NH Medicaid to Schools Billing Guidelines
and Billable Procedure Codes
Companion to the Technical Assistance Guide
Publish Date: March 1, 2022

Purpose: This companion to the Technical Assistance Guide describes the medical services provided in a school setting that can be billed to NH Medicaid and is intended to provide guidance to local educational agencies participating in Medicaid to Schools on correct billing practices.

How changes are made to this document: responses to billing questions received after the publish date of this document will be posted on a monthly basis on the Medicaid to Schools DHHS website with a link to the NH Medicaid to Schools Training and Technical Assistance Center's monthly newsletters: https://airtable.com/shr4Ou0ehv3opVKr4 . This document will be updated to incorporate all the changes and clarifications annually and a new document will be posted on the Medicaid to Schools DHHS website.

Requesting additional procedure codes: requests to add additional procedure codes to the Medicaid to Schools fee schedule should be submitted to the Division of Medicaid Services Rate Setting Unit @ dhhsratesetting@dhhs.nh.gov

Key Takeaways on Billing

Student Information and Parental Consent

1. A signed parental consent form to bill NH Medicaid must be on file. Please see the informational bulletin on parental consent published on March 1, 2022 and posted on the DHHS website https://www.dhhs.nh.gov/ under Medicaid to Schools/ Communication and Guidance/ Provider Information and Resources.
2. Medical services are billable to Medicaid only if they are listed in the IEP, 504 Plan or Health Care Plan.
3. Schools may not bill medical services using an educational diagnosis code (F81.9) on their claims. The diagnosis code (ICD-10) must correspond with the primary medical condition for which the student is receiving treatment as outlined in the IEP, 504 Plan or Health Care Plan.

Licensure and Ordering

4. Providers of medical services in a school setting must be appropriately licensed in NH. Schools may not bill Medicaid for services provided by an unlicensed individual or for an individual whose licensure is pending.

5. Ordering providers of medical services provided in the school setting must be enrolled with NH Medicaid at the time of service. Billing and ordering NPI's are required on all claims.
6. An order is required for all medical services provided in a school setting. Services must be ordered by a qualified ordering provider regardless of who is performing the service (the ordering provider themselves or another non-ordering qualified provider). If an ordering provider orders a service that they themselves will perform, the service is considered self-ordered.
7. Effective 9/1/2021, all claims submitted for payment including transportation claims must have the ordering provider's NPI on the claim form.
8. For Schools who contract with outside providers for medical services, the School is responsible for screening (i.e. verifying licensure and OIG exclusions) all Contractors and is required to bill for these contracted medical services. Contractors shall not bill directly for medical services provided in the school setting.

Billing

9. Schools should code their claims with place of service (03 for school, or 12 for home).
10. Date span billing should not be used. Date span billing means multiple dates of service on a single claim line. Doing so creates claims exceeding the maximum units allowed and results in a cut back on payment.
11. No more than 12 evaluation codes (OT, PT, ST) four (4) of each can be billed in one fiscal year (7/1 to 6/30) for new students in accordance with IDEA, Title 34, Part B 300.301-300.305. Afterwards, evaluations completed should be billed as a reevaluation.
12. Consultation is an integral part of a medical service and is not separately reimbursable.
13. Medical services delivered via telehealth including those services in a school setting are reimbursable pursuant to RSA 167:4-D. Claims should be submitted with the appropriate procedure code and TM modifier along with modifier GT and place of service (02 for telehealth).
14. Assessment and evaluation are terms that are used interchangeably when describing the process for determining for example a student's functional capacity. This could be called a functional capacity assessment or functional capacity evaluation.
15. If there is no timed procedure code that reflects the unit of time a provider spends with a student, billing should reflect this by prorating the service and the charge accordingly. This should be noted in the documentation with a start and stop time.
16. Reimbursement of billings from Schools is calculated at 50% of actual costs or 50% of the established Medicaid fee schedule whichever is less.
17. Maximum units allowed published in this document are effective as of July 1, 2022. These are the maximum units allowed that will be used for auditing purposes on or after July 1, 2022. Failure to comply with the maximum units allowed will result in takeback of payments in excess of the established limits.
18. Group size is two (2) or more students with a limit of up to 5 students. If group services are indicated on the student's care plan, the provider shall bill the group rate even if the group has only one participant due to low attendance/absences.

