DEPARTMENT OF HUMAN SERVICES

Dec. 17, 2025

Frequently asked questions: Current procedural terminology (CPT) codes for Individualized Education Program (IEP) and Individualized Family Service Plan (IFSP) services

Important: The following information does not represent the entire Minnesota Health Care Programs (MHCP) policy for IEP or IFSP services or billing guidance for MHCP enrolled providers. Additionally, the content, language and requirements included in this document are subject to change. Providers should refer to the online MHCP Provider Manual as the primary information source for MHCP coverage policies, rates and billing procedures. The online MHCP Provider Manual is updated on an ongoing basis.

Quicklinks

Access and resources

1. **Where will the frequently asked questions (FAQs) be posted?**
   We will post the FAQs resource on the IEP resources webpage on the Minnesota Department of Human Services website.

Billing and coding

1. **When will an updated code list be available if new codes are added?**
   The code list will be updated periodically. Refer to the MHCP provider news and updates webpage for

announcements related code list updates.

2. **Will there be a final codes list? Or will codes continue to be added?**
   We will add codes on an ongoing basis.

3. **Will there be separate codes for services provided via telehealth?**
   Providers should continue to use the place of service (POS) code along with the appropriate CPT code for the service provided.

4. **Is there a rubric for determining what can be billed through DHS if the provided code list is not comprehensive? Or will it be case-by-case?**
   No, there is no rubric. The initial code list we sent on Sept. 15, 2025, in a memo dropped to provider MN–ITS mailboxes is only a preliminary resource. Providers should use their professional judgement when choosing a code to identify the service they are providing.

5. **Do we need to indicate the number of units billed for per CPT code?**
   Yes, providers need to indicate the number of units provided as they are doing currently.

6. **Can you use more CPT codes? This would be similar to how you can submit claims with several ICD-10 codes.**
   CPT codes describe what service or procedure the provider performed. ICD-10 codes describe why it was performed (the individual's diagnosis). Key rules for CPT coding include the following:
   - Use one CPT code if it fully describes the entire service provided.
   - Add more CPT codes only when distinctly separate services are provided.
   - Do not report multiple CPT codes to describe the same service. This is unlike using ICD-10 codes because multiple diagnosis codes are often appropriate for the same encounter.

7. **How do you log a service when more than one CPT code is appropriate?**
   All services provided must be accurately documented and reported on the claim. Reimbursement for services will be adjudicated to the first code.

8. **What does separate encounter mean? For example, what is a separate encounter for personal care assistance (PCA) services.**
   A separate encounter refers to a distinct service that is not combined with other services provided on the same day; it does not apply to PCA services. Each task or activity (toileting, transferring, eating and so on) is not considered a separate encounter. Continue to bill 1 unit per day per service type which is the current billing process.

9. **Why does nursing have a broad RN services code but audiology has dozens of codes?**
   The codes that represent each service are published by the American Medical Association (AMA).

10. **What services do not have codes?**
    Providers should use the appropriate CPT code for the service they are providing. We did not initially include Special Transportation codes. Those codes have been identified as T2003 + UA modifier for the transportation and T2001 in the case of an aide.

11. **Will codes such as T1013 (sign or oral language) be added for interpreter services?**
    We did not include codes that are remaining the same in the preliminary list. Interpreter services codes remain T1013.

12. **The special transportation code (T1018.U6TM) is missing. Will this code continue?**
    No. T2003 with a UA modifier will be used for Special Transportation. Use T2001 when an aide is involved.

13. **Will reporting annual rates, time and encounter data for fiscal year 2026 be according to service discipline or individual CPT codes?**
    The rate methodology has not changed. Rates are not based on service discipline or individual CPT codes. Please contact MN_DHS_RATES_IEP@state.mn.us for rates related questions.

14. **Is there a minimal time requirement (for example, private practice has a time requirement of eight minutes)? Is this true for schools?**
    Yes, this is also true for schools. 15-minute timed codes cannot be billed for services lasting less than eight minutes.

