Mobile Crisis Intervention Services (MCIS) and Stabilization Services Frequently Asked Questions – Billing

This FAQ must be used in conjunction with the MCIS and Stabilization Services Billing Guide.

General MCIS billing questions

Question 1: What are the two types of MCIS provider specialties and how are they different?

The ***Enhanced*** MCIS Provider Specialty is the designation given to agencies that ensure their two-person Mobile Crisis Intervention Team (MCIT) always includes, at minimum:

- A trained Qualified Mental Health Professional (QMHP), and
- A trained Qualified Mental Health Associate (QMHA) or one other trained behavioral health provider as defined in OAR 309-072-0140 and OAR 309-019-0125
- The MCIT is available 24 hours-a-day/7 days-a-week/every day of the year for initial crisis response.

The Enhanced MCIS Providers are permitted to send a one-person initial crisis response to a non-admitted individual on a hospital campus, but such responses must be billed at the lower rate using the CG modifier. Enhanced MCIS Providers are designated with a specialty code of 203 for billing in MMIS.

The MCIS (non-enhanced) Provider Specialty is the designation given to agencies that do not ensure their MCIT responding in-person for initial crisis responses always

includes a QMHP, or that do not ensure 24 hours-a-day/7 days-a-week/every day of the year availability of a 2-person MCIT for initial crisis response.

The non-enhanced MCIS Provider Specialty is designated with a specialty code of 202 for billing in MMIS.

Please see the Billing Guide for further details about the distinction between these two provider types.

Question 2: CCOs have used code H2011 for a long time. Are the requirements any different than what the CCOs have for this code?

The modifiers used to claim Fee-for-Service reimbursement are important in making distinctions in how code H2011 is implemented and coded for MCIS responses. Given that MCIS is a new service, the requirements are likely different than what CCOs have for this code, but we can't speak to the varying requirements of each CCO and how it relates to this guidance. Please contact your CCO directly with any questions about requirements for specific codes and services.

Question 3: Is there a scenario where H2011 would be billed without the HE or CG modifiers?

Yes. Code H2011 can be used for crisis intervention services that are not mobile, but this falls outside the purview of mobile crisis services. Providers should consult the Behavioral Health Fee Schedule and bill for services provided as identified within the appropriate sections of the Schedule. Crisis intervention services that are mobile would add the HE or CG modifier, depending on provider specialty designation.

Question 4: 90839 and 90840 are the crisis codes covered by commercial payors. Could those codes be included in this program too?

If the MCIT provides psychotherapy as part of the MCIS initial crisis response to a Medicaid member it should be billed under H2011 HE or H2011 CG, depending on provider specialty, rather than these codes. Please contact commercial payors for questions about billing options for non-Medicaid members.

Question 5: How do we bill if our response includes telehealth as well as in-person?

The use of telehealth in an MCIS response must be in accordance with the telehealth rules described in 410-120-1990 and 410-172-0850.

Providers billing for MCIS responses that **combine** telehealth and in-person components must ensure the following information is listed on the claim:

- Use POS code 15 for all MCIS responses that include an in-person component, and
- Do not apply a telehealth modifier (93, 95, GT).

MCIS responses that are rendered exclusively by telehealth, with no in-person component, must be billed with the appropriate POS code and modifier from the telehealth rules and identified on the Behavioral Health Fee Schedule.

Question 6: Can we bill for MCIS while waiting for an individual to be assessed in an ED, if the Initial Crisis Response resulted in their transport to an ED?

Potentially. If the MCIT continues providing MCIS to the individual, it can be billed until such time as there is a handoff to the Emergency Department (ED). Medicaid considers crisis services provided by the MCIT and the ED rendered in the same time frame, duplicative and not allowed. However, this would not prevent the MCIT from providing and billing for follow-up services rendered within 72 hours, even if the individual is still at the hospital.

Question 7: Can we bill for MCIS when an MCIT without an on-site QMHP determines the individual needs an in-person evaluation and brings the individual back to their crisis center for assessment?

No. MCIS is fundamentally about a response to the location of the individual. If the individual needs to be transported elsewhere for appropriate services, services rendered from that location are not considered MCIS. In the example above the crisis center would bill for an assessment, and the MCIT would not bill for MCIS.

Question 8: Can we bill for MCIS when the individual needs to be transported to another level of care?

