The purpose of this change form is to highlight revisions to the Uniform Service Coding Standards (USCS) Manual. Unless otherwise noted, the State (HCPF and OBH) has agreed that it will accept coding provided under the previous edition through Dec 31, 2021. Providers must implement the Jan 2022 edition by Jan 1, 2022 for dates of service Jan 1st and thereafter, regardless of submission date.

Change	Reason for the Change
Merged OBH and Medicaid Coding Pages to create 1 page for each code.	The Coding Committee reviewed the details on each page and has ensured that any disparities between OBH and Medicaid were resolved as reflected in changes indicated below.
Created an OBH-only Coding Page Section at the end of the merged pages	To account for codes that are only covered by OBH but are still appropriate to keep in the manual.
Replaced the Technical Documentation guidance in section IX with expanded guidance language/details. This has now become Section X. Service Documentation Standards	To better clarify the purpose and scope of documentation, as well as the required elements needed for a clinical encounter.
Deleted the Documentation Standards section from each coding page. Added specific documentation guidance to the Notes Section of the page where necessary.	Seeking to reduce administrative burden in documentation, and to realign the manual to reflect Medicaid required standards. This removes the overly prescriptive details on each page and defers to clinical expertise for clinical care as scoped out in the updated Documentation section in the guidance pages.
Deleted E/M documentation standard: "Where time is significant to encounter, documentation that more than 50% of time spent with patient was used counseling and coordinating care is required (e.g., "20 minutes of the 30-minute encounter was used counseling/ coordinating care")"	When CMS issued new guidance for E/M codes in Jan 2021, the use of Time as a guide to select codes was addressed. This 50% standard is no longer indicated.
Moved the SUD Benefit Pages into alphanumeric order within the coding manual	Now that the benefit has been live for 1 year, the plan was to have these codes integrated into the manual like other codes.
Deleted "Refer to the Provider Enrollment Manual for enrollment requirements and procedures" From all SUD service coding pages	Now that the benefit has been live for 1 year, the reference to enrolling procedures is not necessary for these pages. This information is not on any other coding pages and is located elsewhere for providers.
Deleted the notes detailing timing on 3.2 WM Per Diem	This was an oversight when we deleted the 3.2 WM Partial Per Diem.
Changed QRTP POS to 56 (PRTC), removing 14 (Group Home)	To align with FFS POS and as a better indication of the level of care provided in a QRTP.
Deleted POS 55 (RSATF) from H0018 and H0019 Codes	Since the SUD residential codes have been added, and H0018 has explicitly stated it cannot be used for SUD primary diagnosis, this POS is not appropriate for these 2 residential codes.
Changed Title of "Provider Types" to "Service Providers"	This aligns with how this information is currently listed on the coding pages and we are looking to add a box for Medicaid Provider Types to the coding pages.

Inserted a Section for Provider Types	This section will be given more detail in the next edition as we look to add this information on the new coding pages.
Added CAT and CAS to coding pages 98966, 98967, 98968, H2017, H2018	With updated qualifications and scope of work for these credentials, these codes are appropriate for these providers.
Deleted Introductory paragraph for CACs that described the general service provider and restrictions, supervision, etc. This section now just has the description for a CAS and a CAT	This has been updated and is no longer accurate.
Deleted the red text regarding "if services performed by CAC provider, a primary SUD dx is required" on codes 99366, 99367, 99368, H0002, H0004, and H0025	This did not make sense on Medical Team Conference codes and is addressed in "scope of practice" guidance elsewhere in the manual.
Deleted "If this service is provided by a LAC or CAC, the service must be provided at a facility licensed by OBH, or under the supervision of a licensed physician or licensed practitioner of the healing arts (10 CCR 2505-10)" on H0002	This has been updated and is no longer accurate.
Deleted the H2036 coding page that was for OBH	This was an oversight when we added the Joint H2036 SUD pages in January.
Removed large charts from the guidance pages and converted them into Appendixes, in particular, Medicaid State Plan services, 1915 B3 services, Place of Service Codes, and Modifiers	To make the guidance pages narrative more coherent and allow for charted info to be referenced easily in the back of the manual
Reordered Appendixes to accommodate new information	There were blank Appendixes from previously deleted content and this provided a clean up to that section of the manual.
Deleted S3005, T1007, T1019, T1023 from Appendix I (OBH approved codes)	These codes were merged when Social Detox was merged into a new SUD code (H0010). This now creates alignment with OBH providers using the same codes as Medicaid SUD providers for Social Detox (3.2WM).
Added H1011 and H2034 to Appendix I	These codes were missing from the OBH approved list
Changed "Colorado Community Behavioral Health Program" and "Colorado Capitated Behavioral Health Benefit under the Accountable Care Collaborative (ACC)" Throughout the manual to align with new Managed Care rules and state statute that refers to these services as "the Statewide System of Community Behavioral Health Care". We then created the shorthand title of "Medicaid Capitated Behavioral Health Benefit" to be used throughout the manual.	The terms were intermixed throughout. This produces consistency in reference throughout the manual with rule and statute.
Added POS 10 to the POS list and noted in the Telemedicine guidance section for both HCPF and OBH.	Per CMS creating a new POS for Telehealth in a patient's home to be effective Jan 1, Implementation for April 4, 2021.
Deleted the "Exception" to the Telemedicine policy under the OBH guidance related to CYMHTA	This was outdated and was no longer accurate.

Added a definition of Medical Necessity in Section II	This was never included in the manual, but it is appropriate to define this term since services must be medically necessary to be reimbursed by Medicaid.
Deleted the "Manual Format" section under the introduction	Due to the changes that have been made in the manual over the last year, this section was no longer accurate or helpful.
Replaced all terms referring to a recipient of services with the term "member", and added a statement defining this in the introduction to address OBH service recipients	Multiple words including "patent" and "client" were used throughout. "member" reflects Medicaid's preferred language. OBH supports the change.
Split H0023 into 2 coding pages (Outreach and Drop-In)	This conforms with the guidelines to have separate coding pages for code/modifier combinations that provide distinct services.
OBH edited the paragraph language on Covered Diagnoses to remove the discussion of "non-targeted children".	This paragraph had outdated language/content.
Deleted the medical necessity criteria listed under Partial Hospitalization (Section VIII e. VI c.)	Now that we have inserted a formal definition of Medical Necessity for all services, this was no longer necessary.
Compiled and edited information related to Room and Board to bring specific guidance into one place in the manual in Section VIII g. I.	There were several sentences that addressed OBH, SUD, and general Room and Board, but none were complete. This creates one section to reference re: room and board coverage.
Added a statement in the Introduction to clarify this manual is not intended to be used as an audit tool.	To clarify and affirm the purpose of the manual is to establish common definitions, clarify covered services, and assist with standard coding practices.
Edited the Code Descriptions for most E/M codes	Per CMS/HCPCS issued updates
Moved Section IX (now XII) Coding Page Outline to the last section in the guidance pages	To connect it with the sample template page that sits just before the actual coding pages (for ease of reference)
Moved the Definition of a DHOH Interpreter from the Service Provider section to the OBH Code Page T1013 notes section	This is the only code that can be billed by this provider so putting these details on that coding page provides the information in the most appropriate location and does not create confusion that Medicaid will reimburse services for this service provider.
Edited the language under Certified/Registered Medical Assistant to include the CMA/RMA initials	To indicate this is a specific certification and is issued by an accredited school.
Added the general email address for questions about coding/guidance in the manual	To encourage providers/plans to bring their questions to one central location/HCPF staff person for response.