15. **Should providers use different codes if they see the same student in a group and individual setting?**
    All services provided must be accurately documented and reported on the claim. Reimbursement for services will be adjudicated to the first code.

16. **Which code should I use if I see a student who uses AAC and is also working on articulation?**
    Please refer to the initial code list we sent on Sept. 15, 2025, in a memo dropped to provider MN–ITS mailboxes. Additionally, providers should use their professional judgment when choosing a code to identify the service they are providing.

17. **How should I decide what code to use if I am evaluating a student who needs multiple codes (fluency and articulation)?**
    Please refer to the initial code list we sent on Sept. 15, 2025, in a memo dropped to provider MN–ITS mailboxes. Document each service provided and report the corresponding CPT code that best describes the service to the highest level of specificity. Providers should use their professional judgment when choosing a code to identify the service they are providing. If multiple services are provided, it may require additional CPT codes.

18. **Should all services provided for a discipline in one day roll up?**
    No. Document each service provided and report the corresponding CPT that best describes the service to the highest level of specificity. If multiple services are provided, it may require additional CPT codes be reported.

19. **What is the purpose of more specific procedure codes? How will the information be incorporated into claims?**
    Implementing commonly acceptable CPT coding for services allows the ability to track each individual service and allows DHS to collect useful data on the actual services provided by schools.

20. **Do providers still claim one unit if services are rolled up and claimed under one procedure code?**
    For evaluations: Log the start and end times of each evaluation activity and bill one encounter.
    For services: Document each service provided and report the corresponding CPT code that best describes the service to the highest level of specificity.

21. **Are distinct procedure codes rolled on the same claim if providers are not claiming one unit? For example, a student receives two OT services (97530 and 97110). Do providers submit these in one claim? How many units would it have?**
    Providers should document the start and end times and report the corresponding CPT codes on one claim. The number of units reported will depend on how long the service lasted (for time-based codes) or how many times the service was provided. Maximum units allowed per day will apply.

22. **How do providers choose which procedure code to submit?**
    Providers should use their professional judgment when choosing a code to identify the service they are providing. Document the service and report the CPT code to the highest level of specificity.

23. **Do we still need to apply the place of service codes?**
    The service code requirements remain the same and did not change with the addition of the CPT and HCPCS codes.

Modifiers

1. **We need more explanation of modifier 59.**
   Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-evaluation and management (E/M) services performed on the same day.

2. **Does modifier 59 apply to IEP billing when a student sees both speech and OT on the same day?**
   The use of modifier 59 is dependent on CMS NCCI procedure-to-procedure edits. NCCI defines when a modifier is allowed, or not allowed, when certain codes are billed together.

3. **Can we use modifier 52 for 92523 GN for a language-only evaluation?**
   Yes. 92523 with modifier 52 is correct for language only evaluations.

4. **Do we expect modifiers for SPLA/OTAs similar to those for mental health practitioners?**
   We do not. Therapy assistants cannot bill independently so their services should be billed under the supervising therapist's service specific CPT code with the appropriate modifier (GO, GP, GN).

5. **Is there a key for the modifiers? Which services do the modifiers apply to?**
   Yes, the key is included in the CPT code document.

6. **What is the order of modifiers on a claim submission?**
   The code list includes modifiers and the order to use them for claims submission.

Audiology

1. **Since prescription implies physician involvement, should schools use 92605 GN and 92606?**
   Providers should use their professional judgment when choosing a code to identify the service they are providing.

2. **Can additional CPT or HCPCS codes (for example, 92582, 92579, V5275, V5264, 92626, 92593, 92592, 92595, 92594, V5011) be added?**
   Yes, these codes have been added to the preliminary list DHS provided on Sept. 15, 2025.

3. **Why does audiology have so many options versus broader categories like OT?**
   Please refer to the initial code list we sent on Sept. 15, 2025, in a memo dropped to provider MN–ITS mailboxes. Additionally, providers should use their professional judgment when choosing a code to identify the service they are providing.

