Iowa Safety Net Management Information System (SNMIS) Claims Guidance

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Contents

SNMIS Claims Billing Guide

Introduction

This guide establishes the claims processing requirements for organizations and professionals billing services rendered through the Behavioral Health and Disability Services Systems in the state of Iowa. This includes a designated network of substance use disorder treatment providers, who have an existing infrastructure designed to meet the Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) block grant regulations.

The guide outlines essential service-related criteria that providers must meet to qualify for safety net funding reimbursement. It provides links to additional claims guidance including the following:

- Provider and Service Eligibility
- Behavioral Health (BH) Service Provision Requirements
- Disability Service Provision Requirements
- General Billing Policies
- Billing Codes and Fee Schedules

Available Funds

The sources of funding for behavioral health and disability services include both State and Federal resources. State funds are those designated for the Iowa Department of Health and Human Services (Iowa HHS) for specific programming through State of Iowa appropriations. Federal funds are those received through the U.S. Department of Health and Human Services. Providers who qualify for the SUPTRS fee schedule, by meeting specific requirements, are eligible to receive substance use disorder treatment service reimbursement via federal funds. Safety net funds reimbursed through SNMIS are considered the payment of last resort.

Provider and Service Eligibility

Providers Eligible to Participate

To submit claims for services through SNMIS, providers must be enrolled and in good standing with Iowa Medicaid, and any applicable licensing, certification, or accreditation bodies. SNMIS is a separate system from Medicaid but uses the same provider enrollment information. Information on enrolling with Iowa Medicaid can be found here: Medicaid Provider Enrollment.

Services listed on the Behavioral Health Fee Schedule and the Disability Services Fee Schedule are reimbursable for an “open network” of providers. Any provider who is enrolled with Iowa Medicaid and providing services within the scope of their license, accreditation, or certification may bill for services rendered. Qualifications to provide specific services are detailed in the fee schedules below.

Services listed on the SUPTRS Fee Schedule are reimbursable only to a “designated network” of providers who are approved by Iowa HHS. Iowa Medicaid-enrolled, non-profit/not-for-profit organizations (NFPs) are eligible to submit payment for services through SNMIS. Service providers

must meet the qualification requirements to provide the service. An NFP is an entity formed for purposes other than generating a profit and where no part of the organization's income is distributed to its members, directors, or officers.

Financial Eligibility for Individuals

Behavioral Health and SUPTRS Eligibility

For behavioral health services including substance use disorder services under the SUPTRS fee schedule, providers shall complete the financial eligibility form for each individual prior to providing service for the first time and at least annually thereafter. The form and supporting documentation must be kept on file and furnished to Iowa HHS upon request. A copy of the completed form, including the determination of eligibility, must be provided to the individual receiving services or their guardian.

- Behavioral Health Eligibility Form

Reimbursement for behavioral health services and substance use disorder services is subject to the financial eligibility and resource requirements for Iowa residents in Iowa Administrative Code (IAC) 441—301.1. This includes:

- Income for adults, and household income for children, is equal to and less than 200% of the federal poverty level.
- Resource limits are equal to and less than $2,000 in countable value for a single-person household or $3,000 in countable value for a multi person household. The following resources are exempt:
    - A homestead, including equity in a family home or farm that is used as the individual household's principal place of residence. The homestead will include all land that is contiguous to the home and the buildings located on the land.
    - One automobile used for transportation.
    - Tools of an actively pursued trade.
    - General household furnishings and personal items.
    - Burial account or trust limited in value as to that allowed in the medical assistance program.
    - Cash surrender value of life insurance with a face value of less than $1,500 on any one person.
    - Any resource determined excludable by the Social Security Administration because of an approved Social Security Administration work incentive.
- Additional exemptions may apply to individuals who do not qualify for federally funded or state-funded services or other support:
    - A retirement account that is in the accumulation stage.
    - A medical savings account.
    - An assistive technology account.
    - A burial account or trust limited in value as to that allowed in the medical assistance program.
- Assets in an ABLE account and distributions from the account for qualified disability expenses should be disregarded when determining the designated beneficiary's eligibility for Behavioral Health safety net services. A distribution from an ABLE account is not income, but rather, is a

conversion of resource from one form to another. Do not count distributions from an ABLE account as income to the designated beneficiary.

For individuals seeking gambling disorder treatment services, the following may also be taken into consideration:

- Burden of gambling related debt reduces the patient income to or below 200% of the federal poverty level.
- For individuals without financial resources to pay for gambling disorder treatment services, providers must actively support enrollment in Medicaid.

Disability Services Eligibility

For disability services, the form will be completed by the Disability Access Point (DAP). The form and supporting documentation must be kept on file and furnished to Iowa HHS upon request.

Payment for any services rendered without first determining financial eligibility or provided to an individual who does not meet requirements, is subject to recoupment by Iowa HHS. Financial and resource requirements, and needs-based eligibility for Iowa residents in Iowa Administrative Code (IAC) 441—223.1.

Need-based eligibility includes:

- An individual must have a disability and reside in or be at risk of residing in institutional settings due to the individual's disability.
- The results of a standardized functional assessment must support the type and frequency of disability services identified in the individual's case plan.

Reimbursement for disability services is subject to financial eligibility and resource requirements for Iowa residents in IAC 441—223.1. This includes:

- An adult with disabilities will have an income equal to or less than 200% of the federal poverty level.
- A family of a child with disabilities will have an income equal to or less than 200% of the federal poverty level.
- There are no resource limits for families of children seeking services. For adults, resource limits are equal to or less than $2,000 in countable value for a single-person household or $3,000 in countable value for a multi person household. The following resources are exempt:
    - A homestead, including equity in a family home or farm that is used as the individual household's principal place of residence. The homestead will include all land that is contiguous to the home and the buildings located on the land.
    - One automobile used for transportation.
    - Tools of an actively pursued trade.
    - General household furnishings and personal items.
    - Burial account or trust limited in value as to that allowed in the medical assistance program.
    - Cash surrender value of life insurance with a face value of less than $1,500 on any one person.

    - Any resource determined excludable by the Social Security Administration because of an approved Social Security Administration work incentive.
- Additional exemptions may apply to individuals who do not qualify for federally funded or state-funded services or other support:
    - A retirement account that is in the accumulation stage.
    - A medical savings account.
    - An assistive technology account.
    - A burial account or trust limited in value as to that allowed in the medical assistance program.
- Assets in an ABLE account and distributions from the account for qualified disability expenses should be disregarded when determining the designated beneficiary's eligibility for non-Medicaid safety net Disability Services. A distribution from an ABLE account is not income, but rather, is a conversion of resource from one form to another. Do not count distributions from an ABLE account as income to the designated beneficiary.

Client Appeals

If a client is dissatisfied with a financial eligibility determination, they have a right to appeal the decision. The person completing the Financial Eligibility form with the individual is responsible for providing a copy of the appeal rights information. Additional information, including the appeals form for the behavioral health and disability services system for can be found at https://hhs.iowa.gov/appeals.

Requirements for Provision of Behavioral Health Services

Crisis Services

Crisis services are provided to individuals experiencing a behavioral health crisis aimed at assessment and intervention to stabilize the individual's level of functioning.

