This document now includes an appendix which details the decisions of the FY16 efforts of the Encounter Reporting and Financial Work Group, which is a subgroup of EDIT. The Appendix provides detailed guidance on reporting and costing for the following services:

- Community Living Support (H2016) and Personal Care (T1020)
- Community Living Support in an Unlicensed In-Home Setting (H0043 and H2015)
- Community Living Support for Daytime Activity (H2015)
- Crisis Intervention (H2011) and Pre-Admission Screening (T1023)
- Psychiatric Inpatient in a Local Hospital
- Transportation for Day-Time Activity

The appendix also includes a section on reporting rules for ***services that occur at the same time.***

PIHP/CMHSP ENCOUNTER REPORTING
HCPCS and REVENUE CODES

GENERAL RULES FOR REPORTING

1. Rounding rules for unit reporting:

- "Up to 15 minutes"
  - 1-15=1 unit
  - 16-30=2 units
  - 31-45=3 units
  - 46-60=4 units
  - 61-75=5 units
  - 76-90=6 units
  - 91-105=7 units
  - 106-120=8 units
- 15 minutes
  - 1-14 minutes=0*
  - 15-29=1 unit
  - 30-44=2 units
  - 45-59=3 units
  - 60-74=4 units
  - 75-89=5 units
  - 90-104=6 units
  - 105-119=7 units
  - 120=134=8 units
- 30 minutes
  - 0-29 minutes=0*
  - 30-59 minutes=1 unit
  - 60-89 minutes=2 units
- 45 minutes
  - 0-44 minutes=0*
  - 45-89=1 unit
  - 90-134=2 units
  - 135-179=3 units
- 60 minutes
  - 1-59 min=0*
  - 60-119 min=1 unit
  - 120-179 min=2 units
  - 180-239 min=3 units
  - 240-299 min=4 units
  - 300-359 min=5 units
  - 360-419 min=6 units
  - 420-479 min=7 units
  - 480-539 min=8 units

*Do not report if units = 0

Directions for ABA service CPT codes (Note: a unit of time is attained when the mid-point is passed):
1. Select the service (see American Medical Association CPT code descriptions)
2. Report an untimed service (codes 0359T, 0370T-0372T) with 1 code regardless of the duration of the service
3. Report a timed service (codes 0362T-0369T, 0373T, 0374T) based on face-to-face time on the date of service
4. The timed codes are all paired, with the first 30 (16-45) or 60 (31-75) minutes of service reported with the first code and successive 30 minute increments on the same date reported with the second code. Example: Adaptive behavior treatment by protocol (codes 0364T, 0365T) with face-to face technician time of 115 minutes: Report 1 unit of 0364T and 3 units of 0365T

2. Encounters and contacts (face-to-face) that are interrupted during the day: report one encounter; encounters and contacts for evaluations, assessments and Behavior Management committee that are interrupted and span more than one day: report one encounter or contact

3. Face-to-face

All procedures are face-to-face with consumer, except ABA Family Behavior Treatment Guidance, Adaptive Equipment, Behavior Treatment Plan Review, Environmental Modifications, Fiscal Intermediary, Goods and Services, Housing Assistance and Substance Use Disorder Case Management (H0006). Family Training, Family Psycho-Education, and Family Therapy must be face-to-face with a family member. Prevention (Direct Models), Home-based, and Wraparound must be face-to-face with consumer or family member.

4. Modifiers:

AH: Clinical Psychologist provider (must be used for ABA services when a clinical psychologist provides the service)
AJ: Clinical Social Worker provider (must be used for ABA services when a clinical social worker provides the service)
AM: Family psycho-education provided as part of ACT activities
GT: Telemedicine was provided via video-conferencing face-to-face with the beneficiary. For ABA telepractice only for 0368T, 0369T, and 0370T pre-authorized by MDHHS.
H9: Assisted Outpatient Treatment (AOT)
HA: Parent Management Training Oregon model with Home-based, Family Training, and Mental Health therapies (Evidence Based Practice only)
HA: Substance Use Disorder: Child – Adolescent Program (services designed for persons under the age of 18)
HB: Substance Use Disorder: Adult Program – Non-Geriatric (services designed for persons age 18-64)
HC: Substance Use Disorder: Geriatric Program (services designed for adults age 65 and older)
HD: Substance Use Disorder: Women's Specialty Services – pregnant/parenting women program (services provided in a program that treats pregnant women or women with dependent children)
HE*: Certified Peer Specialist provided or assisted with a covered service such as (but not limited to) ACT, CLS, skill-building, and supported employment
HF: With HCPCS or CPT code for any Substance Use Disorder Treatment service that has the same code as a Mental Health services
HG: Substance Use Disorder: Opioid Addiction Treatment Program
HH: Integrated service provided to an individual with co-occurring disorder (MH/SA) (See 2/16/07 Barrie/Allen memo for further instructions)
HH TG: SAMHSA-approved Evidence Based Practice for Co-occurring Disorders: Integrated Dual Disorder Treatment is provided.

HI*: Peer Mentor provided or assisted with a covered service such as (but not limited to) CLS, skill-building and supported employment
HM: With Family Training (S5111) when provided by a trained parent using the MDHHS endorsed curriculum
HJ: Substance Use Disorder: Employee Assistance Program
HK: Beneficiary is HSW enrolled and is receiving an HSW covered service
HN: Bachelor's degree level provider (must be used for ABA services when provider with a Bachelor's degree provides the service**)**
HO: Master's degree level provider (must be used for ABA services when a provider with a Master's degree provides the service**)**
HP: Doctoral degree level provider (must be used for ABA services when a provider with a Doctoral degree provides the service**)**
HQ: Substance Use Disorder: Group Setting (services provided to more than one client in a single treatment event, such that the clients have no particular relationship)
HR: Substance Use Disorder: Family/Couple with Client Present
HS: Family models when beneficiary is not present during the session but family is present
HW: With H0031 for Support Intensity Scale (SIS) face-to-face assessment
QJ: Beneficiary received a service while incarcerated
SE: With T1017 for Nursing Facility Mental Health Monitoring to distinguish from targeted case management
ST: With family training**,** Home-based (H0036), mental health therapy, or trauma assessment when providing Trauma-focused Cognitive Behavioral Therapy (pre-approved by MDHHS)
TD: Registered nurse provided Respite
TE: Licensed practical nurse provided Respite
TF: with ABA Focused Behavioral Intervention (FBI) services; with H0043 average 3-10 hours/day.
TG: With Supported Employment (H2023) to designate evidence-based practice model; with ABA Comprehensive Behavioral Intervention (CBI) services; with H0043 more than an average 10 hours/day
TJ: Program Group, Child and/or Adolescent (group setting)
TS: Monitoring treatment plans with codes for Behavior Treatment Plan-Review (H2000) and Treatment Planning (H0032). Monitoring of behavior treatment (H2000) does not need to be face-to-face with consumer, monitoring of other clinical treatment (H0032) does.
TT: Multiple people are served face-to-face simultaneously with codes for Community Living Supports (H2015 only), Home-based – multiple families (H0036), Out-of-home Non-voc/skill building (H2014), Private Duty Nursing (S9123, S9124, T1000), Dialectical Behavior Therapy (H2019), Peer Specialist (H0038), Peer Mentor H0046), Respite (T1005), and Supported Employment (H2023)
U5: Modifier for ABA must be reported on all encounters covered by the EPSDT Autism Benefit (i.e., ASD diagnostic evaluations, ABA eligibility assessments, ABA CPT codes, and ABA re-evaluations)

*HE and HI modifiers are used **only** when a certified peer specialist or peer mentor provides or assists with a covered service to a beneficiary. Do not use these modifiers with the procedure codes for the activities performed by a peer under the coverage "Peer-Delivered."

5. Add-On Codes: These codes may not be reported alone – they will be rejected. The add-on codes typically used by Michigan's public mental health system are listed below with the procedure codes they should accompany.

- 90785 interactive complexity used with 90791 or 90792 psychiatric evaluation, *99201-99215, *99304-99310, *99324-99328, *99334-99337, *99341-99350 evaluation and management; 90832, 90834, 90837, 90853 mental health therapy; 90832 HF, 90834 HF, 90837 HF substance use disorder interactive individual psychotherapy, 90853 HF substance use disorder interactive group psychotherapy. ***Note:** do not use on Evaluation and Management (E&M) codes unless psychotherapy services were provided.
- 90833 (30 min), 90836 (45 min) and 90838 (60 min) with evaluation management and psychotherapy
- 90840 psychotherapy for crisis, each additional 30 min with ~~H2011~~ 90839 crisis intervention

GENERAL COSTING CONSIDERATION RULES

First consult the Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, when considering the activities to report and the activities that may be covered in the costs of a Medicaid service.

1. Reporting EPSDT (Early Periodic Screening, Diagnosis and Testing) Services.

Effective October 1, 2010, the Centers for Medicare and Medicaid Services (CMS) instructed Michigan that certain 1915(b)(3) services should be characterized as EPSDT services for individuals who were under 21 years of age on the date of service. Therefore, beginning with the FY'11 Medicaid Utilization and Net Cost Report, PIHPs must report these EPSDT services as unique units and costs in a separate column. This change does not impact reporting of encounters. On this chart, EPSDT services are noted in the column "Coverage."

2. Allocating costs for indirect activities and collateral contacts:

Reporting only occurs when a face-to-face contact with the consumer takes place, except for Behavior Treatment Plan Reviews, Family Training, Family Psycho-Education, Family Therapy**,** Fiscal intermediary, Prevention (direct Models) , Home-based, and Wraparound. The costs of other indirect and collateral activities performed by staff on behalf of the consumer are incorporated into the unit costs of the direct activities. The method(s) used to allocate indirect costs to the services should comply with the requirements of Office of Management and Budget Circular A-2 CFR 200 Subpart E Principles.

- Examples of indirect or collateral activities are: writing progress notes, telephoning community resources, talking to family members, telephone contact with consumer, case review with other treatment staff, travel time to visit consumer, etc.

- Special consideration needs to be given to the indirect activities associated with occupational and physical therapy, health services, and treatment planning. Refer to those services within this document for additional guidance.

Other costs to consider including in the cost of the service, where allowed:

Professional and support staff, facility, equipment, staff travel, consumer transportation, contract services, supplies and materials (unless otherwise noted)

3. Medicaid coverage rules for Child Caring Institutions (CCIs): , Services provided to children with serious emotional disturbance (SED) in general Child Caring Institutions (CCIs) many not be funded by Medicaid, unless it is for the purpose of transitioning a child out of an institutional setting (CCI). Children enrolled in, and receiving services funded by, the Habilitation Supports Waiver may not reside in a CCI. However, other children with developmental disabilities and children with substance use disorders may receive Medicaid-funded services in CCIs; and children with SED may receive Medicaid-funded services in Children's Therapeutic Group Homes, a sub-category of CCI licensure.

4. Coverage under Healthy Michigan for Individuals with Substance Use Disorders Only (SUD only): Healthy Michigan coverage is available for a wide array of specialty behavioral health services for individuals with SUD who do not also have a mental illness or an intellectual or developmental disability. All services in the specialty behavioral health array are available to "SUD only" consumers under the Healthy Michigan benefit except the following services: Community Inpatient (revenue codes 0100, 0114,0124,0134,0154); services related to electroconvulsive therapy (revenue codes: 0370, 0710, 0901, CPT: 00104, 90870); inpatient partial hospitalization (0912, 0913); Family Psycho-education (90849, 90849-HS, G0177, S5110, T1015); Nursing Facility E&M (99304-99310); Supports Intensity Scale (SIS) assessment (H0031-HW); Assertive Community Treatment (H0039); I/DD peer mentor (H0046); Medication Algorithm EBP (H2010); Dialectical Behavioral Therapy (H2019); Wraparound (H2021); Supported Employment Services (H2023); Illness Management and Recovery - EBP (H2027); Clubhouse/Psychosocial Rehabilitation (H2030); Home-based services (H2033); Family home care training (S5111); Family Training Oregon Model (S5111-HA); Personal Emergency Response System (S5160); Nursing Home Mental Health Monitoring (T1017 – SE); Private Duty Nursing (S9123, S9124, T1000); and Out-of-Home Prevocational Services (T2015).

DUPLICATE THRESHOLDS

MDHHS has established expected thresholds for the maximum number of units that could be provided to a beneficiary for a procedure code on a date of service. When the reported number of units exceeds the threshold, it is interpreted as evidence of an error of duplicated entry of units. The duplicate threshold is noted in this chart as "DT" and refers to the maximum number of units expected to be provided in one day. Not all procedure codes have DTs.

PLACE OF SERVICE CODES

MDHHS requires that beginning with dates of service that occurred October 1, 2012 and thereafter, place of service codes are reported along with encounters. Below is a chart of place of service codes and the typical Medicaid covered services that are likely to be delivered in each place.

Code	Place of Service	*Typical* Covered Specialty Services & Supports (list is not exclusive)
03	School	Prevention, case management/supports coordination, + co-located services, home-based, wraparound facilitation and non-educational therapy.
02	Telehealth	The location where health services and health related services are provided or received, through a telecommunication system. (Effective January 1, 2017). Note: Do not use this POS with the Q3014 site facility fee code. Also note that according to CMS this should not be used for the originating/ hub site; it should be used at the distant site only.
04	Homeless shelter	Assessments, case management/supports coordination, mental health therapy, + co-located services
05	Indian Health Services	Co-located services
06	Indian Health Service provider-based facility	Co-located services
07	Tribal 638 freestanding facility	Co-located services
08	Tribal 638 Provider-based facility	Co-located services
09	Prison/correctional facility	General fund services only
11	Office	Any outpatient service (including ACT)
12	Home	CLS, Skill-building, case management/supports coordination, family training, respite
14	Group home (specialized residential AFC)	CLS, personal care, respite care, skill-building, case management/supports coordination
15	Mobile unit	Some ACT teams, some crisis teams Note: this is rarely used
16	Temporary lodging	CLS,
21	Inpatient hospital (primary care)	Case management provided as part of discharge planning
23	Emergency room - hospital	Co-located services
31	Skilled nursing facility	Nursing home mental health monitoring
32	Nursing facility	Nursing home mental health monitoring

PIHP/CMHSP ENCOUNTER REPORTING
HCPCS and REVENUE CODES

Code	Place of Service	*Typical* Covered Specialty Services & Supports (list is not exclusive)
33	Custodial care facility (General AFC)	Case management/supports coordination,
34	Hospice	Case management/supports coordination, mental health therapy
41	Ambulance – land	Transportation
42	Ambulance – air or water	Transportation
49	Independent clinic (primary care)	Co-located services
50	Federally qualified health center	Co-located services
51	Inpatient psychiatric facility	Mental Health inpatient services, case management provided as part of discharge planning
52	Psychiatric facility-partial hospitalization	Partial hospitalization service
55	Residential substance use disorder (SUD) treatment facility	Residential SUD treatment
56	Psychiatric residential treatment center	Crisis residential services
57	Non-residential SUD treatment facility	Outpatient SUD services
61	Comprehensive inpatient rehabilitation facility	Co-located services
71	State or local public health clinic	Co-located services
72	Rural health clinic	Co-located services
99	Other place of service not identified above	CLS, skill-building, ACT, supported employment provided in community settings (e.g. homeless shelter)

Note: Co-located services do not require the full set of Quality Improvement BH-TEDS data. Please refer to MDCH/PIHP and CMHSP contract for more details

CODING FOR AUTISM BEHAVIORAL HEALTH AND APPLIED BEHAVIOR ANALYSIS SERVICES

Applied Behavior Analysis (ABA) services are limited to children up to 21 years of age (i.e. eligibility to 21st birthday) who are assessed to have autism spectrum disorder and who are eligible for the services as determined by a qualified licensed practitioner.

1. U5 modifier must be reported on all encounters covered by the EPSDT Autism Benefit (i.e. ASD diagnostic evaluations, ABA eligibility assessments, ABA CPT codes, and ABA re-evaluations).
2. The level of provider is identified by use of a modifier and is mandatory on all codes associated with ABA. Use only one modifier that most closely reflects the credentials of the provider: AH to identify clinical psychologist provider; AJ to identify clinical social work provider; HN to identify bachelor's degree BCaBA provider; HO for other master's degree provider; and HP for other doctoral level degree provider. No modifier for aide-level/behavior technician (BT) providing ABA.
3. TG modifier must be reported on all Comprehensive Behavioral Intervention (CBI) encounters (i.e. 16 or more hours of ABA per week).
4. TF modifier must be reported on all Focused Behavioral Intervention (FBI) encounters (i.e. 15 or less hours of ABA per week).
5. You do not have to use TT for CPT codes 0366T, 0367T, 0371T, or 0372T as the service encounter for those codes identifies that the service is being provided to more than one individual.
6. GT modifier must be reported on all encounters if MDHHS has prior authorized tele-practice services. Tele-practice is ONLY approved for 1. clinical observation and direction or 2. family training/guidance with one family (no TT/group option via tele-practice).
7. 0368T, + 0369T (clinical observation and direction) must be reported face-to-face simultaneously with a BT delivering direct hands-on ABA service with an individual (i.e. 0364T, 0365T, 0366T, 0367T, and 0373T, 0374T ABA service codes).
8. All ABA service encounters must include place of service codes (i.e. home, office, school, other, etc.). Use office place of service code to indicated center-based ABA services. ABA, like other Medicaid services (i.e. CLS), can be delivered in CCI's for individuals with I/DD if medically necessary.

ABA-Diagnostic/Eligibility Determination

ABA Services	HCPCS Code	Mandatory Modifier	Provider Type
Assessments and evaluations to determine eligibility for ABA A comprehensive diagnostic evaluation must be performed before ABA services can start. The evaluation is a neurodevelopmental review of cognitive, behavioral, emotional, adaptive, and social functioning using validated evaluation tools. Based on the evaluation, a practitioner will determine diagnosis, recommend general ASD service options, and refer the child for further ABA behavioral assessment if recommended for the individual.	90791, 90792 , 90785, 96101, 96102, 96118, and 96119 H0031	U5, provider level U5, provider level U5, provider level	Qualified licensed practitioner working within their scope of practice and who is qualified and experienced in diagnosing ASD.

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
ABA Behavior Identification Assessment	**0359T**	Behavior identification assessment by a qualified provider face to face with the individual and caregiver (s); includes interpretation of results and development of the behavioral plan of care. Modifier U5 and Provider Level	Encounter	Line Professional	EPDST State Plan	May include intake review of documents, interview with parents (i.e. behavioral history, current status), child observation, discussion of findings and recommendations with the parent/guardian(s)/individual. Administration of skill assessment tool face-to-face with the individual. Assessment tool examples include, but are not limited to: ABLLS-R, VB-MAPP, AFLS, etc. These tools are required every six months. Report one encounter for all listed activities. Encounter should be submitted after the completion of all activities using the first face-to-face contact as the date of service. Note: This process is similar to reporting for psychological assessments (i.e. administration of a standardized tool, interpretation/recommendations, and preparation of report should all be completed).

