INTRODUCTORY BILLING INFORMATION

The purpose of this manual is to provide billing information for Medicaid (Part One) and Non-Medicaid (Part Two) services authorized by the Delaware Department of Services for Children, Youth, and their Families (DSCYF), Division of Prevention and Behavioral Health Services (DPBHS). This manual is a supplement to DPBHS's Treatment Provider Manual. The billing information provided is in addition to but not in place of other certifications, licensures, and State or Federal requirements. The manual will be updated regularly, and DSCYF/DPBHS reserves the right to change, modify or supersede any of these policies and procedures with or without notice at any time. As revisions occur, the manual will be updated and can be viewed at https://kids.delaware.gov/

Delaware's Medicaid State Plan enables Delaware's Department for Services for Children, Youth and Their Families (DSCYF) Division of Prevention and Behavioral Health Services (DPBHS) to focus on prevention and wellness and improving the integration of behavioral health services earlier in a child's life. The array of services allows interventions to be delivered in natural community-based settings where children and their families live. DPBHS promote lower-intensity services to prevent the need for more restrictive settings and higher-intensity services. The following is a list of Delaware Medicaid State Plan amendments used to authorize behavioral health services for children:

- Other Licensed Practitioners
- Children's Rehabilitation Services
- Substance Use Disorder Services
- Inpatient Psychiatric Care for Under the age 21

In addition to the Medicaid State Plan services, DSCYF/DPBHS provides additional support services for families. Part Two of this manual includes billing guidance for DSCYF Contractors of non-Medicaid contracted supports and services (but not limited to):

- Transportation
- Translation
- Education
- Support Services

All Medicaid services are reimbursed in accordance with the methodologies outlined in the Delaware Medicaid State Plan. The current version of the Delaware Medicaid State Plan can be found at: https://dhss.delaware.gov/dhss/dmma/state_plan.html

Providers/contractors may contact DSCYF/DPBHS directly (see contact information below). All new and existing providers/contractors are encouraged to visit the Providers' page on the DSCYF website for additional resources and information: https://kids.delaware.gov/

BILLING CONTACT INFORMATION:

General Information:
Attn: DPBHS Billing Unit
1825 Faulkland Road
Wilmington, DE 19805
Phone: 302-633-2600
Secure Fax: 302-622-4475
Email: DSCYF_DPBHS_Invoicing@delaware.gov

Program Administrator:
Kelly Dobrowolski
Phone: 302-892-6414
Secure Fax: 302-622-4475
Email: Kelly.Dobrowolski@delaware.gov

Billing Unit Manager:
Eartha Hopkins
Phone: 302-633-2570
Secure Fax: 302-622-4475
Email: Eartha.Hopkins@delaware.gov

Medicaid Systems Administrator:
Reid Millius
Phone: 302-633-2597
Secure Fax: 302-622-4475
Email: Reid.Millius@delaware.gov

PART ONE – MEDICAID SERVICES

DPBHS is responsible for the provision of Delaware's Children's Behavioral Health Medicaid benefit. This section of the manual provides billing guidance for the following Delaware Medicaid State Plan behavioral health services:

- Other Licensed Practitioners Behavioral Health
- Children's Rehabilitation Services
- Substance Use Disorder Services
- Psychiatric Residential Treatment Facility
- Inpatient Psychiatric Hospital

This section of the manual outlines claims and invoice requirements for DSCYF behavioral health contractors. It is for guidance only and does not supersede applicable regulatory requirements or procedures for admission to a program, record keeping, service documentation, initial and ongoing treatment planning, reviews, etc.

GENERAL INFORMATION

Managed Care Benefit. For members under the age of 18, the first 30 units of the Children's Behavioral Benefit is covered by the Managed Care Organizations (MCO) in Delaware.

To provide continuity of care, providers must enroll/panel with Delaware's Managed Care Organizations:

- Highmark Health Options https://www.highmarkhealthoptions.com/
- AmeriHealth Caritas https://www.amerihealthcaritasde.com/
- Delaware Health First https://www.delawarefirsthealth.com/

Providers with children who have exhausted the Medicaid MCO benefit package must complete a referral form and submit to DPBHS' Central Intake Office. DSCYF/DPBHS will work with the provider to authorize medically necessary care in addition to the MCO-covered 30 units[1]. The referral form can be found at:

- http://kids.delaware.gov/pbhs/pbhs_providers_forms.shtml

Higher Level of Care. For more intensive services, provider must complete an Intake Referral Pack and submit it to DPBHS' Central Intake Office.

- https://kids.delaware.gov/pbhs/resources.shtml

Intake Contact Information:
PHONE |1-800-722-7710
DSCYF_Intake_General@delaware.gov
FAX | (302) 622-4475

[1] Delaware Medical Assistance Program General Policy Manual

National Correct Coding Initiative (NCCI) rules must be followed by all providers. NCCI was developed to promote national correct coding and methodologies and to control improper coding leading to improper payment[2].

Coordination of Benefits. Some clients may have health insurance coverage from more than one source. In these instances, benefit coverage is coordinated between primary and secondary payers.
Participating providers should obtain information from members as to whether the member has health benefits coverage from more than one source, and if so, provide this information to DPBHS.
Coordination of benefits amongst different sources of coverage (payers) is governed by the terms of the member's benefit plan and applicable state and/or federal laws, rules and/or regulations.