Procedure Codes and Maximum Units Allowed

19. Only one new procedure code has been added S9152 to reflect speech therapy re-evaluation. Maximum Units Allowed has been updated to reflect the time period, i.e. per day, per month per year, etc.

OCCUPATIONAL THERAPY SERVICES

BILLABLE CATEGORIES OF SERVICE

Billable categories of occupational therapy (OT) services shall include the following:

- Occupational therapy, evaluation and reevaluation
- Therapeutic activities/Occupational therapy, individual; and
- Therapeutic activities/Occupational therapy, group.
- Sensory integration
- Occupational therapy supplies & equipment (i.e.: sensory items that cannot be passed to another student)

BILLING GUIDELINES

- Group size is two (2) or more students with a limit of up to 5 students. Services are reimbursable per date of service for each student in the group unless otherwise defined in the CPT code definition. There is no requirement that all the members of the group be eligible for Medicaid.
- School Districts bill their actual cost for covered OT services and receive 50% of their actual cost or 50% of the allowed rate under the established Medicaid fee schedule, whichever is less. In the group setting, the cost to provide 1 unit of a covered service must be allocated across all students in the group. When the service is provided to more than one student at a time, the actual cost of the services delivered must be divided by the total number of students in the group.
    - For example, a provider's rate is $50.00 per hour. There are 5 students in the group and 2 of these students are Medicaid eligible. To determine the billing amount, divide the provider's rate by the total number of students in the group (both Medicaid and non-Medicaid) The billing amount would be $10.00 per student and a claim submitted for each student.
- Because occupational therapy (OT) evaluation codes are timed coded, Medicaid allows evaluations that span over a month's time to be billed separately recognizing that an evaluation may not be able to be completed in one session. No more than four initial (4) OT evaluation codes can be billed per fiscal year for new students and initial evaluation time would not exceed 3 hours and 15 minutes.
    - Evaluations completed over a month's period of time (e.g. October 1st to October 31st) would be billed as follows:
        - Procedure code 97165 , one unit at 30 minutes
        - Procedure code 97166 , one unit at 45 minutes
        - Procedure code 97167, one unit at 60 minutes
        - Procedure code 97167, one unit at 60 minutes
- OT services require an order and the NPI of the ordering provider needs to be on the claim

- Consults with student present at least 51% of time shall be billed as occupational therapy, individual. Identify the service as a consult in the medical record and provide documentation for auditing purposes.

PHYSICAL THERAPY SERVICES

BILLABLE CATEGORIES OF SERVICE

Billable categories of physical therapy services shall include the following:

- Physical therapy, evaluation and reevaluation;
- Therapeutic activities/Physical therapy, individual;
- Therapeutic activities/Physical therapy, group;
- Physical therapy, Supplies & Equipment

BILLING GUIDELINES

- Group size is two (2) or more student with a limit of up to 5 students. Services are reimbursable per date of service for each student in the group unless otherwise defined in the CPT code. There is no requirement that all members of the group be eligible for Medicaid.
- School Districts bill their actual cost for covered PT services and receive 50% of their actual cost or 50% of the allowed rate under the established Medicaid fee schedule, whichever is less. In the group setting, the cost to provide 1 unit of a covered service must be allocated across all students in the group. When the service is provided to more than one student at a time, the actual cost of the services delivered must be divided by the total number of students in the group,
    - For example, a provider's rate is $50.00 per hour. There are 5 students in the group and 2 of these students are Medicaid eligible. To determine the billing amount, divide the provider's rate by the total number of students in the group (both Medicaid and non-Medicaid) The billing amount would be $10.00 per student and a claim submitted for each student.
- There is no requirement that all the members of the group be eligible for Medicaid.
- Because physical therapy (PT) evaluation codes are timed codes, Medicaid allows evaluations that span over a month's period be billed separately recognizing that an evaluation may not be able to be completed in one session. No more than four initial (4) PT evaluation codes can be billed per fiscal year for new students and initial evaluation time would not exceed 2 hours and 20 minutes.
    - Evaluations completed over a month's period of time (e.g. October 1st to October 31st) would be billed as follows:
        - Procedure code 97161 , one unit at 20 minutes
        - Procedure code 97162 , one unit at 30 minutes
        - Procedure code 97163, one unit at 45minutes
        - Procedure code 97163, one unit at 45 minutes
- PTs can order services and their NPI needs to be on the claim.
- Consults with student present at least 51% of time shall be billed as physical therapy, individual. Identify the service as consult in the medical record and provide documentation for auditing purposes.

