Alameda County ac bh
Behavioral Health Care Services

MENTAL HEALTH & SUBSTANCE USE SERVICES

FREQUENTLY ASKED QUESTIONS:
CPT Codes

ACBH Quality Assurance Office

Last updated 9/6/2023

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General

1. **Will we still use InSyst procedure codes after 7/1/23?**

   No. Multiple unrelated transitions are occurring simultaneously on 7/1/23. 1) ACBH is implementing a new billing system, SmartCare to replace InSyst and eCura, and 2) DHCS is implementing "CalAIM payment reform." CalAIM payment reform is a significant overhaul of procedure codes used in both delivery systems (SMHS and DMC-ODS).

2. **Will ACBH continue to use HCPCs after 7/1/23?** *Updated 9/6/2023*
   Both CPT and HCPC codes will be available in each delivery system on 7/1/23. CPT codes will be used for outpatient clinical services provided by licensed professionals within their scope of practice. HCPCs will continue to be used for non-clinical services (e.g., rehabilitation) and by non-licensed staff.

   CPT codes must (mostly) follow the rules and requirements as specified in the American Medical Association (AMA) CPT Codebook. Rules and requirements for HCPCs can be found the DHCS billing manual for that delivery system. All providers must begin to familiarize themselves and educate their staff on the changes to procedure codes.

3. **How can we best prepare ourselves for the transition to CPT Codes?** *Updated 9/6/2023*

   There are multiple resources available for providers. Please note, many of the questions in this document are covered in the training programs noted in the first two bullets below. Providers are strongly encouraged to listen to these recorded trainings.

   - Begin by reviewing the ACBH CPT Code Training recording and/or reviewing the presentation deck. The recording is on the QA Training page of the ACBH Provider Website, in the section titled: **Current Procedural Terminology**. This training covers the CPT code basics and will answer many of your questions related to CPT codes and how they will be set up in SmartCare.
   - In the same section, ACBH has provided two Procedure Code Tables that list all available CPT codes in SmartCare, their descriptions and specific rules related to each. These are titled MH SmartCare Procedure Code Table Eff 7-1-2023 and SUD SmartCare Procedure Code Table Eff 7-1-2023. These documents are updated periodically as needed, therefore if the links don't work, please find them on the QA Training page in the section titled Current Procedural Terminology.
   - Listen to CalMHSA's training modules on their Learning page. The trainings are under their CalAIM Training section and are titled: **CPT Coding for Direct Service Providers (SMHS)** and **CPT Coding for Direct Service Providers (DMC and DCM-ODS)**
   - Review the **DHCS Billing Manuals for SMHS and DMC-ODS** posted on the MedCC Library page. Scroll down to CalAIM Manuals and References Effective July 1, 2023 to find the Short Doyle Medi-Cal Manuals for SMHS and DMC-ODS.

- Review the **CalAIM Reference Guide for CPT Codes for SMHS and DMC-ODS,** also posted on the MedCC Library page. Scroll down to CalAIM Manuals and References Effective July 1, 2023 to find the Short Doyle Medi-Cal References.
- The CPT Code book can be purchased on the American Medical Association's website and is the rule book for use of CPT codes.
- Attend Brown Bag meetings and other training/Q&A programs being offered by QA. Information regarding these can be found on the QA Training page.

4. **Will Community Based Organization (CBO) staff enter their services into SmartCare through CPT codes or will there be some sort of crosswalk?** *Updated 9/6/2023*

   CBO staff will enter services into SmartCare or Clinician's Gateway using CPT codes and HCPC codes as defined in the following DHCS Billing Manuals. ACBH has created two spreadsheets, MH SmartCare Procedure Code Table and SUD SmartCare Procedure Code Table that include all CPT codes available in SmartCare and relevant details for each code.

5. **Will ACBH provide a list of code descriptions along with role type?** *Updated 9/6/2023*

   Yes, the two Procedure Code tables noted above include information about which provider type can use the code. There are several hidden columns that provide additional information as well. We provided these lists as excel documents with filtering capabilities to assist providers in using that document. Additional information about disciplines can be found in both the SMHS and DMC-ODS Billing Manual.

6. **Where can I find the DHCS billing manuals online?**

   DHCS is posting all billing manuals and related documents on the DHCS MedCCC Library website, the URL is: https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx.

7. **Will all the codes described in the DHCS billing manuals be allowed for all providers?**

   No. Currently only certain codes are available for each program. Codes available for each program will continue to be consistent with the agency's provider contract. If there are codes in the billing manual your agency would like to add, please contact ACBH for discussion.

8. **Can providers use any codes not listed in the SMHS Billing Manual (i.e., will ACBH create any non-DHCS codes)?** *Updated 9/6/2023*

   Providers will still be able to claim for non -Medi-Cal billable services/codes, per their contract (e.g., Outreach (Mode 45), Supportive services (Mode 60), MAA (Mode 55), ACBH special non-billable codes, etc. The *Additional Service Code List* sheet on the SmartCare MH Procedure Code Table lists these codes.

9. **What do we do if there is conflicting information between ACBH guidance and what is in the CPT Codebook?** *Updated 9/6/2023*

Generally, CPT code rules are determined by the AMA (as described in the CPT Codebook). DHCS has indicated a few differences, such as only using *direct patient care* to determine time/units, even when the CPT Codebook indicates differently. Except in certain situations, the information provided by ACBH does not supersede AMA CPT coding rules. Please contact QATA@acgov.org to discuss confusing or conflicting information.