Medicaid is the payer of last resort. Therefore, before seeking payment through Medicaid, provider agencies are required to determine whether there is any other source of payment and, if yes, seek payment from that source. Payment is not available through Medicaid if there is another source of payment.

For claims with other insurance coverage, Third Party Liability (TPL), to be considered for payment, the patient's responsibility must be greater than zero. When calculating payments for claims with TPL as primary, the lessor of patient responsibility or allowed/contracted amount minus TPL paid amount.

If a provider receives payment from a third party after payment has been made, the provider must report the payment. Refer to the Delaware Medical Assistance Portal (DMAP) billing Instructions: ***https://medicaid.dhss.delaware.gov/***

Program Integrity. DPBHS is responsible for identifying and recovering claim overpayments for the Medicaid population served. DPBHS performs several operational activities to ensure the accuracy of claim payments. As a result of these activities, you may be asked to provide supporting documentation including, medical records or itemized bills to support the review of the claim. Prior authorization is not a guarantee of payment for the services authorized. DPBHS reserves the right to adjust any payment made following a review of the medical record or other documentation and/or determination of the medical necessity of the services provided.

As a provider, you are responsible for knowing and abiding by all applicable state and federal laws and regulations and by the fraud, waste, and abuse requirements of Medicaid program. The definitions of Fraud, Waste and Abuse are:

Fraud – an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal and state law.

Waste – The overutilization of services or other practices that results in unnecessary costs. Waste is generally not considered caused by criminally negligent actions but rather misuse of resources.

[2] https://www.cms.gov/Medicare/Coding/NCCI-Coding-Edits

Abuse – Includes provider reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the health program.

Telemedicine. The Delaware Medical Assistance Program (DMAP) covers medically necessary health services furnished to eligible DMAP members as specified in the Medicaid State Plan. To facilitate the ability of recipients to receive medically necessary services, DMAP allows for the use of a telemedicine delivery system for providers enrolled under Delaware Medicaid.

Telemedicine services are subject to and must comply with the state's specifications, conditions, and limitations. Telemedicine is the practice of health care delivery by a practitioner who is located at a site, distant site, other than the site where the patient is located, known as the originating site, for consultation, evaluation, diagnosis, or recommendation of treatment.

Consultations, office visits, individual psychotherapy, and pharmacological management services may be reimbursed when provided via Health Insurance Portability & Accountability Act (HIPAA) compliant telecommunication technology. The consulting or expert provider must bill the appropriate procedure code (Current Procedural Terminology (CPT) codes) with the place of service code 02 (telemedicine) and will be reimbursed at the same rate as a face-to-face service. The originating site, with the consumer present, may bill code Q3014 (telemedicine originating site facility fee). Providers must follow all applicable federal and state security and procedure guidelines for telemedicine. *Telephone conversations, chart reviews, electronic mail messages, facsimile transmissions or internet services for online medical evaluations are not considered telemedicine.*

Rate Methodologies. DPBHS reimburses providers in accordance with the reimbursement methodologies outlined in the federally approved Medicaid State Plan. The most current version of Delaware's Medicaid State Plan can be found on the Department of Health and Social Services website: https://www.dhss.delaware.gov/dhss/dmma/state_plan.html

Except as otherwise noted in the State Plan, the State-developed fee schedule is the same for both government and private individual providers. The fee schedule and any annual/periodic adjustments to the fee schedule are published in the Delaware Register of Regulations. All rates are published on the Delaware Medical Assistance Program (DMAP) website at: www.dmap.state.de.us/downloads/hcpcs.html

The current fee for service rates funded through the Medicaid Children's Behavioral Health Benefit along with the procedure codes, modifiers, and business rules[3] can be found at:
https://kids.delaware.gov/pbhs/providers-billing.shtml

[3] The business rules describe limitations on the service, such as the number of units that can be provided during a period of time and any prohibitions against providing the service on the same day as another service.

If a Medicare fee exists for a defined covered procedure code, then Delaware will pay psychologists at 100% of the Medicaid physician rates. If a Medicare fee exists for a defined covered procedure code, then Delaware Medicaid will pay Licensed Clinical Social Workers (LCSW), Licensed Professional Counselor of Mental Health (LPCMH), and Licensed Marriage and Family Therapists (LMFT) at 75% of the Medicaid physician rates.

Provider Type	Percent of Physician Fee Schedule	2022 Rate
Medicare Physician Rate for CPT Code 99354	100% of Medicare rate	$129.58
Delaware Medicaid Physician and Psychologist	98% of Medicare rate	$126.99
Delaware LCSW, LMFT, LPCMH	75% of Delaware Medicaid physician rate	$95.24

Where Medicare fees do not exist for a covered code, the fee development methodology will build fees considering each component of provider costs as outlined below. These reimbursement methodologies will produce rates sufficient to enlist enough providers so that services under the State Plan are available to beneficiaries at least to the extent that these services are available to the general population, as required by 42 CFR 447.204. These rates comply with the requirements of Section 1902(a)(3) of the Social Security Act and 42 CFR 447.200, regarding payments and are consistent with economy, efficiency, and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. The Medicaid fee schedule will be equal to or less than the maximum allowable under the same Medicare rate, where there is a comparable Medicare rate. Room and board costs are not included in the Medicaid fee schedule. Except as otherwise noted in the State Plan, the State-developed fee schedule is the same for both government and private individual providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the Delaware Register of Regulations.

The fee development methodology will primarily be composed of provider cost modeling through Delaware provider compensation studies, cost data, and fees from similar State Medicaid programs may be considered, as well. The following list outlines the major components of the cost model to be used in fee development.