SPEECH LANGUAGE THERAPY SERVICES

BILLABLE CATEGORIES OF SERVICE:
Billable categories of speech, language services shall include the following:

- Speech, language evaluation and reevaluation
- Speech, language, individual; and
- Speech, language, group.
- Evaluation and treatment of swallowing/feeding dysfunction
- Speech, language therapy, Supplies & Equipment

BILLING GUIDELINES

- Group size is two (2) or more students with a limit of up to 5 students. Services are reimbursable per date of service for each student in the group unless otherwise defined in the CPT code definition. There is no requirement that all the members of the group be eligible for Medicaid.
- School Districts bill their actual cost for covered OT services and receive 50% of their actual cost or 50% of the allowed rate under the established Medicaid fee schedule, whichever is less. In the group setting, the cost to provide 1 unit of a covered service must be allocated across all students in the group. When the service is provided to more than one student at a time, the actual cost of the services delivered must be divided by the total number of students in the group,
    - For example, a provider's rate is $50.00 per hour. There are 5 students in the group and 2 of these students are Medicaid eligible. To determine the billing amount, divide the provider's rate by the total number of students in the group (both Medicaid and non-Medicaid). The billing amount would be $10.00 per student and a claim submitted for each student.
- Medicaid allows no more than four (4) initial speech evaluation codes be billed in in a fiscal year for new students.
    - Evaluations completed over a month's period of time (e.g. October 1st to October 31st) would be billed as follows for a total of 4 units.
        - Procedure code 92521 , one unit
        - Procedure code 92522 , one unit
        - Procedure code 92523, one unit
        - Procedure code 92524, one unit,
- Consults with student present at least 51% of time shall be billed as speech-language therapy, individual. Identify the service as a consult in the medical record and provide documentation for auditing purposes.

THERAPY ASSISTANTS

BILLING GUIDELINES

- Therapy assistants are defined as OT assistants, PT assistants and speech and language assistants
- Therapy Assistants cannot bill for their own services. The supervising licensed professional must bill for the assistant who has provided services to a student. Although the claim will indicate the

provider of record to be the school, the amount billed must reflect the actual cost of the assistant not the supervising licensed therapist.

- The cost of the assistant can include the following:
  - The annualized salary (the hourly rate x amount of hours worked each day x the amount days in a school year) plus benefits. These benefits may include but not be limited to FICA/Medicare, health insurance, disability, retirement, worker comp, unemployment and any other benefit.
  - For example: John Smith works 6.5 hours each day for 184 days at a rate of $15.22 per hour. His yearly salary would be $18,203.12.
  - His benefits are:
    - FICA/Medicare 18,203.12 x .0765 = $1,392.54
    - Health Insurance = $8,700
    - Disability insurance = 215.00
    - Retirement = 2,765.74
    - Worker comp = 80.12
    - Unemployment = 182.00
  - For a total cost of $31,538.52, which equates to $26.37 per hour. ($31,538.52/184/6.5)
  - When John provides therapy assistant services, his rate would be $26.37 per hour.

NURSING SERVICES

BILLABLE CATEGORIES OF SERVICES:

Billable categories of nursing services shall include the following:

- RN assessment or evaluation;
- RN services;
- LPN services
- 1:1 RN services
- 1:1 LPN services
- Supplies and equipment necessary to provide covered nursing services.

Examples of nursing services include the following:

1) Administration of medication(s);
2) Positioning or repositioning;
3) Assistance with specialized feeding programs;
4) Management and care of specialized medical equipment such as:
   a) Bowel and bladder training/Colostomy bags;
   b) Nasogastric tubes; and
   c) Tracheostomy tubes; Respiratory treatments

BILLING GUIDELINES

- Nurses employed by the school districts must bill 1:1 nursing using procedure codes S9123 and S9124.
- School districts that contract with a Medicaid enrolled private duty nursing agency must bill 1:1 nursing using procedure codes S9123 and S9124.

