

**MICHIGAN PIHP/CMHSP ENCOUNTER REPORTING
COSTING PER CODE**

Effective 10-01-07

Service Description Chapter III	HCPCS or Revenue Codes	CONSIDERATIONS FOR REPORTING UNITS	COSTING CONSIDERATIONS
General Rules		<p><u>Rounding rules:</u></p> <ul style="list-style-type: none"> • “Up to 15 minutes” <ul style="list-style-type: none"> ○ 1-15=1 unit ○ 16-30=2 units ○ 31-45=3 units ○ 46-60=4 units ○ 61-75=5 units ○ 76-90=6 units ○ 91-105=7 units ○ 106-120=8 units • 15 minutes <ul style="list-style-type: none"> ○ 1-14 minutes=0* ○ 15-29=1 unit ○ 30-44=2 units ○ 45-59=3 units ○ 60-74=4 units ○ 75-89=5 units ○ 90-104=6 units ○ 105-119=7 units ○ 120=134=8 units • 1 hour <ul style="list-style-type: none"> ○ 1-59 min=0* ○ 60-119 min=1 unit ○ 120-179 min=2 units ○ 180-239 min=3 units ○ 240-299 min=4 units ○ 300-359 min=5 units ○ 360-419 min=6 units ○ 420-479 min=7 units ○ 480-539 min=8 units • Day for CLS/PC=consumer received both services during the day reported • All other “day” units=consumer was in the setting as of midnight <p>*Do not report if units = 0</p> <p><u>Encounters and contacts (face-to-face) that are interrupted during the day: report one encounter; encounters and contacts for evaluations, assessments and Behavior Management committee that are interrupted and span more than one day: report one encounter or contact</u></p> <p><u>Face-to-face</u></p>	<p><u>Consult the Medicaid Provider Manual, Mental Health and Substance Abuse Chapter, first, when considering the activities to report and the activities that may be covered in the costs of a Medicaid service.</u></p> <p><u>Indirect activities and collateral contacts:</u> Except for Behavior management reviews, Chore Services, Family Training, Family Psycho-Education, Fiscal intermediary, Prevention (direct Models) , Home-based, and Wraparound reporting occurs only when a face-to-face contact with the consumer takes place. The costs of other indirect and collateral activities performed by staff on behalf of the consumer are incorporated into the unit costs of the direct activities. The method(s) used to allocate indirect costs to the services should comply with the requirements of Office of Management and Budget Circular A-87.</p> <p>Examples of indirect or collateral activities are: writing progress notes, telephoning community resources, talking to family members, telephone contact with consumer, case review with other treatment staff, travel time to visit consumer, etc. Special consideration needs to be given to the indirect activities associated with occupational and physical therapy, health services, and treatment planning. Refer to those services within this document for additional guidance.</p> <p><u>Other costs to consider including in the unit cost, where allowed:</u> Professional and support staff, facility, equipment, staff travel, consumer transportation, contract services, supplies and materials (unless otherwise noted)</p> <p><u>Note:</u> Services provided in residential IMDs, Child Caring Institutions (CCIs) and jails may not be funded by Medicaid.</p>

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		<p>All procedures are face-to-face with consumer, except Behavior Management Review, Chore Services, Family Training, Family Psycho-Education, Fiscal Intermediary, Prevention (Direct Models), Home-based, and Wraparound</p> <p>Modifiers: HA: use for Parent Management Training Oregon model activities with Home-based, Family Training, and Mental Health Therapies (Evidence Based Practice only) HE: use when Peer Specialist provided a covered service such as ACT, CLS, skill-building, and supported employment HH: use when integrated service is provided to an individual with co-occurring disorder (MH/SA) (See 2/16/07 Barrie/Allen memo for further instructions) HH TG: use when SAMHSA-approved Evidence Based Practice for Co-occurring Disorders: Integrated Dual Disorder Treatment is provided. (See 2/16/07 Barrie/Allen memo for further instructions) HK: use if beneficiary is HSW enrolled and is receiving an HSW covered service HS: use in family models when beneficiary is not present during the training session but family is present QJ: use if beneficiary received a service while in jail SE: use with T1017 for Nursing Facility Mental Health Monitoring to distinguish from targeted case management TS: Use for monitoring treatment plans with codes for Behavior Management Review (H2000) and Treatment Planning (H0032). Monitoring of behavior treatment (H2000) does not need to be face-to-face with consumer, monitoring of other clinical treatment (H0032) does. TT: Use when serving multiple people face-to-face simultaneously with codes for Community Living Supports, Out-of-home Non-voc/Skill-building (H2014), Private Duty Nursing (S9123, S9124, T1000) and Supported Employment (H2023)</p>	
<p>Assertive Community Treatment (ACT)</p>	<p>H0039</p>	<p>15 min face-to-face contact with consumer Count one contact by team regardless of the number of staff on team</p>	<ul style="list-style-type: none"> • Bundled activity • Cost of indirect activities (e.g., ACT team)