10. **Why is ACBH's list of locations different from DHCS/CMS's Place of Service (POS) list?**

    HCPC and CPT codes must be reported with allowable places of service. ACBH calls these Locations and has developed a county specific list. ACBH providers must use ACBH's list. SmartCare will automatically map ACBH locations to the official POS list when the claim is submitted.

11. **Will the daily rate increase if more than the minimum number of hours for full and half-day DR/DTI are provided?**

    For half-day services at least 3 units (hours) of services must be provided. For full-day services at least 4 units (hours) of services must be provided. The rate is per day and does not increase if additional hours are provided beyond the minimum required.

12. **Do SUD residential programs have to use CPT codes?** *Updated 9/6/2023*

    When ACBH is submitting services to Medi-Cal, SUD residential programs will continue to use HCPC H0019 as before for day claims. There will be differences from prior practices due to ACBH's consolidation of residential programs in SmartCare. Additionally, per statewide county feedback, DHCS has adjusted what services are paid via the residential per diem (or "bundle"). This means that care coordination, recovery services, MAT, clinician consultation, and peer services are all claimed and documented separately. In Clinician's Gateway, residential providers must use the *progress note single service* when documenting services not included in the day rate.

    See memo 2023-06 for more information.

13. **How are services claimed for beneficiaries who have both Medicare and Medi-Cal?**

    Often referred to as having Medi-Medi, claiming for these beneficiaries has not changed as a result of CalAIM or payment reform. Because Medi-Cal is the payer of last resort, it is not often known at the time of service or service documentation which insurance system will be billed. As a result, the higher standard between Medicare and Medi-Cal must be followed. This means that for beneficiaries who have Medi-Medi, treatment plans and other Medicare documentation requirements must continue to be completed.

14. **What activities are not billable to Medi-Cal/Medicare?**

    The following activities are not billable to Medi-Cal or Medicare:

    - Completing purely clerical activities including, but not limited to faxing, copying, leaving or listening to voicemails, reading or writing emails, scheduling appointments, filling out forms

- Completing CPS, APS, or Serious Incident Reports
- Completing coursework/homework or job-related activities
- Filling out SSI forms with or for the client
- Time spent driving in order to locate a client (e.g., locating a client who is currently homeless)
- Completing referral paperwork when connection to client's MH symptoms and impairments is not clearly documented
- Providing mental health services for someone other than the client
- Writing court reports or letters
- Documenting necessary information to a client's case discussed during supervision
- Any activity occurs after the client is deceased, including services to family members of deceased.

General Procedure Code Information

15. What are CPT codes?

CPT stands for Current Procedural Terminology. It is a standardized set of medical codes used by health care providers to describe the procedures and services they perform. Each procedure or service is identified with a five-digit code. Guidance on how to claim using CPT codes are determined by the American Medical Association (AMA). Information from the AMA can be found here: https://www.ama-assn.org/topics/cpt-codes.

16. Can ACBH provide clear and definitive descriptions for CPT codes that are unclear?

At this time ACBH is deferring code definitions to official guidance, such as the DHCS billing manuals and AMA CPT Codebook. There are a number of CPT coding resources and trainings available, such as www.aapc.com (not an official recommendation) and ACBH recommends providers utilize those resources.

17. May different services on the same day or different days for the same beneficiary be combined together and claimed at the same time? *Updated 9/6/2023*

No. One of the major changes with Payment Reform is the use of specific procedure codes for specific service activities. CPT code definitions are very specific and must only be used to claim for the code's specific service.

18. What current InSyst codes do not have clear replacements? *Updated 9/6/2023*

Currently we have no clear replacements for the following MH InSyst Codes:

- 317 Collateral Family Group
- 413 90846 Collateral FamCounseling
- 325 90889 Psy Diag Eval (non-face/face)
- 326 90889 Behav Eval (CFE, ANSA, CANS non face/face)

InSyst codes 325 and 326 are for non-face-to-face claiming of documentation time only. Claiming Medi-Cal for documentation will not be allowed after 7/1/23. See Documentation and Travel time section of this FAQ for more information.

For group services, we have asked DHCS and they have stated that the group modifier (HQ) will be added to SMHS codes H0034, H2014, and H2017.

MH Collateral (InSyst codes 310, 311, 317, 413, 614) is being reconceptualized and will be different than we currently understand it. See section on Collateral services.

19. **How do we enter two or more of the exact same type of encounter for the same beneficiary on the same day for the same provider in SmartCare?** *Updated 9/6/2023*

    ACBH has asked this question to DHCS and is awaiting a response. Until we hear back, please claim for distinct services separately.

20. **What does "Medicare COB" mean?**

    In the billing manuals, the column titled "Medicare Coordination of Benefits (COB) Required?" identifies the specific services that may be billed directly to Medi-Cal. If the Medicare COB Required column displays 'Yes' for a particular CPT or HCPCS code, the service is covered by Medicare. If the Medicare COB Required column displays 'No' for a particular CPT or HCPCS code, the service is not covered by Medicare. Medicare must be billed first when the Medicare covered services is rendered by a Medicare eligible provider.

