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

- One day each for community living supports (CLS) and personal care (PC)=consumer received both services in a specialized residential facility during the day reported
- All other "day" units=consumer was in the setting as of 11:59 pm

*Do not report if units = 0

Note: CPT time rules apply to CPT codes that have specific times: If the time spent in face-to-face with the beneficiary is more than half the time of the code time, then that code should be used. For example, for 16-37 minutes, use the 30 minute code; for 38-52 minutes use the 45 minute code; and for 53 minutes and beyond, use the 60 minute code.

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 Behavior Treatment Plan Review, Crisis calls with the Center for Positive Livings Supports, and Fiscal Intermediary. 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 of ABA service/supervision of ABA service
AJ: Clinical Social Worker provider of ABA service/supervision of ABA service
AM: Family psycho-education provided as part of ACT activities
GT: Telemedicine was provided via video-conferencing face-to-face with the beneficiary.
HA: Parent Management Training Oregon model with Home-based, Family Training, and Mental Health therapies (Evidence Based Practice only)
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 Abuse Treatment service that has the same code as Mental Health services (see Substance Abuse treatment service section)
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 MDCH-endorsed curriculum
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.
HK: Beneficiary is HSW enrolled and is receiving an HSW covered service
HN: Bachelor's degree level provider of ABA service
HO: Master's degree level provider of ABA service/supervision of ABA service
HP: Doctoral degree level provider of ABA service/supervision of ABA service
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 MDCH)
TD: Registered nurse provided Respite
TE: Licensed practical nurse provided Respite
TF: With Community Living Supports per diem (H2016) and Personal Care (T1020) for moderate need/cost cases
TG: With Community Living Supports per diem (H2016) and Personal Care (T1020) for high need/cost cases; with Supported Employment (H2023) to designate evidence-based practice model; with Early Intensive Behavioral Intervention (EIBI) services.

TJ – Youth Peer Support Specialist with H0038 or H0038-TT. 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 is only allowed in home-based (H0036-HS), or family psychotherapy (90846-HS or 90849-HS).

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 & Applied Behavioral Analysis Services (H2019), Peer Specialist (H0038), Peer Mentor H0046), Respite (T1005), and Supported Employment (H2023)

U5: Autism benefit-related: under the authority of 1915(i), this modifier must be used in conjunction with assessment of eligibility and ABA services and supervision of those services for children 18 months through 5 years of age. The modifier should not be used for other services, such as OT, rendered to a child during the period he/she is eligible for ABA services under the State Plan Amendment. This modifier should only be added to those services that are included in the cost-settlement.

*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, 90834 HF SA Interactive individual psychotherapy and 90853 HF SA Interactive group psychotherapy
- 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, Mental Health and Substance Abuse 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:

Except for Behavior Treatment Plan Reviews, Crisis calls with the Center for Positive Living Supports, Family Training, Family Psycho-Education, Family Therapy**,** Fiscal intermediary, Prevention (direct Models) , Home-based, and Wraparound reporting occurs only when a face-to-face contact with the consumer takes place. 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-87.

- 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)

Note: Services provided in residential institutions for mental disease (IMDs) and jails may not be funded by Medicaid. In addition, 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.

DUPLICATE THRESHOLDS

MDCH 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. These are not service limitations, but rather 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

MDCH 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
04	Homeless shelter	Assessments, case management/supports coordination, mental health

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Code	Place of Service	*Typical* Covered Specialty Services & Supports (list is not exclusive)
		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, skill-building
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
33	Custodial care facility (General AFC)	CLS, case management/supports coordination, respite
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
52	Psychiatric facility-partial hospitalization	Partial hospitalization service
55	Residential substance abuse treatment facility	Residential substance abuse treatment
56	Psychiatric residential treatment center	Crisis residential services
57	Non-residential substance abuse treatment facility	Outpatient substance abuse 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

Code	Place of Service	*Typical* Covered Specialty Services & Supports (list is not exclusive)
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 data. Please refer to MDCH/PIHP and CMHSP contract Attachment 6.5.1.1. for more details

CODING FOR 1915(i) STATE PLAN AMENDMENT FOR APPLIED BEHAVIOR ANALYSIS (AUTISM BENEFIT)

The ABA Benefit is limited to children aged 18 months through 5 years who are assessed to have autism spectrum disorder and who are eligible for the benefit as determined by independent evaluation of MDCH.

