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

Given that MCIS is a new service the requirements are likely different, 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 2: Is there a scenario where H2011 would be billed without the HE modifier?

Yes. H2011 can be used for crisis intervention services that are not mobile, but this falls outside the purview of mobile crisis services. Crisis intervention services that are mobile would add the HE modifier for MCIS or the CG modifier for mobile crisis (old standard).

Question 3: 90839 and 90840 are the crisis codes covered by commercial payors. Could those codes be included in this program too?

If the Mobile Crisis Intervention Team (MCIT) provides psychotherapy as part of the MCIS initial crisis response to a Medicaid member it should be billed under H2011 HE rather than these codes. Please contact commercial payors for questions about billing options for non-Medicaid members.

Question 4: 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. However, MCIS responses that combine telehealth and in-person components must not be billed according to the telehealth rules. 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.

Question 5: 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 ED. It would be duplicative for the MCIT to bill MCIS and the ED to bill for crisis intervention rendered in the same time frame. 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 6: 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 7: 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.

Question 8: 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 to 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 9: 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 10: 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.

Question 11: Would a CADC II be considered a QMHP?

Provider qualifications are described in OAR 309-019-0125.

Question 12: 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 H2011 with the CG modifier for Mobile Crisis (old standard), and do not use the HE or HT modifiers.

Question 13: 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 14: 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 H2011 and any appropriate modifiers, according to the MCIS billing guide.

Question 15: 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?

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 16: 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 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 17: 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.

Question 18: 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 19: 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 20: 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 21: 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?

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.