

# Transition from MHSA to BHSA: SMHS Procedure Codes (CPT & HCPCS Codes) Part 1

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# TOPICS



- Early Intervention Model Basics
- A (Very) Brief Introduction to Outpatient Specialty Mental Health Services (SMHS)
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- Understanding SMHS Lockout Rules
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- Demo
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# Early Intervention Model Basics

# What is Changing?

- Effective July 1, 2026, the Mental Health Services Act (MHSA) transitions to the Behavioral Health Services Act (BHSA).
- Prevention and workforce responsibilities are shifting from counties to the State.
- Counties must establish and administer **Early Intervention (EI)** programs.
- **90%** of the population served must have **Medi-Cal** or be **Medi-Cal eligible**.



# Early Intervention Model under BHSA

- An Early Intervention program must include the following components:
  - 1) **Outreach** ← billable to MAA
  - 2) **Access and Linkage to Care** ← billable to SMHS
    - Screening
    - Mental Health Consultation (must be connected to a client)
    - Cultural Supports (known as Prevention Visits in the old EI model)
  - 3) **Mental Health Early Treatment Services and Supports** ← billable to SMHS
    - Mental Health Treatment Services
    - Case Management/Brokerage
    - Crisis Intervention
    - Peer Support



# A (Very) Brief Introduction to Outpatient Specialty Mental Health Services (SMHS)

# Outpatient SMHS Services

DHCS defines a set of services that make up Specialty Mental Health Medi-Cal. **Only SMHS services may be claimed to SMHS Medi-Cal.**

Detailed definitions of the different SMH services can be found in several locations:

- [ACBHD QA Manual, Section 12-1](#)
- [DHCS SMHS Billing Manual](#)
- [CA State Medicaid Plan, Section 3, Supplement 3 of Attachment 3.1-A](#)

## Relevance to Procedure Codes

- Procedure codes are used to claim medically necessary SMHS services to its members.
- If a service is allowed by SMHS, Medi-Cal has certified your program to provide it, ACBHD has contracted with your program to provide it, and it is medically necessary for the treatment of the member then that service may be claimed using the most specific procedure code possible.

# Common Outpatient SMH Services\*

- **Assessment**
- **Crisis Intervention**
- **Intensive Care Coordination (ICC)**
- Intensive Home-Based Services (IHBS)
- Medication Support Services
- Mobile Crisis Services
- **Peer Services**
- **Treatment Planning Psychosocial Rehabilitation**
- **Referral/Targeted Case Management**
- Therapeutic Behavioral Services (TBS)
- **Therapy**
- 24-Hour and Day Service
  - Adult Residential
  - Crisis Residential
  - Children's Crisis Residential
  - DR/DTI

Not all programs are contracted to provide all SMH services. The ones in **bold** are most likely for EI programs.



\*not a complete list

# Medi-Cal SMHS Procedure Codes and Claiming: Getting Started

# Getting Started

To understand how and what to claim to SMHS Medi-Cal, providers will need...

- To know the SMHS Medi-Cal allowable services and their definitions.
- To understand scope of practice rules and what services can be claimed by what type of provider.
- To know the procedure codes available and where to find the specific rules for those codes.
- To understand ACBHD specific SMHS implementation.



# Provider Billing & Coding Guidance

- This training is an introduction to key concepts related to Healthcare Common Procedure Coding System (HCPCS) Level I and II coding.
- Providers may only claim for services in accordance with their ACBHD contract and Medi-Cal certification.
- Providers may claim for non-Medi-Cal billable services, per their contract [e.g., Outreach (Mode 45), Supportive services (Mode 60), MAA (Mode 55), ACBHD special non-billable codes, etc.].



# HCPCS & CPT Code Definitions

**HCPCS Codes (Healthcare Common Procedure Coding System)** is a standardized coding system for billing and reporting healthcare services and items.