- Staffing assumptions and staff wages.
- Employee-related expenses, benefits, taxes (e.g., FICA).
- Program-related expenses (e.g., supplies).
- Provider overhead expenses.
- Program billable units.

The fee schedule rates are developed as the ratio of total annual modeled provider costs to the estimated annual billable units.

PROVIDER ENROLLMENT

All providers of Medicaid reimbursable services must enroll as DSCYF/DPBHS provider through the Delaware Medicaid Assistance Program (DMAP) Provider Portal. Instructions for can be found on the Provider Enrollment page.

DMAP Provider Portal - New Provider Registration. After a provider has completed the enrollment and received an approval. All providers must complete a new registration using the Medicaid ID (MCD) provided.

CLAIM SUBMISSION

DSCYF/DPBHS uses the Delaware Medicaid Assistance Program (DMAP) Provider Portal for claim processing and payment. Claims submitted electronically must use the CMS-1500 form for professional providers or the UB-40 for institutional in the Delaware Medicaid Assistance Program (DMAP) Provider Portal. For more specific information, please visit the DMAP website at: https://medicaid.dhss.delaware.gov/

Provider Portal Instructions. Instructions for how to submit claims can be found in the ***How to Corner*** in the DMAP Provider Portal. Providers also have access to DMAP/DMES trainings at: *https://lms-de.myhcplatform.com/*

Claim Timeliness Standard. It is a federal requirement that claims to DMAP must be submitted no later than twelve months from the date of service[4]. Therefore, all claims submitted for payment must be submitted no later than twelve months after the date of service (or date of discharge for inpatient admissions).

AUTHORIZATION NUMBERS

DSCYF/DPBHS Authorization number. Providers receive a Plan of Care, which includes a six-digit DSCYF/DPBHS authorization number. This number provides confirmation of authorized service and approval to start services. The DSCYF/DPBHS authorization number is **NOT** to be used for claim submission.

Admission Authorization Form. Providers are required to submit an Admission Authorization Form for each service authorized. The form must be faxed or emailed to PBH after the initial visit. Forms should be faxed to 302-622-4470 or sent by secure email to: DSCYF_CMH_Contract_Deliverables_FAX@delaware.gov

DMES Authorization Number. The Admission Authorization Form provides DBPHS with the information needed to generate a DMES authorization number. The DMES authorization number must be included on all claims when submitted claims through the DMAP (Delaware Medicaid Assistance Program) Provider Portal https://medicaid.dhss.delaware.gov/provider/Home/tabid/135/Default.aspx

[4] DMAP General Policy Manual section 1.19.1

Providers receive DMES authorization numbers weekly. The DMES authorization number must be present on claims submitted through DMES. The DMES authorization number always beings with "D" followed by a numeric value (ex., D123456).

CODING GUIDANCE

National Correct Coding Initiative (NCCI). All providers must follow the Medicaid national correct coding initiative (NCCI), which was established to promote national correct coding methodologies with the goal of reducing the number of improper coding that result in improper payments for Medicaid[5].

- NCCI procedure-to-procedure (PTP) edits define pairs of HCPCS/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.
- Medically Unlikely Edits (MUE) for each HCPCS/CPT code define the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service.

NCCI edits are updated quarterly. Please note that the presence of a HCPCS/CPT code in a PTP or MUE value does not necessarily indicate that the code is covered by DSCYF/DPBHS or DMMA. Medicaid NCCI website: https://www.medicaid.gov/medicaid/program-integrity/national-correct-coding-initiative/medicaid-ncci-edit-files/index.html

Diagnosis Codes. Providers are required to use the current *International Statistical Classification of Diseases, 10th revision, Clinical Modification* (ICD-10-CM) codes when submitting claims. For additional information on ICM-10-CM visit: https://www.cdc.gov/nchs/icd/icd10cm.htm

Procedure Codes. CPT codes should be used by licensed professionals. HCPCS codes are provided for unlicensed professionals, non-hospital residential providers, and evidence-based teams. A unit of service is defined according to the CPT or HCPCS approved code set consistent with the National Correct Coding Initiative unless otherwise specified.

- Providers cannot redefine procedure codes to meet their needs.
- Providers must maintain documentation supporting the procedure code billed.
- Payments are predicated on the understanding that all services provided are medically necessary.[6]

Add-on Codes. An add-on code is a CPT code used by licensed practitioners in addition that describes a service that, with one exception[7], is performed in conjunction with another primary service defined in the add-on code. An add-on code is eligible for payment only if it is reported with an appropriate primary procedure performed by the same practitioner. An add-on code is never eligible for payment if it is the only procedure reported.[8] The work and documentation must support the use of an add-on code. Examples of add-on codes are:

[5] Medicaid.gov
[6] Provider Policy Manual
[7] CPT code 99292 ((Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes) under a certain circumstance. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2636CP.pdf
[8] https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits

- Add-on codes for psychotherapy: 90833, 90836, and 90838
- Add-on code for interactive complexity: 90785

An example for use of an add-on code:

- Evaluation and Management service plus 30-minute psychotherapy session by a psychiatrist:
  - *Code as*: 99211 (or other appropriate level of E/M code) and 90833 (30 min psychotherapy add-on)

Billable Unit. A billable unit is defined as the smallest unit of time a qualified provider is authorized to bill a service.

