School Health Services (SHS)

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School Health Services (SHS)

Program Overview

The Nevada Medicaid School Health Services (SHS) program allows enrolled Local Education Agencies (LEAs)/State Education Agencies (SEAs) to receive Medicaid payment for providing qualifying health-related services.

Student Requirements

In order to receive services, a student must be enrolled in Nevada Medicaid and be under age 21.

State Policy

For complete coverage and limitations, refer to Medicaid Services Manual (MSM) Chapter 2800 on the Nevada Medicaid website at nevadamedicaid.nv.gov.

Service Requirements

All required evaluations and records must be complete in order for Medicaid to issue payment for services. Duplicate services are not allowed when multiple providers perform the same or similar procedures.

In addition, services must be:

- Provided as part of a screening or diagnostic service, crisis service, or in accordance with an active Plan of Care (POC) that specifies the type, amount, duration, frequency, and location of services.
- Consistent with the intent of the POC's services and planned goals.
- Provided to detect, address and correct, or ameliorate the student's physical, mental and/or emotional condition as identified in the POC.
- Deemed medically necessary and appropriate.
- Meet any Ordering, Prescribing and Referring (OPR) requirements for the service being provided.
- Provided by a qualified practitioner.

Prior Authorization

SHS do not require prior authorization. See the Provider Type 60 Fee Schedule for a list of available procedure codes.

Third Party Liability (TPL)

If a recipient has another insurer (public or private) legally responsible for payment, the other insurer must be billed prior to billing Medicaid for the service provided. If the insurer denies the claim as a non-covered service or a non-covered setting, then documentation of the denial may be submitted with the claim to Medicaid.

The exception to this are services provided in an Individualized Education Program (IEP). All services provided as part of an IEP may be billed with the modifier **TM**. Medicaid pays the claim and then attempts to recover the paid amount from the legally responsible payer. This does not relinquish the LEA's/SEA's responsibility to obtain and disclose all available insurance information and obtain parental consent to bill public and private insurances.

Claim Submission Instructions

Submit claims monthly. Submit claims by using Direct Data Entry (DDE) through the Provider Web Portal (PWP) or by using a trading partner or billing agent. See PWP User Manual Chapter 3: Claims and the electronic billing companion guides for claim submission instructions.

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Use of a Billing Agent

LEAs/SEAs may use a billing agent rather than submitting claims directly to Nevada Medicaid provided that the appropriate business partner agreements are in place. The LEA/SEA is responsible for all claims submitted by its billing agent and must maintain documentation that billing was reviewed and approved prior to its submission to Nevada Medicaid.

To remain current with Nevada Medicaid rules and policies, it is recommended that providers and billing agents review both Nevada Medicaid and Nevada Medicaid provider websites for publication updates, web announcements and newsletters.

National Correct Coding Initiative (NCCI) Edits and Service Limitations

The objective of the National Correct Coding Initiative (NCCI) is to promote correct coding methodologies. The Centers for Medicare & Medicaid Services (CMS) is responsible for the development and administration of the NCCI Edits: *"The CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT Manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices."*

Nevada Medicaid receives quarterly and annual NCCI Edit reports from CMS. The Medicaid Management Information System (MMIS) uses the CMS NCCI Edits to process claims. The MMIS is updated regularly with changes from the reports provided by CMS. The providers can find the most current Annual Code and the quarterly Medically Unlikely Edits (MUE), Procedure to Procedure (PTP) and Add-On Code reports on the CMS website at: cms.gov/medicare/coding-billing/ncci-medicaid

It is not possible to provide the most current quarterly or annual changes in this billing guide; for the most current information please reference the CMS website provided above. Providers are reminded to bill procedures with the correct modifier combinations, units of service provided and correct code combinations.

Note: It is the responsibility of providers to ensure the use of current CPT codes, service limitations and MUEs are applied when billing claims.

Incorrectly Billed Claims

If a claim is paid and Medicaid later discovers that the service was incorrectly billed, incorrectly paid, or invalid in some other way, federal law requires Medicaid to recover overpayment, regardless of the cause.

Modifiers

The following modifiers identify the type of service performed. Proper use of these modifiers is indicated in the sections that follow and in the Provider Type 60 Fee Schedule.

Modifier	Definition
25	Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service
AH	Licensed Board of Examiners Psychologist
AM	Physician, team member service
CO	Outpatient Occupational Therapy Assistant
CQ	Outpatient Physical Therapy Assistant
EP	Routine Healthy Kids Screening
GN	Outpatient Speech Language
GO	Outpatient Occupational Therapy

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Modifier	Definition
GP	Outpatient Physical Therapy
GT	Telephonic Services
HE	Mental health
HF	Substance abuse program
HQ	Group Service
HT	Team Service
SA	Nurse Practitioner
SL	State supplied vaccine
TD	Registered Nurse
TM	Individualized Education Program (IEP)
TS	Follow-up Service

Units

The servicing provider must document the amount of time spent for each service. For codes that specify a time segment in their description, e.g., each 15 minutes or each 30 minutes, each of these timed segments equals one unit. Enter the number of units on the claim; do not enter time spent on the service.

If more than half of a timed segment is performed, round up to the next unit. If less than half of a timed segment is performed, round down. For example, if a code is timed in 15-minute segments, partial timed segments must be at least eight minutes long in order to round the time up to the next unit.

- 22 minutes = 1 unit + 7 remaining minutes: Bill 1 unit.
- 23 minutes = 1 unit + 8 remaining minutes: Bill 2 units.

If a code does not specify a time segment in its description, it is considered an encounter or occurrence code. Bill one unit for the procedure, regardless of time spent.

Ordering, Prescribing and Referring (OPR) Provider Requirements

The Patient Protection and Affordable Care Act and the Centers for Medicare & Medicaid Services (CMS) require all OPR physicians to be enrolled in the state Medicaid program (CFR 455.410 Enrollment and Screening of Providers). The Affordable Care Act (ACA) requires physicians or other eligible practitioners to enroll in the Medicaid program to order, prescribe and refer items or services for Medicaid recipients, even when they do not submit claims to Medicaid. Physicians or other eligible professionals who are already enrolled in Medicaid as participating providers and who submit claims to Medicaid are not required to enroll separately as OPR providers.

For any services or supplies that are ordered, prescribed, or referred, the National Provider Identifier (NPI) of the Nevada Medicaid-enrolled OPR provider must be included on Nevada Medicaid/Nevada Check Up claims or those claims will be denied. To prevent claim denials for this reason, please confirm that the OPR provider is enrolled with Nevada Medicaid. This can be done on the Provider Web Portal by using the Search Providers feature: medicaid.nv.gov/hcp/provider/Resources/SearchProviders/tabid/220/Default.aspx.

For detailed information on Electronic Claims submission refer to the 837P FFS Companion Guide located at: medicaid.nv.gov/providers/edi.aspx.

For detailed information on Direct Data Entry/Provider Web Portal instructions, see the PWP User Manual Chapter 3: Claims.

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Rates

The Provider Type 60 Fee Schedule includes a list of covered codes and the current Nevada Medicaid rates. The fee schedule is online at nevadamedicaid.nv.gov/resources/rates/fee-schedules/.

If you have questions regarding rates, please refer to MSM Chapter 700, Rates and Supplemental Reimbursement.

Covered Services

Medicaid covers the following services provided in a school or other community site:

- Screening and diagnostic services
- Physician services
- Mental Health and alcohol/substance abuse services
- Nursing services
- Physical therapy
- Occupational therapy
- Speech therapy
- Audiology services and supplies
- Medical supplies
- Personal Care Services (PCS)
- Applied Behavior Analysis (ABA) services
- Dental services
- Optometry services
- Case management
- Telehealth

MSM Chapter 2800 and the sections that follow provide detailed coverage information on each service.

With the exception of Durable Medical Equipment (DME) services, providers must document all face-to-face time. Consults, monitoring, and coordination are not paid separately.

The following sections list Current Procedural Terminology (CPT)/Current Dental Terminology (CDT)/Healthcare Common Procedure Coding System (HCPCS) codes and modifiers that LEAs/SEAs must use when billing. Billing must be in accordance with Nevada Medicaid billing instructions and national billing standards.

Screening, Diagnostic and Physician Services

Physician-Administered Drugs

Nevada Medicaid requires a National Drug Code (NDC), the NDC quantity, and the HCPCS code for each claim line with a physician-administered drug. For billing specifications, see the Nevada Medicaid NDC Billing Reference (select "NDC" from the "Providers" menu, then click "Billing Reference").

Vaccines

Nevada Medicaid and Nevada Check Up (NCU) do not reimburse providers for Vaccines for Children (VFC) Program vaccines. Providers are encouraged to enroll with the VFC Program, which provides free vaccines for eligible children. To enroll as a VFC provider, visit the Nevada Division of Public and Behavioral Health (DPBH) website at: dpbh.nv.gov/Programs/VFC/VFC_-_Home/. See the Centers for Disease Control and Prevention (CDC) website for more information on the VFC Program. All vaccine serums require NDCs.

Providers must use a zero rate for reimbursement for VFC vaccines, or the SL modifier. Even with a zero rate on the claim, quantity must be included on the claim or the claim will deny.

Bill administration codes at the usual and customary charge and bill vaccines at a zero-dollar amount. Vaccine claims are billed with the NDC and are limited to one vaccine per claim line and one unit of measure per individual product.

Bill non-VFC vaccinations with the NDC and the usual and customary rate.

For more information on the HPV vaccine uses and restrictions please see Medicaid Services Manual (MSM) Chapter 1200 or the Centers for Disease Control and Prevention (CDC) website cdc.gov/vaccines/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fvaccines%2Fdefault.htm or the FDA vaccine website fda.gov/vaccines-blood-biologics/vaccines.

Healthy Kids also known as Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

Use modifier EP or TS with the appropriate exam code in the table below.

- **Modifier EP** indicates a normal, routine screening.
- **Modifier TS** indicates that referral or follow-up services are recommended. When using modifier TS, complete Field 21 on the CMS-1500 claim form with the most current diagnosis code(s) that reflects the condition requiring follow-up.
- **Modifier 25** must be used with other non-preventive medicine Evaluation & Management (E&M) services (e.g., codes 99212-99215) when reported in conjunction with vaccine administration when the E&M service is significant and separately identifiable. (See Web Announcement 565 for additional instructions for the use of modifiers 25 and EP with vaccine and vaccine administration codes.) Continue to use EP and TS modifiers as well.

Medicaid may cover a sick visit and a Healthy Kids examination for the same recipient, at the same time of service, and for the same provider. All screening elements must be completed during a Healthy Kids examination as indicated in the Periodicity Schedule / Bright Futures and MSM Chapter 1500. Appropriate diagnosis and modifiers must be billed for each respective visit. Vaccines may be administered during a sick visit at the medical professional's discretion.

Services that are **not medical in nature**, including educational interventions, are not Medicaid covered benefits.

Tests can be classified as screening or diagnostic.

- Screening tests are done to detect potential diseases before a patient reports any signs or symptoms of a disease. Diseases uncovered through routine screenings are often easier to treat.
- Diagnostic tests are performed to confirm the presence of a disease, usually in a patient who shows signs or symptoms of a disease.

Referrals

When services are referred as a result of a Healthy Kids exam, a written referral should be furnished to the recipient, the parent/guardian or the provider who will perform the referred service. Referrals should include:

- Recipient's name
- Recipient ID
- Date
- Description of the abnormality
- Contact information for the recipient's primary physician (if different from the screening provider)
- Name of the provider who is to perform the referred service (if known)

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Screening and Diagnostic Services			
Code	**Modifier**	**Description**	**Service Limitations**
Healthy Kids (EPSDT) Screenings			
99382	EP or TS	New patient, early childhood (age 1 through 4 years old). SHS can only bill starting at 3 years old.	• Encounter = 1 unit • Limit of 1 unit per day
99383	EP or TS	New patient, late childhood (age 5 through 11 years old).	• Encounter = 1 unit • Limit of 1 unit per day
99384	EP or TS	New patient, adolescent (age 12 through 17 years old).	• Encounter = 1 unit • Limit of 1 unit per day
99385	EP or TS	New patient, adult (age 18-39 years old). SHS can only bill for up to age 21 years old.	• Encounter = 1 unit • Limit of 1 unit per day
99392	EP or TS	Established patient, early childhood (age 1 through 4 years old). SHS can only bill starting at 3 years old.	• Encounter = 1 unit • Limit of 1 unit per day
99393	EP or TS	Established patient, late childhood (age 5 through 11 years old).	• Encounter = 1 unit • Limit of 1 unit per day
99394	EP or TS	Established patient, adolescent (age 12 through 17 years old).	• Encounter = 1 unit • Limit of 1 unit per day
99395	EP or TS	Established patient, adult (age 18-39 years old). SHS can only bill for up to age 21 years old.	• Encounter = 1 unit • Limit of 1 unit per day
Services to be billed separately Services listed in the following section are not considered part of a Healthy Kids exam and should be **billed separately**, on their own claim line.			
90460		Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered.	• Vaccine = 1 unit • Limit of 9 units per day

