Ohio Department of Medicaid

MEDICAID BEHAVIORAL HEALTH STATE PLAN SERVICES

PROVIDER REQUIREMENTS AND REIMBURSEMENT MANUAL

Version: 1.18
Published on March 18, 2021
Effective March 18, 2021

The most recent version may be found at:
bh.medicaid.ohio.gov/manuals

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

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

Final Version 1.13	Emergency Version updated	State Policy Team	7-17-2020
Final Version 1.14	GT modifier requirement 90785 covered under telehealth	State Policy Team	11-2-2020
Final Version 1.15	E&M coding changes effective 1/1/2021	State Policy Team	12-31-2020
Final Version 1.16	Addition of pharmacist as an eligible provider type for certain services	State Policy Team	1-17-2021
Final Version 1.17	Addition of COVID-19 vaccine services (Pfizer and Moderna)	State Policy Team	2-11-2021
Final Version 1.18	Addition of COVID-19 vaccine services (Johnson & Johnson) & updated NCCI links	State Policy Team	3-18-2021

To return to the Table of Contents after reviewing a section: Click Alt and left arrow.

Contents

SECTION 1 10

INTRODUCTION 10

Organization of the Provider Manual 10

Provider Enrollment – OhioMHAS certified providers (organizations) 10

MITS provider type 84 or 95 11

Out of state MH/SUD providers 11

Rendering Practitioners 11

Paraprofessionals 12

Multi-licensed Practitioners 12

Qualified Providers Overview 13

Medical Behavioral Health Practitioners (M-BHPs) 13

Licensed Independent Behavioral Health Practitioners (I-BHPs) 13

Behavioral Health Practitioners (BHPs) 14

Behavioral Health Paraprofessional Practitioners (BHP-Ps) 15

Overview of Supervision 17

Incident to Services 18

Collateral Contacts 18

Practitioner Modifiers 18

Procedure Modifiers 20

Place of Service (POS) 21

Services Delivered in an Inpatient or Outpatient Hospital Setting 21

"Other Place of Service" Setting 21

Claims Detail Rollup for Same Day Services 21

Third Party Payor (TPP) Coordination of Benefits (COB) 21

Benefits and Prior Authorization 22

Medical Necessity 23

Non-Covered Services 23

Fraud, Waste, Abuse and Errors 24

False Claim Act 24

Codified at 42 U.S.C. 1396a(a)(68). Ohio Medicaid's Surveillance, Utilization and Review Section (SURS) 24

Payment Error Rate Measurement (PERM) 24

Medicaid National Correct Coding Initiative 25
NCCI procedure-to-procedure (PTP) edits 25
Medically Unlikely Edits (MUEs) 26
Time Based CPT Codes 27
SECTION 2 30
Current Procedural Terminology (CPT Coded) Behavioral Health Services 30
Evaluation and Management Codes 31
E/M New Patient 31
E/M Established Patient 31
E/M Home Visit New Patient 33
E/M Home Visit Established Patient 33
Prolonged Visit – First 60 minutes 34
Prolonged Visit – Each Additional 30 Minutes 35
Psychiatric Diagnostic Evaluation w/o Medical 37
Psychiatric Diagnostic Evaluation w/ Medical 37
Electrocardiogram- at least 12 leads w/ interpretation and report 39
Electrocardiogram- tracing only w/o interpretation and report 39
Electrocardiogram- interpretation and report only 39
Medication Administered by Medical Personnel (J-Codes) 40
Other Medication Administration 40
National Drug Code (NDC) 41
Laboratory Services 42
Vaccines 44
Vaccines for Children (VFC) Eligibility Criteria 47
Vaccines for Adults 48
Psychotherapy for Crisis – first 60 minutes 49
Psychotherapy for Crisis – add'l 30 minutes 50
Individual Psychotherapy – 30 minutes 51
Individual Psychotherapy – 45 minutes 51
Individual Psychotherapy – 60+ minutes 52
Individual Psychotherapy w/ E/M Service 53
Family Psychotherapy w/o patient – 50 minutes 54
Family psychotherapy (conjoint, w/ patient present) – 50 minutes 54
Multiple-family group psychotherapy 55
Group Psychotherapy (not multi-family group) 57

Interactive Complexity 58
Psychological Testing 60
Developmental Testing – through 12-31-2018 62
Neurobehavioral Status Exam – through 12-31-2018 62
Neuropsychological Testing – through 12-31-2018 63
Developmental Testing – Effective January 1, 2019 66
Neurobehavioral Status Exam – Effective January 1, 2019 67
Neuropsychological Testing Administration 68
Neuropsychological Testing Evaluation 68
Smoking Cessation 69
Healthcare Common Procedure Coding System (HCPCS) Coded Mental Health Services 71
Individual Therapeutic Behavioral Services (TBS) – 15 minutes 71
Group Therapeutic Behavioral Services (TBS) – 15 minutes 72
Nursing Services – Individual 73
Nursing Services – Group 73
TBS Group Service (Day Treatment) per hour up to two hours – Group 74
TBS Group Service (Day Treatment) per diem 74
Psychosocial Rehabilitation 75
Screening, Brief Intervention and Referral to Treatment (SBIRT) 76
Community Psychiatric Supportive Treatment – Individual 77
Community Psychiatric Supportive Treatment – Group 77
Assertive Community Treatment (ACT) 79
Intensive Home Based Treatment (IHBT) 80
SECTION 4 81
Substance Use Disorder (SUD) COVERAGE 81
SUD Assessment 81
SUD Individual Peer Recovery Support 81
SUD Group Peer Recovery Support 81
Individual Counseling 82
Group Counseling 82
SUD Case Management 84
Urine Drug Screening – collection, handling and point of service testing 85
Nursing Services – Individual 86
Nursing Services – Group 86
Group Counseling IOP Level of Care* 86

Group Counseling PH Level of Care* 87
Withdrawal Management Hourly ASAM 2 WM 88
SECTION 5 89
Clinically Managed Low-Intensity Residential Treatment ASAM 3.1 90
Clinically Managed Withdrawal Management ASAM 3.2 WM 90
Clinically Managed Population-Specific High Intensity Residential Treatment ASAM 3.3 (Adults) 90
Clinically Managed High Intensity Residential Treatment ASAM 3.5 91
Medically Monitored Intensive Inpatient Treatment (Adults) and Medically Monitored High-Intensity Inpatient Services (Adolescent) ASAM 3.7 91
Medically Monitored Inpatient Withdrawal Management ASAM 3.7 WM 92
SECTION 6 93
Opioid Treatment Programs (OTPs) 93
SECTION 7 93
Specialized Recovery Services (SRS) Program [1915(i)] 93
Glossary of Terms 94
Appendix: Ohio Medicaid List of Place of Service Codes 96

Legal Disclaimer: 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) has created this manual to help providers of community behavioral health services understand how to seek reimbursement for services provided under the fee-for-service program.

The Ohio Administrative Code contains specific regulatory information that is the basis for the information contained in this manual. Chapter 5160-1 contains regulatory information on the Medicaid program in general. Additional information is available in the following administrative rules:

- Chapter 5160-1 General Provisions
- Chapter 5160-4 Physician Services
- Chapter 5160-8 Limited Practitioner Services
- Chapter 5160-27 Community Behavioral Health Services
- Chapter 5160-43 Specialized Recovery Services Program

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

Organization of the Provider Manual

This manual is organized into seven 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 services which can be provided by both mental health and substance use disorder (SUD) agencies.
- Section 3 provides specific service requirements and claims billing information for services which can only be performed by mental health agencies. This section includes evidence-based practices.
- Section 4 provides specific service requirements and claims billing information for services which can only be performed by SUD outpatient agencies.
- Section 5 provides specific service requirements and claims billing information for services which can only be performed by SUD residential agencies.
- Section 6 provides brief information on Opioid Treatment Programs (OTPs) and a link to the OTP provider manual effective for services provided on and after January 1, 2017
- Section 7 provides information on the Specialized Recovery Services (SRS) program and related resources.
- Version 1.12 incorporates billing requirements for telehealth pursuant to Ohio Administrative Code 5160-1-18 and is effective for dates of service on or after November 15, 2020.

Provider Enrollment – OhioMHAS certified providers (organizations)

To participate in the Ohio Medicaid program, including contracting with the managed care plans, OhioMHAS certified providers must enroll in the Medicaid Information Technology System (MITS). There are two provider types associated with the behavioral health benefit; provider type 84 is used for accessing the mental health benefit while provider type 95 is used for accessing the substance use disorder benefit. For an organization that will be providing both benefits, it will need to enroll as **BOTH** provider types.

