

**LBHP CHILD/ADOLESCENT LEVEL OF CARE ASSESSMENT,
BRIEF INTERVENTION AND REFERRAL PROCEDURE**

Code: H0031 TG

Unit Length: Event

Service Requirement

Definition. The service code modifier combination (H0031 TG) is being used for the LBHP Child Adolescent Level of Care Utilization System (CALOCUS®), Brief Intervention and Referral procedure which is an event code. This is a procedure for children who are in crisis and at risk of needing 24-hour observation and out of home treatment. One of the goals of the CALOCUS® process is for the assessor to use early interventions, including crisis interventions, to assist with maintaining the member in the community when clinically appropriate.

The Child Adolescent Level of Care Utilization System (CALOCUS®) was developed by the American Association of Community Psychiatrists (AACCP). The CALOCUS® instrument is a method of quantifying the clinical severity and service needs of children and adolescents. You may photocopy and use the CALOCUS® instrument in the original form. The manual for the CALOCUS® is available as a PDF:

http://communitypsychiatry.org/publications/clinical_and_administrative_tools_guidelines/CALOCUSv15.pdf

Target Population

Child (under the age of 21)

Documentation Requirements

OAC 317:30-5, Section 248.

Additional requirements:

Documentation should include the CALOCUS® scores, the composite score, and recommended CALOCUS® level, clinical summary, and all care management recommendations and activities.

Staffing Requirements

Qualified professionals, LBHPs that are individually contracted with OHCA, and have completed the CALOCUS® training. A copy of the CALOCUS® training certificate needs to be placed in the personnel file.

Service/Reimbursement Limitations

Procedure code clinical requirements:

1. **Crisis Intervention Services are included as a part of the procedure:** There needs to be documented efforts in CareConnection® and in the member's record to divert from a higher level of care by providing a crisis intervention services when medically necessary.
2. **CALOCUS®:** Documented completion of the CALOCUS® assessment tool.
3. **Care Management:** Documented completion of all care management activities. This includes referrals as needed and appropriate; monitoring of care; and follow up to ensure that the service recommendations have been successfully accessed and implemented by the member and guardian.

Crisis intervention services (CIS) procedure code (H2011):

- The LBHP is *not* allowed to bill the crisis intervention code (H2011) on the same day as the CALOCUS® Brief Intervention and Referral procedure code (H0031 TG). Billing both on the same day is considered a duplication of service because the CALOCUS® procedure code is an event code which also includes crisis intervention services if medically necessary.
- The CIS code does not require a prior authorization. The maximum for the CIS code is eight units per month and 40 units each 12 months per member.

Prior authorization steps:

1. The LBHP/CALOCUS® assessor needs to complete an initial request in CareConnection® for PG013. The request for the CALOCUS® needs to be listed in the LBHP's name (*not* the OPBH agency or the group name).
2. The CareConnection® request needs to remain in "saved status" until the CALOCUS® process has been completed in its entirety. Keeping the request in saved status allows the LBHP to enter subsequent updates in the record.
3. The request needs to include CALOCUS® scores, the composite score, and recommended CALOCUS® level, clinical summary, and all care management recommendations and activities.
4. The CAR, ASI or TASI is *not* required for this procedure. Please enter the following numbers in the CAR, ASI or TASI sections of the CDC *or* request form:
 - CAR: 99
 - ASI: 9
 - T-ASI: 9
5. Telephonic review with APS Healthcare (800)762-1560 within **48 hours** of the face to face assessment. The LBHP performing the assessment must be the person calling APS to discuss the case.
6. The authorization number will be issued in the LBHP's name, once all of the required clinical services for the CALOCUS®, Brief Intervention and Referral procedure code have been documented in CareConnection® and reported to the APS Healthcare reviewer telephonically.
7. The CALOCUS® assessor needs to make sure that the APS Healthcare reviewer issues the authorization for the correct bill date which is the actual face to face service date.

Inpatient care coordination requirements:

1. If the reviewer and the assessor decide hospitalization is needed, APS Healthcare will assist in locating an available inpatient bed and notify the hospital that the CALOCUS® assessor will be contacting them with the clinical information which was obtained from the CALOCUS® assessment. The APS Healthcare reviewer will give the assessor the hospital contact information, telephone number and the name of the individual who will be handling the intake/referral at the hospital.
2. The assessor contacts the hospital and provides the needed clinical information. The assessor will make arrangements to fax or send the CALOCUS® assessment information with the guardian to the hospital.
3. If the reviewer and assessor cannot agree on a level of care, the APS reviewer will staff the case with an APS physician for determination of the final disposition.
4. The assessor is required to provide follow up care as a part of the CALOCUS® care coordination service which includes insuring that the individual successfully made it to the inpatient program. If the client did not present at the hospital, the assessor must make at least three (3) attempts to contact the family and to notify APS of the circumstances.
5. Once the care coordination/follow up is completed, the CALOCUS® assessor needs to notify the APS reviewer of the outcome in order for the CALOCUS® authorization number to be issued.
6. The authorization needs to be issued for the actual face to face service date.

Outpatient care coordination requirements:

1. If outpatient level of care is determined to be appropriate, the APS Healthcare reviewer can assist the assessor in locating a nearby program that can meet the child's needs.
2. The assessor provides on going care management until the member has been successfully linked to their outpatient provider. The assessor is required to make the referral to the provider and to also make a follow up call to verify that outpatient services have been successfully initiated.
3. The final step in the care coordination process is to notify the APS reviewer of outcome. This is when the APS reviewer will issue the CALOCUS® authorization.

Billing guidelines:

1. The CALOCUS®, Brief Intervention and Referral procedure code is an event code. The CALOCUS® assessor needs to make sure that the APS Healthcare reviewer issues the authorization for the correct bill date which is the actual face to face service date.
2. An Individual contract with OHCA is required. All CALOCUS® assessors, who bill this procedure whether in private practice *or* with an outpatient behavioral health agency, need to be individually contracted with the OHCA. The

authorizations for this procedure are only issued to the individually contracted provider.

3. To inquire about individual contracts, contact provider enrollment at (800) 522-0114 option 5 or go to the website: www.okhca.org. Once at the website, look for the provider enrollment section. Individual contracts can be completed by clicking on the new contracts link.
4. Claims Processing: There are 3 ways to process claims.
 - Outpatient Behavioral Health Agency Contractor: The individually contracted provider is listed as the “rendering provider” on the claim. The OPBH agency is listed as the “pay to” on the claim.
 - Licensed Behavioral Health Practitioner Contractor: The individual contracted provider is listed as the “rendering provider” and the individual contracted provider is listed as the “pay to.”
 - Group or Clinic Contractor: The billing for the CALOCUS® can be completed under a clinic or group contract. This is different than an OPBH agency contract. The OPBH agency or LBHP would list the LBHP provider number in the “rendering section” of the claim, and the group or clinic provider number in the “pay to” section of the claim.
5. Important Contract Designation: The claim payment will go to the bank account listed on the “pay to” file and the income will report to the SSN/FEIN listed on that same file. If the individually contacted LBHP does not want to receive the payment, the contract needs to be set up as a “***no biller***.” For additional information regarding this option, please contact Provider Enrollment at OHCA (800) 522-0114 option 5.
6. EDI Venders: Please check your systems to insure that the individual provider number is listed in the rendering section of the claim.

Service Code Modifiers

First Position:

HE – Mental Health

HF – Substance Abuse

HV – Gambling

HH – Integrated MH&SA

Second Position:

TG – LBHP CALOCUS®, BRIEF INTERVENTION AND REFERRAL