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Screening and Diagnostic Services			
Code	**Modifier**	**Description**	**Service Limitations**
+90461		Each additional vaccine or toxoid component administered (List separately in addition to code for primary procedure). (Use 90460 for each vaccine administered. For vaccines with multiple components [combination vaccines]. Report 90460 in conjunction with 90461 for each additional component in a given vaccine.)	• Vaccine = 1 unit • Limit 8 units per day
90471		Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single combination vaccine/toxoid).	• Vaccine = 1 unit • Limit of 1 unit per day
+90472		Each additional vaccine (single or combination vaccine/toxoid). (List separately in addition to code for primary procedure). (Use in conjunction with 90460, 90471, 90473).	• Vaccine = 1 unit • Limit of 8 units per day
90473		Immunization administration by intranasal or oral route. 1 vaccine (single or combination vaccine/toxoid).	• Vaccine = 1 unit • Limit of 1 unit per day
+90474		Each additional vaccine (single or combination vaccine/toxoid). List separately in addition to code for primary procedure. (Use in conjunction with 90460, 90471, 90473.)	• Vaccine = 1 unit • Limit of 1 unit per day
90791		Psychiatric diagnostic evaluation. NOTE: Integrated biopsychosocial assessment, including history, mental status and recommendations. Psychotherapy services, including for crisis, may not be reported on the same day. Evaluation and Management (E/M) codes may not be reported on the same day performed by the same individual for the same patient. SHS Additional Instructions: Mental Health Assessment at school - A psychiatric diagnostic evaluation is performed, which includes the assessment of the student's psychosocial history, current mental health status, review, and ordering of diagnostic studies followed by appropriate treatment recommendations.	• Covered up to 4 times per calendar year (CASII) or 2 times per calendar year (LOCUS) based on Intensity of Needs grid

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Screening and Diagnostic Services			
Code	**Modifier**	**Description**	**Service Limitations**
90792		Psychiatric diagnostic evaluation with medical services. (Use 90785 in conjunction with 90791, 90792 when the diagnostic evaluation includes interactive complexity services.)	• Encounter = 1 unit • Limit 1 unit per day
+90785		Interactive complexity (list separately in addition to the code for primary procedure). (Use 90785 in conjunction with codes for diagnostic psychiatric evaluation [90791, 90792], psychotherapy [90832, 90834, 90837], psychotherapy when performed with an evaluation and management service [90833, 90836, 90838, 99202-99255,99304-99337, 99341-99350], and group psychotherapy [90853].)	• Encounter = 1 unit • Limit 3 units per day
92521		Evaluation of speech fluency (e.g., stuttering, cluttering).	• Encounter = 1 unit • Limit 1 unit per day
92522		Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria).	• Encounter = 1 unit • Limit 1 unit per day
92523		With evaluation of language comprehension and expression (e.g., receptive and expressive language).	• Encounter = 1 unit • Limit 1 unit per day
92551		Screening test, pure tone, air only. Includes testing of both ears. (Use modifier 52 if a test is applied to one ear instead of two ears.)	• Encounter = 1 unit • Limit 1 unit per day
92620		Evaluation of central auditory function, with report; initial 60 minutes (For use by a qualified Audiologist). (Use 92621 in conjunction with 92620).	• 60 minutes = 1 unit • Limit 1 unit per day
+92621		Each additional 15 minutes. (List separately in addition to code for primary procedure). (Use 92621 in conjunction to 92620). (For use by a qualified Audiologist.)	• 15 minutes = 1 unit • Limit 4 units per day

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Screening and Diagnostic Services			
Code	**Modifier**	**Description**	**Service Limitations**
96110		Developmental screening (e.g., developmental milestone survey, speech, and language delay screen), with scoring and documentation, per standardized instrument.	• 1 instrument = 1 unit • Limit of 3 units per day
96112		Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour.	• 1 hour = 1 unit • Limit of 1 unit per day
+96113		Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes (List separately in addition to code for primary procedure).	• Limit of 6 units per day
96116		Neurobehavioral status exam (clinical assessment of thinking, reasoning, and judgment. e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour.	• 60 minutes = 1 unit • Limit 1 unit per day
+96121		Neurobehavioral status exam (clinical assessment of thinking, reasoning, and judgment, e.g., acquired knowledge, attention, language, memory, planning, and problem solving, and visual spatial abilities). Each additional hour (List separately in addition to code for primary procedure.)	• 60 minutes = 1 unit • Limit of 3 units per day
96156		Health behavior assessment, or re-assessment (i.e., health-focused clinical interview, behavioral observations, clinical decision making). Note: please reference the Outpatient Mental Health Services Section for information on Qualified Provider Type(s).	• Encounter = 1 unit • Limit of 1 unit per day

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Screening and Diagnostic Services			
Code	**Modifier**	**Description**	**Service Limitations**
96158		Health behavior intervention, individual, face-to-face; initial 30 minutes. Note: please reference the Outpatient Mental Health Services Section for information on Qualified Provider Type(s).	• 30 minutes = 1 unit • Limit 1 unit per day
+96159		Health Behavior intervention, individual, face-to-face, each additional 15 minutes. (List separately in addition to code for primary service.) Note: please reference the Outpatient Mental Health Services Section for information on Qualified Provider Type(s).	• 15 minutes = 1 unit • Limit of 4 units per day
96160		Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument.	• Assessment = 1 unit • Limit of 3 units per day
96164		Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes. Note: please reference the Outpatient Mental Health Services Section for information on Qualified Provider Type(s).	• Initial 30 minutes
+96165		Health behavior intervention, group (2 or more patients), face-to-face. Each additional 15 minutes. (List separately in addition to code for primary service.) (Use 96165 in conjunction with 96164.) Note: please reference the Outpatient Mental Health Services Section for information on Qualified Provider Type(s).	• Each additional 15 minutes
96167		Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes. Note: please reference the Outpatient Mental Health Services Section for information on Qualified Provider Type(s).	• 30 minutes = 1 unit • Limit of 1 unit per day
+96168		Health behavior intervention, family (with the patient present), face-to-face. Each additional 15 minutes. (List separately in addition to code for primary service.) Note: please reference the Outpatient Mental Health Services Section for information on Qualified Provider Type(s).	• 15 minutes = 1 unit • Limit of 6 units per day

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Screening and Diagnostic Services			
Code	**Modifier**	**Description**	**Service Limitations**
96170		Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes. Note: please reference the Outpatient Mental Health Services Section for information on Qualified Provider Type(s).	• 30 minutes = 1 unit • Limit of 1 unit per day
+96171		Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service.) Note: please reference the Outpatient Mental Health Services Section for information on Qualified Provider Type(s).	• 15 minutes = 1 unit • Limit of 2 units per day
96127		Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation per standardized instrument. NOTE: This is considered a screening tool. Bill one unit for each screening. NOTE: A screening may also be a component of a full assessment, but only the full assessment (including a CASII or LOCUS) will be reimbursable. Note: please reference the Outpatient Mental Health Services Section for information on Qualified Provider Type(s).	• Assessment = 1 unit • Limit 2 units per day

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Screening and Diagnostic Services			
Code	**Modifier**	**Description**	**Service Limitations**
97161		Physical therapy evaluation, low complexity. Requiring these components: ▪ A history with no personal factors and/or comorbidities that impact the plan of care; ▪ An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; ▪ A clinical presentation with stable and/or uncomplicated characteristics; and ▪ Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.	• 20 minutes = 1 unit • Limit 1 unit per day
97162		Physical therapy evaluation: moderate complexity requiring these components: ▪ A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; ▪ An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following; body structures and functions, activity limitations, and/or participation restrictions; ▪ An evolving clinical presentation with changing characteristics, and ▪ Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.	• 30 minutes = 1 unit • Limit 1 unit per day

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Screening and Diagnostic Services			
Code	**Modifier**	**Description**	**Service Limitations**
97163		Physical therapy evaluation: high complexity, requiring these components: ▪ A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; ▪ An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; ▪ A clinical presentation with unstable and unpredictable characteristics; and ▪ Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.	• 45 minutes = 1 unit • Limit 1 unit per day

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Screening and Diagnostic Services			
Code	**Modifier**	**Description**	**Service Limitations**
97165		Occupational therapy evaluation, low complexity, requiring these components: ▪ An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; ▪ An assessment(s) that identifies 1-3 performance deficits (ie, relating to physical, cognitive or psychosocial skills) that result in activity limitations and/or participation restrictions; and ▪ Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family.	• 30 minutes = 1 unit • Limit 1 unit per day

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Screening and Diagnostic Services			
Code	**Modifier**	**Description**	**Service Limitations**
97166		Occupational therapy evaluation, moderate complexity, requiring these components: ▪ An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; ▪ An assessment(s) that identifies 3-5 performance deficits (i.e., relating to physical, cognitive or psychosocial skills) that result in activity limitations and/or participation restrictions; and ▪ Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family.	• 45 minutes = 1 unit, • Limit 1 unit per day

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Screening and Diagnostic Services			
Code	**Modifier**	**Description**	**Service Limitations**
97167		Occupational therapy evaluation, high complexity, requiring these components: ▪ An occupational profile and medical and therapy history which includes review of medical and/or therapy records an extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; ▪ An assessment(s) that identifies 5 or more performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and ▪ Clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family.	• 60 minutes = 1 unit • Limit 1 unit per day
99174		Instrument-based ocular screening (e.g., photoscreening, automated-refraction), bilateral; with remote analysis and report.	• Encounter = 1 unit • Limit of 1 per day
99188		Application of fluoride varnish by physician or other qualified health care professional.	• Encounter = 1 unit • Limit 1 unit per day
G0312		Immunization Counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service for ages under 21; 5 to 15 mins time	• Limit 1 unit per day
G0313		Immunization Counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service for ages under 21; 16 to 30 mins time	• Limit 1 unit per day

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Screening and Diagnostic Services			
Code	**Modifier**	**Description**	**Service Limitations**
G0314		Immunization Counseling by a physician or other qualified health care professional for COVID-19, ages under 21; 5 to 15 mins time	• Limit 1 unit per day
G0315		Immunization Counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service for ages under 21; 5 to 15 mins time	• Limit 1 unit per day
EPSDT Services that can NOT be billed with Healthy Kids Screening			
99078		Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (e.g., prenatal, obesity, or diabetic instructions).	• Group = 1 unit • Limit 3 units per day
99401		Preventive medicine counseling and/or risk factor reduction intervention(s) provide to an individual (separate procedure); approximately 15 minutes.	• Encounter = 1 unit • Limit 1 unit per day
99402		Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes.	• Encounter = 1 unit • Limit 1 unit per day
99403		Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes.	• Encounter = 1 unit • Limit 1 unit per day
99404		Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes.	• Encounter = 1 unit • Limit 1 unit per day
99406		Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes.	• Encounter = 1 unit • Limit 1 unit per day
99407		Smoking and tobacco use cessation counseling visit; intensive greater than 10 minutes	• Encounter = 1 unit • Limit 1 unit per day

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Screening and Diagnostic Services			
Code	**Modifier**	**Description**	**Service Limitations**
99408		Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes. Do not report services of less than 15 minutes. Use 99408, 99409 only for initial screening and brief intervention.	• Encounter = 1 unit • Limit 1 unit per day
99409		Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes.	• Encounter = 1 unit • Limit 1 unit per day
99411		Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes.	• Encounter = 1 unit • Limit 1 unit per day
99412		Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes.	• Encounter = 1 unit • Limit 1 unit per day

Routine Office Visits

Routine office visits must be billed with the appropriate level of Evaluation and Management (E/M) CPT codes. System reviews (i.e. eyes, cardiovascular, respiratory, skin, constitutional) are included in an office visit. System reviews may be billed separately only when a separate, identifiable need is present and must be reflected in the patient file.

Physician Services			
Code	**Modifier**	**Description**	**Service Limitations**
99202		Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.	• Encounter = 1 unit • Limit 1 unit per day

School Health Services (SHS)

Physician Services			
Code	**Modifier**	**Description**	**Service Limitations**
99203		Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.	• Encounter = 1 unit • Limit 1 unit per day
99204		Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.	• Encounter = 1 unit • Limit 1 unit per day
99205		Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time spent on the date of the encounter.	• Encounter = 1 unit • Limit 1 unit per day
99211		Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.	• Encounter = 1 unit • Limit 1 unit per day
99212		Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.	• Encounter = 1 unit • Limit 2 units per day

School Health Services (SHS)

Physician Services			
Code	**Modifier**	**Description**	**Service Limitations**
99213		Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low-level medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.	• Encounter = 1 unit • Limit 2 units per day
99214		Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total spent on the date of the encounter.	• Encounter = 1 unit • Limit 2 units per day
99215		Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.	• Limit 2 units per 12 rolling months
Medical Team Conference: Use the following code to bill for participation in POC development, review, and revision for medical-related services (educational services and goals are excluded). The claim's date of service is the date on the POC.			
99367		Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 min. or more, participation by physician.	• Encounter = 1 unit • Limit 1 unit per day • Limit of 8 units 99366, 99367, 99368 combined per recipient per year

School Health Services (SHS)

Mental Health and Alcohol/Substance Abuse Services

Qualified Provider Types as noted in the following table:

LCPC: Licensed Clinical Professional Counselor
LCSW: Licensed Clinical Social Worker
LMFT: Licensed Marriage and Family Therapist
QBA: Qualified Behavioral Aide
QMHA: Qualified Mental Health Associate
QMHP: Qualified Mental Health Professional

Outpatient Mental Health Services					
Code	**Modifier**	**Description**	**Service Limitations**	**Intensity of Need**	**Qualified Provider Type(s)**
Screening and Assessment					
H0031		Mental health assessment by non-physician. **Billing Instruction**: Use this code for services provided in a home or community setting, not in an office setting. Psychotherapy services, including for crisis, may not be reported on the same day. E/M codes may not be reported on the same day performed by the same individual for the same patient. **SHS Additional Instructions:** This screening must be conducted face-to-face before the student can be determined eligible for Medicaid Mental Health Services. After the initial screening, student must be re-screened every 90 calendar days to reevaluate their intensity of needs (Level of Care). This code may be used to bill for an intensity of need determination, which includes a CASII or LOCUS.	• Covered up to 4 times per calendar year (CASII) or 2 times per calendar year (LOCUS) based on Intensity of Needs grid	All Levels	QMHP, LCSW, LMFT, LCPC and Clinical Interns working within their scope of practice.