MITS 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: http://mha.ohio.gov/Default.aspx?tabid=123. 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 MITS provider portal. 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. When enrolling as provider type 84, there is only one provider specialty, 840, available so use it. For provider type 95, there are four provider specialties available. At initial enrollment, select provider specialty 950. ODM will add or change specialties as necessary based upon the OhioMHAS/SAMHSA certification(s) and/or OhioMHAS licensure that are attached to the application in number 6 below.

The following documents will be necessary and must be attached to the submitted application(s):

1. The signature page of the provider agreement (obtained as a step in completing the application(s)).
2. An IRS form W-9 completed with the provider (organization) name, address, federal tax identification number, authorized representative signature, and date signed.
3. A copy of the organization's letter/e-mail received from NPPES showing the provider NPI number for the enrollment. If enrolling as both a provider type 84 and provider type 95 separate and unique NPIs will be needed; one for reach provider type.
4. A copy of the organization's Medicare certification letter (if applicable).
5. A copy of the organization's CLIA certificate (if applicable).
6. A copy of the organization's OhioMHAS certificate(s). The organization's OhioMHAS license and/or SAMHSA certificate if the provider is also an opioid treatment program (OTP).

These forms will need to be submitted electronically as attachments to the application by completing the online provider enrollment process, selecting the "Upload required documents" link on the "Confirmation of Receipt" panel displayed at the end of the enrollment process and then following the prompts/instructions.

The following link is to the ODM MITS provider enrollment website:

http://Medicaid.ohio.gov/providers/EnrollmentandSupport/ProviderEnrollment.aspx.

Out of state MH/SUD providers

Pursuant to OAC rule 5160-27-01, for reimbursement of MH and/or SUD agencies/programs operating outside of the state of Ohio, the program must be recognized (regulated) in the state in which they operate as a provider of community-based MH and/or SUD services and be enrolled with Ohio Medicaid as a community MH and/or SUD service provider.

Rendering Practitioners

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

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

Once the provider has obtained an NPI, they must visit the ODM Provider Enrollment page and enroll as a provider in the Ohio Medicaid Program. Each behavioral health agency must ensure that each of its corresponding employed/contracted providers are "affiliated" or linked to their agency. The affiliation step must be performed in the secure section of the Medicaid Information Technology System (MITS) portal by the agency's MITS Administrator or the individual provider during or after the provider enrollment process. More details on this process can be found at: http://mha.ohio.gov/Portals/0/assets/Planning/MACSISorMITS/mits-bits-rendering-providers-part-2-4-19-16.pdf.

Paraprofessionals

- For those in provider type 96, a practitioner could select more than one specialty. For example, one could enroll as QMHS and a care management specialist by selecting specialties 960 (QMHS) and 962 (CMS).
- If a practitioner was enrolled as QMHS and obtains their three (3) years of experience, the employing/contracting agency must provide proof of experience through the MITS portal in order to change the practitioner from QMHS specialty to QMHS 3 specialty.

Practitioner NPIs will be required in the rendering field effective for dates of service on and after July 1, 2018. Most practitioner modifiers will be optional for fee for service. Some practitioner modifiers, however, will continue to be required. Please note: for dates of service January 1, 2018 through June 30, 2018, the practitioner modifiers in Table 1-3 are required on claims.

More details on this process can be found in the April 19, 2016 MITS Bits at https://bh.medicaid.ohio.gov/,

Multi-licensed Practitioners

The Ohio Department of Medicaid (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 multi-license specialty in MITS. This multi-license specialty will allow the practitioner to render services available under their second license. Please refer to Dual Licensure Grid found https://bh.medicaid.ohio.gov/manuals.

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 MITS enrollment application indicating what additional credential/paraprofessional recognition is held. Para-professionals have the ability to select a primary, a secondary or multiple secondary specialty. Be certain to upload the necessary documentation for each license/certificate. If already enrolled in MITS, email ODM Provider Enrollment with necessary information to support the second specialty.

Claim submission:

- **Reporting additional licensure on claims** - Once these practitioners have the multi-licensed practitioner specialty, claims can be submitted:
    - 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 in MITS as an RN who is also an LPCC must have the UH modifier **in addition to their individual practitioner NPI** on to the detail line of the claim in order for MITS to recognize this practitioner as an allowable renderer of the service.

Qualified Providers Overview

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, clinical nurse practitioners, registered nurses, and licensed practical nurses as defined in Chapter 4723. of the Ohio Revised Code and who are licensed and certified by the state of Ohio Nursing Board and legally authorized to practice in the state of Ohio.
- Physician assistants as defined in Chapter 4730. of the Ohio Revised Code, who are licensed by the state of Ohio Medical Board and legally authorized to practice in the state of Ohio.
- Effective January 17, 2021, pharmacists are eligible providers for managing medication therapy under a consulting agreement with a prescribing practitioner, administering immunizations, administering medications. Please see tables 2-1, 2-6 and 2-8 for further details. Ohio Administrative Code rules 5160-27-01, 5160-27-02, and 5160-27-03 also have been amended to incorporate the addition of pharmacists as rendering practitioners.

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 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
- 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 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.
- Licensed independent social workers 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.
- Licensed independent marriage and family therapists 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.
- Licensed independent chemical dependency counselors as defined in Chapter 4758. of the Ohio Revised Code, who are licensed by the Ohio Chemical Dependency Professionals Board and legally authorized to practice in the state of Ohio.

Behavioral Health Practitioners (BHPs)

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

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

Licensed

- Board licensed school psychologists as defined in Chapter 3301. of the Ohio Revised Code and who are licensed by the Ohio Department of Education and legally authorized to practice in the state of Ohio.
- A licensed professional counselor 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.
- A licensed social worker 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
- A licensed marriage and family therapist licensed by of 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 licensed chemical dependency counselor III licensed by the Ohio Chemical Dependency Professional Board in accordance with Chapter 4758. of the Ohio Revised Code and legally authorized to practice in the state of Ohio.
- A licensed chemical dependency counselor II licensed by the Ohio Chemical Dependency Professional Board in accordance with Chapter 4758. of the Ohio Revised Code and legally authorized to practice in the state of Ohio.

Trainees/Assistants

- A psychology assistant/intern/trainee is a person who is working under the supervision of a psychologist licensed by the Ohio Board of Psychology and legally authorized to practice in the state of Ohio.
- A school psychology assistant/intern/trainee is a person who is 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.
- A counselor trainee who is 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.
- A social work trainee who is 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.

- A social work assistant who is 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 registered with 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.
- A chemical dependency counselor assistant 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. Note: Until June 30, 2018, these providers are not enrolled in MITS and are identified by a modifier when billing. Effective for dates of service on and after July 1, 2018, these paraprofessionals will be enrolled in MITS and affiliated with their community behavioral health agency. See Modifier section. BHP-Ps are:

- Peer Recovery Supporter (PRS):
  A peer recovery supporter must:
  - Be certified as a peer recovery supporter by the Ohio department of mental health and addiction services and
  - Be eighteen years of age or older and have a high school diploma or equivalent.

- Care Management Specialist (CMS)

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

- Qualified Mental Health Specialist (QMHS)

  A qualified mental health specialist (QMHS) is an individual who has received training or education in mental health competencies and who has demonstrated, prior to or within ninety

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

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

- Qualified Mental Health Specialist +3

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

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

Overview of Supervision

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

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

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

Ohio Medicaid requires the following practitioners to practice under either direct or general supervision. Reporting supervising NPI on the claim will be optional with the implementation of the services and codes included in this manual. For those practitioners listed below with direct supervision, the service will be paid at direct supervisor's rate when supervisor NPI is included in the header of the claim. If the supervisor NPI is not included on the claim indicating the service is provided under general supervision, the service will be paid at 72.25% of maximum fee.

Table 1-1: Supervision for 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 HCPCS Codes

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

Practitioners requiring supervision must be supervised at all times, including supervisor sick days, trainings, vacations, etc. Each licensing board regulates supervision requirements for their provider types and may have specific requirements pertaining to supervisor coverage during absences. In the absence of board guidance on supervisor coverage, Ohio Medicaid does not require practitioners to be assigned to a specific supervisor, therefore, any qualified supervising practitioner permitted by the practitioner's

respective licensing board's OAC may provide coverage during absences but must assume all supervision responsibilities, including signing off on services provided.

The following websites contain further guidance on supervision:

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

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

Incident to Services

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

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

When a practitioner is permitted to bill for his/her time under the Medicaid State Plan (e.g., OLP or Rehab), it is the state's expectation that the practitioner will bill for his/her time under their own authority.