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			meetings, phone contact with consumer) incorporated into cost of face-to-face units
Assessment, Evaluation & Testing Health Psychiatric Evaluation Psychological testing Other assessments, tests	T1001, 97802, 97803 90801, 90802 96101, 96102, 96103, 96116 96118, 96119, 96120 96110, 96111, 96105, 90887, H0002, H0031, T1023,	ALL Face-to-face with a professional. Telephone screens may not be reported to MDCH. 90801-90802/encounters: psychiatric assessment provided by variety of disciplines (MD, licensed psychologist, clinical social worker) when Medicare rules for content of assessment apply H0031: assessments provided by non-physicians; may be used by a variety of disciplines and provides more flexibility than 90801 H0002: Brief screening for non-inpatient programs T1023: screening for inpatient programs. Use a crisis service code for any crisis follow-up service or treatment contact. 90887: certain collateral encounters by professional staff for interpretation with family/others An assessment code should be used when case managers perform the utilization management function of intake/assessment (H0031); but a case management code should be used when assessment is part of the case management function LPN activity is not reportable, is costed as indirect cost	<ul style="list-style-type: none"> ▪ Cost of indirect activity • Costing if staff provide multiple units • Spreading costs over the various types of services • Costing and productivity assumptions • Some direct contacts are getting very costly due to all the indirect time
Behavior Management Review	H2000	Encounter (event that is not face-to-face with consumer) Report one meeting per day per consumer, regardless of number of staff present. However in order to count as an encounter all staff required by Medicaid Provider Manual should be present. Use Modifier TS for monitoring of the behavior management plan and report separately from the Review. The consumer does not need to be present in order to report monitoring.	Determine average cost: number of persons present, for how long Load costs of Behavior Management Committee monitoring of the behavior management plan into the cost of the committee encounter
Chore Services	S5120	Staff time spent performing chore activities per 15 minutes (consumer does not need to be present)	
Clubhouse Program	H2030	Number of 15 minute units the consumer spent in the program <ul style="list-style-type: none"> • Most use a sign-in/sign-out to capture attendance time • Lunch time: meal prep is reportable activity; meal consumption is not unless there are individual goals re: eating • Meal time exclusion UNLESS there is a targeted goal in the individual's plan of service: set up an automatic deduct of 1 or 2 units rather than elaborate logging of activity 	<ul style="list-style-type: none"> • All cost of the program including Transportation costs • Capital/equipment costs need to comply with regulations • Excludes certain vocational costs • Exclude revenues from MRS, Aging, etc.