**There are two levels of HCPCS codes used in SMHS Medi-Cal:**

## HCPCS Level I: CPT Codes (Current Procedural Terminology)

- Covers medical, surgical, and diagnostic procedures
- Maintained by the [American Medical Association](#) (AMA)
- **Primarily used by LMHPs**
- Format: Numeric, usually 5 digits (e.g. 90791)
- In this training these are called CPT codes

## HCPCS Level II

- Covers non-physician services, supplies, & equipment not covered by CPT codes
- Maintained by CMS (Centers for Medicare & Medicaid Services)
- **Used by both LMHPs and non-licensed staff**
- Format: Usually starts with a letter followed by 4 numbers (e.g. H0031)
- In this training these are called HCPCS codes

# General Procedure Code Rules

- Procedure codes are used to claim allowable activities.
- **Always use the most specific procedure code available.**
- CPT codes are preferred over HCPCS because they are more specific and more insurance programs use CPT coding. If there isn't an appropriate CPT code and a more general HCPCS code makes sense, it's ok to use the HCPCS code.
- SMHS Medi-Cal uses non-standard rules. It's important to review the [DHCS SMHS Billing Manual](#), DHCS FAQs ([1](#) and [2](#)), and coding rules from the [American Medical Association's \(AMA\) CPT Codebook](#) to ensure correct coding.
- If you're certain the service is SMHS billable, but no clear code exists to claim the activity please consult with ACBHD QA by emailing [QATA@acgov.org](mailto:QATA@acgov.org).



# Procedure/Service Code Tables

There are 2 code tables needed to ensure correct SMHS Medi-Cal claim submission.

## 1. ACBHD SmartCare SMHS Procedure Code Table

- Table includes all the SMHS procedure codes available in SmartCare.
- ACBHD publishes one annually for services provided in that fiscal year (FY)
- The *DHCS SMHS Service Table* is embedded within the ACBHD table.
- ACBHD's SMHS codes are based on Medi-Cal codes, but ACBHD's implementation vary slightly due to system factors.
- Not all codes on the DHCS SMHS Service Table are in SmartCare.

**Reference:** Section 13 of the [QA Manual](#) for *MH SmartCare Procedure Code Table FY 25-26*

## 2. DHCS SMHS Service Table

- Contains detailed guidance for each procedure code allowed in SMHS for the FY.
- DHCS rules are the source of truth for SMHS claiming.

**Reference:** [MedCCC Library](#)

# Submitting a Claim

- All claims to ACBHD are submitted via ACBHD’s billing system, SmartCare, using either the individual or batch service entry process.
- The SmartCare service entry screen includes the fields required for claiming. The ones described in this training are: **Procedure Code, Total Duration, Face-to-Face Time, Documentation Time, and Travel Time.**
- SmartCare has been programmed to assist with many of the more complicated processes associated with CPT code claiming.

SmartCare Individual Service Entry Screen

The screenshot shows the SmartCare Individual Service Entry Screen with the following fields and values:

- Procedure:** 90791 Psy. Diag. Eval. (w/T2024 Sub-Co) (Circled in red)
- Total Duration:** 30 Minutes (Circled in red)
- Location:** Office (Primary) (Circled in red)
- Travel Time:** 15 Minutes (Circled in red)
- Face to Face Time:** 30 Minutes (Circled in red)
- Documentation Time:** 15 Minutes (Circled in red)

Other visible fields include: Client..., Status (Show), Start Date (03/04/2026), Program, End Date (03/04/2026), Charge (\$235.14), Balance, Rate ID (40320), and various checkboxes for Client was present, Billable, and Transportation Service.

# Understanding Time When Claiming to SMHS

# Direct Patient Care

- For most codes **only the time spent providing direct services associated with the specific procedure code can be claimed to SMHS Medi-Cal.**
- Depending on the procedure code, **direct patient care** means time spent with:
  - The member for the purpose of providing healthcare services
  - The consultant/members of the member's care team (may include family), when related to the member's care
- Except for **therapy** services, most procedure codes may be billed even if the member is not present, provided the service meets the service and code requirements.
- When selecting codes **only direct patient care time** should be considered.



# SmartCare Field: Total Duration

- In SmartCare the SMHS Medi-Cal billable time is entered in the **Total Duration** field.
- **Total Duration** is a critical time field on the service entry screen, because it is the field used to calculate the # of units that will be claimed to Medi-Cal for the procedure code selected.
- Only include Medi-Cal billable time in **Total Duration**. **Never add travel, transportation, documentation time, and any other non-reimbursable time to Total Duration.**
- Including non-reimbursable time to **Total Duration** is considered overbilling, and the claim would be subject to provider repayment.

The screenshot shows the 'Service Detail' form in SmartCare. The 'Service' section is active, showing fields for Client, Test Case, Status, Start Date (05/28/2026), Program, Procedure, Modifier, Start Time, Total Duration (0.00), End Date, Clinician Name, Location, Attending, Referring, Client was present, Other Person(s) Present, Cancel Reason, Billable, Do Not Complete, Mode Of Delivery, Travel Time, Face to Face Time, Documentation Time, and Note. The 'Procedure' and 'Total Duration' fields are circled in red.

