Mississippi Department of Mental Health

Supporting a Better Tomorrow...One Person at a Time

Provider Service and Billing Manual

Mississippi Department of Mental Health
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Revisions and Updates:

Date	Author	Description of Change
9/22/2022	Dylan McKinion	Updated Services and Rates
2/25/2021	Denise Jones	Added Service Rates for Medication and Physician
1/14/2021	Denise Jones	Additional Information added for rate changes
12/30/2020	Denise Jones	WITS Service Rates modified to reflect the "Fee" amount on the Medicaid rates. Added rates for Substance Use IOP
12/11/2020	Denise Jones	Service Rates have been changed to reflect current Medicaid rates
11/24/2020	Denise Jones	New service added for MERC grant for Incentives
11/11/2020	Denise Jones	New Services added. Incentives and Survey Administration for SOR clients
9/30/2020	Denise Jones	Corrected Vocational Rehabilitation Rates
9/18/2020	Denise Jones	Changes made to Procedure code per Medicaid changes
9/1/2020	Denise Jones	Add service rates for Pregnant and Parenting Residential
8/10/2020	Denise Jones	Pre-Evaluation Screening
8/10/2020	Denise Jones	New Bed Hold Service for Withdrawal Management 4
7/24/2020	Denise Jones	Update rates via Medicaid Rates updated
7/23/2020	Denise Jones	Procedure Code changes to a length of 5
7/21/2020	Denise Jones	Bed Hold Service and Service Rate
7/2/2020	Denise Jones	Crisis Residential Procedure Code changed to T2048
6/23/2020	Denise Jones	Crisis Residential Rate increased to 504.62

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INTRODUCTION

This Provider Contract and Billing Manual is intended to function as a companion to the Mississippi Department of Mental Health Service Provider's Manual. It serves to define billable services, eligible staff (where appropriate), reporting codes, units, unit rates, restrictions (if any), and other conditions of billing the service.

While it is recognized that involvement of family members in the rehabilitation of patients with mental health and substance use disorders may be necessary and appropriate, provision of services where the family is involved must be clearly directed to meeting the identified patient's needs. Services provided to non-Medicaid eligible family members, independent of meeting the identified patient's needs, are not covered by Medicaid.

All billing inquiries should reference the funding source. Questions concerning Medicaid billing should reference the Medicaid Guidelines issued by the Division of Medicaid, Office of the Governor.

Questions relative to this manual should be directed to the Mississippi Department of Mental Health.

ASSESSMENTS

An assessment is a structured interview process that functions to evaluate a patient's present level of functioning and/or presenting needs. The assessment is used to establish additional or modify existing diagnoses, establish new or additional rehabilitation service goals, assess progress toward goals, and/or to determine the need for continued care, transfer, or discharge.

BRIEF BEHAVIORAL HEALTH ASSESSMENT (SCREENING)

Definition:
Brief emotional behavioral assessment (e.g., depression inventory), with scoring and documentation, per standardized instrument. This is not part of the same as providing Screening, Brief Intervention, and Referral to Treatment (SBIRT) services, which is a more comprehensive service.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
96127	Brief Behavioral Health Assessment (Screening) (SBIRT)	1	$4.57

Reporting Unit: 1 assessment

Maximum Billable Unit(s): Limited to 2 service units per day; 12 service units per year

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

FUNCTIONAL ASSESSMENT

Definition:

For all individuals receiving mental health services and/or substance use disorders services, the biopsychosocial assessments are the face-to-face securing of information from the individual receiving services and/or collateral contact, of the individual's family background, educational/vocational achievement, presenting problem(s), problem history, history of previous treatment, medical history, current medication(s), source of referral and other pertinent information in order to determine the nature of the individual's or family's problem(s), the factors contributing to the problem(s), and the most appropriate course of treatment for the individual and/or family.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
FAI	Functional Assessment at Intake	1	$60.50
FRA	Functional Re-Assessment	1	$9.68

Reporting Unit: 1 functional assessment

Maximum Billable Unit(s): Limited to 1 service unit per day; 4 service units per year

Reporting Combination Restrictions if any: Must be actively enrolled in an MDMH certified substance use disorder treatment program.

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

INTAKE / BIOPSYCHOSOCIAL ASSESSMENT

Definition:
For all individuals receiving mental health services and/or substance use disorders services, the biopsychosocial assessments are the face-to-face securing of information from the individual receiving services and/or collateral contact, of the individual's family background, educational/vocational achievement, presenting problem(s), problem history, history of previous treatment, medical history, current medication(s), source of referral and other pertinent information in order to determine the nature of the individual's or family's problem(s), the factors contributing to the problem(s), and the most appropriate course of treatment for the individual and/or family.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
H0031	Intake/Biopsycho-Social Assessment	1	$133.95

Reporting Unit: 1 intake assessment

Maximum Billable Unit(s): Limited to 1 service unit per day; 4 service units per year

Reporting Combination Restrictions if any: Must be actively enrolled in an MDMH certified substance use disorder treatment program.

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

LEVEL OF CARE ASSESSMENT

Definition:
For all individuals receiving mental health services and/or substance use disorders services, the biopsychosocial assessments are the face-to-face securing of information from the individual receiving services and/or collateral contact, of the individual's family background, educational/vocational achievement, presenting problem(s), problem history, history of previous treatment, medical history, current medication(s), source of referral and other pertinent information in order to determine the nature of the individual's or family's problem(s), the factors contributing to the problem(s), and the most appropriate course of treatment for the individual and/or family.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
SUIPA	Level of Care Intake/Placement Assessment	1	$133.95
SUPRA	Level of Care Placement Re-assessment	1	$19.36

Reporting Unit: 1 intake assessment

Maximum Billable Unit(s): Limited to 1 service unit per day; 4 service units per year

Reporting Combination Restrictions if any: Must be actively enrolled in an MDMH certified substance use disorder treatment program.

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

NURSING ASSESSMENT

Definition:
Nursing assessment takes place between a registered nurse and an individual for the purpose of assessing extra-pyramidal symptoms, medication history, medical history, progress on medication, current symptoms, progress or lack thereof since last contact and providing education to the individual and the family about the illness and the course of available treatment.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
T1002	Nursing Assessment (RN services up to 15 minutes)	1	$22.32

Reporting Unit: 1 nursing assessment

Maximum Billable Unit(s): Limited to 4 service units per day; 144 service units per year

Reporting Combination Restrictions if any: Must be actively enrolled in an MDMH certified substance use disorder or mental health treatment program. May not be billed in combination with intake evaluation.

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

PRE-EVALUATION SCREENING

Definition:
Commitment Pre-Evaluation Screening/ Community Billing Form DMH-PES. DMH-PES is completed as backup for Reimbursement of Pre-Evaluation Screening expenses.