15-minute unit billing clarification. Billing a 15-minute unit requires documentation of at least 8 minutes of billable services.

- All activities must be completed on one date of service.
- Multiple activities related to a client on one date should be accumulated into one or more 15-minute units (if at multiple locations for one code, please use the service location that described where the majority of the service took place when submitting a claim).
- If the same service is delivered to the same individual on the same day but at non-sequential times, the total time spent on the service may be submitted as a combined claim. For the place of service code, submit using the code that describes where the majority of the service took place.
- Billing is not allowed for brief activities across multiple dates (minutes cannot be accumulated over multiple dates and billed as a 15-minute unit).

# of Billable Units	# of Minutes of billable activity required
1 unit	≥ 8 minutes through 22 minutes
2 units	≥ 23 minutes through 37 minutes
3 units	≥ 38 minutes through 52 minutes
4 units	≥ 53 minutes through 67 minutes
5 units	≥ 68 minutes through 82 minutes
6 units	≥ 83 minutes through 97 minutes
7 units	≥ 98 minutes through 112 minutes
8 units	≥ 113 minutes through 127 minutes
9 units	≥ 128 minutes through 142 minutes

Examples. These are generic examples as a reference for billing using 15-minute units and are NOT written specific to any service or service definition.

Example 1 - Staff meets with child A in person for 12 minutes. This encounter is the only billable activity on this date of service.
Total Minutes: 12
Billable units: 1 (15 minute) unit

Example 2 - Staff meets with child A before school for 13 minutes, then after school meets with child A for 53 minutes.
Total Minutes: 66
Billable Units: 4 (15 minute) units

Example 3 – On the same day, staff meets with child A for 5 minutes between classes, then meets with child A's school counselor for 15 minutes. Staff meets with child B for 6 minutes. Staff meets with child C for 110 minutes for individual counseling session.
Total Minutes: 136
Billable Units: 1 (15-minute) unit for child A
7 (15-minute) units for child C
* Child B total time was 6 minutes, which does not equal the 8 minutes needed to bill

CODING

The coding listed below are the codes open to providers contracted with DSCYF and enrolled in Delaware Medicaid in the appropriate taxonomies. For a complete listing of coding for providers enrolled in other taxonomies including physician, Clinical Nurse Specialist, Nurse Practitioner, and Physician's Assistants, please see the complete DMAP website at: https://medicaid.dhss.delaware.gov/

Key: "+" designates an add-on code

OUTPATIENT MENTAL HEALTH SERVICES

Outpatient Mental Health Services are authorized under the Medicaid State Plan Authority Other Licensed Practitioner (OLP) and Community Psychiatric Supportive Treatment (CPST) and coded according to the practitioner qualifications.

CPT/ HCPCS	Modifier(s)				Description
	(1)	(2)	(3)	(4)	
+90785	U2				Interactive Complexity
+90785	HO	U2			Interactive Complexity
90785	HP	U2			Interactive Complexity
90791	U2				Psychiatric diagnostic evaluation
90791	HP	U2			Psychiatric diagnostic evaluation
90791	HO	U2			Psychiatric diagnostic evaluation
90832	U2				Psychotherapy, 30 minutes with patient and/or family member.
90832	HP	U2			Psychotherapy, 30 minutes with patient and/or family member.
90832	HO	U2			Psychotherapy, 30 minutes with patient and/or family member.
90834	U2				Psychotherapy, 45 minutes with patient and/or family member.
90834	HP	U2			Psychotherapy, 45 minutes with patient and/or family member.
90834	HO	U2			Psychotherapy, 45 minutes with patient and/or family member.
90837	U2				Psychotherapy, 60 minutes with patient and/or family member.
90837	HP	U2			Psychotherapy, 60 minutes with patient and/or family member.
90837	HO	U2			Psychotherapy, 60 minutes with patient and/or family member.
90839	U2				Psychotherapy for crisis; first 60 minutes.
90839	HP	U2			Psychotherapy for crisis; first 60 minutes.
90839	HO	U2			Psychotherapy for crisis; first 60 minutes.
+90840	U2				Psychotherapy for crisis; each additional 30 minutes (list separately in addition to code for primary service). (Use 90840 in conjunction with 90839.)
+90840	HP	U2			Psychotherapy for crisis; each additional 30 minutes (list separately in addition to code for primary service). (Use 90840 in conjunction with 90839.)
+90840	HO	U2			Psychotherapy for crisis; each additional 30 minutes (list separately in addition to code for primary service). (Use 90840 in conjunction with 90839.)
90846	U2				Family psychotherapy (without the patient present).
90846	HP	U2			Family psychotherapy (without the patient present).
90846	HO	U2			Family psychotherapy (without the patient present).
90847	U2				Family psychotherapy (conjoint psychotherapy) (with patient present).
90847	HP	U2			Family psychotherapy (conjoint psychotherapy) (with patient present).
90847	HO	U2			Family psychotherapy (conjoint psychotherapy) (with patient present).
90849	U2				Multiple-family group psychotherapy.