For most services:  
**Direct Patient Care = Total Duration**

# SmartCare Field: Face to Face Time

On the SmartCare service entry screen the *Face to Face Time* field is used to indicate the **total time** of the service, including any supplemental codes.\*

Since supplemental codes are not commonly used, most of the time *Face to Face Time* will equal *Total Duration*.

**Example:** A 90-minute therapy session required 30 minutes of oral interpretation:

***Total Duration*** = 90 minutes

**Supplemental code time** = 30 minutes

**Face to Face Time** = 120 minutes

The screenshot shows the 'Service Detail' form in SmartCare. The form is divided into three tabs: 'Service Detail', 'Billing Diagnosis', and 'Authorization(s)'. The 'Service Detail' tab is active. The form contains various fields for service entry, including Client, Procedure, Clinician Name, Location, and Start Date. The 'Face to Face Time' field is highlighted with a red circle. Other fields include 'Travel Time', 'Documentation Time', 'Evidence Based Practices', and 'Transportation Service'. There are also checkboxes for 'Client was present', 'Billable', and 'Interpreter Services Needed'.

\* Supplemental codes will be explained in part 2

# What is the *Midpoint Rule*?

- Time-based HCPCS and CPT procedure codes adhere to the “midpoint rule”
- The midpoint rule allows billing a time-based code once more than half of its designated time increment is completed.
- SmartCare automatically applies the midpoint rule to calculate billable units from **Total Duration**.
- **Example:** For H0032 (15-minute unit length), a 67-minute service equals 4 full units (60 minutes) with 7 minutes remaining. Since 7 minutes is less than the 8-minute midpoint, only 4 units are claimed.



# Knowledge Check- Direct Patient Care

## Select the correct answer

- Depending on the procedure code, **Direct Patient Care** includes time spent with a member's care team and/or family, when the services are related to the member's care.
  - True
  - False



# Knowledge Check- Direct Patient Care

- Depending on the procedure code, **Direct Patient Care** can include time spent with a member's care team and/or family, when the services are related to the member's care.

True

False

**Direct Patient Care** includes time spent with the member for the purpose of providing healthcare services, as well as time spent with their care team, including family, when the service is related to the member's care.



# Extending Time - SmartCare Automation

Many codes may be extended beyond the time associated with the primary code. The main ways are:

1. Selecting the next code in the tier
2. Adding on a *Prolonged Service Code*
3. Claiming multiple units of a code
4. Using a *Substitution Code*
5. Combination of above



## THE GOOD NEWS!!!

- Based on the selected code and *Total Duration*, SmartCare **automatically** determines the correct code(s) and units to claim to Medi-Cal.
- The next few slides will explain these concepts for your awareness.

# Tiered Procedure Codes - SmartCare Automation

- Some procedure codes are tiered based on length of time associated with the service.
- For example, see descriptions on the right for codes 90832, 90834 and 90838.
- In SmartCare tiered codes are combined and act a single code.
- For these codes, simply select the combined code and enter the Medi-Cal billable service time in **Total Duration**. **SmartCare will claim the correct procedure code(s) and number of units.**

DHCS Service Table

90832	Therapy	Psychotherapy, 30 minutes with patient
90834	Therapy	Psychotherapy, 45 minutes with patient
90838	Therapy	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service

SmartCare Procedure Code Table

SmartCare Procedure Code	Time Range in Minutes
90791 Psy. Diag Eval. (w/T2024 Sub-Code)	31-1440
90792 Psy. Diag. Eval. w-medical (w/T2024 Sub-Code)	31-1440
90832,90834 & 90837 Psychotherapyw/Patient (w/T2021 Sub-Code)	16-1440

# Add-On/Prolonged Codes - SmartCare Automation

- Add-On/Prolonged Codes can also be used to extend the time for some procedure codes.
- Add-On/Prolonged Codes must be used along with an allowable primary code.
- Take for example, 90839 (w/90840 Add-on) *PsychThpy for Crisis*. When this code is used, SmartCare will automatically claim the correct number of units for **both** 90839 and 90840, based on the time in *Total Duration*.
- **SmartCare has been programmed to do this behind the scenes based on the service time entered in Total Duration.**
- General familiarity with add-on/prolonged codes is helpful, but SmartCare manages the details.