- LPNs work under the direction of a RN and in accordance with scope of practice cannot perform a nursing assessment/evaluation. LPNs can carry out treatment regimens as directed by an RN.
- If a RN or LPN rides the school bus because of a child's medical needs and is responsible for 2 students, billing for that service should be divided between the 2 students, i.e. 50% for the first student, 50% for the second student in accordance with the provider's rate.
- Bundle all the nursing services minutes provided for treatment to a student during the school day and bill total minutes per day.

AUDIOLOGY SERVICES

BILLABLE CATEGORIES OF SERVICES

- Hearing testing- see Appendix 1 for a list of procedure codes

BILLING GUIDELINES

- For CPT code descriptions for Audiology/hearing services with event as the unit of measure, the event is regardless of the time, number of encounters or dates of service it takes to complete the testing. This is a one-time reimbursement.

VISION SERVICES

BILLABLE CATEGORIES OF SERVICES

- Eye exams, new and established patients
- Vision item or service, miscellaneous

BILLING GUIDELINES

- Teachers of the deaf/hearing impaired are not recognized by Medicaid as a qualified treatment provider and their services cannot be billed to Medicaid to Schools

APPLIED BEHAVIORAL ANALYSIS

BILLABLE CATEGORIES OF SERVICES:

- Behavioral assessment to establish a treatment plan
- Behavior treatment

BILLING GUIDELINES

- Medicaid will cover ABA therapy services when provided to a student who has been diagnosed as having Autism Spectrum Disorder by a qualified provider. These providers are either a developmental pediatrician, neurologist, psychiatrist or psychologist.
- BCaBA's and RBT's are billed as rehabilitation assistants.
- BCBA's with a supervisory endorsement on certification can provide the co-signature requirement on services provided by rehabilitation assistants providing ABA support
- The procedure code that should be used for ABA treatment protocol performed by a BCBA is 97153. Although the word "technician" is used in the CPT description for this code, "technician" references the person who is performing the treatment, so in this case the BCBA would be the technician. Mental health and/or other psychotherapy procedure codes should not be used for BCBA treatment

REHABILITATIVE ASSISTANCE SERVICES

BILLABLE CATEGORIES OF SERVICES: the types of services that can be billed are further described in He-W 589

BILLING GUIDELINES

- BCaBA's and RBT's are billed as rehabilitative assistants.
- LNA's are billed as rehabilitative assistants.
- Rehabilitative assistants do not obtain NPI numbers. The NPI number of the supervising provider is used for billing purposes.

PSYCHOTHERAPY/MENTAL HEALTH SERVICES

BILLABLE CATEGORIES OF SERVICES:

- Psychiatric diagnostic evaluation
- Mental health/Psychotherapy individual
- Mental health/Psychotherapy group
- Crisis intervention

BILLING GUIDELINES

- No additional requirements are set forth based on questions from the Schools

PSYCHOLOGICAL TESTING SERVICES

BILLABLE CATEGORIES OF SERVICE INCLUDE: see Appendix 1 for a list of procedure codes

- Psychological or neuropsychological testing
- Psychological or neuropsychological testing with scoring

BILLING GUIDELINES

Billing example: for procedure code 96130 and 96131. Provider rate is $100.00 per hour

Example 1: 1 hour 45 minutes to complete testing

- 96130 Units: 1.0
- 2. 96130 Amount: $100.00
- 3. 96131 Units: 1 unit
- 4. 96131 Amount $75.00

Example 2: 2 hour 15 minutes to complete testing

- 96130 Units: 1 unit
- 2. 96130 Amount: $100.00
- 3. 96131 Units: 2 units
- 4. 96131 Amount $125.00

SPECIALIZED TRANSPORTATION

BILLABLE CATEGORIES OF SERVICE

- Transportation shall be listed in the student's care plan (IEP, Section 504 or Health Care) as a required service and the student shall be physically in the vehicle for the transportation to be billable to Medicaid;
- Transportation shall be considered a required service if:

  a. The student requires transportation in a vehicle specially adapted to serve the needs of the disabled student, including a specially adapted school bus; or

  b. The student resides in an area that does not have school bus transportation, such as those areas in close proximity to a school, but has a medical need for transportation that is noted in the care plan.