90849	HP	U2			Multiple-family group psychotherapy.
90849	HO	U2			Multiple-family group psychotherapy.
90853	U2				Group psychotherapy (other than of a multiple-family group).
90853	HP	U2			Group psychotherapy (other than of a multiple-family group).
90853	HO	U2			Group psychotherapy (other than of a multiple-family group).
+90854	U2				Prolonged service, first hour
+90854	HP	U2			Prolonged service, first hour
+90854	HO	U2			Prolonged service, first hour
+99355	U2				Prolonged service, each additional 30 minutes
+99355	HP	U2			Prolonged service, each additional 30 minutes
+99355	HO	U2			Prolonged service, each additional 30 minutes
96130	U2				Psychological testing evaluation services phys/qhp, first hour
96130	HP	U2			Psychological testing evaluation services phys/qhp, first hour
96130	HO	U2			Psychological testing evaluation services phys/qhp, first hour
+96131	U2				Psychological testing evaluation services phys/qhp, each additional hour
+96131	HP	U2			Psychological testing evaluation services phys/qhp, each additional hour
+96131	HO	U2			Psychological testing evaluation services phys/qhp, each additional hour
96132	U2				Neuropsychological testing evaluation services phys/qhp, first hour
96132	HP	U2			Neuropsychological testing evaluation services phys/qhp, first hour
96132	HO	U2			Neuropsychological testing evaluation services phys/qhp, first hour
+96133	U2				Neuropsychological testing evaluation services phys/qhp, each additional hour
+96133	HP	U2			Neuropsychological testing evaluation services phys/qhp, each additional hour
+96133	HO	U2			Neuropsychological testing evaluation services phys/qhp, each additional hour
96136	U2				Psychological/Neuropsychological testing evaluation services phys/qhp, first hour
96136	HP	U2			Psychological/Neuropsychological testing evaluation services phys/qhp, first hour
96136	HO	U2			Psychological/Neuropsychological testing evaluation services phys/qhp, first hour
+96137	U2				Psychological/Neuropsychological testing evaluation services, each additional hour
+96137	HP	U2			Psychological/Neuropsychological testing evaluation services, each additional hour
+96137	HO	U2			Psychological/Neuropsychological testing evaluation services, each additional hour
96156	U2				Health behavior assessment, or re-assessment
96156	HP	U2			Health behavior assessment, or re-assessment
96156	HO	U2			Health behavior assessment, or re-assessment
96158	U2				Health behavior intervention, individual, face-to-face; initial 30 minutes
96158	HP	U2			Health behavior intervention, individual, face-to-face; initial 30 minutes
96158	HO	U2			Health behavior intervention, individual, face-to-face; initial 30 minutes
+96159	U2				Health behavior intervention, individual, face-to-face; each additional 15 minutes
+96159	HP	U2			Health behavior intervention, individual, face-to-face; each additional 15 minutes
+96159	HO	U2			Health behavior intervention, individual, face-to-face; each additional 15 minutes
H0036	HO	U2			CPST, face-to-face, per 15 minutes, master's degree level, individual office
H0036	HO	U1	U2		CPST, face-to-face, per 15 minutes, master's degree level, individual community
H0036	HO	HQ	U2		CPST, face-to-face, per 15 minutes, master's degree level, group office
H0036	HO	HQ	U1	U2	CPST, face-to-face, per 15 minutes, master's degree level, group community
H0036	HO	HR	U2		CPST, face-to-face, per 15 minutes, master's degree level, family w/client, office
H0036	HO	HR	U1	U2	CPST, face-to-face, per 15 minutes, master's degree level, family w/client, community
H0036	HO	HS	U2		CPST, face-to-face, per 15 minutes, master's degree level, family w/o client, office
H0036	HO	HS	U1	U2	CPST, face-to-face, per 15 minutes, master's degree level, family w/o client, community

**A unit of service is defined according to the CPT or HCPCS approved code set consistent with the National Correct Coding Initiative, unless otherwise specified.*

THERAPEUTIC SUPPORT FOR FAMILIES (TSF)

Therapeutic Support for Families (TSF***)*** are authorized under the Medicaid State Plan Authority Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR) services and coded according to the practitioner qualifications.

HCPCS	Modifier(s)				Description	Unit
	(1)	(2)	(3)	(4)		
H0036	HN	U8			Community psychiatric supportive treatment, face-to-face, per 15 minutes, bachelor's degree level, individual office	15 min
H0036	HN	U1	U8		Community psychiatric supportive treatment, face-to-face, per 15 minutes, bachelor's degree level	15 min
H0036	HN	HQ	U8		Community psychiatric supportive treatment, face-to-face, per 15 minutes, bachelor's degree level, office	15 min
H0036	HN	HQ	U1	U8	Community psychiatric supportive treatment, face-to-face, per 15 minutes, bachelor's degree level	15 min
H0036	HN	HR	U8		Community psychiatric supportive treatment, face-to-face, per 15 minutes, bachelor's degree level	15 min
H0036	HN	HR	U1	U8	Community psychiatric supportive treatment, face-to-face, per 15 minutes, bachelor's degree level	15 min
H0036	HN	HS	U8		Community psychiatric supportive treatment, face-to-face, per 15 minutes, bachelor's degree level	15 min
H0036	HN	HS	U1	U8	Community psychiatric supportive treatment, face-to-face, per 15 minutes, bachelor's degree level	15 min
H0036	HO	U8			Community psychiatric supportive treatment, face-to-face, per 15 minutes, master's degree level, individual office	15 min
H0036	HO	U1	U8		Community psychiatric supportive treatment, face-to-face, per 15 minutes, master's degree level	15 min
H0036	HO	HQ	U8		Community psychiatric supportive treatment, face-to-face, per 15 minutes, master's degree level, Group Max of (1:8), Group Average of (1:3), office	15 min
H0036	HO	HQ	U1	U8	Community psychiatric supportive treatment, face-to-face, per 15 minutes, master's degree level, Group Max of (1:8), Group Average of (1:3)	15 min
H0036	HO	HR	U8		Community psychiatric supportive treatment, face-to-face, per 15 minutes, master's degree level, individual office, family with client present	15 min
H0036	HO	HR	U1	U8	Community psychiatric supportive treatment, face-to-face, per 15 minutes, master's degree level, individual community, family with client present	15 min
H0036	HO	HS	U8		Community psychiatric supportive treatment, face-to-face, per 15 minutes, master's degree level, individual office, family without client present	15 min
H0036	HO	HS	U1	U8	Community psychiatric supportive treatment, face-to-face, per 15 minutes, master's degree level, individual community, family without client present	15 min
H2017	HM	U8			PSR services; per 15 minutes, individual office	15 min
H2017	HM	U1	U8		PSR services; per 15 minutes, individual community	15 min