1. U5 modifier must be reported on the assessments, ABA services, and supervision codes.
2. There are two levels of ABA service: Applied Behavioral Intervention (ABI) and Early Intensive Behavioral Intervention (EIBI). The Level of Intensity of services, whether ABI or EIBI, is determined through clinical assessments and family-centered processes. To denote delivery of ABI, the ABA code H2019 is used with modifier U5. To denote delivery of EIBI, the ABA code H2019 is used with modifiers U5 and TG.
3. The level of provider is identified by use of a modifier. 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 provider; HO for other master's degree provider; and HP for other doctoral level degree provider. No modifier for aide-level.
4. TT modifier is available for use when multiple children are receiving services at the same time in a group as well as when there is supervision of more than one ABA provider at the same time.

The use of the ABA codes ends once children reach age 6 so these codes are not used to denote services for individuals a age 6 years and older. While "ABA-like" services, such as CLS under supervision or family training, etc., could be provided, there is no ABA service for individuals outside of the target group of the 1915(i) State Plan Amendment. DO NOT use the ABA codes or the U5 modifier.

Service	HCPCS Code	Mandatory Modifier
Assessment	90791, 90792 , 90833 , 90836,90838, 90785, 99201-99215, 99324- 99328, 99334-99337, 99341-99345, 99347-99350 96101, 96102, 96118, and 96119 H0031	U5

Applied Behavior Analysis	H2019	U5
Home Care Training to Home Care Client (Supervision of Direct Care Provider)	S5108	U5

Further detail for these codes are found in the HCPCS and Revenue Code chart below.
Please note: Children enrolled in the benefit are also eligible for other services contained in the chart below; however, the services listed above are the services that mandate a U5 modifier to be included with the service codes.

Cost Settlement: Cost settlement is limited to the assessment of a child to diagnose and determine eligibility for the 1915(i) State Plan Amendment, provision of ABA services and supervision of those services, and the required intermittent re-assessment of skills related to the ABA service. Other services that may also be delivered, such as OT, will not be cost-settled. A cost-settlement process is being developed and once finalized, additional information will be provided.

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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
Applied Behavior Analysis	H2019, S5108	H2019: Therapeutic behavioral services Use Modifier U5 for Autism benefit (children ages 18 months through 5 years only) Use TG modifier for Early Intensive Behavioral Intervention (EIBI). No intensity modifier for Applied Behavioral Intervention (ABI). Use TT modifier for services provided to more than one child at the same time by the same provider. Use Modifier AH to identify clinical psychologist provider. AJ to identify clinical social worker provider. HN to identify bachelor's degree provider, HO for other master's degree provider, HP for other doctoral degree provider. No modifier for aide-level. S5108: Home care training to home care client (supervision of direct care provider) Use Modifier U5 for Autism benefit (children ages 18 months through 5 years only) Use TT modifier for supervision of more than one ABA provider at the same time. Use Modifier AH to identify clinical psychologist supervisor. AJ to identify clinical social worker	15 minutes 15 minutes		State Plan (1915i state plan amendment)	When/how to report encounter: -Report only face-to-face contacts. H2019 and S5108 should be reported separately. -Report S5108 only for supervision of ABA services provided to children 18 months through age 5 receiving the autism benefit. Allocating and reporting costs: -Cost includes staff, facility, equipment, staff travel, contract services, supplies and materials Boundaries: *Must use U5 modifier to differentiate ABA service from DBT service

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
		supervisor. HO for other master's degree supervisor, HP for other doctoral degree supervisor.				
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	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	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); but a case management or supports coordination code should be used when assessment is part of the case management or supports coordination function H0031 should be used when intake 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
	~~90801~~, ~~90802~~ **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 **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**	Encounter Refer to code descriptions DT: 2/day ~~90801=1/day~~ ~~90802=1/day~~ 99201-99215=2/day 99324-99328, 99334-99337 and 99341-99350 Refer to Code Descriptions	Line Professional	State Plan (1915i state plan amendment where U5 is used)	
	~~99241- 99275~~	Physician consultations	Refer to code	Line	State Plan	