School Health Services (SHS)

Outpatient Mental Health Services					
Code	**Modifier**	**Description**	**Service Limitations**	**Intensity of Need**	**Qualified Provider Type(s)**
H0002		Behavioral health screening to determine eligibility for admission to treatment program. **Billing Instructions:** This screening must be conducted face-to-face before the recipient can be determined eligible for Medicaid behavioral health services. After the initial screening, recipients must be re-screened every 90 days to reevaluate their intensity of needs (level of care). Use this code to bill for the initial screening and any re-screenings as necessary; "includes a CASII or LOCUS." **SHS Additional Instructions:** This is considered a screening tool. If the screening is a part of a full behavioral health assessment (including a CASII or LOCUS), then this code cannot be billed separately.	• Encounter = 1 unit • Limit of 1 unit per day • Limit 1 time every 90 days • Bill 1 unit for each screening	All Levels	QMHP, LCSW, LMFT, LCPC, QMHA and Clinical Interns working within their scope of practice.
96127		Brief emotional/behavioral assessment (e.g., depression inventory, ADHD) with scoring and documentation per standardized instrument. **SHS Additional Instructions:** This is considered a screening tool. If the screening is a part of a full behavioral health assessment (including a CASII or LOCUS), then this code cannot be billed separately.	• Assessment = 1 unit • Bill 1 unit for each screening • Limit 2 units per day	All Levels	QMHP, LCSW, LMFT, LCPC, QMHA and Clinical Interns working within their scope of practice.

School Health Services (SHS)

Outpatient Mental Health Services					
Code	**Modifier**	**Description**	**Service Limitations**	**Intensity of Need**	**Qualified Provider Type(s)**
90791		Psychiatric Diagnostic Evaluation **Additional Instructions:** Integrated biopsychosocial assessment, including history, mental status and recommendations. Psychotherapy services, including for crisis, may not be reported on the same day. E/M codes may not be reported on the same day performed by the same individual for the same patient. **SHS Additional Instructions:** Mental Health Assessment at school - A psychiatric diagnostic evaluation is performed, which includes the assessment of the student's psychosocial history, current mental health status, review, and ordering of diagnostic studies followed by appropriate treatment recommendations.	• Covered up to 4 times per calendar year (CASII) or 2 times per calendar year (LOCUS) based on Intensity of Needs grid	All Levels	QMHP, LCSW, LMFT, LCPC and Clinical Interns working within their scope of practice.
Medication Management					
H0034	TD	Medication training and support, per 15 minutes. **Billing Instructions:** Modifier TD must be used to indicate the service was provided by a Registered Nurse (QMHA). **Note:** This service must be preceded by a filled medication prescription within 30 days.	• 15 minutes = 1 unit • Limit of 2 unit per calendar month per recipient	All Levels	Registered Nurse (RN) enrolled as a QMHA.
Diagnostic					
96138		Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes.	• First 30 minutes	All Levels	QMHP, LCSW, LMFT, LCPC and Clinical Interns working within their scope of practice.

School Health Services (SHS)

Outpatient Mental Health Services					
Code	**Modifier**	**Description**	**Service Limitations**	**Intensity of Need**	**Qualified Provider Type(s)**
+96139		Psychological or Neuropsychological test administration and scoring by technician, two or more test any method.	• Each additional 30 minutes	All Levels	QMHP, LCSW, LMFT, LCPC and Clinical Interns working within their scope of practice.
96156		Health and behavior assessment, or re-assessment (i.e., health-focused clinical interview, behavioral observations, clinical decision making). **Additional Instructions:** Qualifying recipients present with primary physical illnesses, diagnoses or symptoms and may benefit from interventions that focus on biopsychosocial factors related to the recipient's health status.	• Initial assessment, face-to-face with patient • 4 units allowed per calendar year	All Levels	QMHP, LCSW, LMFT, LCPC and Clinical Interns working within their scope of practice.
96158		Health behavior intervention, individual, face-to-face; initial 30 minutes. **Additional instructions:** Includes promotion of functional improvement, minimizing psychological and/or psychosocial barriers to recovery, and management of and improved coping with medical conditions. These services emphasize active patient/family engagement and involvement. Do not report for less than 16 minutes of service.	• Individual, face-to-face initial 30 minutes	All Levels	QMHP, LCSW, LMFT, LCPC and Clinical Interns working within their scope of practice.

School Health Services (SHS)

Outpatient Mental Health Services					
Code	**Modifier**	**Description**	**Service Limitations**	**Intensity of Need**	**Qualified Provider Type(s)**
+96159		Health Behavior intervention, individual, face-to-face, each additional 15 minutes. (List separately in addition to code for primary service.) **Additional instructions:** Includes promotion of functional improvement, minimizing psychological and/or psychosocial barriers to recovery, and management of and improved coping with medical conditions. These services emphasize active patient/family engagement and involvement.	• Each additional 15 minutes	All Levels	QMHP, LCSW, LMFT, LCPC and Clinical Interns working within their scope of practice.
96164		Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes. **Additional Instructions:** Qualifying recipients present with primary physical illnesses, diagnoses or symptoms and may benefit from interventions that focus on biopsychosocial factors related to the recipient's health status. Do not report for less than 16 minutes of service.	• Initial 30 minutes	All Levels	QMHP, LCSW, LMFT, LCPC and Clinical Interns working within their scope of practice.
+96165		Health behavior intervention, group (2 or more patients), face-to-face. Each additional 15 minutes. (List separately in addition to code for primary service.) (Use 96165 in conjunction with 96164.) **Additional Instructions:** Qualifying recipients present with primary physical illnesses, diagnoses or symptoms and may benefit from interventions that focus on biopsychosocial factors related to the recipient's health status.	• Each additional 15 minutes	All Levels	QMHP, LCSW, LMFT, LCPC and Clinical Interns working within their scope of practice.

School Health Services (SHS)

Outpatient Mental Health Services					
Code	**Modifier**	**Description**	**Service Limitations**	**Intensity of Need**	**Qualified Provider Type(s)**
96167		Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes. **Additional Instructions:** Qualifying recipients present with primary physical illnesses, diagnoses or symptoms and may benefit from interventions that focus on biopsychosocial factors related to the recipient's health status. Do not report for less than 16 minutes of service.	• Initial 30 minutes face-to-face	All Levels	QMHP, LCSW, LMFT, LCPC and Clinical Interns working within their scope of practice.
+96168		Health behavior intervention, family (with the patient present), face-to-face Each additional 15 minutes. (List separately in addition to code for primary service.) **Additional Instructions:** Qualifying recipients present with primary physical illnesses, diagnoses or symptoms and may benefit from interventions that focus on biopsychosocial factors related to the recipient's health status.	• Each additional 15 minutes, face-to-face	All Levels	QMHP, LCSW, LMFT, LCPC and Clinical Interns working within their scope of practice.
96170		Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes **Additional Instructions:** Qualifying recipients present with primary physical illnesses, diagnoses or symptoms and may benefit from interventions that focus on biopsychosocial factors related to the recipient's health status. Do not report for less than 16 minutes of service.	• Initial 30 minutes, face-to-face	All Levels	QMHP, LCSW, LMFT, LCPC and Clinical Interns working within their scope of practice.

School Health Services (SHS)

Outpatient Mental Health Services					
Code	**Modifier**	**Description**	**Service Limitations**	**Intensity of Need**	**Qualified Provider Type(s)**
+96171		Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes. (List separately in addition to code for primary service.) **Additional Instructions:** Qualifying recipients present with primary physical illnesses, diagnoses or symptoms and may benefit from interventions that focus on biopsychosocial factors related to the recipient's health status.	• Each additional 15 minutes, face-to-face • Limit of 2 units per day	All Levels	QMHP, LCSW, LMFT, LCPC and Clinical Interns working within their scope of practice.
Psychotherapy					
+90785		Interactive complexity (list separately in addition to the code for primary procedure). (Use 90785 in conjunction with codes for diagnostic psychiatric evaluation [90791, 90792], psychotherapy [90832, 90834, 90837], psychotherapy when performed with an evaluation and management service [90833, 90836, 90838, 99202-99255,99304-99337, 99341-99350], and group psychotherapy [90853].)	• Encounter = 1 unit • Limit 3 units per day	All Levels	QMHP, LCSW, LMFT, LCPC and Clinical Interns working within their scope of practice.

School Health Services (SHS)

Outpatient Mental Health Services					
Code	**Modifier**	**Description**	**Service Limitations**	**Intensity of Need**	**Qualified Provider Type(s)**
90832		Psychotherapy, 30 minutes with patient. **SHS Additional Instructions**: Psychotherapy is a variety of treatment techniques in which a qualified mental health professional (QMHP) helps a student with a mental illness or behavioral disturbance identify and alleviate any emotional disruptions, maladaptive behavioral patterns, and contributing/exacerbating factors. The treatment can also include encouraging personality growth and development through coping techniques and problem-solving skills. **Documentation Tips** (Behavioral Health Services: Coding & Payment Guide 2022): Since the psychotherapy codes include time as a component of the code, the total time or the start and stop times of the psychotherapy should be noted in the medical record. Each psychotherapy note should include the description of a least one of the techniques used to treat the student's condition, such as insight oriented, behavior modifying, and/or supportive techniques. Providers should also include how the patient benefited by the therapy in reaching his or her goals. For example, "Supportive psychotherapy was utilized to help alleviate the student's depression." Record the major theme of the discussion but consider the student's privacy. Documentation should specify whether this is a single episode or recurrent, the current degree of depression, the presence of psychotic features or symptoms, and remission status (i.e., partial, full) when applicable. Documentation should clearly state the reasons requiring interactive complexity when reported separately.	• 30 minutes; bill 1 unit per day • The patient must be present for all or most of the session	All Levels	QMHP, LCSW, LMFT, LCPC and Clinical Interns working within their scope of practice.

School Health Services (SHS)

Outpatient Mental Health Services					
Code	**Modifier**	**Description**	**Service Limitations**	**Intensity of Need**	**Qualified Provider Type(s)**
+90833		Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code of primary procedure.) (Use in conjunction with 99202-99255, 99304-99337, 99341-99350.) **Additional Instructions:** Include ongoing assessment and adjustment of psychotherapeutic interventions and may include involvement of informants in the treatment process.	• 30 minutes with patient; • Bill 1 unit per day	All Levels	Licensed Board of Examiners Psychologist, Physician or Psychiatrics

School Health Services (SHS)

Outpatient Mental Health Services					
Code	**Modifier**	**Description**	**Service Limitations**	**Intensity of Need**	**Qualified Provider Type(s)**
90834		Psychotherapy, 45 minutes with patient. **SHS Additional Instructions:** Psychotherapy is a variety of treatment techniques in which a QMHP helps a student with a mental illness or behavioral disturbance identify and alleviate any emotional disruptions, maladaptive behavioral patterns, and contributing/exacerbating factors. The treatment can also include encouraging personality growth and development through coping techniques and problem-solving skills. **Documentation Tips** (Behavioral Health Services: Coding & Payment Guide 2022): Since the psychotherapy codes include time as a component of the code, the total time or the start and stop times of the psychotherapy should be noted in the medical record. Each psychotherapy note should include the description of a least one of the techniques used to treat the student's condition, such as insight oriented, behavior modifying, and/or supportive techniques. Providers should also include how the patient benefited by the therapy in reaching his or her goals. For example, "Supportive psychotherapy was utilized to help alleviate the student's depression." Record the major theme of the discussion but consider the student's privacy. Documentation should specify whether this is a single episode or recurrent, the current degree of depression, the presence of psychotic features or symptoms, and remission status (i.e., partial, full) when applicable. Documentation should clearly state the reasons requiring interactive complexity when reported separately.	• 45 minutes; • Bill 1 unit per day • The patient must be present for all or most of the session	All Levels	QMHP, LCSW, LMFT, LCPC and Clinical Interns working within their scope of practice

School Health Services (SHS)

Outpatient Mental Health Services					
Code	**Modifier**	**Description**	**Service Limitations**	**Intensity of Need**	**Qualified Provider Type(s)**
+90836		Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code of primary procedure.) (Use in conjunction with 99202-99255, 99304-99337, 99341-99350.) **Additional Instructions:** Include ongoing assessment and adjustment of psychotherapeutic interventions and may include involvement of informants in the treatment process.	• 45 minutes with patient; • Bill 1 unit per day	All Levels	Licensed Board of Examiners Psychologist, Physician or Psychiatrics

School Health Services (SHS)

Outpatient Mental Health Services					
Code	**Modifier**	**Description**	**Service Limitations**	**Intensity of Need**	**Qualified Provider Type(s)**
90837		Psychotherapy, 60 minutes with patient. **SHS Additional Instructions:** Psychotherapy is a variety of treatment techniques in which a QMHP helps a student with a mental illness or behavioral disturbance identify and alleviate any emotional disruptions, maladaptive behavioral patterns, and contributing/exacerbating factors. The treatment can also include encouraging personality growth and development through coping techniques and problem-solving skills. **Documentation Tips** (Behavioral Health Services: Coding & Payment Guide 2022): Since the psychotherapy codes include time as a component of the code, the total time or the start and stop times of the psychotherapy should be noted in the medical record. Each psychotherapy note should include the description of a least one of the techniques used to treat the student's condition, such as insight oriented, behavior modifying, and/or supportive techniques. Providers should also include how the patient benefited by the therapy in reaching his or her goals. For example, "Supportive psychotherapy was utilized to help alleviate the student's depression." Record the major theme of the discussion but consider the student's privacy. Documentation should specify whether this is a single episode or recurrent, the current degree of depression, the presence of psychotic features or symptoms, and remission status (i.e., partial, full) when applicable. Documentation should clearly state the reasons requiring interactive complexity when reported separately.	• 60 minutes; • Bill 1 unit per day • The patient must be present for all or most of the session	All Levels	QMHP, LCSW, LMFT, LCPC and Clinical Interns working within their scope of practice.

