Mobile Crisis Intervention Services and Stabilization Services Billing Guide

Fee-for-service billing instructions and guidance

Table of Contents

Introduction

This document explains how providers can bill Oregon Health Authority (OHA) for fee-for-service Mobile Crisis Intervention Services (MCIS) and Stabilization Services.

These services are described in Oregon Administrative Rule (OAR) Chapter 309, Division 072. Providers must also follow applicable Medicaid OARs in Chapter 410, Division 120 and Chapter 410, Division 172, including, but not limited to, documentation and record maintenance standards.

Telehealth requirements

MCIS responses that include a telehealth component must be rendered according to OHA's telehealth rules (OARs 410-120-1990 and 410-172-0850). MCIS responses that are rendered exclusively by telehealth, with no in-person component, must also be billed according to those rules. Refer to guideline note A5 (Telehealth, Teleconsultations, and Online/Telephonic Services) for additional information.

Documentation requirements

Providers shall maintain documentation for all services rendered that fully supports the charges billed. Providers are responsible for the completeness, accuracy and secure storage of financial and clinical records and all other documentation of the specific care, services, equipment or supplies for which the provider has requested payment as required by OAR 410-120-1360 and any specific rules in OAR 410-172-0620.

MCIS certification and provider enrollment

Before billing for MCIS, agencies must attain certification from OHA according to OAR Chapter 309, Division 072. Once MCIS has been added to their Certificate of Approval (COA), they must submit this form to initiate enrollment with Oregon Medicaid with the appropriate MCIS provider specialty.

MCIS provider specialty

Agencies that do not ensure their Mobile Crisis Intervention Team (MCIT) responding in-person for initial crisis responses always includes a Qualified Mental Health Professional (QMHP) or that do not ensure 24/7/365 availability of a 2-person MCIT for initial crisis responses must enroll with specialty code 202. The specialty code in the Medicaid Management Information System (MMIS) will ensure appropriate payment.

Enhanced MCIS provider specialty

Agencies that ensure their MCIT responding in-person for Initial Crisis Responses always includes a QMHP and that ensure 24/7/365 availability of a 2-person MCIT for initial crisis responses* must enroll with specialty code 203. The specialty code in MMIS will ensure appropriate payment.
*As per the 3/15/2025 Temporary Rule for OAR 309-072-0140 a 1-person initial crisis response to a non-admitted individual on a hospital campus is acceptable and will not affect enrollment as an Enhanced MCIS provider.

Billing OHA

General billing

Certified Community Behavioral Health Clinics (CCBHCs), Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs)

When providing MCIS and Stabilization Services, CCBHCs, FQHCs, and RHCs shall bill at their established PPS rate. Upon certification, CCBHCs, FQHCs, and RHCs shall complete the provider enrollment form referenced above. While FQHCs and RHCs must be enrolled with an MCIS provider specialty, CCBHCs will bill MCIS under their existing 33/324 provider type and specialty.

Approved Integrated and Co-Occurring Disorder (ICD) treatment providers

When billing for MCIS and Stabilization Services according to this guide, approved ICD treatment providers shall also bill according to the Integrated Co-Occurring Disorders Billing Guide.

Culturally and Linguistically Specific Services (CLSS)

When billing for MCIS and Stabilization Services, approved CLSS providers should also bill according to the CLSS billing guide to receive the CLSS enhanced payment for services rendered in a culturally and linguistically specific way. Approved CLSS providers are culturally and linguistically specific providers who meet the eligibility criteria prescribed in the CLSS billing guide and are approved by OHA.

MCIS billing

MCIS must be rendered according to OAR Chapter 309, Division 072, and only agencies meeting all criteria may bill. MCIS can only be rendered for up to 72 hours from the beginning of the initial crisis response. Only one claim may be submitted per response, rather than one per team member.

- The initial crisis response is when an MCIT responds to an individual experiencing a behavioral health crisis, from the time the MCIT arrives on scene or first makes contact with the individual (whichever is earlier) until the MCIT leaves the scene.
- Any MCIS rendered between the end of the initial crisis response and the end of the 72-hour window is a follow-up response and can be rendered by one or more trained program staff.
- If at any point it is determined another MCIT response is needed to de-escalate and stabilize the individual's behavioral health crisis, such as through another call to 988 or the county crisis line, the 72-hour window begins again with this additional initial crisis response.

Place of Service codes

Use Place of Service (POS) code 15 (Mobile Unit) for any MCIS response with an in-person element. If telehealth is used exclusively during the response, as may be the case with some follow-up responses, it must be billed with the appropriate POS code and modifiers from OAR 410-120-1990.

Diagnosis codes

MCIS can be provided prior to an intake evaluation for behavioral health services and therefore do not necessarily require a qualifying diagnosis from the Diagnostics and Statistical Manual 5-TR (DSM 5-TR) to be eligible for reimbursement.