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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
	99241-99255		descriptions	Professional		due to loading in indirect time
	96101, 96102, 96103, 96116, 96118, 96119, 96120	Psychological testing **Use U5 for Autism Benefit (96101, 96102, 96118, and 96119)**	Per hour	Line Professional	State Plan (1915i state plan amendment where U5 is used)	
	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	
	H0031	H0031: Assessment by non-physician Use ST when trauma assessment is performed as part of trauma-focused ~~CPT~~ CBT. **Use U5 for Autism Benefit. Face-to-face with child or parent. This includes interpretation of results to the family.** H0031 - use also for on-site, face-to-face assessment by CPLS (Center for Positive Living Supports) H0031 – HW: Support Intensity Scale (SIS) Face-to-Face Assessment			(1915i state plan amendment where U5 is used)	
	H0002 T1023	H0002: Brief screening to non-inpatient programs T1023: Screening for inpatient program				
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	<u>When/how to report encounter:</u> 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-

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
						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	15 Minutes DT= 48 /day	Line	State Plan	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 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 99221-99233	0100 – All inclusive room and board plus ancillaries 0101 – All inclusive room and board (Use revenue codes for inpatient ancillary services located on page 11) 0114, 0124, 0134, 0154 – ward size 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 Physician services provided in inpatient	Day Refer to code	Series Institutional Line	State Plan	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 -Count all consumers/days in the inpatient episode for which CMH has a payment liability greater than $0 (Use best estimate if CMH is accruing expenses) -Days of attendance -Option: Hospital claim with additional fields reflecting other insurance offsets can be turned into encounters for submission to DCH Allocating and reporting costs:

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
		hospital care	descriptions	Professional		-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 transportation costs -If physician is paid separately, use inpatient physician codes and cost the 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 case management or supports coordination
Community Living Supports	H2015, H2016, H0043, T2036, T2037	H2015-comprehensive Community Support Services per 15 min. 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 modifiers TG for high need or high cost cases; TF for moderate need or moderate cost cases; no modifier for low need or low cost cases. Use in conjunction with Personal Care T1020 for unbundling specialized residential per diem. H0043 – Community Living Supports provided in unlicensed independent living setting or own home, per day T2036 – therapeutic camping overnight,	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, 1915 (b)(3), & EPSDT	<u>When/how to report encounter:</u> -Face-to-face for 15 minute unit codes -Days of attendance in setting for per diem codes, with a minimum of 15 minutes face-to-face with qualified provider -For an individual receiving CLS that is reported as a per diem, it is also permissible to report for CLS 15 minutes, skill building, or other covered services that are provided outside the home in a 24 hour period. <u>Allocating and reporting costs:</u> -Cost includes staff, facility, equipment, travel, staff and consumer transportation, contract services, supplies and materials -Day rate reported must be net of SSI/room and board, Home Help and Food stamps -Costs for community activities -Costs for vehicles <u>Boundaries:</u>

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
		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				-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. <u>Boundaries:</u> -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):

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 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 H0030, T2034, H2020	H2011: Crisis Intervention Service 90839 psychotherapy for crisis, 1st 60 min 90840 psychotherapy for crisis, each additional 30 min (Add-on code only) H0030: Michigan Center for Positive Living Supports Crisis line (not face-to-face with beneficiary) T2034: Michigan Center for Positive Living Supports Mobile Crisis Team (face-to-face); use modifiers TG for high need or high cost cases; TF for moderate need or moderate cost cases; no modifier for low need or low cost cases H2020: Michigan Center for Positive Living Supports Transition Home (face-to-face)	15 minutes **DT: H2011=96/day** 90839: Encounter 90840: Encounter H0030: Per Service T2034: Day H2020: Day	Line Professional	State Plan	<u>When/how to report encounter:</u> -H0030, T2034, H2030: codes reserved for reporting purchase of crisis intervention services from the Michigan Center for Positive Living Supports. -H2011, T2034, and H2020: face-to-face <u>Allocating and reporting costs:</u> -Cost and contact/productivity model assumptions used -Incorporate phone time as an indirect cost for H2011 -Cost reported for H2020 should include beneficiary travel, PIHP/provider staff time and travel expenses associated with the service
Crisis Residential Services	H0018	Behavioral health; short-term residential (non-hosp resident treatment program) without room and board per diem	Day **DT: 1/day**	Series Professional	State Plan	<u>When/how to report encounter:</u> -Days of attendance -In as of 11:59 pm -If consumer enters and exits the same day