Expenses incurred in the Pre-Evaluation process resulting in recommending an individual for inpatient treatment or community maintenance are reimbursed at a rate of $15.50 per 15-minute unit. The maximum number of evaluation units that can be claimed per individual is 8 units or 2 hours.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
432	Pre-Evaluation Screening	1	$15.50

Reporting Unit: 15 Minutes

Maximum Billable Unit(s): Limited to 8 units

Reporting Combination Restrictions if any: Must be actively enrolled in an MDMH certified substance use disorder or mental health treatment program. May not be billed in combination with intake evaluation.

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

COMMUNITY MAINTENANCE – PRE-EVAL SCREENING

Definition:
Expenses incurred in the Pre-Evaluation process resulting in not recommending an individual for inpatient treatment and providing services to the individual to maintain him/her in the community are reimbursed at a rate of $250.00 per individual.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
CMPES	Community Maintenance – Pre-Eval Screening	1	$250.00

Reporting Unit: Per Individual

Maximum Billable Unit(s): 1 unit

Reporting Combination Restrictions if any: Must be actively enrolled in an MDMH certified substance use disorder or mental health treatment program. May not be billed in combination with intake evaluation.

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

RESIDENTIAL SERVICES

Substance Use Disorders Residential Treatment Services support individuals as they develop the skills and abilities necessary to improve their health and wellness, live self- directed lives, and strive to reach their full potential in a life of recovery. Services are offered in a community-based treatment setting. The residential continuum of care includes both Primary Residential Services and Transitional Residential Services for individuals with SUD.

The Mississippi Department of Mental Health (DMH), Bureau of Behavioral Health/Addictive Services (Addictive Services), will serve as the State Authority for Opioid Treatment Programs under the authority provided under state statute (Section 41-4-7 of the Mississippi Code of 1972, Annotated). Such programs shall provide withdrawal management services to people suffering from chronic addiction to opiates/opiate derivatives. The services support the individual by utilizing methadone, and/or Buprenorphine (including buprenorphine and buprenorphine-naloxone formulation), naltrexone, and other medications approved by the Federal Food & Drug Administration (FDA), while the individual participates in a spectrum of counseling and other recovery support services that are intended to assist the person with successful recovery from addiction.

MEDICAID ELIGIBLE RESIDENTIAL

Definition:
Residential Services is the highest community-based level of care for the treatment of substance use/addictive disorders for Medicaid enrolled individuals. This level of treatment provides a safe and stable group living environment where the individual can develop, practice and demonstrate necessary recovery skills. Medicaid enrolled individuals admitted into Residential Services must receive a medical assessment within forty-eight (48) hours of admission to screen for health risks. The **Billing Rate** for this form of residential services ($50.00 per diem per person) only covers expenses for room and board due to the coverage by Medicaid of other applicable services normally included in the Residential bundled rate per diem ($146.00).

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
MERPD	High-Intensity Residential per diem - Medicaid Eligible (non-pregnant)	1	$53.50
MERD1	High-Intensity Residential Daily per diem - Medicaid Eligible (1 child)	1	$103.50
MERD2	High-Intensity Residential Daily per diem - Medicaid Eligible (2 children)	1	$153.50
MERD3	High-Intensity Residential Daily per diem - Medicaid Eligible (3 children)	1	$203.50
BHLD	Bed Hold - Labor & Delivery (Pregnant Only)	1	$121.00
PPM	High-Intensity Residential Daily per diem - Medicaid Eligible Pregnant	1	$74.90
PPM1	High-Intensity Residential Daily per diem - Medicaid Eligible (1 child) Pregnant	1	$124.90
PPM2	High-Intensity Residential Daily per diem - Medicaid Eligible (2 child) Pregnant	1	$174.90
PPM3	High-Intensity Residential Daily per diem - Medicaid Eligible (3 child) Pregnant	1	$224.90

Reporting Unit: 1 day
Maximum Billable Unit(s): The maximum units billable in one day cannot exceed the number of residential certified beds.

ASAM/Level of Care: 3.1 - Clinically Managed Low-Intensity Residential

Modality: Rehabilitation/Residential-Long Term (more than 30 days)

TEDS Code: 05

Reporting Combination Restrictions if any: Must be actively enrolled in an MDMH certified substance use disorder treatment program. Cannot be billed in conjunction with another residential rate (MH, SA or IDD).

PRIMARY and SOR RESIDENTIAL

Definition:
Primary Residential Services is the highest community-based level of care for the treatment of substance use/addictive disorders. This level of treatment provides a safe and stable group living environment where the individual can develop, practice and demonstrate necessary recovery skills. Individuals admitted into Primary Residential Services must receive a medical assessment within forty-eight (48) hours of admission to screen for health risks.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
PRBND	High-Intensity Residential Daily Per Diem (Bundled)	1	$156.22
PRD1	High-Intensity Residential Daily Per Diem (Parenting one child) (Bundled)	1	$206.22
PRD2	High-Intensity Residential Daily Per Diem (Parenting two children) (Bundled)	1	$256.22
PRD3	High-Intensity Residential Daily Per Diem (Parenting three children) (Bundled)	1	$306.22
BHLD	Bed Hold - Labor & Delivery (Pregnant Only)	1	$121.00
PPR	High-Intensity Residential Daily Per Diem Pregnant (Bundled)	1	$177.62
PP1	High-Intensity Residential Daily Per Diem (Pregnant) (Parenting 1 child) (Bundled)	1	$227.62
PP2	High-Intensity Residential Daily Per Diem (Pregnant) (Parenting 2 children) (Bundled)	1	$277.62
PP3	High-Intensity Residential Daily Per Diem (Pregnant) (Parenting 3 children) (Bundled)	1	$327.62

Reporting Unit: 1 day

Maximum Billable Unit(s): The maximum units billable in one day cannot exceed the number of residential certified beds.

ASAM/Level of Care: 3.5 - Clinically Managed High-Intensity Residential

Modality: Rehabilitation/Residential-Short Term (less than 30 days)

TEDS Code: 04

Reporting Combination Restrictions if any: Must be actively enrolled in an MDMH certified substance use disorder treatment program. Cannot be billed in conjunction with another residential rate (MH, SA or DD).