21. **What location should be selected when a service is provided via telehealth, but the beneficiary is not present for that service?** *New 9/6/2023*

    In SmartCare select *Phone (patient not home)*. In the DHCS billing manuals, this is Place of Service (POS) 02.

Direct Patient Care

22. **What is considered Direct Patient Care?** *Updated 9/6/2023*

    From SMHS Billing Manual (page 185):

    - If the service code billed is a patient care code, direct patient care means time spent with the patient for the purpose of providing healthcare.
    - If the service code billed is a medical consultation code, then direct patient care means time spent with the consultant/members of the beneficiary's care team.
    - Direct patient care does not include travel time, administrative activities, chart review, documentation, utilization review and quality assurance activities or other activities a provider engages in either before or after a patient visit.

    From the DMC-ODS Billing Manual (page 63):

    DHCS policy states that only direct patient care should be counted toward selection of time. Direct patient care does not include travel time, administrative activities, chart review,

documentation, utilization review and quality assurance activities or other activities a provider engages in either before or after a patient visit.

ACBH providers should follow the CalMHSA guidelines for direct patient care.

23. Does "direct service" include activities like record review or preparing for group therapy? *Updated 9/6/2023*

No. Based on the DHCS descriptions, record review, preparing for group therapy, etc. is not considered direct patient care and cannot be included when determining direct service time.

24. CPT codes 99202-99215, allow for reporting of time that is not *direct patient care*. Do we follow the rules in the CPT codebook for determining time for these CPT codes or the definition of direct patient care from the billing manual? *New 9/6/2023*

DHCS has indicted that their rates were designed to include administrative and other non-direct care costs. For these codes, claiming for administrative costs already include. In these cases, DHCS rules override AMA CPT Codebook for these codes.

For all codes, provider must select the code based on how much time spent with the patient.

26. Should non-billable procedure codes be entered into SmartCare? *New 9/6/2023*

Providers should still enter non-billable time for activities or events ACBH has procedure codes for (e.g., no show) and are added to their specific program (aka RU). See the "Additional Service Code" tab of the MH SmartCare Procedure Code list on the Providers website, as it contains a list of the most common non-billable service and tracking codes.

Documentation and Travel Time

27. Will documentation and travel time continue to be reimbursed?

At least through FY23-24, ACBH will continue to reimburse providers separately for documentation and travel time. To do so, providers will,

- Select CPT codes based on Direct service time only.
- Enter the following fields in SmartCare and CG: 1) Start Time and Duration for Direct service ("face to face"), 2) Travel time and 3) Documentation time.
- Receive a monthly report, mimicking the current InSyst invoicing reports, from ACBH for all services (including documentation, travel, and face-to-face time) for the previous month.
- Use the report to bill ACBH for documentation and travel time.

28. How will travel and documentation time will be entered in SmartCare?

Travel time and documentation time must be maintained in the EHR or patients chart documentation. There will also be distinct fields in SmartCare and Clinician's Gateway to enter

travel time and documentation, along with the service time when entering services directly into SmartCare. That information will be used for provider invoicing and payment calculation purposes. See *Current Procedural Terminology* training on the QA Training page for more information regarding documenting these services.

29. **What activities are considered documentation time?** *Updated 9/6/2023*

    Documentation time is the time spent completing any documentation (progress notes, assessments, care plans, safety plans, etc.) for the beneficiary's medical record.

30. **What is the difference between travel time and transportation?**

    Travel time is the time the staff spends traveling to meet the beneficiary in the community and back to the office. Travelling between agency offices is not travel time. Transportation refers to transporting a beneficiary from one location to another and is not considered travel time. Transportation time is only claimable in the SUD system and when specifically provided to coordinate care.

31. **Is concurrent documentation (therapy + documentation completed in a session as a clinical intervention) considered documentation time or service time?** *New 9/6/2023*

    If documentation is occurring concurrently with therapy, the time claimed should be for the duration of the therapy. These concurrent services would be considered therapy (service time) e.g., direct patient care."

Time and Units of Service

32. **What time is considered when reporting or selecting a code?** *Updated 9/6/2023*

    When determining the time for code selection, time spent providing *direct patient care* will most commonly be used. Activities such as travel or documentation time, should not be considered when selecting the CPT or HCPC or for the time used to determine the number of units that will be claimed to Medi-Cal.

33. **In SmartCare what is the difference between Face-to-Face Time and Total Duration Time?** *Updated 9/6/2023*

    Total Duration is the time SmartCare will use to determine the number of units to report for the CPT or HCPC code. Since only direct service time (face-to-face) can be billed to the State, unless an Add-On code is added, *Total Duration* time always equals *Face-to-Face* time. When an Add-On code is added, *Total Duration* is the time used to calculate the number of units for the primary code, which will be different than the actual face-to-face time. See slide 27 of the Current Procedural Terminology training deck for an example.

34. **Why do codes with a time range have the same name in SmartCare (e.g., 99202-99205)?**

This was set up in this way to simplify the user experience. For codes with a time range, providers choose the combined code and direct service time (duration and face-to-face) and SmartCare will choose the correct code based on the time entered.