**A unit of service is defined according to Healthcare Common Procedure Coding System (HCPCS) approved code set unless otherwise specified.*

MULTI-SYSTEMIC THERAPY (MST)

Multi-systemic Therapy (MST) services are authorized under the Medicaid State Plan Authority EPSDT Rehabilitative Services.

HCPCS	Modifier(s)			Description	Unit
	(1)	(2)	(3)		
H2033	UB			Multi-systemic therapy for juveniles, per 15 minutes, bachelor's degree level	15 min

**A unit of service is defined according to Healthcare Common Procedure Coding System (HCPCS) approved code set unless otherwise specified.*

FAMILY BASED MENTAL HEALTH SERVICES (FBMHS)

Family Based Mental Health Services (FBMHS) are authorized under the Medicaid State Plan Authority EPSDT Rehabilitative Services. **Family Based Mental Health Service is a comprehensive service, therefore shall not be billed with other behavioral health services with the exception of psychiatric evaluation and medication management.*

HCPCS	Modifier(s)			Description	Unit
	(1)	(2)	(3)		
H0036	U3			Family based mental health services, 15 minutes	15 min

**A unit of service is defined according to Healthcare Common Procedure Coding System (HCPCS) approved code set unless otherwise specified.*

DIALECTICAL BEHAVIORAL THERAPY (DBT)

Dialectical Behavior Therapy (DBT) are authorized under the Medicaid State Plan Authority EPSDT Rehabilitative Services.

HCPCS	Modifier(s)			Description	Unit
	(1)	(2)	(3)		
H2019	UD			Therapeutic Behavioral Services (Dialectical Behavior Therapy (DBT))	15 min
H2019	HQ	UD		Therapeutic Behavioral Services, (Dialectical Behavior Therapy (DBT)), Group	15 min

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FUNCTIONAL FAMILY THERAPY (FFT)

Functional Family Therapy (FFT) are authorized under the Medicaid State Plan Authority EPSDT Rehabilitative Services and coded according to the practitioner qualifications.

HCPCS	Modifier(s)			Description	Unit
	(1)	(2)	(3)		
H0036	HE	HN		Community psychiatric supportive treatment, face-to-face, per 15 minutes, mental health program, bachelor's degree level family functional therapy (FFT)	15 min
H0036	HE	HO		Community psychiatric supportive treatment, face-to-face, per 15 minutes, mental health program, bachelor's degree level family functional therapy (FFT)	15 min

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MOBILE RESPONSE AND STABLIZATION SERVICES (MRSS)

Mobile Response and Stabilization Services (MRSS) are authorized under the Medicaid State Plan Authority EPSDT Services Crisis Intervention and coded according to the practitioner qualifications.

HCPCS	Modifier(s)				Description	Unit
	(1)	(2)	(3)	(4)		
H2011	UA				Crisis Intervention Service, per 15 minutes	15 min
H0036	HO	UA			Community psychiatric supportive treatment, face-to-face, per 15 minutes, master's degree level, individual office	15 min
H0036	HO	U1	UA		Community psychiatric supportive treatment, face-to-face, per 15 minutes, master's degree level	15 min
H0036	HO	HQ	UA		Community psychiatric supportive treatment, face-to-face, per 15 minutes, master's degree level, Group Max of (1:8), Group Average of (1:3), office	15 min
H0036	HO	HQ	U1	UA	Community psychiatric supportive treatment, face-to-face, per 15 minutes, master's degree level, Group Max of (1:8), Group Average of (1:3)	15 min
H0036	HO	HR	UA		Community psychiatric supportive treatment, face-to-face, per 15 minutes, master's degree level, individual office, family with client present	15 min
H0036	HO	HR	U1	UA	Community psychiatric supportive treatment, face-to-face, per 15 minutes, master's degree level, individual community, family with client present	15 min
H0036	HO	HS	UA		Community psychiatric supportive treatment, face-to-face, per 15 minutes, master's degree level, individual office, family without client present	15 min
H0036	HO	HS	U1	UA	Community psychiatric supportive treatment, face-to-face, per 15 minutes, master's degree level, individual community, family without client present	15 min

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FAMILY PEER SUPPORT SERVICES (FPSS)

Family Peer Support Services (FPSS) are authorized under the Medicaid State Plan Authority EPSDT Rehabilitative Services Family Peer Support Services.