School Health Services (SHS)

Outpatient Mental Health Services					
Code	**Modifier**	**Description**	**Service Limitations**	**Intensity of Need**	**Qualified Provider Type(s)**
+90838		Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code of primary procedure). (Use in conjunction with 99202-99255, 99304-99337, 99341-99350.) **Additional Instructions:** Include ongoing assessment and adjustment of psychotherapeutic interventions and may include involvement of informants in the treatment process.	• 60 minutes with patient • Bill 1 unit per day	All Levels	Licensed Board of Examiners Psychologist, Physician or Psychiatrics

School Health Services (SHS)

Outpatient Mental Health Services					
Code	**Modifier**	**Description**	**Service Limitations**	**Intensity of Need**	**Qualified Provider Type(s)**
90839		Psychotherapy for crisis; first 60 minutes. **Additional Instructions:** Treatment must include psychotherapy, mobilization of resources and implementation of psychotherapeutic interventions. The patient must be present for all or some of the service. **SHS Additional Instructions:** Psychotherapy is a variety of treatment techniques in which a QMHP helps a student with a mental illness or behavioral disturbance identify and alleviate any emotional disruptions, maladaptive behavioral patterns, and contributing/exacerbating factors. The treatment can also include encouraging personality growth and development through coping techniques and problem-solving skills. **Documentation Tips** (Behavioral Health Services: Coding & Payment Guide 2022): Since the psychotherapy codes include time as a component of the code, the total time or the start and stop times of the psychotherapy should be noted in the medical record. Each psychotherapy note should include the description of a least one of the techniques used to treat the student's condition, such as insight oriented, behavior modifying, and/or supportive techniques. Providers should also include how the patient benefited by the therapy in reaching his or her goals. For example, "Supportive psychotherapy was utilized to help alleviate the student's depression." Record the major theme of the discussion but consider the student's privacy. Documentation should specify whether this is a single episode or recurrent, the current degree of depression, the presence of psychotic features or symptoms, and remission status (i.e., partial, full) when applicable. Documentation should clearly state the reasons requiring interactive complexity when reported separately.	• First 60 minutes, face-to-face • Bill 1 unit per day	All Levels	QMHP, LCSW, LMFT, LCPC and Clinical Interns working within their scope of practice.

School Health Services (SHS)

Outpatient Mental Health Services					
Code	**Modifier**	**Description**	**Service Limitations**	**Intensity of Need**	**Qualified Provider Type(s)**
+90840		Psychotherapy for crisis; each additional 30 minutes. (List separately in addition to code for primary service.) (Use in conjunction with 90839.) **Additional Instructions:** Treatment must include psychotherapy, mobilization of resources and implementation of psychotherapeutic interventions. The patient must be present for all or some of the service. **SHS Additional Instructions:** Psychotherapy is a variety of treatment techniques in which a QMHP helps a student with a mental illness or behavioral disturbance identify and alleviate any emotional disruptions, maladaptive behavioral patterns, and contributing/exacerbating factors. The treatment can also include encouraging personality growth and development through coping techniques and problem-solving skills. **Documentation Tips** (Behavioral Health Services: Coding & Payment Guide 2022): Documentation should indicate that psychotherapy was provided for an urgent assessment and history of a crisis state, including mental status examination and disposition, and that the student presented in a high level of distress with a complex or life-threatening problem that required immediate attention. The psychotherapy notes should include the description of at least one of the techniques specific to psychotherapy: insight-oriented, behavior-modifying, and/or supportive techniques. Providers should include how the student benefited from the therapy in reaching his or her goals. Ex "Supportive psychotherapy was utilized to help alleviate the student's depression." Documentation should specify whether this is a single episode or recurrent, the current degree of depression, the presence of psychotic features or symptoms, and remission status (i.e., partial, full) when applicable. Documentation should clearly state the reasons requiring interactive complexity when reported separately.	• Each additional 30 minutes • Bill 1 unit per day	All levels	QMHP, LCSW, LMFT, LCPC and Clinical Interns working within their scope of practice.

School Health Services (SHS)

Outpatient Mental Health Services					
Code	**Modifier**	**Description**	**Service Limitations**	**Intensity of Need**	**Qualified Provider Type(s)**
90845		Psychoanalysis. **SHS Additional Instructions:** The psychiatrist seeks to produce change in maladapted behavior by using psychoanalysis to review medical notes and making clinical setting arrangements, assisting the student in further self-awareness, working through barriers, understanding self-observations, and modifying mental behavior and status while continuing to elicit more information and person exploration. This code also includes follow-up work of documentation, content review, and peer consultation. **Documentation Tips** (Behavioral Health Services: Coding & Payment Guide 2022): Documentation should include a list of student's complaints and conditions present, the current focus of treatment, the treatment framework, the modality of treatment, the frequency and estimated length of the treatment, a list of family and/or friends who could offer support, status of community resources needed when applicable, and an alternative care plan if the student does not show sufficient improvements.	• Bill 1 unit per day • The patient must be present for all or most of the session	All Levels	QMHP, LCSW, LMFT, LCPC and Clinical Interns working within their scope of practice.

School Health Services (SHS)

Outpatient Mental Health Services					
Code	**Modifier**	**Description**	**Service Limitations**	**Intensity of Need**	**Qualified Provider Type(s)**
90846		Family psychotherapy (without the patient present), 50 minutes. **Additional Instructions:** The services must deal with issues relating to the constructive integration/reintegration of the patient into the family. **SHS Additional Instructions:** Family psychotherapy provided in a setting where the care provider meets with the student's family without the student being present. The family dynamics as they relate to the student's mental status and behavior are a main focus of the sessions. Attention is also given to the impact the student's condition has on the family, with therapy aimed at improving the interaction between the patient and the family members. Each student record must have patient-specific documentation. Documentation should include specific participation, contributions, and reactions of each family member.	• 50 minutes • Bill 1 unit per day	All Levels	QMHP, LCSW, LMFT, LCPC and Clinical Interns working within their scope of practice.
90847		Family psychotherapy (conjoint therapy) (with patient present), 50 minutes. **Additional Instructions:** The services must deal with issues relating to the constructive integration/reintegration of the patient into the family. **SHS Additional Instructions:** The therapist provides 50 minutes of family psychotherapy in a setting where the care provider meets with the student and the student's family jointly. Each student record must have patient-specific documentation. Documentation should include specific participation, contributions, and reactions of each family member.	• 50 minutes • Bill 1 unit per day	All Levels	QMHP, LCSW, LMFT, LCPC and Clinical Interns working within their scope of practice.

School Health Services (SHS)

Outpatient Mental Health Services					
Code	**Modifier**	**Description**	**Service Limitations**	**Intensity of Need**	**Qualified Provider Type(s)**
90849		Multiple-family group psychotherapy. **SHS Additional Instructions:** Multiple family group psychotherapy provided to a student and his/her family, as well as other students and families who have similar issues. Each student record must have patient-specific documentation. Documentation should include specific participation, contributions, and reactions of each family member.	• Bill 1 unit per day; maximum of two (2) hours per session	All Levels	QMHP, LCSW, LMFT, LCPC and Clinical Interns working within their scope of practice.
90853		Group psychotherapy (other than of a multiple-family group). (Use in conjunction with 90785 for the specified patient when group psychotherapy includes interactive complexity.) **Additional Instructions:** Other than of a multiple-family group. Minimum group size is 3 and maximum therapist to participant ratio is 1 to 10. **SHS Additional Instructions:** Each student record must have patient-specific documentation. Documentation should include specific participation, contributions, and reactions of each family member.	• Bill 1 unit per day; maximum 2 hours per session	All Levels	QMHP, LCSW, LMFT, LCPC and Clinical Interns working within their scope of practice.

School Health Services (SHS)

Outpatient Mental Health Services					
Code	**Modifier**	**Description**	**Service Limitations**	**Intensity of Need**	**Qualified Provider Type(s)**
H0004		Behavioral health counseling and therapy, per 15 minutes. **Billing Instructions:** Use this code for services provided in home or community setting, not in an office setting. • 1 to 4 units on a claim line equal 1 session. • 5 to 8 units on a claim line equal 2 sessions. • 9 to 12 units on a claim line equal 3 sessions. **NOTE**: Modifier **HQ** indicates group services; only individual services can be billed without the **HQ** modifier. Documentation must reflect medical necessity for in-home and community services. **SHS Additional Instructions:** Use this code for behavioral health counseling and therapy services. Behavioral health counseling and therapy provides individual counseling by a clinician for a student in a private setting such as at the student's home or community setting, and NOT in an office setting at the school site.	• Unit = 15 minutes	All Levels	QMHP, LCSW, LMFT, LCPC and Clinical Interns working within their scope of practice.
Crisis Intervention	***Does not require a diagnosis. Please refer to all specifications in MSM 403.6H**				
H2011		Crisis intervention service, per 15 minutes. **Additional Instructions:** Maximum of four hours per day over a three-day period (one occurrence). **SHS Additional Instructions:** Mental health crisis intervention provides immediate support for an individual in personal crisis at school. The aim of this service is to stabilize the individual during a psychiatric emergency.	• Unit = 15 minutes	All Levels	QMHP, LCSW, LMFT, LCPC and Clinical Interns working within their scope of practice.

School Health Services (SHS)

Outpatient Mental Health Services					
Code	**Modifier**	**Description**	**Service Limitations**	**Intensity of Need**	**Qualified Provider Type(s)**
H2011	GT	Crisis intervention service, per 15 minutes. Modifier GT indicates telephonic services. **Additional Instructions**: Maximum of four hours per day over a three-day period (one occurrence). **SHS Additional Instructions**: Mental health crisis intervention provides immediate support for an individual in personal crisis at school. The aim of this service is to stabilize the individual during a psychiatric emergency.	• Unit = 15 minutes	All Levels	QMHP, LCSW, LMFT, LCPC, QBA and Clinical Interns working within their scope of practice.
H2011	HT	Crisis intervention service, per 15 minutes. Modifier HT indicates team services. **Additional Instructions:** Delivered by a team of providers under the coordinating QMHP-level provider. QBA and QMHA providers render services only within the scope of their certification and practice. Maximum of four hours per day over a three-day period (one occurrence). **SHS Additional Instructions:** Mental health crisis intervention provides immediate support for an individual in personal crisis at school. The aim of this service is to stabilize the individual during a psychiatric emergency.	• Unit = 15 minutes	All Levels	QMHP, LCSW, LMFT, LCPC, QBA and Clinical Interns working within their scope of practice.

School Health Services (SHS)

Outpatient Mental Health Services					
Code	**Modifier**	**Description**	**Service Limitations**	**Intensity of Need**	**Qualified Provider Type(s)**
Rehabilitative Mental Health Services					
H0038		Self-help/peer services, per 15 minutes (Peer-to-Peer Support Services). **Additional Instructions:** Modifier **HQ** indicates group services; only individual services can be billed without the **HQ** modifier; group size is 4 to 15 recipients. **SHS Additional Instructions:** Self-help/peer services are specialized therapeutic interactions that are performed with students who are current or past recipients of behavioral health services. Interactions assist these individuals in their recovery and integration into the school community. The goal is to provide understanding and coping skills and empowerment through mentoring and other supports so that individuals with severe and persistent mental disorders can cope with stress and achieve personal wellness.	• Per 15 minutes • Limit of 208 units per calendar year	All Levels	QMHP, LCSW, LMFT, LCPC, QBA and Clinical Interns working within their scope of practice.

School Health Services (SHS)

Outpatient Mental Health Services					
Code	**Modifier**	**Description**	**Service Limitations**	**Intensity of Need**	**Qualified Provider Type(s)**
H2014		Skills training and development, per 15 minutes **Additional Instructions:** Recipients may receive up to two (2) hours per day for the first 90 days; one (1) hour per day for the next 90 days; based on a rolling calendar and consecutive months with no break in service. Rehabilitative Mental Health (RMH) Services cannot be reimbursed on the same day as ABA services; refer to MSM Chapter 3700. **Additional Instructions:** Modifier **HQ** indicates group services; group size is 4 to 15 recipients. **SHS Additional Instructions:** Skills training and development provides the students with necessary abilities that will enable the individuals to live independently and manage their illness and treatment. Training focuses on skills for daily living and school community integration for students with functional limitations due to psychiatric disorder(s).	• Per 15 minutes; maximum of 2 hours per day (H2014 and H2014 **HQ** combined)	I, II, III, IV, V	QMHP, LCSW, LMFT, LCPC, QBA and Clinical Interns working within their scope of practice.
H2017		Psychosocial rehabilitation services, per 15 minutes. **Additional Instructions:** Intensity of Needs Level III, maximum of 2 hours per day; Level IV & V, maximum of 3 hours per day; Level VI, maximum of 4 hours per day. RMH Services cannot be reimbursed on the same day as ABA services; refer to MSM Chapter 3700.	• Per 15 minutes	Levels III and higher	QMHP, LCSW, LMFT, LCPC, QMHA and Clinical Interns working within their scope of practice.