4. **How should documentation represent interpretation and report-writing because these services do not have codes?**
   Providers should refer to the initial code list we sent on Sept. 15, 2025, in a memo dropped to provider MN–ITS mailboxes that identifies CPT code 92620 for evaluation and report writing.

5. **Audiology includes the use of modifier 59. Typically, this modifier is used to designate a second billable service delivered in the same day. Is the expectation that audiology will allow billing of multiple claim lines per day?**
   Modifier 59 is used to indicate that a procedure or service was distinct or independent from other non-evaluation and management (E/M) services performed on the same day. All services provided must be accurately documented and reported on the claim. Reimbursement for services will be adjudicated to the first code.

Speech language pathology

1. **What code (92605 and 92607) for evaluation for prescription of a speech-generating device should be used?**

It depends on the individual needs of the student. One code is for the evaluation of non-speech generating device and the other code is for a speech generating device.

2. **Which codes should SLPs use?**
   It will depend on the individual needs of the student and the service being provided. Providers should bill codes that reflect the service being provided.

3. **What CPT code should a school social worker select when working on an evaluation summary report?**
   CPT code 90791 includes assessments and evaluations for mental health professionals or clinical trainees under the supervision of a mental health professional. All clinical trainees need the additional HN modifier.

4. **Can a speech language pathologist (SLP) diagnose?**
   Yes, an SLP can diagnose.

Documentation

1. **Can providers continue documenting in SpEd Forms after Sept. 30, 2025, if we are not ready for CPT or HCPCS codes? Or can providers track separately and enter at a later date?**
   Both vendors are aware of the changes and will be able to accept the new CPT codes. Providers should reach out to your vendor for their current timelines and processes. Additionally, continue documenting for all services provided during this transition.

2. **Will state forms be updated? Can you provide a link?**
   DHS will update the MHCP Provider Manual and forms as needed. We also recommend that providers monitor the MHCP provider news and updates webpage for updates and resources.

3. **How does CPT code-based logging overlap with billing? For example, testing fluency, voice, and speech in one session – Does a provider log that as one evaluation or multiple CPT codes?**
   In the given example, providers should use the evaluation code if these are part of the overall evaluation. Additionally, providers should log the start and end times of each evaluation activity and bill one encounter.

Evaluations

Complexity-based evaluations (low, moderate and high)

1. **Do these apply only to initial evaluations?**
   Schools are required to use complexity-based evaluation codes when seeking reimbursement for evaluations determined to be medically necessary. The level of complexity low, moderate, or high should be selected based on the provider's professional judgment and supported by appropriate documentation.

2. **Do they apply to both Part C and Part B?**2.
   Complexity-based evaluation codes apply to both Part C and Part B when the evaluation is determined to be medically necessary. Providers should use their professional judgment to determine the complexity level supported by appropriate documentation.

3. **Does complexity need to match across sessions if evaluations occur throughout multiple days?** The complexity level does not need to match across individual evaluation sessions or activities conducted on multiple days. Providers should determine the CPT code that best reflects the overall complexity of the completed evaluation.

4. **Do we compile all time in one entry? Or do we log each session separately?**
   Document start and end times for each evaluation activity and record total evaluation time at completion. The date of service for billing purposes is the date the evaluation is completed.

5. **Is interpretation and write-up time included? Or are interpretation and write-up time logged differently?**
   Interpretation and report-writing time are included as part of the evaluation. All evaluation activities including interpretation and documentation must have documented start and end times. The total time for all evaluation activities is recorded when the evaluation is complete and billed as one encounter.

Re-evaluations

1. **Does this apply to all Part B, three-year reevaluations?**
   Yes. The same documentation and billing requirements apply to all Part B and Part C evaluations and reevaluations. Each evaluation must include documented start and end times for all evaluation activities, with total time recorded upon completion. The evaluation is billed as one encounter on the date it is completed, using the professional's judgement to choose a CPT code that reflects the overall complexity of the evaluation.