HCPCS	Modifier(s)				Description	Unit
	(1)	(2)	(3)	(4)		
H0038	UC				Self-help/peer services, Office	15 min
H0038	HQ	UC			Self-help/peer services, Group (1:4), Office	15 min
H0038	HS	UC			Self-help/peer services, Family Couple w/o Client Present, Office	15 min
H0038	HS	HQ	UC		Self-help/peer services, Family Couple w/o Client Present, Group (1:4), Office	15 min
H0038	U1	UC			Self-help/peer services, Home/Community	15 min
H0038	HQ	U1	UC		Self-help/peer services, Group (1:4), Home/Community	15 min
H0036	HS	U1	UC		Self-help/peer services, Family Couple w/o Client Present, Home/Community	15 min
H0036	HS	HQ	U1	UC	Self-help/peer services, Family Couple w/o Client Present, Group (1:4), Home/Community	15 min

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OUTPATIENT SUBSTANCE USE DISORDER (SUD)

Outpatient SUD services are authorized under the Medicaid State Plan Authority for Rehabilitative Services – Early and Periodic Screening, Diagnosis, and Treatment Substance Use Disorder and coded according to the practitioner qualifications.

CPT/ HCPCS	Modifier(s)				Description	Unit
	(1)	(2)	(3)	(4)		
90832	HF	U4			Psychotherapy, 30 minutes with patient and/or family member.	
90832	HF	HP	U4		Psychotherapy, 30 minutes with patient and/or family member.	
90832	HF	HO	U4		Psychotherapy, 30 minutes with patient and/or family member.	
90834	HF	U4			Psychotherapy, 45 minutes with patient and/or family member.	
90834	HF	HP	U4		Psychotherapy, 45 minutes with patient and/or family member.	
90834	HF	HO	U4		Psychotherapy, 45 minutes with patient and/or family member.	
90837	HF	U4			Psychotherapy, 60 minutes with patient and/or family member.	
90837	HF	HP	U4		Psychotherapy, 60 minutes with patient and/or family member.	
90837	HF	HO	U4		Psychotherapy, 60 minutes with patient and/or family member.	
90839	HF	U4			Psychotherapy for crisis; first 60 minutes.	
90839	HF	HP	U4		Psychotherapy for crisis; first 60 minutes.	
90839	HF	HO	U4		Psychotherapy for crisis; first 60 minutes.	
+90840	HF	U4			Psychotherapy for crisis; each additional 30 minutes (list separately in addition to code for primary service). (Use 90840 in conjunction with 90839.)	
+90840	HF	HP	U4		Psychotherapy for crisis; each additional 30 minutes (list separately in addition to code for primary service). (Use 90840 in conjunction with 90839.)	
+90840	HF	HO	U4		Psychotherapy for crisis; each additional 30 minutes (list separately in addition to code for primary service). (Use 90840 in conjunction with 90839.)	
90846	HF	U4			Family psychotherapy (without the patient present).	
90846	HF	HP	U4		Family psychotherapy (without the patient present).	
90846	HF	HO	U4		Family psychotherapy (without the patient present).	
90847	HF	U4			Family psychotherapy (conjoint psychotherapy) (with patient present).	
90847	HF	HP	U4		Family psychotherapy (conjoint psychotherapy) (with patient present).	
90847	HF	HO	U4		Family psychotherapy (conjoint psychotherapy) (with patient present).	
90849	HF	U4			Multiple-family group psychotherapy.	
90849	HF	HP	U4		Multiple-family group psychotherapy.	
90849	HF	HO	U4		Multiple-family group psychotherapy.	
90853	HF	U4			Group psychotherapy (other than of a multiple-family group).	
90853	HF	HP	U4		Group psychotherapy (other than of a multiple-family group).	
90853	HF	HO	U4		Group psychotherapy (other than of a multiple-family group).	
H0001	U4				Alcohol and/or drug assessment.	
H0001	U1	U4			Alcohol and/or drug assessment, Home/Community.	
H0004	HF	U4			Behavioral health counseling and therapy	15 min
H0004	HF	U1	U4		Behavioral health counseling and therapy, Home/Community	15 min
H0004	HF	HR	U4		Behavioral health counseling and therapy, family/couple w/client present	15 min
H0004	HF	HR	U1	U4	Behavioral health counseling and therapy, family/couple w/client present, Home/Community	15 min
H0004	HF	HS	U4		Behavioral health counseling and therapy, w/o family/couple w/client present	15 min
H0004	HF	HS	U1	U4	Behavioral health counseling and therapy, w/o family/couple w/client present, Home/Community	15 min

H0005	U4				Alcohol and/or drug services, group counseling by a clinician	15 min
H0005	U1	U4			Alcohol and/or drug services, group counseling by a clinician, Home/Community	15 min
H0048	HF	U4			Alcohol and/or other drug testing: collection and handling only, specimens other than blood.	

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REHABILITATIVE RESIDENTIAL TREATMENT

Rehabilitative Residential Treatment (RRT) are authorized under the Medicaid State Plan Authority for Rehabilitative Services – Early and Periodic Screening, Diagnosis, and Treatment Rehabilitative Residential Support and coded according to the practitioner qualifications.