Collateral Contacts

A collateral contact as referred to in Ohio Administrative Code rules 5160-27-04 and 5160-27-08, occurs when the practitioner contacts individuals who play a significant role in a Medicaid recipient's life. The information gained from the collateral contact can provide insight into treatment OR basic psychoeducation provided to that collateral contact can assist with the treatment of the Medicaid recipient. Because activities related to services which Medicaid does not cover are not considered necessary for the administration of the Medicaid plan, the accompanying costs are not eligible for Medicaid.

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 from 21 to 99, two letters, or a mix (alphanumeric). Ohio Medicaid will accept modifiers in any order, however, modifier fields must be populated in order from one to four (the first modifier field must be populated before the second modifier field, etc.).

Effective for dates of service January 1, 2018 through June 30, 2018, practitioner modifiers are required when submitting claims to Ohio Medicaid rendered by the practitioner types in Table 1-3.

Table 1-3: Practitioner Modifiers

Practitioner Providing the Service:	Professional Abbreviation	Practitioner Modifier
Licensed professional counselor	LPC	U2*
Licensed chemical dependency counselor III	LCDC III	U3*
Licensed chemical dependency counselor II	LCDC II	U3*
Licensed social worker	LSW	U4*
Licensed marriage and family therapist	LMFT	U5*
Psychology assistant, intern, trainee	PSY assistant	U1*
Chemical dependency counselor assistant	CDC-A	U6*
Counselor trainee	C-T	U7*
Social worker assistant	SW-A	U8*
Social worker trainee	SW-T	U9*
Marriage and family therapist trainee	MFT-T	UA*
QMHS – high school	QMHS	HM
QMHS – Associate's	QMHS	HM
QMHS – Bachelor's	QMHS	HN
QMHS – Master's	QMHS	HO
QMHS – 3 years' experience	QMHS	UK
Care management specialist – high school	CMS	HM
Care management specialist – Associate's	CMS	HM
Care management specialist – Bachelor's	CMS	HN
Care management specialist – Master's	CMS	HO
Peer recovery supporter – high school	PRS	HM
Peer recovery supporter – Associate's	PRS	HM
Peer recovery supporter – Bachelor's	PRS	HN
Peer recovery supporter – Master's	PRS	HO

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

Procedure Modifiers

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

Table 1-4: Procedure Modifiers

Service Circumstance	Modifier
Group service	HQ
Physician, team member (ACT)	AM
CNP team member (ACT)	UC
PA or CNS, team member (ACT)	SA
Master's level, RN, LPN, team member (ACT)	HO
Bachelor's level, team member (ACT)	HN
Peer recovery supporter, team member (ACT)	HM
Pregnant/parenting women's program	HD
Complex/high tech level of care	TG
Cognitive Impairment	HI
Licensed practitioners providing TBS Group Hourly/Per Diem (day treatment) or SUD group counseling	HK
OTP Daily Administration	HF
OTP One Week Administration (2 – 7 Days)	TV
OTP Two Week Administration (8 – 14 Days)	UB
OTP Three Week Administration (15 – 21 Days)	TS
OTP Four Week Administration (22 – 28 Days)	HG
Significant, separately identifiable Evaluation & Management (E/M) service by physician or other qualified health professional on the same day of the procedure or other service	25
NCCI modifiers (See NCCI Section)	59, XS, XE, XU and XP
CLIA waived test- certificate of waiver – CMS certificate type code 2 or higher required	QW
Crisis modifier used on T1002, H2017 (PSR only, not LPN nursing service), H2019, H0004 and 90832	KX
Physician delivering SUD group counseling	AF
Secured video-conferencing or other allowable telehealth delivery methods in accordance with OAC 5160-1-18 (See code charts for allowable services)	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.

Services Delivered in an Inpatient or Outpatient Hospital Setting

If a provider wishes to provide services in an inpatient or outpatient hospital setting, they must contract with the hospital to receive reimbursement for those services, as the payment of these services is included in the payment to the facility, with the exception of services rendered in an emergency department where indicated in this manual as an allowable place of service.

"Other Place of Service" Setting

Place of service "99-Other Place of Service" has been redefined for Ohio Medicaid as Community. See Appendix for complete definition of this place of service.

Claims Detail Rollup for Same Day Services

When the same service(s) are provided to the same patient on the same day, claims need to be "rolled up" and submitted as one detail line even if the services are not provided continuously on the same day. The implementation of rendering practitioner NPI, supervisor NPI, and practitioner modifier (U modifier) requirements change the claims rolling process effective January 1, 2018. Services that need to be rolled must be rolled by the same date of service, same client, same HCPCS code, same modifier(s), same individual rendering practitioner NPI, same supervisor NPI, and same place of service.

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

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

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

Claims with practitioners who are not required to individually enroll in Medicaid are rolled at the same date of service, same supervisor NPI, same place of service, same practitioner and other modifier(s). For practitioner(s) not required to enroll in Medicaid, the rendering provider field must be left blank.

Example 2: Two different LSWs provide individual CPST to the same client on the same day under the same supervisor and at the same place of service (office) – those services must be rolled as they use the same practitioner modifier (U4) and the rendering provider field is blank. However, if a LSW and a LPC provide individual CPST to the same client on the same day, those services may be not be rolled because the practitioner NPIs are different.

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

Federal regulation 42 CFR 433.139 requires states to deny (cost avoid) Medicaid claims until after the application of available third party payor benefits since Medicaid is the payer of last resort. Effective January 1, 2018, where Medicare or private insurance coverage exists, payment must be sought from the

TPP before Medicaid is billed. Any payment received from a TPP must be reported on the claim or claims submitted to Ohio Medicaid. Note: A claim that has been submitted to a TPP using a CPT code cannot be recoded to a HCPCS code to bill Ohio Medicaid. Further information on coordination of benefits with Medicare or other third-party payers can be found in rules: OAC 5160-1-08 and 5160-1-05 and in MITS BITS on Medicare enrollment. MITS Bits can be found https://bh.medicaid.ohio.gov/Provider/Overview#55454-mits-bits. For Medicare enrollment information, review the February 2, 2016 and April 22, 2016 MITS Bits.

Benefits and Prior Authorization

A coverage and limitations workbook has been created to assist providers in understanding the redesigned behavioral health benefit from a coding, payment, practitioner, and coverage perspective. The workbook may be found at: http://bh.medicaid.ohio.gov/manuals. In the redesigned benefit package, there are services and/or levels of care that are subject to prior authorization. The table below summarizes those services/levels of care and their associated prior authorization policy.

Table 1-5: Prior Authorization

Description and Code	Benefit Period	Authorization Requirement
Assertive Community Treatment (ACT) H0040	Based on prior authorization approval	ACT must be prior authorized and all SUD services must be prior authorized for ACT enrollees.
Intensive Home Based Treatment (IHBT) H2015	Based on prior authorization approval	IHBT must be prior authorized.
SUD Partial Hospitalization H0015 TG	Calendar year	Prior authorization is required for this level of care for adults and adolescents.
Psychiatric Diagnostic Evaluations 90791, 90792	Calendar year	1 encounter per person per calendar year per code per billing agency for 90791 and 90792. Prior authorization once limit is reached.
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 once limit is reached.
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 once limit is reached.
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 once limit is reached.

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. Applies to first two stays; any stays after that would be subject to full prior authorization.
SUD Peer Recovery H0038	Calendar year	Up to 4 hours per day without prior authorization. Prior authorization would be needed to cover more than 4 hours in a day once limit is reached.
Any service or ASAM level of care not listed in this table is not subject to prior authorization.		

Prior Authorization

Fee for service prior authorization instructions are available on the ODM website - http://medicaid.ohio.gov/PROVIDERS/PriorAuthorizationRequirements.aspx. Information specific to behavioral health prior authorization is available at http://bh.medicaid.ohio.gov/training. For those enrolled in a MyCare Ohio plan, prior authorization requests must be submitted to the MyCare Ohio plan the person is enrolled in for dates of service beginning January 1, 2018.

Effective July 1, 2018, each managed care plan will be responsible for prior authorization for behavioral health services.

Medical Necessity

Requirements for medical necessity can be found at:

5160-1-01 Medicaid medical necessity: definitions and principles.

Non-Covered Services

Non-covered services are described in OAC 5160-1-61. Additionally, the following activity is not covered by Medicaid**:**

CFR 42 § 435.1009 Institutionalized individuals.

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

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

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

Fraud, Waste, Abuse and Errors

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

False Claim Act

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

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

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

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

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

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

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

Payment Error Rate Measurement (PERM)

The Payment Error Rate Measurement (PERM) program measures improper payments in Medicaid and CHIP to produce a national error rate for each program. The error rates are based on reviews of the fee-

for-service (FFS), data processing, and eligibility components of Medicaid and CHIP in the federal fiscal year (FFY) under review. PERM does not measure fraud; it determines the amount of claims paid in error based on our states policies and program requirements.

