Crisis Response and Subacute Mental Health Facility Services Frequently Asked Questions

Questions	Responses
1. Can a Crisis Stabilization Residential Services (CSRS) provider bill for psychiatry services while the member is receiving CSRS?	Services rendered by physicians (medical doctors [MD] and doctors of osteopathy [DO]), particularly psychiatrists; advanced registered nurse practitioners; and physician assistants may be separately billed to Medicaid for services rendered to members admitted to a CSRS center.
2. Can individuals who are referred to CSRS services by an outpatient psychiatry or psychotherapy provider have that service billed on the same day that the individual is admitted to the Crisis Stabilization Residential center?	Yes. Medicaid pays for multiple mental health services furnished to the same patient on the same day. CSRS and psychiatry services may be billed separately for the same date of service. Under specific circumstances, providers will need to indicate that a procedure or service was distinct, separate or independent from other services performed on the same day. Certain modifiers may be appropriate to represent different sessions or patient encounters. Multiple services rendered by a provider on the same day must be billed on the same claim form.
3. There are two separate service rates for CSRS services: • Hourly (S9484) and • Per diem (S9485). Are both of these procedure codes available for Crisis Stabilization Response service providers to use? Or is the per diem rate the expected procedure code to be used? Can both of these codes be used depending on the circumstance?	CSRS per hour S9484 (HP, HO, TD, SA, IA, HN or HM) and modifiers TF and U3 is entered on the claim when services are provided on an hourly basis in the member's community, or S9484 (HP, HO, TD, SA, IA, HN or HM) and modifiers TG and U3 when provided in a CSRS center. Total costs of hourly services may not exceed the daily per diem for CSRS. The CSRS per hour code S9484 and the per diem code S9485 are not billable for the same date of service. Providers must bill for services based on the number of hours of service provided on the specific date of service. A daily rate is applicable when a member has a need for 8 hours or more of service during a 24-hour-period. The 24-hour-period is 12:01 AM to 11:59 PM. If thw member is admitted on April 1 at 10:30 PM and discharges at 10:30 PM on April 2, using the ground rules for hourly services, the provider bills 1 hour for April 1 (1.5 hours rounded down to the hour and 1 day for April 2).
4. If the individual is considered at the day rate we would bill $360.19 per diem and this is to cover all services provided by our staff both paraprofessionals and mental health professionals?	The Residential Crisis Response Service per diem is an "all inclusive" rate meaning that the services of a mental health professional, other than the medical services identified in number 1, rendered while the member is admitted to the CSRS center are the responsibility of the CSRS center.

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5. If during our service, the individual needs to see a psychiatrist our agency is to pay for this service? Currently it costs $250 for crisis clients to see a telehealth psychiatrist while in crisis services.	The services of the psychiatrist are billed separately by the rendering physician. See response to number 1.
6. What happens if a client needs to be transported to another community for something that's relevant to their treatment plan or when they are discharged from Iowa City to Cedar Rapids, Waterloo etc.? Our staff within the$360.19 rate provided wouldn't be able to drive anyone outside of Johnson County. So is there another entity that will be doing transportation? Mileage reimbursement for staff alone to Waterloo would be around $55 roundtrip.	Enrolled FFS members and MCO enrollees with the exception of limited coverage groups may access Non-emergency Medical Transportation (NEMT) to obtain Medicaid covered services. If the member requires emergency transportation, Medicaid covers ambulance services for emergencies.
7. 90791--Psychiatric evaluation with no medical services--Can these services be provided via telehealth?	Yes 90791 and 90792 may be provided via telehealth as follows: The originating sites authorized by law are: • The offices of physicians or practitioners • Hospitals • Critical Access Hospitals (CAHs) • Rural Health Clinics • Federally Qualified Health Centers • Community Mental Health Centers (CMHCs) **Distant Site Practitioners** Practitioners at the distant site who may furnish and receive payment for covered telehealth services (subject to state law) are: • Physicians. • Nurse practitioners (NPs). • Physician assistants (PAs). • Clinical psychologists (CPs) and clinical social workers (CSWs). CPs and CSWs cannot bill for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services. These practitioners may not bill or receive payment for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838.

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8. What procedure code should be used for psychiatric evaluation with medical services? Is this part of the crisis services fee schedule or something separate?	90792 is not covered for provider type 80. Psychiatric Diagnostic Evaluation with Medical Services – This code is used for an initial diagnostic interview exam for an adult or adolescent patient that includes medical services. It includes a: • Chief complaint, • History of present illness, • Review of pertinent systems, • Family and psychosocial history, and • Complete mental status examination, as well as, any medical work such as the ordering and medical interpretation of laboratory or other diagnostic studies or the prescribing of medications. In the past most insurers would reimburse for one 90792 (then a 90801) per episode of illness. The guidelines now allow for billing this on subsequent days when there is medical necessity for an extended evaluation (i.e., when an evaluation of a child that requires that both the child and the parents be seen together and independently).
9. S9484 (hourly) Crisis Stabilization Services (Crisis intervention mental health services) -- Is this service for only face-to-face contact or does phone contact qualify? Do increments less than an hour (i.e., 15 minutes) meet requirements?	Yes this service is required to be delivered face-to-face. 441 IAC 24.38(225C) requires that there is contact between the individual and mental health professional that occurs one time per day and that the individual receives a minimum of one hour per day of additional services intended to stabilize the member. Hours should be rounded to the nearest whole unit, by rounding down for 1-30 minutes and rounding up for 31-59 minutes. When a procedure/service indicates time, more than half of the designated time must be spent performing the service in order for a unit to be billed. In the case of a 60-minute service, at least 31 minutes of the service must be performed.
10. S9485 (per diem) Crisis intervention mental health services--at what point does the rate change from hourly to per diem? If a person is receiving services from 10:30 PM on April 1 until 10:30 PM on April 2, how would that is billed?	A daily rate is applicable when a member has a need for 8 hours or more of service during a 24-hour-period. The 24-hour-period is 12:01 AM to 11:59 PM. If a member is admitted on April 1 at 10:30 PM and discharged at 10:30 PM on April 2, using the ground rules for hourly services, the provider bills 1 hour for April 1 (1.5 hours rounded down to the hour, and 1 day for April 2).