Ohio Department of Medicaid

MEDICAID BEHAVIORAL HEALTH STATE PLAN SERVICES

PROVIDER REQUIREMENTS AND REIMBURSEMENT MANUAL

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Medicaid Behavioral Health State Plan Services Provider Requirements and Reimbursement Manual			
Version	Description of Changes	Last Editor	Release Date
Version 1.0	Initial Draft	State Policy Team	6/14/16
Version 1.1	Cont'd Draft Manual Development	State Policy Team	6/24/16
Version 1.2	Third Party Coordination of Benefits Coordination of Benefits for clients assigned to Managed Care Plans Modifier-position of modifier Treatment Plans/plan updates-provisionally active timeframe/review/update timeframes Supervision-Supervisor Absences False Claims Act-New Section Time Based CPT codes -New Section ECG-Chart updated Adult Vaccines language added TBS Removed pharmacist as an approved provider POS added to individual charts SUD Assessment Chart update CLIA certificate Types added PERM Audits OTP and Methadone administration codes TBS Chart SUD Nursing Chart ACT Claims Rolling ASAM Staffing Levels updated	State Policy Team	1/31/17
Version 1.3	Correction to U6 and U7 modifier in 3 code charts Supervisor clarification to SUD residential code charts HQ and UB corrections in 2 charts Place of service modifications H0014 rate correction	State Policy Team	3/1/17
Version 1.4	Definition of place of service 99 Add information on GT modifier for select codes Rate correction for H0005	State Policy Team	3/10/17
Version 1.5	Remove MH and SUD nursing limit Add GT modifier to applicable codes QMHS +3 yrs experience – TBS Group Hourly/Per Diem POS revisions to selected codes	State Policy Team	3/17/17
Version 1.6	Collateral contacts Add 96372 Clarify rate reduction for TBS/PSR in excess of 6 units per day	State Policy Team	3-31-2017
Version 1.7	Procedure modifier added for oral naltrexone Clarified that 96372 medication administration code is not available to SUD residential providers Add POS 99 to MH nursing codes Add POS 04 homeless shelter to TBS Group Hourly/Per Diem Added modifiers HN and HO to peer recovery to reflect educational level Added POS 99 to H0004 SUD counseling when provided for crisis Added POS 99 to SUD nursing Added POS 11 and 57 to group SUD nursing Rates paid for trainees and assistance with and without supervision Removed collateral examples 96372 rate correction	State Policy Team	4-14-2017
Version 1.8	Add RN/LPN to 96372 POS 99 added to 90838, 90840 Clarify SUD residential needs rendering practitioner PSY assistant rate correction for 96116, 96118 PSY assistant rate clarification for CPT codes Clarification that crisis codes (with UT) can be done in POS 23, 99	State Policy Team	5-10-2017
Final Version 1.0	Addition of MD, DO, CNS, CNP, PA to +99355 QMHS +3 rate for TBS Group per diem POS 99 added to 90846 and 90847 Update Table 1-3 for peer support modifiers	State Policy Team	6-16-2017

Final Version 1.1	Corrected ACT modifiers for CNS, CNP in Table 1-4 Clarify direct and general supervision language Correct rates for 96101 and 96111 Add MH H0004 Add dependently licensed practitioners to SUD H0004 Add "Day Treatment" to rate chart for H2012, H2020	State Policy Team	8-3-2017
Final Version 1.2	Rendering Practitioner section modified (page 10) Paraprofessional enrollment language (pages 13, 17) Procedure modifier UT added to applicable rate charts Remove POS 99 from H0004 UT as POS 99 always available SUD residential codes now in Section 5 Edited legal disclaimer Implementation dates updated	State Policy Team	9-29-2017
Final Version 1.3	Replace UT modifier with KX	State Policy Team	11-15-2017
Final Version 1.4	Clarified places of service for CPT codes for 84s and 95s Clarified for CPT codes, LICDC, LCDC, CDC-A are for SUD agencies only H0001 is now an encounter code	State Policy Team	12-4-2017
Final Version 1.5	Multi –licensure for independent and medical practitioners H0014 AT Clarification for ASAM Levels 3.2 and 3.7 +99355 unit correction Clarification for ACT Master's and Bachelor's levels	State Policy Team	1-30-2018
Final Version 1.6	Update psych testing codes Update MHAS certification information H0014 AT rates added Remove hyperlinks no longer working Various other updates	State Policy Team	12-15-2018
Final Version 1.7	Updated psych testing section to include new codes and rates, description of the new codes, and edits/audits when PA needed Rendering clarifications Noted practitioner modifiers are optional unless dually licensed and referenced MCP Resource Guide Referenced dual licensure grid on BH site Removed language about not reporting NPI if second license is dependent since all report NPIs now Added SUD Peer Recovery to the PA table (4 hours per day maximum) 99354 for first 60 minutes Updated laboratory section about enrolling as a laboratory TBS service chart – not for high school QMHS H0001 place of service 57 Kept H0004 MH/SUD for historical reference H0014 AT rate Updated SUD residential to clearly state per diems do not include room and board costs/payments Updated hyperlinks General cleanup	State Policy Team	3-4-2019
Final Version 1.8	August 1, 2019 rate increases Additional practitioners rendering H2019 E&M, diagnostic evaluation rate increases for CNS, CNP, PA New smoking cessation codes added – Table 3-6.5 Pregnancy lab code added for MH and SUD	State Policy Team	7-23-2019
Final Version 1.9	Addition of modifier AT to Table 1-4 Addition of place of service 18 to 99406-07 Column headings for 90849, page 51 H2019 modifiers for group for LSW, LPC, LMFT Clarify H2019 Psy Asst with Bachelor's Updated OTP two week admin procedure modifier to UB	State Policy Team	7-26-2019
Final Version 1.10	Add POS 99 to H0005 Updated language regarding dependently licensed enrolling in Medicaid	State Policy Team	11-27-2019
Final Version 1.11	Emergency Version issued to identify additional procedure codes now available with GT modifier	State Policy Team	4-1-2020
Final Version 1.12	Emergency Version updated	State Policy Team	6-17-2020

Final Version 1.13	Emergency Version updated	State Policy Team	7-17-2020
Final Version 1.14	GT modifier requirement 90785 covered under telehealth	State Policy Team	11-2-2020
Final Version 1.15	E&M coding changes effective 1/1/2021	State Policy Team	12-31-2020
Final Version 1.16	Addition of pharmacist as an eligible provider type for certain services	State Policy Team	1-17-2021
Final Version 1.17	Addition of COVID-19 vaccine services (Pfizer and Moderna)	State Policy Team	2-11-2021
Final Version 1.18	Addition of COVID-19 vaccine services (Johnson & Johnson)	State Policy Team	3-18-2021
Final Version 1.19	Prolonged services coding changes effective 1/1/2022 Addition of Report of Pregnancy code (T1023) Inclusion of additional claims rollup examples Addition of "community" as allowable POS for vaccine administration Addition of Hep B Vaccine code (90759) Updated COVID-19 vaccine services resources	State Policy Team	12-3-2021
Final Version 1.20	Addition of Table 4-3 (SUD individual counseling) which was removed from version 1.19 in error	State Policy Team	12-23-2021
Final Version 1.21	Addition of Table 3-15(b) reflecting IHBT changes effective 3/1/2022 Addition of Preventive Medicine Counseling code (99401 & 99402)	State Policy Team	2-1-2022
Final Version 1.22	Addition of table 2-12 for CANS Assessment Addition of Table 2-13, 2-14, 2-15 for MRSS services Addition of Section 8 for OhioRISE	State Policy Team	5-27-2022
Final Version 1.23	Clarified CANS assessments must be entered in Ohio's CANS IT system to establish and maintain OhioRISE eligibility Updated Table 3-15(b) to clarify for dates of service between March 1,2022 – June 30, 2022. Effective July 1, 2022, services in table 3-15(b) will be available only under OhioRISE	State Policy Team	6-14-2022
Final Version 1.24	Updated provider enrollment references throughout given PNM implementation effective 10/1/2022 Clarifications to MRSS services section	State Policy Team	9-29-2022
Final Version 1.25	CPT coding changes (including prolonged services updates) effective 1/1/2023 Additions to Table 2-9: Provider Administered Pharmaceuticals Updated CANS rate effective 1/1/2023 Additions to Tables 2-4, 2-5, and 3-4 to reflect they are only valid for dates of service prior to January 1, 2023 Additions to Table 1-5 to clarify that PA for these services was required for dates of service between March 1, 2022 – June 30, 2022 Addition to Table 3-11 to clarify HM as a required modifier to indicate PSR versus MH LPN nursing	State Policy Team	12/19/2022

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SECTION 1

Introduction

The Ohio Department of Medicaid (ODM) has created this manual to help providers of community behavioral health services understand how to seek reimbursement for services provided under the fee-for-service program. The Ohio Administrative Code contains specific regulatory information that is the basis for the information contained in this manual. Chapter 5160-1 contains regulatory information on the Medicaid program in general. Additional information is available in the following administrative rule chapters:

- Chapter 5160-1 General Provisions (includes telehealth)
- Chapter 5160-4 Medical and Surgical Services
- Chapter 5160-8 Therapeutic and Diagnostic Services
- Chapter 5160-27 Community Mental Health Agency Services
- Chapter 5160-43 Specialized Recovery Services Program

Organization of the Provider Manual

This manual is organized into eight sections.

- Section 1 includes information regarding provider enrollment, rendering provider, supervisor requirements, benefit and claims related requirements, and information on fraud, waste and abuse.
- Section 2 is dedicated to medical and behavioral health services that can be provided by both mental health and substance use disorder (SUD) agencies.
- Section 3 provides specific service requirements and claims billing information for services which can only be performed by mental health agencies. This section includes evidence-based practices.
- Section 4 provides specific service requirements and claims billing information for services which can only be performed by SUD outpatient agencies.
- Section 5 provides specific service requirements and claims billing information for services which can only be performed by SUD residential agencies.
- Section 6 provides brief information on Opioid Treatment Programs (OTPs) and a link to the OTP provider manual effective for services provided on and after January 1, 2017
- Section 7 provides information on the Specialized Recovery Services (SRS) program and related resources.
- Section 8 provides information on OhioRISE (Resilience through Integrated Systems and Excellence), a program to help children who have complex and serious behavioral health needs.

Provider Enrollment – OhioMHAS-certified providers (organizations)

Effective October 1, 2022 all provider enrollment applications must be submitted using Ohio Medicaid's new Provider Network Management (PNM) module. After its implementation, the PNM module will be the single point for providers to complete provider enrollment, centralized credentialing, and provider self-service. For more information about the PNM please visit www.managedcare.medicaid.ohio.gov/managed-care/centralized-credentialing.

To participate in the Ohio Medicaid program, including contracting with the managed care plans, OhioMHAS-certified providers must enroll in the Ohio Medicaid program. Effective October 1, 2022 the IT system that supports Ohio Medicaid provider functions is the Provider Network Management (PNM) module. There are two provider types associated with behavioral health benefits; provider type 84 is used for accessing the mental health benefit while provider type 95 is used for accessing the substance use

disorder benefit. Organizations that will be providing both benefits will need to enroll as **BOTH** provider types.

Provider type 84 or 95

Prior to enrollment in the Ohio Medicaid program, a provider must be certified by OhioMHAS as a provider of behavioral health (BH) services. Information on OhioMHAS's service certification can be obtained from the OhioMHAS Bureau of Licensure & Certification by calling 614-752-8880 or by visiting the OhioMHAS licensure and certification webpage here: Licensure & Certification | Department of Mental Health and Addiction Services (ohio.gov). Once certified by OhioMHAS as a BH service provider, an online application or applications for enrollment in the Ohio Medicaid program must be submitted using the PNM module There may be an application fee for applying as provider type 84 and/or 95. During the enrollment process, a provider specialty will need to be selected for each provider type. ODM will add or change specialties as necessary based upon the OhioMHAS/SAMHSA certification(s) and/or OhioMHAS licensure documentation received with the application.

For more information about enrolling as a Medicaid provider, please visit the following link: https://managedcare.medicaid.ohio.gov/managed-care/centralized-credentialing/about-pnm

Out of state MH/SUD providers

Pursuant to Ohio Administrative Code (OAC) rule 5160-27-01, MH and/or SUD agencies/programs operating outside of the state of Ohio must be recognized (regulated) in the state in which it operates as a provider of community-based MH and/or SUD services. That documentation must be submitted along with the organization's Medicaid application.

Rendering Practitioners

ODM requires that the rendering practitioner for behavioral health services be listed on claims submitted to Ohio Medicaid for payment. Their personal NPI must be reported in the rendering field on the claim for each service they provide.

All rendering practitioners are required to have a National Provider Identifier (NPI) to render services to Medicaid enrollees AND they will be required to enroll in the Ohio Medicaid program and affiliate with their employing/contracting agency. An NPI can be obtained by visiting https://nppes.cms.hhs.gov/NPPES/Welcome.do.

Once the provider has obtained an NPI, they must visit the PNM and enroll as a provider in the Ohio Medicaid Program. More details on this process are available at: https://managedcare.medicaid.ohio.gov/managed-care/centralized-credentialing/about-pnm

Paraprofessionals

- Paraprofessionals, practitioners without a professional license, may render some mental health and/or SUD services. They must enroll in Ohio Medicaid following the instructions above. The provider type in Ohio's PNM system is "96". Paraprofessionals may select more than one specialty. For example, one could enroll as Qualified Mental Health Specialist (QMHS) may also enroll as a Care Management Specialist (CMS) by selecting specialties 960 (QMHS) and 962 (CMS).

If a QMHS or CMS practitioner obtains additional educational credentials or years of experience after their initial enrollment, the employing/contracting agency should provide documentation of the educational credential or experience by submitting a provider update to the ODM Provider Enrollment mailbox: medicaid_provider_update@medicaid.ohio.gov. Once the documentation has been received and

approved, the provider's enrollment status will be updated to match. (See more information below about QMHS, CMS and Peer Specialists).

Multi-licensed Practitioners

ODM recognizes that some individuals may hold more than one (1) license or an assistant/trainee credential with differing scopes of practice. In order to allow these practitioners to operate under the scope of multiple professional credentials, ODM is allowing these practitioners to add a multi-license specialty. This multi-license specialty will allow the practitioner to render services available under their second license or credential. Please refer to Dual Licensure Grid located at https://bh.medicaid.ohio.gov/manuals under the Billing and IT Resources section.

To enroll with multi-license specialty:

If a practitioner has more than one credential/paraprofessional recognition, please include a comment in the Notes section of the enrollment application indicating what additional credential/paraprofessional recognition is held. Paraprofessionals have the ability to select a primary, a secondary or multiple secondary specialty. Be certain to upload the necessary documentation for each license/certificate. If already enrolled with ODM, email medicaid_provider_update@medicaid.ohio.gov with necessary information to support the second specialty.

Claim submission:

- **Reporting additional licensure on claims** - Practitioners with the multi-licensed practitioner specialty submit claims as follows:
    - For their original license according to information found elsewhere in this manual: rendering NPI, applicable procedure modifiers, etc.
    - For services under their additional license(s), the claims will require an additional modifier to reflect under what additional license they are operating.
    - For example, a person enrolled with ODM as an RN who is also an LPCC must have the UH modifier **in addition to their individual practitioner NPI** on to the detail line of the claim in order for MITS to recognize this practitioner as an allowable renderer of the service.

  See the "Modifiers" tab on the Dual Licensure spreadsheet referenced above.

Qualified Providers Overview

It is the state's expectation that a practitioner will work within their scope of practice.

Medical Behavioral Health Practitioners (M-BHPs)

Medical Behavioral Health Providers are professionals who are licensed by a professional board in the state of Ohio and are authorized to practice some level of general medicine and have specialty experience and/or training related to persons with behavioral health conditions. M-BHPs are:

- **Physicians** as defined in Chapter 4731. of the Ohio Revised Code who are licensed by the state of Ohio Medical Board and legally authorized to practice in the state of Ohio.
- **Clinical nurse specialists (CNS)**, **certified nurse practitioners (NP)**, **registered nurses (RN)**, and **licensed practical nurses (LPN)** as defined in Chapter 4723. of the Ohio Revised Code who are licensed and certified by the state of Ohio Nursing Board and legally authorized to practice in the state of Ohio.
- **Physician assistants** as defined in Chapter 4730. of the Ohio Revised Code who are licensed by the state of Ohio Medical Board and legally authorized to practice in the state of Ohio.
- Effective January 17, 2021, **pharmacists** became eligible Medicaid providers. Tables 2-1, 2-6 and 2-9 provide further details. Refer to the ODM pharmacy rule 5160-8-52.

Licensed Independent Behavioral Health Practitioners (I-BHPs)

The following are professionals who are licensed by a professional board in the state of Ohio and are authorized to practice independently (they are not subject to professional supervision) and have specialty experience and/or training related to persons with behavioral health conditions. I-BHPs are:

- **Psychologists and school psychologists** as defined in Chapter 4732. of the Ohio Revised Code who are licensed by the state of Ohio Board of Psychology and legally authorized to practice in the state of Ohio.
- **Licensed professional clinical counselors (LPCC), licensed independent social workers (LISW), and licensed independent marriage and family therapists (LIMFT)** as defined in Chapter 4757. of the Ohio Revised Code who are licensed by the state of Ohio Counselor, Social Worker, and Marriage & Family Therapist Board and legally authorized to practice in the state of Ohio.
    - For the purposes of this billing manual, LIMFT has the same meaning as IMFT as used by the Counselor, Social Worker, and Marriage & Family Therapist Board.
- **Licensed independent chemical dependency counselors (LICDC)** as defined in Chapter 4758. of the Ohio Revised Code who are licensed by the Ohio Chemical Dependency Professionals Board and legally authorized to practice in the state of Ohio.