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		<ul style="list-style-type: none"> Reportable clubhouse activity may include social-rec activity and vocational as long as it is a goal in person's IPOS Excludes time spent in transport to and from clubhouse 	
Community Psychiatric Inpatient	0100, 0101, 0114, 0124, 0134, 0154 Use PT73 + Medicaid Provider ID #	<p>Hospital to provide information on room/ward size will determine correct rev code to use</p> <ul style="list-style-type: none"> In hospital as of midnight Count all consumers/days where CMH has a payment liability Days of attendance Option: Hospital claim with additional fields reflecting other insurance offsets can be turned into encounters for submission to DCH 	<ul style="list-style-type: none"> Net of coordination of benefits, co-pays, and deductibles Bundled per diem that includes room and board Includes physician's fees, discharge meds, court hearing transportation costs If physician is paid separately, use inpatient physician codes and cost the activity there Report physician consult activity separately Report ambulance costs under transportation For authorization costs, see assessment codes if reportable as separate encounter, otherwise report as part of PIHP admin Hospital liaison activities (e.g., discharge planning) are reported as case management or supports coordination
Community Living Supports	H2015, H2016, H0043, T2036, T2037	<ul style="list-style-type: none"> Face-to-face time spent with consumer and/or when consumer is present Relationship to DHS Home Help Program (in own home) and Personal Care in Specialized Residential Setting must be considered <p>H2015: 15 minute units; use in own home, and in most supported independent living settings</p> <ul style="list-style-type: none"> 15 minute units of CLS may be reported for activities in the community that occurred on the same days that H2016 is reported for support in specialized residential setting Note the difference between CLS and Skill building when activity is in the community <p>H2016: per diem; use in specialized residential settings, or for CLS provided to children with SED in a foster care setting that is not a CCI; or for CLS provided to children with DD in either a foster care setting or CCI</p> <ul style="list-style-type: none"> Use modifiers to indicate levels of care provided: <ul style="list-style-type: none"> TG=high cost or high need TF=moderate cost or moderate need No modifier=low cost or low need <p>H0043: per diem; while H2015 is the preferred code for CLS provided in independent living or own home, H0043/diem may be used in non-licensed independent</p>	<ul style="list-style-type: none"> Cost includes staff, facility, equipment, travel, staff and consumer transportation, contract services, supplies and materials Day rate reported must be net of SSI/room and board, Home Help and Food stamps Relation to Home Help and Personal Care (see Specialized Residential Unbundling Instructions) Costs for community activities Cost for vehicle

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		<p>living settings or person's own home. There must be a face-to-face contact with the beneficiary during the day in order to report a day of CLS</p> <p>Use Modifier TT when serving multiple consumers face-to-face simultaneously for codes H2015, H2016, and H0043.</p> <p>T2036: camping overnight; report each session T2037: camping day; report each session</p>	
Crisis Intervention	H2011	<ul style="list-style-type: none"> • 15 min, face-to-face • Phone contacts not reportable 	<ul style="list-style-type: none"> • Cost of authorization and screenings, either as PIHP admin or , if face-to-face, reported as assessment (T1023) • Per 15 minute rate • Costing and contact/productivity model assumptions used • Incorporate phone time as an indirect cost
Crisis Observation Care	Rev Code 0762	<ul style="list-style-type: none"> • Enrolled program only • Number of hours consumer spent in observation 	<ul style="list-style-type: none"> • Include only those facility costs and cost of inpatient psychiatrist specific to this program
Crisis Residential Services	H0018	<ul style="list-style-type: none"> • Days of attendance without room and board • In as of midnight • If consumer enters and exits the same day it is not reportable as crisis residential 	<ul style="list-style-type: none"> • Bundled per diem • Includes staff, operational costs, lease, physician • Need to net out SSI per diem equivalent. These costs will be separately reported in the CMHSP sub-element cost report • Per attendance day rate • Assumptions re: occupancy if "purchase" capacity
Electro convulsive Therapy (see Practitioner Manual)	90870, 00104	<p>0901- ECT facility charges 90870- attending physician charges 00104- anesthesia charges 0701 – Recovery room 0370 – Anesthesia</p>	<ul style="list-style-type: none"> • Submit actual costs
Enhanced Medical/Specialized Equipment & Supplies	T2028, T2029, S5199, E1399, T2039	Report by item	<ul style="list-style-type: none"> • Submit actual costs • May include training to use equipment, and repairs
Enhanced Pharmacy	T1999	<p>Over-the-counter items Note: report GF pharmacy costs on the CMHSP Sub-element cost report</p>	<ul style="list-style-type: none"> • Payments to pharmacy • Submit actual costs
Environmental Modification	S5165	Per service.	<ul style="list-style-type: none"> • Submit actual cost