TRANSITIONAL RESIDENTIAL

Definition:
Transitional Residential Services are provided in a safe and stable group living environment which promotes recovery while encouraging the pursuit of vocational or related opportunities. An individual must have successfully completed a Primary Residential substance use disorder treatment program in order to be eligible for admission to Transitional residential services. The primary substance use disorder residential treatment program must be at least four (4) weeks long.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
LIRDA	Low-Intensity Residential Daily Per Diem (Adolescent) (denied VR)	1	$60.00
LIRD1	Low-Intensity Residential Daily per diem – Medicaid Eligible - (1 child)	1	$103.50
LIRD2	Low-Intensity Residential Daily per diem – Medicaid Eligible - (2 children)	1	$153.50
LIRD3	Low-Intensity Residential Daily per diem – Medicaid Eligible - (3 children)	1	$203.50
LPM	Low Intensity Residential Daily per diem – Medicaid Eligible - Pregnant	1	$74.90
LPM1	Low-Intensity Residential Daily per diem – Medicaid Eligible - (1 child) Pregnant	1	$124.90
LPM2	Low-Intensity Residential Daily per diem – Medicaid Eligible - (2 child) Pregnant	1	$174.90
LPM3	Low-Intensity Residential Daily per diem – Medicaid Eligible - (3 child) Pregnant	1	$224.90
MIRAO	Medium-Intensity Residential Daily Per Diem (Adolescent Only)	1	$156.22
TRES1	Low-Intensity Residential Daily Per Diem (Parenting one child) (denied VR)	1	$185.78
TRES2	Low-Intensity Residential Daily Per Diem (Parenting two children) (denied VR)	1	$235.78
TRES3	Low-Intensity Residential Daily Per Diem (Parenting three children) (denied VR)	1	$285.78
TRRES	Low-Intensity Residential Daily Per Diem (denied VR)	1	$135.78

Reporting Unit: 1 day

Maximum Billable Unit(s): The maximum units billable in one day cannot exceed the number of residential certified beds.

ASAM/Level of Care: 3.1 - Clinically Managed Low-Intensity Residential

Modality: Rehabilitation/Residential-Long Term (more than 30 days)

TEDS Code: 05

Reporting Combination Restrictions if any: Must be actively enrolled in an MDMH certified substance use disorder treatment program. Cannot be billed in conjunction with another residential rate (MH, SA or DD).

LOW INTENSITY RESIDENTIAL

Definition:

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
PPRT	Low-Intensity Residential Daily Per Diem Pregnant (Bundled) (denied VR)	1	$154.38
PP1T	Low-Intensity Residential Daily Per Diem Pregnant (Parenting 1 child) (Bundled) (denied VR)	1	$204.38
PP2T	Low-Intensity Residential Daily Per Diem Pregnant (Parenting 2 children) (Bundled) (denied VR)	1	$254.38
PP3T	Low-Intensity Residential Daily Per Diem Pregnant (Parenting 3 children) (Bundled) (denied VR)	1	$304.38
LIRPD	Low-Intensity Residential Daily – Medicaid Eligible (non-pregnant)	1	$53.50

Reporting Unit: 1 day

Maximum Billable Unit(s): The maximum units billable in one day cannot exceed the number of certified beds.

ASAM/Level of Care: 3.1 - Clinically Managed Low-Intensity Residential

Modality:

TEDS Code:

VOCATIONAL REHABILITATION

Definition:
Vocational Rehabilitation counselors help individuals who have major or minor disabilities obtain medical help and evaluate employment skills, abilities, and interests, while providing additional services which include physical aids, training, and employment assistance. The **Billing Rate** for this form of residential services ($50.00 per diem per person) only covers expenses for room and board due to the coverage by Mississippi Department of Rehabilitation Services (MDRS) of other applicable services normally included in the Residential bundled rate per diam ($146.00).

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
BHLD	Bed Hold - Labor & Delivery (Pregnant Only)	1	$121.00
LIRVA	Low-Intensity Residential Daily Per Diem – Adolescent - Vocational Rehab (enrolled in VR)	1	$60.00
PPMV	Low-Intensity Residential Daily Per Diem - Vocational Rehab Pregnant (Bundled) (enrolled in VR)	1	$74.90
PPMV1	Low-Intensity Residential Daily Per Diem - Vocational Rehab Pregnant (1 child) {Bundled) (enrolled in VR)	1	$130.00
PPMV2	Low-Intensity Residential Per Diem - Vocational Rehab – Pregnant (2 children) (Bundled) (enrolled in VR)	1	$180.00
PPMV3	Low-Intensity Residential Daily Per Diem - Vocational Rehab Pregnant (3 children) (Bundled) (enrolled in VR)	1	$230.00
VOCRH	Low-Intensity Residential Daily Per Diem – Vocational Rehab (enrolled in VR)	1	$60.00
VOCR1	Low-Intensity Residential - One Child Daily Per Diem – Vocational Rehab (enrolled in VR)	1	$110.00
VOCR2	Low-Intensity Residential - Two Children Daily Per Diem – Vocational Rehab (enrolled in VR)	1	$160.00
VOCR3	Low-Intensity Residential - Three Children Daily Per Diem – Vocational Rehab (enrolled in VR)	1	$210.00

Reporting Unit: 1 day

Maximum Billable Unit(s): The maximum units billable in one day cannot exceed the number of certified beds.

ASAM/Level of Care: 3.1 - Clinically Managed Low-Intensity Residential

Modality: Rehabilitation/Residential-Long Term (more than 30 days)

TEDS Code: 05

Reporting Combination Restrictions if any: Must be actively enrolled in an MDMH certified substance use disorder treatment program. Cannot be billed in conjunction with another residential rate (MH, SA or DD).

CRISIS RESIDENTIAL

Definition:
Crisis Residential services are time-limited residential treatment services which provide psychiatric supervision, nursing services, structured therapeutic activities, and intensive psychotherapy (individual, family and/or group) to individuals who are experiencing a period of acute psychiatric distress which severely impairs their ability to cope with normal life circumstances. Crisis Residential services must be designed to prevent civil commitment and/or longer-term inpatient psychiatric hospitalization by addressing acute symptoms, distress, and further decomposition. Crisis Residential services content may vary based on each individual's needs but must include close observation/supervision and intensive support with a focus on the reduction/elimination of acute symptoms.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
H0018	Crisis Residential	1	$610.59
BHLD	Bed Hold - Labor & Delivery (Pregnant Only)	1	$121.00

Reporting Unit: 1 day

Maximum Billable Unit(s): Limited to 1 service unit per day; 60 service units per year

ASAM/Level of Care: 3.7 - Medically Monitored Intensive Inpatient

Modality: Crisis Residential

TEDS Code: 75

Reporting Combination Restrictions if any: Must be actively enrolled in an MDMH certified substance use disorder treatment program. This service is all-inclusive and component parts may not be billed separately.