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
ABA Behavioral Follow-up Assessment	0362T	Behavioral follow-up assessment (Functional Behavior Analysis/FBA), Modifier U5 and Provider Level	First 30 minutes	Line Professional	EPDST State Plan	Includes qualified provider onsite for observation of individual with interpretation and report, may include direct testing of environmental conditions with assistance of technician(s). If assessment occurs over multiple days, provider will report first 30 and each additional 30 minute unit(s) for each date of service. **<u>If a behavior plan</u> following a FBA involves any restrictive or intrusive interventions aimed at reducing defined target behavior(s), the author of the plan must follow the MDHHS Technical Requirement (TR) for Behavior Treatment Plan Review (BTPR) and receive PIHP/CMHSP Committee approval prior to implementation of the intervention(s) and plan. See BTPR section of the Medicaid Provider Manual
	0363T	Each additional behavioral follow-up assessment (Functional Behavior Analysis/FBA) Modifier U5 and Provider Level	Each additional 30 minutes			
ABA Adaptive Behavior Treatment	0364T	Adaptive behavior treatment by protocol administered by technician, face to face with one individual Modifier U5 and Provider Level Modifier and TG or TF No modifier for aide-level/behavior technician (BT).	First 30 Minutes	Line Professional	EPDST State Plan	Technician implements ABA behavioral plan of care developed by BCBA or other qualified provider in consultation with family. May involve a BCBA, BCaBA, LP/LLP or QBHP, to deliver this service as well, but the primary provider is a BT.
	0365T	Each additional adaptive behavior treatment by protocol, administered by technician, face to face with one	Each additional 30 minutes			

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
		individual Modifier U5 and Provider Level Modifier and TG or TF No modifier for aide-level/behavior technician (BT).				
ABA Group Adaptive Behavior Treatment	0366T	Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more individuals. Modifier U5 and Provider Level Modifier and TG or TF	First 30 minutes	Line Professional	EPSDT State Plan	Administered by BT face-to-face with multiple individuals. Maximum of 8 individuals.
	0367T	Each additional group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more individuals. Modifier U5 and Provider Level Modifier and TG or TF	Each additional 30 minutes			
ABA Clinical Observation and Direction of Adaptive Behavior Treatment	0368T	Clinical observation & direction of adaptive behavior treatment with protocol modification administered by qualified professional, face- to-face with one individual Modifier U5 and Provider Level Modifier Modifier GT if via tele-practice	First 30 minutes	Line Professional	EPSDT State Plan	May include protocol demonstration to technician(s), guardian(s), with individual present. Must co-occur with 0364T-0367T in order to be reported. *Use GT modifier if MDHHS has authorized tele-practice for an individual
	0369T	Each additional clinical observation & direction of adaptive behavior treatment with protocol modification administered by qualified professional, face- to-face with one individual Modifier U5 and Provider Level	Each additional 30 minutes			

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
		Modifier Modifier GT if via tele-practice				
ABA Family Behavior Treatment Guidance	0370T	Family behavior treatment guidance administered by qualified professional. Untimed Modifier U5 and Provider Level Modifier GT if via tele-practice	Encounter	Line Professional	EPSDT State Plan	Individual not required to be present. *Use GT modifier if MDHHS has authorized tele-practice for an individual. Tele-practice is not allowed for group family guidance and training.
	0371T	Multiple family behavior treatment guidance administered by qualified professional. Untimed, typically 90-105 minutes. Modifier U5 and Provider Level				Individual not required to be present. Maximum 8 families. Tele-practice is not allowed for group family guidance and training.
ABA Adaptive Behavior Treatment Social Skills Group	0372T	Adaptive behavior treatment social skills group. Untimed Modifier U5 and Provider Level	Encounter	Line Professional	EPSDT State Plan	Administered by qualified provider face-to-face with multiple children. Maximum 8 children.
ABA Exposure Adaptive Behavior Treatment	0373T	Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s), face-to-face with individual. Modifier U5 and Provider Level Modifier Modifier TG or TF	First 60 minutes	Line Professional	EPSDT State Plan	Service involves two BT's face-to-face with one individual, but still only one encounter reported for the service by one BT. BCBA, BCaBA, LP/LLP, or QBHP, may also be onsite to direct technicians in implementation utilizing the service encounter for clinical observation & direction.

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
	0374T	Each additional exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s), face-to-face with individual. Modifier U5 and Provider Level Modifier TG or TF	Each additional 30 minutes			
Assertive Community Treatment (ACT)	H0039	ACT Use modifier AM when providing Family Psycho-education as part of the ACT activities	15 minutes DT =48/day	Line Professional	State Plan, Healthy Michigan	When/how to report encounter: -Report only face-to-face contacts -Count one contact by team regardless of the number of staff on team Allocating and reporting costs: -Cost of all ACT activities reported in the aggregate -Cost of indirect activities (e.g., ACT team meetings, phone contact with consumer) incorporated into cost of face-to-face units
Assessments **Health** **Psychiatric Evaluation** **Psychological testing** **Other assessments, tests**	T1001, 97802, 97803	Nursing or nutrition assessments (refer to code descriptions)	Refer to code descriptions DT: T1001=1/day 97802=40/day 97803=40/day	Line Professional	State Plan, Healthy Michigan	When/how to report encounter: -An assessment code should be used when case managers or supports coordinators perform the utilization management function of intake/assessment (H0031). A case management or supports coordination code should be used when assessment is part of the case management or supports coordination function. The utilization management function is outside of the authorization for supports coordination/case management. H0031 should be used when intake
	90791, 90792, 90833, 90836, 90838, 90785 99201- 99215 99304 - 99310 99324 – 99328 99334 – 99337 99341 - 99350	90791 Psychiatric diagnostic evaluation (no medical services) 90792 Psychiatric diagnostic evaluation (with medical services) 90833 (30 min), 90836 (45 min), 90838 (60 min), and 90785 Interactive - add-on codes only **Use U5 for ABA (90791, 90792, ~~90836, 90838,~~ 90785)**	Encounter Refer to code descriptions DT: 2/day ~~90801=1/day~~ ~~90802=1/day~~	Line Professional	State Plan, Healthy Michigan	

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
		99201-99215 Psychiatric evaluation and medication management **99304-99310 Nursing Facility Services evaluation and management** **99324-99328 and 99334-99337 Domiciliary care, rest home, assisted living visits** **99341-99350 Home visits** **90791 & 90792 for SUD:** Use modifier HF to signify that these codes were used for substance abuse treatment, because they are also used for reporting mental health services. **99203-99205 for SUD:** Use modifier HF to signify that these codes were used for substance abuse treatment, because they are also used for reporting mental health services.	99201-99215=2/day 99324-99328, 99334-99337 and 99341-99350 Refer to Code Descriptions		Healthy Michigan, Block Grant & PA2 Healthy Michigan, State Plan, Block Grant, and PA2	and assessment result in a recommendation for services (including additional assessments), but does not result in an individual plan of service. -LPN activity is not reportable, it is an indirect cost Allocating and reporting costs: -Cost of indirect activity -Cost if staff provide multiple units -Spreading costs over the various types of services -Cost and productivity assumptions -Some direct contacts may become costly due to loading in indirect time
	96101, 96102, 96103, 96116, 96118, 96119, 96120	Psychological testing **Use U5 for ABA (96101, 96102, 96118, and 96119)**	Per hour	Line Professional	State Plan, Healthy Michigan	
	96110, 96111, 96105, 90887, 96127	Other assessments, tests (includes inpatient initial review and re-certifications, vocational assessments, interpretations of tests to family, etc. Use modifier TS for re-certifications.)	Refer to code descriptions DT: 96110=10/day 96111=10/day 90887=1/day H0002=1/day **H0031=3/day** T1023=1/day	Line Professional	State Plan, Healthy Michigan	
	H0031	H0031: Assessment by non-physician Use ST when trauma assessment is performed as part of trauma-focused ~~CPT~~ CBT. **Use U5 for ABA. Face-to-face with child or parent. This includes interpretation of results to the family.**				

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
	H0002 T1023	H0031 – HW: Support Intensity Scale (SIS) Face-to-Face Assessment H0002: Brief screening to non-inpatient programs T1023: Screening for inpatient program See Appendix for detailed guidance on reporting rules for T1023.				T1023: Preadmission Screening must be face-to-face
Behavior Treatment Plan Review	H2000	Comprehensive multidisciplinary evaluation Service does not require face-to-face with beneficiary for reporting Modifier TS for monitoring activities associated with a behavior treatment plan	Encounter **DT= 2/day**	Line Professional	State Plan, Healthy Michigan	When/how to report encounter: Report one meeting per day per consumer, regardless of number of staff present. In order to count as an encounter at least two of the three staff required by Medicaid Provider Manual must be present. Staff who are present through video-conferencing may be counted. Allocating and reporting costs: Determine average cost: number of persons present, for how long
Clubhouse Psychosocial Rehabilitation Programs	H2030	Mental Health Clubhouse Services See Appendix for detailed information on reporting of consumer transportation for attendance at Clubhouse.	15 Minutes DT= 48 /day	Line	State Plan, Healthy Michigan	When/how to report encounter: -Use a sign-in/sign-out to capture each individual's attendance time -Lunch time: meal prep is reportable activity; meal consumption is not unless there are individual goals re: eating. (set up an automatic deduct of 1 or 2 units rather than elaborate logging of activity) -Reportable clubhouse activity may include social-rec activity and vocational as long as it is a goal in person's IPOS -Excludes time spent in transport to and from clubhouse

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
						Allocating and reporting costs: -All costs of the program including consumer transportation costs -Capital/equipment costs need to comply with regulations -Excludes certain vocational costs -Exclude revenues from MRS, Aging, etc.
Community Psychiatric Inpatient	0100, ~~0101~~, 0114, 0124, 0134, 0154 See Appendix for important reporting details for encounters and cost reports.	0100 – All inclusive room and board plus ancillaries. Physician services are included in the per diem ~~0101 – All inclusive room and board~~ 0114, 0124, 0134, 0154 – ward size. Physician services are **not** included in the per diem. Must use provider type 73 ~~followed by 7-digit Medicaid Provider ID number. See 10/14/04 instructions and Companion Guide for 837 Institutional Encounters for proper placement in 837~~ See Appendix for instructions for reporting Provider Type and Hospital NPI.	Day	Series Institutional	State Plan, Healthy Michigan for Type 73	When/how to report encounter: Hospital to provide information on room/ward size – this will determine correct rev code to use -In hospital as of 11:59 pm -Report only inpatient episodes for which the CMH has a payment liability greater than $0. In various cost/use reports include accruals as a separate cost (no use data required). Hospital claims for such accruals will be submitted after adjudication completed and there is a residual; payment made by CMHSP/PIHP. -Days of attendance
	99221-99233	Physician services provided in inpatient hospital care	Refer to code descriptions	Line Professional	State Plan, Healthy Michigan	-Option: Hospital claim with additional fields reflecting other insurance offsets can be turned into encounters for submission to MDHHS Allocating and reporting costs: -Reportable cost is net of coordination of benefits, co-pays, and deductibles -Bundled per diem that includes room and board -Includes physician's fees, discharge meds, court hearing

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
						transportation costs -If physician is paid separately, use inpatient physician codes and cost the activity there -Report ambulance costs under transportation -For authorization costs, see assessment codes if reportable as separate encounter, otherwise report as part of PIHP admin Hospital liaison activities (e.g., discharge planning) are reported as case management or supports coordination
Community Living Supports	H2015, H2016, H0043, T2036, T2037	**Important: See Appendix for detailed guidance on correct uses, reporting and costing for H2016, H0043 and H2015** H2016 – comprehensive Community Support Services per day in specialized residential settings, or for children with SED in a foster care setting that is not a CCI, or children with DD in either foster care or CCI. Use in conjunction with Personal Care T1020 for unbundling specialized residential per diem. **Required: Place of Service Code = 14** H0043 – Community Living Supports provided in unlicensed independent living setting or own home, per day **Required: Place of Service Code = 12** **no modifier:** up to 3 hours/day	Refer to code descriptions DT: H2015=96/day H2016=1/day H0043=1/day T2036=1/day T2037=1/day	H2015, T2036, T2037: Line H2016, H0043: Series Professional	Habilitation Supports Waiver, Healthy Michigan, 1915 (b)(3), & EPSDT	When/how to report encounter: -Must be Face-to-face -Days of attendance in setting for per diem codes, Beneficiary must receive at least one CLS activity with a qualified provider for that day to be reported -For an individual receiving CLS that is reported as a per diem, it is also permissible to report f skill building, or other covered services that are provided outside the home in a 24 hour period. **However, as of 10/1/2016 CLS 15 minute can only be reported if place of service is outside of the home/specialized residential home and provided by a different provider** (See Appendix). Allocating and reporting costs for CLS for residential supports: -Cost are based on the assessment of need/hours of the individual consumer.(See Appendix for

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
		TF: Between 3-10 hours/day **TG**: More than 10 hours/day H2015-Comprehensive Community Support Services per 15 min. Place of Service Code = 12: in-home supports Place of Service Code = 99: day-time community engagement activity. See Appendix for other Place of Service codes for H2015 Disallowed: Place of Service Codes for H2015: 14 or 33. **See Appendix for detailed information on reporting of consumer transportation for out-of-home, community engagement CLS (H2015) activities.** T2036 – therapeutic camping overnight, waiver each session (one night = one session) T2037 therapeutic camping day, waiver, each session (one day/partial day = one session) Modifier HK (specialized mental health programs for high-risk populations) must be reported for Habilitation Supports Waiver beneficiaries. No modifier is reported for B3 Services. Modifier TT when multiple consumers are served simultaneously in non-licensed settings.				costing details). -Cost includes staff, equipment, travel, staff and consumer transportation, contract services, supplies and materials -Costs for community activities -Costs for vehicles -Day rate reported must be net of SSI/room and board, Home Help and Food stamps Boundaries: -Between CLS (H2016) and Personal Care (T1020) in Specialized Residential -For H2016 in specialized residential assume: *Less intensive staff involvement than personal care *Staff provide one-on-one training to teach the consumer to eventually perform one or more ADL task(s) independently; OR *One staff to more than one consumer provides training along with prompting and or guiding the consumers to perform the ADL tasks independently; OR *One staff to more than one consumer prompting, cueing, reminding and/or observing the consumers to perform one or more ADL tasks independently; OR *One staff to one or more consumers supervising while consumers are sleeping. Boundaries:

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
						-Between CLS and supported employment (SE): *Report SE if the individual has a job coach who is also providing assistance with ADLs *If the individual has no job coach, but for whom assistance with ADLs while on the job is being purchased, report as CLS -Between CLS and Respite: *Use CLS when providing such assistance as after-school care, or day care when caregiver is normally working and there are specific CLS goals in the IPOS. *Use Respite when providing relief to the caregiver who is usually caring for the beneficiary during that time -Between CLS and Skill-building (SK): *Report SK when there is a vocational or productivity goal in the IPOS and the individual is being taught the skills he/she will need to be a worker (paid or unpaid) *Report CLS when an individual is being taught skills in the home that will enable him/her to live more independently
Crisis Intervention	H2011 90839, 90840	H2011: Crisis Intervention Service See Appendix for detailed guidance on reporting rules for H2011 90839 psychotherapy for crisis, 1st 60	15 minutes **DT: H2011=96/day** 90839:	Line Professional	State Plan, Healthy Michigan	When/how to report encounter: -H2011, face-to-face Allocating and reporting costs: -Cost and contact/productivity model assumptions used -Incorporate phone time as an

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
		min 90840 psychotherapy for crisis, each additional 30 min (Add-on code only)	Encounter 90840: Encounter			indirect cost for H2011
Crisis Residential Services	H0018	Behavioral health; short-term residential (non-hosp resident treatment program) without room and board per diem Use for both child & adult services. ***For SUD please refer to SUD: Residential Services line.***	Day **DT: 1/day**	Series Professional	State Plan, Healthy Michigan	When/how to report encounter: -Days of attendance -In as of 11:59 pm -If consumer enters and exits the same day it is not reportable as crisis residential Allocating and reporting costs: -Bundled per diem *Includes staff, operational costs, lease, physician *Need to net out SSI per diem equivalent. These costs will be separately reported in the CMHSP sub-element cost report Assumptions re: occupancy if "purchase" capacity
Electroconvulsive Therapy (see Practitioner Manual)	90870, 00104 Rev code: 0901	0901- ECT facility charges 90870- attending physician charges 00104- anesthesia charges 0710- Recovery room 0370-anesthesia	Encounter Encounter Minutes DT: 90870=1/day	Series-Institutional Line-Professional Line-Professional	State Plan, Healthy Michigan	When/how to report encounter: -Face-to-face procedure Allocating and reporting costs: -Submit actual costs
Enhanced Medical Equipment & Supplies / Assistive Technology	T2028, T2029, S5199, E1399, T2039	E1399 – DME, miscellaneous T2028 – Specialized supply, not otherwise specified, waiver T2029 – Specialized medical equipment, not otherwise specified, waiver. S5199 – Personal care item, NOS. T2039- Van lifts & wheelchair tie down system	Item DT=1,000/day	Line Professional	Healthy Michigan, Habilitation Supports & 1915(b)(3)	When/how to report encounter: -Per item Allocating and reporting costs: -Submit actual costs -May include: -*costs for training to use the equipment *repairs

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
		Modifier HK (specialized mental health programs for high-risk populations) must be reported for Habilitation Supports Waiver beneficiaries. No modifier is reported for Additional or "b3" Services.				
Enhanced Pharmacy	T1999	Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in "remarks" Modifier HK (specialized mental health programs for high-risk populations) must be reported for Habilitation Supports Waiver beneficiaries. No modifier is reported for Additional or "b3" Services.	Item DT=1,000/day	Line Professional	Healthy Michigan, Habilitation Supports Waiver & 1915(b)(3)	When/how to report encounter: -Per item Allocating and reporting costs: -Submit actual costs
Environmental Modifications	S5165	Home modifications, per service. Modifier HK (specialized mental health programs for high-risk populations) must be reported for Habilitation Supports Waiver beneficiaries. No modifier is reported for Additional or "b3" Services.	Service DT=1,000/day	Line Professional	Healthy Michigan, Habilitation Supports Waiver & 1915(b)(3)	When/how to report encounter: -Per service Allocating and reporting costs: -Submit actual costs
Family Training	S5111	S5111- Home care training, family per session S5111 HM- Parent-to-parent support provided by a trained Parent Support Partner using the MDHHS-endorsed curriculum (can report encounter after completion of initial 3 days of core training but must continue certification process) S5111 ST - Resource Parent Training by parents as part of Children's Trauma Initiative Modifier HK (specialized mental health programs for high-risk populations) must be reported for Habilitation Supports Waiver beneficiaries. No	Encounter DT=2/day	Line Professional	Healthy Michigan, Habilitation Supports Waiver, 1915 (b)(3) & EPSDT	When/how to report encounter: -Face-to-face encounters with family (report one encounter per family no matter how many family members are present) - S5111 HM – Parent Support Partners can also report S5111 HM if they are face-to-face with the parent while another provider is working separately with the child (consumer).Please note, this is not allowed for Wraparound services. If provided as a group modality where families of several beneficiaries are present, report an encounter for each