Behavioral Health Practitioners (BHPs)

Please Note: In the following descriptions, the term "registered with the state of Ohio" means an individual is known to the state professional and/or licensing boards as a practitioner who has met the applicable professional requirements.

The following are professionals who are licensed by a professional board in the state of Ohio and are authorized to practice under direct or general clinical supervision and have specialty experience and/or training related to persons with behavioral health conditions. Note: Effective for dates of service on and after July 1, 2018, these paraprofessionals must be enrolled with ODM and affiliated with their community behavioral health agency. BHPs are:

Licensed

- **Board licensed school psychologists** as defined in Chapter 3301. of the Ohio Revised Code and who are licensed by the Ohio Department of Education and legally authorized to practice in the state of Ohio.
- **Licensed professional counselors (LPC), licensed social workers (LSW),** and **licensed marriage and family therapists (LMFT)** licensed by the Ohio Counselor, Social Worker, and Marriage & Family Therapist Board in accordance with Chapter 4757. of the Ohio Revised Code and legally authorized to practice in the state of Ohio.
    - For the purposes of this billing manual, LMFT has the same meaning as MFT as used by the Counselor, Social Worker, and Marriage & Family Therapist Board.
- **Licensed chemical dependency counselor IIIs** and **licensed chemical dependency counselor IIs** licensed by the Ohio Chemical Dependency Professional Board in accordance with Chapter 4758. of the Ohio Revised Code and legally authorized to practice in the state of Ohio.

Trainees/Assistants

- **Psychology assistant/intern/trainees** working under the supervision of a psychologist licensed by the Ohio Board of Psychology and legally authorized to practice in the state of Ohio.

- **School psychology assistant/intern/trainees** working under the supervision of a psychologist or school psychologist licensed by the Ohio Board of Psychology and legally authorized to practice in the state of Ohio.
- **Counselor trainees** registered with the Ohio Counselor, Social Worker, and Marriage & Family Therapist Board in accordance with Chapter 4757. of the Ohio Revised Code and legally authorized to practice in the state of Ohio. A counselor trainee is seeking licensure as a professional counselor and is enrolled in a practicum or internship in a counselor education program.
- **Social work trainees** registered with the Ohio Counselor, Social Worker, and Marriage & Family Therapist Board in accordance with Chapter 4757. of the Ohio Revised Code and legally authorized to practice in the state of Ohio. A social work trainee is completing their school approved field placement under a council on social work education accredited master's level program.
- **Social work assistants** registered with the Ohio Counselor, Social Worker, and Marriage & Family Therapist Board in accordance with Chapter 4757. of the Ohio Revised Code and legally authorized to practice in the state of Ohio.
- **Marriage and family therapist trainees** registered with the Ohio Counselor, Social Worker, and Marriage & Family Therapist Board in accordance with Chapter 4757. of the Ohio Revised Code and legally authorized to practice in the state of Ohio. A marriage and family therapist trainee is a student enrolled in a marriage and family therapist practicum or internship in Ohio.
- **Chemical dependency counselor assistants** certified by the Ohio Chemical Dependency Professionals Board in accordance with Chapter 4758. of the Ohio Revised and legally authorized to practice in the state of Ohio.

Behavioral Health Paraprofessional Practitioners (BHP-Ps)

The following are eligible paraprofessionals who are **NOT** licensed by a professional board in the state of Ohio but are specially trained to provide a specialty service or services to persons with or in recovery from substance use disorders (SUDs) and/or mental health (MH) conditions. BHP-Ps are:

Peer Recovery Supporter (PRS): For purposes of this manual, "peer recovery supporter" (PRS) has the same meaning as a "certified peer supporter" as certified by OhioMHAS. This includes certified peer recovery supporters, certified youth peer supporters, and certified family peer supporters as described in OAC rule 5122-29-15.1.

Care Management Specialist (CMS) - An individual who has received training for or education in alcohol and other drug addiction, abuse, and recovery and who has demonstrated, prior to or within ninety days of hire, competencies in fundamental alcohol and other drug addiction, abuse, and recovery. A CMS is an individual who is not otherwise designated as a provider or supervisor, and who is not required to perform duties covered under the scope of practice according to Ohio professional licensure. A CMS must be supervised by an individual qualified to be an alcohol and drug treatment services supervisor. Fundamental competencies shall include, at a minimum:

- An understanding of alcohol and other drug treatment and recovery
- An understanding of how to engage a person in treatment and recovery
- An understanding of other healthcare systems, social service systems and the criminal justice system

Qualified Mental Health Specialist (QMHS) - an individual who has received training or education in mental health competencies and who has demonstrated, prior to or within ninety

days of hire, competencies in basic mental health skills along with competencies established by the agency, and who are not otherwise designated as providers or supervisors, and who are not required to perform duties covered under the scope of practice according to Ohio professional licensure. Basic mental health competencies shall include, at a minimum:

- Be at least 18 years old
- Have a high school diploma or equivalent
- An understanding of mental illness, psychiatric symptoms, and impact on functioning and behavior
- An understanding of how to therapeutically engage a person with mental illness
- Concepts of recovery/resiliency
- Crisis response procedures
- An understanding of the community mental health system
- De-escalation techniques
- Understanding how his/her behavior can impact the behavior of individuals with mental illness

Qualified Mental Health Specialist +3 (QMHS +3) - an individual who has received training or education in mental health competencies and has a minimum of three years of relevant work experience and has demonstrated, prior to or within ninety days of hire, competencies in basic mental health skills along with competencies established by the agency, and who are not otherwise designated as providers or supervisors, and who are not required to perform duties covered under the scope of practice according to Ohio professional licensure. Basic mental health competencies shall include, at a minimum:

- Be at least 18 years old
- Have a high school diploma or equivalent
- An understanding of mental illness, psychiatric symptoms, and impact on functioning and behavior
- An understanding of how to therapeutically engage a person with mental illness
- Concepts of recovery/resiliency
- Crisis response procedures
- An understanding of the community mental health system
- De-escalation techniques
- Understanding how his/her behavior can impact the behavior of individuals with mental illness

Overview of Supervision

Ohio Medicaid covers services provided by practitioners who, under state licensing, require supervision. The types of practitioners who may supervise is determined according to the appropriate licensing board.

General supervision: The supervising practitioner must be available by telephone to provide assistance and direction if needed.

Direct supervision: The supervising practitioner must be "immediately available" and "interruptible" to provide assistance and direction throughout the performance of the procedure; however, he or she does not need to be present in the room when the procedure is performed.

Ohio Medicaid requires the following practitioners to practice under either direct or general supervision. Reporting supervising NPI on the claim will be optional with the implementation of the services and codes included in this manual. For those practitioners listed below with direct supervision, the service will be paid at direct supervisor's rate when supervisor NPI is included in the header of the claim. If the

supervisor NPI is not included on the claim indicating the service is provided under general supervision, the service will be paid at 72.25% of maximum fee.

Table 1-1: Supervision for Current Procedural Terminology (CPT®) Codes

Practitioner Providing the Service:	Type of Supervision
Licensed professional counselor	General
Licensed chemical dependency counselor II or III	General
Licensed social worker	General
Licensed marriage and family therapist	General
Psychology assistant, intern, trainee	Direct/General
Chemical dependency counselor assistant	Direct/General
Counselor trainee	Direct/General
Social worker trainee	Direct/General
Marriage and family therapist trainee	Direct/General

Table 1-2: Supervision for Healthcare Common Procedure Coding System (HCPCS) Codes

Practitioner Providing the Service:	Type of Supervision
Psychology assistant, intern, trainee	General
Chemical dependency counselor assistant	General
Counselor trainee	General
Social worker assistant	General
Social worker trainee	General
Marriage and family therapist trainee	General
Qualified Mental Health Specialist	General
Care Management Specialist	General
Certified Peer Supporters	General

Practitioners requiring supervision must have supervision available to them at all times, including supervisor sick days, trainings, vacations, etc. Each licensing board regulates supervision requirements for their provider types and may have specific requirements pertaining to supervisor coverage during absences. In the absence of board guidance on supervisor coverage, Ohio Medicaid does not require practitioners to be assigned to a specific supervisor, therefore, any qualified supervising practitioner permitted by the practitioner's respective licensing board's OAC may provide coverage during absences but must assume all supervision responsibilities, including signing off on services provided. The following websites contain further guidance on supervision:

- State of Ohio Medical Board - http://med.ohio.gov/
- Ohio Nursing Board - http://www.nursing.ohio.gov/
- Counselor, Social Worker and Marriage and Family Therapist Board – https://cswmft.ohio.gov/wps/portal/gov/cswmft/home
- Ohio Chemical Dependency Professionals Board - http://ocdp.ohio.gov/
- Ohio Board of Psychology - http://psychology.ohio.gov/

*This is a brief overview concerning licensure and scope of practice. It is each agency or provider's responsibility to read the laws and rules for a full understanding of the requirements.

Incident to Services

The term "incident to" refers to the services or supplies that are a key part of the physician's personal professional services in the course of diagnosis or treatment of an illness or injury. In plain language: under the "incident to" provision of Medicare, services are submitted under the physician's NPI but are actually performed by someone else. There are restrictions on the types of services that ancillary personnel may perform under this provision. Ohio Medicaid follows the CMS guidelines on "incident to services," which is located in the Medicare Benefit Policy Manual, Chapter 15 Section 60.1: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673

An additional resource for CMS "incident to" billing is located at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/.

Practitioner Modifiers

In order to communicate detailed information in an efficient, standardized way, modifiers are two-character suffixes that healthcare providers or coders attach to a CPT or HCPCS code to provide additional information about the practitioner or procedure. It is extremely important to accurately report modifiers as they are used to count towards soft limits, price services, and adjudicate claims appropriately. Modifiers are always two characters in length. They may consist of two numbers two letters, or a combination of a letter and a number (alphanumeric). Ohio Medicaid will accept modifiers in any order, however, modifier fields on the claim must be populated in order from one to four (the first modifier field must be populated before the second modifier field, etc.).

Table 1-3: Practitioner Modifiers

Practitioner Providing the Service:	Professional Abbreviation	Practitioner Modifier
Licensed professional counselor	LPC	U2*
Licensed chemical dependency counselor III	LCDC III	U3*
Licensed chemical dependency counselor II	LCDC II	U3*
Licensed social worker	LSW	U4*
Licensed marriage and family therapist	LMFT	U5*
Psychology assistant, intern, trainee	PSY assistant	U1*
Chemical dependency counselor assistant	CDC-A	U6*
Counselor trainee	C-T	U7*
Social worker assistant	SW-A	U8*
Social worker trainee	SW-T	U9*
Marriage and family therapist trainee	MFT-T	UA*
QMHS – high school	QMHS	HM
QMHS – Associate's	QMHS	HM
QMHS – Bachelor's	QMHS	HN
QMHS – Master's	QMHS	HO

QMHS – 3 years' experience	QMHS	UK
Care management specialist – high school	CMS	HM
Care management specialist – Associate's	CMS	HM
Care management specialist – Bachelor's	CMS	HN
Care management specialist – Master's	CMS	HO
Peer recovery supporter – high school	PRS	HM
Peer recovery supporter – Associate's	PRS	HM
Peer recovery supporter – Bachelor's	PRS	HN
Peer recovery supporter – Master's	PRS	HO

*For fee for service, these modifiers are optional except when rendering practitioner holds multi-license specialty and is rendering service available under the second license/certificate. For information on MCP requirements, please refer to **https://bh.medicaid.ohio.gov/Provider/Medicaid-Managed-Care-Plans**.

Procedure Modifiers

The following modifiers are required to describe specific circumstances that may occur during a service:

Table 1-4: Procedure Modifiers

Service Circumstance	Modifier
Group service	HQ
Physician, team member (ACT)	AM
CNP team member (ACT)	UC
PA or CNS, team member (ACT)	SA
Master's level, RN, LPN, team member (ACT)	HO
Bachelor's level, team member (ACT)	HN
Peer recovery supporter, team member (ACT)	HM
Required to indicate PSR (rather than MH LPN nursing services)	HM
Pregnant/parenting women's program	HD
Complex/high tech level of care	TG
Cognitive Impairment (SUD residential ASAM level 3.3)	HI
Licensed practitioners providing TBS Group Hourly/Per Diem (day treatment) or SUD group counseling	HK
OTP Daily Administration	HF
OTP One Week Administration (2 – 7 Days)	TV
OTP Two Week Administration (8 – 14 Days)	UB
OTP Three Week Administration (15 – 21 Days)	TS
OTP Four Week Administration (22 – 28 Days)	HG
Significant, separately identifiable Evaluation & Management (E&M) service by physician or other qualified health professional on the same day of the procedure or other service	25
NCCI modifiers (See NCCI Section)	59, XS, XE, XU and XP

CLIA waived test- certificate of waiver – CMS certificate type code 2 or higher required	QW
Crisis modifier used on T1002, H2017 (PSR only, not LPN nursing service), H2019, H0004 and 90832	KX
Physician delivering SUD group counseling	AF
The GT Modifier is required for any service delivered via secured video-conferencing or other allowable telehealth delivery methods in accordance with OAC 5160-1-18 (See the rule appendices for the list of services that may be delivered via telehealth)	GT
Withdrawal management 2-3 hours	AT

Place of Service (POS)

Providers must accurately identify and report on each claim detail line where a service took place using the most appropriate CMS place of service code. Each billing chart in this manual will list the place of service codes covered by Medicaid.

"Other Place of Service" Setting

Place of service "99-Other Place of Service" has been redefined for Ohio Medicaid as "Community". See this manual's Appendix for a more complete definition of this and other places of service.

Claims Detail Rollup for Same Day Services

When the same service is rendered to the same client by the same practitioner at more than one time during the same day, it is acceptable to "roll up" those services into a single detail line on a claim. However, if anything differs except the time the service was rendered, the claims should reported separately. Services that need to be rolled must be rolled by the same date of service, same client, same HCPCS code, same modifier(s), same individual rendering practitioner NPI, same supervisor NPI, and same place of service.

Example 1: Amy Smith, RN (NPI 9876543210) and John Jones, RN (NPI 9876543211) each provide two 15-minute nursing services (H2019) to Betty Brown. The correct way to bill these services is by submitting two detail lines on a single claim.

1. Claim detail one would be: Amy Smith, RN, NPI in rendering provider field: 9876543210, with two units of H2019.
2. Second claim detail would be: John Jones, RN, NPI in rendering provider field: 9876543211, with two units of H2019.

It would be inappropriate to roll these services under either just Amy or John and bill 4 units of H2019 since Amy and John are separately enrolled with ODM with their own unique NPIs.

Example 2: Amy Smith, RN renders TBS to a client in the office in the morning and then again in the office later that afternoon. This is acceptable to roll up the two patient contacts into the same claim line because there is the same service, the same rendering practitioner, the same client, and the same place of service.

Example 3: Amy Smith, RN renders TBS to a client in the office in the morning and then again in the client's home later that afternoon. The services should be reported on separate detail lines with appropriate place of service identifying home or office.

Third Party Payer (TPP) Coordination of Benefits (COB)

Federal regulation 42 CFR 433.139 requires states to deny (cost avoid) Medicaid claims until after the application of available third party payer benefits since Medicaid is the payer of last resort. When Medicare or private insurance coverage exists, payment must be sought from the TPP before Medicaid is billed. When billing the TPP, the provider must follow that payer's rules for claim submission, including prior authorization requirements, claim form type, and coding. Any payment received from a TPP must be reported on the claim or claims submitted to Ohio Medicaid.

Note: A claim that has been submitted to a TPP using a CPT code cannot be recoded to a HCPCS code to bill Ohio Medicaid. Further information on coordination of benefits with Medicare or other third-party payers can be found in rules: OAC 5160-1-08 and 5160-1-05 and ODM FAQ.

Benefits and Prior Authorization

In the behavioral health benefit package, there are services and/or levels of care that are subject to prior authorization. The table below summarizes those services/levels of care and their associated prior authorization policy. Certain services may have prior authorization requirements when provided on the same day as other services. Please refer to OAC Chapter 5160-27 and rule 5160-8-05 for service-specific requirements.

Table 1-5: Prior Authorization

Description and Code	Benefit Period	Authorization Requirement
Assertive Community Treatment (ACT) H0040	Based on prior authorization approval	ACT must be prior authorized and all SUD services must be prior authorized for ACT enrollees.
Intensive Home Based Treatment (IHBT) H2015 Multisystemic Therapy (MST) H2033 Functional Family Therapy (FFT) H2015 TF [1]	All three services are based on prior authorization approval	All three services must be prior authorized.
SUD Partial Hospitalization H0015 TG	Calendar year	Prior authorization is required for this level of care for adults and adolescents.
Psychiatric Diagnostic Evaluations 90791, 90792	Calendar year	1 encounter per person per calendar year per code per billing agency for 90791 and 90792. Prior authorization is required for additional service.
Psychological Testing 96112, 96113, 96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137	Calendar year	Up to 20 hours/encounters per patient per calendar year for all psychological testing codes. Prior authorization is required for additional service.

Screening Brief Intervention and Referral to Treatment (SBIRT) G0396, G0397	Calendar year	One of each code (G0396 and G0397), per billing agency, per patient, per year. Cannot be billed by provider type 95. Prior authorization is required for additional service.
Alcohol or Drug Assessment H0001	Calendar year	2 assessments per patient per calendar year per billing agency. Does not count toward ASAM level of care benefit limit. Prior authorization is required for additional service.
TBS Group Per Diem H2020	Calendar year	1 per day. Prior authorization is required for an additional per diem service to the same client on the same day rendered by a different billing agency.
SUD Residential H2034, H2036	Calendar year	Up to 30 consecutive days without prior authorization. Prior authorization then must support the medical necessity of continued stay, if not, only the initial 30 consecutive days are reimbursed. This applies to first two stays. Third and subsequent stays in the same year require prior authorization from the first day of admission.
SUD Peer Recovery H0038	Calendar year	Up to 4 hours per day without prior authorization. Prior authorization would be needed to cover more than 4 hours in a day once limit is reached.
Any service or ASAM level of care not listed in this table is not subject to prior authorization.		