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<p>Family Training</p>	<p>S5111 S5110 G0177 T1015</p>	<p>Face-to-face encounters with family (report one encounter with family no matter how many family members are present) If provided as a group modality where families of several beneficiaries are present, report an encounter for each consumer represented Consumer does not need to be present, but use HS modifier to indicate that S5110/15 minutes for Family Psycho-Education: skills workshop G0177/session (session must last at least 45 minutes in order to be reported) for Family Psycho-Education: family educational groups (either single or multi-family); and T1015/encounter for Family Psycho-Education: Joining. Use Modifier HA with S5111 if using Parent Management Training Oregon model Use Modifier HS if consumer is not present</p>	<ul style="list-style-type: none"> • Costing of indirect activity • Costing if staff provide multiple services
<p>Fiscal Intermediary Services</p>	<p>T2025</p>	<p>Services performed by a fiscal intermediary on behalf of a beneficiary. Services do not need to be face-to-face in order to report.</p>	<ul style="list-style-type: none"> • Submit actual cost per month
<p>Health Services</p>	<p>97802, 97803, 97804, H0034, S9445, S9446, S9470, T1002</p>	<p>Face-to-face activities 97802-97804: medical nutrition therapy T1002: RN services (up to 15 minutes) S9445, S9446: Patient education H0034: Medication training and support S9470: Nutritional counseling dietician visit LPN activity not reportable (count as indirect or ancillary activity)</p>	<ul style="list-style-type: none"> • Cost of indirect activity, such as non-face-to-face consultation on behalf of a consumer in a specialized residential setting or day program setting should be loaded into the cost of face-to-face activities of health services • Costing if staff provide multiple services • Some direct contacts are getting very costly due to all the indirect time
<p>Home Based Services</p>	<p>H0036</p>	<p>Enrolled program only. Team model of practice Face-to-face with consumer or family, per 15 minutes If parent is the symptom-bearer, the event may be reported using the parent's Medicaid identification number. If parent is not the symptom-bearer, report using the child's Medicaid identification number Use Modifier HA when using the Parent Management Training Oregon Model Use Modifier HS when consumer is not present</p>	<ul style="list-style-type: none"> • Costing of indirect activity • Costing if staff provide multiple services <p>If more than one staff provided different types of contacts – e.g., working with child and someone else at the same time with family/parents – may report the contact with the child or family member</p>
<p>Housing Assistance</p>	<p>T2038</p>	<p>Housing expenses for the month</p> <ul style="list-style-type: none"> • See Medicaid Provider Manual and P. Barrie 11/22/02 memo for clarifications • PATH/Shelter Plus not reported here. Costs to be included in CMHSP sub-element cost report under "Other" 	<ul style="list-style-type: none"> • Costs include non-staff expenses associated with housing: assistance for utilities, home maintenance, insurance, and moving expenses • Deduct SSI • Deduct food stamps, heating tax credits, etc • Submit actual costs for the month
<p>ICF/MR Inpatient Services</p>	<p>Rev 0100</p>	<ul style="list-style-type: none"> • Inpatient days of attendance including DD IST 	<ul style="list-style-type: none"> • Includes net rate and local match costs for IST

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	Use PT 65 + Medicaid Provider ID #	<p>days</p> <ul style="list-style-type: none"> Submit only one encounter for each inpatient day 	days
Inpatient: MR (non-ICF)	Rev 0100 Use PT22 + Medicaid Provider ID #	<ul style="list-style-type: none"> Inpatient days of attendance at Mt. Pleasant including DD IST days where the consumer does not meet ICF-MR criteria Submit only one encounter for each inpatient day 	<ul style="list-style-type: none"> Includes net rate and local match costs for IST days
Inpatient Psychiatric Services in State Hospital Facility	Rev 0100, 0101, 0114, 0124, 0134, 0154 (ward size) Use PT22 + Medicaid Provider ID#	Inpatient days of attendance including IST days at State Hospitals (excludes days at Forensic Center)	<ul style="list-style-type: none"> Bundled per diem using state net rate Includes net rates paid and local match payments <p>Report expenditures for Forensic days in CMHSP Sub-element Cost Report</p>
Institutions for Mental Disease Inpatient Services (IMD)	Rev 0100 Use PT68 + Medicaid Provider ID #	<p>Only use with community-based hospitals PIHP must declare that hospital is an IMD, either as free-standing or as a unit in a facility that qualifies as IMD Hospital to provide information on room/ward size will determine correct rev code to use</p> <ul style="list-style-type: none"> In hospital as of midnight Count all consumers/days where CMH has a payment liability Days of attendance Option: Hospital claim with additional fields reflecting other insurance offsets can be turned into encounters for submission to DCH 	<ul style="list-style-type: none"> Net of coordination of benefits, co-pays, and deductibles Bundled per diem that includes room and board Includes physician's fees, discharge meds, court hearing transportation costs If physician is paid separately, use inpatient physician codes and cost the activity there Report physician consult activity separately Report ambulance costs under transportation For authorization costs, see assessment codes if reportable as separate encounter, otherwise report as part of PIHP admin Hospital liaison activities (e.g., discharge planning) are reported as case management or supports coordination
Intensive Crisis Stabilization Service	S9484	<ul style="list-style-type: none"> Enrolled program only, team model of practice 1 hour, face-to-face If more than one staff involved simultaneously with the consumer, only report one activity Phone contacts not reportable 	<ul style="list-style-type: none"> Costs of the team Bundled activity Face to face contacts only, other contacts (phone, travel) are incorporated in as an indirect activity Costing and contact/productivity model assumptions used Account for contacts where more than one staff are involved
Medication Administration	90772, 99506 and 99211	Face-to-face encounters: Report using this procedure code only when provided as a separate service.	
Medication Review	90862, M0064, H2010	<p>90862: brief assessment, dosage adjustment, minimal psychotherapy and or EPS tardive dyskinesia testing by a physician or physician plus a nurse assist. The nurse involvement is an indirect activity.</p> <p>M0064: brief assessment (generally less than 10</p>	The costs of all indirect activities are included in the unit rate