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
		modifier is reported for Additional or "b3" Services. Modifier HA for Parent Management Training Oregon model Modifier HS when beneficiary is not present Modifier TT when multiple consumers are served simultaneously				consumer represented Allocating and reporting costs: -Include cost of indirect activity performed by staff -Cost if staff provide multiple services
	S5110, G0177, T1015,	S5110 – Family Psycho-Education: skills workshop G0177 – Family Psycho-education: family educational groups (either single or multi-family) T1015 – Family Psycho-Education: joining Note: Please use these codes only when implementing this Evidence Based Practice Modifier HS: consumer was not present during the activity with the family	S5110 = 15 min G0177 = session at least 45 min DT: G0177=1/day T1015 = encounter	Line Professional	Healthy Michigan, 1915(b)(3)	
Fiscal Intermediary Services	T2025	Financial Management, self-directed, waiver.	Per Month	Line Professional	Healthy Michigan, 1915(b)(3)	When/how to report encounter: When service is performed – does not require face-to-face with beneficiary Allocating and reporting costs Submit actual monthly cost
Goods and Services	T5999	Waiver Service not otherwise specified Must use modifier HK: individual is enrolled in Habilitation Supports Waiver	Per Item	Line Professional	Habilitation Supports Waiver only	When/how to report encounter: Per item when service or item was purchased. Allocating and reporting costs: Submit actual item cost
Health Services	97802, 97803, 97804, H0034, S9445, S9446, S9470, T1002	97802-97804 – medical nutrition therapy H0034 Medication training and support S9445 –Pt education NOC non-physician indiv per session S9446 – Pt education NOC non-physician group, per session S9470 – Nutritional counseling dietician	Refer to code descriptions – some are per 15 minutes, some per encounter DT: 97802=40/day	Line Professional	State Plan, Healthy Michigan	When/how to report encounter: -Face-to-face with beneficiary Allocating and reporting costs: -Cost of indirect activity -Cost if staff provide multiple services

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
		visit T1002 – RN services up to 15 min	97803=40/day 97804=20/day H0034=40/day S9445=1/day S9446=1/day S9470=1/day T1002=40/day			
Home Based Services	H0036	Community psychiatric supportive treatment, face-to-face with child or family, per 15 minutes Includes MOM Power Modifier HA for Parent Management Training Oregon model Modifier HS when beneficiary is not present Modifier ST when providing Trauma-focused Cognitive Behavioral Therapy when pre-approved by MDHHS **Modifiers HA & TT when providing Parent Management Training Oregon model to multiple families**	15 minutes DT=96/day	Line Professional	State Plan, Healthy Michigan	When/how to report encounter: -This a bundled service that includes mental health therapy, case management/supports coordination and crisis intervention, therefore these services should not be reported separately -If more than one staff provided different types of contacts – e.g., working with child and someone else at the same time with family/parents – may report the contact with the child or family member Allocating and reporting costs: - Include cost of indirect activity -Cost if staff provide multiple services
	H2033	Multi-systemic therapy (MST) for juveniles provided in home-based program	15 minutes	Line Professional	State Plan, Healthy Michigan	
Housing Assistance	T2038	Community transition, waiver, per service	Service DT=31/day	Line Professional	1915(b)(3), Healthy Michigan	When/how to report encounter: -Report one service for each day provided Allocating and reporting costs: Costs include only non-staff expenses associated with housing: assistance for utilities, home maintenance, insurance, and moving expenses -Deduct SSI -Deduct food stamps, heating tax credits, etc

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
						-Submit actual costs for the month (PATH/Shelter Plus not reported here. Costs to be included in CMHSP sub-element cost report under "Other")
Intensive Crisis Stabilization	S9484	S9484: Crisis intervention mental health services, per hour. Use for the - MDHHS-approved program only.	Hour DT=24/day	Line Professional	State Plan, Healthy Michigan	When/how to report encounter: Face-to-face contacts only, other contacts (phone, travel) are incorporated in as an indirect activity Allocating and reporting costs -Costs of the team -Bundled activity -Cost and contact/productivity model assumptions used -Account for contacts where more than one staff are involved
Inpatient Psychiatric Hospital State Facility Admissions	0100, 0101, 0114, 0124, 0134, 0154	Room & Board Managed State Psychiatric Hospital Inpatient Days - Board Managed State 0100 – All inclusive room and board plus ancillaries 0101 – All inclusive room and board 0114, 0124, 0134, 0154 – ward size Must use provider type 22 See Appendix for instructions for reporting provider Type and Hospital NPI.	Day	Series Institutional	State Plan	When/how to report encounter: -Inpatient days of attendance including IST days at State Hospitals (excluding Forensic Center) -In hospital as of 11:59 pm Allocating and reporting costs: -Bundled per diem using state net rate -Includes net rates paid and local match payments -Report expenditures for Forensic days in the CMHSP sub-element cost report
Institution for Mental Disease Inpatient Psychiatric Services	0100, ~~0101~~, 0114, 0124, 0134, 0154 See Appendix for important reporting details for encounters and	0100 – All inclusive room and board plus ancillaries. Physician services are included in the per diem. ~~0101 – All inclusive room and board~~ 0114, 0124, 0134, 0154 – ward size. Physician services are not included	Day	Series Institutional		When/how to report encounter: Hospital to provide information on room/ward size – that will determine correct rev code to use -In hospital as of 11:59 pm ~~-Count all consumers/days where CMH has a payment liability~~

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
	cost reports.	in the per diem. Must use provider type 68 See Appendix for instructions for reporting provider Type and Hospital NPI.				-Report only inpatient episodes for which the CMH has a payment liability greater than $0. In various cost/use reports include accruals as a separate cost (no use data required). Hospital claims for such accruals will be submitted after adjudication completed and there is a residual; payment made by CMHSP/PIHP -Days of attendance -Option: Hospital claim with additional fields reflecting other insurance offsets can be turned into encounters for submission to MDHHS. <u>Allocating and reporting costs:</u> -Net of coordination of benefits, co-pays, and deductibles -Bundled per diem that includes room and board -Includes physician's fees, discharge meds, court hearing transportation costs -If physician is paid separately, use inpatient physician codes and cost their activity there -Report physician consult activity separately -Report ambulance costs under transportation -For authorization costs, see assessment codes if reportable as separate encounter, otherwise report as part of PIHP admin Hospital liaison activities (e.g., discharge planning) are reported as

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
						case management or supports coordination
Medication Administration	99506, 99211, 96372		Encounter	Line Professional	State Plan, Healthy Michigan	When/how to report encounter: - Report using this procedure code only when provided as a separate service. -Face-to-face with qualified provider -Involvement of other professionals is considered indirect activity Allocating and reporting costs: -The costs of all indirect activities are included in the unit rate
Medication Review	~~90862~~, ~~M0064~~ **99201-99215** **99304 - 99310** **99324-99328** **99334-99337** **99341-99350**	99201-99215 Psychiatric evaluation and medication management **99304-99310 Nursing Facility Services evaluation and management** **99324-99328 and 99334-99337 Domiciliary care, rest home, assisted living visits** **99341-99350 Home visits** **99201 – 99215 for SUD:** Use modifier HF to signify that these codes were used for substance abuse treatment, because they are also used for reporting mental health services. EPS tardive dyskinesia testing is included in medication review services	Refer to Code Descriptions (Face-to-face) DT: 99201-99215=2/day 99324-99328, 99334-99337 and 99341-99350	Line Professional	State Plan, Healthy Michigan State Plan, Healthy Michigan, Block Grant & PA2	When/how to report encounter: -Face-to-face with qualified provider only/per code -Involvement of other professionals is considered indirect activity Allocating and reporting costs: -The costs of all indirect activities are included in the unit rate
	H2010	Comprehensive Medication Services Please use only with Evidence Based Practice – Medication Algorithm	15 minutes	Line Professional	State Plan, Healthy Michigan	
Nursing Facility Mental Health	T1017SE	Use modifier SE to distinguish from case management	15 minutes DT = 48/day	Line Professional	State Plan, Healthy Michigan	When/how to report encounter: -Record must show that this was

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
Monitoring						not a case management visit -Face-to-face with beneficiary Allocating and reporting costs -Staff travel -Indirect time
Occupational Therapy	97110, 97112, 97113, 97116, 97124, 97140, 97530, 97532, 97533, 97535, 97537, 97542, S8990, 97750, 97755, 97760, 97762	OT individual	Refer to code descriptions – some are per 15 minutes, some per encounter DT: 15 min units= 40/day Hour units= 10/day Encounters= 1/day	Line Professional	State Plan, Healthy Michigan	Note: OT and PT have the same codes When/how to report encounter: -Face-to-face with qualified provider only Allocating and reporting costs: -Cost if staff provide multiple units -Cost of non-face-to-face consultation on behalf of a consumer in a specialized residential setting or day program setting or sheltered workshop should be loaded into the cost of face-to-face activities of OT or PT -Cost and productivity assumptions -Some direct contacts may be costly due to loading in the indirect time -Spreading indirect activity and costs over the various types of services
	97150	OT group, per session	Encounter	Line Professional	State Plan, Healthy Michigan	
	~~97003, 97004~~ 97165, 97166, 97167, 97168	OT evaluation/re-evaluation	Encounter	Line Professional	State Plan, Healthy Michigan	
Out of Home Non Vocational Habilitation	H2014HK	Skills training and development Modifier HK (specialized mental health programs for high-risk populations) must be reported for Habilitation Supports Waiver beneficiaries. Services must be furnished four or more hours per day on a regularly scheduled basis for one or more days per week, unless provided as an adjunct to other HSW day activities	15 minutes DT = 40/day	Line Professional	Habilitation Supports Waiver	Allocating and reporting costs: -Cost includes staff, facility, equipment, travel, transportation, contract services, supplies and materials -Capital/equipment costs need to comply with regulations

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
		Modifier TT when multiple consumers are served simultaneously				
Out of Home Prevocational Service	T2015	Habilitation, prevocational, waiver, per hour Modifier HK (specialized mental health programs for high-risk populations) must be reported for Habilitation Supports Waiver beneficiaries.	Hour DT= 8 day	Line Professional	Habilitation Supports Waiver	When/how to report encounter: -Report any face-to-face monitoring by supports coordinator that occurs during prevoc, separately. Deduct supports coordinator time from prevoc time. Allocating and reporting costs: -Cost includes staff, facility, equipment, travel, transportation, contract services, supplies and materials -Capital/equipment costs need to comply with regulations
Outpatient Partial Hospitalization	0912, 0913	Partial hospitalization	Day	Series Institutional	State Plan, Healthy Michigan	When/how to report encounter: Number of days beneficiary spend in the program for which PIHP pays Allocating and reporting costs: Bundled rate per day
Peer Directed and Operated Support Services (MH or DD)	H0023, H0038, H0046	H0023- Drop-in Center attendance, encounter [Note: Optional to report as encounter, but must report on MUNC] …….. H0038- Mental Health Peer specialist services provided by certified peer specialist, 15 min. H0038-TJ – Youth Peer Support Specialist (certified to report encounters after completion of initial 3 days of core training but must continue training process)	Encounters ……. 15 minutes DT: H0038=96/day	Line Professional	1915(b)(3) & EPSDT, Healthy Michigan	When/how to report H0023 encounters: If beneficiary signed time-in/out log report the units as encounters When/how to report H0038 encounters: -Certified peer support specialist performed the activities listed in the Medicaid Provider Manual under the peer coverage. If PSS is assisting with other state plan or b3 services, use modifier HE with that service's procedure code. - Youth peer support specialist:

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
		…… H0046 – Peer mentor services provided by a DD Peer Mentor TT modifier: use when peer service is provided in a group ***For SUD please refer to SUD: Recovery Support Services line.***	……. Encounters			A youth peer specialist can only report a face-to-face service with a consumer using the H0038-TJ or the H0038-TJ-TT codes. The youth peer can also report H0038-TJ or H0038-TJ-TT if they are face-to-face with youth while another provider is working separately with the family. This type of situation will occur only in home-based (H0036 HS), or family psychotherapy 90846 HS 90849 HS or S5111 HM Parent Support Partner. When/how to report H0046 encounters: -Report only when a DD Peer Mentor has performed the activities listed in the Medicaid Provider Manual under the peer coverage. When a DD Peer Mentor assists with, or performs another covered service, use the code for that service and add the HI modifier. Allocating and reporting costs: -Drop-in cost includes staff, facility, equipment, travel, transportation, contract services, supplies and materials -Must report all Drop-in Center Medicaid costs in Medicaid Utilization and Cost Report
Personal Care in Licensed Specialized	T1020	Personal care services provided in AFC certified as Specialized Residential. (not for an inpatient or resident of a	Day DT=1/day	Series Professional	State Plan, Healthy Michigan	When/how to report encounters: -Report one day per day of attendance in a specialized

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
Residential Setting		hospital, nursing facility, CCI or IMD or services provided by home health aide or certified nurse assistant) See Appendix for details on reporting and costing for T1020.				residential setting -Activities outside the home are not considered personal care Boundaries between Personal Care (T1020) and CLS (H2016) in Specialized Residential Setting -For Personal Care, assume a high staff intensity in the delivery of: *hands-on assistance with ADLs; OR *partial hands-on assistance with ADLS along with prompting and/or guiding consumer in completing the task; OR *Prompting, cueing, reminding and otherwise being in attendance for the purpose of assuring the consumer will complete the task; OR -The need for more than one staff to provide assistance to some consumers. -Staffing ratios
Personal Emergency Response System (PERS)	S5160, S5161	S5160- Emergency response system; installation and testing S5161- (PERS) Service fee, per month (excludes installation and testing). Modifier HK (specialized mental health programs for high-risk populations) must be reported for Habilitation Supports Waiver beneficiaries. No modifier is reported for Additional or "b3" Services.	Refer to code descriptions S5160, DT=1 S5161, DT=1/month	Line Professional	Habilitation Supports Waiver & 1915(b)(3), Healthy Michigan	When/how to report encounter: Response to PERS call/notification is not reported as PERS The time spent by staff monitoring the system is included as part of the monthly monitoring/service fee. Allocating and reporting costs: -Submit actual costs If used by more than one person, the cost should be evenly divided between all users, not loaded up under one. If, however, only one person in a home needs the PERS, then it would be appropriate to

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
						report all costs under that one person's encounter. Response to PERS call/notification is not reported as PERS The time spent by staff monitoring the system is included as part of the monthly monitoring/service fee.
Physical Therapy	~~97001, 97002~~ 97161, 97162, 97163, 97164	PT Evaluation/re-evaluation	Encounter DT=1/day	Line Professional	State Plan, Healthy Michigan	Note: OT and PT have the same codes When/how to report encounter: -Face-to-face with qualified provider only Allocating and reporting costs: -Cost if staff provide multiple units -Cost of non-face-to-face consultation on behalf of a consumer in a specialized residential setting or day program setting or sheltered workshop should be loaded into the cost of face-to-face activities of OT or PT -Cost and productivity assumptions -Some direct contacts may be costly due to loading in the indirect time -Spreading indirect activity and costs over the various types of services
	97110, 97112, 97113, 97116, 97124, 97140, 97530, 97532, 97533, 97535, 97537, 97542, 97750, 97760, 97762, S8990	PT individual	Refer to code descriptions – some are per 15 minutes, some per encounter DT: 15 min units = 40/day 30 min units = 20/day Encounters= 1/day	Line Professional	State Plan, Healthy Michigan	
	97150	PT group	Encounter DT=1/day	Line Professional	State Plan, Healthy Michigan	
Prevention Services - Direct Model	H0025, S9482, T2024, T1027, H2027	Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude, and/or behavior); approved MDHHS models only H0025 – School Success & Child Care Expulsion	Face to Face Contact with family or child H0025 – encounter DT=1/day S948215 min unit	Line Professional	**H0025 & S9482 – B(3)s and Healthy Michigan** **T2024, T1027 & H2027 – EPSDT and Healthy Michigan**	When/how to report encounters: If parent is the symptom-bearer, the event may be reported using the parent's Medicaid identification number. If parent is not the symptom-bearer, report using the child's Medicaid identification

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
		S9482 – Infant mental health T2024 – Children of adults with mental illness T1027 – Parent Education H2027- Family Skills Training/Group for children of adults with mental illness	DT= 40/day T2024 – encounter DT= 1/day T1027- 15 min DT=40/day H2027 – 15 min DT=96/day			number Allocating and reporting costs: For all other GF-funded prevention, report on CMHSP Sub-element cost report
Private Duty Nursing	S9123, S9124	Private duty nursing, Habilitation Supports Waiver (individual nurse only) 21 years and over ONLY Modifier HK (specialized mental health programs for high-risk populations) must be reported for Habilitation Supports Waiver beneficiaries. Modifier TT – use for multiple beneficiaries in same setting	Hour DT=24/day	Line Professional	Habilitation Supports Waiver	When/how to report encounters: Hour spent with adult over 21 by nurse, or PDN agency Used for HSW consumer over 21
	S9123, S9124 Rev code: 0582	Private duty nursing, Habilitation Supports Waiver (private duty agency only) Modifier HK (specialized mental health programs for high-risk populations) must be reported for Habilitation Supports Waiver beneficiaries. Modifier TT – use for multiple beneficiaries in same setting	hour	Line Institutional	Habilitation Supports Waiver	
	T1000	Private duty nursing (Habilitation Supports Waiver) T1000 – private duty/independent nursing service(s), licensed Modifier HK (specialized mental health programs for high-risk populations) must be reported for Habilitation Supports Waiver beneficiaries Modifier TD – registered nurse Modifier TE – licensed practical nurse or licensed visiting nurse Modifier TT – use for multiple	Up to 15 minutes DT=96/day	Line Professional	Habilitation Supports Waiver	