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
		Use for both child & adult services.				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 0701- Recovery room 0370-anesthesia	Encounter Encounter Minutes DT: 90870=1/day	Series-Institutional Line-Professional Line-Professional	State Plan	When/how to report encounter: -Face-to-face procedure Allocating and reporting costs: -Submit actual costs
Enhanced Medical Equipment & Supplies	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 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	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
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	Habilitation Supports Waiver & 1915(b)(3)	When/how to report encounter: -Per item Allocating and reporting costs: -Submit actual costs

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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	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 using the MDCH-endorsed curriculum (can report encounter after completion of initial 3 days of core training but must continue certification process) S5111ST - 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 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	Encounter DT=2/day	Line Professional	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) If provided as a group modality where families of several beneficiaries are present, report an encounter for each 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	S5110 = 15 min G0177 = session at least 45 min DT: G0177=1/day T1015 =	Line Professional	1915(b)(3)	

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		implementing this Evidence Based Practice Modifier HS: consumer was not present during the activity with the family	encounter			
Fiscal Intermediary Services	T2025	Financial Management, self-directed, waiver.	Per Month	Line Professional	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 visit T1002 – RN services up to 15 min	Refer to code descriptions – some are per 15 minutes, some per encounter DT: 97802=40/day 97803=40/day 97804=20/day H0034=40/day S9445=1/day S9446=1/day S9470=1/day T1002=40/day	Line Professional	State Plan	When/how to report encounter: -Face-to-face with beneficiary Allocating and reporting costs: -Cost of indirect activity -Cost if staff provide multiple services
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	15 minutes DT=96/day	Line Professional	State Plan	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

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		MDCH **Modifiers HA & TT when providing Parent Management Training Oregon model to multiple families**				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	
Housing Assistance	T2038	Community transition, waiver, per service	Service DT=31/day	Line Professional	1915(b)(3)	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 -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 DCH-approved program only.	Hour DT=24/day	Line Professional	State Plan	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
ICF/MR	0100	0100 - All inclusive room and board plus ancillaries**.** Must use provider type PT 65 followed by the 7-digit Medicaid Provider ID number. See October 14, 2004 instructions and Companion Guide for 837 Institutional Encounters for proper	Day	Series Institutional	State Plan	When/how to report encounters: -Inpatient days of attendance including DD IST days -Submit only one encounter per each inpatient day -In facility as of **11:59 pm** Allocating and reporting costs

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		placement in the 837				-Includes net rate and local match costs for IST days
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 (Use revenue codes for inpatient ancillary services located on page 11) 0114, 0124, 0134, 0154 – ward size Must use provider type 22 followed by the 7-digit Medicaid Provider ID number. See October 14, 2004 instructions and Companion Guide for 837 Institutional Encounters for proper placement in 837	Day	Series Institutional	State Plan	<u>When/how to report encounter:</u> -Inpatient days of attendance including IST days at State Hospitals (excluding Forensic Center) -In hospital as of 11:59 pm <u>Allocating and reporting costs:</u> -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	0100 – All inclusive room and board plus ancillaries 0101 – All inclusive room and board (Use revenue codes for inpatient ancillary services located on page 11) 0114, 0124, 0134, 0154 – ward size Must use provider type 68 followed by the 7-digit Medicaid Provider ID number. See October 14, 2004 instructions and Companion Guide for 837 Institutional Encounters for proper placement in 837	Day	Series Institutional	In lieu of Medicaid state plan inpatient services	<u>When/how to report encounter:</u> 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 -Days of attendance -Option: Hospital claim with additional fields reflecting other insurance offsets can be turned into encounters for submission to DCH <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

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						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 case management or supports coordination
Medication Administration	99506, 99211, 96372		Encounter	Line Professional	State Plan	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**	~~90862 brief assessment, dosage adjustment, minimal psychotherapy, TD testing by physician, or physician plus a nurse; or nurse practitioner~~ 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** ~~M0064 brief assessment (generally less than 10 minutes), med monitoring by nurse; med monitoring or change by a nurse practitioner or a~~	Encounter (Face-to-face) DT: ~~90862=1/day~~ M0064=2/day 99201-99215=2/day 99324-99328, 99334-99337 and 99341-99350 Refer to Code Descriptions	Line Professional	State Plan	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