- Transportation is reimbursable to and from school only on a day when the student receives a Medicaid coverable service at school during the school day; and
- Transportation is reimbursable to and from a Medicaid coverable service in the community during the school day;

BILLING GUIDELINES

- Transportation is reimbursable when services of a nurse, a rehabilitation assistant (RA) or other such professional are medically necessary and ordered in the student's IEP, Section 504 Plan, or Health Care Plan. The school can be reimbursed for the nurse, RA, or other professional, and the transportation. The child does not need to receive a Medicaid service on the day of transportation in this circumstance. The school must use the ordering NPI of the ordering provider for the professional on the bus for the transportation claim. Please note: Children with special education needs who ride the regular school bus with non-disabled children from his/her neighborhood, and does not need a professional on the bus, even if the child receives a covered Medicaid service that day, such as speech therapy, transportation is not billable as it does meet the requirement of specialized transportation as noted in He-W589.04 (au).
- Mileage begins when the first student is picked up and ends when the last student exits the bus for that route. So, if the bus travels 30 miles and picks up 3 students, the calculation is 30 miles divided by 3 students. If only 1 of the 3 students is on Medicaid, 10 miles can be billed for that student so long as the student receives a Medicaid covered service that day.
- Cost per mile should be calculated for each trip daily. The cost is to be calculated for each bus separately and is not the average cost of all buses transporting special education students.
- When a School contracts their transportation, the Contractor's cost to the District is the rate that should be billed.
- When a school contracts with a parent for transportation, the following criteria must be met:
  - Transportation must meet the definition of specialized transportation
  - The IEP, Section 504 Plan or Health Care plan must document the medical need for the transportation
  - A written agreement between the parent and the School District needs to be executed

- For transportation to be covered, the child must receive a Medicaid covered service that day pursuant to an order
- Mileage reimbursement should be the federal mileage reimbursement rate, currently 0.52 cents per mile

DOCUMENTATION REQUIREMENTS

In addition to the documentation required by NH administrative rule He-W 589.06, transportation providers shall maintain a daily transportation log to include:

a. Student's name;

b. Date of service;

c. Clear indication that the student is being transported either one-way or round-trip;

d. The total number of students on the bus, both in the morning and the afternoon;

e. The total miles the bus traveled, both in the morning and in the afternoon;

f. Driver's name; and

g. Driver's signature.

APPENDIX 1 MEDICAID TO SCHOOL BILLABLE PROCEDURE CODES
EFFECTIVE JULY 1,2022

State of NH, OMBP/Finance **JH/sll**

MEDICAID TO SCHOOLS
PROCEDURE CODES AND FEE SCHEDULES
EFFECTIVE JULY 1, 2022

OCCUPATIONAL THERAPY SERVICES

Proc Code	Mod 1	Mod 2	Mod 3	MMIS Rate Prior to 12/31/2019	MMIS Rate Effective 1/1/2020	MMIS Rate Effective 1/1/2021	Unit	Max Units Allowed	Description
97165	TM			$43.17	$44.51	$45.89	EV-Eval	1 per year	Evaluation of occupational therapy, typically 30 minutes
97166	TM			$64.75	$66.76	$68.83	EV-Eval	1 per year	Evaluation of occupational therapy, typically 45 minutes
97167	TM			$86.34	$89.02	$91.78	EV-Eval	2 per year	Evaluation of occupational therapy established plan of care, typically 60 minutes
97168	TM					$58.13	EV-Eval	2 per year	Re-evaluation of occupational therapy, established plan of care; typically 30 minutes
97530	TM			$14.07	$14.51	$14.96	15 Mins	4 per day	Therapeutic activities to improve function, individual; each 15 minutes
97530	TM	HQ		$4.69	$4.84	$4.99	15 Mins	4 per day	Therapeutic activities to improve function, deliver to two or more patients in a group, each 15 minutes
97533	TM					$18.12	15 Mins	4 per day	Sensory integration to enhance processing and adaptation to environmental demands, each 15 minutes
T1999	TM					$50.00	Materials	4 per month	Miscellaneous Therapeutic items and Supplies.