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		minutes), med monitoring or change by a nurse, or physician, or physician plus a nurse Use H2010 only for Medication Algorithm which is an Evidence Based Practice	
Mental Health Therapy Child & Adult Individual Family Group	90808, 90809, 90814, 90815, 90821, 90822, 90828, 90829, 90804, 90810, 90811, 90816, 90817, 90823, 90824, 90806, 90807, 90812, 90813, 90818, 90819, 90826, 90827, 90853, 90857, 90846, 90847, 90849	<ul style="list-style-type: none"> Co-therapy (more than one therapist is present in therapy session)– report only one encounter Groups Therapy – codes based on disconnected time spans 90846: Family therapy without consumer present does not require an HS modifier Use Modifier HA when Parent Management Training Oregon model is used	<ul style="list-style-type: none"> Cost of indirect activity Costing of co-therapists' contacts Costing if staff provide multiple units Spreading costs over the various types of services Costing and productivity assumptions Group size assumptions Some direct contacts are getting very costly due to all the indirect time
Nursing Home Mental Health Monitoring	T1017SE	Face-to-face per 15 min Use modifier SE to distinguish from targeted case management Record must show that this was not a case management visit	
Occupational Therapy and Physical Therapy	97110, 97112, 97113, 97116, 97124, 97140, 97530, 97532, 97533, 97535, 97537, 97542, S8990, 97150, 97003, 97004, 97760, 97762	<ul style="list-style-type: none"> Some group, some individual, but all must be face-to-face Some 15 minutes, some per encounter OT and PT have same codes 	<ul style="list-style-type: none"> Costing if staff provide multiple units Cost of non-face-to-face consultation on behalf of a consumer in a specialized residential setting or day program setting should be loaded into the cost of face-to-face activities of OT or PT Costing and productivity assumptions Some direct contacts are getting very costly due to all the indirect time Spreading indirect activity and costs over the various types of services
Out of Home Non Vocational Habilitation HSW only	H2014HK	Per 15 min beneficiary used the service Use Modifier TT when serving multiple consumers face-to-face simultaneously	<ul style="list-style-type: none"> MDCH definition: cost includes staff, facility, equipment, travel, transportation, contract services, supplies and materials Capital/equipment costs need to comply with regulations
Out of Home Prevocational Service HSW only	T2015HK	Per hours the beneficiary used the service Rounding rule	<ul style="list-style-type: none"> MDCH definition: cost includes staff, facility, equipment, travel, transportation, contract services, supplies and materials Capital/equipment costs need to comply with regulations
Outpatient Partial Hospitalization	Rev 0912, 0913	Number of days beneficiary spent in the program for which PIHP pays	<ul style="list-style-type: none"> Bundled rate per day
Peer Directed/Operated	H0023, H0038	H0023, Drop-in center attendance [Note: Optional to	<ul style="list-style-type: none"> MDCH definition: cost includes staff, facility,