Example of Add on Code on the SmartCare Table

SmartCare Procedure Code	Time Range in Minutes
90839 (w/90840 Add-on) PsychThpy for Crisis	30-465
90847 Family PsychThpy w/Patient (w/T2021 Sub-Code)	26-1440
90849 Mult-Family Grp. PsychThpy (w/T2021 Sub-Code)	43-1440

# Substitution Codes - SmartCare Automation

- A *Substitution Code* is a code that is substituted to extend the time of certain codes.
- On the **ACBHD SMHS SmartCare Procedure Code Table**, codes that allow T2024 or T2021 substitution include that in the code description.
- **SmartCare has been programmed to automatically substitute the correct code based on the time entered into Total Duration.**
- General familiarity with *Substitution Codes* is helpful, but SmartCare manages the details.

SmartCare Procedure Code	Time Range in Minutes
90791 Psy. Diag Eval. (w/T2024 Sub-Code)	31-1440
90792 Psy. Diag. Eval. w-medical (w/T2024 Sub-Code)	31-1440
90832,90834 & 90837 Psychotherapy w/Patient (w/T2021 Sub-Code)	16-1440

# Bringing All This Together - Time Range in Minutes

- To simplify claiming, all SmartCare codes are set up with a minimum and maximum time. Time entered into **Total Duration** must be within that range.
- The **ACBHD SmartCare SMHS Procedure Code Table** provides the **Time Range in Minutes** associated with the SmartCare code.

SmartCare Procedure Code	Time Range in Minutes
90785 Interactive Complexity	N/A
90791 Psy. Diag Eval. (w/T2024 Sub-Code)	31-1440
90792 Psy. Diag. Eval. w-medical (w/T2024 Sub-Code)	31-1440
90832,90834 & 90837 Psychotherapy w/Patient (w/T2021 Sub-Code)	16-1440
90833;90836;90838 Psychotherapy w/Patient w/E/M (w/T2021 Sub-Code)	16-1440
90839 (w/90840 Add-on) PsychThpy for Crisis	30-480
90847 Family PsychThpy w/Patient (w/T2021 Sub-Code)	26-1440

# Knowledge Check- Time Range in Minutes

## Select the correct answer

Why is the *Time Range in Minutes* column important?

- A. It indicates the time of day the service can be provided.
- B. It indicates how long a service can be claimed when all of the ways to extend services are factored in.
- C. It indicates the length of the code's unit.



# Knowledge Check- Time Range in Minutes

## Select the correct answer

Why is the *Time Range in Minutes* column important?

- A. It indicates the time of day the service can be provided.
- B. It indicates how long a service can be claimed when all the ways to extend services are factored in.**
- C. It indicates the length of the code's unit.



# Knowledge Check- SmartCare Automation

Select the correct answer

SmartCare will determine the Medi-Cal codes and number of units to claim based on the SmartCare procedure and *Face to Face Time*?

- True
- False



# Knowledge Check- SmartCare Automation

Select the correct answer

SmartCare will determine the Medi-Cal codes and number of units to claim based on the SmartCare procedure and *Face to Face Time*?

- True
- False

Both the SmartCare procedure selected and **Total Duration** are used to determine the Medi-Cal codes and number of units claimed.



# Optional Time Fields

On the SmartCare service entry screen there are two optional time fields for EI programs:

- **Travel Time:** Time the staff spends traveling to meet the member in the community and back to the office.
- **Documentation Time:** Time spent completing progress notes, care plans, safety plans etc.

EI programs may request reports of travel and documentation time for programmatic decisions.



Service Detail

Service Detail | Billing Diagnosis | Authorization(s)

Service

Client... Testing\_System... Status Show Start Date 03/04/2026

Procedure Modifier... Start Time

Clinician Name

Location Attending

Client was present Other Person(s) Present Cancel Reason

Group... Charge Balance

Billable  Do Not Complete

Mode Of Delivery

Travel Time Note

Face to Face Time

Documentation Time

Evidence Based Practices

Transportation Service No

Override Charge Amount

Override Errors

Interpreter Services Needed

# What is Not Medi-Cal Reimbursable?

- Travel (e.g., time spent traveling to meet a client in a community location, school, or home to provide services).
- Transportation (e.g., transporting a client or their family member for their convenience).
- Chart review
- Documentation
- Administrative and clerical activities (e.g., faxing, copying, leaving, or listening to voicemails, reading or writing emails, scheduling appointments, filling out SSI forms with or for the client, completing CPS or APS reports, writing court reports or letters, documenting a supervision note in the member's chart)
- Purely work-related activities (e.g., supervision, trainings, internal case consultations)
- Missed appointments
- Any activity that occurs after the client is deceased, including services provided to family members of deceased
- Payee related tasks (e.g., purchasing items for a client)
- Utilization review
- Quality assurance activities