35. Can we always use the midpoint rule for code selection? *Updated 9/6/2023*

No, the midpoint rule applies to some codes and not others. An example of a code that uses the midpoint rule is, T1017 Targeted Case Management, 15 minutes. CPT codes that begin with 90* also follow midpoint rules. For codes that follow midpoint rules, the code can only be reported once the midpoint is reached, for T1017 this is once 8 minutes of direct (face-to-face) service is provided. Codes with a time range like 99212-99215, require the service to be within the specific time indicated by the code. Other codes like 99366-99368, indicate they are for services "30 minutes or more."

The MH SmartCare Procedure Code Table and SUD SmartCare Procedure Code Table were set up to assist with this. Column K provides the range of time associated with the code.

36. Does the midpoint rule apply to HCPCs?

Yes, midpoint rules apply to HCPCs as well.

37. What are "Maximum Units"?

Although CPT codes are entered into SmartCare using minutes of time, they are claimed to the State by ACBH using units. Maximum units are the maximum units of service that can be claimed on a service line for the specific outpatient procedure. For example, if a code description allows for a service of up to 15 minutes and a maximum of one unit per day, only one 15-minute service can be claimed using that code, unless an add-on code is used.

Modifiers and Lockouts

38. What are modifiers?

According to the DHCS billing manuals, "Modifiers provide a way to report or indicate that a service or procedure performed was altered by some specific circumstance but not changed in its definition or code. Modifiers will not impact how much a service is reimbursed but may impact how a service should be billed and/or who pays for the service. There are some instances (such as lack of an over-riding modifier) when lack of a modifier will cause a service code to be denied."

39. How does ACBH use modifiers?

Modifiers are built into the SmartCare procedure codes and providers do not need to select any. However, as providers are reviewing the DHCS billing manuals, Modifiers can help to understand procedure codes better.

40. Can ACBH provide a list of all the modifiers we are expected to use and how will modifiers be applied?

    Most of the Modifiers will initially be applied by the use of unique procedure codes in SmartCare and we are working with the SmartCare vendor to develop a system prompt on the service screen(s) for users to indicate the appropriate Duplicate override modifier. We are also planning to develop future automation to add Modifiers during claim submission, that will not require the use of unique procedure codes.

41. What are lockouts?

    Some codes cannot be billed on the same day, others can only be billed on the same day when certain conditions are met. These are called lockouts. In the billing manual and ACBH code tables, codes that cannot be billed on the same day as other codes are listed in the *Lockout Codes* column.

42. Does SmartCare include logic to enforce lockout rules? *New 9/6/2023*

    Not at this time. Providers will need to be mindful of lockouts and build logic into their EHRs. This feature may be added to SmartCare in the future.

Dependent-On Codes

43. What does it mean that some codes are dependent on other codes?

    These are procedures that either indicate that time has been added to a primary procedure (i.e., add-on codes) or modify a procedure (i.e., supplemental codes). Dependent-On procedures cannot be billed unless the same provider first bills for a primary procedure, on the same day and same claim, for the beneficiary.

44. Can G2212 be used as an add-on code for any codes?

    G2212 may only be used for codes that do not have a designated add-on code. For codes that have a designated add-on code, only the designated add-on codes can be used.

45. Does G2212 only apply to Evaluation/Management codes?

    G2212 applies to codes that do not have a dedicated add-on code and to an E/M code that is at the end of the series (has longest time associated with code).

46. Do you have to provide at least 8 minutes of G2212 to be able to claim G2212? *Updated 9/6/2023*

    Yes, in order to claim one unit of G2212, you must have provided at least 8 minutes of service. Starting in FY24-25, per CMS rule change, G2212 can only be reported when 15 minutes of time is reached.

47. How will Add-ons be applied in SmartCare?

On the SmartCare service entry screen, there are fields at the bottom of the screen to enter add-on codes to that service. See Current Procedural Terminology training on the QA Training page for more details.

48. Can multiple Add-on codes be used for the same service?

Yes, if conditions of both Add-on codes are met.

49. What are Existing 24-Hour and Day Codes and how are they used?

Some codes previously used in SMHS and DMC-ODS for 24-hour and day services that claim per day will continue to be used after 7/1/23. Examples of this include some inpatient services, residential DR/DTI, CSU, TFC, NTP/OTP services, etc. All of these codes are HCPCs.

Specific Procedure Code Information

50. How do we claim for a 90-minute psychotherapy session?

90837 for 60 minutes + G2212 for 30 minutes = 90 minutes

51. What procedure codes can be used when the beneficiary is not present for a service?

As a general rule, most CPT codes require that the beneficiary be present for the service. However, some CPT codes specifically say or imply that the beneficiary is not present for the service and those codes can be used as described. HCPCs appear to have a bit more flexibility and some can be used when the beneficiary is not present. Due to confusion around this, counties have asked DHCS to clearly identify codes that can only be used when the beneficiary is present. Also see the answer to question about Collateral services.

52. What CPT codes can be used for case consultation?

A number of codes are present in the billing manual for medical case consultation and can be used by medical providers for this purpose (see codes 99242, 99243, 99244, 99245, 99252, 99253, 99254, 99255). Additionally, a few codes are available for use when the beneficiary or their family members are not present (see codes 99367, 99368). If the consultation is a service to refer, link, or monitor a beneficiary's use of additional services, then it may be that case management codes may apply.