Note: Shaded area means the procedure code is new effective 9-1-2021

MEDICAID TO SCHOOLS
PROCEDURE CODES AND FEE SCHEDULES
EFFECTIVE JULY 1, 2022

PHYSICAL THERAPY SERVICES									
Proc Code	Mod 1	Mod 2	Mod 3	MMIS Rate Prior to 12/31/2019	MMIS Rate Effective 1/1/2020	MMIS Rate Effective 1/1/2021	Unit	Max Units Allowed	Description
97161	TM			$47.60	$49.08	$50.60	EV-Eval	1 per year	Evaluation of physical therapy, typically 20 minutes
97162	TM			$47.60	$49.08	$50.60	EV-Eval	1 per year	Evaluation of physical therapy, typically 30 minutes
97163	TM			$47.60	$49.08	$50.60	EV-Eval	1 per year	Evaluation of physical therapy, typically 45 minutes
97164	TM					$34.48	EV-Eval	2 per year	Re-evaluation of physical therapy, typically 20 minutes
97110	TM					$24.22	15 Mins	4 per day	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97150	TM	HQ	U2			$10.63	15 Mins	4 per day	PT therapeutic intervention/treatment delivered to two or more patients in a group; 15 minutes per unit
97112	TM					$24.71	15 Mins	4 per day	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97116	TM					$21.44	15 Mins	4 per day	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)
T1999	TM					$50.00	Materials	4 per month	Miscellaneous Therapeutic items and Supplies.

Procedure Code 97799 TM is inactivated effective 8/31/2021

Note: Shaded area means the procedure code is new effective 9-1-2021

SPEECH AND LANGUAGE THERAPY SERVICES									
PROC CODE	MOD 1	MOD 2	MOD 3	MMIS RATE PRIOR TO 12/31/19	MMIS RATE EFFECTIVE 1/1/2020	MMIS RATE EFFECTIVE 1/1/2021	UNIT	MAX UNITS ALLOWED	DESCRIPTION
92507	TM			$14.07	$14.51	$14.96	15 Mins	4 per day	Individual Treatment of speech, language, voice, communication and/or hearing processing disorder
92508	TM	HQ		$9.38	$9.67	$9.97	30 Mins	4 per day	Group treatment of speech, language, voice, communication, and/or hearing processing disorder
92521	TM			$114.27	$117.81	$121.46	Eval	1 per year	Evaluation of speech fluency
92522	TM			$92.78	$95.66	$98.63	Eval	1 per year	Evaluation of speech sound production
92523	TM			$192.73	$198.70	$204.86	Eval	1 per year	Evaluation of speech sound production with evaluation of language comprehension and expression
92524	TM			$96.72	$99.72	$102.81	Eval	1 per year	Evaluation of Behavioral and qualitative analysis of voice and resonance
92526	TM					$83.11	Event	2 per week	Individual Treatment of swallowing dysfunction and/or oral function for feeding
92610	TM					$82.86	Eval	2 per year	Evaluation of oral and pharyngeal swallowing function
S9152	TM					$100.72	Eval	2 per year	Speech Therapy, Re-evaluation

Note: Shaded area means the procedure code is new effective 9-1-2021

MEDICAID TO SCHOOLS
PROCEDURE CODES AND FEE SCHEDULES
EFFECTIVE JULY 1, 2022

NURSING SERVICES

CODE	MOD 1	MOD 2	MOD 3	MMIS RATE PRIOR TO 12/31/19	MMIS RATE EFFECTIVE 1/1/2020	MMIS RATE EFFECTIVE 1/1/2021	UNIT	MAX UNITS ALLOWED	DESCRIPTION
S9123	TM					$55.28	Per Hour	8 per day	RN in school 1:1 nursing
S9124	TM					$51.02	Per Hour	8 per day	LPN in school 1:1 nursing
T1001	TM			$28.13	$29.00	$29.90	Eval	1 day	Nursing Assessment/Evaluation
T1002	TM			$14.07	$14.51	$14.96	15 Mins	8 per day	RN Services, up to 15 minutes
T1003	TM					$13.76	15 Mins	8 per day	LPN Services
T1999	TM					$50.00	Materials	4 per month	Miscellaneous Therapeutic items and Supplies.

