with identified treatment goals and monitor treatment effectiveness.
Activities may include:

- Assistance in maintaining, monitoring and modifying covered services as outlined in the member's service plan to address an identified clinical need;
- Brief telephone (place of service 02) or face-to-face interactions with a person, family or other involved member of the clinical team for the purpose of offering assistance in accessing an identified clinical service with the goal of addressing a clinical need to enhance or maintain the member's clinical functioning;
- Assistance in finding and connecting to necessary resources other than covered services to meet basic needs;
- Communication and coordination of care with the person's family, behavioral and general medical and dental health care providers, community resources, and other involved supports including educational, social, judicial, community and other State agencies;
- Coordination of care activities related to continuity of care between levels of care (e.g., inpatient to outpatient care) and across multiple services (e.g., personal assistant, nursing services and family counseling);
- Outreach and follow-up of crisis contacts and missed appointments;
- Participation in staffings, case conferences or other meetings with or without the person or their family participating; and
- Other activities as needed that address and or support the member with identified treatment needs.

Case management does not include:

- Administrative functions such as authorization of services and utilization review;
- Outreach and communication that is does not clinical in nature and directly related to the member's identified treatment needs, clinical presentation and access to services.
- Other covered services listed in the **AHCCCS Covered Behavioral Health Services Guide**.

Service Standards/Provider Qualifications

Case management services must be provided by individuals who are qualified behavioral health professionals, behavioral health technicians, or behavioral health paraprofessionals as defined in **9 A.A.C. 10**.

If case management services are not provided by behavioral health professionals, these services must be provided under their direction or supervision.

The following code modifiers may be billed with HCPC Code T1016:

- **T1016 HO**
  Case Management by Behavioral Health Professional - Office: Case management services (see general definition above for case management services) provided at the provider's work site.
  Provider Qualifications: Behavioral health professional
  Billing Unit: 15 minutes

- **T1016 HO**
  Case Management by Behavioral Health Professional - Out-of-Office: Case management services (see general definition above for case management services) provided at a person's place of residence or other out-of-office setting.
  Provider Qualifications: Behavioral health professional
  Billing Unit: 15 minutes

- **T1016 HN**
  Case Management - Office: Case management services (see general definition above for case management services) provided at the provider's work site.
  Provider Qualifications: Behavioral health technician or Behavioral health paraprofessional
  Billing Unit: 15 minutes

- **T1016 HN**
  Case Management - Out-of-Office: Case management services (see general definition above for case management services) provided at a person's place of residence or other out-of-office setting.

- **T1016 GT with Place of Service 02**
  Case Management – Telemedicine

- **T1016 with Place of Service 02**
  Case Management Telephonic
  Provider Qualifications: Behavioral health technician or behavioral health paraprofessional
  Billing Unit: 15 minutes

AHCCCS Billing Limitations

For case management services the following billing limitations apply:

- Case management services provided by a DLS licensed inpatient, residential or in a therapeutic/medical day program setting are included in the rate for those settings and cannot be billed separately. However, providers other than the inpatient, residential facility or day program can bill case management services provided to the person residing in and/or transitioning out of the inpatient or residential settings or who is receiving services in a day program.
- A single provider may not bill case management for any time associated with a therapeutic interaction, nor simultaneously with any other services.
- Multiple provider agencies may bill for this service during the same time period when more than one provider is simultaneously providing a case management service (e.g., a staffing). In addition, more than one individual within the same agency may bill for this service (e.g., individuals involved in transitioning a person from a residential level of care to a higher (subacute) or lower (outpatient) level of care, staff from each setting may bill case management when attending a staffing. When billing case management in this situation, each staff billing for the service must clearly document their participation in the staffing and unique contribution to the discussion as related to the member's treatment goal.
- Billing for case management is limited to individual providers who are directly involved with service provision to the person (e.g., when a clinical team comprised of multiple providers, physicians, nurses etc. meet to discuss current case plans).
- Transportation provided to an AHCCCS Behavioral Health Services enrolled member is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

Mercy Care Billing Requirements

As noted in the **AHCCCS Covered Behavioral Health Services Guide**, the initial 15 minute unit of service may be billed if 1 minute of service time is completed. Subsequent units of service may not be billed unless the service time exceeds the halfway point of the next 15 minute unit (second unit requires a minimum of 7.5 minutes).

Multiple case management services provided in one day billed under the same AHCCCS Provider ID must be rolled up into one claim line to avoid duplicate claim denials. The clarification that needs to be made is surrounding what units need to be rolled up and how to roll up those units.

Examples to help clarify:

- ***Two BHPs billing for case management on the same day.*** As BHPs (in most cases) will have their own AHCCCS Provider ID and will bill under their own ID, those services may be billed individually under each BHP's AHCCCS Provider ID and no roll up is needed. ***Please ensure that there is sufficient reason for more than one staff to be providing case management to the member within the same day (outside of staffings).***
- The same BHP/BHT/BHPP providing more than one case management service within the same day. Those service times should be rolled up when billed and the unit time guidelines should be followed. If more than one service is provided, but the service time for

subsequent units does not meet the halfway point requirements to bill additional units, then those additional units are not billable.