Crisis services are not subject to financial or needs-based eligibility and are available to any person who needs the service. Crisis services that are reimbursable through SNMIS are:

- Mobile Response
- Crisis Evaluation (including crisis screening and assessment)
- Crisis Stabilization Residential
- Crisis Stabilization Community Based
- 23-hour Observation and Holding

Payment will be approved for services provided by qualified crisis provider staff in the individual's home or location in the community where the individual is experiencing a behavioral health crisis. Payment shall be made only for time spent in face-to-face services with the individual. The provision of crisis services must meet requirements in IAC 441—Chapter 24.

Crisis services for individuals who have co-occurring, or multi-occurring conditions focus on the integration and coordination of treatment services, and supports necessary to stabilize the individual,

without regard to which condition is primary. Crisis services are not to be denied due to the presence of a co-occurring substance use disorder, or developmental or neurodevelopmental disability.

Treatment Services

Treatment services are clinical inpatient, outpatient, or community-based care for individuals with a behavioral health condition or disorder diagnosed utilizing the criteria provided in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association (APA). The type, length, and intensity/frequency of interventions used by a behavioral health provider are based on the presenting symptoms of the individual.

Behavioral health treatment services are subject to financial eligibility requirements. Services that are reimbursable through SNMIS are:

- Diagnostic Evaluation
- Outpatient Therapy
- Psychiatric Medication Prescribing and Management
- Partial Hospitalization
- Inpatient Hospitalization
- Intensive Outpatient Programs (IOP)
- Assertive Community Treatment (ACT)
- Intensive Psychiatric Rehabilitation (IPR)
- Community Psychiatric Support Programs
- Subacute Services

Payment will be approved only for services provided within the scope of practice of the clinician or program's license or accreditation.

Commitment and Jail-Based Services

Behavioral health services related to mental health commitments are reimbursable through SNMIS for services listed on the fee schedule, such as diagnostic evaluation and inpatient hospitalization. Other commitment related expenses such as attorney fees and secure transportation may be reimbursed by invoicing Iowa HHS's Behavioral Health Administrative Services Organization (BH-ASO).

Jail-based services are **not** reimbursable through the SNMIS system. All costs for jail-based services are to be paid by the county where the individual is incarcerated. Counties may be reimbursed for these costs through the BH-ASO.

Requirements for Provision of Substance Use and Gambling Disorder Treatment Service

Outpatient Treatment Services

Substance use and gambling disorder treatment services are subject to financial eligibility requirements. Services that are reimbursable through SNMIS are:

- Assessment
- Outpatient Treatment
- Intensive Outpatient (IOP) Treatment
- Partial Hospitalization (SUD only)
- Residential Treatment (SUD only)

Outpatient Gambling Disorder Treatment Requirement

Per Iowa Code 135.150, a person shall not maintain or conduct a gambling treatment program funded through the department unless the person has obtained a license for the program from the department. The department shall adopt rules to establish standards for the licensing and operation of gambling treatment programs under this section. The rules shall specify, but are not limited to specifying, the qualifications for persons providing gambling treatment services, standards for the organization and administration of gambling treatment programs, and a mechanism to monitor compliance with this section and the rules adopted under this section.

A clinical determination of medical necessity is required for reimbursement of services. Medical necessity is based on the third edition of the American Society of Addiction Medicine (ASAM) criteria. An individual must have a current substance use or gambling disorder diagnosis to be eligible for SNMIS payment of these services.

Requirements for Provision of Disability Services

Long Term Services and Supports (LTSS)

LTSS includes activities that support individuals with disabilities at the most independent level of care possible, including facility diversion or transition to community-based services. Individuals must have an assessed need for assistance with activities of daily living or need assistance due to their inability to function independently in their home or community related to their disability. Assessment tools and level of care tiers will be utilized like those for Medicaid Home and Community-Based Services (HCBS) Waiver and Habilitation programs.

Long Term Services and Supports that are reimbursable through the SNMIS are:

- Supported Community Living (SCL) and Home-Based Habilitation
- Intensive Residential Service Homes (IRSH)
- Residential Care Facility
- Adult Day Service
- Respite
- Attendant Care Services
- Personal Response System
- Portable Locator System
- Supported Employment including Individual Placement and Supports (IPS)
- Long-Term Job Coaching
- Prevocational Services

- Vocational Skills Training
- Day Habilitation

The individual shall have a service plan which is developed by the interdisciplinary team. This must be completed before service provision and annually thereafter, or more often if there is a change in the individual's needs. The interdisciplinary team shall include the individual, or if a minor the individual's custodial parent(s) or guardian.

General Billing Policies

Behavioral health and disability services providers are reimbursed based on a fee schedule.

All providers must follow standard billing procedures unless otherwise specified in this billing guide. Standard procedures include, but are not limited to, use of Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) procedure codes and modifiers, International Classification of Diseases – 10th Edition (ICD-10) diagnosis codes, and other standard codes as detailed in this guide.

Registration and Claim Form Instructions

Enrolled providers must register with Electronic Data Interchange Support Services (EDISS) for the SNMIS line of business. When registering and submitting claims, providers must use Payer ID 18049 which is the same as the Medicaid Payer ID, but must also use Receiver ID 0028, which is different than the Medicaid receiver ID and will be used to differentiate claims being submitted to SNMIS from those submitted to Medicaid.

For providers who are using a vendor/clearinghouse for electronic claim submission, the vendor will also be required to update their registration in EDISS to select the SNMIS line of business.

During registration, providers must set up the transactions for claims submission, and to receive a remittance advice. Select the 837P transaction for professional claims, and/or the 837I transaction for institutional claims, as well as the 835 transaction for the remittance advice.

After successfully registering for the SNMIS line of business, providers will be required to submit 10 test claims for each type of claim (professional or institutional) that they intend to use. It may be possible to skip this step if the provider is using a vendor that has completed enough test claims to have "blanket approval" for production status.

Claim form instructions and billing procedures can be found in the SNMIS Companion Guide.

Providers will submit electronic claims within 45 days from the date of service. A claim may be resubmitted or adjusted if it is submitted within 45 days from the last date of adjudication. No claim will be paid past 180 days from the date of service. Electronic Health Record (EHR) systems may have the ability to submit electronically through an Electronic Data Interchange (EDI) clearinghouse; providers may also opt use the free ABILITY PC-ACE Pro software to generate claims that can be submitted electronically through the Iowa portal.

SNMIS will adjudicate these claims and determine whether to pay or deny the request and a notification will be sent to the provider via an electronic remittance advice. Providers are expected to resolve any system errors or denied claims issues within 45 days of receiving the notification. If a

provider needs assistance with resolving a claim, providers can reach out via the Iowa HHS Behavioral Health email box at BHassistance@hhs.iowa.gov or the Disability Services email box at DSassistance@hhs.iowa.gov.

Claim adjustments to make corrections for claims that that were paid incorrectly, such as those due to an incorrect number of units, missing reimbursement for a covered service, or correcting claims that had a line denied with other paid claims, can be submitted to SNMIS and must include the original Transaction Control Number (TCN) and dates of service. These adjustments will use frequency code "7".

Credit claims are used for returning funds/overpayments that will require SNMIS to take money back, such as those due to duplicate claims, incorrect billings that need to be voided, payment for services not rendered, or client eligibility issues. These can be submitted to SNMIS and must include the original TCN and dates of service. These adjustments will use frequency code "8".

