Provider Reference Guide

Behavioral Health Covered Services

Overview

The Mercy Care Behavioral Health Covered Services Provider Reference Guide provides general information to our providers in lieu of the retirement of the AHCCCS Covered Behavioral Health Services Guide. Mercy Care has taken this opportunity to provide information focusing on certain codes that have proven to be confusing for providers in the past or that have been noted to be problematic from a billing or audit perspective.

Statement of Guidance

The Mercy Care Behavioral Health Covered Services Provider Reference Guide is provided for general information purposes only and is not a comprehensive, all-inclusive document of covered services. Please ensure that you continue to follow all other billing guidelines, including but not limited to, AHCCCS guidelines and policies, CMS guidelines and policies, NCCI edits, etc.

Billing for Services

Providers should review and ensure compliance with all federal, state and local laws, rules, regulations and standards. Providers shall review and comply with all Mercy Care documents, including the Mercy Care Provider Manual, Provider Notifications, Reference Materials and Guides, etc., as these are considered part of the provider's contract.

Services

Case Management

T1016 - Case management activities are intended to serve as a supportive service to assist members with their treatment goals, finding necessary resources, or coordination of care and substantive outreach.

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 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 that include clinically pertinent and substantive contact: Participation in staffings, case conferences or other meetings with or without the person or their family participating.
- 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 not clinical in nature and directly related to the member's identified treatment needs, clinical presentation and access to services.
- Services that may be more appropriately captured by other covered service codes.

Service Standards/Provider Qualifications:
Case management services are provided by individuals that are qualified behavioral health professionals, behavioral health technicians, or behavioral health paraprofessionals as defined in 9 A.A.C.10.

The following code and modifier combinations are eligible with T1016:

Behavioral Health Professional:

- **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. 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. Billing Unit: 15 minutes

Behavioral Health Technician/Paraprofessional:

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

Case management is available to bill via telehealth/telephonic platforms as well.
AHCCCS billing limitations:

- 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).
- Multiple case management services provided in one day billed under the same AHCCCS 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.

Mercy Care Billing Requirements

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.
- 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).

Skills Training

H2014 – Skills training and development, per 15 minutes - Specific, identifiable skills that must be well documented in the progress note and must be face-to-face. Observational activities or time periods are not billable.

- Activities should be based on coached skill, practiced skill, modeled skill.

The documentation must clearly note what skill is being worked on and how this correlates back to the goals on the member's treatment plan.

H2017 – Psychosocial rehabilitation services, per 15 minutes - Skills Training Over 8 Hours: Roll up code for multiple units of H2014 in one day that sum over 8 hours for an individual member within 24 hours.

Short-Term Residential

H0018 – Behavioral health, short-term residential (non-hospital residential treatment program), without room and board, per diem - This is an all-inclusive code that includes onsite behavioral health treatment, therapy and groups. Therapeutic services should not be separately billed, and members should not be taken off site for services unless indicated as a clinical need on the treatment plan.

- The residential agency should ensure that there is documentation for the full 24 hours on a daily basis. This is a 24-hour service and there should be documentation to note that the member is present during the full 24-hour period and that the member is receiving therapeutic treatment, not simply residing at the facility.
- Short-Term residential may be billed as long as the member is onsite at 11:59PM.

Non-Emergency Transportation

Please note that AHCCCS expects that the services are for covered medical and behavioral health services. Services should be limited to the cost of transporting the member to the nearest AHCCCS registered provider capable of meeting the member's needs. There may be exceptions related to member choice, etc., but in general, the transportation should be to the nearest AHCCCS registered provider as stated in the AHCCCS Medical Policy Manual, **310-BB - Transportation**.

> *"Transportation services involve the transporting of a person from one place to another to facilitate the receipt of, or benefit from, medically necessary covered behavioral health services, allowing the person to achieve their service plan goals."*

Please note that while this allows the person to receive transportation services to achieve their service plan goals, the services should be for medical necessary covered services and not simply to locations in which the member can benefit for their service plan goals. This could be argued to be anything or any location. Mercy Care is charged with being good stewards of federal and state funds and we should be cognizant of utilizing these services in the most conservative manner possible while still allowing the members to benefit from the needed covered services."