[1] For dates of service between March 1, 2022 – June 30, 2022. Effective July 1, 2022, these services are available only under OhioRISE

Fee for service prior authorization instructions are available on the ODM website - http://medicaid.ohio.gov/PROVIDERS/PriorAuthorizationRequirements.aspx. Training on how to submit a fee for service prior authorization request for a behavioral health service is available at http://bh.medicaid.ohio.gov/training. Information regarding prior authorization requests for Medicaid clients enrolled with a managed care or My Care plan can be found in the Medicaid Managed Care Plan Resource Guide.

Requirements for medical necessity are found here: OAC 5160-1-01

Non-Covered Services

Non-covered services are described in OAC 5160-1-61 and in OAC 5160-27-02 paragraph (K)Additionally, Ohio Medicaid does not cover services to individuals that meet the following criteria:

CFR 42 § 435.1009 Institutionalized individuals.

(a) Federal Financial Participation (FFP) is not available in expenditures for services provided to;
(1) Individuals who are inmates of public institutions as defined in § 435.1010; or
(2) Individuals under age 65 who are patients in an institution for mental diseases unless they are under age 22 and are receiving inpatient psychiatric services under § 440.160 of this subchapter. (As authorized in 42 CFR 438.6, a managed care plan may cover a short-term IMD stay for a member aged 21-64. This may not be covered through fee-for-service Medicaid).

(b) The exclusion of FFP described in paragraph (a) of this section does not apply during that part of the month in which the individual is not an inmate of a public institution or a patient in an institution for tuberculosis or mental diseases.

(c) An individual on conditional release or convalescent leave from an institution for mental diseases is not considered to be a patient in that institution. However, such an individual who is under age 22 and has been receiving inpatient psychiatric services under § 440.160 of this subchapter is considered to be a patient in the institution until he is unconditionally released or, if earlier, the date he reaches age 22.

Fraud, Waste, Abuse and Errors

OAC rule 5160-1-29 sets forth the Ohio Medicaid policy on Medicaid Fraud, Waste and Abuse. Under the Ohio Medicaid provider agreement, providers are required to comply with the terms of the agreement, Ohio Revised Code, Administrative Code, and federal statutes and rules. In Ohio, the Attorney General is authorized under ORC 109.85 to create a Medicaid Fraud and Control Unit (MFCU) for investigating and prosecuting Medicaid provider fraud in Ohio.. Additional information regarding Ohio's Medicaid Fraud Control unit can be found on their website, Health Care Fraud - Ohio Attorney General Dave Yost

False Claim Act

Section 6032 of the Deficit Reduction Act of 2005 requires state Medicaid plans to provide that any entity that receives or makes annual payments under the state plan of at least $5,000,000, as a condition of receiving such payments:

(A) establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code, any state laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f));

(B) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and

(C) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

Codified at 42 U.S.C. 1396a(a)(68). Ohio Medicaid's Surveillance, Utilization and Review Section (SURS)

Federal law (CFR 42.456.25) requires state Medicaid programs to perform post-payment review of Medicaid claims including recipient and provider profiles to identify and correct any inappropriate utilization practices. This activity is performed by Ohio Medicaid's Surveillance, Utilization and Review Section (SURS) which randomly samples Medicaid data to identify patterns that fall outside the mean.

Providers found to have outlier patterns may be contacted for post-payment review and possible recoupment of overpayments. Providers suspected of fraud, waste or abuse may be referred to the Attorney General's Medicaid Fraud and Control Unit.

Payment Error Rate Measurement (PERM)

The Payment Error Rate Measurement (PERM) program measures improper payments in Medicaid and Children's Health Insurance Program (CHIP) to produce a national error rate for each program. The error rates are based on reviews of the fee-for-service (FFS), data processing, and eligibility components of Medicaid and CHIP in the federal fiscal year (FFY) under review. PERM does not measure fraud; it determines the amount of claims paid in error based on our state's policies and program requirements.

Today's PERM audit process was developed through the establishment of many acts.

- Improper Payments Information Act (IPIA) 2002 required federal agencies to review programs susceptible to erroneous payments.
- Improper Payments Elimination and Recovery Act (IPERA) of 2010 amended the IPIA and required additional processes to identify improper payments.
- The Improper Payments Elimination and Recovery Improvement Act (IPERIA) 2012 amended the IPERA and required additional processes to recover and reduce improper payments.

When a claim is initially selected for review, providers receive 75 days to submit documentation to support the claims billed. If additional documentation is needed to review the claim, providers are given 14 days to submit the verifications. If providers fail to turn in all of the requested documentation, the claim will be considered an error and an overpayment may be recouped by Ohio Medicaid. If the documentation provided does not support the claim as billed, the claim will be considered an error and an overpayment may be recouped by Ohio Medicaid. Failure to respond to documentation requests may initiate a more complex review of claims and medical records.

Medicaid National Correct Coding Initiative

The National Correct Coding Initiative (NCCI) was established by the Centers for Medicare & Medicaid Services (CMS) to promote national correct coding methodologies with the goal to reduce improper coding that results in inappropriate payments for both Medicare and Medicaid. The Affordable Care Act of 2010 (ACA) required state Medicaid programs to incorporate NCCI methodologies in their systems for processing Medicaid claims by October 1, 2010. A complete and up-to-date list of NCCI edits can be found at https://www.medicaid.gov/medicaid/program-integrity/national-correct-coding-initiative/medicaid-ncci-edit-files/index.html. These edits are updated quarterly.

NCCI procedure-to-procedure (PTP) edits and medically unlikely edits (MUEs) are only applicable to a single provider to a single individual on the same date of service. NCCI contains two types of edits:

NCCI procedure-to-procedure (PTP) edits

PTP edits define pairs of Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons. The purpose of the PTP edits is to prevent improper payments when incorrect code combinations are reported.

Example 1: The same physician performs a psychotherapy service and Evaluation and Management (E&M) service on the same day for the same client (significant and separately identifiable services). NCCI will not allow the psychotherapy code 90834 to be billed with an E&M office visit code 99212, as there are separate add-on codes (+90833, +90836, and +90838) for psychotherapy services provided in conjunction with E&M services.

Example 2: The same physician performs a health and behavioral assessment code 96150 and a psychiatric diagnostic evaluation code 90791 on the same day for the same client. NCCI will not permit

these two codes to be billed together as 96150 is too similar a service to 90791. Only the predominant service performed should be billed (90791).

Example 3: A qualified practitioner working for ABC Behavioral Health Agency renders 90791, a psychiatric diagnostic assessment, for a client. On the same day, the same client receives an "evaluation and management" primary care service (e.g. 99202-99205) rendered by another qualified practitioner working for ABC Behavioral Health Agency. According to the NCCI practitioner to practitioner (PTP) edit guidance, this is acceptable because in this scenario, the services were rendered by two different rendering practitioners. The NCCI PTP edits apply only to the same practitioner.

Medicaid PTP, MUE edits, and other relevant information can be found at: https://www.medicaid.gov/medicaid/program-integrity/ncci/edit-files/index.html.

For PTP edits that have a Correct Coding Modifier Indicator (CCMI) of "0," the codes should never be reported together by the same provider for the same individual on the same date of service. If they are reported on the same date of service, the column one code is eligible for payment and the column two code is denied.

For PTP edits that have a CCMI of "1," the codes may be reported together only in defined circumstances which are identified on the claim by the use of specific NCCI-associated modifiers. Where services are "separate and distinct," it may be necessary to override the procedure-to-procedure edit using a specific modifier:

- XE – "Separate encounter, A service that is distinct because it occurred during a separate encounter" (This modifier should only be used to describe separate encounters on the same date of service).
- XS – "Separate Structure, A service that is distinct because it was performed on a separate organ/structure."
- XP – "Separate Practitioner, A service that is distinct because it was performed by a different practitioner."
- XU – "Unusual Non-Overlapping Service, The use of a service that is distinct because it does not overlap usual components of the main service."

Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Modifier 59 should only be utilized if no other more specific modifier is appropriate. Note: high usage of all modifiers, especially modifier 59, is subject to retrospective review.

Medically Unlikely Edits (MUEs)

MUEs define for each HCPCS / CPT code the maximum units of service (UOS) that a provider would report under most circumstances for a single individual on a single date of service. **MUEs cannot be overridden with the 59, XE, XS, XP, XU modifiers.**

Example 1: The same physician performs two diagnostic evaluations (2 units of 90791) to the same client on the same day. NCCI will deny the second evaluation, as it is medically unlikely that one client would need two complete diagnostic evaluations in the same day.

There is extensive guidance regarding Medicaid agencies and national correct coding available at The National Correct Coding Initiative in Medicaid.

Time-Based CPT Codes

When billing time-based codes the CPT/HCPCS time rule applies, unless otherwise specified: For the minimum billable service of the code, divide the time by two and add one minute in order to determine if that code can be billed. For example; 90832 = 30 minutes, therefore the minimum length of service must be 16 minutes (30/2 = 15 then 15 + 1 = 16) in order for the service to be billable.

Conversion Chart Reported in 15 Minute Increments		
Minimum Minutes	Maximum Minutes	Billing Unit(s)
Hour 1		
0	7	N/A
8	22	1
23	37	2
38	52	3
53	67	4
Hour 2		
68	82	5
83	97	6
98	112	7
113	127	8
Hour 3		
128	142	9
143	157	10
158	172	11
173	187	12
Hour 4		
188	202	13
203	217	14
218	232	15
233	247	16

Conversion Chart Hour Based Services Reported in Whole Unit Increments		
Minimum Minutes	Maximum Minutes	Billing Increment
1	30	N/A
31	90	1
91	150	2
151	210	3
211	270	4
271	330	5
331	390	6
391	450	7
451	510	8
511	570	9

Prolonged Services

Effective January 1, 2023, the American Medical Association (AMA) has discontinued prolonged service codes 99354 and 99355 for use with psychotherapy codes. ODM and MCO billing systems were updated to reflect this change. Providers should refer to AMA and National Correct Coding Initiative (NCCI) guidance with regard to billing psychotherapy codes for dates of service on or after January 1, 2023.

Effective January 1, 2022, ODM adopted for Medicaid community behavioral health providers the use of AMA procedure codes of 99415 and 99416 to indicate prolonged E&M services. Providers should refer to the CPT manual for additional information about appropriate use of codes 99415 and 99416.

Also effective January 1, 2022, MITS was updated to follow NCCI Procedure to Procedure (PTP) edits to not allow the use of 99354 and 99355 with E&M codes 99202-99205 and 99211-99215.

Effective January 1, 2021, ODM adopted two new billing codes for prolonged services:

- CPT® code 99417 was adopted in accordance with American Medical Association (AMA)
- HCPCS code G2212 was adopted in accordance with the Centers for Medicare and Medicaid Services (CMS). HCPCS code G2212 should be reported on Medicaid claims for individuals dually-eligible for Medicare.

Providers serving individuals with primary insurance coverage other than Medicaid are advised to follow billing guidance for the primary payer when determining which prolonged services code to use before submitting to Medicaid for secondary payment.

For more information regarding prolonged services codes, please review the prolonged services section of the latest edition of the CPT manual. The link to the CPT website can be found here.

Missed Appointments

There are no procedure codes for missed appointments (i.e., cancellations and/or “no shows”). A missed appointment is a non-service and is not reimbursable by Ohio Medicaid. Per state and federal guidelines, Medicaid clients **cannot** be charged a missed appointment fee. Per the CMS Medicare Program Integrity Manual, missed appointments should be documented in the clinical record.

SECTION 2

Behavioral Health Services

For behavioral health billing, CPT service codes consist of E&M office visits, psychotherapy, psychiatric diagnostic evaluations, psychiatric testing, and appropriate add-on codes. The American Medical Association (AMA) publishes annual CPT reference books, which provide the CPT l codes, their associated descriptions, and guidance on appropriate use. Please note, providers are responsible for utilizing the appropriate AMA and/or CMS guidance for documentation and billing. Therefore, it is recommended that all providers obtain a copy of a current CPT manual and, for those providers/practitioners that participate in the Original Medicare program, the most current version of the Medicare Learning Network "Evaluation and Management Services" guide, the "1995 Documentation Guidelines for Evaluation and Management Services," and the "1997 Documentation Guidelines for Evaluation and Management Services" available through the Medicare Learning Network (MLN). Please note, you must use EITHER the 1995 or the 1997 MLN documentation guidelines; you cannot use both. This section also includes billing guidance for HCPCS codes that are also available to both MH and SUD agencies. Practitioner abbreviations are used in the service charts provided in the remaining sections of this manual. The chart below may be used as a reference to these abbreviations:

Practitioner Abbreviations Key			
MD/DO	Physician	**LSW**	Licensed social worker
CNS	Clinical nurse specialist	**LMFT**	Licensed marriage and family therapist
CNP	Certified nurse practitioner	**LPC**	Licensed professional counselor
PA	Physician assistant	**LCDC II or LCDC III**	Licensed chemical dependency counselor II or III
RN	Registered nurse	**SW-A**	Social worker assistant
LPN	Licensed practical nurse	**SW-T**	Social worker trainee
PSY	Psychologist	**MFT-T**	Marriage and family therapist trainee
LISW	Licensed independent social worker	**C-T**	Counselor trainee
LIMFT	Licensed independent marriage and family therapist	**CDC-A**	Chemical dependency counselor assistant
LPCC	Licensed professional clinical counselor	**CMS**	Care management specialist
LICDC	Licensed independent chemical dependency counselor	**QMHS**	Qualified mental health specialist
Lic school PSY	Board licensed school psychologist	**QMHS +3**	Qualified mental health specialist with 3 years' experience
PSY assistant	Psychology assistant	**PRS**	Peer recovery supporter
RPH	Pharmacist		

Evaluation and Management Codes

Table 2-1: Evaluation & Management Office Visit

MH / SUD				
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate**
E&M New Patient	MD/DO	99201* 99202 99203 99204 99205	-	$49.38 $84.67 $122.93 $188.51 $236.92
	CNS CNP PA	99201* 99202 99203 99204 99205	-	$49.38 $84.67 $122.93 $188.51 $236.92
	RPH†	99202 99203	-	$33.09 $49.09
E&M Established Patient	MD/DO	99211 99212 99213 99214 99215	-	$22.31 $48.97 $82.85 $122.27 $165.15
	CNS CNP PA	99211 99212 99213 99214 99215	-	$22.31 $48.97 $82.85 $122.27 $165.15
	RN LPN	99211	-	$22.31
	RPH†	99211 99212 99213	-	$12.32 $22.72 $37.06
Unit Value	Encounter			
Permitted POS	11, 13, 31, 32 MH also has 53 SUD also has 57	Telehealth allowed with GT modifier. GT modifier is required when service rendered via telehealth.		

*CPT® code 99201 has been deleted effective January 1, 2021. For dates of service on or after January 1, 2021, providers should report appropriate evaluation and management codes in accordance with the AMA.

† Pharmacists are eligible to provide these services effective January 17, 2021.

Table 2-2: Prolonged Service codes for E&M Office Visits

Service	Provider Type	Code	Rate through December 31, 2021	Rate effective Jan 1, 2022
Prolonged Visit – First 60 minutes	MD/DO CNS CNP PA	+99415	-	$10.94
Prolonged Visit – Each Additional 30 Minutes	MD/DO CNS CNP PA	+99416	-	$5.62
Prolonged Visit – Each Additional 15 Minutes (for use with codes 99205 and 99215 only)	MD/DO	+99417	$22.48	$38.53
	CNS CNP PA	+99417	$19.11	$38.53
Prolonged Visit – Each Additional 15 Minutes (for use with codes 99205 and 99215 only)	MD/DO	+G2212	$22.48	$38.53
	CNS CNP PA	+G2212	$19.11	$38.53
Unit Value	+99415 – first 60 minutes +99416– each additional 30 minutes +99417 – each additional 15 minutes +G2212 – each additional 15 minutes			
Permitted POS	Same as base code	Telehealth allowed with GT modifier. GT modifier is required when service rendered via telehealth.		

Table 2-3 Evaluation and Management Office Visit- Report of Pregnancy

MH / SUD				
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate Effective July 1, 2021**
Report of Pregnancy*	MD/DO CNS CNP PA	T1023	-	$30.00

*ODM has added coverage for HCPCS code T1023 to be used for a "Report of Pregnancy". Payment may be made for one report of a pregnancy diagnosed in conjunction with an E&M service that is not associated with a normal obstetrics/gynecology visit. The report must be submitted on form ODM10257, "Report of Pregnancy (ROP)" (7/2021) available here: https://medicaid.ohio.gov/static/Resources/Publications/Forms/ODM10257Fillx.pdf

The report of pregnancy must occur in conjunction with an E&M service and be rendered by a physician, advanced practice registered nurse, or physician assistant. The payment is paid in addition to the E&M visit.

ROP forms should be sent to the county department of job and family services (CDJFS) where the individual resides as well as the pregnancy-related services coordinator of the assigned MCP. CDJFS contact information is available at https://jfs.ohio.gov/County/County_Directory.stm. MCP contact information is available on the Pregnancy Risk Assessment Communication (PRAF) instructions form ODM10207i available at https://medicaid.ohio.gov/static/Resources/Publications/Forms/ODM10207i.pdf.

