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 Entities 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 Updated Table 2-4 to remove coverage for code 99343 effective 1/1/2023 Updated tables 2-5 and 3-4 to remove coverage for prolonged services codes 99354 and 99355 when the codes are used with E&M home visits and individual and group psychotherapy services effective 1/1/2023 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
Final Version 1.26	Updated Table 1-3 to include Psych Intern and Psych Trainee practitioner type numbers in the PSY Assistant definition Additions of TD and TE modifiers to Table 1-3 to indicate RN and LPN Updated Table 1-5 to include MRSS and explain the authorization requirements for stabilization services Updated Care Management Specialist (CMS) description Updated Documentation Guidelines for E&M services references Addition of information previously found in Opioid Treatment Program Manual to Section 6 (Opioid Treatment Program), including tables 6-1 through 6-4 Addition of tables 7-1 (SRS Supported Employment) and 7-2 (SRS Peer Recovery Support) to Section 7 (SRS Program) Removed detailed summary of Vaccines for Children section and added ODH VFC resources Replaced False Claim Act summary language with reference to OAC rule 5160-1-29 Removed interactive complexity narrative, adding reference to CPT book Removed psychological testing narrative, adding reference to CPT book Removed table 3-15(a) (Intensive Home Based Treatment for dates of service prior to March 1, 2022) Removed table 5-1 (SUD Withdrawal Management with Extended On Site Monitoring)	State Policy Team	12-1-2023

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Legal Disclaimer: Ohio Department of Medicaid (ODM) strives to make the information in this manual as accurate, complete, reliable, and timely as possible. However, ODM makes no claims, promises, or guarantees about the accuracy, completeness, or adequacy of this information. This is the most current version of the Medicaid Behavioral Health State Plan Services-Provider Requirements and Reimbursement Manual, which is being released as an informational and educational tool; however, this manual is subject to change and future revisions as the implementation and operations of the Ohio Medicaid program changes. ODM, its employees, agents, or others who provide the answers will not be liable or responsible to you for any claim, loss, injury, liability, or damages related to your use of or reliance upon this information. This manual is intended solely as an informational and educational resource for providers intending to participate in the Medicaid behavioral health programs and for the public. The information contained in this manual is not intended to set new standards and requirements beyond the scope of those standards and requirements found in the Ohio Administrative Code. In the case of any conflict between the information contained in this manual and Ohio Administrative Code or Ohio Revised Code, the Ohio Administrative Code or Ohio Revised Code, as applicable, prevails. This information is not intended to be a substitute for professional legal, financial, or business advice. This manual does not create, nor is it intended to create, an attorney-client relationship between you and Ohio. You are urged to consult with your attorney, accountant, or other qualified professional if you require advice or opinions tailored to your specific needs and circumstances.

SECTION 1

Introduction

The Ohio Department of Medicaid (ODM) created this manual to help providers of community behavioral health services understand coverage and reimbursement for services provided under the fee-for-service programs. Medicaid managed care entities (MCEs) also cover services described in this manual. Providers should refer to the MCE's billing manual for specific information. For purposes of this manual, community behavioral health providers are those who are certified by the Ohio Department of Mental Health and Addiction Services (OhioMHAS) as described in Ohio Administrative Code (OAC) rule 5160-27-01. 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 Behavioral Health Agency Services
- Chapter 5160-28 Federally Qualified Health Center and Rural Health Clinic 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 information on Opioid Treatment Programs (OTPs).
- 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)

To participate in the Ohio Medicaid program, including contracting with the managed care entities, OhioMHAS-certified providers must enroll in the Ohio Medicaid program. All provider enrollment applications must be submitted using Ohio Medicaid's Provider Network Management (PNM) module. The PNM module is 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.

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 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. 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

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

FQHCs and RHCs may be certified by OhioMHAS for the provision of community behavioral health services by enrolling as a provider type 84 and/or 95. OAC Rule 5160-28-03 describes requirements for FQHC and RHC services, including services that are considered FQHC and RHC Prospective Payment System (PPS) services. For OhioMHAS-certified providers who are also FQHCs or RHCs, behavioral health services that are not FQHC or RHC PPS services are covered under OAC Chapter 27 and may be billed under their Ohio Medicaid Provider type 84 or 95 enrollment and will be paid in accordance with OAC Chapter 27 as described in this manual.

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 provider 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.

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 a Qualified Mental Health Specialist (QMHS) and 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 Certified Peer Supporters).

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 the Dual Licensure Grid located at https://medicaid.ohio.gov/resources-for-providers/bh/manuals under the Billing 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 can 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 the detail line of the claim in order for ODM's claims payment system to recognize this practitioner as an allowable renderer of the service.

See the "Modifiers" tab on the Dual Licensure Grid 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 (CNP)**, **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.
- **Pharmacists** as defined in OAC rule 5160-8-52 who are licensed by the state of Ohio Board of Pharmacy. Tables 2-1, 2-6 and 2-9 provide further details.

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 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. 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 4732.01of the Ohio Revised Code and who are licensed by the Ohio Board of Psychology 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 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 Professionals 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:

- **Certified Peer Supporter (CPS) -** An individual who is certified by OhioMHAS as anadult peer [recovery] supporter, youth peer supporter, or family peer supporter as described in OAC rule 5122-29-15.1. Note - Certified Peer Supporter is referred to as Peer Recovery Supporter (PRS) in the PNM system.

- **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.
- **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. Additional information may be found in OAC rule 5160-27-01.
- **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.

Overview of Supervision

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

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 the supervising NPI on the claim is optional. 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
Qualified Mental Health Specialist +3	General
Care Management Specialist	General
Certified peer supporter	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 Medical Board of Ohio- http://med.ohio.gov/
- Ohio Board of Nursing - 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 understand the laws, rules, and requirements applicable to their licensure and scope of practice.

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. More information is available in The "Incident To" Provision of Medicare Fact Sheet.

Additional Resources for CMS "incident to" billing information:

- Medicare Benefit Policy Manual, Chapter 15 Section 60.1
- CMS Medicare Learning Network Articles

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*
Licensed practical nurse	LPN	TE*
Registered nurse	RN	TD*
Psychology assistant, psychology intern, psychology 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
Certified Peer Supporter – high school	CPS	HM
Certified Peer Supporter – Associate’s	CPS	HM
Certified Peer Supporter – Bachelor’s	CPS	HN
Certified Peer Supporter – Master’s	CPS	HO

*For fee for service, these modifiers are optional except when the rendering practitioner holds multi-license specialties and is rendering a service only available under a secondary license/certificate. Additional modifiers (HM, HN, HO, and UK) to designate education level are required for services as listed in this table. For information on MCE requirements, please refer to the applicable MCE manual.

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
Certified Peer 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 intensive outpatient, partial hospitalization, or 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, those services should be "rolled up" into a single detail line on a claim. However, if anything differs except the time the service was rendered, the claims should be 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. Services that are not appropriately rolled up may result in a denial for duplicate services.

Example 1: 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 2: 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)

Coordination of benefits is the process of determining the payment obligations of each health plan, insurance policy, or third-party resource when two or more resources cover the same benefits for a Medicaid recipient. Coordination of benefits is a federal requirement set forth in 42 CFR 433 Subpart D and includes specific activities for state Medicaid agencies related to third-party liability (TPL). Medicaid, or a Medicaid Managed Care Entity (MCE) must be the payer of last resort, except as allowed in OAC rules 5160-1-08 and 5160-26-09.1.

After a provider has gone through all reasonable measures to obtain all third-party payments as described in OAC rules 5160-1-08 and 5160-26-09.1 a claim may be submitted to ODM/MCEs requesting reimbursement for the rendered service(s). Providers who have received a zero payment from a third-party payer (TPP) or a partial payment will need to use the appropriate claim adjustment reason codes (CARCs) from the primary's Explanation of Benefits (EOB) on the claim submission to ODM/MCEs.

ODM maintains a list of specific service procedure codes or combinations of procedure codes and rendering providers that are covered by Ohio Medicaid but are not generally covered by commercial payers or Medicare. This list, known as the *Medicare and TPL list* is located at https://medicaid.ohio.gov/resources-for-providers/bh/manuals under *Billing Resources/Medicare and TPL Bypass list*. The list is separated into three sections – Medicare, Medicare Opioid Treatment Program (OTP), and TPL Bypass (for commercial payers).

- The Medicare list includes procedure codes and procedures code/rendering provider type combinations not covered by Medicare. The Medicare OTP list is only applicable to opioid treatment providers serving individuals with Medicare coverage.
- The TPL Bypass list is applicable to other payers (other than Medicare or Medicaid payers).

For the procedure codes on each of these payer lists, respectively, the provider may "bypass" the requirement to first bill the Third Party Payer (commercial or Medicare payer) and submit the claim directly to Medicaid.

The *Medicare and TPL Bypass List* was created to allow payment for certain services ODM identified that are not typically covered by TPPs. However, if TPP coverage is later discovered through ODM's or an MCE's post payment recovery process, payment may be recouped in accordance with federal Medicaid requirements. Therefore, if a provider is unsure of a specific TPP's coverage policy for any of the services or procedure codes, the provider should confirm coverage prior to billing for the service directly to Medicaid to avoid a future recoupment. , The Bypass List will be periodically updated to account for Medicare and commercial insurance coverage changes.

The *Medicare and TPL Bypass List* only applies to claims submitted by Medicaid provider types 84 (Community Mental Health Agencies) and 95 (Substance Use Disorder Treatment Providers). ODM recommends:

- BH providers require individuals to provide TPP information at the time of service as a best practice.
- BH providers should use the Electronic Data Interchange 270/271 eligibility transaction, check the payer portal, and exhaust any other sources for any TPP information on file, prior to submitting a claim to Medicaid.
- BH providers are required to bill the TPP prior to billing Medicaid for all services except for the service procedure codes listed on the *BH Medicare and TPL Bypass List*.
- BH providers should always notify ODM when they identify incorrect TPL information.