Note that if the service code billed is a medical consultation code then, per the CPT codebook, direct patient care means time spent with the consultant/members of the beneficiary's care team.

53. Will there be a way to bill for time spent completing the CANS, not in the presence of the client/caregiver? In other words what will replace the 326-90889 (CANS Evaluation, not face-to-face) code?

There is no code to claim documentation on it's own. You cannot do a CANS alone and claim it without a face to face service.

54. Can ACBH provide concrete definitions of what can be billed under case management, assessment, and plan development?

Payment reform will not change definitions of MH or SUD services. What is changing is the codes that used to claim for these activities. For SMHS the changes are comparatively minimal (to DMC-ODS) because the DMC-ODS system only previously used HCPCs. Because SMHS also claims to Medicare, many SMHS services already have corresponding CPT codes.

Definitions of services for each delivery system can be found in the SMHS Billing Manual (v 1.4) Section 4.1.1 (page 12) and in the DMC-ODS Billing Manual (v 1.3) in Section 4.1 (page 17). For DMC-ODS additional information about services can be found in BHIN 23-001.

Providers may only claim SMHS and DMC-ODS for the defined services in each delivery system and chose the best code to describe the services provided. If an activity or intervention is provided that does not have a corresponding code, then claiming to SMHS or DMC-ODS for time spent is not billable.

55. In the SMHS billing manual, HCPC H2011 appears in both Service Table 2 and Service Table 4 with different information. Is that an error?

No. H2011 can be used to claim both Community-Based Mobile Crisis Services and Crisis Intervention Services. The Community-Based Mobile Crisis Service is a new service added by DHCS to the State Plan effective 1/1/23 (SPA 22-0043) and has yet to be implemented by ACBH.

56. Can we use CPT 90885 to bill for reviewing a chart prior to a session?

No. 90885 is an assessment code and is used specifically when reviewing records from external agencies for the purpose of making a diagnosis during the assessment process.

57. How do we claim for a psychotherapy session that is longer than 75 minutes?

Psychotherapy is claimed using a series of codes (e.g., 90832-90838) that have specific time ranges built into each code.

- 90832/90833 (30 minutes) = 15 – 36 minutes of direct patient care
- 90834/90836 (45 minutes) = 37 – 52 minutes of direct patient care
- 90837/90838 (60 minutes) = 53 – 67 minutes of direct patient care

To extend psychotherapy beyond 67 minutes, the G2212 code must be used, but it is only acceptable to use G2212 on the last code in this series. G2212 requires at least 8 minutes of direct patient care (midpoint of 15 minutes), so if the therapy service provided is at least 75 minutes long (67 minutes of 90837 + 8 minutes of G2212), you can use 90837 and extend that time using G2212.

58. 90839 (Psychotherapy for Crisis) is not allowed via telephone or telehealth. This service used to be allowed with telehealth/telephone. Is it an error?

No, this is not an error. In 2023, The American Medical Association provided guidance that this code may be delivered via audio. However, DHCS has determined that this code cannot be delivered via telephone or telehealth. When billing for crisis intervention that is provided via telehealth use H2011.

59. How do we use the psychotherapy for crisis codes (90839 and 90840), do they codes follow the same rules regarding time as other codes? *New 9/6/2023*

The psychotherapy for crisis codes (90839/90840) have unique rules, please refer to the CPT Codebook for full guidance. Use 90839 (Psychotherapy for Crisis, First 30-74 minutes), to report the first 30-74 minutes. Code 90840 is used to report additional blocks of time of up to 30 minutes beyond the first 74 minutes. Unlike other CPT codes that start with 90*, the midpoint rule does not apply for these codes. Also, psychotherapy crisis services lasting less than 30 minutes should be reported with the standard psychotherapy codes.

Let's consider three examples:

1. 25 minutes of crisis psychotherapy services were provided:

   Since this service is less than 30 minutes, use 90832 (Psychotherapy with Patient, 30 minutes). This is allowed because 25 minutes is more than the midpoint of 30 minutes.

2. 70 minutes of crisis psychotherapy services were provided:

   Since this service is more than 30 minutes, but less than 74 minutes, use 90839 (Psychotherapy for Crisis, First 30-74 minutes).

3. 130 minutes of psychotherapy for crisis was provided:

   Since this service is longer than 74 minutes, use both 90839 and 90840. Specifically, you would use 90839 for 74 minutes of Direct Patient Care, and 90840 for the additional 56 minutes of Direct Patient Care.

60. How do we bill for group preparation and chart reviews in preparation for a session?

According to DHCS, preparation for therapy sessions is not billable using CPT or HCPCs.

61. What procedure codes can SUD providers use to claim for patient education services?

According to the DHCS DMC-ODS Billing Manual, H2014 Skills Training and Development, should be used when claiming for patient education services.

62. What procedure codes can SUD providers use to claim for completing the ASAM assessment?

According to the DHCS DMC-ODS Billing manual G2011, G0396, and G0397 are to be used when completing an ASAM criteria assessment.

63. How will SUD providers distinguish between the two types of care coordination activities in the SUD system? *Updated 9/6/2023*

Prior to 7/1/23, ACBH had two care coordination codes for each LOC. They were case management: care coordination and case management: service coordination. Case management: care coordination was used when claiming for care coordination activities within the ACBH SUD network. Case Management: Service Coordination was used when claiming for care coordination activities with a provider outside of the ACBH SUD Network.