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<p>Support Services</p>		<p>report as an encounter; <u>must</u> report on Sub-element cost report]. Report only one encounter per day regardless of whether the beneficiary leaves and returns throughout the day H0038, Peer specialist: Per 15 min. consumer received services Note: other covered services provided by a peer specialist should be reported as such using the appropriate code (e.g., for peer specialist providing services as part of an ACT team, use H0039) plus an HE modifier</p>	<p>equipment, travel, transportation, contract services, supplies and materials</p> <ul style="list-style-type: none"> • Must report all Drop-in Center costs in Medicaid Utilization and Cost Report
<p>Personal Care in Licensed Specialized Residential Setting</p>	<p>T1020</p>	<p>Days when staff provide care to the consumer in a specialized residential setting, Activities outside the home are not covered by personal care (use instead CLS/15 minutes) Do not use for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD (code may not be used to identify services provided by home health aide or certified nurse assistant) Use modifier to indicate levels of care need: <ul style="list-style-type: none"> • TG=high cost or high need • TF=moderate cost or moderate need • No modifier=low cost or low need </p>	<ul style="list-style-type: none"> • See Specialized Residential Unbundling Instructions
<p>Personal Emergency Response System (PERS)</p>	<p>S5160, S5161</p>	<p>Per installation, per month</p>	<p>Submit actual costs</p>
<p>Prevention/Direct Model</p>	<p>H0025</p>	<p>Face-to-face contacts with consumer or family member If parent is the symptom-bearer, the event may be reported using the parent's Medicaid identification number. If parent is not the symptom-bearer, report using the child's Medicaid identification number MDCH approved models only. For all other GF-funded prevention, report on CMHSP Sub-element cost report</p>	
<p>Private Duty Nursing</p>	<p>S9123, S9124, T1000, Rev code 0582-</p>	<p>S codes = hour, T codes = up to 15 minutes Hour spent with adult over 21 by nurse, or PDN agency Used for HSW consumer over 21 TT modifier for multiple persons served at the same time T1000; (up to 15 minutes) TD modifier for RN TE modifier for LPN or LVN</p>	

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Respite Care	T1005	<p>Skilled: up to 15 minutes face-to-face with consumer Unskilled: per 15 minutes face-to-face with consumer (Family friend model can be used, but family friend must meet Medicaid qualifications and family may not be paid directly with Medicaid funds)</p> <ul style="list-style-type: none"> Includes in-home, out-of-home, respite/daytime centers, camps, recreation, after school Group activities can be difficult to get time reported Use modifiers: <ul style="list-style-type: none"> TD=RN only TE=LPN only 	<ul style="list-style-type: none"> Pay attention to payment mechanisms such as Vouchers Pay attention to staff qualifications for use of Medicaid funding See Family Friend respite clarification
	S5150	<ul style="list-style-type: none"> Use only for GF-funded unskilled respite where respite provider does not meet Medicaid qualifications and/or the payment mechanism does not meet Medicaid requirements (eg., respite worker is not under contract with CMH or fiduciary) Per 15 minutes 	
	H0045	Respite care provided out of home (e.g., respite center, group home), per diem	
	S5151	Respite care provided in-home, per diem	
Skill Building Assistance	H2014	<p>Face-to-face per 15 min</p> <ul style="list-style-type: none"> Reportable activity: time spent in the program less lunch (unless there are eating goals in IPOS) Excludes time spent in transport Rounding rule <p>Use Modifier TT when serving multiple consumers face-to-face simultaneously</p>	<ul style="list-style-type: none"> MDCH definition: cost includes staff, facility, equipment, travel, transportation, contract services, supplies and materials Capital/equipment costs need to comply with regulations
Speech & Language Therapy	92506, 92610 92507, 92526, 92508	Face-to-face encounters	<ul style="list-style-type: none"> Cost of non-face-to-face consultation on behalf of a consumer in a specialized residential setting or day program setting should be loaded into the cost of face-to-face activities of speech and language therapy Costing if staff provide multiple units
Supported Employment Services	H2023	<p>Number of 15 minutes units the consumer receives the service at job site. Staff must be present to report units</p> <ul style="list-style-type: none"> Exclude MRS cash-match cases/activity Medicaid excludes pre-employment activities Include HK modifier for HSW beneficiaries 	<ul style="list-style-type: none"> MDCH definition: cost includes staff, facility, equipment, travel, transportation, contract services, supplies, and materials Show MRS match on CMHSP sub-element cost report as Other GF expense