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

MEDICALLY MANAGED INTENSIVE INPATIENT (WITHDRAWAL MANAGEMENT)

Definition:
Medically managed intensive inpatient treatment is an organized service in which addiction professionals and clinicians provide a planned regimen of 24-hour medically directed evaluation, care and treatment in an acute care inpatient setting. Patients generally have severe withdrawal or medical, emotional or behavioral problems that require primary medical and nursing services.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
BHLD4	Withdrawal Management 4 bed hold	1	$60.50
MMII	Medically Managed Intensive Inpatient WM per diem (Max 5 days)	1	$605.00
WM-1	Withdrawal Management - 1	1	$60.50
WM-2	Withdrawal Management - 2	1	$60.50
WM3.2	Withdrawal Management - 3.2	1	$60.50
WM3.7	Withdrawal Management - 3.7	1	$60.50
WM-4	Withdrawal Management - 4	1	$605.00

Reporting Unit: 1 day

Maximum Billable Unit(s): 5 days

ASAM/Level of Care: 1-WM - Ambulatory Withdrawal Management without Extended On-Site Monitoring

Modality: Detoxification, 24-Hour Service, Hospital Inpatient

TEDS Code: 01

CRISIS DIVERSION/COMMUNITY TRANSITION RESIDENTIAL

Definition:
The Mississippi Department of Mental Health (DMH) is committed to providing a person- centered, recovery-oriented system of care for all Mississippians in need of mental health services. In effort to allow individuals to receive services in the community of his or her choice; and DMH is offering funding for Community Integration Homes.
Community Integration Homes are community homes which support up to six (6) individuals twenty-four hours per day, seven days per week, who are discharging from long term institutional care to the community.
Crisis Diversion Homes support four (4) individuals twenty-four hours per day, seven days per week, as determined by the DMH Branch of Coordinated Care, who are either in crisis or at risk of being in crisis. Many times, this crisis occurs because a person has exhausted their current living arrangements and has no place to live.
The Department of Mental Health is providing funding for a pilot project with Communicare to offer Community Safe Homes to support an individual, twenty-four hours per day, seven days per week, who are in crisis. The purpose of the Community Safe Homes is to decrease the number of admissions to behavioral health and IDD programs and provide services in the community that are immediately available to the individuals until the crisis is resolved.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
CDCTR	Crisis Diversion/Community Transition Residential (Boswell Regional Center, Region 2, Region 8 and Region 9 only)	1	$245.84

Reporting Unit: 1 day

Maximum Billable Unit(s): Limited to 1 service unit per day

ASAM/Level of Care: 3.1 – Clinically Managed Low-Intensity Residential

Modality: Crisis Diversion/Community Transition Residential

TEDS Code: 73

Reporting Combination Restrictions if any: Must be actively enrolled in an MDMH certified mental health treatment program. This service is all-inclusive and component parts may not be billed separately.

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

OUTPATIENT SERVICES

Psychosocial Rehabilitative Services (PSR) consists of a network of services designed to support and restore community functioning and well-being of adults with a serious and persistent mental illness. The purpose of the program is to promote recovery, resiliency, and empowerment of the individual in his/her community. Program activities aim to improve reality orientation, social skills and adaptation, coping skills, effective management of time and resources, task completion, community and family integration, vocational and academic skills, and activities to incorporate the individual into independent community living; as well as to alleviate psychiatric decompensation, confusion, anxiety, disorientation, distraction, preoccupation, isolation, withdrawal and feelings of low self-worth.

Outpatient Psychotherapeutic Services include initial assessment, and individual, family, group, and multi-family group therapies. Outpatient Psychotherapeutic Services are defined as intentional, face-to-face interactions (conversations or non-verbal encounters, such as play therapy) between a mental health therapist, IDD therapist or A/D therapist (as appropriate to the population being served) and an individual, family or group where a therapeutic relationship is established to help resolve symptoms of a mental and/or emotional disturbance.

Crisis Response is an intensive therapeutic service which allows for the assessment of and intervention in a mental health crisis. Crisis Response Services are provided to children and adults who are experiencing a significant emotional/behavioral crisis in which the individual's mental health and/or behavioral health needs exceed the individual's resources (in the opinion of the mental health professional assessing the situation.) Trained Crisis Response staff provides crisis stabilization directed toward preventing hospitalization. Staff must be able to triage and make appropriate clinical decisions, including assessing the need for inpatient services or less restrictive alternatives. Crisis Response Services will deliver solution-focused and recovery-oriented behavioral health assessments and stabilization of crisis in the location where the individual is experiencing the crisis. Without Crisis Response intervention, the individual experiencing the crisis may be inappropriately and unnecessarily placed in a jail, holding facility, hospital or inpatient treatment facility. (Crisis Response Services do not include the Crisis Intervention/Crisis Support Services provided through the ID/DD Waiver.)

ACUTE PARTIAL HOSPITALIZATION

Definition:
Acute Partial Hospitalization Services (APH) provide medical supervision, nursing services, structured therapeutic activities and intensive psychotherapy (individual, family and/or group) to individuals who are experiencing a period of such acute distress that their ability to cope with normal life circumstances is severely impaired. APH is designed to provide an alternative to inpatient hospitalization for such individuals or to serve as a bridge from inpatient to outpatient treatment. Program content may vary based on need but must include close observation/supervision and intensive support with a focus on the reduction/elimination of acute symptoms. APH may be provided to children with serious emotional disturbance or adults with serious and persistent mental illness.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
H0035	Acute Partial Hospitalization (under 24 hours)	1	$136.73

Reporting Unit: 1 day

Maximum Billable Unit(s): Limited to 1 service unit per day; 100 service units per year

ASAM/Level of Care: 2.1 - Intensive Outpatient

Reporting Combination Restrictions if any: Must be actively enrolled in an MDMH certified substance use disorder treatment program. This service is all-inclusive and component parts may not be billed separately.

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

ASSERTIVE COMMUNITY TREATMENT

Definition:
A program of Assertive Community Treatment (PACT) is an individual-centered, recovery-oriented mental health service delivery model for facilitating community living, psychological rehabilitation and recovery for persons who have the most severe and persistent mental illnesses, have severe symptoms and impairments, and have not benefited from traditional outpatient programs.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
H0039/HW	Assertive Community Treatment, face-to-face per 15 minutes (PACT)	1	$33.28
H0039/HW/GT	Assertive Community Treatment, face-to-face per 15 minutes (PACT) (Telehealth)	1	$33.28
H0039/HW/U8	Assertive Community Treatment, face-to-face per 15 minutes (U8, ICORT)	1	$29.95
H0039/HW/U8/GT	Assertive Community Treatment, face-to-face per 15 minutes (U8, ICORT) (Telehealth)	1	$29.95

Reporting Unit: 15 min.

