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 BHA) has agreed that it will accept coding provided under the previous edition through June 30, 2022. Providers must implement the July 2022 edition by July 1, 2022 for dates of service July 1st and thereafter, regardless of submission date.

Change	Reason for the Change
Coding Pages have been updated with new template	To modernize the coding manual and improve visual layout as well as update key categories of information
Removed the E/M codes from individual coding pages and placed them into an Appendix E – This was merged with former Appendix J related to E/M codes. Deleted Provider Types 37, 38, 63 from this appendix as "Specialty BH Providers"	To accommodate new page templates and the distinct information related to E/M codes that did not align with other pages. This appendix is explicit for E/M codes and only PT 35 and 64 can bill E/M codes to the RAEs.
Added specialty types for SUD residential providers to the Specialty BH Provider chart in Appendix E	These should have been added in January 2021 when the 1115 waiver was opened.
Merged former Appendix G (Revenue Codes) with Appendix D	To begin to mirror Exhibit I in the RAE contract where both sets of information are in one document.
Updated Appendix D to include current code descriptions (and mirrored language on each coding page). Deleted services indicated under State Plan (SP) and B3 services, and corrected Units. Added information on former appendices E and F (codes that must be billed to other payers before billing Medicaid.	This appendix had not been reviewed/edited in a long time and there were identified gaps/errors that needed to be addressed. Since SP/B3 info was moved, we used the existing columns to merge 2 other appendices information on this Appendix in order to streamline information.
Completely Revised Appendix C and include list of codes considered B3/Alternative Services	The info was deleted from Appendix D because there was no clear/consistent way these codes were indicated and it was agreed to move all the info to one place in one appendix.
Added section on Third Party Liability (bringing the language up from former Appendices E and F into the guidance pages)	To make this information clear (Medicaid is payer of last resort) and to provide a clear space to address the policy regarding non-Medicare eligible providers and the use of the HO modifier
Added the definition of Primary and Principal Diagnosis that is in RAE contract under Section III. Diagnoses	To continue to align definitions and language used under the Capitated BH Benefit between RAE and providers
Revised and added guidance under the Medicaid Enrollment subpoint under section V. Provider Types to define rendering providers, supervision, and to clarify newly licensed BH provider can bill under a supervising provider while they work through contracting with a RAE. Added expanded interpretation to include licensed providers hired at a group practice.	Added new information to address common questions received related to these topics. This language re: billing under supervising provider allowed for better continuity of care for providers who are serving members and transition from pre-licensure to licensure and contracting.
Guidance related to modifier FQ (audio only) was added to the Telemedicine Services subpoint	This is a new modifier from CMS
F64.0-9 have been added to the Mental Health Covered Diagnoses. The ICD-10-CM Code Ranges for Mental Health Covered Diagnoses chart was updated to reflect this change.	The Dept has decided to cover these diagnoses under the Capitated BH Benefit.

Added Unlicensed Masters/PHD level provider and Licensed Providers (LCSW, LPC, LMFT) to the Service Providers for Codes 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139. Also edited the notes section on each page to add language to ensure supervision for unlicensed providers, and a note that services must be within scope of practice for the licensed.	Clinically this was considered an appropriate/ reasonable inclusion and rectifies a gap from interns that graduate but are unlicensed.
Added Unlicensed Masters/PHD level provider to code 96146 and deleted all medical staff and licensed BH providers.	To align with notes on this page "If test is administered by a physician, other qualified health care professional, or technician…" to not use this code.
Removed 12 hour minimum from 3.2 WM	This detail was added when a partial per diem code was created, and not deleted when the partial per diem code was deleted. This is consistent with other per diem codes (no Min time indicated).
Changed the POS options on 3.2 WM to 21, 51, 55.	The previous POS were outpatient options, and this is explicit in the service title and service description.
Added POS 55 (RSATF) to Coding Pages H0020, H0033, H0034, 90785, 90792, 96116, 96121, 96130, 96131, 96372	These component services are allowed to be billed in SUD facilities in addition to the per diem. They were not built into the per diem rate as standard bundled services.
Added revenue code 0911 as a code covered under the Capitated BH Benefit for the billing by PRTFs	There was no appropriate code for residential services that allowed for room and board coverage. This is the same code used under FFS to allow for consistency.
Added revenue code 1002 in Appendix D (this is not a new code/expansion of coverage)	This code was referred to on 3.7 WM for hospitals but was not listed on the Revenue Code list explicitly. It has been in Appendix Q.
Added language re: Adding HO Modifier by LPC/LMFT/LAC for members with Medicare coverage	This policy was clarified with the RAEs and required to be operationalized effective July 1, 2022
Updated yellow highlighting on Appendix D to indicate which codes do not require a covered diagnosis	Highlighting had been deleted in previous editions. This updates/corrects what codes can be billed with a non-covered diagnosis.
Deleted Appendix I. CDHS OBH APPROVED PROCEDURE CODE LIST	OBH identified this appendix was no longer necessary now that the Medicaid/OBH coding pages were merged.
Deleted additional documentation details for code H2030 and H2031 (Clubhouse)	There were redundant standards for this service and the extra guidance was removed to eliminate administrative burden and non-required elements
Replaced all references to CHDS/OBH with the Behavioral Health Administration (BHA)	To reflect the official change in status/structure of state government
Created Appendix G: Provider Types	This is to provide a list of HCPF provider types to reference with the new section on the coding pages "Provider Types that can Bill"
Edited/pared down section on Service Categories, deleting significant content	This section was excessively detailed with information that was not helpful/necessary for providers. Removing this level of detail brings this section into alignment with the general overview of material

	presented throughout and is more appropriate for the intended audience.
Created Appendix L: Authorization and Claiming Workflow for Psychological and Neuropsychological testing	This workflow was reviewed and approved by the RAEs and has been added to navigate this nuanced process due to non-covered diagnosis.
Added Unlicensed Master's Level provider to codes 90875 and 90876	This was in response to a provider request and there is no clinical concerns to this addition. It is consistent with other similar codes