Benefits and Prior Authorization

In the behavioral health benefit package, there are services and/or levels of care that are subject to prior authorization. Table 1-5 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 SUD services above ASAM level 1 must be prior authorized for ACT enrollees.
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.

Description and Code	Benefit Period	Authorization Requirement
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 the first two stays. Third and subsequent stays in the same year require prior authorization from the first day of admission.
Peer Support Services 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.
MRSS Stabilization Service S9482	MRSS episode	Prior Authorization is needed for stabilization services rendered more than six weeks from the completion of a mobile response.

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 MyCare Ohio entity 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 rules 5160-1-61 and 5160-27-02. Additionally, Ohio Medicaid does not cover services to individuals who meet the criteria described in OAC rule 5160:1-1-03. A missed appointment is considered a non-service and is not reimbursable by Ohio Medicaid as described in OAC rule 5160-1-13.1.

Fraud, Waste, and Abuse

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.

Review of Provider Records

OAC rule 5160-1-27 sets forth the Ohio Medicaid policy on Review of Provider Records. Please review this rule for more information about Ohio Medicaid audit and review activities.

Payment Error Rate Measurement (PERM)

The CMS Payment Error Rate Measurement (PERM) program measures and reports improper payments in Medicaid and Children's Health Insurance Program (CHIP). Please visit CMS's PERM website for more information.

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. 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: 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.

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) discontinued prolonged service codes 99354 and 99355 for use with psychotherapy codes. ODM and MCE 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, ODM's claims payment system 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.

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 CPT website can be found here.

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 1 codes, their associated descriptions, and guidance on appropriate use, including use of add-on codes. 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 guidance is available through the Medicare Learning Network (MLN). 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 tables provided in the remaining sections of this manual. The *Practitioner Abbreviations Key* 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	**CPS**	Certified peer supporter
RPH	Pharmacist		

Evaluation and Management Codes

Table 2-1: Evaluation & Management Office Visit

<table>
<tr><th colspan="6">MH / SUD</th></tr>
<tr><th>Service</th><th>Provider Type</th><th colspan="2">Code</th><th>Rate through
December 31, 2023</th><th>Rate effective
January 1, 2024</th></tr>
<tr><td rowspan="2">E&M New Patient</td><td>MD/DO
CNS
CNP
PA</td><td colspan="2">99202
99203
99204
99205</td><td>$84.67
$122.93
$188.51
$236.92</td><td>$93.14
$135.22
$207.36
$260.61</td></tr>
<tr><td>RPH</td><td colspan="2">99202
99203</td><td>$33.09
$49.09</td><td>$35.08
$52.04</td></tr>
<tr><td rowspan="3">E&M Established Patient</td><td>MD/DO
CNS
CNP
PA</td><td colspan="2">99211
99212
99213
99214
99215</td><td>$22.31
$48.97
$82.85
$122.27
$165.15</td><td>$24.54
$53.87
$91.14
$134.50
$181.67</td></tr>
<tr><td>RN
LPN</td><td colspan="2">99211</td><td>$22.31</td><td>$24.54</td></tr>
<tr><td>RPH</td><td colspan="2">99211
99212
99213</td><td>$12.32
$22.72
$37.06</td><td>$13.06
$24.42
$39.30</td></tr>
<tr><td>Unit Value</td><td colspan="5">Encounter</td></tr>
<tr><td>Permitted POS</td><td colspan="2">11, 13, 31, 32
MH also has 53
SUD also has 57</td><td colspan="3">Telehealth allowed with GT modifier. GT modifier is required when service rendered via telehealth.</td></tr>
</table>

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

MH / SUD				
Service	**Provider Type**	**Code**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**
Prolonged Visit – First 60 minutes	MD/DO CNS CNP PA	+99415	-	$12.03
Prolonged Visit – Each Additional 30 Minutes	MD/DO CNS CNP PA	+99416	-	$6.18
Prolonged Visit – Each Additional 15 Minutes (for use with codes 99205 and 99215 only)	MD/DO CNS CNP PA	+99417	$38.53	$42.38
Prolonged Visit – Each Additional 15 Minutes (for use with codes 99205 and 99215 only)	MD/DO CNS CNP PA	+G2212	$38.53	$42.38
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**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**
Report of Pregnancy*	MD/DO CNS CNP PA	T1023	$30.00	$30.00

HCPCS code T1023 is to be used for a "Report of Pregnancy" (ROP). 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 through NurtureOhio, available here: https://progesterone.nurtureohio.com/login. 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.

To access the ROP on the NurtureOhio site, the user needs to have an OH|ID linked to their provider in the PNM. For additional information and NurtureOhio login instructions, review the Provider User Guide here: https://progesterone.nurtureohio.com/media/PRAFProviderUserGuide10-1-22.pdf.

Table 2-4: Evaluation & Management Home Visit

MH / SUD				
Service	**Provider Type**	**Code**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**
E&M Home Visit New Patient	MD/DO CNS CNP PA	99341 99342 99343* 99344 99345	$63.65 $91.90 $150.80 $210.78 $255.57	$70.02 $101.09 * $231.86 $281.13
E&M Home Visit Established Patient	MD/DO CNS CNP PA	99347 99348 99349 99350	$64.00 $97.38 $148.16 $205.79	$70.40 $107.12 $162.98 $226.37
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

<u>For dates of service prior to January 1, 2023*</u>

MH / SUD			
Service	**Provider Type**	**Code**	**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**	**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 through December 31, 2023**	**Rate effective January 1, 2024**
Psychiatric Diagnostic Evaluation w/o Medical	MD/DO PSY CNS CNP PA	90791	-	$130.72	$147.39
	LISW LIMFT LPCC LICDC (SUD only) Lic school PSY	90791		$111.11	$125.28
	LSW LMFT LPC LCDC III (SUD only) LCDC II (SUD only)	90791	U4 U5 U2 U3 U3	$111.11	$125.28
	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	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	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 CNS CNP PA	90792	-	$144.35	$162.75
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**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**
Electrocardiogram- at least 12 leads w/ interpretation and report	MD/DO	93000	$15.90	$17.49
	CNS CNP PA	93000	$13.52	$14.87
Electrocardiogram- tracing only w/o interpretation and report	MD/DO	93005	$6.90	$7.59
	CNS CNP PA	93005	$5.87	$6.45
Electrocardiogram- interpretation and report only	MD/DO	93010	$7.90	$8.69
	CNS CNP PA	93010	$6.72	$7.39
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	
	Cogentin (benztropine mesylate), per 1 mg	J0515	None	
	Buprenorphine, oral, 1 mg	J0571	None	
	Injection, buprenorphine (brixadi), 1mg	J0576		
	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	
	Injection, aristada initio, 1mg	J1943	None	
	Injection, aripiprazole lauroxil, 1 mg	J1944	None	
	Lorazepam injection, 2 mg	J2060	None	
	Injection, methylnaltrexone (Relistor), 0.1 mg	J2212	None	
	Injection, naloxone (Narcan), 1 mg	J2310	None	
	Injection, naloxone hydrochloride (zimhi), 1mg	J2311	None	
	Injection, naltrexone (Vivitrol), depot form, 1 mg	J2315	None	
	Olanzapine long acting injectable, 1 mg	J2358	None	
	Paliperidone Palmitate injection (Invega Sustenna or Invega Trinza), 1 mg	J2426	None	
	Injection, Invega Hafyera/Trinza	J2427	None	
	Fluphenazine Decanoate injection, 25 mg	J2680	None	
	Injection, Risperidone, long acting, .5 mg	J2794	None	
	Injection, Risperidone (uzedy), 1 mg	J2799	None	
	Naloxone (nasal route)	J3490	None	
	Valium injection, up to 5 mg	J3360	None	
	Oral Naltrexone	J8499	HG	
Unit Value	Based on HCPCS descriptor			
Unit Value	03, 04, 11, 12, 14 MH also has 53 SUD also has 55, 57			

MH / SUD *					
Service	**Description**	**Provider Type**	**Code**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**
Other Medication Administration	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	MD/DO CNS CNP PA RN/LPN RPH	*96372	$21.39	$23.53
Unit Value	CPT designation				
Permitted POS	03, 04, 11, 12, 14, 16, 18 MH also has 53 SUD also has 57				

* 96372 is not separately reimbursable for individuals receiving substance use disorder (SUD) residential treatment services due to the per diem payment methodology for SUD residential treatment.

National Drug Code (NDC)

Federal law requires that any claim detail line 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 Provider Network Management (PNM) module. 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 Q-codes).

Laboratory Services

Table 2-10: Laboratory Services

MH / SUD			
Service	**Service**	**Code**	**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	
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

Community substance use disorder (SUD) treatment providers (provider type 95) with appropriate CLIA certification are provided the laboratory contract. This provides coverage for clinical laboratory services provided on-site if the provider has the appropriate CLIA certificate for the clinical lab services being performed. See ~~ChapMedicaid-11~~ OAC Chapter 5160-11-11 for Medicaid coverage policies related to laboratory services.

CLIA Certification Overview

To bill laboratory codes besides those listed above, a provider must obtain the appropriate CLIA certification and enroll as a laboratory Medicaid provider with Ohio Medicaid. 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.

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 receive reimbursement for certain vaccines to their adult clients and to children under the Vaccines for Children program, operated by the Ohio Department of Health (ODH). Vaccines are covered when administered at the following places of service: 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. More information about the VFC program can be found on ODH's website and CDC's website.

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

Vaccine CPT	Description
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
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

Please refer to the ODM COVID-19 vaccine administration and billing guidelines for COVID-19 vaccine administration guidance.

Vaccines for Children (VFC) Program

Ohio's Vaccines for Children Program is administered by the Ohio Department of Health. For more information about the program and eligibility criteria for children visit the ODH website resources here:

- Vaccines for Children (VFC) | Ohio Department of Health
- ODH VFC FAQs

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 Table 2-11 for the list 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.