# Is transporting a client a billable activity?

- No. Time spent transporting a member from one location to another is not billable.
- However, if a clinical activity takes place while transporting a member, the time spent on the clinical activity can be reported using an applicable code.
- Time spent connecting a member to transportation services (such as paratransit) is billable as care coordination.



# Knowledge Check- Non-Reimbursable Activities

Select the correct answer

The time spent writing and sending a client an email is not a Medi-Cal billable activity?

- True
- False



# Knowledge Check- Non-Reimbursable Activities

Select the correct answer

The time spent writing and sending a client an email is not a Medi-Cal billable activity?

True

False

Email, texting, and other non-synchronous communication with clients is not currently billable to Medi-Cal.



# SMHS Scope of Practice

# Provider Type/Scope of Practice

- The procedure codes a provider may select for a given service type are determined by their professional scope of practice, which is based on licensure, certification, education, training, and defined professional role.
- The [ACBHD SMHS Scope of Practice Reference Guide](#) is a tool that clarifies the type of services that can be performed by certain provider types, as well as co-signature requirements.



The [ACBHD SMHS Scope of Practice Reference Guide](#) is posted in Section 12 of the [QA Manual](#) on the ACBHD Provider Website.

# Taxonomy Codes, NPI and NPPES



- When a claim is submitted to Medi-Cal, it includes the healthcare provider's NPI and taxonomy code.
- A **NPI** identifies the specific healthcare provider, while the **taxonomy** code identifies their specialty and what **procedure codes** they can use.
- Taxonomy code prefixes available for SMHS can be found in Appendix 1-Taxonomy Codes of the [DHCS SMHS Billing Manual](#).
- Medi-Cal will deny claims when a procedure code is not allowed for the taxonomy.
- The taxonomy code a provider uses in SmartCare for claims must be present on their [NPPES](#) profile. Medi-Cal has informed counties they will start denying claims when the taxonomy on the claim isn't present on a provider's NPPES profile.  
**Providers should update their existing NPPES profile to meet this requirement.**

# What Codes Do Registered Clinicians Use to Bill for Services?

- Registered clinicians are post-graduate, pre-licensed mental health professionals who work in clinical settings under supervision (e.g., ASW, AMFT, APCCs, etc.).
- Registered clinicians use the same taxonomy and procedure codes as the licensed individuals of their profession.
- Registered clinicians have the same scope of practice as the individual whose license they are working under, except when activities are outside the scope of practice of the license they are pursuing.
  - For example, if an AMFT is being supervised by a licensed psychologist, they can only perform activities that are in scope of an MFT.



# What Codes Do Clinical Trainees Use to Bill for Services?

- Clinical trainees are **current** post-secondary students pursuing a licensed mental health profession and are **not registered** with the appropriate board.
- Clinical trainees have the same scope of practice as the individual whose license they are working under, except for activities that fall outside the scope of practice they are pursuing. For example, if a social worker clinical trainee is being supervised by a licensed psychologist, they may only perform activities that fall within the scope of their own training and field of study.
- Most clinical trainees use a taxonomy code that starts with 3902.
- Clinical trainees use the same procedure codes as others in their profession (e.g., PCC-CT uses the same codes as an APCC and LPCC).



# Provider Type/Scope of Practice

- On the **Outpatient Service Codes** tab of the procedure code table, the column **SD/MC Allowable Disciplines** shows what staff types can use that procedure code.
- For example, for an assessment service activity, a **LPCC** may use 90791, while an **Other Qualified Provider** may select H0031.
- Although both codes may relate to assessment activities, the services differ significantly in clinical scope, depth, and provider qualifications.
- **SmartCare is programmed to only allow staff with the correct disciplines to use certain codes.**