AHCCCS FFS Manual Chapter 14 states the following regarding loaded mileage:

"Non-emergency transportation providers must bill the number of trips and the number of loaded miles as units of service on the CMS 1500 claim form. Loaded mileage is defined as the distance traveled, measured in statute miles, with a recipient on board the vehicle and being transported to receive medically necessary AHCCCS covered services."

Provider Travel

A0160 – Non-emergency transportation per mile-case worker or social worker

- This code is for provider travel to provide a service where the member is located.
- The first 25 miles round-trip are included in the rate.
- If the provider travels to where the service is to be provided and the member is not available, this code cannot be billed.
- This code is not to be billed to drive to pick up a member.
- This code cannot be billed while the member is in the vehicle. That is loaded transportation which is noted below.

Loaded Transportation

A0120 - Non-emergency transportation; mini-bus, mountain area transports or other transportation systems

OR

A0100 - Non-emergency transportation; taxi

AND

S0215 – Non-emergency transportation mileage, per mile

For all providers, please note that **loaded transportation** services should be billed with both the appropriate base rate (A0100, A0120) and the associated mileage (S0215). Claims/encounters should not be submitted without both codes for loaded transportation services. Mileage and base rate does not begin until the member is in the vehicle with the driver. The transportation to pick-up the member is not billable in terms of mileage or time.

All non-emergency medical transport providers are required to use the AHCCCS Daily Trip

Report or set up their systems to include elements from the trip report as noted by **AHCCCS FFS Manual Chapter 14** (which states that it is the provider's responsibility to maintain documentation that supports each transport service claimed). The Mercy Care Provider Manual notes these requirements as well. Each NEMT service must have the following documentation noted:

- Complete transport service provider's name and address
- Printed name and signature of the driver who provided the service
- Vehicle identification (license # and state.)
- Vehicle type (car, van, wheelchair van, stretcher, etc.)
- Recipient's full name
- Recipient's AHCCCS ID#
- Recipient's date of birth
- Complete date of service, including month, day and year
- Complete address of pick up destination
- Time of pick up
- Odometer reading at pick up
- Complete address of drop off destination
- Time of drop off
- Odometer reading at drop off
- Type of trip – one way or round trip
- Escort name and relationship to recipient being transported
- Signature (or fingerprint) of recipient verifying services were rendered

AHCCCS does provide further clarification on the recipient signature. The following requirements should be noted:

- If the member is unable to sign or utilize a fingerprint, the parent/guardian, caretaker/escort or family member can sign for the member. The relationship to the member must be noted.
    - If the member that is unable to sign is traveling alone, the trip report may be signed by the provider at the medical or behavioral health service appointment.
    - Per the **AHCCCS FFS Manual Chapter 14** - Transportation, special considerations involving minors: *"In order for a member to sign for their own transportation, they must be either 18 years of age or older or an emancipated minor in accordance with A.R.S. §12- 2451 and §44-131. Emancipated minors must provide that they are emancipated, and then they may sign for their own transportation. Minors that are not emancipated must have their legal guardian sign for their transportation. If a member is a minor and has a minor child, only the legal guardian of the minor child may sign for their transportation" (Page 9)."*
- The driver can never sign for the member.

Please ensure that documentation for NEMT includes all items as noted above. Documentation via a spreadsheet or screenshots of maps does not capture all the required elements.

In terms of the base rate billed under A0120 – while AHCCCS allows 5 units of this service to be billed per day per member, Mercy Care strongly recommends that only 2 units of this service be billed per day – once at the initial pickup and the second unit when the loading occurs to take the member home. While there may be intermittent stops during the trip, there is not enough reason to bill those additional units as the intent is not to start the transportation over, but rather to simply reload the member to continue the trip.

We would also like to remind providers of our previous provider notice regarding NEMT over 100 miles. Any NEMT service over 100 miles will require submission of a trip ticket or EDI information noting the complete pick-up and drop off locations for review prior to payment. Any NEMT over 100 miles without the required documentation will result in a claim denial.