School Health Services (SHS)

Outpatient Mental Health Services					
Code	**Modifier**	**Description**	**Service Limitations**	**Intensity of Need**	**Qualified Provider Type(s)**
H2017	HQ	Psychosocial rehabilitation services, per 15 minutes. Modifier HQ indicates group services. **Additional Instructions:** Group size is 4 to 15 recipients. Intensity of Need Level III, maximum of 2 hours per day; Level IV & V, maximum of 3 hours per day; Level VI, maximum of 4 hours per day; based on a rolling calendar and consecutive months with no break in service. RMH services cannot be reimbursed on the same day as ABA services; refer to MSM Chapter 3700.	• Per 15 minutes; maximum of 2 hours per day (H2017 and H2017 HQ combined)	Levels III and higher	QMHP, LCSW, LMFT, LCPC, QMHA and Clinical Interns working within their scope of practice.
Medical Team Conference: Use the following code to bill for participation in POC development, review, and revision for medical-related services (educational services and goals are excluded). The claim's date of service is the date on the POC.					
99366	HE or HF	Medical team conference with interdisciplinary team of health care professionals, face-to-face with the patient and/or family, 30 min. or more, participation by non-physician qualified health care professional. **SHS Additional Instructions**: Multidisciplinary Team (MDT) meeting and/or coordination of services with other mental health professionals and/or agencies. At least 30 minutes or more must be with the family or student present face-to-face. Also use code for the development of the Plan of Care, review and/or adjustments to the Plan of Care.	• Encounter = 1 unit • Limit of 1 unit per day	N/A	

School Health Services (SHS)

Outpatient Mental Health Services					
Code	**Modifier**	**Description**	**Service Limitations**	**Intensity of Need**	**Qualified Provider Type(s)**
99367	HE or HF	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 min. or more, participation by physician. **SHS Additional Instructions**: Multidisciplinary Team (MDT) meeting and/or coordination of services with other mental health professionals and/or agencies. At least 30 minutes or more must be without the student or family. Also use code for the development of the Plan of Care, review and/or adjustments to the Plan of Care.	• Encounter = 1 unit • Limit of 1 unit per day	N/A	
99368	HE or HF	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 min. or more participation by non-physician health care professional.	• Encounter = 1 unit • Limit of 1 unit per day	N/A	

School Health Services (SHS)

Nursing Services

All nursing services must be Ordered, Prescribed or Referred (OPR) by a Physician, M.D.; Osteopath, D.O.; Advanced Practice Registered Nurse (APRN); or Physician's Assistant (PA). The OPR provider's NPI must be on all nursing claims. For more information on the OPR policy please refer to MSM 2800, School Health Services (SHS) at nevadamedicaid.nv.gov/resources/medicaid-services-manual/chapter-2800-school-health-services/.

The following services must be performed by a registered nurse (RN) in accordance with the POC or a Licensed Practical Nurse (LPN)/Certified Nursing Assistant (CNA)/Nursing Aide under the supervision and direction of a RN. Medicaid does not cover nursing procedures that can be delegated to unlicensed/uncertified assistive personnel by a RN following a competency assessment and proper training.

- Service is limited to 32 combined units per day (i.e., a claim that lists code T1002, code T1003 and code T1004 cannot exceed 32 units in one day).

Nursing Services			
Code	**Modifier**	**Description**	**Service Limitations**
T1001		Nursing assessment and evaluation (RN only).	• Encounter = 1 unit • Limited to 2 units per day
T1002		Registered Nurse (RN) services, up to 15 minutes (direct services).	• 15 min = 1 unit
T1003		Licensed Practical Nurse (LPN)/CNA/Nursing Aide services up to 15 minutes.	• 15 min = 1 unit
T1004		Services of a qualified nursing aide, up to 15 minutes.	• 15 min = 1 unit
Medical Team Conference: Use the following code to bill for participation in POC development, review, and revision for medical-related services (educational services and goals are excluded). The claim's date of service is the date on the POC.			
99366	TD or SA	Medical team conference with interdisciplinary team of health care professionals, face-to-face with the patient and/or family, 30 min. or more, participation by non-physician qualified health care professional.	• Encounter = 1 unit • Limit of 1 unit per day • Limit of 8 units 99366, 99367, 99368 combined per recipient per year
99368	TD or SA	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 min. or more participation by non-physician health care professional.	• Encounter = 1 unit • Limit of 1 unit per day • Limit of 8 units 99366, 99367, 99368 combined per recipient per year

School Health Services (SHS)

Physical Therapy Services

All physical therapy services must be Ordered, Prescribed or Referred (OPR) by a Physician, M.D.; Osteopath, D.O.; Advanced Practice Registered Nurse (APRN); or Physician's Assistant (PA). The OPR provider's NPI must be on all physical therapy claims. For more information on the OPR policy please refer to MSM 2800, School Health Services (SHS) at nevadamedicaid.nv.gov/resources/medicaid-services-manual/chapter-2800-school-health-services/.

Services for physical therapy should have modifier GP.

- Modifier CQ must be used when the service was rendered by a physical therapy assistant.
- Modifiers GP and CQ must both be included with the procedure code to indicate physical therapy services were performed by a physical therapy assistant.

Physical therapy must be provided by or under the supervision of a qualified health care professional in accordance with the POC.

- Code 97116 (gait training) cannot be billed in conjunction when performed on the same extremity.
- Covered codes in the range of 97010-97124 are limited to four modalities and/or therapeutic procedures in one day.
- Codes 97124 and 97533 are limited to four modalities and/or therapeutic procedures in one day.

Physical Therapy Services			
Code	**Modifier**	**Description**	**Service Limitations**
97010	GP or GP/CQ	Application of a modality to one or more areas; hot or cold packs.	• Encounter = 1 unit • Limited to 1 unit per day
97012	GP or GP/CQ	Application of a modality to one or more areas; traction, mechanical.	• Encounter = 1 unit • Limited to 1 unit per day
97014	GP or GP/CQ	Application of a modality to one or more areas; electrical stimulation (unattended).	• Encounter = 1 unit • Limited to 1 unit per day
97016	GP or GP/CQ	Application of a modality to one or more areas; vasopneumatic devices.	• Encounter = 1 unit • Limited to 1 unit per day
97018	GP or GP/CQ	Application of a modality to one or more areas; paraffin bath.	• Encounter = 1 unit • Limited to 1 unit per day
97022	GP or GP/CQ	Application of a modality to one or more areas; whirlpool.	• Encounter = 1 unit • Limited to 1 unit per day

School Health Services (SHS)

Physical Therapy Services			
Code	**Modifier**	**Description**	**Service Limitations**
97024	GP or GP/CQ	Application of a modality to one or more areas; diathermy.	• Encounter = 1 unit • Limited to 1 unit per day
97026	GP or GP/CQ	Application of a modality to one or more areas; infrared.	• Encounter = 1 unit • Limited to 1 unit per day
97028	GP or GP/CQ	Application of a modality to one or more areas; ultraviolet.	• Encounter = 1 unit • Limited to 1 unit per day
97032	GP or GP/CQ	Application of a modality to one or more areas; electrical stimulation (manual).	• 15 minutes = 1 unit • Limited to 4 units per day
97033	GP or GP/CQ	Application of a modality to one or more areas; iontophoresis.	• 15 minutes = 1 unit • Limited to 4 units per day
97034	GP or GP/CQ	Application of a modality to one or more areas; contrast baths.	• 15 minutes = 1 unit • Limited to 2 units per day
97035	GP or GP/CQ	Application of a modality to one or more areas; ultrasound.	• 15 minutes = 1 unit • Limited to 2 units per day
97036	GP or GP/CQ	Application of a modality to one or more areas; Hubbard Tank.	• 15 minutes = 1 unit • Limited to 3 units per day
97110	GP or GP/CQ	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercise to develop strength and endurance, range of motion and flexibility.	• 15 minutes = 1 unit • Limited to 6 units per day
97112	GP or GP/CQ	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities.	• 15 minutes = 1 unit • Limited to 4 units per day
97113	GP or GP/CQ	Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises.	• 15 minutes = 1 unit • Limited to 6 units per day
97116	GP or GP/CQ	Gait training (includes stair climbing).	• 15 minutes = 1 unit • Limited to 4 units per day

School Health Services (SHS)

Physical Therapy Services			
Code	**Modifier**	**Description**	**Service Limitations**
97124	GP or GP/CQ	Therapeutic procedure, one or more areas, each 15 minutes, massage, including effleurage petrissage and/or tapotement (stroking, compression, percussion).	• 15 minutes = 1 unit • Limited to 4 units per day
97140	GP or GP/CQ	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction) one or more regions.	• 15 minutes = 1 unit • Limited to 6 units per day • Or 6 combined units of codes 97140, 97110 and/or 97535
97150	GP or GP/CQ	Therapeutic procedure(s) group (2-4 individuals per group) (Bill 1 unit for each recipient per session).	• 1 encounter = 1 unit • Limited to 1 unit per day
97161	GP or GP/CQ	Physical therapy evaluation, low complexity, requiring these components: ▪ A history with no personal factors and/or comorbidities that impact the plan of care; ▪ An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; ▪ A clinical presentation with stable and/or uncomplicated characteristics; and ▪ Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. • Typically, 20 minutes are spent face-to-face with the patient and/or family.	• 20 minutes = 1 unit • Limited to 1 evaluation per provider, per condition, per calendar year.

School Health Services (SHS)

Physical Therapy Services			
Code	**Modifier**	**Description**	**Service Limitations**
97162	GP or GP/CQ	Physical therapy evaluation, moderate complexity, requiring these components: ▪ A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; ▪ An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following; body structures and functions, activity limitations, and/or participation restrictions; ▪ An evolving clinical presentation with changing characteristics, and ▪ Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. • Typically, 30 minutes are spent face-to-face with the patient and/or family.	• 30 minutes = 1 unit • Limited to 1 evaluation per provider, per condition, per calendar year.
97163	GP or GP/CQ	Physical therapy evaluation, high complexity, requiring these components: • A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; • An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; • A clinical presentation with unstable and unpredictable characteristics; and • Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. • Typically, 45 minutes are spent face-to-face with the patient and/or family.	• 45 minutes = 1 unit • Limited to 1 evaluation per provider, per condition, per calendar year.

School Health Services (SHS)

Physical Therapy Services			
Code	**Modifier**	**Description**	**Service Limitations**
97164	GP or GP/CQ	Re-evaluation of physical therapy established plan of care, requiring these components: • An examination including a review of history and use of standardized tests and measures is required; and • Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.	• 20 minutes = 1 unit • Limited to 1 unit per day
97530	GP or GP/CQ	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes.	• 15 minutes = 1 unit • Limited to 6 units per day
97129	GP or GP/CQ	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes. (Report 97129 only once per day.)	• 15 minutes = 1 unit • Limit 1 unit per day
+97130	GP or GP/CQ	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure.) (Use in conjunction with 97129.)	• 15 minutes = 1 unit • Limit 7 units per day
97533	GP or GP/CQ	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes.	• 15 minutes = 1 unit • Limit of 4 units per day
97535	GP or GP/CQ	Self-care/home management training (e.g., activities of daily living (ADLs) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment), direct one-on-one, each 15 minutes.	• 15 minutes = 1 unit • Limit of 8 units per day

School Health Services (SHS)

Physical Therapy Services			
Code	**Modifier**	**Description**	**Service Limitations**
97542	GP or GP/CQ	Wheelchair management (e.g., assessment, fitting, training), each 15 minutes.	• 15 minutes = 1 unit • Limit of 8 units per day
97760	GP or GP/CQ	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes.	• 15 minutes = 1 unit • Limit of 6 units per day
97761	GP or GP/CQ	Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes.	• 15 minutes = 1 unit • Limit of 6 units per day
Medical Team Conference: Use the following code to bill for participation in POC development, review, and revision for medical-related services (educational services and goals are excluded). The claim's date of service is the date on the POC.			
99366	GP	Medical team conference with interdisciplinary team of health care professionals, face-to-face with the patient and/or family, 30 min. or more, participation by non-physician qualified health care professional.	• Encounter = 1 unit • Limit of 1 unit per day • Limit of 8 units 99366, 99367, 99368 combined per recipient per year
99368	GP	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 min. or more participation by non-physician health care professional.	• Encounter = 1 unit • Limit of 1 unit per day • Limit of 8 units 99366, 99367, 99368 combined per recipient per year

School Health Services (SHS)

Occupational Therapy Services

All occupational therapy services must be Ordered, Prescribed or Referred (OPR) by a Physician, M.D.; Osteopath, D.O.; Advanced Practice Registered Nurse (APRN); or Physician's Assistant (PA). The OPR provider's NPI must be on all occupational therapy claims. For more information on the OPR policy please refer to MSM 2800, School Health Services (SHS) at nevadamedicaid.nv.gov/resources/medicaid-services-manual/chapter-2800-school-health-services/.

Claims submitted by PT 60 for occupational therapy services need to be identified with modifier GO for occupational therapy.

- Modifier CO must be used to indicate the service was rendered by an occupational therapy assistant.
- Modifiers GO and CO must both be included with the procedure code to indicate occupational therapy services were performed by an occupational therapy assistant.

Occupational therapy must be provided by or under the supervision of a qualified health care professional in accordance with the POC.