Maximum Billable Unit(s): Limited to 40 service units per day; 1,600 service units per year

ASAM/Level of Care: 1 - Outpatient Service

Reporting Combination Restrictions if any: Must be actively enrolled in an MDMH certified substance use disorder treatment program. This service is all-inclusive and component parts may not be billed separately.

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

FAMILY THERAPY

Definition:
Family Therapy shall consist of psychotherapy that takes place between a mental health therapist and an individual's family members with or without the presence of the individual. Family Therapy may also include others (DHS staff, foster family members, etc.) with whom the individual lives or has a family-like relationship. This service includes family psychotherapy and psychoeducation provided by a mental health therapist.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
90846	Family Therapy (w/o patient 50 minutes)	1	$106.88
90847	Family Therapy (w/patient 50 minutes)	1	$110.72

Reporting Unit: 1 session

Maximum Billable Unit(s): Limited to 1 service unit per day; 24 service units per year

Reporting Combination Restrictions if any: Must be actively enrolled in an MDMH certified substance use disorder treatment program.

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

GROUP THERAPY

Definition:
Group Therapy shall consist of psychotherapy that takes place between a mental health therapist and at least two (2) but no more than ten (10) children or at least two (2) but not more than twelve (12) adults at the same time. Possibilities include, but are not limited to, groups that focus on relaxation training, anger management and/or conflict resolution, social skills training, and self-esteem enhancement.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
90849	Multi-family Group Therapy	1	$36.88
90853	Group Therapy	1	$28.81

Reporting Unit: 1 session

Maximum Billable Unit(s): Limited to 1 service unit per day; 40 service units per year

Reporting Combination Restrictions if any: Must be actively enrolled in an MDMH certified substance use disorder treatment program.

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES – ICORT

Definition:
Intensive Outpatient Psychiatric (IOP-C/Y) services are defined as treatment provided in the home or community to children and youth with serious emotional disturbance up to the age of twenty-one (21) for family stabilization. Based on a wraparound model, this service is a time-limited, intensive family intervention intended to diffuse the current crisis, evaluate its nature, and intervene to reduce the likelihood of a recurrence. The ultimate goal is to stabilize the living arrangement, promote reunification or prevent the utilization of out-of-home therapeutic resources (i.e., psychiatric hospital, therapeutic foster care, and residential treatment facility).

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
S9480	Intensive Outpatient Psychiatric Services	1	$148.27

Reporting Unit: 1 day

Maximum Billable Unit(s): Limited to 1 service unit per day; 24 service units per year

ASAM/Level of Care: 2.1 - Intensive Outpatient

Reporting Combination Restrictions if any: Must be actively enrolled in an MDMH certified substance use disorder treatment program. This service is all-inclusive and component parts may not be billed separately.

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

INTENSIVE OUTPATIENT PSYCHIATRIC SERVICES – SUBSTANCE USE

Definition:
Intensive Outpatient Psychiatric (IOP-SU) services are defined as treatment provided in the home or community to adults and adolescents. The ultimate goal is to stabilize the living arrangement, promote reunification or prevent the utilization of out-of-home therapeutic resources (i.e., psychiatric hospital, therapeutic foster care, and residential treatment facility).

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
IOPM2	IOP Group Therapy Medicaid Supplement - 2-hour session	1	$14.40
IOPM3	IOP Group Therapy Medicaid Supplement - 3-hour session	1	$28.81
IOPB2	IOP Group Therapy Bundled Rate - 2-hour session	1	$43.21
IOPB3	IOP Group Therapy Bundled Rate - 3-hour session	1	$57.62
IOPT1	IOP Group Therapy Rate - 1-hour session	1	$28.81

Reporting Unit: 1 day

Maximum Billable Unit(s): Limited to 1 service unit per day

ASAM/Level of Care: 2.1 - Intensive Outpatient

Reporting Combination Restrictions if any: Must be actively enrolled in an MDMH certified substance use disorder treatment program. This service is all-inclusive and component parts may not be billed separately.

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

*Providers must keep record of the start and end times of each session in client's individual case file.
*These rates (IOP rate schedule) are subject to change at any time.
*If Medicaid was to establish an IOP Group Therapy rate in the presumed future, DMH's IOP Group Therapy rates will immediately fall into alignment.
*This rate schedule applies to all IOP programs, Adults and Adolescents.

MEDICATION INJECTION

Definition:
Medication injection is the process of a licensed practical nurse, registered nurse, physician, or nurse practitioner injecting an individual with prescribed psychotropic medication for the purpose of restoring, maintaining or improving the individual's role performance and/or mental health status.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
96372	Medication Injection	1	$14.13

Reporting Unit: 1 injection

Maximum Billable Unit(s): Limited to 2 service units per day; 12 service units per year

Reporting Combination Restrictions if any: Must be actively enrolled in an MDMH certified substance use disorder treatment program.

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

PEER SUPPORT

Definition:
Peer Support Services are person-centered activities with a rehabilitation and resiliency/recovery focus that allow consumers of mental health services and substance use disorders services and their family members the opportunity to build skills for coping with and managing psychiatric symptoms, substance use issues and challenges associated with various disabilities while directing their own recovery. Natural resources are utilized to enhance community living skills, community integration, rehabilitation, resiliency and recovery. Peer Support is a helping relationship between peers and/or family members that is directed toward the achievement of specific goals defined by the individual. It may also be provided as a family partner role.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
H0038	Peer Support, Per 15 Minutes	1	$9.47

Reporting Unit: 15 min.

Maximum Billable Unit(s): Limited to 6 service units per day; 200 service units per year

ASAM/Level of Care: 1 - Outpatient Service

Reporting Combination Restrictions if any: Must be actively enrolled in an MDMH certified substance use disorder or mental health treatment program.

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

PSYCHOLOGICAL EVALUATIONS

Definition:
Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
96130	Psychological Evaluation (first hour)	1	$124.80
96131	Psychological Evaluation (each additional hour)	1	$95.67
96136	Psychological Evaluation (first 30 minutes)	1	$47.00
96137	Psychological Evaluation (Each additional 30 minutes)	1	$42.98

Reporting Unit: 1 evaluation

Maximum Billable Unit(s):
96130 and 96136: limited to 1 service unit per day; 8 service units per year 96131 and 96137: limited to 7 service unit per day; 8 service units per year

Reporting Combination Restrictions if any: Must be actively enrolled in an MDMH certified substance use disorder or mental health treatment program. May not be billed in combination with intake evaluation.