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

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

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

Medicaid National Correct Coding Initiative

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

NCCI essentially requires providers to use the appropriate code for the right service within their current scope of practice. In addition, third party insurers are billed first before either Medicare or Medicaid and pay their appropriate share ensuring the public programs are the payer of last resort.

NCCI procedure-to-procedure 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 E/M service on the same day to the same client (significant and separately identifiable services). NCCI will not allow the psychotherapy code 90834 to be billed with an E/M office visit code 99212, as there are separate add-on codes (+90833, +90836, and +90838) for psychotherapy services provided in conjunction with E/M services.

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

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

Medicaid PTP (including those that can be overridden by specific modifiers), MUE edits and other relevant information can be found at: https://www.medicaid.gov/medicaid/program-integrity/national-correct-coding-initiative-medicaid/index.html.

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

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

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

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

Medically Unlikely Edits (MUEs)

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

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

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

Time Based CPT Codes

When billing time-based codes the CPT/HCPCS time rule applies, unless otherwise specified:

For the minimum billable service of the code, divide the time by two and add one minute in order to determine if that code can be billed. For example; 90832 = 30 minutes, therefore the minimum length of service must be 16 minutes (30/2 = 15 then 15 + 1 = 16) in order for the service to be billable.

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

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

Prolonged services codes can only be billed if the total duration of all physician or qualified non-physician practitioner (NPP) direct face-to-face services (including the visit) equals or exceeds the threshold time for the evaluation and management service the physician or qualified NPP provided:

- Prolonged service of less than 31 minutes total duration on a given date is not separately reported because the work involved is included in the total work of the E/M code. There will be no additional payment in this instance.
- In the case of prolonged office services, time spent by office staff with the patient or time the patient remains unaccompanied in the office cannot be billed as a prolonged service.

Code	Typical Time for Code	Threshold Time to Bill Code 99354	Threshold Time to Bill Codes 99354 and 99355
99201*	10	41	86
99202	20	51	96
99203	30	61	106
99204	45	76	121
99205	60	91	136
99212	10	41	86
99213	15	46	91
99214	25	56	101
99215	40	71	116

*****CPT® code 99201 has been deleted effective January 1, 2021. For dates of service on or after January 1, 2021, providers should report appropriate E/M codes in accordance with AMA guidance.

Use 99417 in accordance with CPT guidance and use G2212 in accordance with CMS guidance. ODM is continuing to review additional changes to E/M coding for 2021 and may provide additional guidance as appropriate.

Missed Appointments

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

SECTION 2

Current Procedural Terminology (CPT Coded) Behavioral Health Services

For behavioral health billing, CPT service codes consist of E/M office visits, psychotherapy, psychiatric diagnostic evaluations, psychiatric testing and appropriate add-on codes. The American Medical Association (AMA) publishes annual CPT reference books, which provide the CPT l codes, their associated descriptions and guidance on appropriate use. Please note, providers are responsible for utilizing the appropriate AMA and/or CMS guidance for documentation and billing. Therefore, it is recommended that all providers obtain a copy of a current CPT manual and, for those providers/practitioners that participate in the Original Medicare program, the most current version of the Medicare Learning Network "Evaluation and Management Services" guide, the "1995 Documentation Guidelines for Evaluation and Management Services" and the "1997 Documentation Guidelines for Evaluation and Management Services" available through the Medicare Learning Network (MLN). Please note, you must use EITHER the 1995 or the 1997 MLN documentation guidelines; you cannot use both.

Practitioner abbreviations are used in the service charts provided in the remaining sections of this manual. The chart below may be used as a reference to these abbreviations:

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

Evaluation and Management Codes

Table 2-1: Evaluation & Management Office Visit

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate through July 31, 2019**	**Rate Effective August 1, 2019***
E/M New Patient	MD/DO	99201** 99202 99203 99204 99205	-	$49.38 $84.67 $122.93 $188.51 $236.92	$49.38 $84.67 $122.93 $188.51 $236.92
	CNS CNP PA	99201** 99202 99203 99204 99205	-	$41.97 $71.97 $104.49 $160.23 $201.38	$49.38 $84.67 $122.93 $188.51 $236.92
	RPH†	99202 99203	-	-	$33.09 $49.09
E/M Established Patient	MD/DO	99211 99212 99213 99214 99215	-	$22.31 $48.97 $82.85 $122.27 $165.15	$22.31 $48.97 $82.85 $122.27 $165.15
	CNS CNP PA	99211 99212 99213 99214 99215	-	$22.31 $41.62 $70.42 $103.93 $140.38	$22.31 $48.97 $82.85 $122.27 $165.15
	RN LPN	99211	-	$22.31 $22.31	$22.31 $22.31
	RPH†	99211 99212 99213	-	-	$12.32 $22.72 $37.06

Unit Value	Encounter	
Permitted POS	11, 13, 31, 32 MH also has 53 SUD also has 57	Telehealth allowed with GT modifier. GT modifier is required when service rendered via telehealth.

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

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

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

Table 2-2: Evaluation & Management Home Visit

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate through July 31, 2019**	**Rate Effective August 1, 2019***
E/M Home Visit New Patient	MD/DO	99341 99342 99343 99344 99345	-	$63.65 $91.90 $150.80 $210.78 $255.57	$63.65 $91.90 $150.80 $210.78 $255.57
	CNS CNP PA	99341 99342 99343 99344 99345	-	$54.10 $78.12 $128.18 $179.16 $217.23	$63.65 $91.90 $150.80 $210.78 $255.57
E/M Home Visit Established Patient	MD/DO	99347 99348 99349 99350	-	$64.00 $97.38 $148.16 $205.79	$64.00 $97.38 $148.16 $205.79
	CNS CNP PA	99347 99348 99349 99350	-	$54.40 $82.77 $125.94 $174.92	$64.00 $97.38 $148.16 $205.79
Unit Value	Encounter				
Permitted POS	04, 12, 16				

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

Table 2-3: Prolonged Visits

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

Prolonged Visit – Each Additional 30 Minutes	MD/DO	+99355	-	-	$89.24
	CNS CNP PA	+99355	-	-	$75.85
	PSY	+99355	-	-	$89.24
	LISW LIMFT LPCC LICDC (SUD only) Lic school PSY	+99355	-	-	$75.85
	LSW LMFT LPC LCDC III (SUD only) LCDC II (SUD only)	+99355	U4 U5 U2 U3 U3	-	$75.85
	PSY assistant	+99355	U1	-	Paid at direct supervisor rate when supervisor NPI on claim. Paid at 85% of maximum fee if supervisor NPI not included
	SW-T MFT-T C-T CDC-A (SUD only)	+99355	U9 UA U7 U6	-	Paid at direct supervisor rate when supervisor NPI on claim Paid at 72.25% of maximum fee if supervisor NPI not included

Prolonged Visit – Each Additional 15 Minutes beyond the total time of the primary procedure which has been selected using total time (for use with codes 99205 and 99215 only)	MD/DO	+99417	-	-	$22.48
	CNS CNP PA	+99417	-	-	$19.11
Prolonged Visit – Each Additional 15 Minutes beyond the total time of the primary procedure which has been selected using total time (for use with codes 99205 and 99215 only)	MD/DO	+G2212	-	-	$22.48
	CNS CNP PA	+G2212	-	-	$19.11
Unit Value	+99354 – first 60 minutes +99355 – 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 2-4: Psychiatric Diagnostic Evaluation

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate through July 31, 2019**	**Rate Effective August 1, 2019***
Psychiatric Diagnostic Evaluation w/o Medical	MD/DO PSY	90791	-	$130.72	$130.72
	CNS CNP PA	90791	-	$111.11	$130.72
	LISW LIMFT LPCC LICDC (SUD only) Lic school PSY	90791		$111.11	$111.11
	LSW LMFT LPC LCDC III (SUD only) LCDC II (SUD only)	90791	U4 U5 U2 U3 U3	$111.11	$111.11
	PSY assistant	90791	U1	Paid at direct supervisor rate when supervisor NPI on claim. Paid at 85% of maximum fee if supervisor NPI not included	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	90792	-	$144.35	$144.35
	CNS CNP PA	90792	-	$122.70	$144.35
Unit Value	Encounter				

Permitted POS	03, 04, 11, 12, 13, 14, 16, 18, 31, 32, 99 MH also has 53 SUD also has 57	Telehealth allowed with GT modifier. GT modifier is required when service rendered via telehealth.