- Do not bill code 97116 (gait training) in conjunction if performed on the same extremity.
- Covered codes in the range of 97010-97124 are limited to four modalities and/or therapeutic procedures in one day.

Occupational Therapy Services			
Code	**Modifier**	**Description**	**Service Limitations**
97010	GO or GO/CO	Application of a modality to one or more areas; hot or cold packs.	• Encounter = 1 unit • Limit of 1 unit per day
97014	GO or GO/CO	Application of a modality to one or more areas; electrical stimulation (unattended).	• Encounter = 1 unit • Limit of 1 unit per day
97016	GO or GO/CO	Application of a modality to one or more areas; vasopneumatic devices.	• Encounter = 1 unit • Limit of 1 unit per day
97018	GO or GO/CO	Application of a modality to one or more areas; paraffin bath.	• Encounter = 1 unit • Limit of 1 unit per day
97022	GO or GO/CO	Application of a modality to one or more areas; whirlpool.	• Encounter = 1 unit • Limit of 1 unit per day
97032	GO or GO/CO	Application of a modality to one or more area; electrical simulation (manual), each 15 minutes.	• 15 minutes = 1 unit • Limit of 4 units per day
97033	GO or GO/CO	Application of a modality to one or more areas; iontophoresis, each 15 minutes.	• 15 minutes = 1 unit • Limit of 4 units per day

School Health Services (SHS)

Occupational Therapy Services			
Code	**Modifier**	**Description**	**Service Limitations**
97034	GO or GO/CO	Application of a modality to one or more areas; contrast baths, each 15 minutes.	• 15 minutes = 1 unit • Limit of 2 units per day
97035	GO or GO/CO	Application of a modality to one or more areas; ultrasound, each 15 minutes.	• 15 minutes = 1 unit • Limit of 2 units per day
97036	GO or GO/CO	Application of a modality to one or more areas; Hubbard tank, each 15 minutes.	• 15 minutes = 1 unit • Limit of 3 units per day
97110	GO or GO/CO	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercise to develop strength and endurance, range of motion and flexibility; individual.	• 15 minutes = 1 unit • Limit of 6 units per day
97112	GO or GO/CO	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities.	• 15 minutes = 1 unit • Limit of 4 units per day
97116	GO or GO/CO	Gait training (includes stair climbing).	• 15 minutes = 1 unit • Limited to 4 units per day
97140	GO or GO/CO	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction) one or more regions, each 15 minutes.	• 15 minutes = 1 unit • Limited to 6 units of code 97140 OR 6 combined units of codes 97140, 97110 and/or 97533
97150	GO or GO/CO	Therapeutic procedure(s) group (2 or more individuals).	• 1 Encounter = 1 unit • Limited to 1 unit per day • Bill 1 unit for each recipient per session

School Health Services (SHS)

Occupational Therapy Services			
Code	**Modifier**	**Description**	**Service Limitations**
97165	GO or GO/CO	Occupational therapy evaluation, low complexity, requiring these components: ▪ An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; ▪ An assessment(s) that identifies 1-3 performance deficits (i.e., relating to physical, cognitive or psychosocial skills) that result in activity limitations and/or participation restrictions; and ▪ Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family.	• 1 encounter = 1 unit • Limited to 1 evaluation per provider, per condition, per calendar year

School Health Services (SHS)

Occupational Therapy Services			
Code	**Modifier**	**Description**	**Service Limitations**
97166	GO or GO/CO	Occupational therapy evaluation, moderate complexity, requiring these components: ▪ An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; ▪ An assessment(s) that identifies 3-5 performance deficits (i.e., relating to physical, cognitive or psychosocial skills) that result in activity limitations and/or participation restrictions; and ▪ Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family.	• 1 encounter = 1 unit • Limited to 1 evaluation per provider, per condition, per calendar year

School Health Services (SHS)

Occupational Therapy Services			
Code	**Modifier**	**Description**	**Service Limitations**
97167	GO or GO/CO	Occupational therapy evaluation, high complexity, requiring these components: ▪ An occupational profile and medical and therapy history which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; ▪ An assessment(s) that identifies 5 or more performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and ▪ Clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family.	• 1 encounter = 1 unit • Limited to 1 evaluation per provider, per condition, per calendar year
97168	GO or GO/CO	Re-evaluation of occupational therapy established plan of care, requiring one of these components: ▪ An assessment of changes in patient functional or medical status with revised plan of care; ▪ An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; or ▪ A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family.	• 1 encounter = 1 unit • Limited to 1 unit per day

School Health Services (SHS)

Occupational Therapy Services			
Code	**Modifier**	**Description**	**Service Limitations**
97530	GO or GO/CO	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes.	• 15 minutes = 1 unit • Limit of 6 units per day
97129	GO or GO/CO	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes (Report 97129 only once per day).	• 15 minutes = 1 unit • Limit of 1 unit per day
+97130	GO or GO/CO	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure.) (Use in conjunction with 97129.)	• 15 minutes = 1 unit • Limit of 7 units per day
97533	GO or GO/CO	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes.	• 15 minutes = 1 unit • Limit of 4 units per day
97535	GO or GO/CO	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one, each 15 minutes.	• 15 minutes = 1 unit • Limit of 8 units per day
97542	GO or GO/CO	Wheelchair management/propulsion training, each 15 min.	• 15 minutes = 1 unit • Limit of 8 units per day
97760	GO or GO/CO	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes.	• 15 minutes = 1 unit • Limit of 6 units per day
97761	GO or GO/CO	Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes.	• 15 minutes = 1 unit • Limit of 6 units per day

School Health Services (SHS)

Occupational Therapy Services			
Code	**Modifier**	**Description**	**Service Limitations**
Medical Team Conference: Use the following code to bill for participation in POC development, review, and revision for medical-related services (educational services and goals are excluded). The claim's date of service is the date on the POC.			
99366	GO	Medical team conference with interdisciplinary team of health care professionals, face-to-face with the patient and/or family, 30 min. or more, participation by non-physician qualified health care professional.	• Encounter = 1 unit • Limit of 1 unit per day • Limit of 8 units 99366, 99367, 99368 combined per recipient per year
99368	GO	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 min. or more participation by non-physician health care professional.	• Encounter = 1 unit • Limit of 1 unit per day • Limit of 8 units 99366, 99367, 99368 combined per recipient per year

School Health Services (SHS)

Speech Therapy Services

All speech therapy services must be Ordered, Prescribed or Referred (OPR) by a Physician, M.D.; Osteopath, D.O.; Advanced Practice Registered Nurse (APRN); or Physician's Assistant (PA). The OPR provider's NPI must be on all speech therapy claims. For more information on the OPR policy please refer to MSM 2800, School Health Services (SHS) at nevadamedicaid.nv.gov/resources/medicaid-services-manual/chapter-2800-school-health-services/.

Medicaid provides coverage for the following speech therapy services.

- Do not report code 92508 on the same day in conjunction with 0366T, 0367T or 0372T.

Speech Therapy Services			
Code	**Modifier**	**Description**	**Service Limitations**
92507	GN	Treatment of speech, language, voice, communication and/or auditory processing disorder; individual.	• Encounter = 1 unit
92508	GN	Treatment of speech, language, voice, communication and/or auditory processing disorder; group 2 or more individuals.	• Encounter = 1 unit
92521	GN	Evaluation of speech fluency (i.e., stuttering, cluttering).	• Encounter = 1 unit • Limit of 1 unit per day
92522	GN	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria).	• Encounter = 1 unit • Limit of 1 unit per day
92523	GN	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language).	• Encounter = 1 unit • Limit of 1 unit per day
92526	GN	Treatment of swallowing dysfunction and/or oral function for feeding. (Note: Service must be delivered by a Certificate of Clinical Competence (CCC) SLP in alignment with defined procedures.)	• Encounter = 1 unit
92605	GN	Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient, first hour.	• Encounter = 1 unit • Limit of 1 unit per day
92606	GN	Therapeutic service(s) for the use of non-speech-generating device, including programming and modification.	• Encounter = 1 unit • Limit of 1 unit per day
92607	GN	Evaluation for prescription for speech-generating-augmentative and alternative communication device, face-to-face with the patient; first hour.	• Encounter = 1 unit • Limit of 1 unit per day

School Health Services (SHS)

Speech Therapy Services			
Code	**Modifier**	**Description**	**Service Limitations**
92608	GN	Evaluation for prescription for speech-generating-augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes. (List separately in addition to code for primary procedure.) (Use in conjunction with 92607.)	• 30 minutes = 1 unit • Limit of 4 units per day
92609	GN	Therapeutic services for the use of speech-generating device, including programming and modification.	• Encounter = 1 unit • Limit of 1 unit per day
97129	GN	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes (Report 97129 only once per day.) (Note: Service must be delivered by a Certificate of Clinical Competence (CCC) SLP in alignment with defined procedures.)	• Encounter = 1 unit • Limit of 1 unit per day
+97130	GN	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure.) (Use in conjunction with 97129.) (Note: Service must be delivered by a Certificate of Clinical Competence (CCC) SLP in alignment with defined procedures.)	• 15 minutes = 1 unit • Limit of 7 units per day
Medical Team Conference: Use the following code to bill for participation in POC development, review, and revision for medical-related services (educational services and goals are excluded). The claim's date of service is the date on the POC.			
99366	GN	Medical team conference with interdisciplinary team of health care professionals, face-to-face with the patient and/or family, 30 min. or more, participation by non-physician qualified health care professional.	• Encounter = 1 unit • Limit of 1 unit per day • Limit of 8 units 99366, 99367, 99368 combined per recipient per year

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Speech Therapy Services			
Code	**Modifier**	**Description**	**Service Limitations**
99368	GN	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 min. or more participation by non-physician health care professional.	• Encounter = 1 unit • Limit of 1 unit per day • Limit of 8 units 99366, 99367, 99368 combined per recipient per year

Audiology Services and Supplies

Covered audiology services and supplies are listed on the Provider Type 60 Fee Schedule. These services and supplies must be documented in the recipient's POC in order to receive payment.

All audiology supplies must be Ordered, Prescribed or Referred (OPR) by an Audiologist; Physician, M.D.; Osteopath, D.O.; Advanced Practice Registered Nurse (APRN); or Physician's Assistant (PA). The OPR provider's NPI must be on all audiology supply claims. For more information on the OPR policy please refer to MSM 2800, School Health Services (SHS) at nevadamedicaid.nv.gov/resources/medicaid-services-manual/chapter-2800-school-health-services/.

Durable Medical Equipment (DME), Disposable Supplies, and Supplements

Covered medical supplies are listed on the Provider Type 60 Fee Schedule. Medical supplies must be documented in the recipient's POC in order to receive payment.

All medical supplies must be Ordered, Prescribed or Referred (OPR) by a Physician, M.D.; Osteopath, D.O.; Advanced Practice Registered Nurse (APRN); or Physician's Assistant (PA). The OPR provider's NPI must be on all medical supply claims. For more information on the OPR policy please refer to MSM 2800, School Health Services (SHS) at nevadamedicaid.nv.gov/resources/medicaid-services-manual/chapter-2800-school-health-services/.

Personal Care Services (PCS)

All PCS services must be Ordered, Prescribed or Referred (OPR) by a Physician, M.D.; Osteopath, D.O.; Advanced Practice Registered Nurse (APRN); or Physician's Assistant (PA). The OPR provider's NPI must be on all PCS claims. For more information on the OPR policy please refer to MSM 2800, School Health Services (SHS) at nevadamedicaid.nv.gov/resources/medicaid-services-manual/chapter-2800-school-health-services/

When entering the date(s) of service on the claim, dates on one claim line cannot span more than Sunday through Saturday of one calendar week.

Bill only for the dates when services were actually provided. If a service was provided on one day only, enter the same date in the From and To Date(s) of

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Service fields. If services were provided on Monday and also on Wednesday of the same week, but not on Tuesday, bill Monday and Wednesday individually on separate claim lines. Do not bill as one claim Monday through Wednesday or Sunday through Saturday.

All PCS are billed with HCPCS code T1019 with no modifiers. Enter the number of units you are billing for this claim line. Services are billed in 15-minute increments (15 minutes = 1 unit).

Personal Care Services (PCS)			
Code	**Modifier**	**Description**	**Service Limitations**
T1019		Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment.	• 15 minutes = 1 unit • Limited to units from School Functional Assessment for Service Plan (SFASP)

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Applied Behavior Analysis (ABA)

All ABA services must be Ordered, Prescribed or Referred (OPR) by a Licensed Board of Examiners Psychologist; Neuropsychologist; Physician, M.D.; Osteopath, D.O.; Advanced Practice Registered Nurse (APRN); or Physician's Assistant (PA). The OPR provider's NPI must be on all ABA claims. For more information on the OPR policy please refer to MSM 2800, School Health Services (SHS) at nevadamedicaid.nv.gov/resources/medicaid-services-manual/chapter-2800-school-health-services/.