Please always ensure that the following eligibility and service guidelines are adhered to when providing NEMT services as noted in AHCCCS AMPM Manual Policy 310-BB on Transportation:

- Medically necessary NEMT is a covered benefit when members are transported by NEMT providers to and from **covered** physical or behavioral health services.
    - The NEMT is covered if the member is unable to provide or secure their own transportation and the member is either unable to access free transportation or it is unavailable to the member.
    - The location to which the member is transported should be to the nearest AHCCCS registered provider than can provide the needed service.
    - The member may be transported to obtain Medicare Part D covered prescriptions
    - The member may be transported to participate in local community-based programs identified by AHCCCS. These services should be noted in the member's treatment plan. The member should be transported to the closest program that can meet the members needs as noted on the treatment plan. AHCCCS has identified the eligible community-based programs in Attachment A of AMPM policy 310-BB and are noted below:
        - Alcoholics Anonymous (AA)
        - Narcotics Anonymous (NA)
        - Cocaine Anonymous
        - Crystal Meth Anonymous
        - Dual Recovery Anonymous
        - Heroin Anonymous
        - Marijuana Anonymous
        - Self-Management and Recovery Training (SMART Recovery)
        - National Alliance on Mental Illness (NAMI) Family Support

Refer to **AMPM Chapter 310-BB** for additional information regarding transportation services.
Refer to **AHCCCS FFS Provider Manual Chapter 14, Exhibit 14-1** for the AHCCCS Daily Trip Report for NEMT.
Refer to **AHCCCS FFS Provider Manual Chapter 14, Exhibit 14-2** for instructions on how to fill out the AHCCCS Daily Trip Report for NEMT.

As a reminder:

- Time the member is not in the vehicle is not billable for loaded transportation
- No shows are not billable
- Mileage should be accurate. Billable miles should correlate with Google map mileage or other similar platforms.

Employment services:

These services must be provided face-to-face. Please review **AHCCCS AMPM Manual - 310-B - Title XIX/XXI Behavioral Health Service Benefit**.

H2025 - Ongoing support to maintain employment such as face-to-face interaction in assisting in job tasks when needed and supportive counseling when intervention is needed.
H2027 - Pre-job training and development such as interview techniques, resume writing and assistance in finding employment.

- These services are billable only when direct intervention is done with the member. Observational activities are not billable. If the staff member accompanies the member to work or otherwise sits with the member, the only billable time is time when the staff is redirecting the member or providing a face-to-face service.

Peer Support Services:

H0038 - Peer services are to assist a member in utilizing and navigating the behavioral health system for things such as treatment planning, identifying needs and services as well as overcoming service barriers. Additionally, peer services can assist the member in understanding and coping with the stressors of their disability. Please review **AHCCCS AMPM Manual - 310-B - Title XIX/XXI Behavioral Health Service Benefit**.

H2016 - Comprehensive Community Support - peer services that are for 3 or more hours in duration.

- Service delivery is via an individual that has unique experience as a peer that has been a member themselves within the behavioral health system.
- Services may appear to overlap other services such as skills training, but the delivery is via a peer and the intent of the service is to assist the member in navigating or utilizing the behavioral health system.
- Please refer to 9 A.A.C. 10. A for peer definitions.

Behavioral Health Day Treatment Programs

These services must be a **regularly scheduled and structured** program related to and supported by the individual's compliant treatment plan. Members that present for drop-in services are ***not*** considered part of the day program.

Supervised Day Treatment		
Service Description	**Provider Qualifications**	**Provider Type**
• **H2012** - Includes services such as peer support, skills training or other services as indicated in the program description or curriculum. • **H2015** - Greater than 5 hours, up to 10 hours in duration. Includes services such as peer support, skills training or other services as indicated in the program description or curriculum.	• Behavioral Health Technician • Behavioral Health paraprofessional (as defined in 9 A.A.C.10)	• This program can be provided by both Community Service Agencies (CSA's) and DLS licensed behavioral health agencies.

Therapeutic Behavioral Health Day Treatment		
Service Description	**Provider Qualifications**	**Provider Type**
• **H2019** - Includes services such as peer support, skills training or other services as indicated in the program description or curriculum. • **H2020** - (Greater than 5 hours, up to 10 hours in duration. Includes services such as peer support, skills training or other services as indicated in the program description or curriculum.	• Behavioral Health Professional (as defined in 9 A.A.C.10)	• This program is required to be overseen by a licensed Behavioral Health Professional (BHP). • Must be provided by a DLS licensed behavioral health agency.