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

Table 2-5 - Electrocardiogram

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

Table 2-6: Medications Administered by Medical Personnel

MH / SUD				
Service	**Medication**	**Code**	**Procedure Modifier**	**Rate**
Medication Administered by Medical Personnel (J-Codes)	Injection, aripiprazole (Abilify), intramuscular, 0.25 mg	J0400	None	See the Medicine, Surgery, Radiology And Imaging, And Additional Procedures (Non-Institutional Services) section on the Fee Schedule and Rates page of the ODM website.
	Injection, aripiprazole (Abilify), 1 mg	J0401	None	
	Diphenhydramine hcl (Benadryl), up to 50 mg	J1200	None	
	Haloperidol injection, up to 5 mg	J1630	None	
	Haloperidol Decanoate injection, per 50 mg	J1631	None	
	Lorazepam injection, 2 mg	J2060	None	
	Injection, naloxone (Narcan), 1 mg	J2310	None	
	Olanzapine long acting injectable, 1 mg	J2358	None	
	Fluphenazine Decanoate injection, 25 mg	J2680	None	
	Risperidone, long acting, .5 mg	J2794	None	
	Paliperidone Palmitate injection (Invega Sustenna or Invega Trinza), 1 mg	J2426	None	
	Valium injection, up to 5 mg	J3360	None	
	Cogentin (benztropine mesylate), per 1 mg	J0515	None	
	Injection, naltrexone (Vivitrol), depot form, 1 mg	J2315	None	
	Injection, methylnaltrexone (Relistor), 0.1 mg	J2212	None	
	Oral Naltrexone	J8499	HG	
	Buprenorphine, oral, 1 mg	J0571	None	
Unit Value	Based on HCPCS descriptor			
Permitted POS	03, 04, 11, 12, 14 MH also has 53 SUD also has 55, 57			

MH / SUD *					
Service	**Description**	**Provider Type**	**Code**	**Procedure Modifier**	**Rate**
Other Medication Administration	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	MD/DO CNS CNP PA RN/LPN RPH	96372	None	$21.39
Unit Value	CPT designation				
Permitted POS	03, 04, 11, 12, 14, 16, 18 MH also has 53 SUD also has 57				

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

National Drug Code (NDC)

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

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

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

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

Laboratory Services

Table 2-7: Laboratory Services

MH / SUD				
Service	**Service**	**Code**	**Procedure Modifier**	**Rate**
Laboratory Services	Skin test; tuberculosis, intradermal	86580	-	See 5160-1-60 Appendix DD
	Collection of venous blood by venipuncture	36415	-	
	Alcohol (ethanol), breath	82075	-	
	Urine pregnancy test	81025	QW	
Unit Value	CPT designation			
Permitted POS	03, 04, 11, 12, 14 MH also has 53 SUD also has 55, 57			
Other Considerations	Code 36415 collection of venous blood by venipuncture may be billed for blood draws associated with covered external lab services.			

Laboratory Codes

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

How to Activate the Lab Contract

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

CLIA Certification Overview

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

offices. The program monitors the performance of approximately 8,500 laboratories and investigates clinical laboratory complaints it receives.

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

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

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

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

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

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

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

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

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

Vaccines

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

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

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

Table 2-8 Covered Vaccines for Behavioral Health Providers

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

90698	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Haemophilus influenza type b, and inactivated poliovirus vaccine (DTaP-IPV/Hib), for intramuscular use
90654	Influenza virus vaccine, trivalent (IIV3), split virus, preservative-free, for intradermal use
90658	Vaccine for influenza for administration into muscle, 0.5 ml dosage
90660	Influenza virus vaccine, trivalent, live (LAIV3), for intranasal use
90670	Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use
90680	Rotavirus vaccine, pentavalent (RV5), 3 dose schedule, live, for oral use
90681	Rotavirus vaccine, human, attenuated (RV1), 2 dose schedule, live, for oral use
90696	Diphtheria, tetanus toxoids, acellular pertussis vaccine and inactivated poliovirus vaccine (DTaP-IPV), when administered to children 4 through 6 years of age, for intramuscular use
90713	Poliovirus vaccine, inactivated (IPV), for subcutaneous or intramuscular use
90707	Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use
90710	Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use
90714	Tetanus and diphtheria toxoids adsorbed (Td), preservative free, when administered to individuals 7 years or older, for intramuscular use
Vaccine CPT	**Description**
90715	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use
90716	Varicella virus vaccine (VAR), live, for subcutaneous use
90736	Shingles vaccine (HZV), live, for subcutaneous injection (individuals 60+ years old)
90732	Pneumococcal polysaccharide vaccine, 23-valent (PPSV23), adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use
90733	Meningococcal polysaccharide vaccine, serogroups A, C, Y, W-135, quadrivalent (MPSV4), for subcutaneous use
90734	Vaccine for meningococcus for administration into muscle
90740	Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, 3 dose schedule, for intramuscular use
90746	Hepatitis B vaccine (HepB), adult dosage, 3 dose schedule, for intramuscular use
90747	Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, 4 dose schedule, for intramuscular use
For rates, see the Medicine, Surgery, Radiology And Imaging, And Additional Procedures (Non-Institutional Services) section on the Fee Schedule and Rates page of the ODM website.	

COVID-19 Vaccine Services			
Manufacturer	**Procedure Code**	**Description**	**Payment Rate**
Pfizer* For individuals 16 and older	91300	Vaccine	$0.01
	0001A	Administration of first dose	$16.94
	0002A	Administration of second dose	$28.39
Moderna* For individuals 18 and older	91301	Vaccine	$0.01
	0011A	Administration of first dose	$16.94
	0012A	Administration of second dose	$28.39
Janssen (Johnson & Johnson)* For individuals 18 and older	91303	Vaccine	$0.01
	0031A	Administration of vaccine	$28.39

*Pfizer effective 12/11/2020; Moderna effective 12/18/2020; Janssen effective 2/27/2021

Vaccines for Children (VFC) Eligibility Criteria

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

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

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

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

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

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

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

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

Further VFC resources, including enrollment with the Ohio Department of Health can be found at:
https://odh.ohio.gov/wps/portal/gov/odh/home
http://www.cdc.gov/vaccines/programs/vfc/providers/index.html

Vaccines for Adults

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

SECTION 3

PSYCHOTHERAPY SERVICES

Table 3-1: Psychotherapy for Crisis

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate through July 31, 2019**	**Rate Effective August 1, 2019***
Psychotherapy for Crisis – first 60 minutes	MD/DO PSY	90839	-	$132.08	$171.70
	CNS CNP PA LISW LIMFT LPCC LICDC (SUD only) Lic school PSY	90839	-	$112.27	$145.95
	LSW LMFT LPC LCDC III (SUD only) LCDC II (SUD only)	90839	U4 U5 U2 U3 U3	$112.27	$145.95
	PSY assistant	90839	U1	Paid at direct supervisor rate when supervisor NPI on claim. Paid at 85% of maximum fee if supervisor NPI not included	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

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate through July 31, 2019**	**Rate Effective August 1, 2019***
Psychotherapy for Crisis – add'l 30 minutes	MD/DO PSY	+90840	-	$63.04	$81.95
	CNS CNP PA LISW LIMFT LPCC LICDC (SUD only) Lic school PSY	+90840	-	$53.58	$69.65
	LSW LMFT LPC LCDC III (SUD only) LCDC II (SUD only)	+90840	U4 U5 U2 U3 U3	$53.58	$69.65
	PSY assistant	+90840	U1	Paid at direct supervisor rate when supervisor NPI on claim. Paid at 85% of maximum fee if supervisor NPI not included	Paid at direct supervisor rate when supervisor NPI on claim. Paid at 85% of maximum fee if supervisor NPI not included
	SW-T MFT-T CDC-A (SUD only) C-T	+90840	U9 UA U6 U7	Paid at direct supervisor rate when supervisor NPI on claim Paid at 72.25% of maximum fee if supervisor NPI not included	Paid at direct supervisor rate when supervisor NPI on claim Paid at 72.25% of maximum fee if supervisor NPI not included
Unit Value	90839: 1 which represents first 60 minutes +90840: 1 which represents each additional 30 minutes				
Permitted POS	01, 03, 04, 11, 12, 13, 14, 15, 16, 17, 18, 20, 23, 24, 25, 31, 32, 33, 34, 41, 42, 99 MH also has 53 SUD also has 57		Telehealth allowed with GT modifier for dates of service on and after March 9, 2020. GT modifier is required when service rendered via telehealth.		