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		~~physician's assistant or physician; or PA or MD/DO plus a licensed practical nurse~~ EPS tardive dyskinesia testing is included in medication review services				
	H2010	Comprehensive Medication Services Please use only with Evidence Based Practice – Medication Algorithm	15 minutes	Line Professional	State Plan	
Nursing Facility Mental Health Monitoring	T1017SE	Use modifier SE to distinguish from case management	15 minutes DT = 48/day	Line Professional	State Plan	When/how to report encounter: -Record must show that this was 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	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	
	97003, 97004	OT evaluation/re-evaluation	Encounter	Line Professional	State Plan	
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. Modifier TT when multiple consumers are served simultaneously	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

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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	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 ……. H0046 – Peer mentor services provided by a DD Peer Mentor TT modifier: use when peer service is provided in a group	Encounters ……. . 15 minutes DT: H0038=96/day ……. . Encounters	Line Professional	1915(b)(3) & EPSDT	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: 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.

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						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 Residential Setting	T1020	Personal care services provided in AFC certified as Specialized Residential. (not for an inpatient or resident of a hospital, nursing facility, ICF/MR, CCI or IMD or services provided by home health aide or certified nurse assistant) Use modifier TG for high need or high cost cases; TF for moderate need or moderate need cases; no modifier for low need or low cost cases	Day DT=1/day	Series Professional	State Plan	When/how to report encounters: -Report one day per day of attendance in a specialized 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

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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)	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 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	PT Evaluation/re-evaluation	Encounter DT=1/day	Line Professional	State Plan	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	
	97150	PT group	Encounter DT=1/day	Line Professional	State Plan	
Prevention Services - Direct Model	H0025, S9482, T2024,	Behavioral health prevention education service (delivery of services with	Face to Face Contact with	Line Professional	**H0025 & S9482 –**	When/how to report encounters: If parent is the symptom-bearer, the event

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	T1027, H2027	target population to affect knowledge, attitude, and/or behavior); approved MDCH models only H0025 – School Success & Child Care Expulsion 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	family or child H0025 – encounter DT=1/day S948215 min unit DT= 40/day T2024 – encounter DT= 1/day T1027- 15 min DT=40/day H2027 – 15 min DT=96/day		**B(3)s** **T2024, T1027 & H2027 - EPSDT**	may be reported using the parent's Medicaid identification number. If parent is not the symptom-bearer, report using the child's Medicaid identification number <u>Allocating and reporting costs:</u> 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	<u>When/how to report encounters:</u> 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)	Up to 15 minutes DT=96/day	Line Professional	Habilitation Supports Waiver	

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		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 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	Habilitation Supports Waiver & 1915(b)(3)	<u>When/how to report encounter:</u> 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) <u>Allocating and reporting costs:</u> -Difference in costs between skilled and unskilled staff: -Note payment mechanisms such as Vouchers <u>Boundaries:</u> -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	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	Per diem DT=1/day	Line Professional	Habilitation Supports Waiver & 1915(b)(3)	

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		or "b3" Services.				
	T2036, T2037	Respite care at camp T2036: camping overnight (one night = one session) T2037 for day camp (one day/partial day = one session)	Per session DT=1/day	Line Professional	Habilitation/ Supports Waiver & 1915(b)(3)	
Skill Building Assistance	H2014	Skills training and development, per 15 min Modifier TT when multiple consumers are served simultaneously	15 minutes DT=40/day	Line Professional	1915(b)(3) & EPSDT	<u>When/how to report encounters:</u> 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. <u>Allocating and reporting costs:</u> -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. <u>Boundaries:</u> -Between Skill-building (SK) and Community Living Supports (CLS) *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)