- Please note that day treatment program activities should not be unbundled or billed under individual procedure codes. The time period in which members are receiving day treatment services cannot also be used to bill other services or groups. This code represents all or most of what is done at the facility on a date of service.
- Services must be fully documented and not in check-list format.
- As a reminder, services are face-to-face. Time spent in observation is not billable.
- Please ensure that you have a written copy of the current and previous day program description and curriculum readily available.

Mental Health Assessment-Non-Physician:

H0031 - A comprehensive written report completed annually that is inclusive of a member's service/treatment plan. Please review **AHCCCS AMPM Manual - 310-B - Title XIX/XXI Behavioral Health Service Benefit** and R9-10-307, R9-10-308.

- Due to the high reimbursement rate, this per-diem code should generally only be billed once per year, except in special circumstances as notated on the member's treatment plan.
- Usage of this code is monitored to determine if there is potential abuse occurring.

Personal Care Services:

T1019 - Services include assisting a member to complete daily living tasks such as dressing/personal hygiene. This should not be used for general supervision.

T2020 – Per diem personal care services 12 hours or more

- Personal care cannot be utilized for general supervision.
    - Personal care for general supervision for DD/ALTCS members can be billed, but providers must document the need for this service.
- These services are not for a member that is inpatient, nursing facility or HCTC home. For these providers, the rate includes provision for personal care services, and this should not be billed separately.

Considerations

Factors such as eligibility status and funding may impact the provision and availability of behavioral health services.
Services should be billed in the most conservative manner possible. Keep in mind that not all services are billable and that not all time spent by staff is billable. Most services require face-to-face interaction with a member or family member. Supervision is not billable.
Start and stop times are required on every progress note.
The initial 15-minute unit of service may only 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).
As a reminder, when considering outings with members, transportation is only allowed to and from AHCCCS covered locations. Pleases refer to page 9 of this document or **Attachment A of Policy 310-BB**.
Mercy Care does accept claims billed in a date span, however, the manner in which this should be billed differs depending on the type of code billed. The National Uniform Claim Committee provides instructions on how to bill on the 1500 claim form. These instructions include the following guidance:

- The number of days billed ***must*** correspond with the number of units in box 24G on the 1500 claim form.

The following examples note the appropriate way to bill for date spans:

- For codes that are billed in 15-minute increments, billing through a date span is not appropriate, whether the dates are consecutive or not. The number of units in box 24G do not correspond directly to the number of dates billed in the date span.

The claim can be billed as a multi-line claim with a line for each date with its own unique units.

- For per diem codes that are billed as 1 unit per day, a date span may be utilized only if the claim is for every day in the month (units should be equally divisible by the number of days billed within the date span) or billed for consecutive dates and the units are equally divisible by the number of days billed.

If the claim is billed for less than the full month, the claim would need to be split.
Mercy Care has taken this opportunity to provide information focusing on certain codes that have proven to be confusing for providers in the past or that have been noted to be problematic from a billing or audit perspective. Providers may refer to their contract and fee schedules for assistance on other codes not listed.

References
For further clarification regarding Mercy Care's policies, please review the provider manual and other referenced materials including the following Arizona Administrative Codes:
Arizona Administrative Code Article 3. Behavioral health Inpatient Facilities
Arizona Administrative Code Article 7 Behavioral Health Residential Facilities
Arizona Administrative Code Article 13 Behavioral health specialized transitional Facility
Arizona Administrative Code Article 14 Substance Abuse Transitional Facilities
Arizona Administrative Code Article 13 Behavioral health specialized transitional Facility
Arizona Administrative Code Article 16 Behavioral Health Respite Homes
Arizona Administrative Code R9-10-517 Behavioral Care
For AHCCCS Coding References:
https://www.azahcccs.gov/PlansProviders/MedicalCodingResources.html
https://www.azahcccs.gov/shared/MedicalPolicyManual/
AMA's CPT Guide (Current Procedural Terminology) contains nationally recognized service codes. For more information regarding these codes see the *AMA's CPT Guide (Current Procedural Terminology),* **https://www.ama-assn.org/practice-management/cpt-current-procedural-terminology?-process-how-code-becomes-code**, which contains a systematic listing and coding of procedures and services, such as surgical, diagnostic or therapeutic procedures.
Healthcare Common Procedure Coding System (HCPCS) contains nationally recognized service codes. For more information regarding these codes see the *Healthcare Common Procedure Coding System (HCPCS) Manual.*