MSA Bulletin

MEDICAL SERVICES ADMINISTRATION

Michigan Department of Community Health

Distribution: Community Mental Health Services Programs 03-05

Issued: August 15, 2003

Subject: Conversion of Children's Waiver Program Local Procedure Codes to National Procedure Codes

Effective: October 1, 2003

Programs Affected: Medicaid

The Health Insurance Portability and Accountability Act (HIPAA) requires that all local procedure codes be converted to national procedure codes and modifiers. This bulletin is to notify you of the procedure coding changes for the Children's Waiver Program that will be implemented by the Department of Community Health for dates of service on or after October 1, 2003. For dates of service prior to October 1, 2003, providers should continue to use the Medicaid local procedure codes for the Children's Waiver Program.

This bulletin incorporates a revision to the table contained in CMHSP 03-04, issued August 11, 2003. The changes in the table are indicated in **bold font** for ease of recognition. The subject line has been clarified to denote application to the Children's Waiver Program.

The table below lists the local codes that are being deleted and the new national codes that will replace them. You must refer to your 2003 CPT and/or HCPCS code books for the full descriptions of the national codes and for additional explanatory information that may affect billing. It is important for all staff (e.g., reimbursement, clinical, etc.) to have access to these code books. There is not a one-to-one conversion from the old codes to the national codes. In many cases, the units of service for the national procedure codes differ from the units of service for the local procedure codes. You must bill a quantity to reflect the appropriate units of service provided (i.e., if you provided 1 hour of service and the code description states “per 15 minutes”, the quantity billed will be 4). You must provide the full time designated to bill additional quantities (i.e., if you provide 50 minutes of service for a code that states “per 15 minutes”, the quantity billed would be 3). It will not be possible to correctly report services unless the full descriptions of the CPT and HCPCS codes are referred to in conjunction with the 10/1/03 version of Chapter III for Medicaid Prepaid Health Plans, Mental Health & Substance Abuse.

A detailed explanation of covered services and waiver services is available in Chapter III of the Medicaid Manual for Prepaid Health Plans, Mental Health & Substance Abuse, revised effective 10-1-03. Information regarding the fee screens and coverage parameters (when appropriate) for covered codes will be posted on the MDCH website when available. The website address is www.michigan.gov/mdch, click on Providers, Information for Medicaid Providers, Medicaid Fee Screens.

Old Local Code	Service	HCPCS Code	Billing Unit	Billing Comments
Z9080	Community Living Supports	H2015	Per 15 minutes	
Z9156	Comprehensive Multidisciplinary Evaluation (Behavior Management Review)	H2000	Per session, per beneficiary	Covered up to 5 sessions per month for each beneficiary.
Z9143 Z9144	Crisis Intervention & Stabilization	S9484	Per hour	
Z9149 Z9150	Crisis Residential	H0018	Per diem	
Z9176	Durable medical equipment, miscellaneous	E1399	Per item	Use Remarks to identify the item. Single room air conditioners are limited to one in 5 years and a maximum cost of $400.
Z9104	Enhanced Transportation	S0215	Per mile	
Z9083 Z9084	Family Therapy	90846 90847	Per session	
Z9053	Family Training	S5111	Per session	Formerly called "didactic services"
Z9048 Z9049 Z9111	Health Services	97802 97803 97804 H0034 S9445 S9446 S9470 T1001 T1002	Refer to individual code descriptions.	Group services are only appropriate for services identified as "group" in the code description.
Z9169	Home Modifications (Environmental Accessibility Adaptations)	S5165	Per service	All require PA from MDCH.
Z9046	Medication Administration	90782 90788 99506	Per visit	Only billable as a separate service – not payable when any other service is provided.
Z9114 Z9115	Medication Review	90862 M0064	Per visit	EPS/tardive dyskinesia testing is part of the medication review and not payable separately.
Z9172	Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in remarks .	T1999	Per item	Only adaptive toys can be billed under this code. Adaptive toys are limited to one toy per quarter and a maximum cost of $25. Use Remarks to identify the item.