- As a Diagnostic Procedure code (Group 1119), H2011 will be reimbursed when billed with a diagnosis code from the Diagnostic Workup File (Code Group 6032) or with any diagnosis code from any line of the Prioritized List.
- In the absence of a more specific payable diagnosis, providers should use R45.7 (state of emotional shock and stress, unspecified).
- Once an appropriate diagnosis is made, the Mental Health Assessment (MHA) should be updated. Future claims should include accurate diagnostic codes, per the MHA.

Billing for agencies with Enhanced MCIS provider specialty

Enhanced MCIS providers are those agencies that have had OAR Chapter 309, Division 072 added to their COA, have a 2-person MCIS initial crisis response available 24/7/365, and always include a QMHP as one of the two members of the in-person responding MCIT.

Note: Starting 3/15/2025, Enhanced MCIS providers will be allowed to send a one-person initial crisis response to a hospital campus and still maintain their standing as an Enhanced provider. However, these responses will need to be billed at the lower MCIS provider specialty rate (using the CG modifier). A one-person initial crisis response must be provided by either a trained QMHP or a trained Qualified Mental Health Associate (QMHA). If a QMHP is not sent in person, a QMHP must be available to respond when clinically indicated, either by telehealth or in person.

These agencies must:

- Use code H2011 with the CG modifier for one-person initial crisis responses to a non-admitted individual on a hospital campus.
- Use code H2011 (Crisis Intervention Services per 15 minutes) with the HE modifier for all other responses, including one-person follow-up.

- Use code H2011 with the HT modifier on claims for responses that did not take place in a hospital or facility setting, which include nursing facilities, intermediate care facilities for individuals with intellectual disabilities and psychiatric residential treatment facilities.

Billing for agencies with MCIS provider specialty

MCIS providers are those agencies that have had OAR Chapter 309, Division 072 added to their COA, but either do not have a 2-person MCIS initial crisis response available 24/7/365, or do not always include a QMHP as one of the two members of the in-person, responding MCIT.

These agencies must:

- Use code H2011 (Crisis Intervention Services per 15 minutes) with the HE modifier for all MCIT responses.
- Use code H2011with the CG modifier for all one-person responses.

Billing for CCBHCs

CCBHCs must have OAR Chapter 309, Division 072 added to their COA and must complete the MCIS Provider Specialty Enrollment Form. CCBHCs may provide mobile crisis services at either the MCIS or Enhanced MCIS level. However, because CCBHCs must bill at their established PPS rate using the Medicaid ID that includes the CCBHC specialty (33/324), they will not have an MCIS provider specialty added to their agency's provider record in MMIS.

CCBHCs must use code H2011 (Crisis Intervention Services per 15 minutes) with the HE modifier for all responses.

Stabilization Services billing

Stabilization Services must be available for eligible youth (ages 0–20) and their families as outlined in OAR 309-072-0160 and may be provided by the same team or subcontracted to another provider. All youth must be considered for Stabilization Services as part of the initial crisis and follow up responses. Agencies must bill as follows for Stabilization Services rendered as described in OAR 309-072-0160.

Use the appropriate outpatient procedure codes from the Behavioral Health Fee Schedule for services rendered. If there is a delay in completing the Mental Health Assessment (MHA) and service plan required to bill most outpatient codes, medically necessary and appropriate Stabilization Services must still be provided. In this case, agencies shall bill using code H2011 but must also complete the required MHA and service plan as soon as possible.

Individuals who have received MCIS should be referred for Behavioral Health services through their enrolled CCO, or for 1915(i) Home and Community Based Services. Detailed information about CCOs and the Oregon Health Plan (OHP) can be found on the OHA CCO Plans webpage. For more information about 1915(i) Home and Community Based Services, visit Comagine Health's Oregon Behavioral Health Support Program webpage.

Whether billing code H2011 or other outpatient codes, the TS modifier must be added when billing for Stabilization Services. The HE, HT, and CG modifiers must not be used with code H2011 when it is billed for Stabilization Services.

Billing questions and concerns

Please review this guide, the companion FAQ document, notices received from OHA, and the OHP Billing page. For remaining questions or concerns, see the Provider Services Unit web page for additional resources, and contact them if necessary, at 1-800-336-6016 or dmap.providerservices@oha.oregon.gov.

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact the Medicaid Policy and Fee-for-Service Operations Unit at Medicaid.programs@oha.oregon.gov or 1-800-527-5772. We accept all relay calls.

Medicaid Division
Policy and Fee-for-Service Operations
500 Summer St NE
Salem, OR, 97301
Phone: 800-527-5772
Medicaid.programs@oha.oregon.gov
Oregon.gov/OHA

OREGON HEALTH AUTHORITY