When a claim adjustment or credit claim results in funds owed back to SNMIS, the amount will be offset against other claims processed in that cycle. If the amount in that claim cycle is not enough to cover the adjustment, the provider will have a credit balance that will be offset with future claims.

For claims that were fully denied, corrections should be submitted as a new claim rather than an adjustment.

Billing Policies

The Behavioral Health and Disability Service System is the payor of last resort. Providers must bill Medicaid for individuals eligible for Medicaid. Medicaid eligibility may be checked by calling the Iowa Medicaid Eligibility Verification System (ELVS) line at (800) 338-7752 or accessing the Medicaid secure web portal. Providers who are certified as a Community Mental Health Center (CMHC) or Certified Community Behavioral Health Clinic (CCBHC) must utilize CMHC or CCBHC funding streams rather than billing for services through SNMIS.

Providers must utilize all available funding from third party payors. Safety net funding cannot be used when there is another available payment source.

Safety net payment may be made when a service is not covered by another payment source, however reimbursement cannot be made when funding is available through other sources.

- For example, if an eligible individual has insurance coverage for mental health therapy visits, but their plan does not cover other services such as Crisis Stabilization Residential Services (CSRS), the therapy visits would not be reimbursable under safety net funding, but the CSRS could be reimbursed.

An individual may have different payors for different treatment services.

- For example, an individual may receive medical care through an insurance health plan, or at a Federally Qualified Health Center (FQHC) but may not have coverage for substance use disorder Licensed Program Services. In this example, medical care would be paid for by the health plan or the FQHC, and the substance use disorder treatment Licensed Program Services could be paid by safety net funding.

Safety net funding can pay for Medicaid (b)(3) services that are also on the SNMIS fee schedule but are not covered by Medicaid during the gap period between enrollment in Medicaid and assignment to a managed care organization.

Refusal by an individual's Managed Care Organization (MCO), insurer, or other payor to authorize a service covered by that payor, or the denial of a covered service claim by an MCO, insurer, or other payor, does not make that individual eligible for safety net funding and does not make that service payable through SNMIS.

Billing SNMIS as secondary to another payment source will not be allowed. This includes situations where a person has insurance coverage but has a high deductible. The behavioral health safety net service system is intended to provide services to Iowans who are uninsured or underinsured, but not to supplement other reimbursement.

When billing the safety net system, reimbursement must be accepted as payment in full. Additional fees such as co-pays must not be charged to safety-net service recipients.

Providers shall immediately repay Iowa HHS in full for any claims where the provider received payment from another party after being paid with Behavioral Health Service System funding. If a provider owes any repayment amount, Iowa HHS may offset the sum owed by withholding payment from future claims.

Iowa residents who meet the eligibility requirements may receive services from the enrolled and qualified providers of their choice.

General Requirements for Coverage and Payment

In the provision of services, providers are required to adhere to all state and federal laws and regulations; as well as any requirements related to licensure, accreditation, or certification.

To be reimbursed for services, providers must adhere to the following standards for service documentation and maintenance of fiscal and clinical records.

Documentation

Providers must maintain records for seven years from the date of service as evidence that the services provided were:

- Medically necessary
- Consistent with the diagnosis of the individual's condition, and
- Consistent with evidence-based practice

Individual Record

The individual record shall indicate the individual's history including other known services and supports, plan of care, and progress in response to the services rendered including any changes in treatment, alteration of the plan of care, or revision of the diagnosis. Documentation must include any treatment plan, crisis stabilization plan, comprehensive service plan, or similar plan of care applicable under the provider's scope of licensure, accreditation, or certification.

At the conclusion of services, the individual's record shall include a discharge summary that identifies:

- Reason for discharge
- Date of discharge
- Recommended action or referrals upon discharge
- Treatment progress and outcomes. The discharge summary shall be included in the individual's record within 72 hours of discharge

For Mobile Response, a contact note which includes recommended follow-up, actions, and referrals will meet the requirement for a discharge summary.

Progress Notes

The provider's file for each individual must include progress notes for each date of service that details specific services rendered related to the covered service for which a claim is submitted. The following items must be included in each progress note entry, for each individual, and for each date of service:

- The date and amount of time services were delivered, including the beginning and ending time of service delivery, including AM or PM.
- The full name of the provider agency.
- The first and last name and title of provider staff rendering the service, as well as that person's signature and any accompanying credentials.
- A description of the specific components of the service being provided, including the nature of contact, relative to the service that was rendered. The progress note must describe what specifically was done, and how the service addressed the symptoms or behaviors resulting from the individual's condition.
- The place or location where service was rendered.
- The type and number of units provided.
- For services other than Mobile Response, progress notes shall include the progress and barriers to achieving the goals and objectives stated in the treatment plan, service plan, or crisis stabilization plan.

Access to Records

Providers shall permit any authorized representative of Iowa HHS, and where federal funds are involved the Comptroller General of the United States, or any other authorized representative of the United States government, to access and examine, audit, excerpt, and transcribe any directly pertinent books, documents, papers, electronic or optically stored and created records or other records of the provider relating to orders, invoices or payments, wherever such records may be located. A provider shall not impose a charge for audit or examination of the provider's books and records.

Policy Regarding Discrimination, Harassment, Affirmative Action and Equal Employment Opportunity

It is the policy of the Iowa HHS to provide equal treatment in employment and provision of services to applicants, employees and clients without regard to race, color, national origin, sex, sexual orientation, religion, age, disability, political belief or veteran status.

If you feel HHS has discriminated against or harassed you, please send a letter detailing your complaint to: Iowa HHS, Lucas Building, Bureau of Human Resources, 4th Floor, 321 East 12th Street, Des Moines, IA 50319 -0114 or via email HR@hhs.iowa.gov.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.), should contact the agency (state or local) where they applied for benefits. Additionally, program information may be made available in languages other than English.

This institution is an equal opportunity provider.

Billing Codes and Fee Schedules

Behavioral Health Services Fee Schedule

Behavioral Health crisis and treatment services may be billed based on the following fee schedule.

Providers may only bill for services for which they are qualified under the scope of their licensure, certification, or accreditation and adhere to the Medicaid provider-specific policies, unless otherwise specified in this billing guide. Providers must be enrolled under the applicable Medicaid provider type for the service (see *Service Specific Requirements and Limitations* below).

All claims on this fee schedule must be billed on the Professional claim form unless otherwise noted in the Billing Requirements and Limitations column.

Procedure Code	Modifier (see Modifier key)	Service Name	Description	Unit Type	Rate	Eligible Provider Types (see Provider Type key)	Billing Requirements & Limitations (see Place of Service code key)
90791	--	Diagnostic Evaluation	Integrated behavioral health assessment, including history, mental status, and recommendations. Also includes crisis evaluation.	Per Evaluation	$135.15	02, 03, 21, 29, 48, 50, 62, 68, 80, 88	Limitation: Access Centers may not bill this for patients subsequently admitted to CSRS, as evaluation is included in the CSRS rate.
90792	--	Diagnostic Interview with Medical Services	Integrated behavioral health diagnostic assessment, with medical services Note: this code may be used for billing the initial medical assessment for Medications for Opioid Use Disorder (MOUD)	Per Evaluation	$168.94	02, 03, 21, 50, 62, 68, 80, 88	Limitation: Access Centers may not bill this for patients subsequently admitted to CSRS, as evaluation is included in the CSRS rate.