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						*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	~~92506~~, 92610	Evaluation of swallowing function	Encounter DT=1/day	Line Professional	State Plan	<u>When/how to report encounters:</u> for face-to-face contact only <u>Allocating and reporting costs:</u> -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	
	92522	Evaluation of speech sound production	Encounter DT=1/day	Line Professional	State Plan	
	92523	Evaluation of speech sound production with evaluation of language comprehension and expression	Encounter DT=1/day	Line Professional	State Plan	
	92524	Behavioral and qualitative analysis of voice and resonance	Encounter DT=1/day	Line Professional	State Plan	
	92507, 92526,	S&L therapy, individual, per session	Encounter DT=1/day	Line Professional	State Plan	
	92508	S&L therapy, group, per session	Encounter DT=1/day	Line Professional	State Plan	
Substance abuse: Individual Assessment	H0001	H0001 – Alcohol and/or drug assessment (done by provider)	Encounter DT: H0001=1/day	Line Professional	State Plan	<u>When/how to report encounter:</u> -H0001 is face-to-face with qualified professional only -HD modifier for all qualified WSS <u>Allocating and reporting costs:</u> - Include cost of indirect activity -Cost if staff provide multiple services

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Substance abuse: Outpatient Care	H0004, ~~90804 – 90815~~, ~~90826~~ 90832, 90834, 90837 Rev Codes: 0900, 0914, 0915, 0916, 0919	H0004 -Behavioral health counseling and therapy, per 15 minutes ~~90804 90815 HF – Psychotherapy (individual)~~ 90832 -- 30 minutes of psychotherapy 90834 -- 45 minutes of psychotherapy 90837-- 60 minutes of psychotherapy 90785- add-on only Use modifier HF to signify that these codes were used for substance abuse treatment, because they are also used for reporting mental health services	Refer to code descriptions DT: H0004=40/day ~~90804=1/day~~ ~~90805 90815=2/day~~ 90832, 90834, 90837 =4/day	Series/Line (depends on other payers) Institutional or Professional (depends on other payers)	State Plan	<u>When/how to report encounter:</u> -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 <u>Allocating and reporting costs:</u> - Include cost of indirect activity -Cost if staff provide multiple services
	H0005, H0015, H0022, H2027, H2035, H2036, H0038, H0050, T1012, 90846, 90847, 90849, 90853, **90785** Rev codes: 0900, 0914, 0915, 0916, 0919, 0906	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 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 –SUD treatment program and/or care coordination, per hour H2036 –SUD treatment program and/or care coordination, per diem H0038 HF– Recovery Coach (Peer services), per 15 minutes H0050 – Brief intervention or care coordination per 15 minutes T1012 **–**Recovery Supports ~~90826~~ **90834 HF** – Interactive individual psychotherapy per 45 min	H0005 = Encounter H0015 = Day H2035 = Hour H2036 = Day H0050= 15 minutes Encounter Encounter Encounter Encounter	Series/Line (depends on other payers) Institutional or Professional (depends on other payers)		Use HF modifier with H2027 to distinguish it from the Mental Health Prevention model.

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		+90785 – interactive complexity (Add on code only) 90846 **HF**– Family psychotherapy 90847 **HF**– Family psychotherapy 90849 **HF**- Family psychotherapy 90853 **HF–** Group psychotherapy ~~90857~~ **90853 -HF– Interactive group psychotherapy** **+90785 – interactive complexity (Add on code only)** Use modifier HF to signify that these codes were used for substance abuse treatment, because they are also used for reporting mental health services 0906 – Intensive Outpatient Services – Chemical dependency	DT: 90847=1/day **90834=3/day** **90853=3/day** **~~90857=3/day~~**			
Substance abuse: 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	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
Substance abuse: 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	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 abuse:	H0018, H0019	H0018 Alcohol and/or drug services;	Day	Series	State Plan	When/how to report encounter:

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Residential Services	Rev code: 1002	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 referred to as long-term residential (non-medical, non-acute care in residential treatment program where stay is typically longer than 30 days)	DT: H0018=1/day	Institutional		-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
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 evidenced-based supported employment program that have has at least one fidelity review Modifier TT when multiple consumers are served simultaneously	15 minutes DT=40/day	Line Professional	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 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

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						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	Habilitation Supports Waiver, 1915(b)(3) & EPSDT	<u>When/how to report encounter:</u> -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 (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. <u>Allocating and reporting costs:</u> - Include indirect activity -Cost if staff provide multiple services <u>Boundaries:</u>

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						-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 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	<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,

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						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 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.

