Service Description (Chapter III & PIHP Contract)	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold (DT)	Reporting Technique & Claim Format	Coverage	Reporting and Costing Considerations
Peer-Directed and Operated Support Services (MH or DD)	**H0023** **H0038** **H0046**	H0023: Drop-In Center attendance, encounter [Note: Optional to report as encounter, but must report on MUNC] H0038: Mental Health Peer specialist services provided by certified peer specialist, 15 min. H0046: Peer mentor services provided by a DD Peer Mentor. TT modifier: Use when peer service is provided in a group	Encounters 15 minutes DT=96/day Encounters	Line Professional	1915(b)(3) & EPSDT	When/how to report H0023 encounters: If beneficiary signed time-in/out log report the units as encounters When/how to report H0038 encounters: - Certified peer support specialist performed the activities listed in the Medicaid Provider Manual under the peer coverage. If PSS is assisting with other state plan or b3 services, use modifier HE with that service's procedure code. When/how to report H0046 encounters: - Report only when a DD Peer Mentor has performed the activities listed in the Medicaid Provider Manual under the peer coverage. When a DD Peer Mentor assists with, or performs another covered service, use the code for that service and add the HI modifier. Allocating and reporting costs: - Drop-in cost includes staff, facility, equipment, travel, transportation, contract services, supplies and materials - Must report all Drop-in Center Medicaid costs in Medicaid Utilization and Cost Report
Supports Coordination	**T1016**	T1016: Case management, each 15 minutes. Modifier HK (specialized mental health programs for high-risk populations) must be reported for Habilitation Supports Waiver beneficiaries. No modifier s reported for Additional or "b3" Services.	15 minutes	Line Professional	Habilitation Supports Waiver, 1915(b)(3) & EPSDT	When/how to report encounter: - Face-to-face only - Includes supports coordinators activities of pre-planning, treatment planning, periodic review of plan (collateral contacts are indirect time/activity) - Activities of supports coordination assistants or aides, service brokers, and case management assistants may be reported, but not for the same time period for which there is a supports coordination activity reported. - Typically supports coordination may not be reported for the time other Medicaid-covered services (e.g. medication reviews, skill-building) are occurring. However, in cases where a per diem is being paid for a service – e.g., CLS and Personal care – it is acceptable to report units of supports coordination for the same day. Allocating and reporting costs: - Include indirect activity - Cost if staff provide multiple services Boundaries - Between Supports Coordination (SC) and Targeted Case Management (TCM).

						*Use SC for all HSW beneficiaries *Use SC when any Medicaid beneficiary (SMI, DD, or SED) has goals of community inclusion and participation, independence or productivity (see 1915 b3 or Additional Supports and Services in the Medicaid Provider Manual) and needs assistance with planning, linking, coordinating, brokering, access to entitlements, or coordination with health care providers, but does not meet the criteria for TCM (see below) *Use SC when on or more of functions will be provided by a supports coordinator assistant or service broker. - Between SC and Community Living Supports (CLS): *a staff who functions as supports coordinator may also provide CLS, but should report the CLS functions as CLS not SC. - Between SC and other covered services and supports: *a staff who functions as supports coordinator may also provide other covered services, but having done so should report those covered services rather than SC.
Targeted Case Management	**T1017**	Targeted case management	15 minutes (face-to-face) DT=48/day	Line Professional	State Plan	<u>When/how to report encounter:</u> - Face-to-face only - Includes case manager's activities of pre-planning, treatment planning, periodic review of plan (Collateral contacts are indirect time/activity) - Typically case management may not be reported for the time other Medicaid-covered services (e.g., medication reviews, skill building) are occurring. However, in cases where a per diem is being paid for a service – e.g. CLS and Personal Care – it is acceptable to report units of case management for the same day. <u>Allocation and reporting costs:</u> - Include indirect activity - Cost if staff provide multiple services <u>Boundaries:</u> - Between Supports Coordination (SC) and Targeted Case Management (TCM) *Use SC for all HSW beneficiaries *Use SC when any other Medicaid beneficiary (SMI, DD or SED) has goals of community inclusion and participation, independence or productivity (see 1915b3 or Additional Supports and Services in the Medicaid Provider Manual) and needs assistance with planning, linking, coordinating, brokering, access to entitlements, or coordination with health care providers, but does not meet the criteria for TCM (see below). *Use SC when on or more of functions will be provided by a supports coordinator assistant or service broker. - Between SC and Community Living Supports (CLS): *a staff who functions as supports coordinator may also provide CLS, but should report the CLS functions as CLS, not SC. - Between SC and other covered services and supports: *a staff who functions as supports coordinator, may also provide other covered services, but having done so should report those covered services rather than SC.