Procedure Code	Modifier (see Modifier key)	Service Name	Description	Unit Type	Rate	Eligible Provider Types (see Provider Type key)	Billing Requirements & Limitations (see Place of Service code key)
90832	--	Psychotherapy, Individual, 30 mins	Psychotherapy services 30 minutes with patient by a licensed mental health provider	30 Minutes	$50.57	02, 03, 21, 29, 48, 50, 62, 68, 88	Valid POS codes: 02, 10, 11, 12, 17, 19, 20, 22, 27, 53, 57, 58, 71, 72
90833	--	Psychotherapy, Individual, 30 mins, with E&M	Psychotherapy services 30 minutes with patient, add-on to evaluation and management visit	30 Minutes	$59.76	02, 03, 21, 50, 62, 68, 88	Valid POS codes: 02, 10, 11, 12, 17, 19, 20, 22, 27, 53, 57, 58, 71, 72
90834	--	Psychotherapy, Individual, 45 mins	Psychotherapy services 45 minutes with patient by a licensed mental health provider	45 Minutes	$75.85	02, 03, 21, 29, 48, 50, 62, 68, 88	Valid POS codes: 02, 10, 11, 12, 17, 19, 20, 22, 27, 53, 57, 58, 71, 72
90836	--	Psychotherapy, Individual, 45 mins, with E&M	Psychotherapy services 45 minutes with patient, add-on to evaluation and management visit	45 Minutes	$66.50	02, 03, 21, 50, 62, 68, 88	Valid POS codes: 02, 10, 11, 12, 17, 19, 20, 22, 27, 53, 57, 58, 71, 72
90837	--	Psychotherapy, Individual, 60 mins	Psychotherapy services 60 minutes with patient by a licensed mental health provider	60 Minutes	$101.12	02, 03, 21, 29, 48, 50, 62, 68, 88	Valid POS codes: 02, 10, 11, 12, 17, 19, 20, 22, 27, 53, 57, 58, 71, 72
90838	--	Psychotherapy, Individual, 60 mins, with E&M	Psychotherapy services 60 minutes with patient, add-on to evaluation and management visit	60 Minutes	$75.32	02, 03, 21, 50, 62, 68, 88	Valid POS codes: 02, 10, 11, 12, 17, 19, 20, 22, 27, 53, 57, 58, 71, 72

Procedure Code	Modifier (see Modifier key)	Service Name	Description	Unit Type	Rate	Eligible Provider Types (see Provider Type key)	Billing Requirements & Limitations (see Place of Service code key)
90839	--	Psychotherapy for crisis, initial 60 minutes	Psychotherapy for Crisis, first hour, including urgent assessment and history of the crisis state, mental status exam, and disposition.	60 Minutes	$87.30	02, 03, 21, 29, 48, 50, 62, 68, 88	Valid POS codes: 03, 11, 12, 15, 16, 17, 19, 20, 21, 22, 27, 53, 57, 58, 71, 72 Unit Maximum: 1 Unit
90840	--	Psychotherapy for crisis, additional 30 minutes	Psychotherapy for Crisis, add-on for each additional 30 minutes	30 Minutes	$34.92	02, 03, 21, 29, 48, 50, 62, 68, 88	Valid POS codes: 03, 11, 12, 15, 16, 17, 19, 20, 21, 22, 27, 53, 57, 58, 71, 72 Unit Maximum: 3 Units
90846	--	Psychotherapy, Family Therapy without Patient, 50 mins	Family Psychotherapy services without patient, 50 minutes by a licensed mental health provider	50 Minutes	$99.04	02, 03, 21, 29, 48, 50, 62, 68, 88	Valid POS codes: 02, 10, 11, 12, 17, 19, 20, 22, 27, 53, 57, 58, 71, 72
90847	--	Psychotherapy, Family Therapy with Patient, 50 mins	Family Psychotherapy services with patient, 50 minutes by a licensed mental health provider	50 Minutes	$99.04	02, 03, 21, 29, 48, 50, 62, 68, 88	Valid POS codes: 02, 10, 11, 12, 17, 19, 20, 22, 27, 53, 57, 58, 71, 72
90849	--	Psychotherapy, Multi-family Group Therapy, 60 mins	Multi-Family Group Psychotherapy services, 60 minutes by a licensed mental health provider	60 Minutes	$56.29	02, 03, 21, 29, 48, 50, 62, 68, 88	Valid POS codes: 02, 10, 11, 17, 19, 20, 22, 27, 53, 57, 58, 71, 72
90853	HE	Psychotherapy, Group Psychotherapy	Mental Health Group Psychotherapy services, 60 minutes by a licensed mental health provider	60 Minutes	$56.29	02, 03, 21, 29, 48, 50, 62, 68, 88	Valid POS codes: 02, 10, 11, 17, 19, 20, 22, 27, 53, 57, 58, 71, 72

Procedure Code	Modifier (see Modifier key)	Service Name	Description	Unit Type	Rate	Eligible Provider Types (see Provider Type key)	Billing Requirements & Limitations (see Place of Service code key)
96127	--	Brief Emotional-Behavioral Assessment	Brief assessment using standardized instrument	Per Assessment	$52.28	02, 03, 21, 29, 48, 50, 62, 68, 88	
99202	--	Psychiatric Visit, New patient, straightforward, avg 15 mins	Psychiatric Outpatient Office Visit, New Patient, with straightforward medical decision making, 15 minutes	15 Minutes	$13.95	02,03, 21, 50, 62, 68, 88	Valid POS codes: 02, 10, 11, 12, 17, 19, 20, 22, 27, 53, 57, 58, 71, 72
99203	--	Psychiatric Visit, New patient, low, avg 30 mins	Psychiatric Outpatient Office Visit, New Patient, with low level of medical decision making, 30 minutes	30 Minutes	$27.91	02, 03, 21, 50, 62, 68, 88	Valid POS codes: 02, 10, 11, 12, 17, 19, 20, 22, 27, 53, 57, 58, 71, 72
99204	--	Psychiatric Visit, New patient, moderate, avg 45 mins	Psychiatric Outpatient Office Visit, New Patient, with moderate level of medical decision making, 45 minutes	45 Minutes	$50.50	02, 03, 21, 50, 62, 68, 88	Valid POS codes: 02, 10, 11, 12, 17, 19, 20, 22, 27, 53, 57, 58, 71, 72
99205	--	Psychiatric Visit, New patient, high, avg 60 mins	Psychiatric Outpatient Office Visit, New Patient, with high level of medical decision making, 60 minutes	60 Minutes	$56.81	02, 03, 21, 50, 62, 68, 88	Valid POS codes: 02, 10, 11, 12, 17, 19, 20, 22, 27, 53, 57, 58, 71, 72
99211	--	Psychiatric Visit, Established patient, may not req physician, avg 5 mins	Psychiatric Outpatient Office Visit, Established Patient, for Evaluation and Management that may not require presence of healthcare professional, Avg 5 minutes	5 Minutes	$11.63	02, 03, 21, 50, 62, 68, 88	Valid POS codes: 02, 10, 11, 12, 17, 19, 20, 22, 27, 53, 57, 58, 71, 72