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
		beneficiaries in same setting.				
Respite Care	T1005	Respite care services, up to 15 minutes. No modifier = all providers (including unskilled, and Family Friend) except RN & LPN TD modifier = RN only TE modifier = LPN only TT modifier – use for multiple beneficiaries in same setting Modifier HK (specialized mental health programs for high-risk populations) must be reported for Habilitation Supports Waiver beneficiaries. No modifier is reported for Additional or "b3" Services.	15 minutes DT=96/day	Line Professional	Healthy Michigan, Habilitation Supports Waiver & 1915(b)(3)	When/how to report encounter: Family friend model may be used and funded by Medicaid, however family friend must meet Medicaid qualifications and family may not be paid directly with Medicaid funds) Allocating and reporting costs: -Difference in costs between skilled and unskilled staff: -Note payment mechanisms such as Vouchers Boundaries: -Respite care and Community Living Supports (CLS): *Use CLS when providing such assistance as after-school care, or day care when caregiver is normally working and there are specific CLS goals in the IPOS *Use Respite when providing relief to the caregiver
	H0045	Respite care services, day in out-of-home setting Modifier HK (specialized mental health programs for high-risk populations) must be reported for Habilitation Supports Waiver beneficiaries. No modifier is reported for Additional or "b3" Services.	Day DT=1/day	Line Professional	Healthy Michigan, Habilitation Supports Waiver & 1915(b)(3)	
	S5150	Respite care by unskilled person, per 15 minutes (use also for "Family Friend" respite)	15 minutes DT=96/day	Line Professional	GF only	
	S5151	Respite care, day, in-home Modifier HK (specialized mental health programs for high-risk populations) must be reported for Habilitation Supports Waiver beneficiaries. No modifier is reported for Additional or "b3" Services.	Per diem DT=1/day	Line Professional	Healthy Michigan, Habilitation Supports Waiver & 1915(b)(3)	
	T2036, T2037	Respite care at camp T2036: camping overnight (one night = one session) T2037 for day camp (one day/partial day	Per session DT=1/day	Line Professional	Healthy Michigan, Habilitation/Supports Waiver & 1915(b)(3)	

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
		= one session)				
Skill Building Assistance	H2014	Skills training and development, per 15 min Modifier TT when multiple consumers are served simultaneously See Appendix for detailed information on reporting of consumer transportation for attendance at skill-building activities.	15 minutes DT=40/day	Line Professional	Healthy Michigan, 1915(b)(3) & EPSDT	When/how to report encounters: Skill-building in the community (outside a facility-based program) may include transportation time to and from the site(s). If the same staff provides transportation and skill-building, include time of transportation from pick-up time through the entire episode to drop-off. -Exclude time spent in transport to and from facility-based program -Report any face-to-face monitoring by case manager or supports coordinator that occurs during skill building, separately. Deduct case management or supports coordinator time from skill-building time. Allocating and reporting costs: -Cost includes staff, facility, equipment, travel, transportation to and from facility, contract services, supplies and materials -Capital/equipment costs need to comply with regulations -The cost of OT, PT, RN and dietary consultations with skill-building staff at facility-based program are not reported as, or booked to, skill-building. Boundaries: -Between Skill-building (SK) and Community Living Supports (CLS) *Report SK when there is a vocational or productivity goal in

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
						the IPOS and the individual is being taught the skills he/she will need to be a worker (paid or unpaid) *Report CLS when an individual is being taught skills in the home that will enable him/her to live more independently -Between SK and Supported Employment (SE): *Report SK when the individual has a vocational or productivity goal to learn how to be a worker. *Report SE when the goal is to obtain a job (integrated, supported, enclave, etc), and assistance is being provided to obtain and retain the job.
Speech & Language Therapy	92610	Evaluation of swallowing function	Encounter DT=1/day	Line Professional	State Plan, Healthy Michigan	When/how to report encounters: for face-to-face contact only Allocating and reporting costs: -Cost of non-face-to-face consultation on behalf of a consumer in a specialized residential setting or day program setting or sheltered workshop should be loaded into the cost of face-to-face activities of speech and language therapy -Costing if staff provide multiple units **92522 and 92523 cannot be reported on the same day.**
	92521	Evaluation of speech fluency (e.g., stuttering, cluttering)	Encounter DT=1/day	Line Professional	State Plan, Healthy Michigan	
	92522	Evaluation of speech sound production	Encounter DT=1/day	Line Professional	State Plan, Healthy Michigan	
	92523	Evaluation of speech sound production with evaluation of language comprehension and expression	Encounter DT=1/day	Line Professional	State Plan, Healthy Michigan	
	92524	Behavioral and qualitative analysis of voice and resonance	Encounter DT=1/day	Line Professional	State Plan, Healthy Michigan	
	92507, 92526,	S&L therapy, individual, per session	Encounter DT=1/day	Line Professional	State Plan, Healthy Michigan	
	92508	S&L therapy, group, per session	Encounter DT=1/day	Line Professional	State Plan, Healthy Michigan	

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
	92607	Evaluation for prescription for speech-generating augmentative and alternative communication devices, face-to-face with patient, first hour.	60 Minutes DT = 1/day	Line Professional	State Plan, Healthy Michigan	
	92608	Add-on codes for 92607, each additional 30 minutes	30 Minutes DT = 24/day	Line Professional	State Plan, Healthy Michigan	
	92609	Therapeutic services for the use of speech-generating device, including programming and modification.	Encounter DT=1/day	Line Professional	State Plan, Healthy Michigan	
Substance Use Disorder: Individual Assessment	H0001	H0001 – Individual face-to-face alcohol and/or drug assessment at the licensed provider level for the purpose of identifying functional and treatment needs and to formulate the basis for the Individualized Treatment Plan.	Encounter DT: H0001=1/day	Line Professional	State Plan, Healthy Michigan, Block Grant, PA2	When/how to report encounter: -H0001 is face-to-face with qualified professional only -HD modifier for all qualified WSS Allocating and reporting costs: - Include cost of indirect activity -Cost if staff provide multiple services
Substance Use Disorder: Outpatient Care	H0004	H0004 -Behavioral health counseling and therapy, per 15 minutes	15 Minutes DT: H0004=40/day	Series/Line (depends on other payers) Institutional or Professional (depends on other payers)	State Plan, Healthy Michigan , Block Grant, PA2	When/how to report encounter: -Face-to-face with qualified professional only -H0038 Face-to-face with qualified peer specialist -HD modifier for all qualified WSS -Per diem rate for H0015 and H2036 -15 minutes of an SUD program for H0050 Allocating and reporting costs: - Include cost of indirect activity -Cost if staff provide multiple services
	H0005,H0015, H0022, H2011, H2027, H2035, H2036, H0050,	H0005 – Alcohol and/or drug services; group counseling by a clinician H0015 – Alcohol and/or drug services; intensive outpatient (from 9 to 19 hours of structured programming	H0005 = Encounter H0015 = Day	Series/Line (depends on other payers) Institutional or		Use HF modifier with H2027 to distinguish it from the Mental Health Prevention model.

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
		per week based on an individualized treatment plan), including assessment, counseling, crisis intervention, and activity therapies or education H0022 – Early Intervention services, per encounter H2011 HF – Crisis Intervention, per 15 minutes H2027 HF – Didactics, per 15 minutes H2035 –Outpatient alcohol/other drug treatment services, per hour H2036 –Outpatient alcohol/other drug treatment services, per diem H0050 – Alcohol and/or other drug services, brief intervention, per 15 minutes 0906 – Intensive Outpatient Services – Chemical dependency	H0022= Encounter H2011 = 15 minutes H2027 = 15 min H2035 = Hour H2036 = Day H0050 = 15 minutes	Professional (depends on other payers)		
Substance Use Disorder: Laboratory Tests	H0003, H0048, 80300, 80301, 80302, 80303, 80304	H0003 - Laboratory analysis of specimens to detect presence of alcohol or drugs. H0048 - Alcohol and drug testing, collection and handling only, specimens other than blood. 80300-80304 - Drug Screen.	Encounter	Line Professional	Block Grant, Healthy Michigan PA2, State Plan	State Plan coverage for Methadone only.
Substance Use Disorder: Methadone	H0020	Alcohol and/or drug services; Methadone administration and/or service (provision of the drug by a licensed program)	Encounter	Line Professional	State Plan, Healthy Michigan, Block Grant, PA2	When/how to report encounter: - Report each daily dosage per person -HD modifier for all qualified WSS Allocating and reporting costs: -The costs for drug screens are included in the unit rate

PIHP/CMHSP ENCOUNTER REPORTING
HCPCS and REVENUE CODES

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
Substance Use Disorder: Pharmacological Support - Buprenorphine or Suboxone	H0033	H0033 -Oral medication administration, direct observation. (Use for Buprenorphine or Suboxone administration and/or service - provision of the drug).	Encounter	Line Professional	Healthy Michigan, Block Grant, PA2, Medicaid Savings	
Substance Use Disorder: Recovery Support Services	G0409, H0023, H0038, T1012	G0409 – Social work and psychological services H0023 HF – Peer Directed and Operated Support Services H0038 HF– Recovery Coach (Peer services), per 15 minutes T1012 –Recovery Supports	G0409 = 15 minutes H0023 = Encounter H0038 = 15 minutes T1012 = Encounter	Line	State Plan, Healthy Michigan under SUD Benefit, Block Grant, PA2	
Substance Use Disorder: Sub-Acute Detoxification	H0010, H0012, H0014 Rev code: 1002	H0010 – Alcohol and/or drug services; sub-acute detoxification; medically monitored residential detox (ASAM Level III.7.D) H0012 – Alcohol and/or drug services; sub-acute detoxification (residential addiction program outpatient) H0014 - Alcohol and/or drug services; sub-acute detoxification; medically monitored residential detox (ASAM Level I.D) 1002 – Residential treatment – chemical dependency	Day DT: H0012=1/day	Series Institutional	State Plan, Healthy Michigan,, Block Grant, PA2	When/how to report encounter: -Days of attendance -In as of midnight -If consumer enters and exits the same day it is not reportable -HD modifier for all qualified WSS Allocating and reporting costs: -Bundled per diem *Includes staff, operational costs, lease, physician
Substance Use Disorder: Residential Services	H0018, H0019 Rev code: 1002	H0018 HF Alcohol and/or drug services; corresponds to services provided in a ASAM Level III.1 program, previously referred to as short term residential (non-hospital residential treatment program) H0019 Alcohol and/or drug services; corresponds to services provided in ASAM Level III.3 and ASAM Level III.5 programs, previously	Day DT: H0018=1/day	Series Institutional	State Plan, Healthy Michigan, Block Grant, PA2	When/how to report encounter: -Days of attendance -In as of midnight -If consumer enters and exits the same day it is not reportable -HD modifier for all qualified WSS Allocating and reporting costs: -Bundled per diem *Includes staff, operational costs, lease, physician

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
		referred to as long-term residential (non-medical, non-acute care in residential treatment program where stay is typically longer than 30 days)				
Substance Use Disorder: Treatment Planning	T1007	Alcohol and/or substance abuse services, Treatment plan development and/or modification	Encounter	Series/Line (depends on other payers)	State Plan, , Healthy Michigan, Block Grant, PA2	
Supported Employment Services	H2023	Supported employment Modifier HK (specialized mental health programs for high-risk populations) must be reported for Habilitation Supports Waiver beneficiaries. Modifier TG for Evidence-based Practice/Individual & Placement Support-IPS (supported employment) program **that has had and maintains EBP/IPS fidelity score of FAIR or higher**. For persons with serious mental illness only. Modifier TT when multiple consumers are served simultaneously See Appendix for detailed information on reporting of consumer transportation for attendance at Supported Employment services.	15 minutes DT=40/day	Line Professional	Healthy Michigan, Habilitation Supports Waiver, 1915(b)(3) & EPSDT	When/how to report encounters: -Report face-to-face units the consumer receives of job development and on-site job supports. Staff must be present to report units -Exclude MRS cash-match cases/activity -Exclude transportation time and units Allocating and reporting costs -Include the transportation costs, where appropriate, to and from supported employment services -Include cost of staff, facility, equipment, travel, transportation, contract services, supplies, and materials -Include cost of indirect job development and job coach activities - -Show MRS match on CMHSP sub-element cost report as "Other GF Expense" Boundaries: -Between Supported Employment (SE) and Community Living Support (CLS) *For assistance with ADLs on the

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
						job: report SE if job coaching is also occurring while on the job; if not, report CLS. -Between SE and Skill building (SK) *Report SK when the individual has a vocational or productivity goal to learn how to be a worker *Report SE when the goal is to obtain a job (integrated, supported, enclave, etc), and assistance is being provided to obtain and retain the job -Between SE and Transportation: *add costs of transportation to SE when transporting to and from a job site when other SE services are being provided. Transportation to a job, when other job supports are not identified in the IPOS, is not an allowable Medicaid expense.
Supports Coordination	T1016	T1016 Case management, each 15 minutes. Modifier HK (specialized mental health programs for high-risk populations) must be reported for Habilitation Supports Waiver beneficiaries. No modifier is reported for Additional or "b3" Services.	15 minutes DT=48/day	Line Professional	Healthy Michigan, Habilitation Supports Waiver, 1915(b)(3) & EPSDT	When/how to report encounter: -Face-to-face only -Includes supports coordinator's activities of pre-planning, treatment planning, periodic review of plan (Collateral contacts are indirect time/activity) -Activities of supports coordination assistants or aides, service brokers, and case management assistants may be reported, but not for the same time period for which there is a supports coordinator activity reported -Typically supports coordination may not be reported for the time other Medicaid-covered services

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
						(e.g., medication reviews, skill building) are occurring. However, in cases where a per diem is being paid for a service – e.g. CLS and Personal Care – it is acceptable to report units of supports coordination for the same day. Allocating and reporting costs: - Include indirect activity -Cost if staff provide multiple services Boundaries: -Between Supports Coordination (SC) and Targeted Case Management (TCM) *Use SC for all HSW beneficiaries *Use SC when any Medicaid beneficiary (SMI, DD or SED) has goals of community inclusion and participation, independence or productivity (see 1915 b3 or Additional Supports and Services in the Medicaid Provider Manual) and needs assistance with planning, linking, coordinating, brokering, access to entitlements, or coordination with health care providers, but does not meet the criteria for TCM (see below) *Use SC when one or more of functions will be provided by a supports coordinator assistant or service broker -Between SC and Community Living Supports (CLS): *a staff who functions as supports

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
						coordinator, may also provide CLS, but should report the CLS functions as CLS not SC. -Between SC and other covered services and supports: *a staff who functions as supports coordinator, may also provide other covered services, but having done so should report those covered services rather than SC.
Targeted Case Management	T1017	Targeted Case management	15 minutes (Face to Face) DT=48/day	Line Professional	State Plan, Healthy Michigan	<u>When/how to report encounter:</u> -Face-to-face only -Includes case manager's activities of pre-planning, treatment planning, periodic review of plan (Collateral contacts are indirect time/activity) -Typically case management may not be reported for the time other Medicaid-covered services (e.g., medication reviews, skill building) are occurring. However, in cases where a per diem is being paid for a service – e.g. CLS and Personal Care – it is acceptable to report units of case management for the same day. <u>Allocating and reporting costs:</u> - Include indirect activity -Cost if staff provide multiple services <u>Boundaries:</u> -Between Supports Coordination (SC) and Targeted Case Management (TCM) *Use SC for all HSW beneficiaries *Use SC when any other Medicaid beneficiary (SMI, DD or SED) has

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
						goals of community inclusion and participation, independence or productivity (see 1915 b3 or Additional Supports and Services in the Medicaid Provider Manual) and needs assistance with planning, linking, coordinating, brokering, access to entitlements, or coordination with health care providers, but does not meet the criteria for TCM (see below) *Use SC when one or more of functions will be provided by a supports coordinator assistant or service broker -Between SC and Community Living Supports (CLS): *a staff who functions as supports coordinator, may also provide CLS, but should report the CLS functions as CLS not SC. -Between SC and other covered services and supports: *a staff who functions as supports coordinator, may also provide other covered services, but having done so should report those covered services rather than SC.
Telemedicine Facility Fee	Q3014	Telehealth originating site facility fee	Per Service	Line Professional	State Plan	
Therapy (mental health) **Child & Adult, Individual, Family, Group**	90837, 90785	Individual therapy, adult or child, **60** minutes 90837 for SUD: Use modifier HF to signify that these codes were used for substance abuse treatment, because they are also used for	Encounter	Line Professional	State Plan, Healthy Michigan State Plan, Healthy Michigan, Block Grant, PA2	When/how to report encounter: -Face-to-face with qualified professional only Allocating and reporting costs -Cost of indirect activity -Cost of co-therapists' contacts -Cost if staff provide multiple units -Spreading costs over the various

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
		reporting mental health services.				types of services

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
	90832, 90785	Individual therapy, adult or child, ~~20-30~~ **30** minutes 90832 for SUD : Use modifier HF to signify that these codes were used for substance abuse treatment, because they are also used for reporting mental health services.	Encounter	Line Professional	State Plan, Healthy Michigan State Plan, Healthy Michigan, Block Grant, PA2	
	90834, 90785	Individual therapy, adult or child, **45** minutes 90834 for SUD: Use modifier HF to signify that these codes were used for substance abuse treatment, because they are also used for reporting mental health services.	Encounter DT=2/day	Line Professional	State Plan Healthy Michigan State Plan, Healthy Michigan, Block Grant, PA2	
	90833, 90836, 90838	90833 (30 min), 90836 (45 min) 90838 (60 min) evaluation and management and psychotherapy add-on codes only	DT=2/day	Line Professional	State Plan, Healthy Michigan	
	90853, 90785	Group therapy, adult or child, per session 90853 - Includes MOM Power 90853 for SUD: Use modifier HF to signify that these codes were used for substance abuse treatment, because they are also used for reporting mental health services.	Encounter DT=1/day	Line Professional	State Plan, Healthy Michigan State Plan, Healthy Michigan, Block Grant, PA2	
	90846, 90847 90849	Family therapy, per session For 90846 and 90847 use modifier HA when reporting Parent Management Training Oregon Model. Use modifier HA with 90849 when	Encounter DT=1/day	Line Professional	State Plan, Healthy Michigan	

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
		reporting Parent Management Training Oregon model (Parenting Through Change Group**)** Modifier HS: consumer was not present during activity with family 90846, 90847, and 90849 for SUD: Use modifier HF to signify that these codes were used for substance abuse treatment, because they are also used for reporting mental health services.			State Plan, Healthy Michigan Block Grant, PA2	
	H2019	Therapeutic Behavioral Services: Use for individual Dialectical Behavior Therapy (DBT) provided by staff trained and certified by MDHHS. Add TT modifier for group skills training **Note: this code with a U5 modifier indicates Applied Behavior Analysis (see above).**	15 minutes	Line Professional	State Plan, Healthy Michigan	When/how to report encounter DBT phone contacts are not reported, however the costs are loaded into face-to-face treatment or training. Group skills training is reported only when more than one individual is present during the skills training session
Transportation	A0080, A0090, A0100, A0110, A0120, A0130, A0140, A0170, S0209, S0215 T2001-T2005	~~[Note: Optional to report on Encounter report]~~ Only report these codes for transportation to/from services **other than** day-time activity. Cost for transportation for day-time activity should be included in the respective day-time activity. Non-emergency transportation services. Refer to code descriptions. Do not report transportation as a separate Habilitation Supports Waiver service, or when provided to transport the beneficiary to skill-	Refer to code descriptions DT: Mile codes= 1,000/day Per diem codes= 1/day	Line Professional	State Plan, Healthy Michigan, 1915(b)(3),	When/how to report encounter: Preferred option for ambulance: turn in claim information as submitted by the ambulance service Other transportation services should not be reported separately Allocating and reporting costs: Other transportation costs should be included in the cost of the service to which the beneficiary is being transported (e.g., supported