Note: Shaded area means the procedure code is new effective 9-1-2021

AUDIOLOGY/HEARING SERVICES

CODE	MOD 1	MOD 2	MOD 3	MMIS RATE PRIOR TO 12/31/19	MMIS RATE EFFECTIVE 1/1/2020	MMIS RATE EFFECTIVE 1/1/2021	UNIT	MAX UNITS ALLOWED	DESCRIPTION
92551	TM					$5.32	Eval	2 per year	Pure tone hearing test, air
92552	TM					$7.97	Eval	2 per year	Pure tone, audiometry, air only
92553	TM					$10.63	Eval	2 per year	Audiometry air & bone
92555	TM					$5.32	Eval	2 per year	Speech threshold audiometry
92556	TM					$15.95	Eval	2 per year	Speech Audiometry threshold; w/ Speech Recognition
92557	TM					$26.58	Eval	2 per year	Comprehensive audiometry threshold eval & Speech recognition
92567	TM					$8.51	Eval	2 per year	Tympanometry (Impedance Testing)
92568	TM					$7.97	Eval	2 per year	Acoustic reflect testing; threshold
92570	TM					$14.65	Eval	2 per year	Acoustic immittance testing
92579	TM					$17.18	Eval	2 per year	Visual audiometry (vra)
92582	TM					$7.97	Eval	2 per year	Conditioning play audiometry
92587	TM					$30.03	Eval	2 per year	Evoked auditory test limited
92588	TM					$48.90	Eval	2 per year	Evoked auditory test complete
92620	TM					$59.91	60 Mins	2 per year	Auditory function
92621	TM					$14.35	15 Mins	8 units 2x per year	Central Auditory Function w/Report; EA Additional 15 mins

Note: Shaded area means the procedure code is new effective 9-1-2021

VISION SERVICES									
CODE	MOD 1	MOD 2	MOD 3	MMIS RATE PRIOR TO 12/31/19	MMIS RATE EFFECTIVE 1/1/2020	MMIS RATE EFFECTIVE 1/1/2021	UNIT	MAX UNITS ALLOWED	DESCRIPTION
92002	TM					$43.66	Visit	2 per year	Eye & Medical Exam for diagnosis and treatment; new patient
92012	TM					$40.07	Visit	2 per year	Eye Exam; Estab Patient
V2799	TM			$23.13	$23.85	$24.59	Eval	4 per month	Vision item or service, miscellaneous

Note: Shaded area means the procedure code is new effective 9-1-2021

APPLIED BEHAVIORAL ANALYSIS									
CODE	MOD 1	MOD 2	MOD 3	MMIS RATE PRIOR TO 12/31/19	MMIS RATE EFFECTIVE 1/1/2020	MMIS RATE EFFECTIVE 1/1/2021	UNIT	MAX UNITS ALLOWED	DESCRIPTION
97151	TM					$15.95	15 min	8 Units 4 per year	Behavior identification assessment, face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan.
97153	TM					$17.27	15 min	8 units per day	Adaptive behavior treatment by protocol, administered by technician under direction of qualified health care professional to one patient

Note: Shaded area means the procedure code is new effective 9-1-2021

PROCEDURED CODES AND FEE SCHEDULES

EFFECTIVE JULY 1, 2022

REHABILITATIVE ASSISTANCE									
CODE	MOD 1	MOD 2	MOD 3	RATE PRIOR TO 12/31/19	RATE EFFECTIVE 1/1/2020	RATE EFFECTIVE 1/1/2021	UNIT	MAX UNITS ALLOWED	DESCRIPTION
H2017	TM			$5.94	$6.12	$6.31	15 min	48 per day	Psychosocial rehabilitation services
H2017	TM	HQ		$3.13	$3.23	$3.33	15 min	48 per day	Psychosocial rehabilitation services