Table 2-4: Evaluation & Management Home Visit

MH / SUD				
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate**
E&M Home Visit New Patient	MD/DO	99341 99342 99343* 99344 99345	-	$63.65 $91.90 $150.80 $210.78 $255.57
	CNS CNP PA	99341 99342 99343* 99344 99345	-	$63.65 $91.90 $150.80 $210.78 $255.57
E&M Home Visit Established Patient	MD/DO	99347 99348 99349 99350	-	$64.00 $97.38 $148.16 $205.79
	CNS CNP PA	99347 99348 99349 99350	-	$64.00 $97.38 $148.16 $205.79
Unit Value	Encounter			
Permitted POS	04, 12, 16			

*CPT® code 99343 has been deleted effective January 1, 2023. For dates of service on or after January 1, 2023, providers should report appropriate evaluation and management codes in accordance with the AMA.

Table 2-5: Prolonged Service codes for E&M Home Visits
For dates of service prior to January 1, 2023*

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
Prolonged Visit – First 60 minutes (Use in conjunction with covered BH codes 99341-99350)	MD/DO	+99354	-	-	$89.90
	CNS CNP PA	+99354	-	-	$76.42
Prolonged Visit – Each Additional 30 minutes (Use in conjunction with covered BH codes 99341-99350)	MD/DO	+99355	-	-	$89.24
	CNS CNP PA	+99355	-	-	$75.85
Unit Value	+99354 – first 60 minutes +99355 – each additional 30 minutes				
Permitted POS	Same as base code	Telehealth allowed with GT modifier. GT modifier is required when service rendered via telehealth.			

Table 2-6: Preventive Medicine Counseling

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rates**
Preventive Medicine Counseling – 15 minutes	MD/DO CNS CNP PA RPH	+99401	-	-	For rates, see the Medicine, Surgery, Radiology and Imaging, and Additional Procedures (Non-Institutional Services) schedule on the Fee Schedule and Rates page of the ODM website.
Preventive Medicine Counseling – 30 minutes	MD/DO CNS CNP PA RPH	+99402	-	-	
Unit Value	See code description				
Permitted POS	Same as base code	Telehealth allowed with GT modifier. GT modifier is required when service rendered via telehealth.			

Table 2-7: Psychiatric Diagnostic Evaluation

MH / SUD				
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate**
Psychiatric Diagnostic Evaluation w/o Medical	MD/DO PSY	90791	-	$130.72
	CNS CNP PA	90791	-	$130.72
	LISW LIMFT LPCC LICDC (SUD only) Lic school PSY	90791		$111.11
	LSW LMFT LPC LCDC III (SUD only) LCDC II (SUD only)	90791	U4 U5 U2 U3 U3	$111.11
	PSY assistant	90791	U1	Paid at direct supervisor rate when supervisor NPI on claim. Paid at 85% of maximum fee if supervisor NPI not included
	SW-T MFT-T CDC-A (SUD only) C-T	90791	U9 UA U6 U7	Paid at direct supervisor rate when supervisor NPI on claim. Paid at 72.25% of maximum fee if supervisor NPI not included
Psychiatric Diagnostic Evaluation w/ Medical	MD/DO	90792	-	$144.35
	CNS CNP PA	90792	-	$144.35
Unit Value	Encounter			
Permitted POS	03, 04, 11, 12, 13, 14, 16, 18, 31, 32, 99 MH also has 53 SUD also has 57		Telehealth allowed with GT modifier. GT modifier is required when service rendered via telehealth.	

Table 2-8 - Electrocardiogram

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
Electrocardiogram-at least 12 leads w/ interpretation and report	MD/DO	93000	-	-	$15.90
	CNS CNP	93000	-	-	$13.52
	PA	93000	-	-	$13.52
Electrocardiogram-tracing only w/o interpretation and report	MD/DO	93005	-	-	$6.90
	CNS CNP	93005	-	-	$5.87
	PA	93005	-	-	$5.87
Electrocardiogram-interpretation and report only	MD/DO	93010	-	-	$7.90
	CNS CNP	93010	-	-	$6.72
	PA	93010	-	-	$6.72
Unit Value	Encounter				
Permitted POS	11 MH also has 53 SUD also has 57				

Table 2-9: Provider Administered Pharmaceuticals

MH / SUD				
Service	**Medication**	**Code**	**Procedure Modifier**	**Rate**
Medication Administered by Medical Personnel (J-Codes)	Injection, aripiprazole (Abilify), intramuscular, 0.25 mg	J0400	None	For rates, see the Provider Administered Pharmaceuticals schedule on the Fee Schedule and Rates page of the ODM website.
	Injection, aripiprazole (Abilify), 1 mg	J0401	None	
	Injection, aristada initio, 1mg	J1943	None	
	Injection, aripiprazole lauroxil, 1 mg	J1944	None	
	Diphenhydramine hcl (Benadryl), up to 50 mg	J1200	None	
	Haloperidol injection, up to 5 mg	J1630	None	
	Haloperidol Decanoate injection, per 50 mg	J1631	None	
	Lorazepam injection, 2 mg	J2060	None	
	Injection, naloxone (Narcan), 1 mg	J2310	None	
	Injection, naloxone hydrochloride (zimhi), 1mg	J2311	None	
	Naloxone (nasal route)	J3490	None	
	Olanzapine long acting injectable, 1 mg	J2358	None	
	Fluphenazine Decanoate injection, 25 mg	J2680	None	
	Risperidone, long acting, .5 mg	J2794	None	
	Paliperidone Palmitate injection (Invega Sustenna or Invega Trinza), 1 mg	J2426	None	
	Valium injection, up to 5 mg	J3360	None	
	Cogentin (benztropine mesylate), per 1 mg	J0515	None	
	Injection, naltrexone (Vivitrol), depot form, 1 mg	J2315	None	
	Injection, methylnaltrexone (Relistor), 0.1 mg	J2212	None	
	Oral Naltrexone	J8499	HG	
	Buprenorphine, oral, 1 mg	J0571	None	
Unit Value	Based on HCPCS descriptor			
Permitted POS	03, 04, 11, 12, 14 MH also has 53 SUD also has 55, 57			

MH / SUD *					
Service	**Description**	**Provider Type**	**Code**	**Procedure Modifier**	**Rate**
Other Medication Administration	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	MD/DO CNS CNP PA RN/LPN RPH	*96372	None	$21.39
Unit Value	CPT designation				
Permitted POS	03, 04, 11, 12, 14, 16, 18				

	MH also has 53 SUD also has 57

* 96372 is not covered in substance use disorder (SUD) residential treatment programs (provider type 95 with provider specialty 954) due to the per diem payment methodology for SUD residential treatment.

National Drug Code (NDC)

With the exception of hospital claims, federal law requires that any code for a drug covered by Medicaid must be submitted with the 11-digit NDC assigned to each drug package. The NDC specifically identifies the manufacturer, product and package size. Each NDC is an 11-digit number, sometimes including dashes in the format 55555-4444-22. When submitting claims to Medicaid, providers should submit each NDC using the 11-digit NDC **without** dashes or spaces. The NDC included on the claim must be the exact NDC that is on the package used by the provider.

Some drug packages include a 10-digit NDC. In this case, the provider should convert the 10 digits to 11 digits when reporting this on the claim. When converting a 10-digit NDC to an 11-digit NDC, a leading zero should be added to only one segment:

- If the first segment contains only four digits, add a leading zero to the segment;
- If the second segment contains only three digits, add a leading zero to the segment;
- If the third segment contains only one digit, add a leading zero to the segment.

All claims reporting NDC information must be submitted either as an Electronic Data Interchange (EDI) transaction or through the MITS Web Portal. The NDC will be required at the detail level when a claim is submitted with a code that represents a drug (e.g., J-codes and S-codes).

Laboratory Services

Table 2-10: Laboratory Services

MH / SUD				
Service	**Service**	**Code**	**Procedure Modifier**	**Rate**
Laboratory Services	Skin test; tuberculosis, intradermal	86580	-	For rates, see the Medicine, Surgery, Radiology and Imaging, and Additional Procedures (Non-Institutional Services) schedule on the Fee Schedule and Rates page of the ODM website.
	Collection of venous blood by venipuncture	36415	-	
	Alcohol (ethanol), breath	82075	-	
	Urine pregnancy test	81025	QW	
Unit Value	CPT designation			
Permitted POS	03, 04, 11, 12, 14 MH also has 53 SUD also has 55, 57			
Other Considerations	Code 36415 collection of venous blood by venipuncture may be billed for blood draws associated with covered external lab services.			

Laboratory Codes

Effective January 1, 2019, ODM added the laboratory contract for any community substance use disorder (SUD) treatment provider (provider type 95) with appropriate CLIA certification. This will allow a provider to perform clinical laboratory services on-site if the provider has the appropriate CLIA certificate for the clinical lab services being performed.

How to Activate the Lab Contract

ODM must have the CLIA certification on file for the SUD provider to access the appropriate laboratory codes. Once the certificate is uploaded to the PNM, the appropriate laboratory contract will be made available to the SUD agency.

CLIA Certification Overview

To bill laboratory codes besides those listed above, a provider must obtain the appropriate CLIA certification and enroll as a laboratory provider with Ohio Medicaid. These laboratory services under CLIA are carved into Managed Care and payment must be coordinated with the individual plans.
The Laboratory Certification Program works to ensure Ohioans receive accurate, cost-effective clinical laboratory testing as a part of their health care. Each year, the program inspects and monitors clinical laboratories located in hospitals, independent laboratories, plasmapheresis centers, and physicians' offices. The program monitors the performance of approximately 8,500 laboratories and investigates clinical laboratory complaints it receives.

Services
The program monitors all clinical laboratories for compliance to federal (42 Code of Federal Regulations Part 493 Clinical Laboratory Improvement Amendments of 1988 (CLIA)) and state requirements (Ohio Revised Code Chapter 3725 Plasmapheresis Centers). The program conducts on-site inspections for compliance, monitors accuracy and reliability of testing via proficiency review of testing scores/reports, investigates complaints, and answers both regulatory and technical questions related to clinical laboratories.

New Applications
Generally, each separate location or address is required to have a separate CLIA number. There are exceptions for not-for-profit/government-owned laboratories or hospitals. Call the Ohio Department of Health if you think your organization qualifies for one of these exceptions.

Clinical Laboratory Improvement Amendments (CLIA) Certificate Types
Certificate of Registration — CMS Certificate Type Code 9
This certificate permits a laboratory to conduct moderate- or high-complexity laboratory testing (or both) until the entity is determined by survey to be in compliance with CLIA regulations.

Certificate of Compliance — CMS Certificate Type Code 1
This certificate is issued to a laboratory after an inspection that finds the laboratory to be in compliance with all applicable CLIA requirements.

Certificate of Accreditation — CMS Certificate Type Code 3
This certificate is issued to a laboratory on the basis of the laboratory's accreditation by an organization approved by CMS.

Certificate for Provider-Performed Microscopy Procedures (PPMP) — CMS Certificate Type Code 4
This certificate is issued to a laboratory in which a physician, mid-level practitioner, or dentist performs no tests other than microscopy procedures. This certificate also permits the laboratory to perform waived tests.

Certificate of Waiver — CMS Certificate Type Code 2
This certificate permits a laboratory to perform only waived tests. Note: Waived tests have been determined to be so simple and accurate that there is little risk of error or harm to the patient if the test is performed incorrectly. The need for higher-level certification is waived, not the need for certification altogether.

Note: Adding QW to the procedure code of any other high- or moderate-complexity test does not make it a waived procedure.

More information on the CLIA certification process can be found at:
https://odh.ohio.gov/wps/portal/gov/odh/home.

Vaccines

Ohio Medicaid allows BH providers to administer and receive reimbursement for a limited number of vaccines to their adult clients and to children under the Vaccines for Children program, operated by the Ohio Department of Health (ODH). Vaccines may be administered at the following place of services: office, inpatient and outpatient residential facilities, in the community, and Community Mental Health Centers (CMHC).

The Vaccines for Children (VFC) program is a federally-funded program overseen by the Centers for Disease Control and Prevention (CDC) and administered by ODH. The VFC program supplies vaccines at no cost to public and private health care providers who enroll and agree to immunize eligible children in their medical practice or clinic. The VFC program was created by the Omnibus Budget Reconciliation Act of 1993 and began on October 1, 1994. The VFC program was designed to:

- Reduce the cost of vaccines for a physician or medical practice.
- Create fewer barriers for parents to immunize their children.
- Save parents about $2,200 per child in expenses for vaccines.
- Keep children in their medical home when they qualify for VFC.

Table 2-11 Covered Vaccines for Behavioral Health Providers

Vaccine Administration Code	Description
90460	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other health care professional; first or only component of each vaccine or toxoid administered
90471	Immunization administration (includes percutaneous, intradermal, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)
+90472 (add-on to 90471)	Immunization administration; each additional vaccine. List separately in addition to code for primary procedure
90473	Administration of 1 nasal or oral vaccine
90474	Immune administration oral or nasal additional
Vaccine CPT	**Description**
90633	Hepatitis A vaccine (HepA), pediatric/adolescent dosage-2 dose schedule, for intramuscular use
90634	Hepatitis A vaccine (HepA), pediatric/adolescent dosage-3 dose schedule, for intramuscular use
90632	Hepatitis A vaccine (HepA), adult dosage, for intramuscular use
90371	Hepatitis B immune globulin (HBIg), human, for intramuscular use
90650	Human Papillomavirus vaccine, types 16, 18, bivalent (2vHPV), 3 dose schedule, for intramuscular use
90649	Human Papillomavirus vaccine, types 6, 11, 16, 18, quadrivalent (4vHPV), 3 dose schedule, for intramuscular use
90644	Vaccine for meningococcal and Hemophilus influenza B (4 dose schedule) injection into muscle, children 6 weeks-18 months of age
90698	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Haemophilus influenza type b, and inactivated poliovirus vaccine (DTaP-IPV/Hib), for intramuscular use

90654	Influenza virus vaccine, trivalent (IIV3), split virus, preservative-free, for intradermal use
90658	Vaccine for influenza for administration into muscle, 0.5 ml dosage
90660	Influenza virus vaccine, trivalent, live (LAIV3), for intranasal use
90670	Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use
90680	Rotavirus vaccine, pentavalent (RV5), 3 dose schedule, live, for oral use
90681	Rotavirus vaccine, human, attenuated (RV1), 2 dose schedule, live, for oral use
90696	Diphtheria, tetanus toxoids, acellular pertussis vaccine and inactivated poliovirus vaccine (DTaP-IPV), when administered to children 4 through 6 years of age, for intramuscular use
90713	Poliovirus vaccine, inactivated (IPV), for subcutaneous or intramuscular use
90707	Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use
90710	Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use
90714	Tetanus and diphtheria toxoids adsorbed (Td), preservative free, when administered to individuals 7 years or older, for intramuscular use
Vaccine CPT	**Description**
90715	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use
90716	Varicella virus vaccine (VAR), live, for subcutaneous use
90736	Shingles vaccine (HZV), live, for subcutaneous injection (individuals 60+ years old)
90732	Pneumococcal polysaccharide vaccine, 23-valent (PPSV23), adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use
90733	Meningococcal polysaccharide vaccine, serogroups A, C, Y, W-135, quadrivalent (MPSV4), for subcutaneous use
90734	Vaccine for meningococcus for administration into muscle
90740	Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, 3 dose schedule, for intramuscular use
90746	Hepatitis B vaccine (HepB), adult dosage, 3 dose schedule, for intramuscular use
90747	Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, 4 dose schedule, for intramuscular use
90759	Hepatitis B vaccine (HepB) 10 mcg dosage, 3 dose schedule, for intramuscular use
For rates, see the Medicine, Surgery, Radiology and Imaging, and Additional Procedures (Non-Institutional Services) schedule on the Fee Schedule and Rates page of the ODM website.	
For rates and coding information regarding COVID-19 vaccine counseling and administration, please refer to the ODM COVID-19 resource page for guidance.	

COVID-19 Vaccine Administration

Due to the quickly changing nature of the COVID-19 pandemic, please refer to the ODM COVID-19 resource page for COVID-19 vaccine administration guidance. Information concerning ODM's response to COVID-19 will continue to be updated on the website.

Vaccines for Children (VFC) Eligibility Criteria

Children through 18 years of age who meet at least one of the following criteria are eligible to receive VFC vaccines:

- Medicaid eligible: A child who is eligible for the Medicaid program. (For the purposes of the VFC program, the terms "Medicaid-eligible" and "Medicaid-enrolled" are equivalent and refer to children who have health insurance covered by a state Medicaid program.)
- Uninsured: A child who has no health insurance coverage.
- American Indian or Alaska Native: As defined by the Indian Health Care Improvement Act (25 U.S.C. 1603).
- Underinsured: A child who has health insurance, but the coverage does not include vaccines; a child whose insurance covers only selected vaccines (VFC eligible for non-covered vaccines only). Underinsured children are eligible to receive VFC vaccines only through a Federally Qualified Health Center (FQHC), or Rural Health Clinic (RHC) or under an approved deputation agreement.

Children whose health insurance covers the cost of vaccinations are not eligible for VFC vaccines, even when a claim for the cost of the vaccine and its administration would be denied for payment by the insurance carrier because the plan's deductible had not been met.

Screening to determine a child's eligibility to receive vaccines through the VFC Program and documentation of the screening results must take place with each immunization visit. The patient eligibility screening record provides a means of recording parent responses to VFC eligibility questions. The parent, guardian or provider may complete this form. Verification of parent/guardian responses is not required. To maximize efficiency, providers may elect to incorporate these screening questions into an existing form; however, any revision must include the core screening information listed on the CDC-developed form and be approved by the state Immunization Program. Patient eligibility screening records should be maintained on file for a minimum of 3 years after service to the patient has been completed unless state law/policy establishes a longer archival period.

Report clinically significant adverse events that follow vaccination through the Federal Vaccine Adverse Event Reporting System (VAERS) or call the 24 hour national toll-free hotline at 800-822-7967.

VAERS is a post-marketing safety surveillance program, collecting information about adverse events (possible side effects) that occur after the administration of vaccines licensed for use in the United States.