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		<ul style="list-style-type: none"> • Use Modifier TT when serving multiple consumers face-to-face simultaneously 	
Supports Coordination	T1016	<p>T1016: Face-to-face with consumer (only) per 15 minutes</p> <ul style="list-style-type: none"> • Includes face-to-face pre-planning, treatment planning, periodic review of plan by supports coordinator • Collateral contacts are indirect time/activity • Activities of supports coordination assistants or aides, service brokers, and case management assistants may be reported, but not for the same time period for which there is a supports coordinator activity reported • Include HK modifier for HSW beneficiaries 	<ul style="list-style-type: none"> • Costing of indirect activity • Costing if staff provide multiple services
Targeted Case Management	T1017	<p>Face-to-face with consumer (only) per 15 minutes</p> <ul style="list-style-type: none"> • Includes face-to-face case management assessment, pre-planning, treatment planning, periodic review of plan by case manager • Collateral contacts are indirect time/activity 	<ul style="list-style-type: none"> • Costing of indirect activity • Costing if staff provide multiple services
Transportation	A0080, A0090, A0100, A0110, A0120, A0130, A0140, A0170, S0209, S0215 T2001-T2005	<p>[Note: Optional to report] Ambulance is GF expense only Other transportation costs should be included in the cost of the service to which the beneficiary is being transported (e.g., supported employment, community living supports) Do not report transportation separately when using HSW funds</p>	<p>Preferred option for ambulance: turn in claim information as submitted by the ambulance service</p>
Treatment Planning	H0032	<p>Report encounters: staff time spent face-to-face with consumer in pre-planning and person-centered planning activities (including subsequent periodic reviews of the plan), and in monitoring the implementation of the plan</p> <ul style="list-style-type: none"> • Count independent facilitator and all professional staff, where the consumer has chosen them to attend, participating in a person-centered planning or plan review session with the consumer • Case manager or supports coordinator do not report treatment planning as this is part of TCM and SC • Monitoring the implementation of part(s) of the plan by clinician, such as OT, PT or dietitian. • Assessments and evaluations by clinicians should not be coded as Treatment Planning but rather as the appropriate discipline (e.g., 	<ul style="list-style-type: none"> • Major implications for indirect contribution to other activities • Costing of indirect activity • The cost of a clinician's monitoring the implementation of plan that does not involve a face-to-face contact with the consumer is an indirect cost of treatment planning

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		OT, PT, speech and language) Use Modifier TS when clinician performs monitoring of the plan face-to-face with the consumer	
Wraparound Services	H2021 H2022	<ul style="list-style-type: none"> Medicaid funds may be used only for planning and coordination for Wraparound Report face-to-face (with consumer or family member) planning and coordination activities as Wraparound Facilitation; report treatment planning (H0032) when other clinicians attend; treatment activities are reported as appropriate Report that child is receiving wraparound services in QI data, item 13. Neither case management or supports coordination should be reported when consumer is using Wraparound as it is a bundled service that contains supports coordination <p>GF may be spent on other wraparound activities or items. Report as day of Wraparound and actual cost of activities/items</p>	<ul style="list-style-type: none"> Since the Wraparound model involves other community agencies that may contribute funds for the support or treatment of the beneficiary, care should be taken to report only those costs to the CMHSP/PIHP Only report face-to-face contacts with child or family member so costing of indirect activity is critical. Costing if staff provide multiple services

Additional Codes for Reporting

Service Description	HCPCS or Revenue Codes	ISSUES FOR UNITS	ISSUES FOR COSTING
Foster care per diem that includes room and board Use for adult days in Residential IMDs (S5140) and children's days in CCIs or foster care (S5145)	S5140, S5145	Days of care for children or adults <ul style="list-style-type: none"> Should not include days when bed is vacant or consumer is absent from the home Licensed setting only Only report for bundled GF-funded services – otherwise see personal care and CLS in specialized residential setting, or CLS in children's foster care that is not a CCI (for children with SED), or CLS in children's foster care or CCI for children with DD. 	
Laboratory Services Related to Mental Health	80000 range		Submit actual costs
Injectable Psychotropics	J1630, J1631, J2680, J0515	Billed directly to MSA	Submit actual costs
Psychiatric Inpatient Consultation by Psychiatrist	99241 – 99275 (99261, 99262, and 99263 have been deleted from the HCPCS)	Encounters	Per encounter rate

**MICHIGAN PIHP/CMHSP ENCOUNTER REPORTING
COSTING PER CODE**

Effective 10-01-07

Service Description	HCPCS or Revenue Codes	ISSUES FOR UNITS	ISSUES FOR COSTING
Residential Room and Board	S9976	Lodging per diem. Use for crisis residential	Room and board costs per day