Yes, if providing the transportation directly to the individual, or if riding along with another person providing transportation to the individual, such as a family member. Please note: in these instances, a service must be occurring in order to bill for it. The expectation is that when transporting or riding along, the MCIT is actively engaging to deescalate the crisis situation.

Question 9: Can we bill for MCIS when an MCIT responds to a BH crisis at a jail?

OAR 410-200-0140(2) indicates that "if an HSD Medical Program beneficiary becomes a resident of a public institution, medical benefits shall be suspended for the duration of the period in which the individual is a resident of that institution." OAR 410-200-0140(3) indicates that this suspension is effective the day following the date of on which the individual becomes a resident of a public institution. Therefore, Medicaid cannot be billed for most MCIS responses at a jail, unless the individual experiencing a BH crisis has arrived at the jail that same day. In that case, the member's medical benefit would not be suspended until the next day, so the initial crisis response could be billed. Please see OAR 410-200-0140 for more information, along with 410-200-0015(69) for the definition of "Resident of a public institution."

Question 10: If a Medicaid member also has private insurance, do we need to get a denial before billing Medicaid?

Please see the third-party liability requirements in OAR 410-120-1280(10) and contact Medicaid.programs@oha.oregon.gov with further questions.

Team makeup questions

Question 11: Does the QMHP have to be there in-person, or can they be available on a tablet?

OAR 309-072-0140 (4)(c) says, "If a QMHP is not part of the two-person MCIT in person, a QMHP must be available to respond when clinically indicated, either by telehealth or in person." Agencies that do not send a QMHP in person for every initial crisis response would be enrolled with the MCIS provider specialty (202).

Question 12: Would a CADC II be considered a QMHP?

Provider qualifications are described in OAR 309-019-0125. Additionally, please visit the Mental Health and Addiction Certification Board of Oregon (MHACBO) for details and requirements on QMHP certification.

Question 13: If we do not have two staff to respond (e.g., someone calls out or other capacity issues), how should we bill?

If you are unable to meet the MCIS staffing requirements, bill code H2011 with the CG modifier for Mobile Crisis, and do not use the HE or HT modifiers.

Question 14: Who can serve on an MCIT?

OAR 309-072-0110(9) defines an MCIT as "a team of qualified behavioral health professionals that may include peer support specialists, as defined in ORS 414.025, and other health care providers such as nurses or social workers who provide timely, developmentally appropriate and trauma-informed interventions, screening, assessment, de-escalation and other services necessary to stabilize an individual experiencing a behavioral health crisis in accordance with requirements established by the authority by rule."

In addition to the behavioral health provider types described in OAR 309-019-0125, "other health care providers" from the definition above may also include EMS providers. All MCIT program staff must meet all personnel related requirements in OAR Chapter 309, Division 072.

Follow-up services questions

Question 15: What services can be rendered as part of the MCIS follow-up response?

According to the definition in OAR 309-072-0110(8), “’Mobile Crisis Intervention Services (MCIS)’ means all necessary services, supports, and treatments for an individual experiencing a behavioral health crisis. Services are delivered by providers in a community-based setting and are intended to de-escalate and stabilize an individual in crisis through a timely therapeutic response that meets the needs of the individual in crisis and is individual and family centered.”

Given this, the scope of an MCIS follow-up response must be determined by the needs of the individual in crisis, and can include an array of services, assessments, referrals, peer supports, and care coordination. This includes, but is not limited to, services that would otherwise be billed under Outpatient, Peer Delivered, or SUD procedure codes such as psychotherapy for crisis, environmental intervention for medical management purposes, consultation with family, medication training and support, training and educational services related to the care and treatment of mental health, behavioral health counseling and therapy, case management, self-help/peer services, skills training and development, and alcohol and/or drug outreach. Rendered as a follow-up response under MCIS, claims must be submitted using code H2011 and any appropriate modifiers, according to the MCIS billing guide.

Question 16: Can you use the H2011 code multiple times within the 72-hour window, regardless of whether you have a two-person team or a one-person team responding?

Code H2011 can be billed multiple times within the 72-hour window if MCIS is provided multiple times during that period. Only one claim may be submitted per MCIS encounter, regardless of the number of providers engaged in rendering the MCIS.

Question 17: OAR mandates we attempt to provide follow-up services, but the billing guidance indicates these can only be provided when medically necessary. Does this put us in a place where we may be required to provide a service for which we cannot bill?