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

PSYCHOTHERAPY

Definition:
Individual Therapy is defined as one-on-one psychotherapy that takes place between a mental health therapist and the individual receiving services.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
90832	Psychotherapy - (w/pt 30 minutes)	1	$72.68
90833	Psychotherapy with E/M (w/pt 30 minutes)	1	$74.35
90834	Psychotherapy - (w/pt 45 minutes)	1	$96.68
90836	Psychotherapy with E/M (w/pt 45 minutes)	1	$94.17
90837	Psychotherapy - (w/pt 60 minutes)	1	$144.81
90838	Psychotherapy with E/M (w/pt 60 minutes)	1	$123.84

Reporting Unit: 1 session

Maximum Billable Unit(s): Limited to 1 service unit per day; 36 service units per year

Reporting Combination Restrictions if any: Must be actively enrolled in an MDMH certified substance use disorder or mental health treatment program. May not be billed in combination with intake evaluation.

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

TREATMENT PLAN DEVELOPMENT & REVIEW (BY NON- PHYSICIAN)

Definition:
The treatment plan is the overall plan that directs the treatment of the individual receiving services. The plan must be based on the strengths and needs, or challenges, of the individual receiving services and his/her family/legal representative (if applicable) and identified outcomes. Outcomes should be identified by the individual, family/legal representative (if applicable), and treatment/support team.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
H0032	Treatment Plan Development & Review (By Non-Physician)	1	$22.32

Reporting Unit: 1 Plan

Maximum Billable Unit(s): Limited to 1 service unit per day; 4 service units per year

Reporting Combination Restrictions if any: Must be actively enrolled in an MDMH certified substance use disorder or mental health treatment program.

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

DAY TREATMENT (CHILD)

Definition:
Day Treatment Services are the most intensive outpatient services available to children/youth with SED. The services must provide an alternative to residential treatment or acute psychiatric hospitalization or serve as a transition from these services. Day Treatment Services are a behavioral intervention and strengths-based program, provided in the context of a therapeutic milieu, which provides primarily school age children/adolescents with serious emotional disturbances the intensity of treatment necessary to enable them to live in the community. Day Treatment Services are based on behavior management principles and include, at a minimum, positive feedback, self- esteem building and social skills training. Additional components are determined by the needs of the participants at a particular site and may include skills training in the areas of impulse control, anger management, problem solving, and/or conflict resolution.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
H2012	Day Treatment (Child)	1	$38.72

Reporting Unit: 60 min.

Maximum Billable Unit(s): Limited to 5 service units per day

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

PROLONGED SERVICES

Definition:

Prolonged Services **Definition:**s in the office or other outpatient setting, Medicare will pay for prolonged physician services (CPT code 99354) (with direct face-to-face patient contact that requires one hour beyond the usual service), when billed on the same day by the same physician or qualified NPP as the companion evaluation and management codes. The time for usual service refers to the typical/average time units associated with the companion E&M service as noted in the CPT code book. You should report each additional 30 minutes of direct face-to-face patient contact following the first hour of prolonged services with CPT code 99355.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
99354	Prolonged Service 60 minutes	1	$132.33
99355	Prolonged Service 30 minutes (add on)	1	$100.56

Reporting Unit: Minutes

Maximum Billable Unit(s): Limited to 1 service unit per day

Reporting Combination Restrictions if any: Must be actively enrolled in an MDMH certified substance use disorder or mental health treatment program.

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

PSYCHOSOCIAL REHABILITATION

Definition:
Psychosocial Rehabilitative Services (PSR) consists of a network of services designed to support and restore community functioning and well-being of adults with a serious and persistent mental illness. The purpose of the program is to promote recovery, resiliency, and empowerment of the individual in his/her community. Program activities aim to improve reality orientation, social skills and adaptation, coping skills, effective management of time and resources, task completion, community and family integration, vocational and academic skills, and activities to incorporate the individual into independent community living; as well as to alleviate psychiatric decompensation, confusion, anxiety, disorientation, distraction, preoccupation, isolation, withdrawal and feelings of low self-worth.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
H2017	Psychosocial Rehabilitation Services, Per 15 Minutes	1	$4.68

Reporting Unit: 15 min.

Maximum Billable Unit(s): Limited to 20 service units per day

Reporting Combination Restrictions if any: Must be actively enrolled in an MDMH certified substance use disorder or mental health treatment program.

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

COMMUNITY SUPPORT SERVICES

Definition:

Community Support Services provide an array of support services delivered by community-based, mobile Community Support Specialists. CSS are only provided by certified DMH/C and DMH/P providers. CSS are directed towards adults, children, adolescents and families and will vary with respect to hours, type and intensity of services, depending on the changing needs of each individual. The purpose/intent of CSS is to provide specific, measurable, and individualized services to each person served. CSS should be focused on the individual's ability to succeed in the community; to identify and access needed services; and to show improvement in school, work, family, and community participation.

A variety of community services and supports is available. Services are provided to adults with mental illness, children and youth with serious emotional disturbance, children and adults with intellectual/developmental disabilities, persons with substance abuse problems, and persons with Alzheimer's disease or dementia. Services are provided by DMH operated programs and DMH certified providers, depending on the program/provider and location.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
H2015	Community Support Services (Management of the individual) 15 min	1	$18.00

Reporting Unit: 15 minutes

Maximum Billable Unit(s): Limited to 6 service units per day; 400 service units per year

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

TARGETED CASE MANAGEMENT

Definition:
Targeted Case Management Services are defined as services that provide information/referral and resource coordination for individuals and/or his/her family, or other supports. Targeted Case Management Services are directed towards helping the individual maintain his/her highest possible level of independence. Case managers monitor the individual service plan and ensure team members complete tasks that are assigned to them, that follow up and follow through occur and help identify when the person's team may need to review the service plan for updates if the established plan is not working.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
T1017	Targeted Case Management	1	$18.30

Reporting Unit: 15 minutes

Maximum Billable Unit(s): Limited to 2 service units per day; 260 service units per year

Reporting Combination Restrictions if any: Must be actively enrolled in an MDMH certified substance use disorder or mental health treatment program.

Targeted case management may be provided face-to-face or via telephone. Targeted case management is not designed to be a mobile service, but there is no prohibition on services being provided in a location other than a community mental health center Location should be in compliance with all applicable federal, state, and local codes.

IDD TARGETED CASE MANAGEMENT

Definition::

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
T2023/HW/HT	Targeted Case Management (0 - 21 years old)	1	$1,452.00
T2023/HW/U7	Targeted Case Management (18 & up years old)	1	$182.72

Reporting Unit: Monthly

Reporting Combination Restrictions if any: Must be actively enrolled in an MDMH certified IDD treatment program.