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

Table 3-2: Individual Psychotherapy

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

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

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate**	**Rate with KX Modifier Only***
	PSY assistant	90837	U1	Paid at direct supervisor rate when supervisor NPI on claim. Paid at 85% of maximum fee if supervisor NPI not included	-
	SW-T MFT-T CDC-A (SUD only) C-T	90837	U9 UA U6 U7	Paid at direct supervisor rate when supervisor NPI on claim Paid at 72.25% of maximum fee if supervisor NPI not included	-
Individual Psychotherapy w/ E/M Service	MD/DO	+90833 +90836 +90838	-	$65.37 $83.03 $109.53	-
	CNS CNP PA	+90833 +90836 +90838	-	$55.56 $70.58 $93.10	-
Unit Value	1 which represents encounter				
Permitted POS	03, 04, 11, 12, 13, 14, 16, 18, 31, 32, 34, 99 MH also has 53 SUD also has 57 For 90832 KX – POS 23 is also available			Telehealth allowed with GT modifier. 90832 KX telehealth allowed with GT modifier for dates of service on or after March 9, 2020. GT modifier is required when service rendered via telehealth.	
Crisis psychotherapy of 16 to 30 minutes	Add KX modifier to 90832 to indicate when service is crisis psychotherapy between 16 and 30 minutes, as allowable within the practitioner's scope of practice. For crisis psychotherapy of 31 or more minutes, please use crisis psychotherapy coding above.				

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

Table 3-3: Family Psychotherapy

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

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
	LSW LMFT LPC LCDC III (SUD only) LCDC II (SUD only)	90847	U4 U5 U2 U3 U3	-	$85.61
	PSY assistant	90847	U1	-	Paid at direct supervisor rate when supervisor NPI on claim. Paid at 85% of maximum fee if supervisor NPI not included
	SW trainee MFT trainee CDC-A (SUD only) C-T	90847	U9 UA U6 U7	-	Paid at direct supervisor rate when supervisor NPI on claim Paid at 72.25% of maximum fee if supervisor NPI not included
Multiple-family group psychotherapy	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate through July 31, 2019**	**Rate Effective August 1, 2019***
	MD/DO PSY	90849	-	$31.28 per patient	$40.66
	CNS CNP PA LISW LIMFT LPCC LICDC (SUD only) Lic school PSY	90849	-	$26.59	$34.57
	LSW LMFT LPC LCDC III (SUD only) LCDC II (SUD only)	90849	U4 U5 U2 U3 U3	$26.59	$34.57

MH / SUD					
	Provider Type	**Code**	**Practitioner Modifier**	**Rate through July 31, 2019**	**Rate Effective August 1, 2019***
	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.		

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

Table 3-4: Group Psychotherapy

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate through July 31, 2019**	**Rate Effective August 1, 2019***
Group Psychotherapy (not multi-family group)	MD/DO PSY	90853	-	$25.45	$33.09
	CNS CNP PA LISW LIMFT LPCC LICDC (SUD only) Lic school PSY	90853	-	$21.63	$28.12
	LSW LMFT LPC LCDC III (SUD only) LCDC II (SUD only)	90853	U4 U5 U2 U3 U3	$21.63	$28.12
	PSY assistant	90853	U1	Paid at direct supervisor rate when supervisor NPI on claim. Paid at 85% of maximum fee if supervisor NPI not included	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.		

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

Interactive Complexity

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

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

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

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

Interactive complexity is often present with patients who:

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

The following examples are NOT interactive complexity:

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

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

Table 3-5: Interactive Complexity

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

Psychological Testing

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

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

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

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

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

Other Psychological Testing Codes

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

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

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

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

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

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

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

Table 3-6: Psychological Testing through December 31, 2018

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
Psychological Testing – through 12-31-2018	MD/DO PSY PA CNS CNP LISW LIMFT LPCC Lic school PSY	96101	-	-	$59.26
	LSW LMFT LPC PSY assistant	96101	U4 U5 U2 U1	-	$59.26

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
	SW-T MFT-T C-T	96101	U9 UA U7	-	$59.26
Developmental Testing – through 12-31-2018	MD/DO PSY CNS CNP LISW LIMFT LPCC Lic school PSY	96111	-	-	$56.11
	LSW LMFT LPC PSY assistant	96111	U4 U5 U2 U1	-	$56.11
	SW-T MFT-T C-T	96111	U9 UA U7	-	$56.11
Neurobehavioral Status Exam – through 12-31-2018	MD/DO PA PSY CNS CNP	96116	-	-	$64.10
	PSY assistant	96116	U1	-	$64.10

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
Neuropsychological Testing – through 12-31-2018	MD/DO PA PSY CNS CNP	96118	-	-	$78.31
	PSY assistant	96118	U1	-	$78.31
Unit Value	96111: 1 which represents an encounter 96101, 96116, 96118: per hour				
Permitted POS	03, 04, 11, 12, 13, 14, 16, 31, 53, 57		Secure video conferencing allowed with GT modifier.		

Table 3-6.1: Psychological Testing Effective January 1, 2019

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
Psychological Testing Administration – Effective January 1, 2019	MD/DO PSY PA CNS CNP LISW LIMFT LPCC Lic school PSY	96136	-	-	$30.86
	LSW LMFT LPC PSY assistant	96136	U4 U5 U2 U1	-	$30.86
	SW-T MFT-T C-T	96136	U9 UA U7	-	$30.86
	MD/DO PSY PA CNS CNP LISW LIMFT LPCC Lic school PSY	96137	-	-	$28.39

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
	LSW LMFT LPC PSY assistant	96137	U4 U5 U2 U1	-	$28.39
	SW-T MFT-T C-T	96137	U9 UA U7	-	$28.39
Psychological Testing Evaluation – Effective January 1, 2019	MD/DO PSY PA CNS CNP LISW LIMFT LPCC Lic school PSY	96130	-	-	$59.26
	LSW LMFT LPC PSY assistant	96130	U4 U5 U2 U1	-	$59.26
	SW-T MFT-T C-T	96130	U9 UA U7	-	$59.26
	MD/DO PSY PA CNS CNP LISW LIMFT	96131	-	-	$59.26

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
	LPCC Lic school PSY				
	LSW LMFT LPC PSY assistant	96131	U4 U5 U2 U1	-	$59.26
	SW-T MFT-T C-T	96131	U9 UA U7	-	$59.26
Developmental Testing – Effective January 1, 2019	MD/DO PSY CNS CNP LISW LIMFT LPCC Lic school PSY	96112	-	-	$56.11
	LSW LMFT LPC PSY assistant	96112	U4 U5 U2 U1	-	$56.11
	SW-T MFT-T C-T	96112	U9 UA U7	-	$56.11
	MD/DO PSY CNS CNP LISW LIMFT LPCC Lic school PSY	96113	-	-	$28.06

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
	LSW LMFT LPC PSY assistant	96113	U4 U5 U2 U1	-	$28.06
	SW-T MFT-T C-T	96113	U9 UA U7	-	$28.06
Neurobehavioral Status Exam – Effective January 1, 2019	MD/DO PA PSY CNS CNP	96116	-	-	$64.10
	PSY assistant	96116	U1	-	$64.10
	MD/DO PA PSY CNS CNP	96121	-	-	$64.10
	PSY assistant	96121	U1	-	$64.10

MH / SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
Neuropsychological Testing Administration	MD/DO PA PSY CNS CNP	96136	-	-	$30.86
	PSY assistant	96136	U1	-	$30.86
	MD/DO PA PSY CNS CNP	96137	-	-	$28.39
	PSY assistant	96137	U1	-	$28.39
Neuropsychological Testing Evaluation	MD/DO PA PSY CNS CNP	96132	-	-	$97.37
	PSY assistant	96132	U1	-	$97.37
	MD/DO PA PSY CNS CNP	96133	-	-	$78.31
	PSY assistant	96133	U1	-	$78.31
Unit Value					

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

Table 3-6.5: Smoking Cessation

MH / SUD				
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate Effective August 1, 2019***
Smoking and Tobacco Use Cessation Counseling – Intermediate: Greater than 3 minutes and up to 10 minutes	MD/DO PSY	99406	-	$9.43
	CNS CNP PA	99406	-	$9.43
	LISW LIMFT LPCC LICDC (SUD only) Lic school PSY	99406	-	$8.02
	LSW LMFT LPC LCDC III (SUD only) LCDC II (SUD only)	99406	U4 U5 U2 U3 U3	$8.02
	PSY assistant	99406	U1	Paid at direct supervisor rate when supervisor NPI on claim. Paid at 85% of maximum fee if supervisor NPI not included
	SW-T MFT-T	99406	U9 UA	Paid at direct supervisor rate when supervisor NPI on claim

	CDC-A (SUD only) C-T		U6 U7	Paid at 72.25% of maximum fee if supervisor NPI not included
Smoking and Tobacco Use Cessation Counseling – Intensive: Greater than 10 minutes	MD/DO PSY	99407	-	$19.00
	CNS CNP PA	99407	-	$19.00
	LISW LIMFT LPCC LICDC (SUD only) Lic school PSY	99407	-	$16.15
	LSW LMFT LPC LCDC III (SUD only) LCDC II (SUD only)	99407	U4 U5 U2 U3 U3	$16.15
	PSY assistant	99407	U1	Paid at direct supervisor rate when supervisor NPI on claim. Paid at 85% of maximum fee if supervisor NPI not included
	SW-T MFT-T CDC-A (SUD only) C-T	99407	U9 UA U6 U7	Paid at direct supervisor rate when supervisor NPI on claim Paid at 72.25% of maximum fee if supervisor NPI not included
Unit Value	1 which represents an encounter			
Permitted POS	03, 04, 11, 12, 13, 14, 16, 18, 31, 32, 34, 99 MH also has 53 SUD also has 57		Telehealth allowed with GT modifier. GT modifier is required when service rendered via telehealth.	