No. Medical necessity for any required elements of MCIS (including an attempted follow-up response) is established by the behavioral health crisis that precipitated the initial crisis response. Since code H2011 can be billed for up to 72 hours from the initial crisis response, follow-up services provided should be those that are clinically indicated by the situation.

Question 18: Is non-client-facing time spent making referrals and coordinating care billable?

Yes, if the individual is engaged as appropriate and services are documented correctly, according to documentation standards identified in 410-120-1360 and 410-172-0620.

Question 19: During a crisis intervention, the MCIT will spend time with the individual in crisis, but may also need to speak to family members, law enforcement, or others present at the scene to gather information and stabilize the situation appropriately. Is the entire time spent on scene rendering the service billable? Does billing change if the individual cannot be found or engaged?

Yes, if the individual is engaged as appropriate and services are documented correctly, the entire time spent on scene rendering the service can be billed. Medicaid cannot be billed if the Medicaid-eligible individual cannot be found or engaged.

Question 20: Can we bill for MCIS when an individual is accepted to inpatient but has to wait 5 days until a bed opens and needs follow up several times in that span?

MCIS can be billed for the first 72 hours and Stabilization Services can be billed after that.

72-hour window questions

Question 21: What if a family calls for an adult that is in the home and 6 hours later the neighbor calls and then 2 hours later someone from the grocery store calls. Is that a separate call or is it all included under the first 72 hours for the individual?

The 72-hour window is not connected to the number of calls received, but to the onset of a behavioral health crisis requiring an MCIT to respond. Anytime someone is experiencing a behavioral health crisis and an MCIT responds to intervene, de-escalate, and stabilize the situation, the 72-hour window begins again.

Stabilization Services questions

Question 22: If somebody is already engaged in CMHP services and they have a crisis episode and our mobile crisis responds to that, and they go back to receiving services that they had already been scheduled to have,

would we add the TS modifier? How would we determine if this is part of Stabilization Services?

It should be noted that the TS modifier denotes Stabilization Services rendered to youth and their families. Children experiencing a crisis episode should be provided Stabilization Services if they are medically necessary and appropriate. OAR 309-072-0160 describes the purpose, eligibility criteria, and service array of Stabilization Services, as well as the intake process. If the child is not intentionally enrolled in stabilization services according to the process and criteria in this section, existing outpatient services would not be considered Stabilization Services, and the TS modifier would not be used.

For adults in the situation described in the question, the MCIT would bill for the initial 72-hour response. If the individual has services in place within the CMHP service array, billing for those services would be done through the regular process, as the transition would have occurred to these established services. The TS modifier should not be used for adults receiving MCIS and Stabilization Services.

Questions related to January 1, 2025 and March 15, 2025 Temporary Rules

Question 23: What does the January 1, 2025 temporary rule about one person responses during the hours of 12:00am to 8:00am mean for our responses and billing of them?

The January temporary rule does not affect provider specialty designation. This temporary rule allows agencies that are only able to send a one-person response between the hours of 12:00am and 8:00am to still be compliant of MCIS guidelines. This temporary rule will be repealed on June 29, 2025, and two-person team responses will again be required 24 hours-a-day/7 days-a-week/every day of the year.

Question 24: What does the March 15, 2025 temporary rule about one person responses to a non-admitted individual on a hospital campus mean for our responses and billing for them?

The March temporary rule means that responses to non-admitted individuals on a hospital campus may now consist of a single MCIT member and still be within the

guidelines of MCIS. This will not change the designation as a 202 or 203 provider and now gives MCIT providers the flexibility to send a single person response to a non-admitted individual on a hospital campus. All single MCIT member responses should be billed with the CG modifier.

Question 25: How do the new temporary rules affect our provider specialty designation and how we may bill for services provided?

The temporary rules do not affect provider specialty designations. However, the rules do alter the definition of enhanced (203) providers, who may now send a one-person response to a non-admitted individual on a hospital campus and still qualify as an enhanced specialty provider. For non-enhanced providers (202), this rule change does not alter the designation or billing.

Billing Questions and Concerns

Please review this FAQ document, the companion Billing Guide, 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.

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Medicaid Division
Medicaid Policy and Fee-for-Services Operations Unit
500 Summer St. NE
Salem, OR 97301
1-800-527-5772
Medicaid.programs@oha.oregon.gov
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