2. **Is there differentiation between complexity levels?**
   Yes. Providers should use their professional judgment to determine the appropriate complexity level (low, moderate, or high) for each medically necessary evaluation. The selected CPT code should reflect the overall scope, intensity, and clinical reasoning of the completed evaluation and supported by the appropriate documentation.

3. **For OT or PT evaluations every three years, should providers use low, moderate, high complexity codes or re-evaluation codes?**
   Providers should use their professional judgment, according to their licensing standards, when determining which code is appropriate for each service being provided.

Implementation and timeline

1. **When will the Minnesota Department of Human Services accept the codes?**
   We are scheduled to accept the codes effective Dec. 8, 2025.

2. **Why couldn't the effective date be Jan. 1, 2026, instead of Oct. 1, 2025?**
   We do not have the full background on the timelines for this project. We appreciate the question and will share the concern with our managers.

3. **When will the Minnesota Department of Human Services process new claims after settle-up?**
   We are scheduled to accept the codes effective Dec. 8, 2025.

4. **How is MN–ITS planning to assist schools when multiple claims are denied?**
   We do not expect claims to be denied if they are submitted using the correct CPT code for the service provided. If claims are denied, providers should continue to follow the same process for resubmitting those claims or call the MHCP Provider Resource at 651-431-2700 or 800-366-5411 for assistance.

5. **Will there be a delay in private insurance denials?**
   We do not expect that the CPT codes requirement to impact this process.

6. **Do you know how insurance denials from private insurance companies will look like going forward?**
   We do not expect any changes to the requirement for private insurance company denials at this time.

Policy and coverage

1. **Will the new reporting direction impact a student's lifetime limits since we are using the same codes as medical institutions? Or are Medical Assistance (MA) claims exempt?**

   No, MA claims do not impact a student's lifetime limits. The following guidance from IEP Billing and Authorization Requirements in the MHCP Provider Manual remains the standard.

   Districts may not use a child's benefits if that use would:
   - Decrease available lifetime coverage or any other insured benefit
   - Result in the family paying for services that would otherwise be covered by the public benefits or insurance program and that are required for the child outside of the time the child is in school
   - Increase premiums or lead to the discontinuation of benefits or insurance
   - Risk loss of eligibility for home and community-based waivers, based on aggregate health-related expenditures.

   Refer to Individualized Education Program (IEP) Services or Individualized Family Services Plan (IFSP) Parent Brochure for more information.

2. **Will billing be blocked if a student receives outside services on the same day because schools use the same mental health codes as medical institutions? Or is this the exemption from NPI numbers?**
   Federal regulations ensure that when schools access federal Medicaid funds for health-related IEP or IFSP services it does not prevent a child from receiving needed services in the community. This means a student can receive and seek reimbursement for community-based services on the same day as an IEP or IFSP service. Schools use the district's organizational NPI number when they bill and that identifies the service as part of the student's IEP or IFSP.

3. **Do providers need to renew NPI numbers yearly or is there a different timeframe?**
   No, providers do not need to renew their NPI numbers annually. An NPI number is valid indefinitely once issued.

4. **Will schools need to credential or link those provider NPIs in MN–ITS to the school?**
   Yes.

5. **Will you have a link to access the NPI application?**
   To apply for the NPI number, refer to the National Plan and Provider Enumeration System (NPPES) (nppes.cms.hhs.gov/login) website. To enroll as an MHCP provider with DHS, refer to Individual Provider Enrollment Application (DHS-4016) (PDF) and Enrollment with Minnesota Health Care Programs (MHCP) in the MHCP Provider Manual for more information.

6. **Do schools need to renew NPI numbers every five years or just the providers as of right now?**
   No, neither schools or providers need to renew NPI numbers because NPI numbers do not expire. Schools must revalidate MHCP provider enrollment every five years.

7. **Can we bill for services starting at the beginning of the school year if staff provided services on Sept. 1, 2026, but didn't get their NPI number assigned until Sept. 15, 2026? Or would we bill for services when the NPI number is approved?**
   We will typically deny claims submitted for dates of service occurring before the NPI effective date.