After 7/1/23, outpatient SUD providers should use T1017 Targeted Case Management in place of Case Management Care Coordination and H2021 Community-Based Wrap-Around Services in place of Case Management: Service Coordination. SUD providers may also use the other identified care coordination codes as defined in DHCS' DMC-ODS billing manual.

64. How do SUD providers claim for recovery services?

The definition of recovery services has changed significantly from when the DMC-ODS was first implemented in Alameda County in July of 2018 (see DHCS BHINs 21-020 and 23-001). Recovery services is no longer a distinct level of care (LOC), beneficiaries no longer require a SUD remission diagnosis, recovery services can be provided at all SUD LOCs, it can be provided as a standalone service, it can be provided concurrently with other SUD services, and it is no longer only an aftercare service. After 7/1/23, there will be two primary codes for recovery services at outpatient LOCs:

- H2015 Comprehensive community support services, per 15 minutes
- H2017 Psychosocial rehabilitation, per 15 minutes.

See this FAQ for information about standalone SUD services.

65. What are standalone SUD services?

Standalone SUD services are ones that can be provided when no other SUD services are being provided. Only Recovery Services, Peer Support Services, Care Coordination, and MAT/Medication Services may be provided as a standalone service, when clinically appropriate. If a beneficiary is appropriate for a standalone SUD service, providers should admit the beneficiary to the assessed ASAM LOC and use procedure codes for that LOC. Standalone services are only available at non-OTP outpatient programs at this time. If a beneficiary is receiving services at a residential program and requires standalone services, they should be discharged from the residential program and referred to a non-OTP outpatient LOC.

66. What are Community-based Wrap-Around Services?

Community-based wrap around services (HCPC H2021) refers to coordination of care between providers in either the SMHS or DMC-ODS system and providers who are outside that delivery system. For example, use H2021 to claim for a care coordination service between a DMC-ODS provider and a non-DMC-ODS provider. For other kinds of coordination, other codes in Service Table 8 may be used.

Collateral Services and Interactive Complexity

67. Can we use Interactive Complexity for some collateral support at the end or beginning of a session?

Codes can only be used as described in the billing manuals and AMA CPT Codebook. If the support to the caregiver meets the definition of Interactive Complexity than it may be used on allowable codes. Note that for many CPT codes that allow the interactive complexity add-on, including therapy, the time spent without the beneficiary present is not considered as direct patient care or for code selection. Interactive Complexity does increase the reimbursement rate of the service.

68. Can Interactive Complexity (90785) and Sign language or Oral Interpretation (T1013) be claimed together? *New 9/6/2023*

No. These codes cannot be claimed together, please choose the one that best fits the service.

69. Can SUD providers continue to claim for services when working with a beneficiary's collateral supports?

Yes. Collateral was removed as a distinct service component in DMC-ODS on 1/1/22 and there are no longer distinct collateral procedure codes. However, services provided to beneficiaries' significant support persons (when related to the beneficiary's treatment), are still reimbursable. SUD providers may use several codes, including assessment, individual counseling, rehabilitation, and family therapy. Note that most CPT codes require the beneficiary to be present for the service unless the code specifies otherwise.

70. Other counties have published draft guidance on some CPT coding, including to address collateral services. Has ACBH reviewed and considered that guidance? *Updated 9/6/2023*

Per ACBH Memo 2023-46, although collateral services can't be billed as a standalone service, they can be a component of many types of services, including but not limited to, Assessment, Rehabilitation, Plan Development, Peer Support, Targeted Case Management, Crisis, or Therapeutic Foster Care. Providers should select the service code that most closely fits the service provided and make clear in a Progress Note that the service was provided to a collateral contact. Note that some procedure code descriptions clearly describe the service as occurring with the client present. Those procedure codes should not be selected for collateral sessions.

SUD collateral has largely been eliminated (see BHIN 23-001 and the DHCS CalAIM FAQ) and services to support persons may be provided using other available procedure codes (e.g., individual counseling).

71. How can Interactive Complexity be used and billed?

Please refer to the DHCS billing manual information on *interactive complexity*, it may be used as described. A full definition of *interactive complexity* is available in the billing manuals and in the CPT Codebook.

72. Can we use the APA one-page guideline on Interactive Complexity?

Officially the definition of *interactive complexity* (CPT 90875) comes from the AMA CPT Codebook. All codes need to follow AMA guidance for the corresponding year of the claim. ACBH strongly recommends all agencies purchase the official AMA CPT Codebook for specific guidance on CPT coding. That being said, there are a number of resources on CPT coding, including from the APA that may be used as long as it is consistent with official guidance.

Group Services

73. What codes can be used to claim group services?

In both delivery systems, some codes are individual only (e.g., 90791), some are group only (e.g., 90849), and some can be both for individual and group services (e.g., H2014). If a code is both an individual or group code, modifier HQ needs to be applied when used as a group service. Group only codes do not require the HQ modifier. DHCS is updating the billing manuals to be more clear about group codes and in SmartCare ACBH will have distinct codes for all group services.

74. How do we enter the time in for group services in SmartCare?

In the SmartCare service entry screen, enter in the actual group time in minutes. For documentation time, enter only the documentation time for that beneficiary. For travel time, enter only the beneficiary's portion, such as the total round trip time divided by the total number of group participants, or only enter total travel time but just on one beneficiary's service.