Old Local Code	Service	HCPCS Code	Billing Unit	Billing Comments
Z9055 Z9056	Non-Family Training	S5115	Per session	Formerly called "QMRP, Masters Social Worker/LLP – Psychological Behavioral Treatment"
Z9116 Z9117 Z9118 Z9119 Z9120 Z9121 Z9122 Z9123	Occupational Therapy and Physical Therapy	**97110** **97112** **97113** **97116** **97140** **97150** **97520** **97530** **97532** **97533** **97535** **97537** **97542** S8990	Refer to individual code descriptions.	Covered up to a maximum of 8 sessions per month.
		97001 **97002** **97003** 97004	Refer to individual code descriptions.	Evaluation
Z9113	Other Testing & Assessments	96105 96110 96111	Refer to individual code descriptions.	
Z9171	Personal care item, NOS (ADL Aids)	S5199	Per item	Use remarks to identify the item. Limited to 5 per quarter and a maximum cost of $100.
Z9110	Psych Evaluation	90801 90802	Per visit	
Z9112	Psych Testing	96100 96115 96117	Per hour	
Z9131 Z9132 Z9133 Z9134 Z9135 Z9137 Z9138	Psychotherapy	90804 **90805** **90806** **90807** **90808** **90809** **90810** **90811** **90812** **90813** **90814** 90815 90853	Refer to individual code descriptions.	

Old Local Code	Service	HCPCS Code	Billing Unit	Billing Comments
Z9177	Repairs	E1340	Per 15 minutes of labor	Requires PA from MDCH.
Z9029 Z9030 Z9033 Z9034 Z9037 Z9038	Respite	T1005	Per 15 minutes	Use modifier TD for RN, modifier TE for LPN, no modifier for other than RN or LPN. If an RN or LPN is providing respite services to more than one beneficiary at the same time, the modifiers TD or TE are reported for one beneficiary at a time. During that time, other beneficiaries must be billed using the same procedure code with no modifier. When billing only aide level staffing, use Modifier TT for each beneficiary to indicate one caregiver to multiple patients. **If a RN provides respite and PDN, the record must clearly delineate the discrete time spent on each function.**
		S5151	Per diem	**Vacation respite is covered up to a maximum of 14 days per year.** Use Modifier TT to indicate one caregiver (aide level only) to multiple patients. If a RN provides respite and PDN, the record must clearly delineate the discrete time spent on each function.
Z9165	Specialized Medical Equipment, NOC, waiver	T2029	Per item	Use Remarks to specify the item. Environmental safety and control devices are limited to 5 per quarter and a maximum cost of $250.
Z9167 Z9174 Z9175	Specialized supply, NOC, waiver	T2028	Per item	Use Remarks to identify the item. Allergy control supplies are limited to 5 per quarter and a maximum cost of $100.
Z9085 Z9086 Z9087 Z9088	Specialty Services	G0176 97124	Refer to individual code descriptions.	Up to a limit of 4 sessions per month per type of specialty service
Z9124 Z9125 Z9126 Z9127 Z9128	Speech, Language Therapy	92506 92507 92508 92526	Refer to individual code descriptions.	Covered up to a maximum of 8 sessions per month.

Old Local Code	Service	HCPCS Code	Billing Unit	Billing Comments
Z9153 Z9154 Z9161	Targeted Case Management	T2023	Per month	Targeted Case Management includes assessment, care/services plan development, linking/coordination of services, reassessment/follow-up and monitoring of services. The frequency of the face-to-face contacts must be consistent with the intensity of the beneficiary's needs. The record must document all case management activities that occur during the month, identify the professionals involved, and document the type of contact. Targeted Case Management should be billed once per calendar month. The date of service should be the last day of the month.
Z9173	Vehicle modifications, waiver, per service	T2039	Per service	Van lifts and tie-downs are limited to a maximum cost of $5,500, once every 5 years. PA must be obtained from MDCH for lifts exceeding $5,500 or when replacement is needed before 5 years. All other vehicle modifications require PA from MDCH.

Manual Maintenance

Retain this bulletin for future reference.

The following bulletin is obsolete and should be discarded:

CMHSP 03-04 – Conversion of Local Procedure Codes to National Procedure Codes

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231 or e-mail ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll free 1-800-292-2550.

Approval

Paul Reinhart, Director
Medical Services Administration