Cod	Code Type	Service (Brief Definition) Based on 2024 Rules	SD/MC Allowable Disciplines
90791	Assessment	Psychiatric diagnostic evaluation, 60 minutes	CNS, CNS-CT, LCSW, LCSW-CT, LMFT, LMFT-CT, LPCC, LPCC-CT, MD/DO, MD/DO-Clerks, NP, NP-CT, PA, PA-CT, PhD-CT/PsyD-CT, PhD/PsyD

Cod	Code Type	Service (Brief Definition) Based on 2024 Rules	SD/MC Allowable Disciplines
H0031	Assessment	Mental health assessment by nonphysician, 15 minutes	AOD, CNS, CNS-CT, LCSW, LCSW-CT, LMFT, LMFT-CT, LOT, LOT-CT, LPCC, LPCC-CT, LPT, LPT-CT, LVN, LVN-CT, MHRS, NP, NP-CT, Other, PA, PA-CT, PhD-CT/PsyD-CT, PhD/PsyD, Pharm, Pharm-CT, RN, RN-CT

# Knowledge Check- Scope of Practice

## Select the correct answer

- A provider's NPI is used to determine what procedure codes they can bill?
  - True
  - False



# Knowledge Check- Scope of Practice

A provider's NPI is used to determine what procedure codes they can bill?

- True
- False

Medi-Cal uses the **taxonomy code** on the claim to determine what procedure codes that provider can use. NPI is a unique identifier for healthcare professionals, while taxonomy codes are used to identify professional specialties. Taxonomy codes can be used by multiple providers across the healthcare system, while a NPI is unique to that specific provider.



# Understanding SMHS Lockout Rules

# Lockouts

Medi-Cal enforces two types of service lockouts:

1. Per CA regulations some services cannot be provided to a member on the same day or when outpatient services are provided as part of a bundle of services.

These type of lockouts apply across the system, not just per provider or per agency

2. Per [CMS/NCCI](#) rules some procedure codes cannot be billed together, and others can only be billed together in special circumstances.

These types of lockouts apply to services provided to the same member, by the same provider, on the same day.

Code	Code Type	Service (Brief Definition) Based on 2024 Rules	Outpatient Non-Overrideable Lockout Codes	Outpatient Overrideable Lockouts with Appropriate Modifiers (Overrideable Modifiers for codes with * are: 59, XE, XP or XU) Overrideable Modifiers for codes with ** are: 27, 59, XE, XP or XU)
90791	Assessment	Psychiatric diagnostic evaluation, 60 minutes	90839, 90840, 90847, 90853	90832*, 90833*, 90834*, 90836*, 90837*, 90838*, 90845*, 90849*, 90865*, 90867*, 90868*, 90869*, 90870*, 90880*, 90885*, 90887*, 96116*, 96127*, 96161*, 99202**, 99203**, 99204**, 99205**, 99212**, 99213**, 99214**, 99215**, 99221**, 99222**, 99223**, 99231**, 99232**, 99233**, 99234**, 99235**, 99236**, 99238**, 99239**, 99242**, 99243**, 99244**, 99245**, 99252**, 99253**, 99254**, 99255**, 99304**, 99305**, 99306**, 99307**, 99308**, 99309**, 99310**, 99341**, 99342**, 99344**, 99345**, 99347**, 99348**, 99349**, 99350**, 99366**, 99367**, 99368**, 99415**, 99416**, 99418**, 99441**, 99442**, 99443**, 99451**, 99605**, 99606**

In this example, CPT Code 90791 (Assessment), cannot be claimed with 90839 (PsychThpy for Crisis), 90840 (PsychThpy for Crisis Add-on code), 90847 (Family PsychThpy w/Patient) or 90853 (Group PsyThpy).

# Lockout Overrides

- Some lockouts can be overridden by including a modifier on the claim.
- On the **DHCS SMHS Service Table**, lockouts that can be overridden are indicated in the **Overridable Lockouts** column.
- Code combinations that cannot be manually overridden are indicated in the **Outpatient Non-Overridable Lockout Codes** column.
- As SmartCare is not fully automated to manage lockouts, providers must reference lockout rules from the **Outpatient Service Codes** tab of the **DHCS SMHS Service Table** and **manually add** modifiers during service entry, as appropriate.