VAERS provides a nationwide mechanism by which adverse events following immunization may be reported, analyzed, and made available to the public. VAERS also provides a vehicle for disseminating vaccine safety-related information to parents and guardians, health care providers, vaccine manufacturers, state vaccine programs, and other constituencies.

Remember, please report all suspected cases of vaccine-preventable diseases to your state or local health department.

Further VFC resources, including enrollment with the Ohio Department of Health can be found at:

https://odh.ohio.gov/wps/portal/gov/odh/home
http://www.cdc.gov/vaccines/programs/vfc/providers/index.html

Vaccines for Adults

Each year, the Advisory Committee on Immunization Practices (ACIP) approves immunization schedules recommended for persons living in the United States. The adult immunization schedule provides a summary of ACIP recommendations on the use of licensed vaccines routinely recommended for adults aged 19 years or older. The adult immunization schedule is also approved by the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), the American College of Obstetricians and Gynecologists (ACOG), and the American College of Nurse-Midwives (ACNM). **Medicaid may not cover all recommended vaccinations. See above listing of covered vaccines for behavioral health providers.**

Child and Adolescent Needs Strengths (CANS) Assessment

The CANS is completed at prescribed intervals or whenever there is a significant change in a member's condition or circumstances. CANS assessors should aim to conduct minimally invasive practice and maintain the best interest of youth/caregivers throughout the assessment process. Accordingly, assessors should not over-assess youth/caregivers or ask them to tell their stories multiple times. The Ohio Children's Initiative CANS assessment and the state CANS IT system supports the practice of building upon what we already know about the youth/caregiver's story and avoiding over-assessment. Prior to engaging the youth/caregiver in the CANS assessment process, the CANS assessors should access the CANS IT System to determine if a recent CANS assessment has been completed with the youth/caregiver. If a recent CANS assessment is available in the CANS IT system, the assessor should use their professional judgment to determine if an update needs to occur or if the most recent assessment can be used.

The Ohio Children's Initiative CANS was launched for use in October 2021. While waiting for the system work necessary to identify this as a stand-alone service, ODM issued interim billing guidance that allowed for billing of community psychiatric supportive treatment (CPST), therapeutic behavioral service (TBS), and/or psychiatric diagnostic evaluation for administration of a CANS assessment. Beginning July 1, 2022, the Ohio Children's Initiative CANS assessment may only be billed using the H2000 code. CPST, TBS, and/or psychiatric diagnostic evaluation may no longer be billed for administration of a CANS assessment for dates of service on/after July 1, 2022.

Requirements for Billing:

- Rendering practitioner must be appropriately certified and trained in the administration of the Ohio Children's Initiative CANS assessment
- The rendering practitioner must have an NPI, be enrolled in Medicaid, add the "ORC" specialty to the individual Ohio Medicaid enrollment and be affiliated with the billing provider (add specialty by sending email request to MEDICAID_PROVIDER_UPDATE@medicaid.ohio.gov)
- CANS assessments must be entered in Ohio's CANS IT system to establish and maintain OhioRISE eligibility

Table 2-12: Child and Adolescent Needs and Strengths (CANS) Assessment

Effective date 7/1/2022

MH/SUD Requires the addition of the "ORC" specialty to the rendering provider's enrollment						
Service	**Rendering Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate (dates of service 7/1/2022-12/31/2022)**	**Rate (dates of service on or after 1/1/2023)**
Child and Adolescent Needs and Strength (CANS) Assessment	MD/DO	H2000	*		$341.60	$527.25
	PA CNS CNP	H2000	*		$211.74	$324.67
	PSY LPCC LISW LIMFT LICDC Lic school PSY	H2000	*		$112.86	$170.43
	LPC LSW LMFT LCDC II LCDC III	H2000	*		$109.38	$165.00
	PSY assistant SW-A SW-T MFT-T C-T CDC-A QMHS CMS	H2000	*		$98.31	$147.72
Unit Value	Per Assessment (Brief or Comprehensive)					
Permitted POS	Any valid place of service code may be used					
Billing Instructions	• If the CANS is completed over multiple dates of service, the claim date of service is the date the CANS was completed • Telehealth allowed with GT modifier. GT modifier is required when service rendered via telehealth. • Diagnosis code is required – any valid ICD-10 diagnosis code may be used, including "Z-codes"					

*For individuals with a primary enrollment in Medicaid as one of the allowable provider types listed above, a practitioner modifier is not required. However, a practitioner modifier (see Table 1-3) may be required if an individual is enrolled with additional specialties and the primary enrollment is not one of the allowable provider types listed above. Please refer to the "Modifiers" worksheet found in the "Dual Licensure Grid" at bhmedicaid.ohio.gov for additional information.

The CANS billing chart above is specific to those billed by Ohio Medicaid Provider types 84, 95, and OhioRISE Care Management Entities (CME). Other relevant billing providers will follow the claims submission policies consistent with their billing provider type.

Mobile Response and Stabilization Service (MRSS)

Information about service descriptions, eligibility, clinical criteria, and limitations can be found in OAC rules 5160-27-13 (ODM) and 5122-29-14 (OMHAS). The MRSS Practice Standards and other provider resources can be found on the OhioMHAS MRSS site: https://mha.ohio.gov/community-partners/early-childhood-children-and-youth/resources/mobile-response-stabilization-services.

Requirements for Billing:

- Addition of the "ORM" specialty to the primary Ohio Medicaid billing provider type
- The rendering practitioner must have an NPI, be enrolled in Medicaid, and be affiliated with the billing provider
- MRSS hourly and 15-minute codes cannot be billed for time spent administering a CANS assessment during an MRSS event

Table 2-13: MRSS Crisis Mobile Response

Effective date 7/1/2022

MH/SUD Requires the billing provider have the "ORM" specialty					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
Crisis Mobile Response	PSY LPCC LISW LIMFT Licensed school PSY LICDC	S9485	*		$476.64
	LPC LSW LMFT LCDC II LCDC III	S9485	*		$466.34
	PSY assistant SW-A SW-T MFT-T C-T CDC-A QMHS CMS	S9485	*		$432.63
	PRS	S9485	*		$365.55
Unit Value	Per diem				

Permitted POS	Any valid place of service code may be used
Billing Information	• Billed on the date the initial mobile response is initiated by the MRSS provider; or to report the MRSS team's first encounter after the crisis response is initiated** • Code can be billed by all practitioners participating in the initial mobile response • May not be billed more than once in the Mobile Response period • Do not use for follow-up after the initial mobile response • Diagnosis code is required – any valid ICD-10 code may be used, including "Z-codes" • Telehealth allowed in accordance with MRSS practice standards - GT modifier is required when service rendered via telehealth

*For individuals with a primary enrollment in Medicaid as one of the allowable provider types listed above, a practitioner modifier is not required. However, a practitioner modifier (see Table 1-3) may be required if an individual is enrolled with additional specialties and the primary enrollment is not one of the allowable provider types listed above. Please refer to the "Modifiers" worksheet found in the "Dual Licensure Grid" at bhmedicaid.ohio.gov for additional information.

** For MRSS providers using an external entity that is not part of the MRSS billing provider agency to support 24/7 coverage, as allowed during an MRSS provider's first year of initial certification, there may be situations where the external entity initiates the crisis response prior to handing off to the MRSS provider. When this occurs, the MRSS provider will use the initial Crisis Mobile Response code S9485 to report services provided during the MRSS team's first encounter with the youth/family after hand-off from the external entity who initiated the crisis response. If the external entity is a Medicaid provider, the external entity may bill for any Medicaid-covered services rendered prior to handing-off to the MRSS team (e.g. psychotherapy for crisis). After the first encounter by the MRSS team reported using the initial Crisis Mobile Response code S9485, subsequent services rendered by the MRSS team during the mobile response phase are billed using the Crisis Mobile Response Follow-up code, S9484.

This table is specific to Community BH Agency (Ohio Medicaid PT 84 and 95) billing. Hospitals certified to provide this service should use the code set and billing instructions for Outpatient Hospital Behavioral Health Services.

Table 2-14: MRSS Crisis Mobile Response Follow Up

Effective date 7/1/2022

MH/SUD Requires the billing provider have the "ORM" specialty					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
	PSY LPCC LISW	S9484	*		$139.92

Crisis Mobile Response Follow-Up	LIMFT Licensed school PSY LICDC				
	LPC LSW LMFT LCDC II LCDC III	S9484	*		$136.49
	PSY assistant SW-A SW-T MFT-T C-T CDC-A QMHS CMS	S9484	*		$125.25
	PRS	S9484	*		$102.89
Unit Value	Per hour				
Permitted POS	Any valid place of service code may be used				
Billing Information	• Billed for follow-up activities during the mobile response phase (up to 72 hours from the initial mobile response) • Dates of service should be within 3 calendar days of the initial mobile response • The initial mobile response (S9485) code must be billed before this code can be billed • Code can be billed by all practitioners participating in the follow up response • Can be billed on the same date of service as the initial response if the initial response concluded and follow-up activities were provided later the same date • Code may not be billed for time spent administering the CANS assessment • Diagnosis code is required – any valid ICD-10 code may be used, including "Z-codes" • Telehealth allowed - GT modifier is required when service rendered via telehealth.				

*For individuals with a primary enrollment in Medicaid as one of the allowable provider types listed above, a practitioner modifier is not required. However, a practitioner modifier (see Table 1-3) may be required if an individual is enrolled with additional specialties and the primary enrollment is not one of the allowable provider types listed above. Please refer to the "Modifiers" worksheet found in the "Dual Licensure Grid" at bhmedicaid.ohio.gov for additional information.

This table is specific to Community BH Agency (Ohio Medicaid PT 84 and 95) billing. Hospitals certified to provide this service should use the code set and billing instructions for Outpatient Hospital Behavioral Health Services.

Table 2-15: MRSS Stabilization Service

Effective date 7/1/2022

MH/SUD Requires the billing provider have the "ORM" specialty					
Service	**Rendering Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
MRSS Stabilization Service	PSY LPCC LISW LIMFT Licensed school PSY LICDC	S9482	*		$34.95
	LPC LSW LMFT LCDC II LCDC III	S9482	*		$34.01
	PSY assistant SW-A SW-T MFT-T C-T CDC-A QMHS CMS	S9482	*		$30.92
	PRS	S9482	*		$24.77
Unit Value	Per 15 minutes				
Permitted POS	Any valid place of service code may be used				
Billing Information	• The initial mobile response (S9485) code must be billed before this code can be billed • Code can be billed by all practitioners providing the stabilization service • Requires prior authorization to extend beyond 6 weeks from the end of the de-escalation phase • Cannot be billed for youth enrolled in IHBT, MST, FFT or ACT • Code may not be billed for time spent administering the CANS assessment • Diagnosis code is required – any valid ICD-10 code may be used, including "Z-codes" • Telehealth allowed - GT modifier is required when service rendered via telehealth				

*For individuals with a primary enrollment in Medicaid as one of the allowable provider types listed above, a practitioner modifier is not required. However, a practitioner modifier (see Table 1-3 Behavioral Health Manual) may be required if an individual is enrolled with additional specialties and the primary enrollment is not one of the allowable provider types listed above. Please refer to the "Modifiers" worksheet found in the "Dual Licensure Grid" at bhmedicaid.ohio.gov for additional information.

This table is specific to Community BH Agency (Ohio Medicaid PT 84 and 95) billing. Hospitals certified to provide this service should use the code set and billing instructions for Outpatient Hospital Behavioral Health Services.

SECTION 3

Psychotherapy Services

Table 3-1: Psychotherapy for Crisis

MH / SUD				
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate**
Psychotherapy for Crisis – first 60 minutes	MD/DO PSY	90839	-	$171.70
	CNS CNP PA LISW LIMFT LPCC LICDC (SUD only) Lic school PSY	90839	-	$145.95
	LSW LMFT LPC LCDC III (SUD only) LCDC II (SUD only)	90839	U4 U5 U2 U3 U3	$145.95
	PSY assistant	90839	U1	Paid at direct supervisor rate when supervisor NPI on claim. Paid at 85% of maximum fee if supervisor NPI not included.
	SW-T MFT-T CDC-A (SUD only) C-T	90839	U9 UA U6 U7	Paid at direct supervisor rate when supervisor NPI on claim Paid at 72.25% of maximum fee if supervisor NPI not included.
	MD/DO PSY	+90840	-	$81.95

MH / SUD				
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate**
Psychotherapy for Crisis – add'l 30 minutes	CNS CNP PA LISW LIMFT LPCC LICDC (SUD only) Lic school PSY	+90840	-	$69.65
	LSW LMFT LPC LCDC III (SUD only) LCDC II (SUD only)	+90840	U4 U5 U2 U3 U3	$69.65
	PSY assistant	+90840	U1	Paid at direct supervisor rate when supervisor NPI on claim. Paid at 85% of maximum fee if supervisor NPI not included.
	SW-T MFT-T CDC-A (SUD only) C-T	+90840	U9 UA U6 U7	Paid at direct supervisor rate when supervisor NPI on claim Paid at 72.25% of maximum fee if supervisor NPI not included.
Unit Value	+90839: 1 which represents first 60 minutes +90840: 1 which represents each additional 30 minutes			
Permitted POS	01, 03, 04, 11, 12, 13, 14, 15, 16, 17, 18, 20, 23, 24, 25, 31, 32, 33, 34, 41, 42, 99 MH also has 53 SUD also has 57		Telehealth allowed with GT modifier for dates of service on and after March 9, 2020. GT modifier is required when service rendered via telehealth.	

Table 3-2: Individual Psychotherapy

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate**	**Rate with KX Modifier Only***
Individual Psychotherapy – 30 minutes	MD/DO PSY	90832	-	$63.11	$82.04
	CNS CNP PA LISW LIMFT LPCC LICDC (SUD only) Lic school PSY	90832	-	$53.64	$69.73
	LSW LMFT LPC LCDC III (SUD only) LCDC II (SUD only)	90832	U4 U5 U2 U3 U3	$53.64	$69.73
	PSY assistant	90832	U1	Paid at direct supervisor rate when supervisor NPI on claim. Paid at 85% of maximum fee if supervisor NPI not included.	Paid at direct supervisor rate when supervisor NPI on claim. Paid at 85% of maximum fee if supervisor NPI not included.
	SW trainee MFT trainee CDC-A (SUD only) C-T	90832	U9 UA U6 U7	Paid at direct supervisor rate when supervisor NPI on claim Paid at 72.25% of maximum fee if supervisor NPI not included.	Paid at direct supervisor rate when supervisor NPI on claim Paid at 72.25% of maximum fee if supervisor NPI not included.
Individual Psychotherapy – 45 minutes	MD/DO PSY	90834	-	$82.05	-
	CNS CNP PA LISW LIMFT LPCC LICDC (SUD only) Lic school PSY	90834	-	$69.74	-

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate**	**Rate with KX Modifier Only***
	LSW LMFT LPC LCDC III (SUD only) LCDC II (SUD only)	90834	U4 U5 U2 U3 U3	$69.74	-
	PSY assistant	90834	U1	Paid at direct supervisor rate when supervisor NPI on claim. Paid at 85% of maximum fee if supervisor NPI not included.	-
	SW trainee MFT trainee CDC-A (SUD only) C-T	90834	U9 UA U6 U7	Paid at direct supervisor rate when supervisor NPI on claim Paid at 72.25% of maximum fee if supervisor NPI not included.	-
Individual Psychotherapy – 60+ minutes	MD/DO PSY	90837	-	$120.36	-
	CNS CNP PA	90837	-	$102.31	-
	LISW LIMFT LPCC LICDC (SUD only) Lic school PSY	90837	-	$102.31	-
	LSW LMFT LPC LCDC III (SUD only) LCDC II (SUD only)	90837	U4 U5 U2 U3	$102.31	-
	PSY assistant	90837	U1	Paid at direct supervisor rate when supervisor NPI on claim. Paid at 85% of maximum fee if supervisor NPI not included	-

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate**	**Rate with KX Modifier Only***
	SW-T MFT-T CDC-A (SUD only) C-T	90837	U9 UA U6 U7	Paid at direct supervisor rate when Supervisor NPI on claim Paid at 72.25% of maximum fee if supervisor NPI not included.	-
Individual Psychotherapy w/ E&M Service	MD/DO	+90833 +90836 +90838	-	$65.37 $83.03 $109.53	-
	CNS CNP PA	+90833 +90836 +90838	-	$55.56 $70.58 $93.10	-
Unit Value	1 which represents encounter				
Permitted POS	03, 04, 11, 12, 13, 14, 16, 18, 31, 32, 34, 99 MH also has 53 SUD also has 57 For 90832 KX – POS 23 is also available			Telehealth allowed with GT modifier. 90832 KX telehealth allowed with GT modifier for dates of service on or after March 9, 2020. GT modifier is required when service rendered via telehealth.	
Crisis psychotherapy of 16 to 30 minutes	Add KX modifier to 90832 to indicate when service is crisis psychotherapy between 16 and 30 minutes, as allowable within the practitioner's scope of practice. For crisis psychotherapy of 31 or more minutes, please use crisis psychotherapy coding above.				

Table 3-3: Family Psychotherapy

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
Family Psychotherapy w/o patient – 50 minutes	MD/DO PSY	90846	-	-	$102.28
	CNS CNP PA LISW LIMFT LPCC LICDC (SUD only) Lic school PSY	90846	-	-	$86.94
	LSW LMFT LPC LCDC III (SUD only) LCDC II (SUD only)	90846	U4 U5 U2 U3 U3	-	$86.94
	PSY assistant	90846	U1	-	Paid at direct supervisor rate when supervisor NPI on claim. Paid at 85% of maximum fee if supervisor NPI not included.
	SW-T MFT-T CDC-A (SUD only) C-T	90846	U9 UA U6 U7	-	Paid at direct supervisor rate when supervisor NPI on claim Paid at 72.25% of maximum fee if supervisor NPI not included.
Family psychotherapy (conjoint, w/ patient present) – 50 minutes	MD/DO PSY	90847	-	-	$100.72
	CNS CNP PA LISW LIMFT LPCC LICDC (SUD only) Lic school PSY	90847	-	-	$85.61

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
	LSW LMFT LPC LCDC III (SUD only) LCDC II (SUD only)	90847	U4 U5 U2 U3 U3	-	$85.61
	PSY assistant	90847	U1	-	Paid at direct supervisor rate when supervisor NPI on claim. Paid at 85% of maximum fee if supervisor NPI not included.
	SW trainee MFT trainee CDC-A (SUD only) C-T	90847	U9 UA U6 U7	-	Paid at direct supervisor rate when supervisor NPI on claim Paid at 72.25% of maximum fee if supervisor NPI not included.
Multiple-family group psychotherapy	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate**	
	MD/DO PSY	90849	-	$40.66	
	CNS CNP PA LISW LIMFT LPCC LICDC (SUD only) Lic school PSY	90849	-	$34.57	
	LSW LMFT LPC LCDC III (SUD only) LCDC II (SUD only)	90849	U4 U5 U2 U3 U3	$34.57	

MH / SUD				
	Provider Type	**Code**	**Practitioner Modifier**	**Rate**
Multiple-family group psychotherapy	PSY assistant	90849	U1	Paid at direct supervisor rate when supervisor NPI on claim. Paid at 85% of maximum fee if supervisor NPI not included.
	SW-T MFT-T CDC-A (SUD only) C-T	90849	U9 UA U6 U7	Paid at direct supervisor rate when supervisor NPI on claim Paid at 72.25% of maximum fee if supervisor NPI not included.
Unit Value	1 which represents an encounter			
Permitted POS	03, 04, 11, 12, 13, 14, 16, 31, 32, 34 MH also has 53 SUD also has 57 For 90846 and 90847 – 99 is also available		Telehealth allowed with GT modifier. GT modifier is required when service rendered via telehealth.	

Table 3-4: Prolonged Service Codes for Psychotherapy
For dates of service prior to January 1, 2023*

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
Prolonged Visit – First 60 minutes (Use in conjunction with covered BH codes 90837, 90847)	MD/DO PSY	+99354	-	-	$89.90
	CNS CNP PA LISW LIMFT LPCC LICDC (SUD only) Lic school PSY	+99354	-	-	$76.42
	LSW LMFT LPC LCDC III (SUD only) LCDC II (SUD only)	+99354	U4 U5 U2 U3 U3	-	$76.42
	PSY assistant	+99354	U1	-	Paid at direct supervisor rate when supervisor NPI on claim. Paid at 85% of maximum fee if supervisor NPI not included
	SW-T MFT-T C-T CDC-A (SUD only)	+99354	U9 UA U7 U6	-	Paid at direct supervisor rate when supervisor NPI on claim Paid at 72.25% of maximum fee if supervisor NPI not included

Prolonged Visit – Each Additional 30 Minutes (Use in conjunction with covered BH codes 90837, 90847)	MD/DO PSY	+99355	-	-	$89.24
	CNS CNP PA LISW LIMFT LPCC LICDC (SUD only) Lic school PSY	+99355	-	-	$75.85
	LSW LMFT LPC LCDC III (SUD only) LCDC II (SUD only)	+99355	U4 U5 U2 U3 U3	-	$75.85
	PSY assistant	+99355	U1	-	Paid at direct supervisor rate when supervisor NPI on claim. Paid at 85% of maximum fee if supervisor NPI not included
	SW-T MFT-T C-T CDC-A (SUD only)	+99355	U9 UA U7 U6	-	Paid at direct supervisor rate when supervisor NPI on claim Paid at 72.25% of maximum fee if supervisor NPI not included
Unit Value	+99354 – first 60 minutes +99355 – each additional 30 minutes				
Permitted POS	Same as base code	Telehealth allowed with GT modifier. GT modifier is required when service rendered via telehealth.			

*CPT® codes 99354 and 99355 have been deleted effective January 1, 2023. Providers can refer to AMA and NCCI guidance with regard to billing psychotherapy for dates of service on or after January 1, 2023.

Table 3-5: Group Psychotherapy

MH / SUD				
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate**
Group Psychotherapy (not multi-family group)	MD/DO PSY	90853	-	$33.09
	CNS CNP PA LISW LIMFT LPCC LICDC (SUD only) Lic school PSY	90853	-	$28.12
	LSW LMFT LPC LCDC III (SUD only) LCDC II (SUD only)	90853	U4 U5 U2 U3 U3	$28.12
	PSY assistant	90853	U1	Paid at direct supervisor rate when supervisor NPI on claim. Paid at 85% of maximum fee if supervisor NPI not included
	SW-T MFT-T CDC-A (SUD only) C-T	90853	U9 UA U6 U7	Paid at direct supervisor rate when supervisor NPI on claim. Paid at 72.25% of maximum fee if supervisor NPI not included.
Unit Value	1 which represents an encounter			
Permitted POS	03, 04, 11, 12, 13, 14, 16, 31, 32, 34, 99 MH also has 53 SUD also has 57		Telehealth allowed with GT modifier. GT modifier is required when service rendered via telehealth.	

Interactive Complexity

Interactive complexity is an add-on code which may be reported in conjunction with Psychiatric Diagnostic Evaluation (90791, 90792), Psychotherapy (90832, 90834, and 90837), Psychotherapy add-ons (90833, 90836, and 90838), and Group Psychotherapy (90853).

Interactive complexity refers to specific communication factors that complicate the delivery of a psychiatric procedure and occur ***during*** the delivery of the service. Common factors include more difficult communication with discordant or emotional family members and engagement of young and verbally undeveloped or impaired patients. Include 90785 in addition to the primary procedure, when at least one of the following communication factors is present during the visit:

- The need to manage maladaptive communication (related to, e.g., high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicates delivery of care.
- Caregiver emotions or behaviors that interfere with implementation of the treatment plan.
- Evidence or disclosure of a sentinel event and mandated report to a third party (e.g., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.
- Use of play equipment, physical devices, interpreter or translator to overcome barriers to diagnostic or therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language.

These factors are used to communicate with the patient to overcome the barriers to therapeutic or diagnostic interaction between the behavioral health professional and patient who is not fluent in the same language as the professional, or has not developed, or has lost, either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the professional if he/she were to use typical language for communication.

Interactive complexity is often present with patients who:

- Have other individuals legally responsible for their care, such as minors or adults with guardians, or
- Request others to be involved in their care during the visit, such as adults accompanied by one or more participating family members or interpreter or language translator, or
- Require the involvement of other third parties, such as child welfare agencies, parole or probation officers, or schools.

The following examples are NOT interactive complexity:

- Multiple participants in the visit with straightforward communication.
- Patient attends visit individually with no sentinel event or language barriers.
- Treatment plan explained during the visit and understood without significant interference by caretaker emotions or behaviors.

Per the Center for Medicare and Medicaid Services (CMS), “90785 generally should not be billed solely for the purpose of translation or interpretation services” as that may be a violation of federal statute.

Table 3-6: Interactive Complexity

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
Interactive Complexity	MD/DO PSY	+90785	-	-	$13.81
	CNS CNP PA LISW LIMFT LPCC LICDC (SUD only) Lic school PSY	+90785	-	-	$11.74
	LSW LMFT LPC LCDC III (SUD only) LCDC II (SUD only)	+90785	U4 U5 U2 U3 U3	-	$11.74
	PSY assistant	+90785	U1	-	Paid at direct supervisor rate when supervisor NPI on claim. Paid at 85% of maximum fee if supervisor NPI not included
	SW-T MFT-T CDC-A (SUD only) C-T	+90785	U9 UA U6 U7	-	Paid at direct supervisor rate when supervisor NPI on claim Paid at 72.25% of maximum fee if supervisor NPI not included
	Interactive Complexity is an add-on code that is only valid in conjunction with codes as determined by the AMA.				
Unit Value	1 which represents an encounter				
Permitted POS	POS must be the same as the base code to which interactive complexity is being added		Telehealth allowed with GT modifier for dates of service on and after November 15, 2020. GT modifier is required on claim when service rendered via telehealth.		

Psychological Testing

Codes 96130, 96131, 96136 and 96137 (psychological testing) include the administration, interpretation, and scoring of the tests mentioned in the CPT descriptions and other medically accepted tests for evaluation of intellectual strengths, psychopathology, psychodynamics, mental health risks, insight, motivation, and other factors influencing treatment and prognosis.

Documentation: The medical record must indicate the presence of mental illness or signs of mental illness for:

- Detection of neurologic diseases based on quantitative assessment of neurocognitive abilities (e.g., mild head injury, anoxic injuries, AIDS dementia)
- Differential diagnosis between psychogenic and neurogenic syndromes
- Delineation of the neurocognitive effects of central nervous system disorders
- Neurocognitive monitoring of recovery or progression of central nervous system disorders; or
- Assessment of neurocognitive functions for the formulation of rehabilitation and/or management strategies among individuals with neuropsychiatric disorders. Psychological testing is indicated as an aid in the diagnosis and therapeutic planning. The record must show the tests performed, scoring and interpretation, as well as the time involved.

Comments: These codes do not represent psychotherapeutic modalities, but are diagnostic aids. Use of such tests when mental illness is not suspected would be a screening procedure not covered by Medicaid. Each test performed must be medically necessary. Therefore, standardized batteries of tests are not acceptable unless each test in the battery is medically necessary.

Changes in mental illness may require psychological testing to determine new diagnoses or the need for changes in therapeutic measures. Repeat testing not required for diagnosis or continued treatment would be considered medically unnecessary. Nonspecific behaviors that do not indicate the presence of, or change in, a mental illness would not be an acceptable indication for testing. Psychological or psychiatric evaluations that can be accomplished through the clinical interview alone (e.g., response to medication) would not require psychological testing, and such testing might be considered as medically unnecessary. Adjustment reactions or dysphoria associated with moving to a nursing facility do not constitute medical necessity for psychological testing.

Other Psychological Testing Codes

Neuropsychological testing codes (96132, 96133, 96136 and 96137) are defined by the CPT narrative and describes testing which is intended to diagnose and characterize the neurocognitive effects of medical disorders that impinge directly or indirectly on the brain.

Documentation: The medical record must document according to requirements in rules 5122-27-02 through 5160-22-05 of the Ohio Administrative Code.

The content of neuropsychological testing procedure differs from that of psychological testing in that neuropsychological testing consists primarily of individually administered ability tests that comprehensively sample cognitive and performance domains that are known to be sensitive to the functional integrity of the brain (e.g., abstraction, memory and learning, attention, language, problem solving, sensorimotor functions, constructional praxis, etc.). These procedures are objective and quantitative in nature and require the patient to directly demonstrate his/her level of competence in a particular cognitive domain. Neuropsychological testing does not rely on self-report questionnaires such

as the Minnesota Multiphasic Personality Inventory 2 (MMPI-2), rating scales such as the Hamilton Depression Rating Scale, or projective techniques such as the Rorschach or Thematic Apperception Test (TAT).

Typically, psychological testing will require from four (4) to six (6) hours to perform, including administration, scoring and interpretation. If the testing is done over several days, the testing time should be combined and reported all on the last date of service. If the testing time exceeds eight (8) hours, a report may be requested to indicate the medical necessity for extended testing.

Limitations:
Evaluations of the mental status that can be performed within the clinical interview, such as a list of questions concerning symptoms of depression or organic brain syndrome, corresponding to brief questionnaires such as the Folstein Mini Mental Status Examination or the Beck Depression Scale, should not be billed as psychological testing, but are considered included in the clinical interview. Psychological testing to evaluate adjustment reactions or dysphoria associated with placement in a nursing home is not medically necessary. Routine testing of nursing home patients is considered screening and is not covered.

The psychological testing codes should not be reported by the treating physician for reading the testing report or explaining the results to the patient or family. Payment for these services is included in the payment for other services rendered to the patient, such as evaluation and management services.

Table 3-7: Psychological Testing

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
Psychological Testing Administration	MD/DO PSY PA CNS CNP LISW LIMFT LPCC Lic school PSY	96136	-	-	$30.86
	LSW LMFT LPC PSY assistant	96136	U4 U5 U2 U1	-	$30.86

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
	SW-T MFT-T C-T	96136	U9 UA U7	-	$30.86
	MD/DO PSY PA CNS CNP LISW LIMFT LPCC Lic school PSY	96137	-	-	$28.39
	LSW LMFT LPC PSY assistant	96137	U4 U5 U2 U1	-	$28.39
	SW-T MFT-T C-T	96137	U9 UA U7	-	$28.39
Psychological Testing Evaluation	MD/DO PSY PA CNS CNP LISW LIMFT LPCC Lic school PSY	96130	-	-	$59.26

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
	LSW LMFT LPC PSY assistant	96130	U4 U5 U2 U1	-	$59.26
	SW-T MFT-T C-T	96130	U9 UA U7	-	$59.26
	MD/DO PSY PA CNS CNP LISW LIMFT LPCC Lic school PSY	96131	-	-	$59.26
	LSW LMFT LPC PSY assistant	96131	U4 U5 U2 U1	-	$59.26
	SW-T MFT-T C-T	96131	U9 UA U7	-	$59.26
Developmental Testing	MD/DO PSY CNS CNP PA LISW LIMFT LPCC Lic school PSY	96112	-	-	$56.11

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
	LSW LMFT LPC PSY assistant	96112	U4 U5 U2 U1	-	$56.11
	SW-T MFT-T C-T	96112	U9 UA U7	-	$56.11
	MD/DO PSY CNS CNP PA LISW LIMFT LPCC Lic school PSY	96113	-	-	$28.06
	LSW LMFT LPC PSY assistant	96113	U4 U5 U2 U1	-	$28.06
	SW-T MFT-T C-T	96113	U9 UA U7	-	$28.06
Neurobehavioral Status Exam	MD/DO PA PSY CNS CNP	96116	-	-	$64.10
	PSY assistant	96116	U1	-	$64.10

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
	MD/DO PA PSY CNS CNP	96121	-	-	$64.10
	PSY assistant	96121	U1	-	$64.10
Neuropsychological Testing Administration	MD/DO PA PSY CNS CNP	96136	-	-	$30.86
	PSY assistant	96136	U1	-	$30.86
	MD/DO PA PSY CNS CNP	96137	-	-	$28.39
	PSY assistant	96137	U1	-	$28.39
Neuropsychological Testing Evaluation	MD/DO PA PSY CNS CNP	96132	-	-	$97.37

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
	PSY assistant	96132	U1	-	$97.37
	MD/DO PA PSY CNS CNP	96133	-	-	$78.31
	PSY assistant	96133	U1	-	$78.31
Unit Value	96112, 96116, 96130, 96132: first 60 minutes 96136: first 30 minutes 96113, 96137: additional 30 minutes 96121, 96131, 96133: additional 60 minutes				
Permitted POS	03, 04, 11, 12, 13, 14, 16, 31 MH also has 53 SUD also has 57		Telehealth allowed with GT modifier. GT modifier is required when service rendered via telehealth.		

Table 3-7.5: Smoking Cessation

MH / SUD				
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate**
Smoking and Tobacco Use Cessation Counseling – Intermediate: Greater than 3 minutes and up to 10 minutes	MD/DO PSY	99406	-	$9.43
	CNS CNP PA	99406	-	$9.43
	LISW LIMFT LPCC LICDC (SUD only) Lic school PSY	99406	-	$8.02
	LSW LMFT LPC LCDC III (SUD only) LCDC II (SUD only)	99406	U4 U5 U2 U3 U3	$8.02
	PSY assistant	99406	U1	Paid at direct supervisor rate when supervisor NPI on claim. Paid at 85% of maximum fee if supervisor NPI not included
	SW-T MFT-T CDC-A (SUD only) C-T	99406	U9 UA U6 U7	Paid at direct supervisor rate when supervisor NPI on claim Paid at 72.25% of maximum fee if supervisor NPI not included
Smoking and Tobacco Use Cessation Counseling – Intensive: Greater than 10 minutes	MD/DO PSY	99407	-	$19.00
	CNS CNP PA	99407	-	$19.00
	LISW LIMFT LPCC LICDC (SUD only) Lic school PSY	99407	-	$16.15

	LSW LMFT LPC LCDC III (SUD only) LCDC II (SUD only)	99407	U4 U5 U2 U3 U3	$16.15
	PSY assistant	99407	U1	Paid at direct supervisor rate when supervisor NPI on claim. Paid at 85% of maximum fee if supervisor NPI not included
	SW-T MFT-T CDC-A (SUD only) C-T	99407	U9 UA U6 U7	Paid at direct supervisor rate when supervisor NPI on claim Paid at 72.25% of maximum fee if supervisor NPI not included
Unit Value	1 which represents an encounter			
Permitted POS	03, 04, 11, 12, 13, 14, 16, 18, 31, 32, 34, 99 MH also has 53 SUD also has 57		Telehealth allowed with GT modifier. GT modifier is required when service rendered via telehealth.	

Healthcare Common Procedure Coding System (HCPCS) Coded Mental Health Services

Table 3-8: Therapeutic Behavioral Services (TBS)

MH					
Individual Therapeutic Behavioral Services (TBS) – 15 minutes					
Service Code	**Provider Type**	**Code**	**Modifiers**	**Rate**	**Rate with KX Modifier Only***
Individual Therapeutic Behavioral Services (TBS) – 15 minutes	MD/DO CNS CNP PA PSY LISW LIMFT LPCC Lic school PSY	H2019	-	$22.47 in office $28.59 in community	$29.21 in office $37.17 in community
	LSW LMFT LPC	H2019	U4 U5 U2	$22.47 $28.59	$29.21 $37.17
	PSY assistant (Master's)	H2019	U1 and HO	$22.47 $28.59	$29.21 $37.17
	SW-T (Master's)	H2019	U9 and HO	$22.47 $28.59	$29.21 $37.17
	SW-T (Bachelor's)	H2019	U9 and HN	$19.96 $25.46	$25.95 $33.10
	SW-A (Master's)	H2019	U8 and HO	$22.47 $28.59	$29.21 $37.17
	SW-A (Bachelor's)	H2019	U8 and HN	$19.96 $25.46	$25.95 $33.10
	MFT-T (Master's)	H2019	UA and HO	$22.47 $28.59	$29.21 $37.17
	MFT trainee (Bachelor's)	H2019	UA and HN	$19.96 $25.46	$25.95 $33.10
	C-T (Master's)	H2019	U7 and HO	$22.47 $28.59	$29.21 $37.17
	C-T (Bachelor's)	H2019	U7 and HN	$19.96 $25.46	$25.95 $33.10
	QMHS (Bachelor's)	H2019	HN	$19.96 $25.46	$25.95 $33.10
	QMHS (Master's)	H2019	HO	$22.47 $28.59	$29.21 $37.17

	QMHS (3 yrs+ Exp.)	H2019	UK	$19.96 $25.46	$25.95 $33.10
Group Therapeutic Behavioral Services (TBS) – 15 minutes					
Service Code	**Provider Type**	**Code**	**Modifiers**	**Rate**	
Group Therapeutic Behavioral Services (TBS) – 15 minutes	MD/DO CNS CNP PA PSY LISW LIMFT LPCC Lic school PSY	H2019	HQ	$8.99	
	LSW LMFT LPC	H2019	U2, U4, or U5 and HQ	$8.99	
	PSY assistant (Master's)	H2019	U1, HO HQ	$7.31	
	SW-T (Master's)	H2019	U9, HO HQ	$7.31	
	SW-T (Bachelor's)	H2019	U9, HN HQ	$6.49	
	SW-A (Master's)	H2019	U8, HO HQ	$7.31	
	PSY assistant (Bachelor's)	H2019	U1, HN, HQ	$6.49	
	SW-A (Bachelor's)	H2019	U8, HN HQ	$6.49	
	MFT-T (Master's)	H2019	UA, HO HQ	$7.31	
	MFT-T (Bachelor's)	H2019	UA, HN HQ	$6.49	
	C-T (Master's)	H2019	U7, HO HQ	$7.31	
	C-T (Bachelor's)	H2019	U7, HN HQ	$6.49	
	QMHS (Bachelor's)	H2019	HN HQ	$6.49	
	QMHS (Master's)	H2019	HO HQ	$7.31	

	QMHS (3 yrs+ Exp.)	H2019	UK HQ	$6.49
Unit Value	15 minutes			
Permitted POS	Individual TBS – 03, 04, 11, 12, 13, 14, 16, 18, 23, 31, 32, 34, 53, 99 Group TBS – 11, 53 If more than six (6) units are delivered on the same date of service by the same agency in places of service 11 and/or 53, subsequent units will be paid at 50% of the above rates.			Telehealth allowed with GT modifier for dates of service on and after March 9, 2020. GT modifier is required when service rendered via telehealth.
TBS to address a crisis	Add KX modifier to indicate TBS provided when a patient is experiencing a crisis, as allowable within the practitioner's scope of practice.			

Table 3-9: RN and LPN Nursing Services

MH				
Service	**Provider Type**	**Code**	**Procedure Modifier**	**Rate**
Nursing Services – Individual	RN	H2019	-	$31.92 – provided in the office $41.00 – provided in the community
	LPN	H2017	-	$22.54 $29.13
Nursing Services – Group	RN	H2019	HQ	$10.37
Unit Value	15 minutes			
Permitted POS	Individual RN/LPN nursing services - 03, 04, 11, 12, 13, 14, 16, 18, 31, 32, 34, 53, 99 Group RN nursing services – 11, 53 For H2019 KX – POS 23 is also available			Telehealth allowed with GT modifier for dates of service on and after March 9, 2020. GT modifier is required when service rendered via telehealth.
RN nursing service to address a crisis	Add KX modifier to indicate RN nursing service provided when a patient is experiencing a crisis, as allowable within the practitioner's scope of practice. KX is not allowable with group RN nursing services (HQ modifier).			

Table 3-10: TBS Group Service-Hourly and Per Diem (Day Treatment)

MH				
Service Code	**Provider Type**	**Code**	**Modifiers**	**Rate**
TBS Group Service (Day Treatment) per hour less than 2.5 hours (See hour-based services, pg. 27)	PSY	H2012	HK HQ	$36.53
	LISW LIMFT LPCC Lic school PSY	H2012	HK HQ	$36.53
	LSW LMFT LPC	H2012	U4, HK, HQ U5, HK, HQ U2, HK, HQ	$36.53
	PSY assistant (Master's) SW-T (Master's) SW-A (Master's) MFT-T (Masters) C-T (Master's) QMHS (Master's)	H2012	U1, HO, HQ U9, HO, HQ U8, HO, HQ UA, HO, HQ U7, HO, HQ HO, HQ	$27.37
	PSY asst (Bachelor's) SW-T (Bachelor's) SW-A (Bachelor's) MFT-T (Bachelor's) C-T (Bachelor's) QMHS (Bachelor's)	H2012	U1, HN, HQ U9, HN, HQ U8, HN, HQ UA, HN, HQ U7, HN, HQ HN, HQ	$24.10
	QMHS (3 yrs+ Exp.)	H2012	UK, HQ	$24.10
TBS Group Service (Day Treatment) or more hours (per diem)	**Provider Type**	**Code**	**Modifiers**	**Rate**
	PSY	H2020	HK	$182.66
	LISW LIMFT LPCC Lic school PSY	H2020	HK	$182.66
	LSW LMFT LPC	H2020	U4 and HK U5 and HK U2 and HK	$182.66
	PSY assistant (Master's) SW-T (Master's) SW-A (Master's) MFT-T (Master's) C-T (Master's) QMHS (Master's)	H2020	U1 and HO U9 and HO U8 and HO UA and HO U7 and HO HO	$152.17
	PSY asst (Bachelor's) SW-T (Bachelor's) SW-A (Bachelor's) MFT-T (Bachelor's) C-T (Bachelor's)	H2020	U1 and HN U9 and HN U8 and HN UA and HN U7 and HN	$135.92

	QMHS (Bachelor's)		HN	
	QMHS (3 yrs+ Exp.)	H2020	UK	$135.92
Unit Value	H2012: Hourly, maximum of 2 per day H2020: Per diem			
Permitted POS	03, 04, 11, 14, 53		Telehealth allowed with GT modifier for dates of service on and after March 9, 2020. GT modifier is required when service rendered via telehealth.	

Table 3-11: Psychosocial Rehabilitation (PSR)

MH					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate**	**Rate with KX Modifier Only***
Psychosocial Rehabilitation	SW-T	H2017	U9 and HM	$15.84 $20.32	$20.59 $26.42
	SW-A	H2017	U8 and HM	$15.84 $20.32	$20.59 $26.42
	MFT-T	H2017	UA and HM	$15.84 $20.32	$20.59 $26.42
	C-T	H2017	U7 and HM	$15.84 $20.32	$20.59 $26.42
	QMHS (high school)	H2017	HM	$15.84 $20.32	$20.59 $26.42
	QMHS (Associate's)	H2017	HM	$15.84 $20.32	$20.59 $26.42
Unit Value	15 minutes				
Permitted POS	03, 04, 11, 12, 13, 14, 16, 18, 23, 31, 32, 34, 53, 99 If more than six (6) units are delivered on the same date of service by the same agency in places of service 11 and/or 53, subsequent units will be adjudicated at 50% of the above rates		Telehealth allowed with GT modifier for dates of service on and after March 9, 2020. GT modifier is required when service rendered via telehealth. HM modifier is required when billing PSR to differentiate PSR and MH LPN nursing.		
PSR to address a crisis	Add KX modifier to indicate PSR provided when a patient is experiencing a crisis, as allowable within the practitioner's scope of practice.				

Table 3-12: Screening, Brief Intervention and Referral to Treatment

MH					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
Screening, Brief Intervention and Referral to Treatment (SBIRT)	MD/DO CNS CNP PA PSY RN LPN LISW LIMFT LPCC Lic school PSY	G0396	-	-	$25.05
	LSW LMFT LPC	G0396	U4 U5 U2	-	$25.05
	PSY assistant SW-T MFT-T C-T	G0396	U1 U9 UA U7	-	$25.05
Screening, Brief Intervention and Referral to Treatment (SBIRT)	MD/DO CNS CNP PA PSY RN LPN LISW LIMFT LPCC Lic school PSY	G0397	-	-	$47.68
	LSW LMFT LPC	G0397	U4 U5 U2	-	$47.68
	PSY assistant SW-T MFT-T C-T	G0397	U1 U9 UA U7	-	$47.68
Unit Value	G0396: Encounter from 15 to 30 minutes G0397: Encounter over 30 minutes				
Permitted POS	03, 04, 11, 12, 13, 14, 16, 31, 32, 53			Telehealth allowed with GT modifier for dates of service on and after March 9, 2020. GT modifier is required when service rendered via telehealth.	

Table 3-13: Community Psychiatric Supportive Treatment (CPST)

MH					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
Community Psychiatric Supportive Treatment – Individual	MD/DO	H0036	-	-	$19.54
	CNS CNP PA PSY	H0036	-	-	$19.54
	LISW LIMFT LPCC Lic school PSY	H0036	-	-	$19.54
	LSW LMFT LPC	H0036	U4 U5 U2	-	$19.54
	PSY assistant SW-T SW-A MFT-T C-T	H0036	U1 U9 U8 UA U7	-	$19.54
	QMHS (3 yrs+ Exp.) QMHS (high school) QMHS (Associate's) QMHS (Bachelor's) QMHS (Master's)	H0036	UK HM HM HN HO	-	$19.54
Community Psychiatric Supportive Treatment – Group	MD/DO	H0036	-	HQ	$8.99
	CNS CNP PA PSY	H0036	-	HQ	$8.99
	LISW LIMFT LPCC Lic school PSY	H0036	-	HQ	$8.99
	LSW LMFT LPC	H0036	U4 U5 U2	HQ	$8.99
	PSY assistant SW-T SW-A MFT-T C-T	H0036	U1 U9 U8 UA U7	HQ	$8.99
	QMHS (3 yrs+ Exp.) QMHS (high school) QMHS (Associate's) QMHS (Bachelor's) QMHS (Master's)	H0036	UK HM HM HN HO	HQ	$8.99

MH					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
Unit Value	15 minutes				
Permitted POS	03, 04, 11, 12, 13, 14, 16, 18, 23, 31, 32, 33, 34, 53, 99 If more than six (6) units are delivered on the same date of service by the same agency, subsequent units will be adjudicated at 50% of the above rates.		Telehealth allowed with GT modifier. GT modifier is required when service rendered via telehealth.		

Assertive Community Treatment (ACT)

Table 3-14: Assertive Community Treatment (ACT)

MH					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
Assertive Community Treatment	MD/DO	H0040	AM	-	$615.64
	CNP CNS PA	H0040	UC SA SA	-	$352.75
	Licensed practitioner MH practitioner with a Master's degree*	H0040	HO	-	$251.91
	MH practitioner with a Bachelor's degree	H0040	HN	-	$199.70
	Peer recovery supporter	H0040	HM	-	$159.24
Unit Value	1 representing a per diem				
Permitted POS	03, 04, 11, 12, 13, 14, 16, 17, 18, 20, 53, 99			Telehealth allowed with GT modifier for dates of service on and after March 9, 2020. GT modifier is required when service rendered via telehealth.	

*Please refer to Ohio Administrative Code 5160-27-04(L) (2) for information on which practitioners are included in this level.

Intensive Home Based Treatment (IHBT)

Table 3-15(a): Intensive Home Based Treatment (IHBT)
For dates of service prior to March 1, 2022

MH					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
Intensive Home Based Treatment	PSY	H2015	-	-	$33.26
	LISW LIMFT LPCC	H2015	-	-	$33.26
	LSW LMFT LPC	H2015	U4 U5 U2	-	$33.26
Unit Value	15 minutes				
Permitted POS	03, 04, 11, 12, 14, 16, 18, 23, 53, 57, 99			Telehealth allowed with GT modifier for dates of service on and after March 9, 2020. GT modifier is required when service rendered via telehealth.	

Table 3-15(b): Intensive Home Based Treatment (IHBT)

For dates of service between March 1, 2022 – June 30, 2022. Effective July 1, 2022, these services will be available only under OhioRISE

MH					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
Multi-Systemic Therapy for Juveniles (MST)	LISW LPCC LIMFT PSY	H2033	*	-	$42.24
	LSW LPC LMFT	H2033	*	-	$41.10
Functional Family Therapy for Juveniles (FFT)	LISW LPCC LIMFT PSY	H2015	*	TF	$34.98
	LSW LPC LMFT	H2015	*	TF	$34.05
Intensive Home Based Treatment (other than MST or FFT)	LISW LPCC LIMFT PSY	H2015	*	-	$38.60
	LSW LPC LMFT	H2015	*	-	$37.57
	QMHS PSY assistant SW-A SW-T MFT-T C-T	H2015	*	-	$34.21
	PRS	H2015	*	-	$27.51
Unit Value	15 minutes				
Permitted POS	03, 04, 11, 12, 14, 16, 18, 23, 53, 57, 99		GT modifier is required when service rendered via telehealth.		

*For individuals with a primary enrollment in Medicaid as one of the allowable provider types listed above, a practitioner modifier is not required. However, a practitioner modifier (see Table 1-3) may be required if an individual is enrolled with additional specialties and the primary enrollment is not one of the allowable provider types listed above. Please refer to the "Modifiers" worksheet found in the "Dual Licensure Grid" at bhmedicaid.ohio.gov for additional information.

Any valid ICD-10 diagnosis code will be accepted on the claim.

SECTION 4

Substance Use Disorder (SUD) Coverage

The Ohio Medicaid program has selected the American Society of Addiction Medicine (ASAM) placement criteria as the standard of measure for guiding treatment for individuals with SUD conditions, including individuals with co-occurring MH conditions. The ASAM criteria has been selected to bring an objective strengths-based evaluation and placement methodology into practice to address individual patient needs, strengths, and supports.

The Ohio Medicaid program covers community-based SUD services to Medicaid beneficiaries provided by SUD programs within Ohio that are certified by OhioMHAS and enrolled with ODM as a community SUD service provider.

Table 4-1: SUD Assessment

SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
SUD Assessment	PSY assistant	H0001	U1	-	$77.22
	SW-T	H0001	U9	-	$77.22
	MFT-T	H0001	UA	-	$77.22
	CDC-A	H0001	U6	-	$77.22
	C-T	H0001	U7	-	$77.22
Unit Value	Encounter				
Permitted POS	03, 04, 11, 12, 13, 14, 16, 18, 23, 31, 32, 34, 57, 99			Telehealth allowed with GT modifier. GT modifier is required when service rendered via telehealth.	

Table 4-2: SUD Peer Recovery Support

SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
SUD Individual Peer Recovery Support	PRS	H0038	HM, HN, HO	-	$15.51
SUD Group Peer Recovery Support	PRS	H0038	HM, HN, HO	HQ	$1.94
Unit Value	15 minutes				
Permitted POS	03, 04, 11, 12, 13, 14, 16, 18, 23, 31, 32, 33, 34, 53, 57, 99			Telehealth allowed with GT modifier for dates of service on and after March 9, 2020. GT modifier is required when service rendered via telehealth.	

Table 4-3: Individual Counseling

SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate**	**Rate with KX Modifier Only****
Individual Counseling	LSW * LMFT * LPC * LCDC III, LCDC II *	H0004	U4 U5 U2 U3	$22.50	-
	PSY assistant	H0004	U1	$19.31	$25.10
	SW-T	H0004	U9	$19.31	$25.10
	MFT-T	H0004	UA	$19.31	$25.10
	CDC-A	H0004	U6	$19.31	$25.10
	C-T	H0004	U7	$19.31	$25.10
Unit Value	15 minutes				
Permitted POS	03, 04, 11, 12, 13, 14, 16, 18, 31, 32, 34, 57, 99 H0004 KX - POS 23 also available		Telehealth allowed with GT modifier. GT modifier is required when service rendered via telehealth.		
Individual counseling to address a crisis	Add KX modifier to indicate behavioral health counseling provided when a patient is experiencing a crisis, as allowable within the practitioner's scope of practice.				

*H0004 will be available for licensed dependent practitioners until June 30, 2018. For individual counseling services provided on and after July 1, 2018, these practitioners will use CPT individual psychotherapy codes.

**Rates are effective for dates of service on or after August 1, 2019.

Table 4-4: Group Counseling

SUD				
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate**
Group Counseling	MD/ DO	H0005	AF	$11.02
	CNS CNP PA PSY LISW LIMFT LPCC LICDC	H0005	HK	$9.37
	LSW LMFT LPC LCDC III, LCDC II	H0005	U4 and HK U5 and HK U2 and HK U3 and HK	$9.37
	PSY assistant	H0005	U1	$8.37
	SW-T	H0005	U9	$8.37
	MFT-T	H0005	UA	$8.37
	CDC-A	H0005	U6	$8.37

	C-T	H0005	U7	$8.37	
Unit Value	15 minutes				
Permitted POS	03, 04, 11, 12, 13, 14, 16, 31, 32, 34, 57 and 99			Telehealth allowed with GT modifier. GT modifier is required when service rendered via telehealth.	