Procedure Code	Modifier (see Modifier key)	Service Name	Description	Unit Type	Rate	Eligible Provider Types (see Provider Type key)	Billing Requirements & Limitations (see Place of Service code key)
99212	--	Psychiatric Visit, Established patient, straightforward, avg 10 mins	Psychiatric Outpatient Office Visit, Established Patient, with straightforward medical decision making, 10 minutes	10 Minutes	$20.35	02, 03, 21, 50, 62, 68, 88	Valid POS codes: 02, 10, 11, 12, 17, 19, 20, 22, 27, 53, 57, 58, 71, 72
99213	--	Psychiatric Visit, established patient, low, avg 20 mins	Psychiatric Outpatient Office Visit, Established Patient, with low level of medical decision making, 20 minutes	20 Minutes	$29.07	02, 03, 21, 50, 62, 68, 88	Valid POS codes: 02, 10, 11, 12, 17, 19, 20, 22, 27, 53, 57, 58, 71, 72
99214	--	Psychiatric Visit, established patient, moderate, avg 30 mins	Psychiatric Outpatient Office Visit, Established Patient, with moderate level of medical decision making, 30 minutes	30 Minutes	$31.40	02, 03, 21, 50, 62, 68, 88	Valid POS codes: 02, 10, 11, 12, 17, 19, 20, 22, 27, 53, 57, 58, 71, 72
99215	--	Psychiatric Visit, Established patient, high, avg 40 mins	Psychiatric Outpatient Office Visit, Established Patient, with high level of medical decision making, 40 minutes	40 Minutes	$53.65	02, 03, 21, 50, 62, 68, 88	Valid POS codes: 02, 10, 11, 12, 17, 19, 20, 22, 27, 53, 57, 58, 71, 72
99223	--	Initial hospital Inpatient or Observation Care, E&M	Initial hospital inpatient or observation care visit involving evaluation and management, any length of time	Per Visit	$67.70	02, 03, 50, 68	

Procedure Code	Modifier (see Modifier key)	Service Name	Description	Unit Type	Rate	Eligible Provider Types (see Provider Type key)	Billing Requirements & Limitations (see Place of Service code key)
99233	--	Subsequent Hospital Inpatient or Observation Care, E&M	Subsequent hospital inpatient or observation care visit involving evaluation and management, any length of time	Per Visit	$26.44	02, 03, 50, 68	
H0017	--	Psychiatric Inpatient	Inpatient Psychiatric Hospitalization (non-MHI)	Daily	$747.21	01	Institutional Claim. Include Revenue Code 0190
H2011	--	Mobile Crisis Response	Mobile Crisis Response, 15 minutes	15 Minutes	$53.76	80	
H2013	--	Subacute Facility	Mental Health Subacute Facility, Per Diem	Daily	$391.00	81	Institutional Claim. Include Revenue Code 0190
H2017	--	Intensive Psychiatric Rehabilitation (IPR)	Intensive Psychiatric Rehabilitation Program, 15 Minutes	15 Minutes	$21.68	62	Unit Maximum: 25 Units
S0201	--	23-hour Crisis Observation & Holding	23 Hour Crisis Observation and Holding, 8 to 23 Hours, Per Diem	Daily	$403.84	01, 80	Institutional Claim. Include Revenue Code 762
S9480	--	Intensive Outpatient Program	Mental Health Intensive Outpatient Program, Per Diem	Daily	$96.48	01, 62	
S9484	--	Crisis Stabilization Community-Based Services	Crisis Stabilization Community Based, Hourly, Under 8 Hours	Hourly	$53.76	80	

Procedure Code	Modifier (see Modifier key)	Service Name	Description	Unit Type	Rate	Eligible Provider Types (see Provider Type key)	Billing Requirements & Limitations (see Place of Service code key)
S9484	TG	Crisis Stabilization Residential Services	Crisis Stabilization Residential, Hourly, Under 8 Hours	Hourly	$72.44	80	
S9485	TF	Crisis Stabilization Community-Based Services	Crisis Stabilization Community Based, 8 to 24 hours	Daily	$352.09	80	Institutional Claim. Include Revenue Code 761
S9485	TG	Crisis Stabilization Residential Services	Crisis Stabilization Residential Services, 8 to 24 hours	Daily	$352.09	80	Institutional Claim. Include Revenue Code 762
T2048	--	Psychiatric Medical Institutions for Children (PMIC)	Psychiatric Medical Institutions for Children, Per Diem; By Exception to Policy Only	Daily	$395.21	41	Limitation: Reimbursable only by Exception to Policy Valid POS codes: 56
H0035	HE	Mental Health Partial Hospitalization	Mental Health Partial Hospitalization, Under 24 hours	Daily	$302.86	01, 62	Date span billing is allowable
H0037	--	Community Psychiatric Supportive Treatment Program	Mental Health Community Support Program, Monthly, Low Intensity	Monthly	$146.69	62	

Procedure Code	Modifier (see Modifier key)	Service Name	Description	Unit Type	Rate	Eligible Provider Types (see Provider Type key)	Billing Requirements & Limitations (see Place of Service code key)
H0037	TF	Community Psychiatric Supportive Treatment Program	Mental Health Community Support Program, Monthly, High Intensity	Monthly	$413.95	62	
H0040	--	Assertive Community Treatment	Assertive Community Treatment Program, Daily	Daily	$71.32	62, 67	Limitation: Reimbursable a maximum of 5 days per week

IOWA | Health and Human Services

SUPTRS Fee Schedule

Iowa HHS has allocated a portion of the SUPTRS Block Grant to subsidize the cost of substance use disorder (SUD) treatment services. Designated SUD treatment providers, who have an existing infrastructure designed to meet the SUPTRS federal regulations, may utilize this fee schedule.

These providers must ensure residential treatment services are readily accessible, comprehensive, appropriate to the persons seeking the services, flexible to meet the evolving needs of patients, and effective. Residential treatment must be available when needed, with minimal wait times, regardless of available funding.

All claims on this fee schedule must be billed on the Professional claim form.

Procedure Code	Modifier (see modifier key)	Service Name	Description	Unit Type	Rate	Service Limitations (see Place of Service code key)
90791	HF	Diagnostic Evaluation/ Assessment	Integrated behavioral health, SUD assessment Also includes crisis evaluation. OWI assessments are not reimbursable.	Per Evaluation	$159.00	Once per Treatment Episode Valid POS codes: 02, 09, 55, 57, 58
90791	HV	Diagnostic Evaluation/ Assessment	Integrated behavioral health, SUD assessment Also includes crisis evaluation. OWI assessments are not reimbursable.	Per Evaluation	$159.00	Once per Treatment Episode Valid POS codes: 02, 09, 55, 57, 58
90791	QJ	Diagnostic Evaluation/ Assessment	Integrated behavioral health, SUD assessment Also includes crisis evaluation. OWI assessments are not reimbursable	Per Evaluation	$159.00	Once per Treatment Episode Valid POS codes: 02, 09, 55, 57, 58
H0004	--	Behavioral health counseling and therapy, per 15 minutes	Behavioral health counseling and therapy, per 15 minutes	15 Minutes	$29.75	4 Units Per Day Valid POS codes: 02, 55, 57, 58