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

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

Table 3-7: Therapeutic Behavioral Services (TBS)

MH					
Service Code	**Provider Type**	**Code**	**Modifiers**	**Rate**	**Rate with KX Modifier Only***
Individual Therapeutic Behavioral Services (TBS) – 15 minutes	MD/DO CNS CNP PA PSY LISW LIMFT LPCC Lic school PSY	H2019	-	$22.47 in office $28.59 in community	$29.21 in office $37.17 in community
	LSW LMFT LPC	H2019	U4 U5 U2	$22.47 $28.59	$29.21 $37.17
	PSY assistant (Master's)	H2019	U1 and HO	$22.47 $28.59	$29.21 $37.17
	SW-T (Master's)	H2019	U9 and HO	$22.47 $28.59	$29.21 $37.17
	SW-T (Bachelor's)	H2019	U9 and HN	$19.96 $25.46	$25.95 $33.10
	SW-A (Master's)	H2019	U8 and HO	$22.47 $28.59	$29.21 $37.17
	SW-A (Bachelor's)	H2019	U8 and HN	$19.96 $25.46	$25.95 $33.10
	MFT-T (Master's)	H2019	UA and HO	$22.47 $28.59	$29.21 $37.17
	MFT trainee (Bachelor's)	H2019	UA and HN	$19.96 $25.46	$25.95 $33.10
	C-T (Master's)	H2019	U7 and HO	$22.47 $28.59	$29.21 $37.17
	C-T (Bachelor's)	H2019	U7 and HN	$19.96 $25.46	$25.95 $33.10
	QMHS (Bachelor's)	H2019	HN	$19.96 $25.46	$25.95 $33.10
	QMHS (Master's)	H2019	HO	$22.47 $28.59	$29.21 $37.17
	QMHS (3 yrs+ Exp.)	H2019	UK	$19.96 $25.46	$25.95 $33.10

Service Code	Provider Type	Code	Modifiers	Rate through July 31, 2019	Rate Effective August 1, 2019*
Group Therapeutic Behavioral Services (TBS) – 15 minutes	MD/DO CNS CNP PA PSY LISW LIMFT LPCC Lic school PSY	H2019	HQ	-	$8.99
	LSW LMFT LPC	H2019	U2, U4, or U5 and HQ	-	$8.99
	PSY assistant (Master's)	H2019	U1, HO HQ	$5.62	$7.31
	SW-T (Master's)	H2019	U9, HO HQ	$5.62	$7.31
	SW-T (Bachelor's)	H2019	U9, HN HQ	$4.99	$6.49
	SW-A (Master's)	H2019	U8, HO HQ	$5.62	$7.31
	PSY assistant (Bachelor's)	H2019	U1, HN, HQ	$4.99	$6.49
	SW-A (Bachelor's)	H2019	U8, HN HQ	$4.99	$6.49
	MFT-T (Master's)	H2019	UA, HO HQ	$5.62	$7.31
	MFT-T (Bachelor's)	H2019	UA, HN HQ	$4.99	$6.49
	C-T (Master's)	H2019	U7, HO HQ	$5.62	$7.31
	C-T (Bachelor's)	H2019	U7, HN HQ	$4.99	$6.49
	QMHS (Bachelor's)	H2019	HN HQ	$4.99	$6.49
	QMHS (Master's)	H2019	HO HQ	$5.62	$7.31
	QMHS (3 yrs+ Exp.)	H2019	UK HQ	$4.99	$6.49
Unit Value	15 minutes				
Permitted POS	Individual TBS – 03, 04, 11, 12, 13, 14, 16, 18, 23, 31, 32, 34, 53, 99			Telehealth allowed with GT modifier for dates of service on and after March 9, 2020.	

	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.	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.	

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

Table 3-8: RN and LPN Nursing Services

MH					
Service	**Provider Type**	**Code**	**Procedure Modifier**	**Rate through July 31, 2019**	**Rate Effective August 1, 2019***
Nursing Services – Individual	RN	H2019	-	$31.92 – provided in the office $41.00 – provided in the community	$31.92 – provided in the office $41.00 – provided in the community
	LPN	H2017	-	$22.54 $29.13	$22.54 $29.13
Nursing Services – Group	RN	H2019	HQ	7.98	$10.37
Unit Value	15 minutes				
Permitted POS	Individual RN/LPN nursing services - 03, 04, 11, 12, 13, 14, 16, 18, 31, 32, 34, 53, 99 Group RN nursing services – 11, 53 For H2019 KX – POS 23 is also available			Telehealth allowed with GT modifier for dates of service on and after March 9, 2020. GT modifier is required when service rendered via telehealth.	
RN nursing service to address a crisis	Add KX modifier to indicate RN nursing service provided when a patient is experiencing a crisis, as allowable within the practitioner's scope of practice. KX is not allowable with group RN nursing services (HQ modifier).				

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

Table 3-9: TBS Group Service-Hourly and Per Diem (Day Treatment)

MH					
Service Code	**Provider Type**	**Code**	**Modifiers**	**Rate through July 31, 2019**	**Rate Effective August 1, 2019***
TBS Group Service (Day Treatment) per hour up to two hours – Group	PSY	H2012	HK HQ	$28.10	$36.53
	LISW LIMFT LPCC Lic school PSY	H2012	HK HQ	$28.10	$36.53
	LSW LMFT LPC	H2012	U4, HK, HQ U5, HK, HQ U2, HK, HQ	$28.10	$36.53
	PSY assistant (Master's) SW-T (Master's) SW-A (Master's) MFT-T (Masters) C-T (Master's) QMHS (Master's)	H2012	U1, HO, HQ U9, HO, HQ U8, HO, HQ UA, HO, HQ U7, HO, HQ HO, HQ	$21.05	$27.37
	PSY asst (Bachelor's) SW-T (Bachelor's) SW-A (Bachelor's) MFT-T (Bachelor's) C-T (Bachelor's) QMHS (Bachelor's)	H2012	U1, HN, HQ U9, HN, HQ U8, HN, HQ UA, HN, HQ U7, HN, HQ HN, HQ	$18.54	$24.10
	QMHS 3 yrs +	H2012	UK, HQ	$18.54	$24.10
TBS Group Service (Day Treatment) per diem	**Provider Type**	**Code**	**Modifiers**	**Rate through July 31, 2019**	**Rate Effective August 1, 2019***
	PSY	H2020	HK	$140.51	$182.66
	LISW LIMFT LPCC Lic school PSY	H2020	HK	$140.51	$182.66
	LSW LMFT LPC	H2020	U4 and HK U5 and HK U2 and HK	$140.51	$182.66
	PSY assistant (Master's) SW-T (Master's) SW-A (Master's) MFT-T (Master's) C-T (Master's) QMHS (Master's)	H2020	U1 and HO U9 and HO U8 and HO UA and HO U7 and HO HO	$117.05	$152.17
	PSY asst(Bachelor's) SW-T (Bachelor's) SW-A (Bachelor's) MFT-T (Bachelor's)	H2020	U1 and HN U9 and HN U8 and HN UA and HN	$104.55	$135.92

	C-T (Bachelor's) QMHS (Bachelor's)		U7 and HN HN		
	QMHS 3 yrs +	H2020	UK	$104.55	$135.92
Unit Value	H2012: Hourly, maximum of 2 per day H2020: Per diem				
Permitted POS	03, 04, 11, 14, 53		Telehealth allowed with GT modifier for dates of service on and after March 9, 2020. GT modifier is required when service rendered via telehealth.		