CPT/ HCPCS	Modifier(s)				Description	Unit
	(1)	(2)	(3)	(4)		
H0018	U7				Behavioral health; short-term residential (non-hospital residential treatment program), without room and board	Per diem
H0018	HW	U7			Room and Board for BH Tx, Non-Hospital, funded by state mental health agency	
H0036	HO	U8			Community psychiatric supportive treatment, face-to-face, master's degree level, individual office	15 min
H0036	HO	U1	U8		Community psychiatric supportive treatment, face-to-face, master's degree level	15 min
H0036	HO	HQ	U8		Community psychiatric supportive treatment, face-to-face, master's degree level, Group Max of (1:8), Group Average of (1:3), office	15 min
H0036	HO	HQ	U1	U8	Community psychiatric supportive treatment, face-to-face, master's degree level, Group Max of (1:8), Group Average of (1:3)	15 min
H0036	HO	HR	U8		Community psychiatric supportive treatment, face-to-face, master's degree level, individual office, family with client present	15 min
H0036	HO	HR	U1	U8	Community psychiatric supportive treatment, face-to-face, master's degree level, individual community, family with client present	15 min
H0036	HO	HS	U8		Community psychiatric supportive treatment, face-to-face, master's degree level, individual office, family without client present	15 min
H0036	HO	HS	U1	U8	Community psychiatric supportive treatment, face-to-face, master's degree level, individual community, family without client present	15 min
H2017	HM	U8			PSR services, individual office	15 min
H2017	HM	U1	U8		PSR services, individual community	15 min
H0036	HN	U8			Community psychiatric supportive treatment, face-to-face, bachelor's degree level, individual office	15 min
H0036	HN	U1	U8		Community psychiatric supportive treatment, face-to-face, bachelor's degree level	15 min
H0036	HN	HQ	U8		Community psychiatric supportive treatment, face-to-face, bachelor's degree level, office	15 min
H0036	HN	HQ	U1	U8	Community psychiatric supportive treatment, face-to-face, bachelor's degree level	15 min
H0036	HN	HR	U8		Community psychiatric supportive treatment, face-to-face, bachelor's degree level	15 min
H0036	HN	HR	U1	U8	Community psychiatric supportive treatment, face-to-face, bachelor's degree level	15 min
H0036	HN	HS	U8		Community psychiatric supportive treatment, face-to-face, bachelor's degree level	15 min
H0036	HN	HS	U1	U8	Community psychiatric supportive treatment, face-to-face, bachelor's degree level	15 min

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PARTIAL HOSPITALIZATION PROGRAM

Partial Hospitalization Program (PHP) is a 5-full-day intensive program that provides developmentally appropriate intervention for seriously disturbed children or adolescents who are unable to fulfill the functional requirements of his developmental stage without this level of intensive service.

Revenue Code	Description	Unit
0912	Behavioral Health Partial Hospitalization	Per diem
0913	Behavioral Health Partial Hospitalization	Per diem

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PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

A PRTF is any non-hospital facility with a provider agreement with a State Medicaid Agency to provide the inpatient services benefit to Medicaid-eligible individuals under the age of 21 (psych under 21 benefit).

Revenue Code	Description	Unit
0154	Psychiatric Residential Treatment Facility	Per diem

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INPATIENT PSYCHIATRIC HOSPITALIZATION

Acute psychiatric inpatient hospitalization is a highly structured level of care designed to meet the needs of individuals who have emotional and behavioral manifestations that put them at risk of harm to self or others, or otherwise render them unable to care for themselves.

Revenue Code	Description	Unit
0124	Psychiatric Inpatient Room & Board Semi-private two beds	Per diem

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ADDITIONAL CODING GUIDANCE

The provider should submit claims consistent with the national and industry standards. To ensure adherence to these standards, DPBHS relies on claims edits and investigative processes to identify claims that are not in accordance with national and industry standards. The process includes CMS's National Correct Coding Initiative (NCCI), which consist of:

- Procedure-to-Procedure edits that define pairs of HCPCS/CPT codes that should not be reported together.
- Medically Unlikely Edits (MUE) or units-of-service edits. This component defines for each HCPCS/CPT code the number of units of service that is unlikely to be correct and therefore needs to be supported by medical records.
- Other Edits for Improperly Coded Claims – regulatory or level of care requirements for correct coding.

Examples of claim edits include, but are not limited to the following:

- Invalid procedure and/or diagnosis code(s)
- Invalid code for place of service
- Invalid or inappropriate modifier for a code
- Diagnosis codes that do not support the procedure
- Add-on codes reported without a primary requirement
- No authorization on file for service

Medicaid National Correct Coding Initiative

The National Correct Coding Initiative (NCCI) was established by 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) requires that state Medicaid programs NCCI methodologies incorporated into their systems for processing Medicaid claims by October 1, 2010. The NCCI contains two types of edits:

- NCCI procedure-to-procedure (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: The same physician performs a psychotherapy service and E&M service on the same day to the same individual (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.*
- Medically Unlikely Edits (MUEs) define for each HCPCS / CPT code the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. *Example: The same physician performs two diagnostic evaluations (2 units of 90791) to the same individual on the same day. NCCI will deny the second evaluation, as it is medically unlikely that one client would need two complete diagnostic evaluations on the same day.*

NCCI edits are updated quarterly. Please note that the presence of a HCPCS / CPT code in a PTP edit or an MUE value for a HCPCS / CPT code does not necessarily indicate that the code is covered by DSCYF or DMMA. Information regarding billable codes by type of provider is included in this manual. The guidance contained in this manual is not exhaustive but is provided to assist providers with the billing process. Providers should become familiar with the NCCI and how to access the edit files. A complete list of NCCI edits, as well as information and documentation on the NCCI program can be found at: https://www.cms.gov/Medicare/Coding/NCCI-Coding-Edits

DPBHS complies with all federal and state regulations for member privacy and data security, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA).