Office of Mental Health

Office of Addiction Services and Supports

Department of Health

New York State Crisis Intervention Benefit: Mobile Crisis Component

Medicaid Managed Care Benefit and Billing Guidance

February 2025

Introduction: Mobile Crisis Services

The Crisis Intervention (CI) benefit, including Mobile Crisis services (implemented in 2019), was authorized under the New York State (NYS or the State) 1115 waiver as a demonstration benefit for adults aged 21 and older in Medicaid managed care. Mobile Crisis services for children up to age 21 were developed under the Children and Family Treatment and Support Services (CFTSS) array implemented through the Children's Medicaid Transformation in 2019. Medicaid Advantage Plus (MAP) Plans began covering the CI benefit in January 2023.

On June 29, 2023, NYS received approval from the Centers for Medicare and Medicaid Services (CMS) for the CI State Plan Amendment (SPA) #22-0026. The CI SPA has a retroactive effective date of April 1, 2022. The CI SPA consolidated and aligned Medicaid authority, coverage, and reimbursement policies for children and adult Mobile Crisis services. Mobile Crisis services previously authorized under the NYS 1115 waiver are now State Plan services. Mobile Crisis services developed under the CFTSS array remain State Plan services.

Mobile Crisis programs are funded through local and State initiatives and in most cases, are authorized for reimbursement for services delivered to individuals enrolled in Medicaid fee-for-service (FFS) and Medicaid Managed Care Plans (collectively referred to as MMCPs), including Mainstream Medicaid Managed Care Organizations, Health and Recovery Plans (HARPs), HIV Special Needs Plans (HIV SNPs), Medicaid Advantage Plus (MAP) Plans, and Children's Health Insurance Program (CHIP).

Mobile Crisis providers are identified by Local Governing Units' Mental Hygiene Directors through the Counties' crisis response planning. Providers are eligible for reimbursement under the SPA. The NYS Office of Mental Health (OMH), in consultation with the NYS Office of Addiction Services and Supports (OASAS), counties, and the City of New York, designates all Mobile Crisis providers eligible to deliver Mobile Crisis Services under this benefit. Through the collaboration between the Local and State governments, the State is able to ensure access to CI services across NYS and that Mobile Crisis services are effectively integrated into the State's crisis response system.

This document outlines guidance for the Mobile Crisis component of the CI SPA for children, youth, and adults. Medicaid reimbursement for the Mobile Crisis service array is available through Medicaid FFS and MMCPs. MMCPs must reimburse for services provided under the CI SPA and meet network requirements as outlined in this guidance. Until such time as the *Transition of Behavioral Health Benefit into Medicaid Managed Care and Health and Recovery Program Implementation*, the *Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract (Medicaid Managed Care Model Contract)*, the *Behavioral Health Guidance for Managed Care Organizations Carving Behavioral Health into Medicaid Advantage Plus*, *the CFTSS Provider Manual*, and the *Medicaid Advantage Plus (MAP) Model Contract* are updated to reflect requirements applicable to CI services, the provisions contained therein regarding CI services remain applicable, except where this guidance differs, this guidance will control.

This document is organized into the following sections:

I. Overview and Program Standards

Mobile Crisis services are available to all individuals, including Medicaid enrollees. The Mobile Crisis component of the CI SPA includes response methods, corresponding activities, and CI services. Each response method is eligible for reimbursement when a Mobile Crisis service component is delivered by a qualified staff, either directly to the individual or their identified collaterals for the individual's benefit and recommended by a Licensed Practitioner of the Healing Arts (LPHA).

The goals of these services are engagement, symptom reduction, and stabilization. These services can be provided to individuals who appear to be experiencing, or are at imminent risk of experiencing, a behavioral health (BH) (psychiatric or substance use) crisis, regardless of age or ability to pay. These services are designed to interrupt or ameliorate a crisis by:

- Providing crisis response immediately in the community where individuals live, work, learn, and socialize;
- Supporting timely crisis resolution and de-escalation, and development of a crisis or safety plan;
- Delivering services directly to the individuals or their identified collaterals within the context of a potential or actual BH crisis while also diverting an emergency room visit or inpatient admission, if appropriate;
- Providing services that are culturally and linguistically responsive, person-centered, and trauma-informed to determine level of safety, risk, and to plan for the next level of services emphasizing symptom reduction, restoring individuals to a previous level of functioning, and preventing crises in the future;
- Engaging individuals and their families and support systems in mental health and substance use assessments and tools;
- Providing care coordination, service planning, safety planning, individual, family and group counseling, family advocacy and/or peer support services; and
- Ensuring services include family-focused engagement, integration of natural supports and other collaterals while ensuring all services including family or other collaterals are for the direct benefit of the beneficiary.

1. Provider Designation and Oversight

The NYS Office of Mental Health (OMH), in consultation with the NYS Office of Addiction Services and Supports (OASAS), counties, and the City of New York, designates all Mobile Crisis providers eligible to deliver Mobile Crisis Services under this benefit.

OMH and OASAS have shared oversight of the CI benefit and coordinate with other NYS agencies as applicable. Counties and the City of New York provide oversight of those agencies/providers consistent with current operations (e.g., could include site visits or outcome reports). Counties and the City of New York ensure coordination of existing crisis services.

As of June 29, 2023, Comprehensive Psychiatric Emergency Program (CPEP) providers are approved to provide and be reimbursed for all Mobile Crisis services for adults and children for claims billed using the Crisis Intervention rate codes under the CI SPA. Previously used CPEP rate code 4010 for Interim Crisis retired effective July 1, 2023, and rate code 4009 for Crisis Outreach was retired effective July 1, 2024.

Mobile Crisis providers can be approved to deliver Mobile Crisis services via telehealth based on applicable regulations and State guidance. For more information on Mobile Crisis services delivered via telehealth, please refer to the *Mobile Crisis Program Guidance* and *Telehealth Services Guidance for OMH Providers*.

NYS reserves the right to make oversight visits and rescind provider approvals to deliver Mobile Crisis services.

2. Definitions

A. Behavioral Health (BH) Crisis

- A BH crisis is an acute psychological or emotional change which results in a marked increase in personal distress, requires a rapid response, and exceeds the abilities and the resources of the individual and those involved to effectively resolve.

B. Behavioral Health Crisis Intervention (BHCI)

- BHCI is defined as response by providers of CI services to interrupt or ameliorate the individual's BH crisis.

C. Qualifying Behavioral Health Crisis Intervention (BHCI) Episode

- A Qualifying BHCI episode begins with the provider's initial contact with the individual. The end of the crisis episode is defined by the amelioration of the individual's presenting symptoms or, if clinically indicated, when the person is transferred to the recommended level of care.

3. Service Components

Mobile Crisis services are available 24 hours a day, 7 days a week, and 365 days a year. Programs maintain the capacity to respond immediately or within timeliness standards established by the State. Mobile Crisis services are delivered telephonically, in person, or via telehealth to individuals at risk of or experiencing a BH crisis and their collaterals for the direct benefit of the individual in crisis.

Mobile Crisis services are provided within the following response methods to individuals based on need in the community:

- Telephonic Triage and Response;
- Telephonic Crisis Follow Up;
- Mobile Crisis Response; and
- Mobile Crisis Follow Up.

Mobile Crisis services components include:

- Mental Health and Substance Use Assessments;
- Crisis Planning;
- Safety Planning;
- Individual and Family Counseling;
- Care Coordination; and
- Peer/Family Peer Support.

4. Licensed Practitioner of the Healing Arts (LPHA) Recommendation

Mobile Crisis Services must be recommended by an LPHA operating within their state license scope of practice, who may or may not be part of the Mobile Crisis program. This recommendation should be documented in the enrollee's record for every crisis episode. LPHA recommendations are valid throughout an enrollee's episode of care. Enrollees previously discharged and re-engaging in a Mobile Crisis service will need a new LPHA recommendation.

Medicaid Managed Care Plans shall not require providers to submit documentary evidence of the LPHA recommendation in order to initiate or be reimbursed for services. MMCPs may request documentation of an LPHA recommendation for provider quality management purposes. It is the Mobile Crisis provider's responsibility to retain LPHA recommendation information in the enrollee's case record.

Additional information on the LPHA recommendation can be found in the *Mobile Crisis Program Guidance*.

5. Staffing Standards

CI Professional staff licensed in NYS include:

- Physician (MD or DO) including Psychiatrists and Addictionologist/Addiction Specialist;
- Nurse Practitioner;
- Registered Professional Nurse;
- Clinical Nurse Specialist;
- Physician Assistant;
- Licensed Psychologist;
- Licensed Psychoanalyst;
- Licensed Social Worker (Licensed Master Social Worker (LMSW) or Licensed Clinical Social Worker (LCSW));
- Licensed Marriage & Family Therapist;
- Licensed Mental Health Counselor (LMHC);
- Licensed Creative Arts Therapist;
- Licensed Behavioral Analyst; and
- Licensed Occupational Therapist.

For services provided to individuals 21 years and older, the definition of CI Professionals also includes: Certified Psychiatric Rehabilitation Practitioners certified by the Psychiatric Rehabilitation Association, Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification, Therapeutic Recreation Therapists certified by the National Council on Therapeutic Recreation or the American Therapeutic Recreation Association, and Counselors certified by and currently registered with the National Board for Certified Counselors.

CI staff are qualified practitioners who are at least 18 years of age and have a bachelor's degree, which may be substituted for a high school diploma, high school equivalency, or State Education Commencement Credential plus experience, credentials, or certifications. Individuals without a bachelor's degree must also meet one or more of the following qualifications:

- For services delivered to individuals over age 21: minimum one year of experience providing services and supports to individuals living with a mental health disorder or addiction, and their identified/preferred supports;
- For services delivered to children/youth under age 21 and their identified supports: two years of work experience in children's mental health, addiction, or foster care;
- A student or intern within a Department of Health (DOH) approved NYS Education Department (NYSED) program;
- Licensed Practical Nurse;
- Credentialed Alcoholism and Substance Abuse Counselor (CASAC); or
- Individuals with lived experience with emotional, behavioral, addiction, or co-occurring disorders or as a parent/primary caregiver of a child, youth, young adult, adult with emotional, behavioral, addiction, or co-occurring disorders and who are not qualified peers. For the purposes of this section, qualified peers include qualified peer support workers or advocates. NYS may also waive the education requirement for these individuals to provide services.

CI services are also provided by Qualified Peers, who are individuals with lived experience as someone engaging in recovery from emotional, behavioral, addiction, or co-occurring disorders or as a parent/primary caregiver of a child with emotional, behavioral, addiction, or co-occurring disorders and who are provisionally or professionally certified or credentialed as a Family Peer Advocate (FPA-C), Certified Recovery Peer Advocate (CRPA, CRPA-Y, CRPA-F), Youth Peer Advocate (YPA-C), and/or Peer Specialists (NYCPS) who have completed all required State approved trainings specific to the their title.

All CI staff require training on the administration of opioid antagonists (e.g., naloxone), trauma-informed care, de-escalation strategies, harm reduction, and culturally and linguistically responsive service provision.

6. Service Standards

A. Service Provision

- Depending on local conditions, mobile and telephonic crisis response should be integrated with local emergency systems (e.g., 911, 988, local crisis hotlines), crisis stabilization services, emergency medical services, and law enforcement;
- Mobile Crisis providers must be approved to deliver Mobile Crisis services via telehealth based on applicable regulations and State guidance. For more information on Mobile Crisis services delivered via telehealth, please refer to Part 596 of Title 14 of the New York Codes, Rules, and Regulations;
- Only qualified licensed CI Professional and CASACs supervised by a CI Professional may conduct assessments, consistent with their scope of practice as defined by the NYS Education law or OASAS Credentialing Unit for CASACs;
- Other qualified CI staff are eligible to provide services based on their qualifications and within their scope of practice while under the supervision of a qualified CI Professional or other staff approved to supervise CI services; and
- Certified/Credentialed and Provisionally Certified/Credentialed Peers provide peer, youth and family peer support services via crisis follow up or mobile crisis response under the

supervision of a qualified CI Professional staff or other CI staff approved to supervise Qualified Peers/Advocates;
- Mobile Crisis providers must document all follow-up activities and efforts to link the individual and the family or caregiver to supports and services.

B. Telephonic Triage and Response
- Telephonic crisis response and telephonic crisis follow up is available to all Medicaid enrollees regardless of age including children and their collaterals.

C. Mobile Crisis Response
- A two-person Mobile Crisis Response to an individual's crisis episode is preferred and should include a CI Professional and a qualified CI staff.
- Mobile Crisis Response provided by less than two program staff must be determined at triage, justified, and documented in the record.
- If determined at triage that only one team member is required for a Mobile Crisis Response either a CI Professional or a CI staff with a master's degree may respond with a CI Professional available via telehealth.
- If determined at triage that only one team member is required to respond for a Substance Use Disorder crisis, a CASAC may respond with a licensed practitioner available via telehealth.

D. Crisis Follow Up
- Crisis Follow up includes coordination with, and referrals to, health, social, and other services and supports as needed. Services must be provided by CI Professional staff, CI staff with at least a bachelor's degree, or Qualified Peers working within their scope of practice.
- Crisis Follow up is provided in person, via telehealth, or telephonically. Follow up services must be related to the Qualifying BHCI episode.

II. Medicaid Managed Care Plan Responsibilities and Provider Oversight

1. Utilization Management

Prior authorization for Mobile Crisis services is prohibited.[1] Also, MMCPs may not subject Mobile Crisis services to any other form of utilization review, per Section 10.21(a) of the *Medicaid Managed Care Model Contract* and Section 10.7(c) of the *MAP Model Contract*. Mobile Crisis service activities must occur within the context of a potential or actual psychiatric crisis.[2]

MAP Plan utilization management and eligibility requirements for Mobile Crisis services are the same as the requirements in HARPs and the Mainstream Managed Care Plans. Please refer to the *New York State Medicaid Advantage Plus (MAP) Plans Behavioral Health Billing and Coding Manual* for additional information.

2. Member Services

[1] *Medicaid Managed Care Model Contract*, Emergency Services- Section 10.13(e), and Mental Health Services- Section 10.21(i).
[2] *Medicaid Managed Care Model Contract*, Appendix K- Section 48. Crisis Intervention Services.

MMCPs must ensure Member Services staff responsible for providing intake, referral, or crisis response referrals to enrollees receive adequate training regarding the Mobile Crisis benefit and are provided access to updated training materials, whether these staff are employed by the MMCP directly or through subcontract. Specifically, per Sections 10.13(a) and 12.1(e)(vi) of the *Medicaid Managed Care Model Contract*, Member Services staff must receive adequate training on transferring enrollees identified as in crisis to properly trained crisis clinicians for triage. In addition to the State's requirements for handling crisis calls, per section 3.4(C)(iv) of the *New York Request for Qualifications For Adult Behavioral Health Benefit Administration: Managed Care Organizations and Health and Recovery Plans,* the MMCPs must ensure there are protocols for assisting and triaging callers who may be in crisis by accessing a qualified clinician to take the call without placing the caller on hold. The qualified clinician shall assess the crisis and shall warm transfer the call to the crisis provider, call 911, refer the individual for services, refer the caller to his or her provider, or resolve the crisis over the telephone as appropriate. For the purposes of this guidance, qualified clinician means CI Professional.