For example, a group of 5 people is from 9am to 10:30am. The clinician travelled 60 minutes round trip and writing this beneficiary's note took 15 minutes. For this example, enter the following in the various time fields:

Face-to-Face/Duration: 90 minutes
Travel: 12 minutes (report on all beneficiaries' claims)
Documentation: 15 minutes

OR
Face-to-Face/Duration: 90 minutes
Travel: 60 minutes (only report on one beneficiary's claim)
Documentation: 15 minutes

Telehealth

75. What Location Codes should be used if providing Collateral sessions remotely without the beneficiary present? *New 9/6/2023*

Location/Place of Service Codes are allowable places where services can be performed. The DHCS Billing manuals has a long list of Place of Service Codes and their descriptions (see Table 2 of the SMHS Billing Manual). ACBH does not use the official DHCS/CMS Place of Service

(POS) code but uses a custom list. The list can be viewed in the Place of Service/Location Codes tab in the Procedure Code Table document. Column D maps to the official list and there are definitions of each of those POS/Locations.

When services are provided in-person, both individuals are in the same place and the most accurate POS/location should be selected. This applies to all services, including collateral.

If the service is being provided via telephone or telehealth, then there are four ACBH options:

- Phone (audio only) – Patient not at home or not present
- Telehealth (audio/video) – Patient not at home or not present
- Phone (audio only) – Patient at home
- Telehealth (audio/video) – Patient at home

When a service is provided via telephone or telehealth and a beneficiary is not present, the provider should use the appropriate "patient not at home or not present" options.

76. Does Medi-Cal allow out-of-state providers to render services via telehealth? *New 9/6/2023*

Per DHCS, a licensed health care provider rendering Medi-Cal covered benefits or services via a telehealth modality must be licensed in California, enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP), and affiliated with an enrolled Medi-Cal provider group. The enrolled Medi-Cal provider group for which the health care provider renders services via telehealth must meet all Medi-Cal program enrollment requirements and must be located in California or a border community.

A person who is licensed as a health care practitioner in another state and is employed by a tribal health program does not need to be licensed in California to perform services for the tribal health program in California or a border community.

Other helpful telehealth resources: BHIN-23-018, Telehealth Consent Requirements

Interpretation

77. When a provider speaks to the beneficiary in the beneficiary's native language (non-English), can the provider claim T1013 (interpretation)?

No, a claim for interpretation (T1013) should not be submitted if the provider delivers treatment and communicates information to the beneficiary in the beneficiary's language.

78. When oral or sign language interpretation (T1013) be used? *Updated 9/6/2023*

A claim for interpretation can be submitted when the provider and the patient cannot communicate in the same language, and the provider uses an on-site interpreter and/or individual trained in medical interpretation to provide medical interpretation. Interpretation time may not exceed the time spent providing a primary service. For example, if a therapy session lasted 45 minutes, a maximum of three units of T1013 may be claimed.

79. Can residential and inpatient programs claim for T1013? *Updated 9/6/2023*

No, interpretation is included in the residential rate. Interpretation may not be claimed during an inpatient or residential stay as the cost of interpretation is included in the residential rate in the Drug Medi-Cal (DMC) or Specialty Mental Health (SMH) systems.

80. Can interpretation (T1013) be claimed when using a third party (e.g., language line, relay service) for interpretation? *New 9/6/2023*

No. T1013 cannot be claimed for automated/digital translation or relay services.

Scope of Practice

81. Why are taxonomy codes important?

In short, taxonomy codes help to ensure that the provider making the claim has the scope of practice to do so. DHCS uses the first four (4) characters of the rendering provider's taxonomy code to verify that the rendering provider is eligible to use the procedure code. DHCS will deny all service lines where the first four characters of the rendering provider's taxonomy code are not allowed for the procedure code. Additional information is available in DHCS's SMHS and DMC-ODS billing manuals.

82. Can a provider have multiple taxonomy codes in SmartCare? *New 9/6/2023*

SmartCare currently only allows one taxonomy code per provider. If a provider meets criteria for multiple taxonomy codes (e.g., has multiple licenses), please select the taxonomy code for the role they were hired and/or the code that will allow the most amount of services.

83. The billing manuals do not include taxonomy codes for all staff types, in those situations what should we do? *Updated 9/6/2023*

At this time we are awaiting further guidance from DHCS. Some information is provided for the following disciplines:

MHRS – Use one of the taxonomy codes specified for *MHRS* in the Appendix 1-Taxonomy Codes section

Other Qualified Provider: Use one of the taxonomy codes specified for *Other Qualified Provider* in the Appendix 1-Taxonomy Codes section

BBS Registered Staff: No clear taxonomy codes are present in the billing manuals. DHCS is aware of this issue and will provide additional information.

SUD Counselors: Taxonomy codes beginning with 101YA may be used for SUD Counselors.