MOBILE CRISIS SERVICES (FACE-TO-FACE)

Definition:
Mobile Crisis Response Teams provide community-based crisis services that deliver solution-focused and recovery-oriented behavioral health assessments and stabilization of crisis in the location where the individual is experiencing the crisis. Mobile Crisis Response Teams (MCeRTs) work hand-in-hand with local law enforcement, Chancery Judges and Clerks, and the Crisis Stabilization Units to ensure a seamless process. The teams ensure an individual has a follow-up appointment with their preferred provider and monitor the individual until the appointment takes place. MCeRTs are coordinated through the local Community Mental Health Centers.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
602	Mobile Crisis Services	1	$36.30

Reporting Unit: 1 episode

Maximum Billable Unit(s): Limited to 32 service units per day; 224 service units per year

Face-to-face contact (i.e., Mobile Crisis Response) with a mental health professional twenty-four (24) hours a day, seven (7) days a week must be available. The staff person is not required to see the individual in the individual's home, but this is permissible and recommended. There must be designated, strategic, publicized locations where the person can meet with a mental health professional. The individual must be seen within one (1) hour of initial time of contact if in an urban setting and within two (2) hours of initial time of contact if in a rural setting. A team approach to mobile crisis response should be utilized if warranted to adequately address the situation.

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

CRISIS RESPONSE SERVICES / WALK-IN EMERGENCY

Definition:
A mental health crisis is any situation in which someone's behavior puts them at risk of becoming unable to properly provide self-care, of functioning in the community, or maybe even of hurting themselves. Just as with physical health problems, there may be times when a mental health crisis occurs unexpectedly.

The provider must ensure that a mental health representative is available to speak with an individual in crisis and/or family members/legal representatives of the individual twenty-four (24) hours a day, seven (7) days a week, inclusive of individuals who may be a "walk-in" at any program site.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
H2011/HW/HE	Crisis Response, Face-to-Face (Modifier HW/HE)	1	$36.30

Reporting Unit: 1 episode

Maximum Billable Unit(s): Limited to 32 service units per day; 224 service units per year

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

CRISIS RESPONSE SERVICES / TELEPHONE EMERGENCY

Definition:
A mental health crisis is any situation in which someone's behavior puts them at risk of becoming unable to properly provide self-care, of functioning in the community, or maybe even of hurting themselves. Just as with physical health problems, there may be times when a mental health crisis occurs unexpectedly.

The provider must ensure that a mental health representative is available to speak with an individual in crisis and/or family members/legal representatives of the individual twenty-four (24) hours a day, seven (7) days a week.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
H2011/HW/TF	Crisis Response, Telephone Service (Modifier HW/TF)	1	$26.47

Reporting Unit: 1 episode

Maximum Billable Unit(s): Limited to 32 service units per day; 224 service units per year

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

SUPPORTED LIVING - IDD

Definition:
Supported living provides limited support of up to four hours per day for persons who can live independently in their own home or apartment. The support helps provide access to the community, pay bills, shop for groceries, access medical care, and other personal assistance as needed.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
S5135	Supported Living - IDD (Non-Medicaid)	1	$7.67

Reporting Unit: 15 minutes

Maximum Billable Unit(s): Waiver is limited to 8 hours per day and 1915i is 4 hours per day.

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

DAY SERVICES ADULT - IDD

Definition:
This service assists individuals in gaining the greatest level of independence while supporting them in meaningful activities of their choice throughout the day.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
S5100	Day Services – Adult – IDD (Non-Medicaid)	1	$4.57
S5135	Supported Living - IDD (Non-Medicaid)	1	$7.67

Reporting Unit: 15 minutes

Maximum Billable Unit(s): Limited to 6 hours per day; 138 hours per month

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

PRE-VOCATIONAL - IDD

Definition:
This service teaches pre-employment skills and assists in exploring job opportunities in the community.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
T2015	Prevocational Services – IDD (Non-Medicaid)	1	$15.10
S5135	Supported Living - IDD (Non-Medicaid)	1	$7.67

Reporting Unit: 15 minutes

Maximum Billable Unit(s): Limited to 6 hours per day; 138 per month

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

SUPPORTED EMPLOYMENT - IDD

Definition:
Supported employment provides a job coach to assist in finding a job and training a person to work independently.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
H2023	Supported Employment - Job Devel - IDD-Non-Medicaid	1	$10.65

Reporting Unit: 15 minutes

Maximum Billable Unit(s): Limited to 90 hours per certification year

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

SUPPORTED EMPLOYMENT - IDD

Definition:
Supported employment provides a job coach to assist in finding a job and training a person to work independently.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
H2025	Supported Employment - Job Maint - IDD-Non-Medicaid	1	$10.10

Reporting Unit: 15 minutes

Maximum Billable Unit(s): No Maximum

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

EVALUATIONS

Evaluation of the level of observation that is required for all individuals receiving services. Policy and **Procedure**s should allow for evaluation upon admission and at regular intervals during the course of treatment. If the evaluation or clinical judgement indicates a greater frequency of observation is necessary, policies and **Procedure**s should reflect those practices. Policy and **Procedure**s should identify who is responsible for conducting the assessment (s). Please refer to the DMH Operational Standards for more information.

EVALUATION & MANAGEMENT – NEW PATIENTS

Definition: Office or other outpatient visit for the evaluation and management of a new patient.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
99201	Office/Outpatient Visit (Evaluation & Management) Current Patients (99201)	1	$45.04
99202	Office/Outpatient Visit (Evaluation & Management) Current Patients (99202)	1	$75.27
99203	Office/Outpatient Visit (Evaluation & Management) Current Patients (99203)	1	$107.04
99204	Office/Outpatient Visit (Evaluation & Management) Current Patients (99204)	1	$164.51
99205	Office/Outpatient Visit (Evaluation & Management) Current Patients (99205)	1	$208.31

Reporting Unit: 1 evaluation

Maximum Billable Unit(s): Limited to 1 service unit per day

Reporting Combination Restrictions if any: Must be actively enrolled in an MDMH certified substance use disorder or mental health treatment program. May not be billed in combination with intake evaluation.

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

EVALUATION & MANAGEMENT – CURRENT PATIENTS

Definition:
Office or other outpatient visit for the evaluation and management of an established patient.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
99211	Office/Outpatient Visit (Evaluation & Management) Current Patients (99211)	1	$22.60
99212	Office/Outpatient Visit (Evaluation & Management) Current Patients (99212)	1	$44.71
99213	Office/Outpatient Visit (Evaluation & Management) Current Patients (99213)	1	$74.58
99214	Office/Outpatient Visit (Evaluation & Management) Current Patients (99214)	1	$108.69
99215	Office/Outpatient Visit (Evaluation & Management) Current Patients (99215)	1	$146.42

Reporting Unit: 1 evaluation

Maximum Billable Unit(s): Limited to 1 service unit per day

Reporting Combination Restrictions if any: Must be actively enrolled in an MDMH certified substance use disorder or mental health treatment program. May not be billed in combination with intake evaluation.