3. Quality Management

As outlined in the *Medicaid Managed Care Model Contract* sections 16.1(c)(iii) and 16.2(d), MMCP BH Utilization Management (UM) Committees are charged with implementing a process to collect, monitor, analyze, evaluate, and report utilization and cost data, identify any findings of under and overutilization of BH services, interpret any variances, review outcomes, develop interventions, and approve interventions based on utilization and cost data.

MMCPs shall also develop and implement protocols for identifying participating providers that do not adhere to practice guidelines and for making reasonable efforts to improve the performance of these providers.

MMCPs should implement processes to ensure participating Mobile Crisis providers are delivering services to enrollees according to State-issued guidelines. For State-issued guidelines for Mobile Crisis services, please refer to the *Mobile Crisis Program Guidance*. MMCPs may conduct outlier management for purposes of enrollee care management and provider education. MMCPs shall have effective mechanisms to obtain information from Mobile Crisis providers and report such information and related analytical data in a manner and format to be determined by the State, and to evaluate the enrollee's level of care, service plan adequacy, provider qualifications, enrollee health and safety, financial accountability, and compliance with the terms of this guidance and the *Medicaid Managed Care Model Contract*.

III. Network Requirements

1. Credentialing

MMCPs must accept the Mobile Crisis provider's State designation or provisional designation to fulfill the MMCP's credentialing requirements. MMCPs may not individually credential staff employed by Mobile Crisis programs. The State's approval of a Mobile Crisis provider meets the MMCP's credentialing requirement to assure Mobile Crisis providers possess the qualifications to provide Mobile Crisis services.

MMCPs must ensure Mobile Crisis provider agencies/programs are designated by the State and staff have not been disqualified or de-barred from participation in any other federal or State program.

MMCPs maintain responsibility to ensure program integrity pursuant to federal law. The MMCP's credentialing committee shall develop and adhere to procedures consistent with 42 CFR 455.436, Sections 18.9 and 21.4(a)(ii) of the *Medicaid Managed Care Model Contract,* and Section 18.9 of the *MAP Model Contract*. If an MMCP determines a Mobile Crisis provider or a practitioner is excluded, any claims submitted for services provided by such provider or practitioner must be denied.

2. Network Adequacy Requirements and Reporting

MMCPs must ensure access to Mobile Crisis services for their enrollees, as outlined in this guidance. The State will conduct ongoing network adequacy reviews for Mobile Crisis services using the Children's Network Contracting Status Report (Exhibit 4) and Crisis Services Contracting Status Report Workbook (Exhibit C) network reporting templates.

Per section 21.19(d), "Crisis Intervention Services Providers" of the *Medicaid Managed Care Model Contract* and Section 1.0(A)(2)(ii) of the *Behavioral Health Guidance for Managed Care Organizations Carving Behavioral Health into Medicaid Advantage Plus,* MMCPs are required to offer contracts to all State-approved Mobile Crisis providers in their service area.

MMCPs are required to reimburse State-approved providers regardless of the provider's contracting status. See section 10.13(d.ii.D) of the *Medicaid Managed Care Model Contract* and Section 1.0(A)(2)(ii) of the *Behavioral Health Guidance for Managed Care Organizations Carving Behavioral Health into Medicaid Advantage Plus.*

3. Culturally and Linguistically Responsive Provider Networks

Pursuant to Sections 15.10 and 15.11 of the *Medicaid Managed Care Model Contract* and Section 15.3 of the *MAP Model Contract*, MMCPs must maintain a culturally responsive provider network capable of delivering services to all enrollees, including those with limited English proficiency. Information on the NYS approved cultural competence training offered by the United States Department of Health and Human Services (HHS) can be found in *Cultural Competency Training for Participating Providers*. MMCPs must arrange for language assistance services and adequately reimburse Mobile Crisis providers for language assistance services when network providers cannot meet an enrollee's language needs. MMCPs are also responsible for informing Mobile Crisis providers how to access and be adequately reimbursed for language assistance services for enrollees with limited English proficiency.