Code	Code Type	Service (Brief Definition) Based on 2024 Rules	Outpatient Non-Overridable Lockout Codes	Outpatient Overridable Lockouts with Appropriate Modifiers (Overridable Modifiers for codes with * are: 58, XE, XP or XU) Overridable Modifiers for codes with ** are: 27, 58, XE, XP or XU
90791	Assessment	Psychiatric diagnostic evaluation, 60 minutes	90839, 90840, 90847, 90853	90832*, 90833*, 90834*, 90836*, 90837*, 90838*, 90845*, 90849*, 90865*, 90867*, 90868*, 90869*, 90870*, 90880*, 90885*, 90887*, 96116*, 96127*, 96161*, 99202**, 99203**, 99204**, 99205**, 99212**, 99213**, 99214**, 99215**, 99221**, 99222**, 99223**, 99231**, 99232**, 99233**, 99234**, 99235**, 99236**, 99238**, 99239**, 99242**, 99243**, 99244**, 99245**, 99252**, 99253**, 99254**, 99255**, 99304**, 99305**, 99306**, 99307**, 99308**, 99309**, 99310**, 99341**, 99342**, 99344**, 99345**, 99347**, 99348**, 99349**, 99350**, 99366**, 99367**, 99368**, 99415**, 99416**, 99418**, 99441**, 99442**, 99443**, 99451**, 99605**, 99606**

In this example, there is no way to override the lockout for CPT Code 90791 against 90839, 90840, 90847 or 90853, but there are override modifiers for many other CPT codes that are locked out against 90791.

# Modifiers Requiring Manual Entry into SmartCare

Modifiers that can be **manually** entered in **SmartCare** are:

- **27** Multiple Outpatient Hospital E/Ms
- **59** Distinct Procedure Service
- **76** Repeat Procedure by Same Person
- **77** Repeat Procedure by Different Person
- **HK** IHBS
- **XE** Separate Encounter
- **XP** Separate Practitioner
- **XU** Unusual Non-Overlapping Service

**Modifiers**

Modifiers provide a way to report or indicate that a service or procedure that has been performed has been modified by some specific circumstance but not changed in its definition. 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. HCPCS (alpha) modifiers can be used with CPT and HCPCS codes, but CPT (numeric) modifiers can only be used with CPT codes.

For a transaction to be HIPAA-compliant, a claim must use a current code and a procedure code cannot use more than four modifiers. DHCS recommends that, in the rare situations that MHPs exceed four modifiers per procedure code in a given transaction, they not use telehealth modifiers.

Modifier	Definition	When to Use	Codes/Code Types This Modifier Applies To
22	Increased Procedural Services: When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code.	Use this Modifier to specify that Parent Child Interaction Therapy (PCIT) services were performed.	90832, 90833, 90834, 90836, 90837, 90838, 90847
27	<b>Multiple Outpatient Hospital Evaluation and Management (E/M) Encounters on the Same Date:</b> For hospital outpatient reporting purposes, utilization of hospital resources related to separate and distinct E/M encounters performed in multiple outpatient hospital settings on the same date may be reported by adding modifier 27 to each	Use this modifier, as appropriate, to override those lockout codes that can be overridden with a modifier. The lockout codes that can be overridden are listed in Column K, "Outpatient Overridable Lockouts with Appropriate Modifiers" and have ** next to them in the Service Table. This modifier needs to be used even if the over-ridable lockout combinations were provided	This modifier will only be used with CPT codes that are part of an over-ridable lockout combination.

< > ... 24-Hour Service Codes | Monthly Service Codes | Provider Type Abbreviations | Place of Service Codes | **Modifiers** | +

Refer to the **Modifiers** tab of the **DHCS SMHS Service Table** for detailed definitions and instructions for use.

# Knowledge Check- Lockouts

## Select the correct answer

- Lockout rules only apply to the services I provide at my program?
  - True
  - False



# Knowledge Check- Lockouts

Lockout rules only apply to the services I provide at my program?

- True
- False

While it's true that some lockout rules apply based on a provider's unique NPI. Others apply across the system regardless of program or provider NPI.