84. In SMHS, what procedure codes can all, including non-licensed, practitioners use?

- H2000 Comprehensive Multidisciplinary Evaluation, 15 minutes
- H2011 Crisis Intervention Service, per 15 minutes

- T1017 Targeted Case Management
- H2017 Psychosocial Rehabilitation, per 15 minutes
- H2021 Community-Based Wrap-Around Services, per 15 minutes

85. In DMC-ODS, what procedure codes can all, including non-licensed, practitioners use?

In DMC-ODS all providers must either be a Licensed/Registered/Waivered LPHA, Licensed/Certified/Registered SUD Counselor, or Certified Peer Specialist. Individuals who do not fit into one of these categories are not able to claim for any DMC-ODS services.

86. What procedure codes can MHRS's use?

MHRS's can use the following codes: H2000 (eval), H2011 (crisis), H0031 (MH assessment), H0032 (MH plan), H2019 (TBS) and add-on codes: 90875 (interactive complexity) and T1013 (interpretation).

87. What procedure codes can MH graduate students use to claim for MH services? *Updated 9/6/23*

Students can currently bill SMHS Medi-Cal using several codes including assessment, rehabilitation, care coordination, and crisis services. ACBH has created codes specific to MH graduate student for individual, group, and family psychotherapy. These are available on the most recent version of MH Procedure Code Table posted on the QA Training page in the *Current Procedural Terminology* section. Providers will be notified once we receive additional guidance from DHCS. See ACBH memo 2023-50 for more information.

88. How do MH graduate students claim for services with DMC-ODS?

For DMC-ODS, per CA Assembly Bill 1860, Ch. 523, CA Health & Safety Code 11833, and DHCS BHIN 23-008, graduate students are allowed to provide services within the DMC-ODS system, however the current version of the DMC-ODS does not address students clearly. ACBH has several questions into DHCS about this matter and is awaiting a response.

89. Can a MH graduate student provide therapy and claim it as rehabilitation?

No. All procedure codes claimed must be for the activity that is actually provided. It would be considered fraudulent to conduct one activity but claim it as a different code to avoid procedure code staff designations.

90. In the DMC-ODS, what procedure codes can Certified Peer Support Specialists use?

- H0025 Behavioral Health Prevention Education Service, delivery of service with target population to affect knowledge, attitude, and/or behaviors (use for Educational Skill Building Groups)
- H0038 Self-help/peer services, per 15 minutes (use for Engagement and Therapeutic Activity)
- H0050 Alcohol and/or Drug Services, brief intervention, 15 minutes (Use for Contingency Management services)

91. How does a registered or waivered provider claim for services?

An unlicensed (but registered or waivered provider, e.g., AMFT) essentially has the same scope of their licensed supervisor and the individual whose license they are working under. In the new DHCS billing manuals, these staff are described as interns and claims must be submitted along with modifier HL. SmartCare will automatically add this modifier to appropriate claims.

92. What staff designations/taxonomy codes should waivered staff use?

Waivered clinicians should use the taxonomy code most appropriate to the licensed/registered professionals of their desired credential. Additional information about professional licensing waivers can be found on the DHCS PLW website.

Opioid Treatment Programs (OTPs)

93. Can OTP claims include documentation and travel time after 7/1/23?

Like other DMC-ODS services, OTPs are allowed to include documentation time on claims. Travel time, however, is not allowed for OTPs because per licensing rules all OTP services need to occur either on-site, or via telehealth.

94. After 7/1/23 how will OTP services be claimed?

ACBH is still working with DHCS to understand claiming for rendered services at OTPs after 7/1/23. It is clear that some aspects of claiming will stay the same and other aspects will be changing. According to the new DHCS DMC-ODS Billing Manual (v 1.3) H0020, S5000, and S5001 are all considered day services and should be used to bill for administration of Methadone and other medications in an NTP setting. Some OTP services are considered components of H0020, S5000, S5001, however, counseling, care coordination, and recovery services should be billed separately. V 1.4 of the DMC-ODS billing manual will include updated guidance on how to bill for OTP services.

95. There are many procedure codes in the DMC-ODS Billing Manual that accept the OTP/NTP modifiers (UA and HG), however several of these codes do not seem consistent with the definition of the NTP level of care. Is it accurate that all codes with UA, HG modifier can be used at OTP/NTPs or will those modifiers be removed from some of those codes in version 1.4 of the DMC billing manual?

DHCS is aware of this issue and will be re-evaluating the codes that currently can and cannot take the UA and HG modifiers after July 1, 2023.

96. Will the CPT change apply to OTP providers?

Billing for NTP/OTP services will continue to use some of the same codes and follow the same rules (e.g., for dosing/administration), but new and other codes will be added to NTP/OTP contracts. NTP/OTPs like other Medi-Cal services will be required to use additional more specific procedure codes and claiming rules as specified in the DHCS DMC-ODS billing manual. It does appear that NTP/OTPs will be required to use CPT coding when applicable, but further clarification from DHCS has been requested by counties.

97. What procedure code do OTPs use for medical psychotherapy?

The DMC-ODS manual states, “Medical Psychotherapy is a counseling service conducted by the medical director of a Narcotic Treatment Program on a one-to-one basis with the beneficiary” (p.19). Therefore, H0004:UA:HG would be appropriate.

98. May Licensed Vocational Nurses (LVNs) provide services at OTPs? *New 9/6/2023*

DHCS has not designated LVNs as a provider discipline in DMC-ODS at this time. However, LVNs are allowed to provide dosing services at OTPs due to the way the OTP dosing bundle is designed.