IV. Rates and Billing Requirements

Under the CI SPA authority, Medicaid billing rates and rate code structures for children and adult Mobile Crisis services were consolidated and made uniform.

1. Rate Requirements

MMCPs are required to reimburse both participating and non-participating Mobile Crisis providers for services, and rates for non-participating providers shall be the same as for

participating providers.[3] MMCPs shall not deny claims for no prior authorization or claims submitted by non-participating network providers for being out of network. Additionally, MMCPs may not deny payments to a participating provider or a non-participating provider for the failure of the provider or enrollee to provide notification regarding service provision.

CMS-approved Medicaid FFS rates for Mobile Crisis services are effective April 1, 2022, and are posted on the *OMH Medicaid Reimbursement webpage*. Pursuant to Chapter 57 of the Laws of 2022, and as a result of the approval of SPA #22-0026, MMCPs are required to pay State-mandated rates for adult and children Mobile Crisis services effective April 1, 2022.

However, as MAP Plans began covering additional ambulatory services on January 1, 2023, any updates related to the CI SPA are only retroactive back to the MAP Plan BH carve-in date of January 1, 2023.

2. Billing

Only Mobile Crisis service providers designated by the State and enrolled in the Medicaid program are eligible to bill Medicaid Managed Care. Information on enrolling in Medicaid can be found at: https://www.emedny.org/info/ProviderEnrollment/index.aspx.

Mobile Crisis service providers may bill for CI services delivered through an approved response method during a qualifying BHCI episode when services are delivered directly to the individual or natural support or collaterals for the beneficiary's benefit and are recommended by an LPHA. Mobile Crisis services must be documented in the individual's chart in accordance with Medicaid regulations.[4]

Billable services are differentiated by service, duration, and practitioner type (licensed, unlicensed, or qualified peer). Services are billed daily (per diem) or in 15-minute increments. Effective May 1, 2024, providers delivering adult and children's Mobile Crisis services bill using the same rate codes, associated procedure codes, and modifier combinations as outlined below. Rates for Mobile Crisis services are posted on the *OMH Medicaid Reimbursement webpage*.

Per Section 21.22 of the *Medicaid Managed Care Model Contract* and Section 1.0(B)(i)(a) of the *Behavioral Health Guidance for Managed Care Organizations Carving Behavioral Health into Medicaid Advantage Plus*, MMCPs are expected to provide education and technical assistance related to claims submission and payment to Mobile Crisis providers. MMCPs may also initiate claims testing with providers to ensure claims processing and payment procedures are accurately configured.

Mobile Crisis providers must submit all claims using the appropriate combination of rate codes, procedure codes, and modifiers for the service provided in Tables A-D below. Providers are

[3] Please refer to Section 10.13(d)(ii)(D) of the *Medicaid Model Contract* and Section 1.0(A)(2)(ii) of the *Behavioral Health Guidance for Managed Care Organizations Carving Behavioral Health into Medicaid Advantage Plus*.
[4] See 18 NYCRR Part 541.1.

permitted to round up service duration as outlined in Table E: Timed Units per Encounter of Service.[5]

For additional MMCP claiming and billing resources, please see the *New York State Health and Recovery Plan (HARP)/Mainstream Behavioral Health Billing and Coding Manual* (Claims, page 5, claiming and encounter reporting processes), information available on the Managed Care Technical Assistance Center (MCTAC) website, and the MCTAC Interactive Billing Tool.