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Therapy (mental health) Child & Adult, Individual, Family, Group	~~90808~~, ~~90814, 90815~~, ~~90821~~, ~~90822, 90828~~, ~~90829~~, **90837**	Individual therapy, adult or child, ~~75-80~~ **60** minutes	Encounter DT: ~~90808, 90814, 90815~~=2/day	Line Professional	State Plan	<u>When/how to report encounter:</u> -Face-to-face with qualified professional only <u>Allocating and reporting costs</u> -Cost of indirect activity -Cost of co-therapists' contacts -Cost if staff provide multiple units -Spreading costs over the various types of services -Cost and productivity assumptions -Group size assumptions -Some direct contacts are may be costly due to loading in the indirect time
	~~90804~~, ~~90810, 90811~~, ~~90816, 90817, 90823, 90824~~, **90832**	Individual therapy, adult or child, ~~20-30~~ **30** minutes	Encounter DT: ~~90804=1/day Others~~=2/day	Line Professional	State Plan	
	~~90806~~, ~~90812, 90813~~, ~~90818, 90819, 90826, 90827~~, **90834**	Individual therapy, adult or child, ~~45-50~~ **45** minutes	Encounter DT=2/day	Line Professional	State Plan	
	90833, 90836, 90838	**90833 (30 min), 90836 (45 min) 90838 (60 min) psychotherapy add-on codes only**	DT=2/day	Line Professional	State Plan	
	90853, ~~90857~~	Group therapy, adult or child, per session Modifier HA: Parent Management Training Oregon model 90853 - Includes MOM Power	Encounter DT=1/day	Line Professional	State Plan	
	90846, 90847 90849	Family therapy, per session Use modifier HA with 90849 when reporting Parent Management Training Oregon model (PTC Group**)** Modifier HS: consumer was not present during activity with family	Encounter DT=1/day	Line Professional	State Plan	
	~~90805, 90807, 90809~~	~~Individual psychotherapy by a physician when provided as part of a medical visit~~	~~Refer to code descriptions DT=2/day~~	~~Line Professional~~	~~State Plan~~	
	H2019	Therapeutic Behavioral Services: Use for individual Dialectical Behavior Therapy (DBT) provided by staff trained and certified by MDCH. 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	<u>When/how to report encounter</u> 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

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Transportation	A0080, A0090, A0100, A0110, A0120, A0130, A0140, A0170, S0209, S0215 T2001-T2005	[Note: Optional to report on Encounter report] 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-building, clubhouse, supported employment, or community living activities	Refer to code descriptions DT: Mile codes= 1,000/day Per diem codes= 1/day	Line Professional	State Plan & 1915(b)(3)	<u>When/how to report encounter:</u> Preferred option for ambulance: turn in claim information as submitted by the ambulance service Other transportation services should not be reported separately <u>Allocating and reporting costs:</u> 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)
Treatment Planning	H0032	Mental health service plan development by non-physician Modifier TS for clinician monitoring of treatment H0032TS – use also for on-site, face-to-face monitoring of treatment by CPLS (Center for Positive Living Supports)	Encounter DT=1,000/day	Line Professional	State Plan	<u>When/how to report encounter:</u> -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 <u>Allocating and reporting costs</u> -Major implications for indirect contribution to other activities -Indirect activity -The cost of a clinician's monitoring the implementation of plan that does not

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						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	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 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

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						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.
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

Additional Codes for Reporting

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 only for per diem bundled rate that does not include Medicaid-funded personal care and/or community living supports	Day	Series Professional	GF only	<u>When/how to report encounters</u> -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

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						with DD.
Laboratory Services Related to Mental Health		Refer to HCPCS codes in 80000 range		Line Professional		Submit actual costs
Pharmacy (Drugs & Biologicals)		NDC codes for prescription drugs		Line Pharmacy - NCPDP	GF only services	Submit actual costs
Residential Room and Board	S9976	Lodging, per diem, not otherwise specified	Day	Series	GF only service	Room and board costs per day
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		

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Substance Abuse – Suboxone	H0033	Oral medication administration	Direct observation	Line Professional		Submit actual costs
Transportation	A0427, A0425	Non Medicaid-funded ambulance	Refer to code descriptions.	Line Professional	GF only services	Submit actual costs