Procedure Code	Modifier (see modifier key)	Service Name	Description	Unit Type	Rate	Service Limitations (see Place of Service code key)
H0004	HV	Behavioral health counseling and therapy, per 15 minutes	Behavioral health counseling and therapy, per 15 minutes	15 Minutes	$29.75	4 Units Per Day Valid POS codes: 02, 55, 57, 58
H0005	--	Alcohol, drug and/or gambling services; group counseling by a clinician	Alcohol, drug and/or gambling services; group counseling by a clinician>15 min	15 Minutes	$16.55	None Valid POS codes: 02, 55, 57, 58
H0005	HV	Alcohol, drug and/or gambling services; group counseling by a clinician	Alcohol, drug and/or gambling services; group counseling by a clinician>15 min	15 Minutes	$16.55	None Valid POS codes: 02, 55, 57, 58
H2034	--	Level III.1 Clinically Managed Low Intensity Residential Treatment (Halfway House) Substance Use	Level III.1 Clinically Managed Low Intensity Residential Treatment (Halfway House) Substance Use	Daily	$138.84	1 Unit Per Day Valid POS codes: 55 Date span billing is allowable
H2034	HK	Level III.1 Clinically Managed Low Intensity Residential Treatment (Halfway House) Substance Use	Level III.1 Clinically Managed Low Intensity Residential Treatment (Halfway House) Substance Use	Daily	$238.84	1 Unit Per Day Valid POS codes: 55 Date span billing is allowable
H0015	--	Alcohol, drug and/or gambling services; intensive outpatient	Alcohol, drug and/or gambling services; intensive outpatient	Daily	$223.66	1 Unit Per Day; Max of 3 Units per 7-day period Valid POS codes: 02, 55, 57, 58 Date span billing is allowable
H0015	HV	Alcohol, drug and/or gambling services; intensive outpatient	Alcohol, drug and/or gambling services; intensive outpatient	Daily	$223.66	1 Unit Per Day; Max of 3 Units per 7-day period Valid POS codes: 02, 55, 57, 58

Procedure Code	Modifier (see modifier key)	Service Name	Description	Unit Type	Rate	Service Limitations (see Place of Service code key)
						Date span billing is allowable
H0018	--	Level III.5 Clinically Managed High Intensity Residential Treatment Substance Use	Level III.5 Clinically Managed High Intensity Residential Treatment Substance Use	Daily	$559.19	1 Unit Per Day Valid POS codes: 55 Date span billing is allowable
H0018	HK	Level III.5 Clinically Managed High Intensity Residential Treatment Substance Use	Level III.5 Clinically Managed High Intensity Residential Treatment Substance Use (Women & Children)	Daily	$659.19	1 Unit Per Day Valid POS codes: 55 Date span billing is allowable
H0035	HF	Substance Use partial hospitalization, treatment, less than 24 hours	Substance Use partial hospitalization, treatment, less than 24 hours	Daily	$356.30	1 Unit Per Day; Max of 3 Units per 7-day period Valid POS codes: 55, 57, 58 Date span billing is allowable

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Disability Services Fee Schedule

Long Term Supports and Services (LTSS) may be billed based on the following fee schedule.

Providers may only bill for services they are qualified to provide under the scope of their licensure, certification, or accreditation. Providers must be enrolled and HCBS certified under the applicable Medicaid provider type for the services (see *Service Specific Requirements and Limitations* below).

All claims on this fee schedule must be billed on the Professional claim form unless otherwise noted in the Billing Requirements and Limitations column.

Procedure Code	Modifier (see modifier key)	Service Name	Description	Unit Type	Service Rate	Eligible Provider Types (see provider type key)	Billing Requirements & Limitations (see Place of Service code key)
A0130	--	Transportation, nonemergency medical	Transportation; nonemergent wheelchair van; individual; trip	Per Trip	$54.83	99	
A0130	U3	Transportation, nonemergency medical	Transportation; nonemergent wheelchair van; group; trip	Per Trip	$43.86	99	
H2015	--	Supported Community Living Services	Supported Community Living; 15-minute unit	15 Minutes	$10.92	09, 99	
H2016	U1	Supported Community Living Services	Comprehensive Community Support Services/Supported Community Living (SCL) – without day services*	Daily	$213.70	09, 99	Date span billing is allowable
H2016	U2	Supported Community Living Services	Supported Community Living (SCL) – without day services*	Daily	$229.08	09, 99	Date span billing is allowable
H2016	U3	Supported Community Living Services	Supported Community Living (SCL) – without day services*	Daily	$304.83	09, 99	Date span billing is allowable

Procedure Code	Modifier (see modifier key)	Service Name	Description	Unit Type	Service Rate	Eligible Provider Types (see provider type key)	Billing Requirements & Limitations (see Place of Service code key)
H2016	U4	Supported Community Living Services	Supported Community Living (SCL) – without day services*	Daily	$308.21	09, 99	Date span billing is allowable
H2016	U5	Supported Community Living Services	Supported Community Living (SCL) – without day services*	Daily	$525.97	09, 99	Date span billing is allowable
H2016	U6	Supported Community Living Services	Supported Community Living (SCL) – without day services*	Daily	$703.90	09, 99	Date span billing is allowable
H2016	U7	Intensive Residential Services (SCL, HBH)	Intensive Residential Services, 24 hours per day, per diem	Daily	$582.23	64, 99	Date span billing is allowable
H2016	HI	Supported Community Living Services	SCL provided in a residential care facility (RCF) licensed for 6 or more beds - without day services	Daily	$140.81	99	Date span billing is allowable
H2016	UA	Home Based Habilitation, Per Diem	Home-Based Habilitation High Recovery .25 to 2 hours as needed	Daily	$58.70	64	Date span billing is allowable
H2016	UB	Home Based Habilitation, Per Diem	Home-Based Habilitation Recovery Transitional 2.25 to 4 hours per day as needed	Daily	$126.67	64	Date span billing is allowable
H2016	UC	Home Based Habilitation, Per Diem	Home-Based Habilitation Medium Need 4.25 to 8.75 hours per day as needed	Daily	$146.81	64	Date span billing is allowable
H2016	UD	Home Based Habilitation, Per Diem	Home-Based Habilitation Intensive I 9 to 12.75 hours per day	Daily	$236.99	64	Date span billing is allowable

Procedure Code	Modifier (see modifier key)	Service Name	Description	Unit Type	Service Rate	Eligible Provider Types (see provider type key)	Billing Requirements & Limitations (see Place of Service code key)
H2016	U8	Home Based Habilitation, Per Diem	Home-Based Habilitation Intensive II 13 to 16.75 hours per day	Daily	$240.27	64	Date span billing is allowable
H2016	U9	Home Based Habilitation, Per Diem	Home-Based Habilitation Intensive III 17- 24 hours per day	Daily	$421.87	64	Date span billing is allowable
H2023	U3	Small-Group Supported Employment	Supported Employment; (2 to 8 Individuals): Tier 1, Group of 2-4); 15-minute unit	15 Minutes	$3.19	64, 99	Date span billing is allowable
H2023	U5	Small-Group Supported Employment	Supported Employment; (2 to 8 Individuals): Tier 2, Group of 5-6); 15-minute unit	15 Minutes	$1.99	64, 99	Date span billing is allowable
H2023	U7	Small-Group Supported Employment	Supported Employment; (2 to 8 Individuals): Tier 3, Group of 7-8); 15-minute unit	15 Minutes	$1.42	64, 99	Date span billing is allowable
H2025	U4	Long-Term Job Coaching	Supported Employment (Long Term Job Coaching), Tier 1	Monthly	$76.05	64, 99	Limitation: 1 contact per month
H2025	U3	Long-Term Job Coaching	Supported Employment (Long Term Job Coaching) Tier 2	Monthly	$406.33	64, 99	Limitation: 2 - 8 hours per month
H2025	U5	Long-Term Job Coaching	Supported Employment (Long Term Job Coaching) Tier 3	Monthly	$811.53	64, 99	Limitation: 9 - 16 hours per month
H2025	U7	Long-Term Job Coaching	Supported Employment (Long Term Job Coaching) Tier 4	Monthly	$1,268.94	64, 99	Limitation: 17 - 25 hours per month