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
		building, clubhouse, supported employment, or community living activities T2001-2005, S0215, A0100, and A0110 for SUD: Use modifier HF to signify that these codes were used for substance abuse treatment, because they are also used for reporting mental health services.			State Plan, Healthy Michigan, Block Grant, & PA2	employment, skill building, and community living supports)
Treatment Planning	H0032	Mental health service plan development by non-physician Modifier TS for clinician monitoring of treatment	Encounter DT=100/day	Line Professional	State Plan, Healthy Michigan	When/how to report encounter: -Count independent facilitator and all professional staff, where the consumer has chosen them to attend, participating in a person-centered planning or plan review session with the consumer -Case manager or supports coordinator do not report treatment planning as this is part of TCM and SC -Report monitoring the implementation of part(s) of the plan by clinician, such as OT, PT or dietitian. -Assessments and evaluations by clinicians should not be coded as Treatment Planning but rather as the appropriate discipline (e.g., OT, PT, speech and language) -Use Modifier TS when clinician performs monitoring of plan face-to-face with consumer Allocating and reporting costs -Major implications for indirect contribution to other activities -Indirect activity -The cost of a clinician's

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
						monitoring the implementation of plan that does not involve a face-to-face contact with the consumer is an indirect cost of treatment planning
Wraparound Services (Medicaid Specialty Services and Supports)	H2021	Specialized Wraparound Facilitation	15 minutes	Line Professional	EPSDT & Healthy Michigan	When/how to report encounters: -Medicaid funds may be used only for planning and coordination for Wraparound -Report face-to-face (with consumer or family member) planning and coordination activities as Wraparound Facilitation; -When other clinicians, other service providers attend Wraparound meetings, they do not report the activity separately; -When Home-based staff attend Wraparound meetings their activity is not reported as either Wraparound or Home-based. However, the cost of their time can be counted as indirect to Home-based -treatment activities are reported as appropriate -Report that child is receiving wraparound services in QI data, item 13. -Neither targeted case management nor supports coordination should be reported when consumer is using Wraparound as it is a bundled service that contains supports coordination -Children may receive Home-based Services and Wraparound Services on the same day, but not at the

Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
						same time. However, since each are bundled services that contain supports coordination/case management activities, PIHPs should take care when costing activities of these two coverages, so that they are not paying or reporting twice for the same activity. Allocating and reporting costs: -Since the Wraparound model involves other community agencies that may contribute funds for the support or treatment of the beneficiary, care should be taken to report only those costs to the CMHSP/PIHP -Wraparound staff must be dedicated to that service for that beneficiary and not provide other covered services to the same beneficiary -The cost of clinicians, service providers or home-based staff who attend Wraparound meeting must be allocated to the cost of their specific service (not Wraparound) - Costing of indirect activity is critical.

Additional Codes for Reporting

PIHP/CMHSP ENCOUNTER REPORTING
HCPCS and REVENUE CODES

Service Description	HCPCS & Revenue Codes	Reporting Code Description	Reporting Units	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
Dental Services (routine)		Refer to ADA CDT codes		Line Dental		Report actual costs if CMHSP paid GF for service
Foster care	S5140, S5145	S5140- Foster care, adult, per diem (use for residential IMD) S5145- Foster care, therapeutic, child, per diem (use for CCI) Licensed settings only. Report for per diem bundled rate paid for residential services in a non-certified setting or other residential settings where Medicaid funding cannot be used	Day	Series Professional	GF only	When/how to report encounters -Days of care for children or adults *Should not include days when bed is vacant or consumer is absent from the home -Licensed setting only Only report for bundled GF-funded services – otherwise see personal care and CLS in specialized residential setting, or CLS in children's foster care that is not a CCI (for children with SED), or CLS in children's foster care or CCI for children with DD.
Laboratory Services Related to Mental Health		Refer to HCPCS codes in 80000 range		Line Professional	GF only services	Submit actual costs
Pharmacy (Drugs & Biologicals)		NDC codes for prescription drugs		Line Pharmacy - NCPDP	GF only services	Submit actual costs
SUD Consultation	99241-99255	Physician consultations	Refer to code descriptions	Line Professional	Block Grant and PA2	
Residential Room and Board	S9976	Lodging, per diem, not otherwise specified S9976 for SUD: Use modifier HF to signify that these codes were used for substance abuse treatment, because they are also used for reporting mental health services.	Day	Series	GF only service Block Grant & PA2	Room and board costs per day
Substance Use Disorder: Acupuncture	97810, 97811	97810 - Acupuncture, 1 or more needles, initial 15 minutes. 97811 - Acupuncture, 1 or more needles, each additional 15 minutes.	Encounter	Line Professional	Block Grant, PA2	
Substance Use Disorder: Case Management	H0006	Services provided to link clients to other essential medical, educational, social and/or other services.	Encounter	Line Professional	Block Grant, PA2	Does not have to be face-to-face.
Substance Use Disorder: Child Sitting Services	T1009	Care of the children of the individual receiving alcohol and/or substance abuse	Encounter	Line Professional	Block Grant, PA2	

Service Description	HCPCS & Revenue Codes	Reporting Code Description	Reporting Units	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
		services.				
Revenue Codes for Inpatient Hospital Ancillary Services	0144, 0183, 0250, 0251, 0252, 0253, 0254, 0257, 0258, 0270, 0271, 0272, 0300, 0301, 0302, 0305, 0306, 0307, 0320, 0370, 0410, 0420, 0421, 0422, 0423, 0424, 0430, 0431, 0432, 0433, 0434, 0440, 0441, 0442, 0443, 0444, 0450, 0460, 0470, 0471, 0472, 0610, 0611, 0636, 0710, 0730, 0731, 0740, 0762, 0900, 0901, 0902, 0903, 0904, 0911, 0914, 0915, 0916, 0917, 0918, 0919, 0925, 0940, 0941, 0942	Revenue Codes for ancillary Services. Refer to the State Uniform Billing Manual for code descriptions	Refer to code descriptions.	Series Institutional		.
Transportation	A0427, A0425	Non Medicaid-funded ambulance	Refer to code descriptions.	Line Professional	GF only services	Submit actual costs
Wraparound Services (GF)	T5999	Supply, not otherwise specified	Item	Line Professional	GF only	-GF may be spent on other wraparound activities or items. -Report actual cost of activities/items

APPENDIX: ENCOUNTER REPORTING AND FINANCIAL WORK GROUP DATA INTEGRITY EFFORTS, 2016

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Reporting of Community Living Support, per diem (H2016) and Personal Care, per diem (T1020) in Licensed and Certified Residential Settings

TOPIC:
Reporting of State Plan Personal Care (T1020) and EPSDT/B3/HSW Community Living Supports (H2016) in a licensed/certified home. These services are also covered under Healthy Michigan as of October 1, 2014.

PURPOSE OF THIS DOCUMENT:
To provide a succinct but comprehensive description of the use and reporting of residential services/supports - namely Personal Care (PC) and Community Living Support services (CLS) in licensed and certified settings.

The CMH system encounter reporting has evolved over the past few decades, with a major shift in 2004 with the advent of federally defined codes, and again in 2013 with the federal requirement to include financial data on price/cost in the encounter. Over the years, descriptions and requirements have been somewhat scattered, plus there have been a number of workgroups that have looked at reporting of Personal Care (PC) and Community Living Support (CLS) in these specialized mental health residential settings. The intent here is to pull together all of this into one go-to place for CMH staff involved with reporting and costing in order to drive a more consistent reporting of these services (high volume - i.e., a large percentage of PIHP/CMHSP spend - approximately 27%) across the state.

GENERAL INSTRUCTIONS

The system should no longer be thinking about this as a "specialized residential day". That does not exist as a Medicaid benefit. There are TWO services the person may receive in these locations from "residential" staff, i.e., Personal Care (T1020) and Community Living Supports (H2016). Staffing requirements for the home are dictated by licensing rules and take into account to some degree the level of severity of the consumers residing in the home as well as the fire/safety evacuation scores for the residents. When purchasing PC and CLS the PIHP/CMHSP/purchasing entity should in general take into account the overall staffing of the facility to ensure they can adequately meet the needs of consumers as determined by their needs assessment and plan of service – but ultimately staffing is the responsibility of the licensee. The amount

of PC and/or CLS paid to the provider via the per diem code is based on the assessed needs of the individual.
The contracts and billing/claims and encounter reporting for these services must comport with Medicaid requirements and reflect the two services. Contracting for one 'day' and then behind the scenes re-stating as two encounters by the purchasing entity should not occur as that is not consistent with Medicaid coverage - and thus jeopardizes the use of Medicaid funds. Therefore separate encounters/claims are submitted for CLS/H2016 and for Personal Care/T1020. Thus these two encounters reflect that the consumer received two different services which are consistent with their assessed needs and their Individual Plan of Service.
Use of local procedure codes should not occur. That practice is not consistent with HIPAA. The procedure codes that should be used are T1020 and H2016.

The purchaser is expected to monitor the quality of these services and to monitor that the consumer is receiving activities that meet their needs. Changes in the consumer's needs (beyond a temporary change) should result in a re-assessment and redetermination of the level of hours/activity needed by the consumer, and the cost per unit rates for PC and CLS for the individual.

These services are also subject to Medicaid claims verification process.

DEFINITION OF LIVING ARRANGEMENT WHERE THESE MEDICAID BENEFITS/CODES CAN BE PURCHASED/PROVIDED

- A group home that is licensed as an adult foster care and certified as a mental health residential service provider where the PIHP system is purchasing CLS and/or Personal Care on behalf of a consumer.
- H2016/T1020 may continue to be reported if the residents of the home have to be temporarily housed elsewhere, as long as these residential services are still provided by the licensed provider.
- A CMHSP/PIHP may purchase CLS/PC in a General AFC, i.e. only some of the capacity - but the home must still have been certified as specialized mental health residential program, and thus Place of Service is still 14.

- **Place of service = 14 (Specialized Residential AFC)**
  No other place of service codes to be used.

Reporting for BH-TEDS
Living Arrangement data element:
Field A052, all should use value 22
Field A053, value 221

Medicaid does not cover residential services provided to children with serious emotional disturbance in Child Caring Institutions (CCI) unless it is licensed as a "children's therapeutic group home" as defined in Section 722.111 Sec.1(f) under Act No.116 of the Public Acts of 1973, as amended.

Medicaid does cover services provided to children with developmental disabilities in a CCI that exclusively serves children with developmental disabilities, and has an enforced policy of prohibiting staff use of seclusion and restraint. They may use physical management as defined by MDCH policy and PA 116. (DCH memo from Liz Knisely dated April 16, 2014).

Includes child foster care if certified as a mental health residential program and may be licensed as a Therapeutic Home, which is a sub-category of CCI licensure.

Personal Care (T1020) and Community Living Supports (H2016) are **not** provided in the following residential settings:

- General AFC residential settings where the home/bed receives no specialized services (PC and/or CLS) from the PIHP/CMHSP system. These homes may provide personal care to a resident, which is billed by the AFC home to the state (ASAP) **but ONLY if the PIHP/CMHSP system has not purchased CLS or Personal Care for that resident**;
- Child caring institutions (CCIs) when used by a child with SED due to seclusion/restraint limitation. In these instances the S5145 code should be used and is only funded by GF;
- If a home serving adults is not certified as a mental health residential service or does not meet Medicaid requirements, then S5140 code should be used and charged all to GF

PIHP SERVICES COVERED:

There are two Medicaid covered services provided in these settings: Personal Care (T1020) and CLS (H2016). A beneficiary receives at least one of these two services in this setting. They may not need both.

Persons with more medical needs will likely get more PC.
Persons with more behavioral needs may only receive CLS.

EXCLUDES Room and Board - as ongoing housing costs are not a covered Medicaid benefit.

All other services provided in the home MUST be separately billed, e.g., professional services such as case management, supports coordination, OT, PT, speech, nutrition, and/or health services.

Licensing rules require levels of staffing based on the needs/severity of the residents and 24/7 supervision.

The licensing standards require the home to provide transportation, including for school, day activity services, and/or community activity. These costs can be rolled up into the CLS rates.
Note: This does create a dissonance for the rates for the daytime activity codes but will have only a minimal impact on the CLS and PC rates in general (there will be exceptions at an individual basis where the person needs a lot of transport - e.g. medical conditions - where this has not been covered by DHHS or Medicaid Health Plans). Thus it is best, but **NOT** required to cover these transportation costs via a separate contract and payment so that those costs can be attributed to the services for which the person is being transported

Personal Care: Services that assist the beneficiary in performing personal daily activities (hands on services/supports) including

- Assistance with for preparation, clothing, laundry, housekeeping
- Eating/feeding
- Toileting
- Bathing

- Grooming
- Dressing
- Transferring
- Ambulation
- Medications

Community Living Supports: Services used to increase or maintain personal self-sufficiency with a goal of community inclusion/participation, independence and productivity.

- Assisting, reminding, observing, guiding and/or training
  - Meal prep
  - laundry
  - routine household care and maintenance
  - activities of daily living
  - shopping
- Assistance, support and/or training
  - money management
  - non-medical care
  - socialization and relationship building
  - transportation
  - participation in community activities and recreation opportunities
  - attendance at medical appointments
- Reminding, observing and/or monitoring of medication administration
- Staff assistance with preserving the health and safety of the beneficiary

ASSESSMENT

Through the person-centered planning and IPOS development the person is assessed for each of these two services. This assessment should occur at least annually. For transitional placements, this should be done every quarter.

The assessment should result in an identification of the level of need (average/typical hours/day) for each of these services.
Note - Do not based costs on twenty-four hours of service per day unless the person's needs dictate twenty-four hours of care. Note - the hours are also assumed to be an average over time as there will be daily fluctuations in the actual time.

Note: there should be consistency between criteria used by PIHPs and DHS (Home Help), especially for Personal care. Other DCH guidelines for CLS in other DCH programs (e.g., CW) also provides a guide.

The assessment of need and delivery of services is overseen by a variety of monitoring activities, including case management visits, Medicaid verification, quality monitoring and other on-site monitoring. If the needs appear to have changed or the home is providing a level that is not consistent with the assessment/plan, then a re-assessment is warranted.

REPORTING

Personal Care (T1020) and Community Living Support (H2016) are per diem codes.

The beneficiary must receive at least one activity within the service for that day to be reported and the activity must relate to the goals as specified in the IPOS. If the beneficiary receives NO service on a day (i.e, midnight to midnight), this day cannot be counted/reported/billed.

The preferred documentation is "time spent" in each activity described in plan of service, rather than a check mark.

The Medicaid rule regarding not reporting/billing day of discharge is assumed to be a primary rule governing which provider can report/bill that day. The CMHSP/PIHP cannot report the day of exit when the consumer is going to another per diem setting.

The same day may **NOT** be reported by two homes (transfers**); NOR** if the person is moving from a certified/licensed setting to a non-licensed setting which will be using H0043 per diem code; **NOR** if persons have a hospitalization or nursing home stay; **NOR** as persons terminate the licensed/certified CLS/PC services, including leaving the CMH system. The discharge day or the day the person "moves" to the other setting is not reportable as a CLS/PC per diem by the home for the person is who "leaving".

The "day" of attendance/service is based on the beneficiary receiving at least one activity in Personal Care and/or CLS, and as noted above is not moving that day to another setting (permanently or in the case of hospitalization on a temporary basis).

However, the beneficiary may be absent from the home for other leaves, e.g., visits with family/friends. For both the day they leave and the day they return, IF they receive at least one activity in Personal Care and/or CLS, then that day may be reported. If the person is out of the home on leave for an entire 24-hour day, that day is not reportable.

NOTE: In the past DCH had allowed the concurrent use of H2015 for 1-1 staffing needed on a temporary/emergency basis for an individual consumer. **As of 10/1/16 this is no longer allowed**. **THIS IS A CHANGE FROM PAST PRACTICE**: See below in pricing section.

The use of modifiers was removed for FY16. These 3-level modifiers have been a challenge to the system and have created a high degree of inconsistency in application and thus appear to no longer be of use. Plus, these homes are very regulated and requirements dictate the staffing and levels of needs of the residents. These services are more stable and have little impact from the use of natural supports that impacts services in non-licensed settings.

The encounter data is now reported to the state with actual individualized rates - and thus more reflective of need, especially with the costing/pricing rules delineated below.

It is also hoped that assessment data (CAFAS, LOCUS, SIS) will further illuminate need variance in per diem "rates".

RELATIONSHIP TO DAY-TIME ACTIVITIES

In most circumstances the consumer will also have week-day, day-time activity to complement their licensed/certified residential services (CLS, Personal Care). This allows the resident to get out into their community and receive additional services that support their inclusion in their community. When the day-program services were unbundled in 2004, along with state plan benefit (clubhouse/PSR) there were a number of services added as an alternative (B3) service – including consumer-run drop-ins, skill-building and supported employment, as well as community living supports (CLS) as a non-vocational activity.

For FY17, DHHS will continue to allow the reporting of CLS as a per diem (H2016) and as a CLS day-time activity using H2015. This is allowed if a) the daytime activity is from a

different provider (the two encounters reporting the H2016 and the H2015 must have either a different Billing Provider NPI or Billing Provider Name (2010AA in the NM1 segment (or REF segment for an atypical provider)) b) there are appropriate separate daytime activity goals, and c) the place of service code is not one reflecting living arrangement – primarily it will be code 99. Note – this use of H2015 will likely change in the future.

PRICING

While the system started with a bundled day concept for these services, those days are long gone.
The PIHP/CMH/MCPN/Core Provider is responsible for purchasing the two services separately.

These services do not include room and board (R&B) costs. Those expenses are expected to be covered by other funding sources collected by the home provider (e.g., SSI/SSD, Bridge card/food).
Note there is a personal allowance component to the funds received by the consumer that is deducted before applying the rest of these funds to R&B. SSI only personal allowance rate (2015 at $44) and other/non-SSI personal allowance rate (2015 at $64). It is important to note that if these other fund sources (SSI, SSD, 1st party payment, Bridge card) are not sufficient to cover the cost of housing and food, then any residual room/board expense MUST be charged to GF.
The use of S9976 is not intended to be used to report costs that were netted out and thus submission of an encounter for that code is unnecessary. This code was primarily added as a GF-only code to capture GF costs in crisis residential programs.