PT 60 must bill with modifiers that apply to provider specialties rendering ABA services. The ABA specialties and modifiers applicable to this billing instruction are:

Specialty Number	Specialty Description	Applicable Modifier
310	Licensed and Board Certified Behavior Analyst (BCBA)	HO
312	Licensed and Board Certified Assistant Behavior Analyst (BCaBA)	HN
314	Registered Behavior Technician (RBT)	HM

Applied Behavior Analysis (ABA) Services			
Code	**Modifier**	**Description**	**Service Limitations**
Assessments			
97151		Behavior identification assessment, administered by a physician or other qualified healthcare professional, each 15 minutes of the physician's or other qualified healthcare professional's time face-to-face with patient and/or guardian(s)/care-giver(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.	• 15 minutes = 1 unit • 1 session of 16 units per 180 days
97152		Behavior identification-supporting assessment, administered by one technician under the direction of a physician or other qualified health care professional, face-to-face with the patient each 15 minutes.	• 15 minutes = 1 unit • 1 session of 4 units per 180 days

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Applied Behavior Analysis (ABA) Services			
Code	**Modifier**	**Description**	**Service Limitations**
0362T		Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: • Administered by the physician or other qualified health care professional who is on site • With the assistance of two or more technicians • For a patient who exhibits destructive behavior • Completed in an environment that is customized to the patient's behavior. Per the American Medical Association (AMA) CPT 2022 Codebook, code 0362T is reported based on a single technician's face-to-face time with the patient and not the combined time of multiple technicians [e.g., one hour with three technicians equals one hour of service].	• 15 minutes = 1 unit • 1 session of 4 units per 180 days
Adaptive Behavior Treatment - Individual			
97153		Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes.	• 15 minutes = 1 unit
97155		Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes.	• 15 minutes = 1 unit • The maximum number of units that can be used for supervision is 20% of the total number of hours

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Applied Behavior Analysis (ABA) Services			
Code	**Modifier**	**Description**	**Service Limitations**
0373T		Adaptive behavior treatment by protocol with modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: • Administered by the physician or other qualified healthcare professional who is onsite • With the assistance of two or more technicians • For a patient who exhibits destructive behavior • Completion in an environment that is customized to the patient's behavior. Per the American Medical Association (AMA) CPT 2022 Codebook, code 0373T is reported based on a single technician's face-to-face time with the patient and not the combined time of multiple technicians [e.g., one hour with three technicians equals one hour of service]. Limit of 40 hours per recipient per week combined, regardless of NPI for CPT codes: 97151- 97155, 0362T, 97153-97155, 0373T, 97156-97158.	• 15 minutes = 1 unit
Adaptive Behavior Treatment – Group and/or Family			
97154		Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes.	• 15 minutes = 1 unit
97158		Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients	• 15 minutes = 1 unit
97156		Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes.	• 15 minutes = 1 unit • 1 session of 4 units per week
97157		Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional (without the patient present), face-to-face with multiple sets of guardian(s)/caregiver(s), each 15 minutes.	• 1 session of 4 units per calendar month

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Applied Behavior Analysis (ABA) Services			
Code	**Modifier**	**Description**	**Service Limitations**
Medical Team Conference: Use the following code to bill for participation in POC development, review, and revision for medical-related services (educational services and goals are excluded). The claim's date of service is the date on the POC.			
99366		Medical team conference with interdisciplinary team of health care professionals, face-to-face with the patient and/or family, 30 min. or more, participation by non-physician qualified health care professional.	• Encounter = 1 unit • Limit of 1 unit per day • Limit of 8 units 99366, 99367, 99368 combined per recipient per year
99368		Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 min. or more participation by non-physician health care professional.	• Encounter = 1 unit • Limit of 1 unit per day • Limit of 8 units 99366, 99367, 99368 combined per recipient per year

Dental Services

Dental Services			
Code	**Modifier**	**Description**	**Service Limitations**
Diagnostic and Preventive (D0120-D1575)			
D0120		Periodic oral evaluation.	• Limit of 1 service unit per 6 rolling months
D0140		Limit oral evaluation problem focus.	• Limit of 2 service units per 6 rolling months
D0150		Comprehensive oral evaluation.	• Limit of 1 service unit per 12 rolling months
D0160		Extensive oral evaluation problem focus.	• Limit of 1 service unit per 6 rolling months
D0170		Re-evaluation – limited, problem focused (established patient; not post-operative visit).	• Limit of 1 service unit per 6 rolling months
D0190		Screening of a patient.	• Limit of 1 service unit per 6 rolling months
D0191		Assessment of a patient.	• Limit of 1 service unit per 6 rolling months

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Dental Services			
Code	**Modifier**	**Description**	**Service Limitations**
D0210		Intraoral complete series of radiographic images.	• Limit of 1 service unit (one complete series) per 36 rolling months. D0210 may not be billed on the same date of service as D0220 and/or D0230. Use code D0210 when providing 14 or more intraoral exams on the same date of service.
D0220		Intraoral periapical first film.	• Limit of 1 service unit per 12 rolling months. D0220 may not be billed on the same date of service as D0210.
D0230		Intraoral periapical each additional radiographic image.	• Limit of 12 units per rolling year. D0230 may not be billed on the same date of service as D0210. No more than 13 units of any combinations of D0220 and/or D0230 may be billed within any rolling year.
D0240		Intraoral occlusal film.	• Limit of 2 units per 12 rolling months
D0270		Dental bitewing single film.	• Limit of 1 unit per 6 months
D0272		Dental bitewings two films.	• Limit of 1 unit per 6 months
D0273		Bitewings- three films.	• Limit of 1 unit per 6 months
D0274		Dental bitewings four films.	• Limit of 1 unit per 6 months
D0277		Vert bitewings-seven to eight radiographic films.	• Limit of 1 unit per 6 months
D0322		Dental tomographic survey.	• Limit of 1 unit per 6 months
D0330		Dental panoramic film.	• Limit of 1 unit per 36 months
D0340		Dental cephalometric film.	• Limit of 1 unit per 36 months
D0364		Cone beam CT capture and interpretation with limited field of view - less than one whole jaw.	• Limit of 1 unit per 6 months
D0365		Cone beam CT capture and interpretation with field of view of one full dental arch – mandible.	• Limit of 1 unit per 6 months
D0366		Cone beam CT capture and interpretation with field of view of one full dental arch - maxilla, with or without cranium.	• Limit of 1 unit per 6 months

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Dental Services			
Code	**Modifier**	**Description**	**Service Limitations**
D0367		Cone beam CT capture and interpretation with field of view of both jaws; with or without cranium.	• Limit of 1 unit per 6 months
D0414		Laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report.	• Limit of 1 service unit per 6 months
D0415		Collection of microorganisms for culture and sensitivity.	• Limit of 1 unit per 6 months
D0416		Viral culture.	• Limit of 1 unit per 6 months
D0460		Pulp vitality tests.	• Limit of 1 service unit per patient, per day, same provider
D0470		Diagnostic casts.	• Limit of 1 unit per 12 rolling months
D0502		Other oral pathology procedures, by report.	• Limit of 1 unit per 12 months
D0600		Non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin, and cementum.	• Limit of 1 unit per 6 months
D1110		Dental prophylaxis adult (ages 14-20).	• Limit of 1 unit per 6 months
D1120		Dental prophylaxis child (ages 0-13).	• Limit of 1 unit per 6 months
D1206		Topical application of fluoride varnish.	• Limit of 1 unit per 6 months
D1208		Topical application of fluoride – excluding varnish.	• Limit of 1 unit per 6 months
D1351		Dental sealant per tooth. Billing Note: Limited to fully erupted permanent pre-molars and 1st and 2nd molars.	• Limit of 1 unit per 60 months,
D1352		Preventive resin restoration in a moderate to high caries risk patient- permanent tooth.	• Once in a lifetime per tooth
D1353		Sealant repair- per tooth.	• Limit of 1 unit per 36 months
D1354		Interim caries arresting medicament application – per tooth silver diamide fluoride (SDF) application.	• Limit of 1 unit per 6 months per tooth
D1510		Space maintainer -fixed, unilateral-per quadrant.	• Limit of 4 units any provider and 2 units per 12 months
D1516		Space maintainer- fixed bilateral, maxillary.	• Limit of 2 units any provider and 1 unit per 12 months
D1517		Space maintainer – fixed bilateral, mandibular.	• Limit of 2 units any provider and 1 unit per 12 months

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Dental Services			
Code	**Modifier**	**Description**	**Service Limitations**
D1520		Space maintainer -removable, unilateral – per quadrant.	• Limit of 4 units any provider and 2 units per 12 months
D1526		Space maintainer – removable, bilateral, maxillary.	• Limit of 2 units any provider and 1 unit per 12 months
D1527		Space maintainer – removable, bilateral, mandibular.	• Limit of 2 units any provider and 1 unit per 12 months
D1551		Recement or re-bond bilateral space maintainer, maxillary.	• Limit of 2 units per lifetime
D1552		Recement or re-bond bilateral space maintainer, mandibular.	• Limit of 2 units per lifetime
D1553		Recement or re-bond unilateral space maintainer, per quadrant.	• Limit of 2 units per lifetime
D1556		Removal of fixed unilateral space maintainer, per quadrant.	• Limit of 1 unit per lifetime
D1557		Removal of fixed bilateral space maintainer, maxillary.	• Limit of 1 unit per lifetime
D1558		Removal of fixed bilateral space maintainer, mandibular.	• Limit of 1 unit per lifetime
D1575		Distal shoe space maintainer – fixed, unilateral per quadrant.	• Limit of 4 units any provider and 2 units per 12 months
Restorative (D2140-D2980)			
D2140		Amalgam - one surface, primary or permanent.	• Limit of 1 unit per 36 months per tooth
D2150		Amalgam - two surfaces, primary or permanent.	• Limit of 1 unit per 36 months per tooth
D2160		Amalgam - three surfaces, primary or permanent.	• Limit of 1 unit per 36 months per tooth
D2161		Amalgam – four or more surfaces, primary permanent.	• Limit of 1 unit per 36 months per tooth
D2330		Resin – based composite, one surface, anterior.	• Limit of 1 unit per 36 months per tooth
D2331		Resin – based composite, two surfaces, anterior.	• Limit of 1 unit per 36 months per tooth
D2332		Resin - based composite, three surfaces, anterior.	• Limit of 1 unit per 36 months per tooth
D2335		Resin – based composite, four or more surfaces or involving incisal angle (anterior).	• Limit of 1 unit per 36 months per tooth
D2390		Resin -based composite crown, anterior.	• Limit of 1 unit per 36 months per tooth
D2391		Resin – based composite, one surface, posterior.	• Limit of 1 unit per 36 months per tooth
D2392		Resin – based composite, two surfaces, posterior.	• Limit of 1 unit per 36 months per tooth
D2393		Resin – based composite, three surfaces, posterior.	• Limit of 1 unit per 36 months per tooth
D2394		Resin – based composite, four or more surfaces, posterior.	• Limit of 1 unit per 36 months per tooth
D2712		Crown ¾ resin-based composite (indirect).	• Once in a lifetime per tooth

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Dental Services			
Code	**Modifier**	**Description**	**Service Limitations**
D2721		Crown resin with predominantly base metal.	• Once in a lifetime per tooth
D2740		Crown porcelain/ceramic.	• Once in a lifetime per tooth
D2751		Crown porcelain fused to predominantly base metal.	• Once in a lifetime per tooth
D2781		Crown ¾ cast predominantly base metal.	• Once in a lifetime per tooth
D2791		Crown full cast predominantly base metal.	• Once in a lifetime per tooth
D2910		Re-cement or re-bond inlay, onlay , veneer or partial coverage restoration.	• Limit of 1 unit per 12 months per tooth
D2915		Re-cement or re-bond indirectly fabricated or prefabricated post and core	• Once in a lifetime per tooth
D2920		Re-cement or re-bond crown.	• Limit of 1 unit per 12 months per tooth
D2929		Prefabricated porcelain/ceramic crown – primary tooth.	• Once in a lifetime per tooth
D2930		Prefabricated stainless steel crown – primary tooth.	• Limit of 1 unit per 36 months per tooth
D2931		Prefabricated stainless steel crown- permanent tooth.	• Once in a lifetime per tooth
D2932		Prefabricated resin crown.	• Limit of 1 unit per 36 months per tooth
D2933		Prefabricated stainless steel crown with resin window.	• Limit of 1 unit per 36 months per tooth
D2940		Dental Sedative Filling	• Limit of 2 units per 6 months per tooth
D2950		Core build-up, including any pins when required.	• Limit of 1 unit per 36 months per tooth
D2951		Pin retention – per tooth, in addition to restoration.	• Limit of 2 units per 36 months per tooth
D2952		Post and core cast in addition to crown, indirectly fabricated.	• Once in a lifetime per tooth
D2953		Each additional indirectly fabricated post – same tooth.	• Once in a lifetime per tooth
D2954		Prefabricated post and core in addition to crown.	• Once in a lifetime per tooth
D2955		Post removal.	• Once in a lifetime per tooth
D2957		Each additional prefabricated post – same tooth.	• Once in a lifetime per tooth
D2960		Labial veneer (resin laminate) – chairside.	• Once in a lifetime per tooth
D2961		Labial veneer (resin laminate) – laboratory.	• Once in a lifetime per tooth
D2962		Labial veneer (porcelain laminate) – laboratory.	• Once in a lifetime per tooth
D2975		Coping.	• Once in a lifetime per tooth
D2980		Crown repair necessitated by restorative material failure.	• Once in a lifetime per tooth
Endodontics (D3110-D3950)			
D3110		Pulp cap - direct (excluding final restoration).	• Limit of 1 unit per 36 months per tooth
D3120		Pulp cap – indirect (excluding final restoration).	• Limit of 1 unit per 36 months per tooth