PSYCHOTHERAPY/MENTAL HEALTH									
CODE	**MOD 1**	**MOD 2**	**MOD 3**	**RATE PRIOR TO 12/31/19**	**RATE EFFECTIVE 1/1/2020**	**RATE EFFECTIVE 1/1/2021**	**UNIT**	**MAX UNITS ALLOWED**	**DESCRIPTION**
90791	TM			$60.00	$61.86	$63.78	30 Eval	2 per year	Psychiatric Diagnostic Evaluation
90832	TM			$50.00	$51.55	$53.15	30 Min	1 per day	Individual Mental Health Psychotherapy, 30 minutes
90832	TM	HQ		$25.00	$25.78	$26.58	30 Min	1 per day	Mental Health Psychotherapy, in a group, each 30 minutes
90834	TM			$65.00		$67.02	45 Min	1 per day	Individual Mental Health Psychotherapy, 45 minutes with patient
90837	TM			$72.00		$74.23	60 Min	1 per day	Individual Mental Health Psychotherapy, 60 minutes with patient
90839	TM					$89.19	60 Min	1 per day	Individual Mental Health Psychotherapy for crisis, first 60 minutes with patient
90840	TM					$22.74	Addt'l 30 Min	2 per day	Individual Mental Health Psychotherapy for crisis, each additional 30 minutes

The following procedure codes are inactivated effective 8/31/2021 - H0046 TM, T1024 TM and T1027 TM

Note: Shaded area means the procedure code is new effective 9-1-2021

PSYCHOLOGICAL TESTING									
CODE	MOD 1	MOD 2	MOD 3	RATE PRIOR TO 12/31/19	RATE EFFECTIVE 1/1/2020	RATE EFFECTIVE 1/1/2021	UNIT	MAX UNITS ALLOWED	DESCRIPTION
96130	TM					$142.79	First Hour	2 per year	Psychological testing evaluation services by physician or other QHCP; first hour
96131	TM					$142.79	Addt'l Hour	6 per year	Psychological testing evaluation by qualified health care professional, each additional hour
96132	TM					$147.22	First hour	2 per year	Neuropsychological testing evaluation services by physician or other QHCP; first hour
96133	TM					$105.08	Addt'l hour	6 per year	Neuropsychological testing evaluation services by physician or other QHCP; each additional hour
96136	TM					$73.61	First 30 min	2 per year	Psychological or neuropsychological test administration and scoring by physician or other QHCP, two or more tests; any method; first 30 minutes
96137	TM					$73.61	Addt'l 30 min	6 per year	Psychological or neuropsychological test administration and scoring by physician or other QHCP, two or more tests; any method; each addtl 30 minutes
96138	TM					$71.40	First 30 Min	2 per year	Psychological or neuropsychological test administration and scoring by technician, first 30 minutes
96139	TM					$71.40	Add'tl 30 Minutes	6 per year	Psychological or neuropsychological test administration and scoring by technician, additional 30 minutes
96146	TM					$142.79	Eval	2 per year	Psychological or neuropsychological test administration and scoring by single standardized instrument via electronic platform with automated result

Note: Shaded area means the procedure code is new effective 9-1-2021

SPECIALIZED TRANSPORTATION									
CODE	MOD 1	MOD 2	MOD 3	MMIS RATE PRIOR TO 12/31/19	MMIS RATE EFFECTIVE 1/1/2020	MMIS RATE EFFECTIVE 1/1/2021	UNIT	MAX UNITS ALLOWED	DESCRIPTION
T2003	TM					$2.54	Per Mile	999	Non Emergency, Transportation

Note: Shaded area means the procedure code is new effective 9-1-2021

Procedure Code A0425 - TM is inactivated effective 8/31/2021

MEDICAL SERVICES									
CODE	MOD 1	MOD 2	MOD 3	MMIS RATE PRIOR TO 12/31/19	MMIS RATE EFFECTIVE 1/1/2020	MMIS RATE EFFECTIVE 1/1/2021	UNIT	MAX UNITS ALLOWED	DESCRIPTION
90791	TM			$60.00	$61.86	$63.78	Eval	2 per year	Psychiatric Diagnostic Evaluation

Procedure Code 99201 - TM was inactivated effective 12/31/2020