The pricing of each service (PC and CLS) is expected to be done at the individual beneficiary level and be based on the assessment of need/hour. This is consistent with individual budgets and self-determination. It is recognized that there may have been a history of capacity based contracts - it is expected that the purchasing system (i.e., PIHPs, CMHSPs, MCPNs, core providers) will move away from such contracts by the end of FY16.

An example of when staffing patterns may impact the rates for an individual would be when the overall evacuation scores for the residents are such that additional staff are needed to ensure the health and safety of everyone in the home.

The pricing is derived from an average cost per staff hour which should take into account such "staffing" costs as salary, fringes, home administration, CSS/M, transport, overhead, etc. Staff time is driven primarily by the needs of the consumers in the home. As noted above - pricing should NOT include facility costs (lease, utilities, maintenance, food) as these are to be covered by other fund sources. It is not intended that each home have a different cost of a staff person per hour - in fact the purchaser should move to a more consistent rate across their network - where the variance is attributable to the complexity of the consumer and their needs (staffing intensity, transportation).

For personal care the hours would be in general based on 1-1 staffing, but may also need to account more for activities when more than one staff is required.

For CLS, the calculation should take into account that some of the activity may be provided by staff to more than one consumer at the same time.

The assessment for each service (i.e., time needed by each consumer) thus drives the individualized per diem rate for each service.

NOT acceptable reporting/pricing

- PC is 4 hours thus 1/6 of day and thus 1/6 of total per diem
- The total cost to run the home is $285,000 and there are six people living there with different level of needs:
    - 6 people times 365 days = 2,190 total days for a total per diem of $130.14
    - With PC as 1/6 reporting PC as $21.69 and CLS as $108.45, **These rate calculations are NOT acceptable**

EFFECTIVE October 2016

Community Living Supports in Non-licensed In-Home Settings: H0043 (per diem) and H2015 (15 minute)

BACKGROUND

Community Living Supports (CLS) first appeared in Michigan as a new coverage under the Habilitation C-waiver in the 1990s. At that time, it was all about additional supports in the home (both licensed and non-licensed). With the advent of the B3 coverage for alternative services in 2004, and limiting skill-building to a vocational emphasis, the use of CLS was expanded to include its use as a community inclusion service. Thus, currently CLS is used for a number of different purposes and settings, leading to variance in units/person as well as cost/unit and cost/person. Plus, we have lost the ability to identify activities and costs associated with "residential" supports – i.e., those units and costs to meet a basic living arrangement need. Thus, the state has no ability to identify the aggregated costs of residential supports/services.

In addition, the use of H0043 per diem code has increased significantly reflecting the CMH system and state value of inclusion and choice. The variance in the cost/day as reported with H0043 has also increased.

PURPOSE OF THIS DOCUMENT

To provide a description of the various ways CLS as a non-licensed in-home support is used and to be reported and priced via the per diem code (H0043) and 15-minute code (H2015)

SERVICE DEFINITION

Coverage for community living supports includes assisting, prompting, reminding, cueing, observing, guiding and training in activities of daily living and other activities that increase or maintain and individual's self-sufficiency such as meal preparation and laundry. Coverage also includes staff assistance, support or training with money management, non-medical care, socialization, participation in community activities, attending medical appointments, and transportation for community activities (excluding medical appointments) as well as reminding, observing or monitoring of medication

administration. CLS coverage also includes staff assistance with preserving the health and safety of the individual in order that he/she may reside in the most integrated, independent community setting.

1. CLS as Primarily an In-Home Support in Non-licensed Living Arrangements

This is when CLS qualified staff provide CLS supports to persons living in non-licensed homes. This includes apartments, condominiums, houses, where the consumer and their "room" mates (if they have any) lease/rent the residence, and also includes when the consumer lives with their family or others where someone else may be responsible for the house/rent payment. The key is that the residence is **not** a licensed setting. Thus H0043 is **never** provided in a general AFC or licensed/certified AFC. In addition, as of 10/1/16, H2015 is never provided in a general AFC or licensed/certified AFC. H2015 authorizations for provision in a general AFC or licensed/certified AFC must be phased out by 10/1/2016 as it was not an eligible service in this setting.

This CLS is not limited to just the staff time spent in the residence. As part of the overall goal of community inclusion, the CLS staff will also accompany the consumer to community activities (shopping, recreation, church, etc). However, the preponderance of staff time is intended to assist the consumer to live within their own home (i.e., a non-licensed living arrangement).

CLS in non-licensed living arrangements is often provided in conjunction with personal care, also known as Home Help which is a State Plan benefit. This benefit is managed by county DHHS staff, and more recently with the advent of the MiHealth Link pilots for persons with dual coverage (Medicaid and Medicare) the Personal Care/Home help benefit is managed by the Integrated Care Organizations (ICO), i.e. Health Plans.

NOTE: There is an additional, and limited use for what is now seen as supportive housing, rather than CLS, such as an apartment program where there is a residential manager who will have intermittent contact with the residents to see how they are doing. The tracking of the 15-minute code is not an efficient practice for this model of service. It is expected that this model will be transitioned to a supportive housing reporting construct under the new PIHP specialty 1115 waiver in 2017 and therefore use a different code.

Reporting Rules

In 2004, the CLS for these non-licensed residential settings was limited to procedure code H2015 (15-minute code), but subsequently H0043 (per diem) was opened up. The use of H0043 covers a number of different circumstances that have a major impact on the per diem amount. To date these were all in the same reporting category - leading to significant variance in the per diem across the system. In addition, distinguishing the use of H0043 in shared living arrangements was lost when the use of TT modifier was discontinued. Shared living arrangements provide an efficiency as compared to persons living by themselves.

In general, H0043 per diem is used when the level of CLS needed is on a relatively steady basis.

Where the person has lower needs for CLS staff time and it is more intermittent (e.g., when there are natural supports, and thus needs to be more individualized), and also where there may be significant variability in the use due to the needs of the person, then H2015 is the preferred code to use. In general, the use of such CLS (H2015) occurs when the person's needs are less than 2-3 hours per day, and may not occur every day.

The exception to this 2-3 hour thresh-hold is when the consumer is in a self-determined arrangement and uses various staff during the day. These staff are not from the same provider agency and each needs to be paid based on their activity. In this case, continued use of H2015 is appropriate. Fiscal intermediary Services (T2025) are reported on a monthly basis.

The use of the per diem reporting, H0043, is also the preferred code for shared living arrangements so that the CLS worker does not have to track their time spent with each person and collectively.

Effective October 1, 2016 modifiers will be added to the reporting of H0043 to distinguish the scope/intensity of services provided, and use of TT modifier will be re-introduced to distinguish CLS services to persons where there is a shared living arrangement with their room-mate(s) also getting CLS services.

The scope/intensity with respect to use of per diem code appears to have three levels attached to it (see later regarding definition of the levels and modifiers).
There is an additional, and limited use for what is seen as supportive housing such as an apartment program where there is a residential manager who will have intermittent contact with the residents to see how they are doing and the tracking of the 15-minute code is not an efficient practice (note it is expected that this last model will be transitioned to a supportive housing reporting construct under the new PIHP specialty waiver and therefore use a different code).

The day is reported only if the consumer has face-to-face CLS activity with the CLS worker and is engaged in activities consistent with their IPOS. The day can be reported if the consumer leaves to visit family or some other absence from their home, as long as they received CLS activity in that day, In general, the reporting of the per diem is used when the consumer receives at least an average of 2-3 hours of CLS per day on an ongoing/regular basis, although in almost all cases the time would be much higher, up to 24 hours.

Note: Discharge day rule - if the consumer is being discharged from that service and is moving to another "per diem" service, then that discharge day is not reported; if the person is hospitalized, the day they enter the hospital is not reported as a H0043 service.

Modifiers to Categorize Intensity and thus per diem Variance

The thresh-holds are based on averages, i.e., a typical average daily number of hours. There may well be intermittent days which exceed or are below the thresh-hold. The needs assessment of the individual's need for supports should place the person into one of the levels.
NOTE: Persons in these settings are eligible for **Home Help** from the local DHHS office. This is a form of personal care. The hours of Home Help a person gets should be deducted from the hours needed for supports to derive the CLS level of need

no modifier: Low need/Low supports - up to 3 hours/day of CLS (net of home help hours)
TF: Between 3-10 hours/day (net of home help hours)
TG: More than 10 hours/day (net of home help)

Needs Assessment

Through the person-centered planning and IPOS development the person is assessed for this CLS service. This assessment should occur at least annually. For transitional placements, this should be done every quarter.

The assessment should result in an identification of the level of need (average/typical hours/day) for this service. Such assessment should be done consistent with Utilization Management guidelines. The assessment should also take into account the hours being provided through Home Help.

Note - the hours are also assumed to be an average over time as there will be daily fluctuations in the actual time.

For persons in shared living arrangements the needs should be assessed separately for each individual to determine the modifier level and rates paid based on the average need assumptions for the person. It is recognized that there will be fluctuation in actual practice across the room-mates. It should be noted that as the level of need is based on the individual's level of need, the modifier will not change for a person if the person's roommate(s) are away.

The assessment of need and delivery of services is overseen by a variety of monitoring activities, including case management visits, Medicaid verification, quality monitoring and other on-site monitoring. If the needs appear to have changed or the home is providing a level that is not consistent with the assessment/plan, then a re-assessment is warranted.

Use of TT modifier

When the CLS aide is typically providing CLS to two or more consumers in the same unlicensed setting, TT modifier should be used.
If the other roommate(s) is gone for a day or so, the TT modifier should still be used to designate the preponderance of the nature of the activity received by the consumer.

Place of Service Code

For these services, the preponderance of time is spent by the CLS staff person in the person's home/private residence. ONLY one location code is to be reported with H0043.

ONLY Use **Location Code 12 (home, private residence) with H0043.**

BH-TEDS: living arrangement

Field A052
Codes 23, 33, 72
23 = living in a private residence (i.e., not licensed) that is not owned by the PIHP/CMHSP; living alone, or with spouse, or with non-relative room-mates
33= living in a private residence (i.e., not licensed) that is owned by the PIHP/CMHSP; living alone, or with spouse, or with non-relative room-mates
72=living with natural or adoptive family members

Relationship between H0043 and H2015 for the Same Consumer

For FY17, DHHS will continue to allow the reporting of CLS as a per diem (H0043) and as a CLS day-time activity using H2015. This is allowed if a) the daytime activity is from a different provider (the two encounters reporting the H0043 and the H2015 must have either a different Billing Provider NPI or Billing Provider Name (2010AA in the NM1 segment (or REF segment for an atypical provider)) b) there are appropriate separate daytime activity goals, and c) the place of service code is not one reflecting living arrangement – primarily it will be code 99. Note – this use of H2015 will likely change in the future.

Note: DHHS is developing a different approach for reporting day-time CLS for FY18 implementation.

Pricing H0043

This is primarily a staffing cost.

Should **never** include the housing costs (room/board – housing rent/lease/mortgage, utilities, food) for the consumer - any such costs that exceed the consumer's contribution are charged to GF and should not be included in the cost of CLS. Room and Board is not a Medicaid benefit for these settings.

For the portion of time spent in community outings accompanied by the CLS worker, the CLS H0043 costs include transport costs and miscellaneous costs incurred (after use of the consumer's personal allowance).

Cost includes staff salary and fringes (staff time includes indirect time by the CLS worker – e.g., required training, planning meetings, supervision, travel time), provider agency overhead/supervision/administration, staff and consumer transportation for community inclusion activities, staff and consumer out-of-pocket expenses for community outings (net of consumer discretionary funding).

The per diem rate should be based on the individual needs assessment conducted at least annually in which the **average number of hours of CLS** needed by the consumer are determined. It is these average hours of need that drive the per diem rate.

NOTE CLS hours needed should be net of any hours provided by Home Help.

With shared living arrangements, each consumer should be assessed separately and thus have an individualized per diem rate. The rate for each person can be calculated as an average across several months and does not require re-calibration each month.

If the needs of the consumer changes, there should be a reassessment and a re-calculation of hours and thus the CLS per diem.

2. CLS As a 15-Minute In-Home Support Service in Non-Licensed Living Settings: H2015

Generally, H2015, as an in-home support, is used as a way to provide more individualized and intermittent CLS to the consumer where they live. Often these persons may have natural supports from family/friends. It is also used if the person has variable needs requiring that they contract with multiple providers who collectively provide on average 2-3 hours of CLS services per day; but in this case cannot use the H0043.
In general, the use of such CLS (H2015) occurs when the person's needs are less than 2-3 hours per day, and may not occur every day.

Their use of CLS may be categorized as 'low supports', but the individual may be higher need level - but get natural supports from others.

They are also eligible to get Personal Care/Home Help from DHHS local offices or from ICO's if they are enrolled in the MiHealthLink pilot.

The average number of hours needed should be determined by the needs assessment process - at least annually, and re-assessed if their needs change and/or the availability of natural supports changes.

It is critical that in the determination of hours of CLS/H2015 to be authorized, that the CMHSP/PIHP/purchasing entity apply a consistent assessment process and use a consistent utilization management guide to determine hours

Procedure Code

Code H2015 - 15 minute increments
Should be net of Home Help time

Use of TT Modifier

When the CLS aide is typically providing CLS/H2015 to two or more consumers in the same "private residence" setting, TT modifier should be used.
If the other roommate(s) is gone for a day or so, the TT modifier should still be used to designate the preponderance of the nature of the activity received by the consumer.

Place of Service Code: ONLY use place of service 12 (home/private residence) when using H2015 as an in-home support in the person's non-licensed residence.
It is not expected that the CLS "residential" worker change location codes as they accompany the consumers out into the community. Use the preponderance rule

BH-TEDS: living arrangement
Field A-052: codes 23, 33, 72

Relationship to Daytime Community Inclusion Activities

This topic is confusing as the same code, i.e., H2015, gets used for two different purposes. As noted earlier, there is a need to be able to identify how much of H2015 is used for residential services/supports. This is being accomplished by the use of place of service codes. It is also being accomplished by diminishing the use of H2015 as a residential support and instead using the non-licensed residential per diem code H0043. When the consumer is getting CLS/H2015 as both a residential supports and as a day-time community engagement activity, these activities will 1) be done by two different provider entities/staff the encounters for the H0043 and the H2015 must have either a different Billing Provider NPI or Billing Provider Name 2) use different place of service codes and 3)the IPOS should also be very clear as to the intent and goals for each of these activities, and the amount/scope to be provided for each.

Pricing H2015 - As Used To Provide In-Home Supports

This is primarily a staffing cost.
Should **never** include the housing costs (room/board) for the consumer. Room and Board is NOT a Medicaid covered benefit.

For the portion of time spent in community outings accompanied by the in-home CLS worker - primarily an evening or week-end activity - the CLS H2015 costs may include transport costs and miscellaneous costs incurred (after use of the consumer's personal allowance). Cost includes staff salary and fringes (staff time includes indirect time by the CLS worker – e.g., required training, planning meetings, supervision, travel time), provider agency overhead/supervision/administration, staff and consumer transportation for community inclusion activities (excluding weekday daytime transport), staff and consumer out-of-pocket expenses for community outings (net of consumer discretionary funding used for such outings).

Community Living Support (H2015) for Daytime Activity Reporting

BACKGROUND:

Many of the CMH system consumers are in need of constructive day-time activity. Approximately 20% of Medicaid costs are involved with day-time activity. These activities fall into the following service categories:

- Psycho-social Rehabilitation/Clubhouse (state plan: H2030)
- Skill Building Assistance (H2014)
- Supported Employment (H2023)
- Community Living Services (H2015)
- Peer operated drop-in programs (H0023 or ~~N/A~~aggregate costs for drops-ins are reported in cost reports only and outside of the encounter system)

For persons with an intellectual or developmental disability who are enrolled in the Habilitation Supports Waiver (HSW)

- Out of home non-vocational (H2014HK)
- Pre-vocational (T2015HK – an hour code)
- Supported Employment (H2023HK)
- Community Living Services (H2015HK)

STATEMENT OF THE ISSUES:

There are several issues that have arisen with respect to the reporting of these services:

1. BHDDA plans to phase out reporting CLS (H2015) as a daytime activity if the person is also getting a per diem CLS (i.e., H2016 or H0043)
2. HSW codes and use is challenging – the non-vocational has a 4-hour condition and uses the same code as skill-building; the pre-vocational code is an hour code which is difficult to use.
3. Transportation costs associated with these services has been reported in a variety of ways leading to inconsistency in cost per unit for the various services.

H2015 REPORTING CHANGES FOR FY17

As of 10/1/16, DHHS will no longer allow use of H2015 to report added staffing due to emergency needs of consumers in licensed/certified settings. These temporary added costs must be incorporated in the per Community Living Support diems.

For FY17 DHHS will allow continued use of H2015 as a day-time CLS activity for persons also getting a per diem CLS (H0043 or H2016). This decision will be re-valuated in the context of the 1115 waiver. This will likely be disallowed in the future and an alternative be developed to address these situations. For FY17, there are conditions attached to this use of H2015 as a CLS day-time activity:

- The staff persons providing this activity cannot be the same as staff providing the CLS residential services.
- The IPOS must delineate goals specific to these day-time CLS activities
- The place of service code is not one reflecting living arrangement – primarily it will be code 99, "*in the community*".

H2014HK REPORTING OF HSW NON-VOCATIONAL SERVICES:

Reminder that there are time constraints attached to use of H2014HK:

- Assistance with self-help, socialization and adaptive skills
- Outside of the home
- Services must be furnished FOUR OR MORE hours per day on a regularly scheduled basis for one or more days per week, unless provided as an adjunct to other HSW day activities

OTHER USES OF CLS - H2015 and T2037/2038

1. H2015 - as used to provide staff support costs for regular/ongoing day-time community activities provided by a "day" program provider agency: Non-facility based community activities

Code: H2015 reported in 15-minute increments

Use of TT modifier
When the CLS aide is typically providing CLS to two or more consumers at the same time in the community setting (i.e., group activities) TT modifier should be used.

Place of Service Code : DHHS hopes to get a new one for "community", in the meantime use 99

Assessment of Need
The use (amount, scope, duration, frequency) of CLS/H2015 as a day-time activity should be based on a consistent needs assessment process, and application of Utilization Management guidelines.

Pricing H2015 : Cost includes staff salary and fringes (staff time includes indirect time by the CLS worker – e.g., required training, planning meetings, supervision, travel time), provider agency overhead/supervision/administration, staff and consumer transportation for community inclusion activities, staff and consumer out of pocket expenses for community outings (net of consumer personal allowance contribution).

Transportation: If the transportation to H2015 community activities is done by a separate transportation company, then that cost is to be rolled into the H2015 service row in the UNCs, and will also be shown in a new informational row on UNCs: "Transport for Day-time/H2015 CLS". Transportation encounters should NOT be reported separately.