Procedure Code	Modifier (see modifier key)	Service Name	Description	Unit Type	Service Rate	Eligible Provider Types (see provider type key)	Billing Requirements & Limitations (see Place of Service code key)
H2025	UC	Long-Term Job Coaching	Supported Employment (Long Term Job Coaching) Tier 5	Hourly	$50.75	64, 99	Limitation: 26 + hours per month
S0215	--	Transportation, per mile	Transportation; per mile; individual	Per Mile	$3.11	99	
S0215	U3	Transportation, per mile	Transportation; per mile; group	Per Mile	$2.11	99	
S5102	U1	Adult Day Service	Adult Day Care Tier 1; full day	Daily	$63.33	64, 99	Date span billing is allowable
S5102	U2	Adult Day Service	Adult Day Care Tier 2; full day	Daily	$66.45	64, 99	Date span billing is allowable
S5102	U3	Adult Day Service	Adult Day Care Tier 3; full day	Daily	$75.67	64, 99	Date span billing is allowable
S5102	U4	Adult Day Service	Adult Day Care Tier 4; full day	Daily	$76.75	64, 99	Date span billing is allowable
S5102	U5	Adult Day Service	Adult Day Care Tier 5; full day	Daily	$89.37	64, 99	Date span billing is allowable
S5102	U6	Adult Day Service	Adult Day Care Tier 6; full day	Daily	$109.28	64, 99	Date span billing is allowable
S5125	--	Attendant Care Services Agency, unskilled	CDAC (agency); 15-minute unit	15 Minutes	$6.02	09, 99	
S5125	U3	Attendant Care Services Agency, skilled	CDAC (agency); 15-minute unit	15 Minutes	$6.02	09, 99	
S5130	--	Home Maintenance Support	Homemaker and chore service by agency, 15-minute units	15 Minutes	$5.84	99	Limitation: 64 units per month

Procedure Code	Modifier (see modifier key)	Service Name	Description	Unit Type	Service Rate	Eligible Provider Types (see provider type key)	Billing Requirements & Limitations (see Place of Service code key)
S5136	U1	Supported Community Living	Supported Community Living (SCL) Tier 1 – with day services, per diem	Daily	$190.54	99	
S5136	U2	Supported Community Living	Supported Community Living (SCL) Tier 2 – with day services, per diem	Daily	$205.30	99	Date span billing is allowable
S5136	U3	Supported Community Living	Supported Community Living (SCL) Tier 3 – with day services, per diem	Daily	$245.41	99	Date span billing is allowable
S5136	U4	Supported Community Living	Supported Community Living (SCL) Tier 4 – with day services, per diem	Daily	$248.80	99	Date span billing is allowable
S5136	U5	Supported Community Living	Supported Community Living (SCL) Tier 5 – with day services, per diem	Daily	$436.85	99	Date span billing is allowable
S5136	U6	Supported Community Living	Supported Community Living (SCL) Tier 6 – with day services, per diem	Daily	$602.91	99	Date span billing is allowable
S5136	HI	Supported Community Living- RCF licensed	SCL provided in a residential care facility (RCF) licensed for 6 or more beds - with day services	Daily	$118.96	99	Modifier indicates RCF setting Date span billing is allowable
S5136	UA	Residential-based supported community living (RBSCL)	Residential-Based Supported Community Living (RBSCL), youth only (17 and under), per diem	Daily	$531.85	99	Date span billing is allowable Limitation: For ages 17 and under only
S5136	UB	Residential-based supported	Residential-Based Supported Community Living (RBSCL),	Daily	$853.24	99	Date span billing is allowable

Procedure Code	Modifier (see modifier key)	Service Name	Description	Unit Type	Service Rate	Eligible Provider Types (see provider type key)	Billing Requirements & Limitations (see Place of Service code key)
		community living (RBSCL)	youth only (17 and under), per diem				Limitation: For ages 17 and under only
S5136	UC	Residential-based supported community living (RBSCL)	Residential-Based Supported Community Living (RBSCL), youth only (17 and under), per diem	Daily	$1,437.03	99	Date span billing is allowable Limitation: For ages 17 and under only
S5150	--	Basic Individual Respite – non-facility	Respite, Basic Individual; 15-minute unit	15 Minutes	$5.37	99	
S5150	U3	Specialized Individual Respite – non-facility	Respite, Specialized Individual; 15-minute unit	15 Minutes	$10.07	09, 99	
S5150	UC	Agency: Basic Individual Respite	Respite (Agency, Basic Individual); 15-minute unit	15 Minutes	$5.37	09, 99	
S5150	U3	Agency: Specialized Individual Respite	Respite (Agency, Specialized Individual); 15-minute unit	15 Minutes	$10.07	09, 99	
S5160	--	Personal Response System	Personal Emergency Response (initial fee for install)	Initial One-Time	$58.48	64, 99	
S5160	U1	Portable Locator System	Personal Emergency Locator (initial fee for install)	Initial One-Time	$58.48	64, 99	
S5161	--	Personal Response System	Personal Emergency Response (monthly)	Monthly	$45.48	64, 99	

Procedure Code	Modifier (see modifier key)	Service Name	Description	Unit Type	Service Rate	Eligible Provider Types (see provider type key)	Billing Requirements & Limitations (see Place of Service code key)
S5161	U1	Portable Locator System	Personal Emergency Locator (monthly)	Monthly	$45.48	64, 99	
S5170	--	Home-Delivered Meals	Home delivered meals noon meals, per meal	Per Meal	$9.00	99	Limitation: 31 units per month
S5170	UJ	Home-Delivered Meals	Home delivered meals liquid supplemental meal; 2 cans per meal	Per Meal	$5.72	99	Limitation: 31 units per month
T1005	--	Agency: Group Respite	Respite care services (group); 15-minute unit	15 Minutes	$3.91	64, 99	
T2003	--	Transportation, per trip	Transportation; 1-way trip; individual	Per Trip	$30.00	99	
T2003	U3	Transportation, per trip	Transportation; 1-way trip; group	Per Trip	$25.00	99	
T2015	None	Prevocational Services	Prevocational services; per hour	Hourly	$11.24	64, 99	
T2015	U3	Prevocational Services – Career Exploration	Prevocational Services – Career Exploration; per hour	Hourly	$43.00	64, 99	
T2018	U3	Supported Employment, Individual Placement and Supports (IPS), per outcome	Supported Employment, Individual Placement and Support (IPS), Per Outcome	Completed Employment Plan (1 Unit)	$1,462.22	64, 99	Completed Employment Plan
T2018	U4	Supported Employment, Individual Placement and	Supported Employment, Individual Placement and Support (IPS), Per Outcome	1st Day of Successful Placement (1 Unit)	$2,229.54	64, 99	1st Day of Successful Placement