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

MH/SUD Requires the addition of the "ORC" specialty to the rendering provider's enrollment						
Service	**Rendering Provider Type**	**Code**	**Practitioner Modifier**	**Rate (dates of service 7/1/2022-12/31/2022)**	**Rate (dates of service 1/1/2023-12/31/2023)**	**Rate effective January 1, 2024**
Child and Adolescent Needs and Strength (CANS) Assessment	MD/DO	H2000	*	$341.60	$527.25	$594.47
	PA CNS CNP	H2000	*	$211.74	$324.67	$366.07
	PSY LPCC LISW LIMFT LICDC Lic school PSY	H2000	*	$112.86	$170.43	$192.16
	LPC LSW LMFT LCDC II LCDC III	H2000	*	$109.38	$165.00	$186.04
	PSY assistant SW-A SW-T MFT-T C-T CDC-A QMHS CMS	H2000	*	$98.31	$147.72	$166.55
Unit Value	Per Assessment (Brief or Comprehensive)					
Permitted POS	Any valid place of service code, except POS 02 or 10, 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" when used in accordance with coding guidelines.					

*For individuals with a primary enrollment in Medicaid as one of the allowable provider types listed in Table 2-12, 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 in Table 2-12. Please refer to the "Modifiers" worksheet found in the "Dual Licensure Grid" at bhmedicaid.ohio.gov for additional information.

The CANS billing Table 2-12 is specific to those services 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 (OhioMHAS). 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

Service effective date 7/1/2022

<table>
<tr><th colspan="6">MH/SUD
Requires the billing provider have the "ORM" specialty</th></tr>
<tr><th>Service</th><th>Provider Type</th><th>Code</th><th>Practitioner Modifier</th><th>Rate through December 31, 2023</th><th>Rate effective January 1, 2024</th></tr>
<tr><td rowspan="4">Crisis Mobile Response</td><td>PSY
LPCC
LISW
LIMFT
Licensed school PSY
LICDC</td><td>S9485</td><td>*</td><td>$476.64</td><td>$537.41</td></tr>
<tr><td>LPC
LSW
LMFT
LCDC II
LCDC III</td><td>S9485</td><td>*</td><td>$466.34</td><td>$525.80</td></tr>
<tr><td>PSY assistant
SW-A
SW-T
MFT-T
C-T
CDC-A
QMHS
CMS</td><td>S9485</td><td>*</td><td>$432.63</td><td>$487.79</td></tr>
<tr><td>CPS</td><td>S9485</td><td>*</td><td>$365.55</td><td>$412.16</td></tr>
<tr><td>Unit Value</td><td colspan="5">Per diem</td></tr>
<tr><td>Permitted POS</td><td colspan="5">Any valid place of service code may be used</td></tr>
<tr><td>Billing Information</td><td colspan="5">• 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," when used in accordance with coding guidelines
• Telehealth allowed in accordance with MRSS practice standards - GT modifier is required when service rendered via telehealth</td></tr>
</table>

*For individuals with a primary enrollment in Medicaid as one of the allowable provider types listed in Table 2-13, 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 in Table 2-13. 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.

Table 2-13 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

<table>
<tr><th colspan="6">MH/SUD
Requires the billing provider have the “ORM” specialty</th></tr>
<tr><th>Service</th><th>Provider Type</th><th>Code</th><th>Practitioner Modifier</th><th>Rate through December 31, 2023</th><th>Rate effective January 1, 2024</th></tr>
<tr><td rowspan="4">Crisis Mobile Response Follow-Up</td><td>PSY
LPCC
LISW
LIMFT
Licensed school PSY
LICDC</td><td>S9484</td><td>*</td><td>$139.92</td><td>$157.76</td></tr>
<tr><td>LPC
LSW
LMFT
LCDC II
LCDC III</td><td>S9484</td><td>*</td><td>$136.49</td><td>$153.89</td></tr>
<tr><td>PSY assistant
SW-A
SW-T
MFT-T
C-T
CDC-A
QMHS
CMS</td><td>S9484</td><td>*</td><td>$125.25</td><td>$141.22</td></tr>
<tr><td>CPS</td><td>S9484</td><td>*</td><td>$102.89</td><td>$116.01</td></tr>
<tr><td>Unit Value</td><td colspan="5">Per hour</td></tr>
<tr><td>Permitted POS</td><td colspan="5">Any valid place of service code may be used</td></tr>
<tr><td>Billing Information</td><td colspan="5">• 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,” when used in accordance with ICD-10.
• Telehealth allowed - GT modifier is required when service rendered via telehealth.</td></tr>
</table>

*For individuals with a primary enrollment in Medicaid as one of the allowable provider types listed in Table 2-14, 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 in Table 2-14. Please refer to the "Modifiers" worksheet found in the "Dual Licensure Grid" at bhmedicaid.ohio.gov for additional information.

Table 2-14 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

MH/SUD Requires the billing provider have the "ORM" specialty					
Service	**Rendering Provider Type**	**Code**	**Practitioner Modifier**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**
MRSS Stabilization Service	PSY LPCC LISW LIMFT Licensed school PSY LICDC	S9482	*	$34.95	$39.41
	LPC LSW LMFT LCDC II LCDC III	S9482	*	$34.01	$38.35
	PSY assistant SW-A SW-T MFT-T C-T CDC-A QMHS CMS	S9482	*	$30.92	$34.86
	CPS	S9482	*	$24.77	$27.93
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 MST 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" when used in accordance with ICD-10 • 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 in Table 2-15, 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 in Table 2-15. Please refer to the "Modifiers" worksheet found in the "Dual Licensure Grid" at bhmedicaid.ohio.gov for additional information.

Table 2-15 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.

Peer Support Service

Peer Support Services are available to individuals with a Substance Use Disorder (SUD) diagnosis billed by PT95. At the effective date of Ohio Administrative Code Rule 5160-27-14, anticipated for September 1, 2024, Peer Support Services are also available to individuals with a mental health diagnosis billed by PT84 for DOS September 1, 2024, or later. Please refer to the rule for additional information.

Table 2-16: Peer Support Service

MH*/SUD							
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**(SUD only) Rate through December 31, 2023**	**(SUD only) Rate effective January 1, 2024***	**MH/SUD Rate effective September 1, 2024***
Individual Peer Support	CPS	H0038	HM, HN, HO	-	$15.51	$17.49	$17.49
Group Peer Support	CPS	H0038	HM, HN, HO	HQ	$1.94	$2.19	$2.19
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. GT modifier is required when service rendered via telehealth.					

*Rates for SUD peer support services through December 31, 2023 and effective January 1, 2024; rates for MH peer support services effective for DOS September 1, 2024 or later only.

SECTION 3

Psychotherapy Services

Table 3-1: Psychotherapy for Crisis

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**
Psychotherapy for Crisis – first 60 minutes	MD/DO PSY	90839	-	$171.70	$193.59
	CNS CNP PA LISW LIMFT LPCC LICDC (SUD only) Lic school PSY	90839	-	$145.95	$164.55
	LSW LMFT LPC LCDC III (SUD only) LCDC II (SUD only)	90839	U4 U5 U2 U3 U3	$145.95	$164.55
	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.	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.	Paid at direct supervisor rate when supervisor NPI on claim Paid at 72.25% of maximum fee if supervisor NPI not included.

<table>
<tr><th colspan="6">MH / SUD</th></tr>
<tr><th>Service</th><th>Provider Type</th><th>Code</th><th>Practitioner Modifier</th><th>Rate through December 31, 2023</th><th>Rate effective January 1, 2024</th></tr>
<tr><td rowspan="5">Psychotherapy for Crisis – add'l 30 minutes</td><td>MD/DO
PSY</td><td>+90840</td><td>-</td><td>$81.95</td><td>$92.40</td></tr>
<tr><td>CNS
CNP
PA
LISW
LIMFT
LPCC
LICDC (SUD only)
Lic school PSY</td><td>+90840</td><td>-</td><td>$69.65</td><td>$78.54</td></tr>
<tr><td>LSW
LMFT
LPC
LCDC III (SUD only)
LCDC II (SUD only)</td><td>+90840</td><td>U4
U5
U2
U3
U3</td><td>$69.65</td><td>$78.54</td></tr>
<tr><td>PSY assistant</td><td>+90840</td><td>U1</td><td>Paid at direct supervisor rate when supervisor NPI on claim. Paid at 85% of maximum fee if supervisor NPI not included.</td><td>Paid at direct supervisor rate when supervisor NPI on claim. Paid at 85% of maximum fee if supervisor NPI not included.</td></tr>
<tr><td>SW-T
MFT-T
CDC-A (SUD only)
C-T</td><td>+90840</td><td>U9
UA
U6
U7</td><td>Paid at direct supervisor rate when supervisor NPI on claim
Paid at 72.25% of maximum fee if supervisor NPI not included.</td><td>Paid at direct supervisor rate when supervisor NPI on claim
Paid at 72.25% of maximum fee if supervisor NPI not included.</td></tr>
<tr><td>Unit Value</td><td colspan="5">+90839: 1 which represents first 60 minutes
+90840: 1 which represents each additional 30 minutes</td></tr>
<tr><td>Permitted POS</td><td colspan="3">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</td><td colspan="2">Telehealth allowed with GT modifier.
GT modifier is required when service rendered via telehealth.</td></tr>
</table>

Table 3-2: Individual Psychotherapy

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**
Individual Psychotherapy – 30 minutes	MD/DO PSY	90832	-	$63.11 $82.04 (KX)	$71.16 $92.50 (KX)
	CNS CNP PA LISW LIMFT LPCC LICDC (SUD only) Lic school PSY	90832	-	$53.64 $69.73 (KX)	$60.49 $78.63 (KX)
	LSW LMFT LPC LCDC III (SUD only) LCDC II (SUD only)	90832	U4 U5 U2 U3 U3	$53.64 $69.73 (KX)	$60.49 $78.63 (KX)
	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 (both KX and non-KX).	Paid at direct supervisor rate when supervisor NPI on claim. Paid at 85% of maximum fee if supervisor NPI not included. (both KX and non-KX).
	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 (both KX and non-KX).	Paid at direct supervisor rate when supervisor NPI on claim. Paid at 72.25% of maximum fee if supervisor NPI not included. (both KX and non-KX).

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**
Individual Psychotherapy – 45 minutes	MD/DO PSY	90834	-	$82.05	$92.51
	CNS CNP PA LISW LIMFT LPCC LICDC (SUD only) Lic school PSY	90834	-	$69.74	$78.63
	LSW LMFT LPC LCDC III (SUD only) LCDC II (SUD only)	90834	U4 U5 U2 U3 U3	$69.74	$78.63
	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.	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.	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	$135.71
	CNS CNP PA	90837	-	$102.31	$115.35

<table>
<tr><th colspan="6">MH / SUD</th></tr>
<tr><th>Service</th><th>Provider Type</th><th>Code</th><th>Practitioner Modifier</th><th>Rate through December 31, 2023</th><th>Rate effective January 1, 2024</th></tr>
<tr><td rowspan="4">Individual Psychotherapy – 60 minutes (continued)</td><td>LISW
LIMFT
LPCC
LICDC (SUD only)
Lic school PSY</td><td>90837</td><td>-</td><td>$102.31</td><td>$115.35</td></tr>
<tr><td>LSW
LMFT
LPC
LCDC III (SUD only) LCDC II (SUD only)</td><td>90837</td><td>U4
U5
U2
U3
U3</td><td>$102.31</td><td>$115.35</td></tr>
<tr><td>PSY assistant</td><td>90837</td><td>U1</td><td>Paid at direct supervisor rate when supervisor NPI on claim. Paid at 85% of maximum fee if supervisor NPI not included</td><td>Paid at direct supervisor rate when supervisor NPI on claim. Paid at 85% of maximum fee if supervisor NPI not included</td></tr>
<tr><td>SW-T
MFT-T
CDC-A (SUD only)
C-T</td><td>90837</td><td>U9
UA
U6
U7</td><td>Paid at direct supervisor rate when Supervisor NPI on claim
Paid at 72.25% of maximum fee if supervisor NPI not included.</td><td>Paid at direct supervisor rate when Supervisor NPI on claim
Paid at 72.25% of maximum fee if supervisor NPI not included.</td></tr>
<tr><td rowspan="2">Individual Psychotherapy w/ E&M Service</td><td>MD/DO</td><td>+90833
+90836
+90838</td><td>-</td><td>$65.37
$83.03
$109.53</td><td>$73.70
$93.62
$123.50</td></tr>
<tr><td>CNS
CNP
PA</td><td>+90833
+90836
+90838</td><td>-</td><td>$55.56
$70.58
$93.10</td><td>$62.65
$79.58
$104.98</td></tr>
<tr><td>Unit Value</td><td colspan="5">See CPT code description. ODM follows NCCI edits.</td></tr>
<tr><td>Permitted POS</td><td colspan="3">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</td><td colspan="2">Telehealth allowed with GT modifier. 90832 KX telehealth allowed with GT modifier. GT modifier is required when service rendered via telehealth.</td></tr>
<tr><td>Crisis psychotherapy of 16 to 30 minutes</td><td colspan="5">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 in table 3-1.</td></tr>
</table>

Table 3-3: Family Psychotherapy

<table>
<tr><th colspan="6">MH / SUD</th></tr>
<tr><th>Service</th><th>Provider Type</th><th>Code</th><th>Practitioner Modifier</th><th>Rate through December 31, 2023</th><th>Rate effective January 1, 2024</th></tr>
<tr><td rowspan="5">Family Psychotherapy w/o patient – 50 minutes</td><td>MD/DO
PSY</td><td>90846</td><td>-</td><td>$102.28</td><td>$115.32</td></tr>
<tr><td>CNS
CNP
PA
LISW
LIMFT
LPCC
LICDC (SUD only)
Lic school PSY</td><td>90846</td><td>-</td><td>$86.94</td><td>$98.02</td></tr>
<tr><td>LSW
LMFT
LPC
LCDC III (SUD only)
LCDC II (SUD only)</td><td>90846</td><td>U4
U5
U2
U3

U3</td><td>$86.94</td><td>$98.02</td></tr>
<tr><td>PSY assistant</td><td>90846</td><td>U1</td><td>Paid at direct supervisor rate when supervisor NPI on claim. Paid at 85% of maximum fee if supervisor NPI not included.</td><td>Paid at direct supervisor rate when supervisor NPI on claim. Paid at 85% of maximum fee if supervisor NPI not included.</td></tr>
<tr><td>SW-T
MFT-T
CDC-A (SUD only)
C-T</td><td>90846</td><td>U9
UA
U6

U7</td><td>Paid at direct supervisor rate when supervisor NPI on claim
Paid at 72.25% of maximum fee if supervisor NPI not included.</td><td>Paid at direct supervisor rate when supervisor NPI on claim
Paid at 72.25% of maximum fee if supervisor NPI not included.</td></tr>
<tr><td>Family psychotherapy (conjoint, w/ patient present) – 50 minutes</td><td>MD/DO
PSY</td><td>90847</td><td>-</td><td>$100.72</td><td>$113.56</td></tr>
</table>

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**
Family psychotherapy (conjoint, w/ patient present) – 50 minutes *(continued)*	CNS CNP PA LISW LIMFT LPCC LICDC (SUD only) Lic school PSY	90847	-	$85.61	$96.53
	LSW LMFT LPC LCDC III (SUD only) LCDC II (SUD only)	90847	U4 U5 U2 U3 U3	$85.61	$96.53
	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.	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.	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	MD/DO PSY	90849	-	$40.66	$45.84
	CNS CNP PA LISW LIMFT LPCC LICDC (SUD only) Lic school PSY	90849	-	$34.57	$38.96

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**
Multiple-family group psychotherapy *(continued)*	LSW LMFT LPC LCDC III (SUD only) LCDC II (SUD only)	90849	U4 U5 U2 U3 U3	$34.57	$38.96
	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.	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.	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 3-5: Group Psychotherapy

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**
Group Psychotherapy (not multi-family group)	MD/DO PSY	90853	-	$33.09	$37.31
	CNS CNP PA LISW LIMFT LPCC LICDC (SUD only) Lic school PSY	90853	-	$28.12	$31.71
	LSW LMFT LPC LCDC III (SUD only) LCDC II (SUD only)	90853	U4 U5 U2 U3 U3	$28.12	$31.71
	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.	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.	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

The use of interactive complexity codes is further described in CPT guidance. For more information, please reference the CPT book.

Table 3-6: Interactive Complexity

<table>
<tr><th colspan="6">MH / SUD</th></tr>
<tr><th>Service</th><th>Provider Type</th><th>Code</th><th>Practitioner Modifier</th><th>Rate through December 31, 2023</th><th>Rate effective January 1, 2024</th></tr>
<tr><td rowspan="5">Interactive Complexity</td><td>MD/DO
PSY</td><td>+90785</td><td>-</td><td>$13.81</td><td>$15.57</td></tr>
<tr><td>CNS
CNP
PA
LISW
LIMFT
LPCC
LICDC (SUD only)
Lic school PSY</td><td>+90785</td><td>-</td><td>$11.74</td><td>$13.23</td></tr>
<tr><td>LSW
LMFT
LPC
LCDC III (SUD only)
LCDC II (SUD only)</td><td>+90785</td><td>U4
U5
U2
U3
U3</td><td>$11.74</td><td>$13.23</td></tr>
<tr><td>PSY assistant</td><td>+90785</td><td>U1</td><td>Paid at direct supervisor rate when supervisor NPI on claim. Paid at 85% of maximum fee if supervisor NPI not included.</td><td>Paid at direct supervisor rate when supervisor NPI on claim. Paid at 85% of maximum fee if supervisor NPI not included.</td></tr>
<tr><td>SW-T
MFT-T
CDC-A (SUD only)
C-T</td><td>+90785</td><td>U9
UA
U6
U7</td><td>Paid at direct supervisor rate when supervisor NPI on claim
Paid at 72.25% of maximum fee if supervisor NPI not included.</td><td>Paid at direct supervisor rate when supervisor NPI on claim
Paid at 72.25% of maximum fee if supervisor NPI not included.</td></tr>
<tr><td colspan="6">Interactive Complexity is an add-on code that is only valid in conjunction with codes as determined by the AMA.</td></tr>
<tr><td>Unit Value</td><td colspan="5">1 which represents an encounter</td></tr>
<tr><td>Permitted POS</td><td>POS must be the same as the base code to which interactive complexity is being added.</td><td colspan="4">Telehealth allowed with GT modifier. GT modifier is required on claim when service rendered via telehealth.</td></tr>
</table>

Psychological Testing

The use of psychological testing codes is further described in CPT guidance. For more information, please reference the CPT book.

Table 3-7: Psychological Testing

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**
Psychological/ Neuropsychological* Testing Administration	MD/DO PSY PA CNS CNP LISW LIMFT LPCC Lic school PSY	96136	-	$30.86	$34.79
	LSW LMFT LPC PSY assistant	96136	U4 U5 U2 U1	$30.86	$34.79
	SW-T MFT-T C-T	96136	U9 UA U7	$30.86	$34.79
	MD/DO PSY PA CNS CNP LISW LIMFT LPCC Lic school PSY	+96137	-	$28.39	$32.01

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**
Psychological/ Neuropsychological* Testing Administration *(continued)*	LSW LMFT LPC PSY assistant	+96137	U4 U5 U2 U1	$28.39	$32.01
	SW-T MFT-T C-T	+96137	U9 UA U7	$28.39	$32.01
Psychological Testing Evaluation	MD/DO PSY PA CNS CNP LISW LIMFT LPCC Lic school PSY	96130	-	$59.26	$66.82
	LSW LMFT LPC PSY assistant	96130	U4 U5 U2 U1	$59.26	$66.82
	SW-T MFT-T C-T	96130	U9 UA U7	$59.26	$66.82

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**
Psychological Testing Evaluation *(continued)*	MD/DO PSY PA CNS CNP LISW LIMFT LPCC Lic school PSY	+96131	-	$59.26	$66.82
	LSW LMFT LPC PSY assistant	+96131	U4 U5 U2 U1	$59.26	$66.82
	SW-T MFT-T C-T	+96131	U9 UA U7	$59.26	$66.82
Neuropsychological Testing Evaluation	MD/DO PA PSY CNS CNP	96132	-	$97.37	$109.78
	PSY assistant	96132	U1	$97.37	$109.78
	MD/DO PA PSY CNS CNP	+96133	-	$78.31	$88.29
	PSY assistant	+96133	U1	$78.31	$88.29

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**
Developmental Testing	MD/DO PSY CNS CNP PA LISW LIMFT LPCC Lic school PSY	96112	-	$56.11	$63.26
	LSW LMFT LPC PSY assistant	96112	U4 U5 U2 U1	$56.11	$63.26
	SW-T MFT-T C-T	96112	U9 UA U7	$56.11	$63.26
	MD/DO PSY CNS CNP PA LISW LIMFT LPCC Lic school PSY	+96113	-	$28.06	$31.64
	LSW LMFT LPC PSY assistant	+96113	U4 U5 U2 U1	$28.06	$31.64
	SW-T MFT-T C-T	+96113	U9 UA U7	$28.06	$31.64

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**
Neurobehavioral Status Exam	MD/DO PA PSY CNS CNP	96116	-	$64.10	$72.27
	PSY assistant	96116	U1	$64.10	$72.27
	MD/DO PA PSY CNS CNP	+96121	-	$64.10	$72.27
	PSY assistant	+96121	U1	$64.10	$72.27
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.	

*Neuropsychological Testing Administration only allowable by appropriate medical providers (MD/DO, PA, PSY, CNS, CNP).

Table 3-7.5: Smoking Cessation

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**
Smoking and Tobacco Use Cessation Counseling – Intermediate: Greater than 3 minutes and up to 10 minutes	MD/DO PSY CNS CNP PA	99406	-	$9.43	$10.37
	LISW LIMFT LPCC LICDC (SUD only) Lic school PSY	99406	-	$8.02	$8.81
	LSW LMFT LPC LCDC III (SUD only) LCDC II (SUD only)	99406	U4 U5 U2 U3 U3	$8.02	$8.81
	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.	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.	Paid at direct supervisor rate when supervisor NPI on claim Paid at 72.25% of maximum fee if supervisor NPI not included.

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**
Smoking and Tobacco Use Cessation Counseling – Intensive: Greater than 10 minutes	MD/DO PSY CNS CNP PA	99407	-	$19.00	$20.90
	LISW LIMFT LPCC LICDC (SUD only) Lic school PSY	99407	-	$16.15	$17.77
	LSW LMFT LPC LCDC III (SUD only) LCDC II (SUD only)	99407	U4 U5 U2 U3 U3	$16.15	$17.77
	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.	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.	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) 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 through December 31, 2023**	**Rate effective January 1, 2024**
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 (KX) $37.17 in community (KX)	$25.33 in office $32.24 in community $32.93 in office (KX) $41.91 in community (KX)
	LSW LMFT LPC	H2019	U4 U5 U2	$22.47 in office $28.59 in community $29.21 in office (KX) $37.17 (KX)	$25.33 in office $32.24 in community $32.93 in office (KX) $41.91 in community (KX)
	PSY assistant (Master's)	H2019	U1 and HO	$22.47 in office $28.59 $29.21 in office (KX) $37.17 in community (KX)	$25.33 in office $32.24 in community $32.93 in office (KX) $41.91 in community (KX)
	SW-T (Master's)	H2019	U9 and HO	$22.47 in office $28.59 in community $29.21 in office (KX) $37.17 in community (KX)	$25.33 in office $32.24 in community $32.93 in office (KX) $41.91 in community (KX)
	SW-T (Bachelor's)	H2019	U9 and HN	$19.96 in office $25.46 in community $25.95 in office (KX) $33.10 in community (KX)	$22.50 in office $28.71 in community $29.26 in office (KX) $37.32 in community (KX)
	SW-A (Master's)	H2019	U8 and HO	$22.47 in office $28.59 in community $29.21 in office (KX) $37.17 in community (KX)	$25.33 in office $32.24 in community $32.93 in office (KX) $41.91 in community (KX)

Individual Therapeutic Behavioral Services (TBS) – 15 minutes *(continued)*	SW-A (Bachelor's)	H2019	U8 and HN	$19.96 in office $25.46 in community $25.95 in office (KX) $33.10 in community (KX)	$22.50 in office $28.71 in community $29.26 in office (KX) $37.32 in community (KX)
	MFT-T (Master's)	H2019	UA and HO	$22.47 in office $28.59 in community $29.21 in office (KX) $37.17 in community (KX)	$25.33 in office $32.24 in community $32.93 in office (KX) $41.91 in community (KX)
	MFT trainee (Bachelor's)	H2019	UA and HN	$19.96 in office $25.46 in community $25.95 in office (KX) $33.10 in community (KX)	$22.50 in office $28.71 in community $29.26 in office (KX) $37.32 in community (KX)
	C-T (Master's)	H2019	U7 and HO	$22.47 in office $28.59 in community $22.47 in office (KX) $28.59 in community (KX)	$25.33 in office $32.24 in community $32.93 in office (KX) $41.91 in community (KX)
	C-T (Bachelor's)	H2019	U7 and HN	$19.96 in office $25.46 in community $25.95 in office (KX) $33.10 in community (KX)	$22.50 in office $28.71 in community $29.26 in office (KX) $37.32 in community (KX)
	QMHS (Bachelor's)	H2019	HN	$19.96 in office $25.46 in community $25.95 in office (KX) $33.10 in community (KX)	$22.50 in office $28.71 in community $29.26 in office (KX) $37.32 in community (KX)
	QMHS (Master's)	H2019	HO	$22.47 in office $28.59 in community $29.21 in office (KX) $37.17 in community (KX)	$25.33 in office $32.24 in community $32.93 in office (KX) $41.91 in community (KX)

Individual Therapeutic Behavioral Services (TBS) – 15 minutes *(continued)*	QMHS (3 yrs+ Exp.)	H2019	UK	$19.96 in office $25.46 in community $25.95 in office (KX) $33.10 in community (KX)	$22.50 in office $28.71 in community $29.26 in office (KX) $37.32 in community (KX)
Group Therapeutic Behavioral Services (TBS) – 15 minutes					
Service Code	**Provider Type**	**Code**	**Modifiers**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**
Group Therapeutic Behavioral Services (TBS) – 15 minutes	MD/DO CNS CNP PA PSY LISW LIMFT LPCC Lic school PSY	H2019	HQ	$8.99	$10.14
	LSW LMFT LPC	H2019	U4, HQ U5, HQ U2, HQ	$8.99	$10.14
	PSY assistant (Master's)	H2019	U1, HO HQ	$7.31	$8.24
	SW-T (Master's)	H2019	U9, HO HQ	$7.31	$8.24
	SW-T (Bachelor's)	H2019	U9, HN HQ	$6.49	$7.32
	SW-A (Master's)	H2019	U8, HO HQ	$7.31	$8.24
	PSY assistant (Bachelor's)	H2019	U1, HN, HQ	$6.49	$7.32
	SW-A (Bachelor's)	H2019	U8, HN HQ	$6.49	$7.32
	MFT-T (Master's)	H2019	UA, HO HQ	$7.31	$8.24
	MFT-T (Bachelor's)	H2019	UA, HN HQ	$6.49	$7.32
	C-T (Master's)	H2019	U7, HO HQ	$7.31	$8.24
	C-T (Bachelor's)	H2019	U7, HN HQ	$6.49	$7.32

Group Therapeutic Behavioral Services (TBS) – 15 minutes *(continued)*	QMHS (Bachelor's)	H2019	HN HQ	$6.49	$7.32
	QMHS (Master's)	H2019	HO HQ	$7.31	$8.24
	QMHS (3 yrs+ Exp.)	H2019	UK HQ	$6.49	$7.32
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. 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 through December 31, 2023**	**Rate effective January 1, 2024**
Nursing Services – Individual	RN	H2019	-	$31.92 in office $41.00 in community	$35.99 in office $46.23 in community
	LPN	H2017	-	$22.54 in office $29.13 in community	$25.41 in office $32.84 in community
Nursing Services – Group	RN	H2019	HQ	$10.37	$11.69
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. 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 through December 31, 2023**	**Rate effective January 1, 2024**
TBS Group Service (Day Treatment) per hour less than 2.5 hours (See Time-Based CPT Codes in Section 1)	PSY LISW LIMFT LPCC Lic school PSY	H2012	HK HQ	$36.53	$41.19
	LSW LMFT LPC	H2012	U4, HK, HQ U5, HK, HQ U2, HK, HQ	$36.53	$41.19
	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	$30.86
	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	$27.17
	QMHS (3 yrs+ Exp.)	H2012	UK, HQ	$24.10	$27.17
	Provider Type	**Code**	**Modifiers**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**

TBS Group Service (Day Treatment) 2.5 or more hours (per diem)	PSY LISW LIMFT LPCC Lic school PSY	H2020	HK	$182.66	$205.95
	LSW LMFT LPC	H2020	U4, HK U5, HK U2, HK	$182.66	$205.95
	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, HO U9, HO U8, HO UA, HO U7, HO HO	$152.17	$171.57
	PSY asst (Bachelor's) SW-T (Bachelor's) SW-A (Bachelor's) MFT-T (Bachelor's) C-T (Bachelor's) QMHS (Bachelor's)	H2020	U1, HN U9, HN U8, HN UA, HN U7, HN HN	$135.92	$153.25
	QMHS (3 yrs+ Exp.)	H2020	UK	$135.92	$153.25
Unit Value	H2012: Hourly, maximum of 2 per day H2020: Per diem				
Permitted POS	03, 04, 11, 14, 53		Telehealth allowed with GT modifier. GT modifier is required when service rendered via telehealth.		

Table 3-11: Psychosocial Rehabilitation (PSR)

MH					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**
Psychosocial Rehabilitation (PSR)	SW-T	H2017	U9 and HM	$15.84 in office $20.32 in community $20.59 (KX) in office $26.42 (KX) in community	$17.86 in office $22.91 in community $23.22 (KX) in office $29.79 (KX) in community
	SW-A	H2017	U8 and HM	$15.84 in office $20.32 in community $20.59 (KX) in office $26.42 (KX) in community	$17.86 in office $22.91 in community $23.22 (KX) in office $29.79 (KX) in community
	MFT-T	H2017	UA and HM	$15.84 in office $20.32 in community $20.59 (KX) in office $26.42 (KX) in community	$17.86 in office $22.91 in community $23.22 (KX) in office $29.79 (KX) in community
	C-T	H2017	U7 and HM	$15.84 in office $20.32 in community $20.59 (KX) in office $26.42 (KX) in community	$17.86 in office $22.91 in community $23.22 (KX) in office $29.79 (KX) in community
	QMHS (high school)	H2017	HM	$15.84 in office $20.32 in community $20.59 (KX) in office $26.42 (KX) in community	$17.86 in office $22.91 in community $23.22 (KX) in office $29.79 (KX) in community
	QMHS (Associate's)	H2017	HM	$15.84 in office $20.32 in community $20.59 (KX) in office $26.42 (KX) in community	$17.86 in office $22.91 in community $23.22 (KX) in office $29.79 (KX) in community
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. GT modifier is required when service rendered via telehealth. HM modifier is required when billing PSR to differentiate PSR and MH LPN nursing.	

MH	
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 (SBIRT)

MH					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**
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	$27.56
	LSW LMFT LPC	G0396	U4 U5 U2	$25.05	$27.56
	PSY assistant SW-T MFT-T C-T	G0396	U1 U9 UA U7	$25.05	$27.56
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	$52.45
	LSW LMFT LPC	G0397	U4 U5 U2	$47.68	$52.45
	PSY assistant SW-T MFT-T C-T	G0397	U1 U9 UA U7	$47.68	$52.45
Unit Value	G0396: Encounter from 15 to 30 minutes G0397: Encounter over 30 minutes				

MH		
Permitted POS	03, 04, 11, 12, 13, 14, 16, 31, 32, 53	Telehealth allowed with GT modifier. 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 through December 31, 2023**	**Rate effective January 1, 2024**
Community Psychiatric Supportive Treatment – Individual	MD/DO CNS CNP PA PSY LISW LIMFT LPCC Lic school PSY	H0036	-	-	$19.54	$22.03
	LSW LMFT LPC	H0036	U4 U5 U2	-	$19.54	$22.03
	PSY assistant SW-T SW-A MFT-T C-T	H0036	U1 U9 U8 UA U7	-	$19.54	$22.03
	QMHS (3 yrs+ Exp.) QMHS (high school) QMHS (Associate’s) QMHS (Bachelor’s) QMHS (Master’s)	H0036	UK HM HM HN HO	-	$19.54	$22.03
Community Psychiatric Supportive Treatment – Group	MD/DO CNS CNP PA PSY LISW LIMFT LPCC Lic school PSY	H0036	-	HQ	$8.99	$10.14

MH						
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**
	LSW LMFT LPC	H0036	U4 U5 U2	HQ	$8.99	$10.14
	PSY assistant SW-T SW-A MFT-T C-T	H0036	U1 U9 U8 UA U7	HQ	$8.99	$10.14
	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	$10.14
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**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**
Assertive Community Treatment	MD/DO	H0040	AM	$615.64	$694.13
	CNP CNS PA	H0040	UC SA SA	$352.75	$397.73
	Licensed practitioner *	H0040	HO	$251.91	$284.03
	Unlicensed practitioner	H0040	HN	$199.70	$225.16
	Certified peer supporter	H0040	HM	$159.24	$179.54
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. 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)

For information on billing IHBT, refer to the OhioRISE Provider Enrollment and Billing Guidance.

SECTION 4

Substance Use Disorder (SUD) Coverage

OAC rule 5160-27-09 establishes the American Society of Addiction Medicine (ASAM) placement criteria as the standard for Ohio Medicaid coverage of substance use disorder treatment services. The SUD services described in this section are covered when provided by eligible providers as defined in 5160-27-01.

Table 4-1: SUD Assessment

SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**
SUD Assessment	PSY assistant	H0001	U1	$77.22	$87.07
	SW-T	H0001	U9	$77.22	$87.07
	MFT-T	H0001	UA	$77.22	$87.07
	CDC-A	H0001	U6	$77.22	$87.07
	C-T	H0001	U7	$77.22	$87.07
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: Individual Counseling

SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**
Individual Counseling	PSY assistant	H0004	U1	$19.31 $25.10 (KX)	$21.77 $28.30 (KX)
	SW-T	H0004	U9	$19.31 $25.10 (KX)	$21.77 $28.30 (KX)
	MFT-T	H0004	UA	$19.31 $25.10 (KX)	$21.77 $28.30 (KX)
	CDC-A	H0004	U6	$19.31 $25.10 (KX)	$21.77 $28.30 (KX)
	C-T	H0004	U7	$19.31 $25.10 (KX)	$21.77 $28.30 (KX)
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.	

Table 4-3: Group Counseling

SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**
Group Counseling	MD/ DO	H0005	AF	$11.02	$12.43
	CNS CNP PA PSY LISW LIMFT LPCC LICDC	H0005	HK	$9.37	$10.56
	LSW LMFT LPC LCDC III, LCDC II	H0005	U4 and HK U5 and HK U2 and HK U3 and HK	$9.37	$10.56
	PSY assistant	H0005	U1	$8.37	$9.44
	SW-T	H0005	U9	$8.37	$9.44
	MFT-T	H0005	UA	$8.37	$9.44
	CDC-A	H0005	U6	$8.37	$9.44
	C-T	H0005	U7	$8.37	$9.44
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 4-4: SUD Case Management

<table>
<tr><th colspan="6">SUD</th></tr>
<tr><th>Service</th><th>Provider Type</th><th>Code</th><th>Practitioner Modifier</th><th>Rate through December 31, 2023</th><th>Rate effective January 1, 2024</th></tr>
<tr><td rowspan="9">SUD Case Management</td><td>MD/DO
CNS
CNP
PA
PSY
LISW
LIMFT
LPCC
LICDC
Lic school PSY</td><td>H0006</td><td>-</td><td>$19.54</td><td>$22.03</td></tr>
<tr><td>LSW
LMFT
LPC
LCDC II or LCDC III</td><td>H0006</td><td>U4
U5
U2
U3</td><td>$19.54</td><td>$22.03</td></tr>
<tr><td>PSY assistant</td><td>H0006</td><td>U1</td><td>$19.54</td><td>$22.03</td></tr>
<tr><td>SW-T</td><td>H0006</td><td>U9</td><td>$19.54</td><td>$22.03</td></tr>
<tr><td>SW-A</td><td>H0006</td><td>U8</td><td>$19.54</td><td>$22.03</td></tr>
<tr><td>MFT-T</td><td>H0006</td><td>UA</td><td>$19.54</td><td>$22.03</td></tr>
<tr><td>CDC-A</td><td>H0006</td><td>U6</td><td>$19.54</td><td>$22.03</td></tr>
<tr><td>C-T</td><td>H0006</td><td>U7</td><td>$19.54</td><td>$22.03</td></tr>
<tr><td>CMS high school
CMS Associate’s
CMS Bachelor’s
CMS Master’s</td><td>H0006</td><td>HM
HM
HN
HO</td><td>$19.54</td><td>$22.03</td></tr>
<tr><td>Unit Value</td><td colspan="5">15 minutes</td></tr>
<tr><td>Permitted POS</td><td colspan="3">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.</td><td colspan="2">Telehealth allowed with GT modifier. GT modifier is required when service rendered via telehealth.</td></tr>
</table>

Table 4-5: SUD Drug Screening

<table>
<tr><th colspan="6">SUD</th></tr>
<tr><th>Service</th><th>Provider Type</th><th>Code</th><th>Practitioner Modifier</th><th>Rate through December 31, 2023</th><th>Rate effective January 1, 2024</th></tr>
<tr><td rowspan="3">Non-blood specimen collection for alcohol/other drug testing</td><td>MD/DO
CNS
CNP
PA
RN, LPN
PSY
LISW
LIMFT
LPCC
LICDC
Lic school PSY</td><td>H0048</td><td>-</td><td>$14.48</td><td>$16.33</td></tr>
<tr><td>LSW
LMFT
LPC
LCDC III, LCDC II</td><td>H0048</td><td>U4
U5
U2
U3</td><td>$14.48</td><td>$16.33</td></tr>
<tr><td>PSY assistant
SW-T
SW-A
MFT-T
CDC-A
C-T
CMS high school
CMS Associate’s
CMS Bachelor’s
CMS Master’s</td><td>H0048</td><td>U1
U9
U8
UA
U6
U7
HM
HM
HN
HO</td><td>$14.48</td><td>$16.33</td></tr>
<tr><td>Unit Value</td><td colspan="5">Encounter</td></tr>
<tr><td>Permitted POS</td><td colspan="5">11, 57</td></tr>
</table>