A. Telephonic Triage and Response

Rate Code Description	Rate Code	Procedure Code	Modifier(s)	Unit Measure	Unit Limit/Day
Licensed Professional	4609	H2011	GT	15 Minutes	Up to 90 minutes[6] (6 Units)
Unlicensed/Certified Peer	4610	H2011	GT, HO	15 Minutes	Up to 90 minutes (6 Units)
Licensed Professional	4611	S9485	GT	Per Diem	90 minutes- 3 hours (1 Unit)
Unlicensed/Certified Peer	4612	S9485	HO	Per Diem	90 minutes- 3 hours (1 Unit)

B. Telephonic Crisis Follow-Up Services

Rate Code Description	Rate Code	Procedure Code	Modifier(s)	Unit Measure	Unit Limit/Day
Licensed Professional	4613	H2011	TS, GT	15 Minutes	Up to 60 minutes (4 Units)
Unlicensed/Certified Peer	4614	H2011	TS, HM	15 Minutes	Up to 60 minutes (4 Units)

Note: The unit limits for rate codes 4613 and 4614 are considered soft limits. Providers may exceed these limits; however, utilization beyond the soft limits should be medically necessary and is expected to be infrequent.

C. Mobile Crisis Response

Rate Code Description	Rate Code	Procedure Code	Modifier(s)	Unit Measure	Unit Limit/Day
One-person response: Licensed	4615	H2011	HE	15 Minutes	Up to 90 minutes (6 Units)
Two-person response: Licensed and Unlicensed/ Certified Peer	4616	H2011	HK	15 Minutes	Up to 90 minutes (6 Units)
Two-person response: Both Licensed	4617	H2011	HE, HK	15 Minutes	Up to 90 minutes (6 Units)

[5] CFTSS Rate Codes 7906-7910, 7936-7945 retired on 5/1/2024. Providers approved to deliver children's (ages 0-20) Crisis Intervention services will bill using rate codes 4609-4624 for Mobile Crisis and 4627 for Crisis Residence.
[6] The unit limit of up to 90 minutes excludes minute 90.

Rate Code Description	Rate Code	Procedure Code	Modifier(s)	Unit Measure	Unit Limit/Day
Two-person response: Licensed and Unlicensed/ Certified Peer	4618	S9485	HE, U5	Per Diem	90 – 180 minutes (1 Unit)
Two-person response: Both Licensed	4619	S9485	HE, HK, U5	Per Diem	90 – 180 minutes (1 Unit)
Two-person response: Licensed and Unlicensed/Certified Peer	4620	S9485	HE	Per Diem	At minimum 3 hours of face-to-face contact (1 Unit)
Two-person response: Both Licensed	4621	S9485	HE, HK	Per Diem	At minimum 3 hours of face-to-face contact (1 Unit)

D. Mobile Crisis Follow-Up Services

Rate Code Description	Rate Code	Procedure Code	Modifier(s)	Unit Measure	Unit Limit/Day
One-person face-to-face response: Licensed	4622	H2011	TS	15 Minutes	Up to 90 minutes (6 Units)
One-person face-to-face response: Unlicensed Bachelors/Certified Peer	4623	H2011	TS, HE	15 Minutes	Up to 90 minutes (6 Units)
Two-person face-to-face response: Licensed and Unlicensed Bachelors/ Certified Peer	4624	H2011	TS, SC	15 Minutes	Up to 90 minutes (6 Units)

Note: The unit limits for rate codes 4622-4624 are considered soft limits. Providers may exceed these limits; however, utilization beyond the soft limits should be medically necessary and is expected to be infrequent.

E. Modifier Definitions

Modifier	Modifier Definition
GT	Via interactive audio and video telecommunication services
HO	Master's degree level
TS	Follow-up service
HM	Less than Bachelor's degree level
HE	Mental Health Program
HK	Specialized mental health programs for high-risk populations
U5	Partial (state-defined)
SC	Medically necessary service or supply
ET	Emergency Services

F. Timed Units per Encounter of Service

Range of Minutes per Face-to-Face Encounter	Billable Minutes	Billable Units (15 Minutes per Unit)
Under 8 minutes	1-7 minutes	Not billable
8-22 minutes	15 minutes	1 unit
23-37 minutes	30 minutes	2 units
38-52 minutes	45 minutes	3 units
53-67 minutes	60 minutes	4 units
68-82 minutes	75 minutes	5 units
83-97 minutes	90 minutes	6 units
98-112 minutes	105 minutes	7 units
113-127 minutes	120 minutes	8 units