Procedure Code	Modifier (see modifier key)	Service Name	Description	Unit Type	Service Rate	Eligible Provider Types (see provider type key)	Billing Requirements & Limitations (see Place of Service code key)
		Supports (IPS), per outcome					
T2018	U5	Supported Employment, Individual Placement and Supports (IPS), per outcome	Supported Employment, Individual Placement and Support (IPS), Per Outcome	45 Days Successful Job Retention (1 Unit)	$2,229.54	64, 99	45 Days Successful Job Retention
T2018	U6	Supported Employment, Individual Placement and Supports (IPS), per outcome	Supported Employment, Individual Placement and Support (IPS), Per Outcome	90 Days Successful Job Retention (1 Unit)	$811.53	64, 99	90 Days Successful Job Retention
T2018	UC	Individual Supported Employment	Supported Employment (Individual Employment & Job Development), Hourly	Hourly	$74.32	64, 99	Limitation: initial authorization not to exceed 40 hourly units; extended authorization not to exceed 20 hourly units
T2020	U1	Day Habilitation	Day Habilitation Tier 1; per day	Daily	$76.20	64, 99	Date span billing is allowable
T2020	U2	Day Habilitation	Day Habilitation Tier 2; per day	Daily	$79.96	64, 99	Date span billing is allowable
T2020	U3	Day Habilitation	Day Habilitation Tier 3; per day	Daily	$91.07	64, 99	Date span billing is allowable
T2020	U4	Day Habilitation	Day Habilitation Tier 4; per day	Daily	$92.36	64, 99	Date span billing is allowable

Procedure Code	Modifier (see modifier key)	Service Name	Description	Unit Type	Service Rate	Eligible Provider Types (see provider type key)	Billing Requirements & Limitations (see Place of Service code key)
T2020	U5	Day Habilitation	Day Habilitation Tier 5; per day	Daily	$107.55	64, 99	Date span billing is allowable
T2020	U6	Day Habilitation	Day Habilitation Tier 6; per day	Daily	$131.51	64, 99	Date span billing is allowable
T2021	--	Day Habilitation	Day Habilitation; 15-minute unit	15-Minute	$3.93	64, 99	
T2033	UC	RCF Maintenance	Residential Care Facility (RCF) Maintenance	Daily	$37.60	23	Date span billing is allowable Valid POS codes: 14, 33, 99 Institutional claim: Include Revenue Code 0160.
T2033	U1	RCF Per Diem	RCF Per Diem for Individuals at the Habilitation High Recovery .25 to 2 hours Tier	Daily	$58.70	23	Date span billing is allowable Valid POS codes: 14, 33, 99 Institutional claim: Include Revenue Code 0160.
T2033	U2	RCF Per Diem	RCF Per Diem for Individuals at the Habilitation Recovery Transitional 2.25 to 4 hours Tier	Daily	$126.67	23	Date span billing is allowable Valid POS codes: 14, 33, 99

Procedure Code	Modifier (see modifier key)	Service Name	Description	Unit Type	Service Rate	Eligible Provider Types (see provider type key)	Billing Requirements & Limitations (see Place of Service code key)
							Institutional claim: Include Revenue Code 0160.
T2033	U3	RCF Per Diem	RCF Per Diem for Individuals at the Habilitation Medium Need 4.25 to 8.75 hours Tier	Daily	$146.81	23	Date span billing is allowable Valid POS codes: 14, 33, 99 Institutional claim: Include Revenue Code 0160.
T2033	U4	RCF Per Diem	RCF Per Diem for Individuals at the Habilitation Intensive I 9 to 12.75 hours Tier	Daily	$236.99	23	Date span billing is allowable Valid POS codes: 14, 33, 99 Institutional claim: Include Revenue Code 0160.
T2033	U5	RCF Per Diem	RCF Per Diem for Individuals at the Habilitation Intensive II 13 to 16.75 hours Tier	Daily	$240.27	23	Date span billing is allowable Valid POS codes: 14, 33, 99 Institutional claim: Include Revenue Code 0160.
T2033	U6	RCF Per Diem	RCF Per Diem for Individuals at the Habilitation Intensive III 17 to 24 hours Tier	Daily	$421.87	23	Date span billing is allowable

Procedure Code	Modifier (see modifier key)	Service Name	Description	Unit Type	Service Rate	Eligible Provider Types (see provider type key)	Billing Requirements & Limitations (see Place of Service code key)
							Valid POS codes: 14, 33, 99 Institutional claim: Include Revenue Code 0160.
T2033	U7	RCF Per Diem	Non-Habilitation Residential Care Facility (RCF) High Recovery 16 beds or more	Daily	$106.82	23	Date span billing is allowable Valid POS codes: 14, 33, 99 Institutional claim: Include Revenue Code 0160.
T2033	U8	RCF Per Diem	Non-Habilitation RCF-PMI	Daily	$179.57	23	Date span billing is allowable Valid POS codes: 14, 33, 99 Institutional claim: Include Revenue Code 0160.
T2037	--	Respite Care: Camps	Respite (group day camp) 15-minute unit	15-Minute	$3.91	64, 99	

Modifier Key:

HE: Mental Health Program
HV: Gambling Disorder -SUPTRS State Only
HK: Women & Children's Program -SUPTRS

HF: Substance Use Disorder
HI: Supported Community Living in a Residential Care Facility
TF: Community Based
TG: Residential
QJ: Jail Based Service-SUPTRS State Only
UJ: Liquid Supplement Meals
U--: All modifiers beginning with “U” correspond to the Level of Care or Tier, based on the individual assessment.

Provider Type Key:

01 General Hospital (Does not include state MHIs)
02 Physician M.D., with Specialty Code 26 – Psychiatry or 86 Neuropsychiatry
03 Physician D.O. with Specialty Code 26 – Psychiatry or 86 Neuropsychiatry
09 Home Health Agency
21 CMHC
23 Residential Care Facility
29 Psychologist
41 PMIC
48 Clinical Social Worker
50 Nurse Practitioner, with Specialty Code 26 – Psychiatry or 86 Neuropsychiatry
62 Behavioral Health
64 Habilitation Services
67 Assertive Community Treatment
68 Physician Assistant, with Specialty Code 26 – Psychiatry or 86 Neuropsychiatry
80 Crisis Response Services
81 Subacute Mental Health Facility
88 CCBHC
99 Waiver

Place of Service Code Key:

02 Telehealth
03 School
09 Correction Facility
10 Telehealth in patient home
11 Office
12 Patient’s Home
14 Group Home

15 Mobile Unit
16 Temporary Lodging
17 Walk-in Retail Health Clinic
19 Off Campus Outpatient Hospital
20 Urgent Care Facility
21 Inpatient Hospital
22 On Campus Outpatient Hospital
27 Outreach Street
33 Custodial Care Facility
53 CMHC
55 Residential Substance Abuse Treatment Facility
56 Psychiatric Residential Treatment Center
57 Non-Residential Substance Abuse Treatment Facility
58 Non-Residential Opioid Treatment Facility
71 State or Local Public Health Clinic
72 Rural Health Clinic
99 Other Unlisted Facility