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

PSYCHIATRIC DIAGNOSTIC EVALUATIONS

Definition:
A psychiatric diagnostic evaluation is an integrated assessment that includes history, mental status and recommendations. It may include communicating with the family and ordering further diagnostic studies. A psychiatric diagnostic evaluation with medical services includes a psychiatric diagnostic evaluation and a medical assessment. It may require a physical exam, communication with the family, prescription medications and ordering laboratory or other diagnostic studies. A psychiatric diagnostic evaluation with medical services also includes physical examination elements.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
90791	Psychiatric Diag Eval w/o Medical Services	1	$148.52
90792	Psychiatric Diag Eval w/Medical Services	1	$164.17

Reporting Unit: 1 evaluation

Maximum Billable Unit(s): Limited to 1 service unit per day; 4 service units per year

Reporting Combination Restrictions if any: May not be billed in combination with intake evaluation.

90791 may be provided by a Licensed Masters, Physician, Psychologist, PMHNP, or PA.
90792 may only be provided by a Physician, PMHNP, or PA.

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

MISCELLANEOUS SERVICES

A miscellaneous service is a service that can be billed and is not included in the services described previously in this document.

URINE DRUG SCREENS (ONLINE)

Definition:
Alcohol and/or drug screening; laboratory analysis of specimens for presence of alcohol and/or drugs

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
H0003	Urine Drug Screens Onsite	1	$14.65

Reporting Unit: 1 screen

WRAPAROUND FACILITATION

Definition:
Wraparound is an approach to individualized care planning encompassing the concept of wrapping services and supports around children, youth and families, utilizing both clinical treatment services and natural supports. Wraparound is built on the collective action of a committed group of family, friends, community, professionals, and cross- system supports mobilizing resources and talents from a variety of sources. This results in the creation of an Individualized Support Plan that is the best fit between the family vision and story, strengths, needs, team mission, and strategies.

Wraparound facilitation is for children/youth with serious emotional disturbances (SED) who have highly complex needs and/or have multiple agency involvement and are at risk of out-of-home placement. With ratios of 1 Wraparound Facilitator to 10 families and youth, youth can be diverted from residential placements and served in their communities and homes.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
H2021	Wraparound Facilitation	1	$18.00

Reporting Unit: 15 min.

Maximum Billable Unit(s): Limited to 16 service units per day; 200 service units per year

Reporting Combination Restrictions if any: Must be actively enrolled in an MDMH certified substance use disorder or mental health treatment program.

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

MEDICATION-ASSISTED TREATMENT

Definition:
Medication-Assisted Treatment (MAT) combines counseling and behavioral therapies with medication, to provide a whole-patient approach to the treatment of opioid and substance use disorders. Medications help reduce the cravings and other symptoms associated with withdrawal from a substance, block the neurological pathways that produce the rewarding sensation caused by a substance, or induce negative feelings when a substance is taken.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
11981	Insertion of single non-biodegradable implant	1	$140.74
GBNFS	Generic Buprenorphine-naloxone 8 mg (30 film strips)	1	$243.56
GBNTB	Generic Buprenorphine-naloxone 8 mg (30 tablets)	1	$88.43
GBSTB	Generic Buprenorphine (Subutex) 8 mg (30 tablets)	1	$56.64
GON50	Generic Oral Naltrexone 50 mg (30 tablets)	1	$38.56
J0570	Probuphine (buprenorphine) 6-month implant (all 4 rods)	1	$6,003.16
J2315	Vivitrol (naltrexone) injection	1	$1,541.14
MT120	Methadone 5 mg (120 ml)	1	$22.93
MT30	Methadone 5 mg (30 ml)	1	$15.97
MT60	Methadone 5 mg (60 ml)	1	$18.30
Q9991	Sublocade (buprenorphine) 100 mg injection	1	$1,925.46
Q9992	Sublocade (buprenorphine) 300 mg injection	1	$1,925.46
SUB8M	Suboxone (buprenorphine-nalox) 8 mg (30 film strips)	1	$11.78
SUB2M	Suboxone (buprenorphine-naloxone) 2 mg (30 film strips) *	1	$188.30
T1502	Medication Administration (per injection)	1	$5.76
ZUBSV	Zubsolv (buprenorphine-naloxone) 5.7 mg (30 tablets)	1	$315.19

Reporting Unit: 1 dosage

Maximum Billable Unit(s): Limited to 2 service units per day

Reporting Combination Restrictions if any: Must be actively enrolled in an MDMH certified substance use disorder treatment program.

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

SOR INCENTIVES and SURVEY ADMINISTRATION

Definition:
SOR Incentives and Survey Administration are available for clients entered into a SOR program to conduct the GPRA intake, 6-month GPRA and Discharge GPRA.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
INCTV	Incentives	1	$25
SRVAD	Survey Administration	1	$60.50

Reporting Unit: Incentives: 1 Unit = 1 GPRA
Survey Administration = $50.00 for the 6-month GPRA

Maximum Billable Unit(s): Limited to 3 service units per client for Incentives

Reporting Combination Restrictions if any: Must be actively enrolled in an MDMH certified substance use disorder treatment program.

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

MERC INCENTIVES

Definition:
MERC Incentives are available for clients entered into a MERC program to conduct the 6 month GPRA.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
MRCIN	MERC Incentives	1	$20

Reporting Unit: Incentives: 1 Unit = 6-month GPRA

Maximum Billable Unit(s): Limited to 1 service units per client for Incentives

Reporting Combination Restrictions if any: Must be actively enrolled in an MDMH certified substance use disorder treatment program.

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

Ancillary, Medication, Physician

Definition:
MERC Ancillary, Medication, and Physician service and service rate have been added to accommodate the billing for charges that do not comply with standard rate charges. For example, if you pay a physician for services, you can use the Physician services with a rate of $1.00 and include the number of units to be able to be reimbursed for your charge.

Reporting Code:

Procedure	Description	Billing Unit	Billing Rate
ANCIL	Ancillary	1	$1.00
MEDIC	Medication	1	$1.00
PHYSC	Physician	1	$1.00

Reporting Unit: Incentives: 1 Unit = 1 dollar

Maximum Billable Unit(s): Units have a maximum of 9999

Reporting Combination Restrictions if any: Must be actively enrolled in an MDMH certified substance use disorder treatment program.

Services are to be delivered in a setting that is acceptable for both the patient and staff member, that affords an adequate therapeutic environment, and that protects the patient's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.