Table 4-6: SUD RN and LPN Nursing Services

<table>
<tr><th colspan="6">SUD</th></tr>
<tr><th>Service</th><th>Provider Type</th><th>Code</th><th>Modifier</th><th>Rate through December 31, 2023</th><th>Rate effective January 1, 2024</th></tr>
<tr><td rowspan="2">Nursing Services – Individual</td><td>RN</td><td>T1002</td><td>-</td><td>$31.92 –in office
$41.00 –in community</td><td>$35.99 - in office
$46.23 - in community</td></tr>
<tr><td>LPN</td><td>T1003</td><td>-</td><td>$22.54
$29.13</td><td>$25.41
$32.84</td></tr>
<tr><td>Nursing Services – Group</td><td>RN</td><td>T1002</td><td>HQ</td><td>$10.37</td><td>$11.69</td></tr>
<tr><td>Unit Value</td><td colspan="4">15 minutes</td><td></td></tr>
<tr><td>Permitted POS</td><td colspan="3">Individual RN/LPN nursing services - 03, 04, 11, 12, 13, 14, 16, 18, 31, 32, 33, 34, 57, 99
Group RN nursing services – 11 and 57
For T1002 KX – POS 23 is also available</td><td colspan="2">Telehealth allowed with GT modifier.
GT modifier is required when service rendered via telehealth.</td></tr>
<tr><td>RN nursing service to address a crisis</td><td colspan="5">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).</td></tr>
</table>

Table 4-7: Intensive Outpatient (IOP) Level of Care Group Counseling

SUD					
Service	**Provider Type**	**Code**	**Modifier**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**
Group Counseling IOP Level of Care*	MD/DO CNS CNP PA PSY LISW LIMFT LPCC LICDC	H0015	HK	$149.88	$168.99
	LSW LMFT LPC LCDC III, LCDC II	H0015	U4, HK U5, HK U2, HK U3, HK	$149.88	$168.99
	PSY assistant SW-T MFT-T CDC-A C-T	H0015	U1 U9 UA U6 U7	$103.04	$116.18
Unit Value	Per diem. For IOP group counseling when 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. 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 4-8: Partial Hospitalization (PH) Level of Care Group Counseling

SUD						
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**
Group Counseling PH Level of Care*	MD/DO CNS CNP PA PSY LISW LIMFT LPCC LICDC	H0015	HK	TG	$224.82	$253.48
	LSW LMFT LPC LCDC III LCDC II	H0015	U4, HK U5, HK U2, HK U3, HK U3, HK	TG	$224.82	$253.48
	PSY assistant SW-T MFT-T CDC-A C-T	H0015	U1 U9 UA U6 U7	TG	$154.56	$174.27
Unit Value	Per diem. For PH group counseling when provided to a client for a minimum length of 3 hours and 1 minute.					
Permitted POS	03, 04, 11, 14, 16, 57		Telehealth allowed with GT modifier. 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 4-9: SUD Withdrawal Management with Extended On Site Monitoring

<table>
<tr><th colspan="6">SUD</th></tr>
<tr><th>Service</th><th>Provider Type</th><th>Code</th><th>Procedure Modifier</th><th>Rate through December 31, 2023</th><th>Rate effective January 1, 2024</th></tr>
<tr><td rowspan="4">Withdrawal Management Hourly ASAM 2 WM</td><td>RN</td><td>H0014</td><td>-</td><td>$127.68</td><td>$143.96</td></tr>
<tr><td>RN</td><td>H0014</td><td>AT</td><td>$338.35</td><td>$381.49</td></tr>
<tr><td>LPN</td><td>H0014</td><td>-</td><td>$90.16</td><td>$101.66</td></tr>
<tr><td>LPN</td><td>H0014</td><td>AT</td><td>$238.92</td><td>$269.38</td></tr>
<tr><td>Withdrawal Management Per Diem ASAM 2 WM</td><td>MD/DO
CNS
CNP
PA</td><td>H0012</td><td>-</td><td>$360.36</td><td>$406.31</td></tr>
<tr><td>Unit Value</td><td colspan="5">H0012: Per diem
H0014: 1 hour
H0014 AT: 2-3 hours</td></tr>
<tr><td>Permitted POS</td><td colspan="2">11, 55, 57</td><td colspan="3">Telehealth allowed with GT modifier.
GT modifier is required when service rendered via telehealth.</td></tr>
</table>

SECTION 5

SUD Residential Treatment

Providers must be certified by OhioMHAS for residential and withdrawal management substance use disorder services to bill for SUD residential treatment. Providers must have the ODM provider specialty "954 – SUD RESIDENTIAL FACILITY" for provider type "95 – OMHAS CERTIFIED/LICENSED TREATMENT PROGRAM" 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.

SUD Withdrawal Management with Extended On Site Monitoring

For information on billing Withdrawal Management Per Diem ASAM 2 WM, refer to Table 4-9 (SUD Withdrawal Management with Extended On Site Monitoring)

Table 5-1: Clinically Managed Low-Intensity Residential Treatment

SUD				
Service	**Provider Type**	**Code**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**
Clinically Managed Low-Intensity Residential Treatment ASAM 3.1	Any independently licensed practitioner with an SUD scope of practice	H2034	$152.57	$172.02
Unit Value	Per diem			
Permitted POS	55		Telehealth allowed with GT modifier. GT modifier is required when service rendered via telehealth.	

Table 5-2: Clinically Managed Residential Withdrawal Management

SUD				
Service	**Provider Type**	**Code**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**
Clinically Managed Withdrawal Management ASAM 3.2 WM	Any independently licensed practitioner with an SUD scope of practice	H0010	$256.33	$289.01
Unit Value	Per diem			
Permitted POS	55		Telehealth allowed with GT modifier. GT modifier is required when service rendered via telehealth.	

Table 5-3: Clinically Managed Population-Specific High Intensity Residential Treatment (Adults)

SUD					
Service	**Provider Type**	**Code**	**Procedure Modifier**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**
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	$240.95
Unit Value	Per diem				
Permitted POS	55			Telehealth allowed with GT modifier. GT modifier is required when service rendered via telehealth.	

Table 5-4: Clinically Managed High Intensity Residential Treatment

SUD				
Service	**Provider Type**	**Code**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**
Clinically Managed High Intensity Residential Treatment ASAM 3.5	Any independently licensed practitioner with an SUD scope of practice	H2036	$213.70	$240.95
Unit Value	Per diem			
Permitted POS	55		Telehealth allowed with GT modifier. GT modifier is required when service rendered via telehealth.	

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

SUD					
Service	**Provider Type**	**Code**	**Procedure Modifier**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**
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	$342.18
Unit Value	Per diem				
Permitted POS	55			Telehealth allowed with GT modifier. GT modifier is required when service rendered via telehealth.	

Table 5-6: Medically Monitored Inpatient Withdrawal Management

SUD				
Service	**Provider Type**	**Code**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**
Medically Monitored Inpatient Withdrawal Management ASAM 3.7 WM	Any independently licensed practitioner with an SUD scope of practice	H0011	$392.86	$442.95
Unit Value	Per diem			
Permitted POS	55		Telehealth allowed with GT modifier. GT modifier is required when service rendered via telehealth.	

SECTION 6

Opioid Treatment Programs

This section includes services provided by Opioid Treatment Programs (OTPs) licensed by OhioMHAS as a methadone administration program and/or certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) as an OTP.

Provider Network Management (PNM) Enrollment for Opioid Treatment Programs

OTP providers must be enrolled with Ohio Medicaid as provider type 95, community substance use disorder treatment provider, with the 950 provider specialty. Additionally, to bill Medicaid for OTP specialty services, the provider agency must be licensed as an OTP by OhioMHAS and certified by the Substance Abuse and Mental Health Services Administration (SAMHSA). Medicaid OTP provider specialties differ by type:

- Providers of Methadone enroll as Medicaid provider specialty 951.
- Providers of Buprenorphine enroll as Medicaid provider specialty 953.
- Providers of both Methadone and Buprenorphine enroll with both specialties 951 and 953.

These specialties can be added by request through the ODM Provider Network Management (PNM) system. OTPs will need to upload their documentation of OhioMHAS licensure and SAMHSA Certification. Once submitted, the request for a new provider specialty and the supporting documentation will be reviewed by ODM Provider Enrollment and the provider will be notified when the specialty is added or if additional information is needed.

Buprenorphine Administration for SUD Treatment Programs

For information on billing for Buprenorphine administration, refer to Table 2-9: Provider Administered Pharmaceuticals

OTP Billing Guidance

1. **Daily Administration.** H0020 with the HF modifier is used for daily methadone administration, including single take-home doses provided in accordance with Ohio Administrative Code 5122-40-06. T1502 is used for daily buprenorphine administration, including single take home doses provided in accordance with Ohio Administrative Code 5122-40-06.
    a. If a patient is seen every day in order to receive methadone or buprenorphine, modifier HF must be used with H0020 and T1502 respectively.
    b. The date of service for H0020 or T1502 with modifier HF is the date of administration of the medication or in the case of a daily take-home dose, the date the patient will take the dose.
2. **Weekly Administration.** H0020 or T1502 with a modifier representing 1, 2, 3 or 4 weeks (see Table 6-1) is used for weekly medication administration that includes take-home doses provided in accordance with 42 Ohio Administrative Code 5122-40-06. The OTP must maintain documentation in the patient record that supports the number of take-home doses administered.
    a. If any weekly administration modifier has been billed, the OTP cannot bill H0020 or T1502 again during that time period (1, 2, 3, or 4 weeks).
    b. Date of service on the claim must be the date the patient was seen in the office by the OTP in order to receive their take-home medication.