Table 4-5: SUD Case Management

SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
SUD Case Management	MD/DO	H0006	-	-	$19.54
	CNS CNP PA PSY	H0006	-	-	$19.54
	LISW LIMFT LPCC LICDC Lic school PSY	H0006	-	-	$19.54
	LSW LMFT LPC LCDC II or LCDC III	H0006	U4 U5 U2 U3	-	$19.54
	PSY assistant	H0006	U1	-	$19.54
	SW-T	H0006	U9	-	$19.54
	SW-A	H0006	U8	-	$19.54
	MFT-T	H0006	UA	-	$19.54
	CDC-A	H0006	U6	-	$19.54
	C-T	H0006	U7	-	$19.54
	CMS high school CMS Associate's CMS Bachelor's CMS Master's	H0006	HM HM HN HO	-	$19.54
Unit Value	15 minutes				
Permitted POS	03, 04, 11, 12, 13, 14, 16, 18, 23, 31, 32, 33, 34, 57, 99 If more than six (6) units are delivered on the same date of service by the same agency, subsequent units will be adjudicated at 50% of the above rates.			Telehealth allowed with GT modifier. GT modifier is required when service rendered via telehealth.	

Table 4-6: SUD Urine Drug Screening

SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
Urine Drug Screening – collection, handling and point of service testing	MD/DO CNS CNP PA RN, LPN PSY LISW LIMFT LPCC LICDC Lic school PSY	H0048	-	-	$14.48
	LSW LMFT LPC LCDC III, LCDC II	H0048	U4 U5 U2 U3	-	$14.48
	PSY assistant SW-T SW-A MFT-T CDC-A C-T CMS high school CMS Associate's CMS Bachelor's CMS Master's	H0048	U1 U9 U8 UA U6 U7 HM HM HN HO	-	$14.48
Unit Value	Encounter				
Permitted POS	11, 57				

Table 4-7: SUD RN and LPN Nursing Services

SUD				
Service	**Provider Type**	**Code**	**Modifier**	**Rate**
Nursing Services – Individual	RN	T1002	-	$31.92 – provided in the office $41.00 – provided in the community
	LPN	T1003	-	$22.54 $29.13
Nursing Services – Group	RN	T1002	HQ	$10.37
Unit Value	15 minutes			
Permitted POS	Individual RN/LPN nursing services - 03, 04, 11, 12, 13, 14, 16, 18, 31, 32, 33, 34, 57, 99		Telehealth allowed with GT modifier for dates of service on and after March 9, 2020.	

	Group RN nursing services – 11 and 57 For T1002 KX – POS 23 is also available	GT modifier is required when service rendered via telehealth.
RN nursing service to address a crisis	Add KX modifier to indicate RN nursing service provided when a patient is experiencing a crisis, as allowable within the practitioner's scope of practice. KX is not allowable with group RN nursing services (HQ modifier).	

Table 4-8: Intensive Outpatient Level of Care Group Counseling

SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
Group Counseling IOP Level of Care*	MD/DO CNS CNP PA PSY	H0015	HK	-	$149.88
	LISW LIMFT LPCC LICDC	H0015	HK	-	$149.88
	LSW LMFT LPC LCDC III, LCDC II	H0015	U4, HK U5, HK U2, HK U3, HK	-	$149.88
	PSY assistant SW-T MFT-T CDC-A C-T	H0015	U1 U9 UA U6 U7	-	$103.04
Unit Value	Per diem. IOP group counseling must be provided to a client for a minimum length of 2 hours and 1 minute.				
Permitted POS	03, 04, 11, 14, 16, 57		Telehealth allowed with GT modifier for dates of service on and after March 9, 2020. GT modifier is required when service rendered via telehealth.		

***** When practitioners are co-facilitating an IOP group counseling service, it is up to the agency to determine under which practitioner to bill, to ensure billing for this per diem service is not duplicative, and to ensure the practitioner to patient ratio of no more than 1:12 is maintained.

Table 4-9: Partial Hospitalization (PH) Level of Care Group Counseling

SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
Group Counseling PH Level of Care*	MD/DO CNS CNP PA PSY	H0015	HK	TG	$224.82
	LISW LIMFT LPCC LICDC	H0015	HK	TG	$224.82
	LSW LMFT LPC LCDC III LCDC II	H0015	U4, HK U5, HK U2, HK U3, HK U3, HK	TG	$224.82
	PSY assistant SW-T MFT-T CDC-A C-T	H0015	U1 U9 UA U6 U7	TG	$154.56
Unit Value	Per diem. PH group counseling must be provided to a client for a minimum of 3 hours and 1 minute.				
Permitted POS	03, 04, 11, 14, 16, 57			Telehealth allowed with GT modifier for dates of service on and after March 9, 2020. GT modifier is required when service rendered via telehealth.	

*****When practitioners are co-facilitating a PH group counseling service, it is up to the agency to determine under which practitioner to bill, to ensure billing for this per diem service is not duplicative, and to ensure the practitioner to patient ratio of no more than 1:12 is maintained.

Table 4-10: SUD Withdrawal Management with Extended On Site Monitoring

SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
Withdrawal Management Hourly ASAM 2 WM	RN	H0014	-	-	$127.68
	RN	H0014	-	AT	$338.35
	LPN	H0014	-	-	$90.16
	LPN	H0014	-	AT	$238.92
Withdrawal Management Per Diem ASAM 2 WM	MD/DO CNS CNP PA	H0012	-	-	$360.36
Unit Value	H0012: Per diem H0014: 1 hour H0014 AT: 2-3 hours				
Permitted POS	11, 55, 57		Telehealth allowed with GT modifier for dates of service on and after March 9, 2020. GT modifier is required when service rendered via telehealth.		

SECTION 5

SUD Residential Treatment

In order to assure SUD residential treatment programs are able to bill the correct health care common procedure codes (HCPCS) in this section for SUD residential treatment, ODM added provider specialty "954 – SUD RESIDENTIAL FACILITY" for provider type "95 – OMHAS CERTIFIED/LICENSED TREATMENT PROGRAM". It is important to keep in mind that only provider types 95 with provider specialty 954 will be able to bill using the SUD residential treatment benefit package.

In order to bill a SUD residential per diem at least one documented face-to-face service must be provided by one of the clinical/treatment team members to the patient at the SUD residential treatment program site. Per diem payments do not include room and board.

Table 5-1: SUD Withdrawal Management with Extended On Site Monitoring

SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
Withdrawal Management Per Diem ASAM 2 WM	MD/DO CNS CNP PA	H0012	-	-	$360.36
Unit Value	H0012: Per diem				
Permitted POS	11, 55, 57		Telehealth allowed with GT modifier for dates of service on and after March 9, 2020. GT modifier is required when service rendered via telehealth.		

Table 5-2: Clinically Managed Low-Intensity Residential Treatment

SUD

Service	Provider Type	Code	Practitioner Modifier	Procedure Modifier	Rate
Clinically Managed Low-Intensity Residential Treatment ASAM 3.1	Any independently licensed practitioner with an SUD scope of practice	H2034	-	-	$152.57
Unit Value	Per diem				
Permitted POS	55		Telehealth allowed with GT modifier for dates of service on and after March 9, 2020. GT modifier is required when service rendered via telehealth.		

Table 5-3: Clinically Managed Residential Withdrawal Management

SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
Clinically Managed Withdrawal Management ASAM 3.2 WM	Any independently licensed practitioner with an SUD scope of practice	H0010	-	-	$256.33
Unit Value	Per diem				
Permitted POS	55		Telehealth allowed with GT modifier for dates of service on and after March 9, 2020. GT modifier is required when service rendered via telehealth.		

Table 5-4: Clinically Managed Population-Specific High Intensity Residential Treatment (Adults)

SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**

Clinically Managed Population-Specific High Intensity Residential Treatment ASAM 3.3 (Adults)	Any independently licensed practitioner with an SUD scope of practice	H2036	-	HI	$213.70
Unit Value	Per diem				
Permitted POS	55		Telehealth allowed with GT modifier for dates of service on and after March 9, 2020. GT modifier is required when service rendered via telehealth.		

Table 5-5: Clinically Managed High Intensity Residential Treatment

SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
Clinically Managed High Intensity Residential Treatment ASAM 3.5	Any independently licensed practitioner with an SUD scope of practice	H2036	-	-	$213.70
Unit Value	Per diem				
Permitted POS	55		Telehealth allowed with GT modifier for dates of service on and after March 9, 2020. GT modifier is required when service rendered via telehealth.		

Table 5-6: Medically Monitored Intensive Inpatient Treatment (Adults) and Medically Monitored High-Intensity Inpatient Services (Adolescent)

SUD

Service	Provider Type	Code	Practitioner Modifier	Procedure Modifier	Rate
Medically Monitored Intensive Inpatient Treatment (Adults) and Medically Monitored High-Intensity Inpatient Services (Adolescent) ASAM 3.7	Any independently licensed practitioner with an SUD scope of practice	H2036	-	TG	$303.49
Unit Value	Per diem				
Permitted POS	55		Telehealth allowed with GT modifier for dates of service on and after March 9, 2020. GT modifier is required when service rendered via telehealth.		

Table 5-7: Medically Monitored Inpatient Withdrawal Management

SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
Medically Monitored Inpatient Withdrawal Management ASAM 3.7 WM	Any independently licensed practitioner with an SUD scope of practice	H0011	-	-	$392.86
Unit Value	Per diem				
Permitted POS	55		Telehealth allowed with GT modifier for dates of service on and after March 9, 2020. GT modifier is required when service rendered via telehealth.		

SECTION 6

Opioid Treatment Programs (OTPs)

The Ohio Medicaid program provides a specialized benefit to those receiving opioid treatment through a select SUD provider specialty network (provider type 95 with provider specialty 951 and/or 953). Please

see the Ohio Department of Medicaid Opioid Treatment Programs manual located here: https://bh.medicaid.ohio.gov/manuals for additional information on the OTP benefit.

SECTION 7

Specialized Recovery Services (SRS) Program [1915(i)]

The SRS program is available to individuals who meet certain financial criteria and have been diagnosed with a serious and persistent mental illness (SPMI). Individual eligibility and program enrollment criteria are detailed in Administrative Code rule 5160-43-02. In addition to full Medicaid coverage, individuals enrolled in the SRS program have access to the new services described below: Individualized Placement and Support-Supported Employment (IPS-SE) and Peer Recovery Support (PRS). For dates of service on or after March 9, 2020, SRS program services are covered when rendered via telehealth.

SECTION 8

OhioRISE

The Ohio Department of Medicaid (ODM) supported by the Governor's Family and Children First Cabinet Council, and in partnership with state sister agencies, stakeholders, and providers, developed Ohio's first-ever integrated program to help children who have complex and serious behavioral health needs. OhioRISE (Resilience through Integrated Systems and Excellence) aims to improve care and outcomes for these children and their families or caregivers by:

- Creating a seamless delivery system for children and youth, families/caregivers, and system partners.
- Providing a "locus of accountability" by offering community-driven comprehensive care coordination through local Care Management Entities (CMEs).
- Expanding access to critical behavioral health treatment services and supports needed for this population such as Intensive and Moderate Care Coordination, Mobile Response and Stabilization, Behavioral Health Respite, Intensive Home-Based Treatment, and Flexible Funds.
- Assisting youth, families, state, and local child serving agencies, and other health providers to locate and use these services.

The OhioRISE program covers a range of behavioral health (BH) services for youth that are comprised of existing, enhanced, and new behavioral health and care coordination services. For more information about billing for the new and enhanced services for youth enrolled in OhioRISE, please refer to the OhioRISE Provider Enrollment and Billing Guidance. For youth enrolled in OhioRISE, existing behavioral health services will be covered in accordance with the OhioRISE Mixed Services Protocol and will be billed consistent with the billing policies outlined in the appropriate provider type billing guidelines.

Glossary of Terms

Add-on CPT Code: An add-on CPT code describes additional intra-service work associated with the primary procedure and can never be reported as a stand-alone code.

Base CPT Code: A base CPT code is a primary procedure to which add-on codes may be applied.

Coordination of Benefits (COB): The process of determining which health plan or insurance policy will pay first and/or determining the payment obligations of each health plan, medical insurance policy, or third party resource (example: commercial or Medicare) when two or more health plans, insurance policies or third party resources cover the same benefits for a Medicaid consumer.

Crisis: An acute circumstance that, in the opinion of a practitioner with knowledge of the member's condition, has overwhelmed the individual/family's ability to cope, and requires rapid and time-limited care or treatment in order to reduce the likelihood of severe pain or more significant deterioration in functioning.

Family: The primary care-giving unit and is inclusive of the wide diversity of primary caregiving units in our culture. Family is a birth, foster, adoptive or self-created unit of people residing together, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood/caregiving for the child(ren). Persons within this unit share bonds, culture, language, practices and a significant relationship. Birth parents, siblings and others with significant attachment to the individual living outside the home are included in the definition of family. For the purposes of this provider manual, "family" is defined as the persons who live with, or provide care to, a child and may include a parent, spouse, sibling, children, relatives, grandparents, guardians, foster parents or others with significant attachment to the individual.

Home Setting or Community Setting: The settings in which client primarily resides or spends time, as long as it is not a hospital nursing facility, intellectual or developmental disability (IDD), intermediary care facility (ICF), psychiatric nursing facility. Note: this is distinguished from a home and community-based setting, which is a requirement under an HCBS program.

Medicare benefits: "Medicare Benefits" means the health care services available to the consumer through the Medicare program where payment for the services are either completely the obligation of the Medicare program or in part the obligation of the Medicare program with the remaining payment (cost sharing) obligations belonging to the consumer, some other third party payer and/or Medicaid.

Licensed Practitioner of the Healing Arts (LPHA): A professional who is licensed as a clinical nurse specialist, certified nurse practitioner, psychiatrist, psychologist, licensed independent social worker (LISW), licensed independent marriage & family therapist (LIMFT), licensed professional clinical counselor (LPCC), licensed independent chemical dependency counselors (LICDC), or physician and practicing within the scope of their state license to recommend rehabilitation services. Clinical nurse specialist, LISWs, LIMFTs, LPCCs, LICDCs, occupational therapists, and physician assistants who are licensed and practicing within the scope of their state license may recommend rehabilitation services, only where noted in the approved State Plan and manual. LPHAs are licensed by a professional board in the state of Ohio and are authorized to practice under direct or general clinical supervision and have specialty experience and/or training related to persons with behavioral health conditions. This category includes psychology assistants, social work trainees, social work assistants, marriage and family therapist trainees, chemical dependency counselor assistants, and counselor trainees.

Natural Supports: Informal resources a family/caregiver/individual can access, independent of formal services. These supports are a significant source of culturally relevant emotional support and caring friendships for children and families. Natural supports can be short-term or long-term and are usually sustainable and available to the child and family/caregiver after formal services have ended.

Person-Centered Care: Services that reflect an adult/child and family's goals and emphasize shared decision-making approaches that empower families, provide choice, and minimize stigma. Services that are designed to optimally treat illness and emphasize wellness and attention to the family's overall well-being and adult/child's full community inclusion.

Person-Centered Plan: A comprehensive plan that integrates all components and aspects of care that are deemed medically necessary, needs based, are clinically indicated, and are provided in the most appropriate setting to achieve the individual's goal.

Recovery-Oriented: The principle that all individuals have the capacity to recover from mental illness and/or substance use disorders. Specifically, services should support the acquisition of living, vocational, and social skills and be offered in home and community-based settings that promote hope and encourage each person to establish an individual path towards recovery.

School Setting: A facility whose primary purpose is child education. Includes private schools meeting the standards under division (D) of section 3301.07 of the Revised Code and certain programs for children with disabilities.

Substance Use Disorder (SUD): A diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to use of a substance. The diagnosis of a substance use disorder is based from criteria defined in the current ICD-10 diagnosis codes manual and can be applied to all 10 classes of drugs including: alcohol; cannabis; hallucinogens; inhalants; opioids; sedatives, hypnotics, and anxiolytics; stimulants; tobacco; and other (or unknown) substances.

Third Party Payer (TPP): An entity responsible for adjudicating and paying claims for third party benefits rendered to an eligible Medicaid consumer.

Third Party Benefit: Any health care service(s) available to consumers through any medical insurance policy or through some other resource that covers medical benefits and the payment for those services is either completely the obligation of the TPP or in part the obligation of the consumer, the TPP and/or Medicaid. (Examples of a third party benefit include private health or accidental insurance, Medicare, CHAMPUS or worker's compensation.)

Third Party Liability (TPL): The payment obligations of the TPP for health care services rendered to eligible Medicaid consumers when the consumer also has third party benefits.

Appendix: Ohio Medicaid List of Place of Service Codes

Listed below are places of service that are included in the above tables. For a complete list of place of service codes, please see CMS Place of Service Code Set.

For services delivered via telehealth, providers may use either the place of service code that reflects the location of the practitioner or the location of the patient. The appendix to OAC 5160-27-03 includes a list of allowable places of service codes for each procedure code. Please note, place of service code 02 is not allowed. Providers should use the GT modifier to identify telehealth services.

Code(s)	Place of Service Name	Place of Service Description
01	Pharmacy	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
03	School	A facility whose primary purpose is education.
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	Group Home	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).
16	Temporary Lodging	A short term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code.
17	Walk-in Retail Health Clinic	A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.
18	Place of Employment/Worksite	A location, not described by any other POS code, owned or operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic or rehabilitative services to the individual.

		Payment Rate: Not applicable for adjudication of Medicare claims; systems must recognize for HIPAA
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
22	On Campus-Outpatient Hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Room - Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate postpartum care as well as immediate care of new born infants.
31	Skilled Nursing Facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial Care Facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
41	Ambulance - Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance - Air or Water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
53	Community Mental Health Center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services. If the facility is not certified by Medicare as a CMHC, POS should be 11, indicating office.

55	Residential Substance Abuse Treatment Facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
99	Community	May only be used when a more specific place of service is not available. Place of service 99 shall not be used to provide services to a recipient of any age if the recipient is in custody and held involuntarily through the operation of law enforcement authorities in a public institution as defined in 42 CFR 435.1010 (October 1, 2016).