2. H2015 - as used to provide staff support costs for regular/ongoing day-time community activities provided by a "day" program provider agency: Facility based community activities

Code: H2015 reported in 15-minute increments

Use of TT modifier:
When the CLS aide is providing CLS to two or more consumers at the same time in the facility (i.e., group activities), TT modifier should be used.

Place of Service Code: 99

Pricing: This is primarily a staffing cost but may include facility costs if the CLS activity is being provided at a community facility. This community facility-based activity usually occurs when the consumer has goals for their day-time activity that are NOT vocational oriented (e.g., older adults, medically fragile, adult daily living skills). Cost includes staff costs (including supervisory staff), facility (lease/mortgage, utilities, maintenance), equipment, travel, consumer transportation to the site when provided by the CLS provider agency (and for administrative efficiency bundled into the rate to the CLS agency), contract services, supplies and materials , and provider administration

Transportation: If the transportation to the facility is done by a separate transportation company, then that cost will be included in the H2015 service row, and also reported as an added new informational row on UNCs: "Transport for CLS". Encounters not to be reported.

3. H2015 - as used to provide staff support by CMH staff - generally an intermittent activity

This use of H2015 that occurs at a CMH program/clinic generally falls into several alternatives:

a) CLS as provided by peers who are not yet certified
b) Provision of some specialized CLS activity -- often done in a group at the CMH site
c) Outreach activities

Use of TT modifier
When the CLS aide is providing CLS to two or more consumers at the same time (i.e., group activities), TT modifier should be used.

Code: H2015 reported in 15-minute increments

Place of Service Code:

Codes expect to see in most instances:

11- office, when done at the CMH site
04 - homeless shelters - when CLS staff reach out to these shelters to assist persons
New code - in the community
12 - home

Locations EXCLUDED:

- Location 14 -- licensed residential
- Location 33 - general AFC
- Nursing homes (31,32)

This is primarily a staffing cost but may include facility costs if the CLS activity is being provided at a CMH office. Cost includes staff costs (including supervisory staff), facility (lease/mortgage, utilities, maintenance), equipment, travel, supplies and materials , and provider administration

4. Therapeutic Camping (also can be respite): T2037, T2038

For Medicaid use, these camps must meet licensure/certification requirements and the services should address goals in the IPOS (either CLS oriented goals or respite goals)

Codes: per day/session code

Pricing - the camp customary rate

ASSOCIATED TRANSPORTATION COSTS

This is described in more detail in the Transportation document.
As of October 1, transportation associated with any of these various day-time services listed above in the background section will NOT be reported using transportation codes. CMH provider may continue to use those transport codes for billing/payment, but they should NOT be reported on to the state.

The costs for transportation will be either incorporated into the service encounter (usually when it is provided by the day-time activity provider) OR it will be shown as a cost in the various end of year reports (layered into the appropriate service row, but with a footnote row showing the transport cost).

Crisis Intervention and Pre-Admission Screening Assessment

About this document:

- This document is intended to be a training document that addresses coding, documentation and encounter reporting guidelines related to Inpatient Pre-Admission Screening Assessments and Crisis Intervention Services. This training proposes to emphasize the difference between Crisis Intervention which is to be considered treatment/intervention and the Pre-Admission Inpatient Screening Assessment which is not treatment but rather as assessment to determine whether alternative services are appropriate and available.

Medicaid Provider Manual 5.6.B.4 Crisis Services

Crisis Interventions are unscheduled activities conducted for the purpose of resolving a crisis situation requiring immediate attention. Activities include crisis response, crisis line, assessment, referral, and direct therapy. The standard for whether or not a crisis exists is a "prudent layperson" standard. That means that a prudent layperson would be able to determine from the beneficiary's symptoms that crisis services are necessary. Crisis means a situation in which an individual is experiencing the signs and symptoms of a serious behavioral health disorder, and one of the following applies:

- The individual can reasonably be expected within the near future to physically injure himself or another individual, either intentionally or unintentionally;
- The individual is unable to provide himself food, clothing, or shelter, or to attend to basic physical activities such as eating, toileting, bathing, grooming, dressing, or ambulating, and this inability may lead in the near future to harm to the individual or to another individual; or
- The individual's judgment is so impaired that he is unable to understand the need for treatment and, in the opinion of the behavioral health professional, his continued behavior as a result of the behavioral health disorder can reasonably be expected in the near future to result in physical harm to the individual or to another individual.

If the beneficiary developed a crisis plan, the plan is followed with permission from the beneficiary.

Medicaid Provider Manual Section 8 Inpatient Psychiatric Hospital Admissions

The PIHP is responsible to manage and pay for Medicaid mental health services in community-based psychiatric inpatient units for all Medicaid beneficiaries who reside within the service area covered by the PIHP. The PIHP may delegate these responsibilities to CMHSPs, MCPNs (Wayne County) or contracted providers.[1] This means that the PIHP is responsible for timely screening and authorization/certification of requests for admission, notice and provision of several opinions, and continuing stay for inpatient services, defined as follows:

Screening means the PIHP/delegated entity has been notified of the beneficiary's needs and has been provided enough information to make a determination of the most appropriate services. The screening may be provided on-site, face-to-face by PIHP/delegated entity personnel, or over the telephone.

Authorization/certification means that the PIHP/delegated entity has screened the beneficiary and has approved the services requested. Telephone screening must be followed-up by the written certification.

PIHP responsibilities include:

- Pre-admission screening to determine whether alternative services are appropriate and available.
- Severity of Illness and Intensity of Service clinical criteria will be used for such prescreening.
- Inpatient pre-screening services must be available 24-hours-a-day, seven-days-a-week.
- Provision of notice regarding rights to a second opinion in the case of denials.
- Coordination with substance abuse treatment providers, when appropriate.
- Provision of, or referral to and linkage with, alternative services, when appropriate.
- Communication with the treating and/or referring provider.
- Communication with the primary care physician or health plan.
- Planning in conjunction with hospital personnel for the beneficiary's after-care services.

[1] This language was added to the paragraph and is not part of the Medicaid Provider Manual description in Section

- In most instances, the beneficiary will receive services in a community-based psychiatric unit in the PIHP service area where he resides. There may be instances when a PIHP is responsible for a resident that they have placed into a community program in another county or state. In these cases, the responsible PIHP or delegated entity, i.e., the one managing the case, is responsible for authorizing admission and/or continuing stay.
- If a beneficiary experiences psychiatric crisis in another PIHP region, the PIHP in that county/region should provide crisis intervention/services as needed and contact the PIHP for the county of the beneficiary's residence for disposition.

Training and Discussion Points

A **Crisis Intervention** service can be and often is, provided without the follow-up transaction of an Inpatient Pre-Admission Screening (Assessment). The Crisis Intervention *service/treatment* that the person receives may fully address and currently resolve the crisis situation the person is experiencing. In this instance the provider of the Crisis Intervention service will document the HCPCS Code of H2011 and will also report all face-to-face time spent (*actively providing treatment*) on an encounter reporting claim (any non-face to face time should be incorporated into the indirect cost of the service). There may be multiple Crisis Intervention services in the same day.

- However, when the provider determines that a Crisis Intervention service/treatment is not going to resolve or fully address the symptoms and signs the person is experiencing, he may decide that an Inpatient Pre-Admission Screening Assessment is necessary to determine whether alternative services are appropriate and available. Thus in this instance, that Crisis Intervention service/treatment (H2011) now ends and Inpatient Pre-Admission Screening Assessment (T1023) starts.
- The T1023 assessment encounter ends at the time the disposition decision is made.
- The provider will also report all face to face time on an encounter reporting claim (any non-face to face time should be incorporated into the indirect cost of the service).

The time post T1023 that is spent face to face only (*actively providing treatment*) with the consumer (working on a diversion plan, etc.), will be considered H2011.

Service Description	HCPCS Code	Reporting Unit	Reporting Technique	Coverage	Reporting and Costing Considerations
Crisis Intervention	H2011	15 Minute	Line Professional	State Plan	Face to Face; Incorporate all phone time is an indirect cost
Screening for Inpatient Program	T1023	Encounter	Line Professional	State Plan	Incorporate all phone time is an indirect cost

Psychiatric Inpatient in a Local Hospital

Background on Reporting of This Service

- Unlike health care where inpatient services constitute 50% of use/costs, in the CMH system use of community hospitals is less than 10%.
- This service needs to be reported to distinguish Institutes for Mental Disease (IMD, PT68) from Community Inpatient (PT73). Why --This has been necessary in order to apply the "in lieu" of language to PT68 as a place/service for use of Medicaid funding (started in 2004). PLUS, there is a recent issue with PT68 not initially covered by HMP. With the 2016 federal managed care rules allowing some Medicaid/HMP use of PT68, this need to distinguish between PT68 and PT73 continues to be important.
- The original intent of the data was about "utilization" – i.e., this is such an important service for persons with mental illness and it is a high risk/high cost service and one that we manage carefully from crisis to screening to admission to discharge, especially for active CMH consumers.
- The DCH reporting rule from 2004 was to report all episodes where CMH was actively involved in the admission for an existing consumer. For others-the reporting of episodes was more tied to CMH role re authorized/approved admission, PLUS the ability to get information about the length of stay - especially challenging for Medicare-covered persons.
- In 2013 with the addition of including financial information on encounters, some CMHSPs/PIHPs went to reporting encounters only if they paid something for the episode. Thus a number of MME episodes are not reported – i.e., when Medicare payment covered the cost of the stay.
- Cost per day as reported across PIHPs shows we have inconsistency on how COB use/costs is being reported.

Reasons for FY17 Changes

- Based on the FY14 MUNC, the range for an inpatient day is $372-$975. A small part of this variance is due to market forces with respect to per diems as negotiated by CMHSPs/PIHPs. But the larger factors include a) how Coordination of Benefit is handled/reported, b) how accruals are reported, and c) how physician costs are paid.
- PIHPs with lower average per diems have included episodes (days used and cases) with a COB (including days with zero-paid by PIHP/CMHSP), whereas PIHPs with the higher average cost per day have included COB costs but not all of the days.
- Some PIHPs have made estimates for use (days/cases) for accruals – others have not.
- Most hospitals have agreed to a bundled per diem; some require the physician cost (can be 10-15% of the cost) to be paid/reported separately.
- FY17 reporting, instructions will address these sources of variance in how this service is reported.

Services Being Reported

Psychiatric inpatient admissions result from a crisis service (H2011 if face-face) and inpatient admission screening (T1023 if conducted face-face) disposition that the person does meet criteria (severity/intensity) for an inpatient admission. In most instances the PIHP/CMHSP or their agent authorizes the admission and will indicate a) the need for continued stay reviews, and b) payer of last resort responsibilities.
There will be a few crisis interventions that result in a referral to a hospital but without an authorization i.e., for persons with third party insurance, including Medicare-only, who do not meet the CMHSP general fund (GF) priority population criteria.

The CMHSP/PIHP system has responsibility to authorize and pay for psychiatric inpatient services provided in either a full-array community hospital (PT73) or free standing psychiatric hospitals (PT68) for persons with a) Medicaid - including dual eligible -MME, b) Healthy Michigan , c) MiChild, d) GF priority populations (un-insured and under-insured). Note: The 2016 managed care rules limit the use of Medicaid/HMP funds for adults (age 19-64) in PT68 facilities to stays of less than 16 days.

The free-standing psychiatric hospitals (PT68) meet the definition of an IMD facility. The federal Medicaid rules previously precluded the use of Medicaid funds for IMDs for

persons with mental illness between the ages of 21-64. However, Michigan received direction/permission from CMS in 2004 that these services could be purchased by PIHPs with Medicaid funding under the "in lieu" of rules – i.e., as a service substitution for the state plan benefit provided in community hospitals - under a set of CMS prescribed requirements (separate reporting, average price of IMD per diem to be less than per diem in full community hospital). Based on CMS's Medicaid Managed Care Rule effective July 6th Medicaid/HMP funds can now be used for IMD stays 15 days and under for adults ages 19-64. This 15 day limitation does not apply to children or persons over age 64.

DCH, now DHHS, is the keeper of the lists as to which facilities are PT68.

These are per diem codes. In general, the preferred cost reporting is as a bundled per diem, including the physician costs.
The services include the costs of admission in the per diem, i.e., excludes any emergency costs as incurred by the admitting hospital as a separate charge.
In some instances, the hospital will not bundle in the physician cost into the per diem. These are separately reported.

The hospital, in conjunction with the purchaser - as dictated by the contract terms - is responsible for providing the supports needed for the certification and court hearings related to involuntary commitment.

These services do not include other primary or acute health care services that the person might need during their psychiatric inpatient episode. In most instances, these costs are NOT the responsibility of the PIHPs/CMHSPs. With a limited scope, there may be ancillary services that are covered by the PIHP/CMHSP scope, such as electroconvulsive therapy (ECT). These are to be reported separately.

<u>Reporting Encounters</u> (that get rolled up into UNCs based on fund source): Effective 10/1/16

Encounters should be reported for all episodes where there is an amount paid by the PIHP/CMHSP. Encounters where there is $0 paid by the PIHP/CMHSP for the entire inpatient episode do not need to be reported to DHHS. This is a shift from past practice where the emphasis was "utilization".

- These inpatient services use revenue codes (see later)
- Encounter reporting is required to distinguish between episodes at a community hospital (PT73) and those at free-standing psychiatric hospitals (also known as IMDs) (PT68)
- PT68 is used to report all use at these free-standing facilities - regardless of age of the consumer.
- Financial Reporting Subgroup is comfortable with Milliman and MDHHS using the Hospital NPI reported with the **Billing Provider Name** in the Encounter (Loop 2010AA, Segment NM1, Element NM109).
    - Example: **NM1∗85∗2∗ABC HOSPITAL∗∗∗∗∗XX∗1234567890~**
- For FY17, the PIHP will continue to report the Hospital Type (i.e., 22, 68 or 73) as reported in the first two digits of the **Service Facility Location Name** in the Encounter (Loop 2310E, Segment REF, Element REF02). However, the legacy Hospital ID that is currently reported along with the Hospital ID Type will no longer be required or used.
    - Example 1: **REF*LU*22~**
    - **Example 2: REF*LU*73xxxxxxx** Where xxxxxxx is still the Hospital ID used or any combination of 7 characters such as: 0000000. This is an option that allows for no/little changes being made to your system.

- If a payment is made for inpatient services, the days of an inpatient episode to be reported INCLUDE both those days when a third party, is the payer as well as the days when the PIHP is the payer. The days to be reported EXCLUDE the day of discharge, or any day where the person is not in the psychiatric inpatient unit as of 11:59pm
- In most instances the inpatient episode is submitted in its entirety with one encounter, from admit date to discharge date.
- In a few instances the episode may be split into more than one encounter. This usually occurs for long episodes, and the hospital desires payment.
- It is also permissible, but not necessary, that episodes crossing 9/30 are reported as two encounters. Milliman currently prorates such episodes between the two fiscal years.
- Medicare COB for these services has several facets -- deductibles (changes each January), co-pays (which change at certain length of stay) as well as for re-admissions within a short time. Medicare currently has a 190 day lifetime

inpatient coverage care limit. It is expected that CMHSP/PIHP staff who are involved with adjudicating claims are very familiar with each of these issues.

- PIHPs involved with the MiHealth link pilots are reporting their Medicaid costs through the usual PIHP reporting (including showing the Medicare cost in the encounter financial loops), as well as submitting encounters to the ICOs for the Medicare share of the cost.

Revenues codes

These services use REVENUE codes to identify different types of services under the psychiatric inpatient umbrella. The characteristics that distinguish revenue codes include a) includes/excludes physician costs and b) ward size.

All Inclusive Rate (includes physician cost)		
Flat fee charge incurred on either a daily basis or total stay basis for services rendered. Charge may cover room and board plus ancillary services or room and board only.		
All-Inclusive Room and Board/Plus Ancillary	ALL INCL R&B/ANC with Physician costs	0100
Per Diem Excludes the Physician Cost		
All-Inclusive Room and Board/Plus Ancillary (no physician cost)	ALL INCL R&B/ANC excludes Physician costs	0114, 0124, 0134, 0154

Reporting Costs Incurred

Encounters minimally must include the payment made by the PIHP/CMHSP.
For persons with a coordination of benefit (COB), it is expected that all the financial loops will be populated to show the other revenues used to support the episode.
BHDDA will be working with the PIHPs so that all are reporting COBs by 10/1/2017.

Inpatient Reporting and Current Cost Reports

Reporting Costs Incurred But Not Reported

PIHPs/CMHSPs are on an accrual basis, thus as they close out the books for the year they will likely have a residual IBNR/Accrual. This is booked as a financial liability for that service year. This should be accounted for separately between PT68 and PT73. This amount is reported separately in the UNC reports and is already included in the Medicaid hospital report, as well as in FSR expenses.

Adjusting Prior Year

Subsequent adjustments to prior year accruals is **not** included as a service cost in the current year, i.e., not included in UNC rows for PT68/PT73. This is to be shown as a "write off" or "prior year adjustment" as a reconciling item between costs reported in UNCs and FSR.

Hospital Reimbursement Adjustment (HRA)

Up to FY16, the PIHPs were used as a vehicle to provide Medicaid reimbursement adjustments to hospitals where there has been a use by Medicaid eligibles. The payment is independent of the purchase of services via the per diems by the PIHPs/CMHSPs.
To assist in this process, the PIHPs annually populate a Medicaid and HMP use (per diems and expenses, HMP excludes use of PT68) report. This is used by MDHHS to determine each hospital's share of the HRA payment in a subsequent year (2-year lag).

During the year, MDHHS distributes a monthly HRA report that is used by the PIHPs to make quarterly payments to some of the PT68 and PT73 hospitals.

BHDDA will develop a plan to transition HRA payments to be compliant with CMS Managed Care Final Rule requirements related to pass-through payments.

Summary of Changes to Utilization and Net Costs Reports

Currently there are just two rows in the various UNC reports - one for PT68 facilities and one for PT73 facilities.

For FY16 there will be added rows under each provider type:

a) Use where there is no COB - on average this would reflect the full per diem negotiated by the PIHP
b) Use when there is COB (typically Medicare) and the PIHP/CMHSP made some or a partial payment for the episode. This would show much lower cost/unit.
c) Use when the physician cost is reported separately.
d) Accruals – estimated accrual for each of PT68 and PT73: There can be a significant lag in processing these claims. Thus the end of year FSRs will likely include an estimated accrual for costs incurred but not reported (IBNR). IBNR estimates will also be reported in the Utilization and Net Costs Reports and Sub-element Cost Report. The actual encounters for these IBNR episodes will not be reported to DHHS until the claim has been reported by the hospital and adjudicated by the payer (PIHP/CMHSP or their agent).