3. OTPs administering buprenorphine must bill the appropriate J code (see Table 6-2) for the medication that was administered. OTPs may bill for take-home doses using S5000 or S5001.
4. 99211 may be used for the nasal administration of naloxone (J2310). This coding combination is only used when the naloxone is administered nasally on site.
5. 96372 may be used for the injectable administration of naloxone (J2310). This coding combination is only used when the naloxone is administered by injection on site.
6. J2310 is used for injectable/nasal naloxone administered in accordance with the Ohio Board of Pharmacy requirements.
7. OTPs may bill for the cost of oral naltrexone (J8499) under their Ohio Board of Pharmacy license.
8. OTPs may bill for the collection of blood using venipuncture (36415), per draw when the sample is sent to an outside laboratory for testing.
9. Any of the OTP services must be performed by one of the following medical professionals within their scope of practice: physician, clinical nurse specialist, certified nurse practitioner, physician assistant, registered nurse, or a licensed practical nurse.
10. Please reference Table 6-1 for additional information on service coding, rates and modifiers.

Table 6-1: Opioid Treatment Programs

Provider Type 95/951 – State Licensed Methadone Program						
Service	**Description**	**Provider Type**	**Code**	**Modifier**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**
Methadone Administration	Daily	MD/DO CNS CNP PA RN LPN	H0020	HF	$16.38	$18.47
	Weekly (2 – 7 days)	MD/DO CNS CNP PA RN LPN	H0020	TV	$114.66	$129.28
	Two Weeks (8 – 14 days)			UB	$229.32	$258.56
	Three Weeks (15 – 21 days)			TS	$343.98	$387.84
	Four Weeks (22 – 28 days)			HG	$458.64	$517.12
Medications	Oral Naltrexone, per 50 mg tablet	-	J8499	HG	$1.20	$1.35
	Injection/Nasal, naloxone (Narcan), 1mg	-	J2310	-	See Medicaid fee schedule in effect for date of service.	
Laboratory Services	Collection of venous blood by venipuncture	Per CPT guidelines 1	36415	-	See Medicaid fee schedule in effect for date of service.	
Unit Value	CPT or HCPCS designation					

Table 6-2: Opioid Treatment Programs

Provider Type 95/953 – SAMHSA Certified Opioid Treatment Program						
Service	**Description**	**Provider Type**	**Code**	**Modifier**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**
Buprenorphine/ Naloxone Administration	Daily	MD/DO CNS CNP PA RN LPN	T1502	HF	$16.38	$18.47
	Weekly (2 – 7 days)			TV	$114.66	$129.28
	Two Weeks (8 – 14 days)			UB	$229.32	$258.56
	Three Weeks (15 – 21 days)			TS	$343.98	$387.84
	Four Weeks (22 – 28 days)			HG	$458.64	$517.12
Medications	Buprenorphine, oral, 1 mg.	-	J0571	-	See Medicaid fee schedule in effect for date of service.	
	Buprenorphine/naloxone, oral, less than or equal to 3 mg.	-	J0572	-	See Medicaid fee schedule in effect for date of service.	
	Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg.	-	J0573	-	See Medicaid fee schedule in effect for date of service.	
	Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg.	-	J0574	-	See Medicaid fee schedule in effect for date of service.	
	Buprenorphine/naloxone, oral, greater than 10 mg.	-	J0575	-	See Medicaid fee schedule in effect for date of service.	

Provider Type 95/953 – SAMHSA Certified Opioid Treatment Program						
Service	**Description**	**Provider Type**	**Code**	**Modifier**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**
Medications *(continued)*	Inj buprenorphine (brixadi) 1mg injection, buprenorphine extended-release (brixadi), 1 mg		J0576		See Medicaid fee schedule in effect for date of service.	
	Buprenorphine/naloxone, generic, per 1mg buprenorphine/0.25 mgnaloxone	-	S5000	-	$1.20	$1.35
	Buprenorphine generic, per 1 mg.	-	S5000	HD	$0.55	$0.62
	Buprenorphine/naloxone, brand, per 1mg	-	S5001	-	$2.30	$2.59
	Buprenorphine/0.25mg naloxone	-	-	-	$2.30	$2.59
	Oral Naltrexone, per 50mg tablet	-	J8499	HG	$1.20	$1.35
	Injection/Nasal, naloxone (Narcan), 1mg	-	J2310	-	See Medicaid fee schedule in effect for date of service.	
	Injection, Buprenorphine XR, 100mg or less		Q9991	-	See Medicaid fee schedule in effect for date of service.	
	Injection, Buprenorphine XR, more than 100mg		Q9992	-	See Medicaid fee schedule in effect for date of service.	
Laboratory Services	Collection of venous blood by venipuncture	Per CPT guidelines [1]	36415	-	See Medicaid fee schedule in effect for date of service.	
Unit Value	CPT or HCPCS Designation					

[1] Separate billing for collection of venous blood is only allowable when a provider draws the blood and sends it to a non-related outside facility without performing any testing.

Coordination of Benefits: Medicare Opioid Treatment Program Benefit

ODM is required by CMS to coordinate Medicaid payment for OTP services to individuals with Medicare to ensure services and costs that are covered by the Medicare OTP are not being paid by Medicaid or a Medicaid managed care entity. Based on the Medicare OTP benefit as of the date this manual was

published, Table 6-3 identifies OTP services covered by Medicaid that are included in the Medicare bundled payment, as well as those that are not part of the Medicare bundled payment. Medicaid claims for dually eligible recipients will need to show proof of Medicare denial and valid reason for non-payment prior to Medicaid making any payment for the OTP services that are designated as included in the Medicare bundled payment. The Medicare OTP benefit is subject to change; therefore, Table 6-3 should be used as reference. OTP providers are responsible for billing Medicare prior to Medicaid payers for services that are included in the Medicare OTP bundle.

Table 6-3: Medicare Opioid Treatment "Bundle" Billing Codes

Medicaid procedure codes covered under Medicare OTP payment			
	ASAM Level 1	**ASAM Level 2**	**ASAM Level 3**
Ohio Medicaid Codes Covered by Medicare	H0020/T1502 – med admin 90791-92, H0001 – assessment 99201-05, 99211-15, 99341-50 H0004 – individual counseling H0005 – group counseling H0048 –non-blood specimen collection for alcohol/other drug testing 90832-38 – individual counseling 90853 – group counseling 96372 – injection admin	H0020/T1502 90791-92, H0001 99201-05, 99211-15, 99341-50 H0004 H0005 H0048 90832-38 90853 96372	H0020/T1502
Ohio Medicaid Medication codes Covered by Medicare	S5000-01, J0571-75, J2310, J8499		
Ohio Medicaid Lab Drug Testing Codes Covered by Medicare	80305-07, 80320-36, 80338-77, 83992, G0480-83		
Medicaid procedure codes not covered under Medicare OTP payment			
Ohio Medicaid Codes **NOT** Covered by Medicare	H0006 – care management H0038 - peer support service T1002 – RN services T1003 – LPN services	H0015 – IOP* H0015 TG – PH H0012 – detox H0014 – detox H0006 H0038 T1002 T1003	H2034 – residential H2036 – residential H0010 – detox H0011 – detox

* intensive outpatient program (IOP) service covered for Medicare OTP patients must be billed to Medicare

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) or a diagnosed chronic condition listed in Administrative Code rule 5160-43-02 (A) (3). SRS 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 these additional services: Recovery Management and Individualized Placement and Support - Supported Employment (IPS-SE). To deliver and submit claims for payment for Recovery Management and Individualized Placement and Support- Supported Employment providers must meet all the requirements listed in Administrative Code rule 5160-43-04 in addition to having the following Provider Type and Specialty:

Service	Provider Type	Provider Specialty
Recovery Management	45	845
Individualized Placement and Support – Supported Employment (IPS-SE)	84	851

For behavioral health agencies to provide and submit for IPS-SE services they must comply with the rules set forth in 5160-43-04 and 5160-27 of the Administrative Code.

SRS program services are covered when rendered via telehealth. For details on the requirements to render SRS program services, refer to Administrative Code rule 5160-43-04.

Table 7-1: SRS Supported Employment

MH				
Service	**Provider Type**	**Code**	**Rate through December 31, 2023**	**Rate effective January 1, 2024**
SRS Supported Employment, Initial	Any unlicensed practitioners per OAC 5160-27-01, except CPS and “supervised trainees” under general supervision.	H2023	$19.53	$22.02
SRS Supported Employment, Subsequent	Any unlicensed practitioners per OAC 5160-27-01, except CPS and “supervised trainees” under general supervision.	H2025	$19.53	$22.02
Unit Value	15 minutes			
Permitted POS	03, 04, 11, 12, 13, 14, 16, 17, 18, 19, 20, 23, 53, 55, 56, 57 **POS 56 not allowable for initial service*		Telehealth allowed with GT modifier. GT modifier is required when service rendered via telehealth.	

Table 7-2: SRS Peer Support Service

MH					
Service	**Provider Type**	**Code**	**Procedure Modifier**	**Rate through December 31, 2023**	**Rate effective January 1, 2024 through August 31, 2024***
SRS Individual Peer Support,	CPS	H0038	-	$15.51	$17.49
SRS Group Peer Support Service,	CPS	H0038	HQ	$1.94	$2.19
Unit Value	15 minutes				
Permitted POS	Not allowed in 02, 05, 06, 07, 08, 41, 42, 55			Telehealth allowed with GT modifier. GT modifier is required when service rendered via telehealth.	

*See Table 2-16: Peer Support Service for Peer Support Service rates September 1, 2024 and later

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), launched on July 1, 2022, 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) and care coordination services for youth. For more information about billing for 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.

Appendix: Ohio Medicaid List of Place of Service Codes

Listed below are place of service codes that are included in the tables throughout this manual. 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).
15	Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventative, screening, diagnostic, and/or treatment services.
16	Temporary Lodging	A short-term accommodation such as a hotel, campground, 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.

Code(s)	Place of Service Name	Place of Service Description
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.
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 newborn 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 individuals with intellectual disabilities.
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.

Code(s)	Place of Service Name	Place of Service Description
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
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	Other Place of Service	Other place of service not identified above. May be used when a more specific place of service code is not available, including community.