- Multiple BHTs/BHPPs billing case management under the clinic ID within the same day. As long as the services are well documented, the roll up for service times would not be necessary and individual units could be billed. ***Please ensure that there is sufficient reason for more than one staff to be providing case management to the member within the same day (outside of staffings).***

Please note that the above guidelines do not apply to crisis call centers.

T1016 - Case Management Review and Billing Concerns

It's important to note that Mercy Care may periodically audit provider billing practices by reviewing documentation to ascertain claims are being appropriately billed in accordance with Mercy Care and AHCCCS guidelines. Documentation must support appropriate billing for this code. If the documentation does not support the billing, additional administrative action may be taken, including the recoupment of the claim and potential reporting to AHCCCS.

Based on review of previous claims submitted and careful review of requested documentation, Mercy Care has identified several concerns that may help you avoid inappropriate billing including:

- Multiple case management services provided in one day billed under the same AHCCCS Provider ID must be rolled up into one claim line.
- Administrative functions are not to be billed under case management or any other code.
- Appointment reminders or services that do not include actual clinical intervention should not be billed as case management or any other code.
- Services provided for care coordination or other purposes that do not involve actual clinical intervention should still be documented as contact notes, but are not billable.
- Phone calls are considered an extension of the office and should be billed with the office place of service.
- Staffings should only be billed by individuals directly involved in the member's care and should only be billed for actual clinical discussion/intervention. Each individual needs to either write their own note or include their own notes within the body of the main note.
- Having one individual dictate the note and having others sign it with the inclusion of a line such as "I participated in this staffing" is not sufficient.
- Case management cannot be billed simultaneously with any other services.
- Emails can be used in limited circumstances, but the email must be included in the record and should not be the main method of communication with the member.
- Voice messages can be billed in limited circumstances. Asking for a return call or appointment reminders are not billable. There should be sufficient documentation to justify the need to bill for the voice message. Listening to voice messages cannot be billed.
- T1016 should not be used as a catch-all to bill for services not otherwise billable under other covered service codes.
- Quality of the service is what drives billing, not quantity.
- Simply because the service meets the time guidelines to bill does not mean it should be billed. The main key is not the time but the intent of the service. Is the intent of the service the delivery of a clinical service/assessment or an administrative function?

Appropriate documentation to support the billing of this service is required.

Appropriate and Inappropriate Scenarios That Support the Billing of HCPCS Code T1016

Please remember that accurate documentation must be made to justify billing for T1016. The following are different scenarios of documentation submitted by providers.

A patient is a no show for an appointment. An outreach call is made after the no show to assess safety and that call lasts two minutes.

If the case manager's intent is to outreach because the member missed an appointment and the case manager is asking about any increase in symptoms, immediate needs, status of medication refills, options for next appointment, scheduling the next appointment with confirmation from the member, transportation needs and any other needs between the phone call and next appointment, this detail would need to be in the documentation.

If the case manager calls to reschedule the appointment and asks the member if everything is OK, that does not substantiate billing T1016.

An SMI patient missed their injection today and the care team takes 3 minutes to assess if an amendment and pick up order is warranted.

Clinical intervention intent would be to talk to the member about missing the injection, assessment of symptoms and need for higher level of care, adherence to COT, reason for medications related to wellness, barriers in missing the injection and the plan to get the member in for his/her injection that day. Care coordination with the team related to amendment of a pick-up order would need to be discussed with clinical team/doctor, etc. This detail needs to be documented to bill for T1016.

A 3 minute call to assess an amendment seems too short. Since there is no further documentation, it would be inappropriate to bill for T1016.

Group facilitator calls the transportation company to set up transport for patient to and from group. The call lasts 4 minutes.

This is an administrative function and does not warrant billing for T1016 – case management.

Care coordinator calls the guardian to check on status and complete the CASII. Call lasts 5 minutes.

Is the care manager only asking and recording the CASII score/response from the guardian or is there a clinical intervention/discussion in completing the CASSII? What is the purpose of getting the CASII - clinical evaluation of the scores and responses of the guardian and plan of action. Detail would need to be provided.

Substance use patient has a dirty UA. Therapist, Care Coordinator, Nurse, and medical provider staff the case to discuss if patient should be detoxed. Staffing takes 2 minutes.

What is the clinical discussion occurring with the group? Dirty UA for what? What is the risk of the substance use, considerations of treatment referral and engagement plan with the

member? Why did the member relapse? What are the treatment topics being reviewed and discussed to determine the clinical recommendation of detox vs another intervention? This needs to be detailed in the notes to qualify for T1016 billing.

It's important to remember that time is not the final determining factor in billing T1016. Questions that need to be answered and documented are whether the service is medically necessary and why? The documentation needs to clearly document the need. The key to appropriate documentation is that the content of the note justifies the care coordination (intent of the activity, discussion and outcome as related to the treatment plan for the member).

In addition to the above, AHCCCS provides a **Case Management Services Guide** that provides specific scenarios and what you need to ask yourself in order to bill T1016 – Case Management.