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Dental Services			
Code	**Modifier**	**Description**	**Service Limitations**
D3220		Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament.	• Limit of 1 unit per 36 months per tooth
D3222		Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development.	• Once in a lifetime per tooth
D3230		Pulpal therapy (resorbable filling) – anterior primary tooth (excluding final restoration).	• Once in a lifetime per tooth
D3240		Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration).	• Once in a lifetime per tooth
D3310		Endodontic therapy, anterior tooth (excluding final restoration).	• Once in a lifetime per tooth
D3320		Endodontic therapy, premolar tooth (excluding final restoration).	• Once in a lifetime per tooth
D3330		Endodontic therapy, molar tooth (excluding final restoration).	• Once in a lifetime per tooth
D3351		Apexification/recalcification – initial visit (apical closure/calcific repair or perforations, root resorption, etc.).	• Once in a lifetime per tooth
D3352		Apexification/recalcification – interim medication replacement.	• Once in a lifetime per tooth
D3353		Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.).	• Once in a lifetime per tooth
D3410		Apicoectomy – anterior.	• Once in a lifetime per tooth
D3421		Apicoectomy – premolar (first root).	• Once in a lifetime per tooth
D3425		Apicoectomy – molar (first root).	• Once in a lifetime per tooth
D3426		Apicoectomy (each additional root).	• Once in a lifetime per tooth
D3430		Retrograde filling – per root.	• Once in a lifetime per tooth- multiple roots may be claimed; you must attach documentation to claim if multiple roots are involved on the same tooth
D3450		Root amputation – per root.	• Once in a lifetime per tooth
D3460		Endondontic endosseous implant.	• Once in a lifetime per tooth
D3920		Hemisection (including any root removal), not including root canal therapy.	• Once in a lifetime per tooth
D3950		Canal preparation and fitting of preformed dowel or post.	• Once in a lifetime per tooth

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Dental Services			
Code	**Modifier**	**Description**	**Service Limitations**
Periodontics (D4210-D4910)			
D4210		Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant.	• Limit of 4 units per 60 months
D4211		Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant.	• Limit of 4 units per 60 months
D4212		Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth.	• Limit of 4 units per 60 months
D4230		Anatomical crown exposure – four or more contiguous teeth or tooth bounded spaces per quadrant.	• Limit of 4 units per 60 months
D4231		Anatomical crown exposure – one to three teeth or tooth bounded spaces per quadrant.	• Limit of 4 units per 60 months
D4240		Gingival flap procedure, including root planning – four or more contiguous teeth or tooth bounded spaces per quadrant.	• Limit of 4 units per 60 months
D4241		Gingival flap procedure, including root planning – one to three contiguous teeth or tooth bounded spaces per quadrant.	• Limit of 4 units per 60 months
D4249		Clinical crown lengthening - hard tissue.	• Limit of 4 units per 60 months
D4260		Osseous surgery (including elevation of a full thickness flap and closure) four or more contiguous teeth or tooth bounded spaces per quadrant.	• Limit of 4 units per 60 months
D4261		Osseous surgery (including elevation of full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant.	• Limit of 4 units per 60 months
D4263		Bone replacement graft – retained natural tooth - first site in quadrant.	• Limit of 4 units per 60 months
D4264		Bone replacement graft – retained natural tooth – each additional site in quadrant.	• Limit of 4 units per 60 months
D4265		Biologic materials to aid in soft and osseous tissue regeneration.	• Limit of 4 units per 60 months
D4266		Guided tissue regeneration – resorbable barrier, per site.	• Limit of 4 units per 60 months
D4267		Guided tissue regeneration – non-resorbable barrier, per site (includes membrane removal).	• Limit of 4 units per 60 months
D4270		Pedicle soft tissue graft procedure.	• Limit of 4 units per 60 months
D4273		Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft.	• Limit of 4 units per 60 months
D4274		Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area).	• Limit of 4 units per 60 months

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Dental Services			
Code	**Modifier**	**Description**	**Service Limitations**
D4320		Provision splinting – intracoronal.	• Limit of 4 units per 60 months
D4321		Provisional splinting – extracoronal.	• Limit of 4 units per 60 months
D4341		Periodontal scaling and root planning – four or more teeth per quadrant.	• Limit of 4 units per 12 months- Service limitations are for recipients age 14+
D4342		Periodontal scaling and root planning – one to three teeth per quadrant.	• Limit of 4 units per 12 months- Service limitations are for recipients age 14+
D4346		Scaling presence of generalized moderate or severe gingival inflammation- full mouth, after oral evaluation.	• Limit of 1 unit per 12 rolling months
D4355		Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit.	• Limit of 1 unit per 12 rolling months
D4381		Localized delivery antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth.	• Limit of 1 unit per 12 rolling months
D4910		Periodontal maintenance.	• Limit of 1 unit per 3 months
Adjunctive General Services (D9110-D9994)			
D9110		Palliative (emergency) treatment of dental pain – minor procedure.	• Limit of 1 unit per day • 2 units per 6 months
D9120		Fixed partial denture sectioning.	• Limit of 1 unit per 60 months
D9210		Local anesthesia not in conjunction with operative or surgical procedures.	
D9212		Trigeminal division block anesthesia.	
D9215		Local anesthesia in conjunction with operative or surgical procedures.	
D9222		Deep sedation /general anesthesia - first 15 minutes.	• Limit of 1 unit per day
D9223		Deep sedation/general anesthesia – each subsequent 15-minute increment.	• Limit of 4 units per day
D9230		Inhalation of nitrous oxide/analgesia, anxiolysis.	• Limit of 6 units per 12 rolling months
D9239		Intravenous moderate (conscious) sedation/analgesia - first 15 minutes.	• 1 unit per day
D9243		Intravenous moderate (conscious) sedation/analgesia – each subsequent 15-minute increment.	• 4 units per day
D9248		Non-intravenous conscious sedation.	• Limit of 6 units per 12 rolling months
D9310		Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician.	• Payable for providers at different service location; not in the same office

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Dental Services			
Code	**Modifier**	**Description**	**Service Limitations**
D9311		Consultation with a medical health care professional.	• Limit of 1 unit per 6 months
D9410		House/extended care facility call.	
D9420		Hospital or ambulatory surgical center call.	
D9440		Office visit – after regularly scheduled hours.	• Limit of 1 unit per 12 months
D9610		Therapeutic parenteral drug, single administration.	• Limit of 1 unit per 12 months
D9612		Therapeutic parenteral drugs, two or more administrations, different medications.	• Limit of 1 unit per 12 months
D9630		Drugs or medicaments dispensed in the office for home use.	
D9930		Treatment of complications (post-surgical) – unusual circumstances, by report.	• Limit of 1 unit per 12 rolling months
D9942		Repair and/ or reline occlusal guard.	• Once in a lifetime
D9944		Occlusal guard – hard appliance, full arch.	• Limit of 1 unit per 36 months
D9945		Occlusal guard – soft appliance, full arch.	• Limit of 1 unit per 36 months
D9946		Occlusal guard – hard appliance, partial arch.	• Limit of 1 unit per 36 months
D9950		Occlusion analysis – mounted case.	• Once in a lifetime
D9951		Limited occlusal adjustment.	• Once in a lifetime
D9952		Complete occlusal adjustment.	• Once in a lifetime
D9991		Dental case management – addressing appointment compliance barriers.	• Limit of 1 unit per 6 months
D9992		Dental case management – care coordination.	• Limit of 1 unit per 6 months
D9993		Dental case management – motivational interviewing.	• Limit of 1 unit per 6 months
D9994		Dental case management – patient education to improve oral health literacy.	• Limit of 1 unit per 6 months

Optometry Services

Optometry Services			
Code	**Modifier**	**Description**	**Service Limitations**
92002		Ophthalmological services medical examination and evaluation, with initiation of diagnostic and treatment program; intermediate, new patient.	• Encounter = 1 unit • Limit of 1 unit per 12 months
92004		Comprehensive, new patient, 1 or more visits.	• Encounter = 1 unit • Limit of 1 unit per 12 months

School Health Services (SHS)

Optometry Services			
Code	**Modifier**	**Description**	**Service Limitations**
92012		Ophthalmological services medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient.	• Encounter = 1 unit • Limit of 1 unit per 12 months
92014		Comprehensive, established patient, 1 or more visits.	• Encounter = 1 unit • Limit of 1 unit per 12 months
92015		Determination of refractive state.	• Encounter = 1 unit • Limit of 1 unit per 12 months
92018		Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; complete.	• Encounter = 1 unit • Limit of 1 unit per 12 months
92019		Eye exam and treatment, limited.	• Encounter = 1 unit • Limit of 1 unit per 12 months
92020		Gonioscopy (separate procedure).	• Encounter = 1 unit • Limit of 1 unit per 12 months
92060		Sensorimotor examination with multiple measurements of ocular deviation (e.g., restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure).	• Encounter = 1 unit • Limit of 1 unit per 12 months
92081		Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (e.g., tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent.	• Encounter = 1 unit • Limit of 1 unit per 12 months
92082		Intermediate examination (e.g., at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33).	• Encounter = 1 unit • Limit of 1 unit per 12 months
92083		Extended examination (e.g., Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30°, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)	• Encounter = 1 unit • Limit of 1 unit per 12 months
V2020		Frames, purchases.	• Encounter = 1 unit • Limit of 1 unit per 12 months

School Health Services (SHS)

Optometry Services			
Code	**Modifier**	**Description**	**Service Limitations**
Medical Team Conference: Use the following code to bill for participation in POC development, review, and revision for medical-related services (educational services and goals are excluded). The claim's date of service is the date on the POC.			
99366		Medical team conference with interdisciplinary team of health care professionals, face-to-face with the patient and/or family, 30 min. or more, participation by non-physician qualified health care professional.	• Encounter = 1 unit • Limit of 1 unit per day • Limit of 8 units 99366, 99367, 99368 combined per recipient per year
99367		Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 min. or more, participation by physician.	• Encounter = 1 unit • Limit of 1 unit per day • Limit of 8 units 99366, 99367, 99368 combined per recipient per year
99368		Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 min. or more participation by non-physician health care professional.	• Encounter = 1 unit • Limit of 1 unit per day • Limit of 8 units 99366, 99367, 99368 combined per recipient per year

Procedures, services, or supplies: When dispensing optical supplies, specify spectacle services using CPT codes 92340-92371 and supply of materials using HCPCS codes V2100-V2799 (non-covered codes in this range are V2744, V2756, V2761, V2788 and V2702).

Days or units: When submitting a claim for lenses, bill 1 unit for 1 lens, and 2 units for 2 lenses.

Case Management Services

Code	Modifier	Description	Service Limitations
T1016		Targeted Case Management for Non-Severely Emotionally Disturbed (non-SED) children with a mental illness. Qualified Provider Type: QMHP, LCSW, LMFT, LCPC, QMHA and Clinical Interns working within their scope of practice.	• 15 minutes = 1 unit • 10 hours for initial calendar month, 5 hours for the next three consecutive calendar months. Services are allowed on a rolling calendar year. (17 years of age and younger).

School Health Services (SHS)

Code	Modifier	Description	Service Limitations
T1016		Targeted Case Management for Non-Seriously Mentally Ill (non-SMI) with a mental illness. Qualified Provider Type: QMHP, LCSW, LMFT, LCPC, QMHA and Clinical Interns working within their scope of practice.	• 15 minutes = 1 unit • 10 hours for initial calendar month, 5 hours for the next three consecutive calendar months. Services are allowed on a rolling calendar year. (18 years of age and older).
Billing Instructions: Targeted Case Management is covered for children and adults that meet Levels I and II in the Intensity of Needs Grid only. Providers must bill using the U1 modifier to determine the first starting month, U2 for the second month, U3 for the third month and U4 for the fourth month. If the claim is outside the four consecutive months, do not bill with modifiers U1 to U4.			
Medical Team Conference: Use the following code to bill for participation in POC development, review, and revision for medical-related services (educational services and goals are excluded). The claim's date of service is the date on the POC.			
99366		Medical team conference with interdisciplinary team of health care professionals, face-to-face with the patient and/or family, 30 min. or more, participation by non-physician qualified health care professional.	• Encounter = 1 unit • Limit of 1 unit per day • Limit of 8 units 99366, 99367, 99368 combined per recipient per year
99368		Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 min. or more participation by non-physician health care professional.	• Encounter = 1 unit • Limit of 1 unit per day • Limit of 8 units 99366, 99367, 99368 combined per recipient per year

Telehealth

Telehealth is the use of a telecommunications system instead of an in-person recipient encounter for professional consultations, office visits, office psychiatry services, and a limited number of other medical services. Please review Medicaid Services Manual (MSM) Chapter 3400 (Telehealth Services) for complete policy, covered services, non-covered services and coverage requirements. The telecommunications system used must be an interactive audio and video system. Standard telephones, facsimile machines, or electronic mail do not meet this criteria.

The **distant site** is the site where the provider delivering services is located at the time the service is provided via a telecommunications system. The provider at the distant site must use Place of Service (POS) Code 02 when billing for services provided via telehealth. Use of the POS code certifies the service meets telehealth requirements. Note that for distant site services billed under Critical Access Hospital (CAH) method II on institutional claims, the GT modifier (telehealth service rendered via interactive audio and video telecommunications system) is required.

School Health Services (SHS)

The **originating site** is the location where an eligible Medicaid/Nevada Check Up recipient is at the time the service is provided via a telecommunications system.

Telehealth may be used by any Nevada Medicaid and Nevada Check Up provider working within their scope of practice to provide services that can be appropriately provided via telehealth. If the originating site is enrolled as a Nevada Medicaid provider, they may bill HCPCS code Q3014. If the telecommunication system used is a recipient's smart phone or home computer, the facility fee may not be billed.

Code	Modifier	Description	Service Limitations
Q3014		Telehealth originating site facility fee.	Limit of 1 unit per day