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

Table 3-10: Psychosocial Rehabilitation (PSR)

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

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

Table 3-11: Screening, Brief Intervention and Referral to Treatment

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

Table 3-12: Community Psychiatric Supportive Treatment (CPST)

MH					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
Community Psychiatric Supportive Treatment – Individual	MD/DO	H0036	-	-	$19.54
	CNS CNP PA PSY	H0036	-	-	$19.54
	LISW LIMFT LPCC Lic school PSY	H0036	-	-	$19.54
	LSW LMFT LPC	H0036	U4 U5 U2	-	$19.54
	PSY assistant SW-T SW-A MFT-T C-T	H0036	U1 U9 U8 UA U7	-	$19.54
	QMHS (3 yrs+ Exp.) QMHS (high school) QMHS (Associate's) QMHS (Bachelor's) QMHS (Master's)	H0036	UK HM HM HN HO	-	$19.54
Community Psychiatric Supportive Treatment – Group	MD/DO	H0036	-	HQ	$8.99
	CNS CNP PA PSY	H0036	-	HQ	$8.99
	LISW LIMFT LPCC Lic school PSY	H0036	-	HQ	$8.99
	LSW LMFT LPC	H0036	U4 U5 U2	HQ	$8.99
	PSY assistant SW-T SW-A MFT-T C-T	H0036	U1 U9 U8 UA U7	HQ	$8.99
	QMHS (3 yrs+ Exp.) QMHS (high school) QMHS (Associate's) QMHS (Bachelor's) QMHS (Master's)	H0036	UK HM HM HN HO	HQ	$8.99
Unit Value	15 minutes				

MH					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
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.			

Table 3-13: Behavioral Health Counseling *

MH					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
Behavioral Health Counseling	LSW LMFT LPC	H0004	U4 U5 U2	-	$22.50
	LSW LMFT LPC	H0004	U4 U5 U2	HQ	$9.87
Unit Value	15 minutes				
Permitted POS	03, 04, 11, 12, 13, 14, 16, 18, 31, 32, 34, 53, 99 H0004 KX – 23 also available				
Behavioral Health 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. KX is not allowable with group behavioral health counseling (HQ modifier).				

***This code will only be available until June 30, 2018. For individual and group counseling services provided on and after July 1, 2018, these practitioners will need to use CPT individual and group psychotherapy codes.**

Assertive Community Treatment (ACT)

Table 3-14: Assertive Community Treatment (ACT)

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

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

Intensive Home Based Treatment (IHBT)

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

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

SECTION 4

Substance Use Disorder (SUD) COVERAGE

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

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

Table 4-1: SUD Assessment

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

Table 4-2: SUD Peer Recovery Support

SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
SUD Individual Peer Recovery Support	PRS	H0038	HM, HN, HO	-	$15.51
SUD Group Peer Recovery Support	PRS	H0038	HM, HN, HO	HQ	$1.94
Unit Value	15 minutes				

Permitted POS	03, 04, 11, 12, 13, 14, 16, 18, 23, 31, 32, 33, 34, 53, 57, 99	Telehealth allowed with GT modifier for dates of service on and after March 9, 2020. GT modifier is required when service rendered via telehealth.

Table 4-3: Individual Counseling

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

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

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

Table 4-4: Group Counseling

SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Rate through July 31, 2019**	**Rate Effective August 1, 2019***
Group Counseling	MD/ DO	H0005	AF	$8.48	$11.02
	CNS CNP PA PSY LISW LIMFT	H0005	HK	$7.21	$9.37

	LPCC LICDC				
	LSW LMFT LPC LCDC III, LCDC II	H0005	U4 and HK U5 and HK U2 and HK U3 and HK	$7.21	$9.37
	PSY assistant	H0005	U1	$6.44	$8.37
	SW-T	H0005	U9	$6.44	$8.37
	MFT-T	H0005	UA	$6.44	$8.37
	CDC-A	H0005	U6	$6.44	$8.37
	C-T	H0005	U7	$6.44	$8.37
Unit Value	15 minutes				
Permitted POS	03, 04, 11, 12, 13, 14, 16, 31, 32, 34, 57 and 99**		Telehealth allowed with GT modifier. GT modifier is required when service rendered via telehealth.		

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

**POS 99 effective for dates of service 11-28-2019 and after.

Table 4-5: SUD Case Management

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

Table 4-6: SUD Urine Drug Screening

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

Table 4-7: SUD RN and LPN Nursing Services

SUD					
Service	**Provider Type**	**Code**	**Modifier**	**Rate through July 31, 2019**	**Rate Effective August 1, 2019***
Nursing Services – Individual	RN	T1002	-	$31.92 – provided in the office $41.00 – provided in the community	$31.92 – provided in the office $41.00 – provided in the community
	LPN	T1003	-	$22.54 $29.13	$22.54 $29.13
Nursing Services – Group	RN	T1002	HQ	$7.98	$10.37
Unit Value	15 minutes				
Permitted POS	Individual RN/LPN nursing services - 03, 04, 11, 12, 13, 14, 16, 18, 31, 32, 33, 34, 57, 99 Group RN nursing services – 11 and 57 For T1002 KX – POS 23 is also available			Telehealth allowed with GT modifier for dates of service on and after March 9, 2020. GT modifier is required when service rendered via telehealth.	
RN nursing service to address a crisis	Add KX modifier to indicate RN nursing service provided when a patient is experiencing a crisis, as allowable within the practitioner's scope of practice. KX is not allowable with group RN nursing services (HQ modifier).				

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

SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
Group Counseling IOP Level of Care*	MD/DO CNS CNP PA PSY	H0015	HK	-	$149.88
	LISW LIMFT LPCC LICDC	H0015	HK	-	$149.88
	LSW LMFT LPC LCDC III, LCDC II	H0015	U4, HK U5, HK U2, HK U3, HK	-	$149.88
	PSY assistant SW-T MFT-T CDC-A C-T	H0015	U1 U9 UA U6 U7	-	$103.04

Unit Value	Per diem. IOP group counseling must be provided to a client for a minimum length of 2 hours and 1 minute.	
Permitted POS	03, 04, 11, 14, 16, 57	Telehealth allowed with GT modifier for dates of service on and after March 9, 2020. GT modifier is required when service rendered via telehealth.

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

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

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

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

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

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

SECTION 5

SUD Residential Treatment

A major component of the behavioral health redesign project specific to substance use disorder (SUD) treatment is the implementation of discrete coverage of SUD residential treatment using a per diem payment methodology. In order to assure SUD residential treatment programs are able to bill the correct health care common procedure codes (HCPCS) in this section for SUD residential treatment, the Medicaid Information Technology System (MITS) has been updated to include a new provider specialty "954 – SUD RESIDENTIAL FACILITY" for provider type "95 – OMHAS CERTIFIED/LICENSED TREATMENT PROGRAM". It is important to keep in mind that only provider types 95 with provider specialty 954 will be able to bill using the SUD residential treatment benefit package.

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

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

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

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

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

Clinically Managed Low-Intensity Residential Treatment ASAM 3.1	Agency	H2034	NPI of rendering practitioner overseeing treatment in rendering field	-	$152.57
Unit Value	Per diem				
Permitted POS	55			Telehealth allowed with GT modifier for dates of service on and after March 9, 2020. GT modifier is required when service rendered via telehealth.	

Table 5-3: Clinically Managed Residential Withdrawal Management

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

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

SUD					
Service	**Provider Type**	**Code**	**Practitioner Modifier**	**Procedure Modifier**	**Rate**
Clinically Managed Population-Specific High Intensity Residential Treatment ASAM 3.3 (Adults)	Agency	H2036	NPI of rendering practitioner overseeing treatment in rendering field	HI	$213.70
Unit Value	Per diem				
Permitted POS	55			Telehealth allowed with GT modifier for dates of service on and after March 9, 2020.	

		GT modifier is required when service rendered via telehealth.

Table 5-5: Clinically Managed High Intensity Residential Treatment

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

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

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

Table 5-7: Medically Monitored Inpatient Withdrawal Management

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

SECTION 6

Opioid Treatment Programs (OTPs)

The Ohio Medicaid program provides a specialized benefit to those receiving opioid treatment through a select SUD provider specialty network (provider type 95 with provider specialty 951 and/or 953). Please see the Ohio Department of Medicaid Opioid Treatment Programs manual located here: https://bh.medicaid.ohio.gov/manuals for additional information on the OTP benefit.

SECTION 7

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

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

Glossary of Terms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix: Ohio Medicaid List of Place of Service Codes

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

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

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

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

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