NOTE: Adjustments to hospital accruals from prior years is NOT reported as a service cost (as it was for a previous year - UNCS represent current year use), but reported as a reconciling item and FSR adjusting item.

For the PIHPs involved with the MIHealth Link MME pilots, MUNC reporting will only include the Medicaid share of these episodes. EDIT will be discussing whether MIHealth Link pilots should report the MIHealth Link expenses on the sub-element cost reports.

Coordination of Benefits

Copays are an issue as there is variation across PIHPs in how Medicaid/Medicare inpatient stays are reported as well as other inpatient stays for which there is a third-party payer. In addition, the PIHP/CMHSP typically does not receive the hospital claims for those inpatient days for which the PIHP does not have financial responsibility, even if for an active CMH consumer.

An added complication exists for MI Health Link where the PIHP is responsible for all inpatient days. It was noted that PIHPs involved in MI Health Link will be reporting encounters for Medicaid/Medicare inpatient days differently than the other PIHPs. The 837 will have the gross cost as well as the Medicaid cost for inpatient. However, the amount paid by the PIHP is still the Medicaid net.

For FY17 reporting, the PIHP/CMHSP will **report all days** of the consumer's inpatient stay including those stays for which the PIHP/CMHSP covers only a portion of the cost of the stay (as in the case of a Medicare deductible).

For FY16 UNCs (MUNC, HMPUNC, GFUNC, SECR) there will be added rows for both provider types to distinguish between various levels of payment responsibility:

- **a row for inpatient costs and units for which the PIHP/CMHSP makes 100% payment for the inpatient episode**
- **a second row for which the PIHP/CMHSP makes partial payment for an inpatient episode**

Physician Costs

Some hospitals do not bundle the physician cost into the per diem. These costs can be a significant percentage of the cost of the episode and thus result in a per diem variance.

For FY16 UNCs (MUNC, HMPUNC, GFUNC, SECR) there will be added rows for both provider types to distinguish between costs with bundled per diems and those with the physician services excluded:

- **A third row for which the PIHP/CMHSP makes 100% payment for an inpatient encounter where the physician cost is NOT included**
- **A 4th row for which the PIHP/CMHSP makes a partial payment for an inpatient encounter/episode where the physician costs are NOT included**

Claims that lag

Psychiatric inpatient claims are adjudicated in a less timely manner than are other claims. As a result, some claims are not processed by the end of the year for reporting on the UNCs.

For FY16 UNC reporting there will be two added rows to report IBNR/Accruals for services in the reporting year but for which there has not been an adjudicated claim at the time the report is compiled. One row for each of PT68 and for PT73 will be added to include the reporting of the accrued cost in the UNCs

Psychiatric Inpatient in a Local Hospital

Given the above discussion, the proposed inpatient rows on the FY2016 would appear as follows on the MUNC. Similar rows will be added to the Healthy Michigan UNC as well as the General Fund cost template and the sub-element cost report.

Service Description	HCPCS Code	Modifier	Revenue Code	Description	Reporting units	Unique Cases Served	State Plan Services Units	State Plan Services Total Costs
Local Psychiatric Hospital/IMD		PT68	0100	All-inclusive room and board plus ancillaries and physician	Day			
PIHP has 100% Medicaid payment for the encounter and physician costs are included in the per diem								
PIHP has partial Medicaid payment for the encounter and physician costs are included in the per diem								
Local Psychiatric Hospital/IMD		PT68	0114,0124, 0134,0154	All-inclusive room and board plus ancillaries				
PIHP has 100% Medicaid payment for the encounter and physician costs ARE NOT included in the per diem								
PIHP has partial Medicaid payment for the encounter and physician costs ARE NOT included in the per diem								
Local Psychiatric Hospital/Acute Community		PT73	0100	All-inclusive room and board plus ancillaries and physician	Day			
PIHP has 100% Medicaid payment for the encounter and physician costs are included in the per diem								
PIHP has partial Medicaid payment for the encounter and physician costs are included in the per diem								
Local Psychiatric Hospital/Acute Community		PT73	0114,0124, 0134,0154	All-inclusive room and board plus ancillaries	Day			
PIHP has 100% Medicaid payment for the encounter and physician costs ARE NOT included in the per diem								
PIHP has partial Medicaid payment for the encounter and physician costs ARE NOT included in the per diem								
Cost estimates of current year IBNR/Accrual								
Local Psychiatric Hospital/IMD		PT68	0100, 0114,0124, 0134,0154	All-inclusive room and board plus ancillaries	Day			
Local Psychiatric Hospital/Acute Community		PT73	0100,0114, 0124,0134, 0154	All-inclusive room and board plus ancillaries	Day			

Transportation Costs for Daytime Activities

Background

With the advent of encounter reporting using HCPC codes in FY04 and with the advent of B3 waiver authority for alternative services, the direction from EDIT/DCH for reporting transportation was that it was not a service that should be reported via encounters, and thus costs should be layered onto the service cost for which the person is being transported.

Over the years, there has been inconsistency with respect to following that instruction. This results in inconsistency for reporting cost per unit for those services, with some PIHPs/CMHSPs including the transportation costs, and some excluding those costs and reporting them separately. For some of the day-time activity services the cost of transportation can be significant, thus skewing the cost/unit.

Scope of Transportation as a Medicaid Cost

There have also been questions as to which transportation costs can be charged to Medicaid (and now HMP). The EDIT work group notes that there is inconsistency across CMHSPs in interpretation of the following passage from the Medicaid manual. The highlighted sentence could be interpreted to mean either that Medicaid covers any necessary transportation (with a limitation/condition related to medical office visits and role of DHS and MHPs) OR it could be interpreted to mean that Medicaid coverage is limited to only “day program” transportation costs.

Medicaid Policy Manual 3.27 on TRANSPORTATION:

Current Language

3.27 TRANSPORTATION
PIHPs are responsible for transportation to and from the beneficiary’s place of residence when provided so a beneficiary may participate in a state plan, HSW or additional/B3 service at an approved day program site or in a clubhouse psychosocial rehabilitation program. MHPs are responsible for assuring their enrollees’ transportation to the primary health care services provided by the MHPs, and to (non-mental health) specialists and out-of-state medical providers. MDHHS is responsible for assuring transportation to medical appointments for Medicaid beneficiaries not enrolled in MHPs; and to dental,

substance abuse, and mental health services (except those noted above and in the HSW program described in the Habilitation Supports Waiver for Persons with Developmental Disabilities Section of this chapter) for all Medicaid beneficiaries. (Refer to the local MDHHS office or MHP for additional information, and to the Ambulance Chapter of this manual for information on medical emergency transportation.)
PIHP's payment for transportation should be authorized only after it is determined that it is not otherwise available (e.g., MDHHS, MHP, volunteer, family member), and for the least expensive available means suitable to the beneficiary's need.

The Work group has proposed the following rewrite of the highlighted passage:

Proposed rewrite

PIHPs are responsible for transportation to and from the beneficiary's place of residence when provided so a beneficiary may participate in a PIHP–covered state plan, HSW or additional/B3 service within the consumer's community or for transportation associated with inpatient or crisis residential. *Further*, PIHP's payment for transportation should be authorized only after it is determined that it is not otherwise available (e.g., DHS, MHP, volunteer, family member), and for the least expensive available means suitable to the beneficiary's need.

Current Status

BHDDA management is reviewing this clarification, however, consideration is being given to the budget impact of this revision. In addition, further understanding is needed as to what responsibility local DHS offices do currently have for non-day treatment and PSR transportation costs. There is also request for clarification transportation coverage for consumers in the Dual Eligible Project (MHL)

Reporting Of Transportation Costs

The 2004 instructions and code manual indicate that transportation costs are to be layered onto the service costs. This is usually accomplished by adding costs on to the relevant rows in the various UNC reports. Also payments to the service provider may have included a bundling of both service and transportation costs with the two costs added together into the overall rate.

The Code Manual states: 'Do not report transportation as a separate Habilitation Supports Waiver service, or when provided to transport the beneficiary to skill-building, clubhouse, supported employment, or community living activities. Other transportation

costs should be included in the cost of the service to which the beneficiary is being transported (e.g., supported employment, skill building, and community living supports)'.

The challenge is that transportation is arranged and paid for in a wide variety of ways. In reviewing the cost reports, half of the PIHPs use the individual transportation codes such as A0080, A0090, T2003 etc.

Issues with Consistency

Most CMHSPs/PIHPs have been following DHHS instructions to roll the cost into the cost of the service and include the transportation cost in the service row in the MUNC or other cost report. Essentially transportation was NOT seen as a service - it was an indirect cost. As noted, however, some PIHPs/CMHPS report transportation as separate encounters/costs.

These two approaches to handling transportation costs can create dissonance between encounter cost/unit vs MUNC cost/unit within a PIHP/CMHSP. In addition, across agencies, the cost per unit of service (e.g., supported employment) for places where transport is reported separately will always be lower -- transport can be 25-30% of the cost of day services - especially in rural areas.

Solution: Starting with FY16 Reports

A state-wide approach for encounter reporting for transport for each service would be very inefficient and a value-subtracted activity. However, transportation costs that are currently being layered into service rows for skill-building, supported employment, clubhouse and community living support for daytime activity will now be reported in new rows at the bottom of the MUNC and HMPUNC (which will not be rolled up into total MUNC spend). Thus, the service row will include both the service costs and the transportation costs. The new rows at the bottom of the MUNC and HMPUNC will be for information only. It should be noted that PIHPs/CMHSPs who pay a bundled rate to the service provider will not be required to break these costs out for reporting on the MUNC or other cost reports.

In addition, transportation encounters for these day-time activities should NOT be included in the FY16 end of year "UNC" and sub-element reports. As noted above, these costs should be layered on to the appropriate service. It is recognized that for FY16, the allocation of these costs to each day-time service may be an estimate.

Starting as of 10/1/16 for FY17

For FY17, Medicaid-covered transportation encounters associated with the identified day-time activities, are NOT to be submitted to DHHS

Transportation Costs for Daytime Activities

Illustration of Reporting on Utilization and Net Cost Reports:

Service Description	HCPCS Code	Modifier	Revenue Code	Description	Reporting units	Unique Cases Served	Service Units	Total Costs
Skill-Building (total costs including transportation)	H2014			Skills training and development	15 Minutes	962	644,459	2,525,717
Community Living Support	H2015			Comprehensive Community Support Services	15 Minutes	2,143	1,843,406	11,386,087
Supported Employment Services	H2023			Supported employment	15 Minutes	691	217,265	2,420,221
Clubhouse Psychosocial Rehabilitation Programs	H2030			Mental Health Clubhouse	15 Minutes	342	334,846	2,032,661
****Informational Rows that will show below the total expenditure lines****								
Transportation Costs for Skill Building included in the service row above	Transportation for H2014							250,123
Transportation Costs for Community Living Support included in the service row above	Transportation for H2015							1,496,123
Transportation Costs for Supported Employment included in the service row above	Transportation for H2023							252,123
Transportation Costs for Clubhouse and Psychosocial Rehabilitation included in the service row above	Transportation for H2030							214,123

Same-Time Services Reporting

Background

In general, in health care reporting only one service can be reported for a given time period. While there may be other staff present, the service reported is the one that is primary as experienced by the consumer. While CMHSPs and/or providers may, for internal fi nancial purposes, track the time/cost of additional staff or services during the primary service, not all information is reported to the state.

There are some exceptions to the general rule of reporting one service for a given time period.

Per Diem and Day Service Codes

When services can be reported as ancillary to a per diem

The per diem codes used by the CMH system (inpatient, MH/DD ~~residential~~ community living support and personal care, respite, IOP, MH crisis residential) are inclusive of all services in the service code description. However, the CMH system is to report those other services that the consumer may receive during the day that are not included in the per diem bundle.

This rule also applies to SUD residential services (H0010, H0012, H0018 & H0019) and H0014 which is a non-residential day. As with CMH system per diem services, the additional services provided must not replace those services that are part of the SUD residential bundle. Examples of additional services that can be provided are Methadone services (H0020) and associated counseling from the Methadone clinic.

Two per diems cannot be reported on the same day

Per diem codes have a day in/day out rule as the person transfers between services that are both reported as a per diem. Examples are inpatient, ~~residential~~ personal care and community living support(T1020/H2016, and H0043), detox (H0010/H0012), and SUD residential (H0018HF, H0019). The rule is that the 'day out' (i.e., discharge day) is not reported.

A residential per diem code cannot be reported on same day as an inpatient per diem code.

Services with the same description that are provided as both per diem services as well as some other unit measure cannot be reported on the same day.

- Cannot report H0045 or S5151 per diem **respite** with 15 minute **respite** (S5150, T1005).

- Cannot report **SUD treatment program** as both H2035 (hour) and H2036 (day) on the same day.

- Cannot report **CLS** H2016 (per diem) with **CLS** H2015 (15 minute) previously used for emergency staffing as both are Community Living Support and in the same location.
  (See-documents on community living support for exceptions for the use of these two codes). The Department is reviewing the simultaneous use of these two codes on the same day for possible future changes.

When services can be reported on the same day as a 'day' code

Some service codes are reported as a day. These day codes can only be reported once on any given day. These are typically bundled services and any services that are part of the bundle cannot be reported separately.

- Partial Hospitalization (0912) is a bundled day service. Other services can be provided on this day as long as they are provided by a different provider and outside of the hours during which the partial hospitalization is occurring.

- Sub-acute detoxification ASAM Level I.D. (H0014) is an ambulatory, non-residential detox service and can be reported on the same day as other services. For example, admissions for outpatient treatment as a step down from H0014 can be reported on the same day.

- Other services can be provided outside of the time that intensive SUD outpatient (H0015) is provided. However, the other services cannot substitute for those services that are part of the H0015 requirement.

- Other services can be provided outside of the time that SUD treatment program and care coordination (H2036) is provided.

Other ambulatory/outpatient services that can be reported at same time

1. Treatment Planning (H0032) can be reported by an independent facilitator and all professional staff for the same session. In addition, it can be reported by multiple staff at same time that the case manager/supports coordinator also reports that time using their own code: T1016, T1017, H0039, H0036, H2022, or H2021. It should be noted that only one staff person can attend an IPOS in the behavioral health case management role. In their role providing services and supports planning, Adult Peer Specialists and Recovery Coaches will report H0032 with their appropriate, respective modifiers. Youth Peer Support Specialists will report H0038 with the TJ modifier and Parent Support Partners S5111 with the HM modifier.

2. Only one encounter per consumer can be reported for Behavior Treatment Committee (H2000) regardless of how many staff are present. This service does not require face-to-face with consumer to be reported.

3. Family Training – Home Care Training (S5111) can be provided when the symptom bearer is not present at the same time as another service being provided to the symptom bearer. However, under certain circumstances, to be clinically sound, Family Training must be provided with the parent and child present. For example, if a parent is being trained by a PT on a treatment regimen or use of equipment specified in the plan, the beneficiary may need to be present during the training to effectively train the parent.

4. For S5111-U5 the child is not required to be present and can receive other face-to-face services. Starting October 1, 2016, the new ABA code for family training/guidance will be 0370T and 0371T and in the comments column it explains “Child not required to be present”. This new code should also be allowed to be provided at the same time as another face-to-face service to the child by other qualified providers.

5. Parent peers can report Parent-to-parent support (S5111 – HM) at same time other services are being provided to the child. Also, the PIHP/CMHSP can report Parent Management Training Oregon S5111 HA if a provider is face-to-face with the parent while another provider is working separately with the child (consumer).

6. The child is not present during Resource Parent Training (S5111 ST). Therefore, a parent of a child can attend Resource Parent Training at the same time as their child is receiving Trauma-focused CBT therapy.

7. Autism Adaptive Behavioral Treatment face-to-face with the child and Clinical Observation and Direction can be reported at same time: old codes H2019-U5 and S5108-U5; new codes: 0364/0365/0366/0367 and 0368/0369.

8. Autism Family Behavior Treatment Guidance with the family (0370/0371) can be reported at the same time as Autism Adaptive Behavioral Treatment (0364-0367) face-to-face with the child. Clinical Observation and Direction can only be reported concurrently with Autism Family Treatment Guidance **IF** there are two separate qualified providers.

   Reasoning:

   0370/0371 can be provided without the child present.

   0364-0367 ABA Treatment can be provided to the child while the family is receiving Guidance.

   0368-0369 Clinical Observation of the child receiving ABA can be done at this time also. Obviously the same provider would not be able to provided Clinical Observation and Guidance at the same time.

9. Autism Behavioral follow-up assessment (H0031/0362/0363) and Autism Adaptive Behavioral Treatment (H2019/0364-0367) can be reported as the same time.

10. Face-to-face interactive Case Management monitoring (T1016/T1017) can be reported at the same time as in-home service such as community living support and personal care, and certain day-time activity services (clubhouse, supported

employment, prevocational skill building, community activities). Professionals and specialty providers will report treatment plan monitoring (H0032-TS) at the same time that the consumer is receiving the service for which they are being monitored in the above settings.

The consumer must be present and have at least 15 minutes of interaction with the case manager/supports coordinator for the monitoring activity and the service being monitored to be reported at same time.

11. Face-to Face monitoring by home-based staff (H0036) and ACT (H0039) team members can be reported at the same time as day-time activity services. The consumer must be present and have at least 15 minutes of interaction with the home-based staff or ACT team member for the monitoring activity and the service being monitored to be reported at same time.

12. Supports Intensity Scale (SIS) Assessment. Per the Michigan SIS Implementation manual Community Living Support aides may bill concurrently if they are providing a CLS service at the same time as the SIS assessment. Case management/Supports Coordination may **not** be billed concurrently. These staff should account for their time as indirect/pre-planning activity, but they cannot report a CM/SC Service during the same time as attending the SIS assessment.

Specific scenarios in which two services cannot be reported together (Compiled in response to questions from PIHPs and CMHSPs)

- Case managers and supports coordinators cannot report their time spent accompanying a consumer to a medical visit as this activity is not part of the case management function. The CM/SC's time should be accounted for as indirect time.

- Case managers and supports coordinators cannot report their time spent accompanying a consumer to a psychological evaluation or medication review as this activity is not part of the case management function. The CM/SC's time should be accounted for as indirect time.

- CMHSPs cannot report encounters for services such as home-based, parent peers, mental health therapy, case management that are provided at the same time the consumer is attending Individualized Educational Plan (IEP).

- Face-to-face interactive Case Management monitoring (T1016/T1017) cannot be reported at the same time as Applied Behavioral Analysis (ABA) as these ABA services are already being monitored by the ABA professional.

- CLS aides **cannot** report Community Living Support services during a person-centered planning meeting unless they are providing Community Living Support during this time. Community Living Support service does not include the function of service and supports planning. The aide's time should be accounted for as indirect time.

August 23, 2016