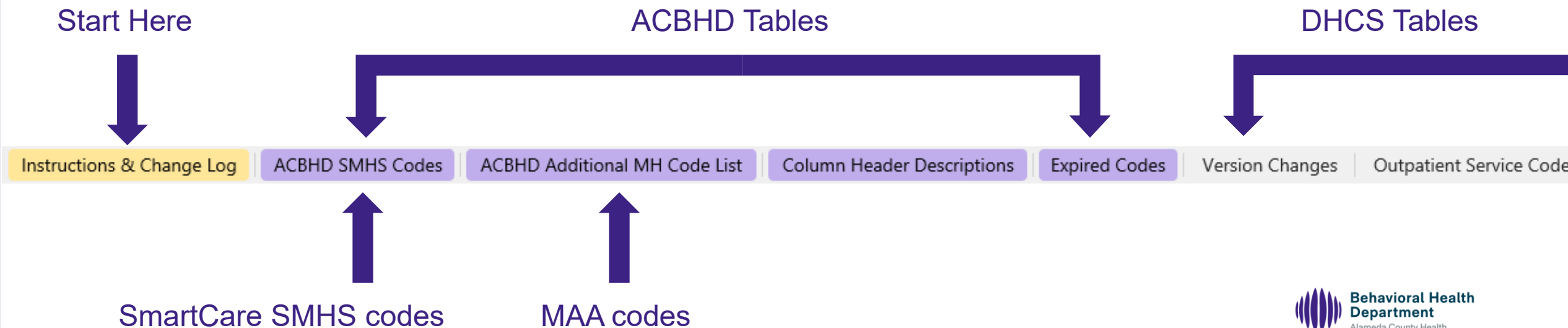
For example, if a member is receiving inpatient services. During the time the member is receiving inpatient treatment, most outpatient mental health services are locked out and will be denied if submitted for claiming.



# Getting Familiar with the Procedure/Service Tables

# The ACBHD MH SmartCare Procedure Code Table

- The *ACBHD MH SmartCare Procedure Code Table* is one of the core resources on your journey to understanding SMHS Medi-Cal and related procedure codes.
- It is available on the [ACBHD QA Manual](#) page, in Section 13
- Always use the table for the fiscal year based on the date of service
- The **Instructions & Change Log** tab provides a lot useful information about using the worksheet.
- The **Column Header Descriptions** tab explains each of the columns.



**Demo**



# Practice Using Procedure Code Tables

# Practice Using Procedure Code Table

- Find and open **13-12 FY25-26 ACBHD SMHS SmartCare Procedure Code Table** in section 13 of the QA Manual.
- Link to QA Manual: [QA Manual | ACBH Providers Website](#)
- **Give a thumbs up when you have the table open**

13

## SERVICE AND BILLING RESOURCES

13-1	<a href="#">MH LOCKOUT GRID</a> - <b>REVISED 7/6/23</b>
13-2	<a href="#">SMARTCARE DIAGNOSIS DOCUMENT INSTRUCTIONS</a> - <b>NEW 11/16/23</b>
13-3	<a href="#">ACBHD DIAGNOSIS AND CODE GUIDANCE</a> - <b>NEW 2/11/26</b>
13-4	<a href="#">MH SMARTCARE PROCEDURE CODE TABLE FY 23/24 EFF. 7-1-2023</a> - <b>UPDATED 4/12/24</b>
13-5	<a href="#">SUD SMARTCARE PROCEDURE CODE TABLE FY 23/24 EFF. 7-1-2023</a> - <b>UPDATED 8/2/23</b>
13-6	<a href="#">FY24-25 PROLONGED ADD-ON AND REPLACEMENT CODES GRID</a> - <b>NEW 8/23/24</b>
13-7	<a href="#">DHCS SERVICE TABLES FY 24-25</a> - <b>NEW 8/26/24</b>
13-8	<a href="#">PROFESSIONAL SERVICES EM SERVICE CODES DEFINITIONS</a> - <b>NEW 11/6/24</b>
13-9	<a href="#">IHBS Service Table</a> - <b>NEW 1/27/25</b>
13-10	<a href="#">MH SmartCare Procedure Code Table - FY24-25</a> - <b>NEW 4/24/25</b>
13-11	<a href="#">SUD SMARTCARE PROCEDURE CODE TABLE FY 25-26</a> - <b>NEW 11/7/25</b>
→ 13-12	<a href="#">PUBLICATION OF FY25-26 ACBHD SMHS SMARTCARE PROCEDURE CODE TABLE</a> - <b>NEW 12/16/25</b> ←

# Question- Family PsychThpy Code

## On the ACBHD SMHS Codes Tab

1. What is the Procedure Code for **Family PsychThpy w/Patient (w/T2021 Sub-Code)**
2. What is the time range for that code?
3. Can non-licensed Mental Health Rehabilitation (MHRS) provider types use this code?



# Question- Rehabilitation Services

## On the ACBHD SMHS Codes Tab

1. What is the procedure code for Rehabilitation Services?
2. What is the time range for this code?
3. Can ACBHD Peer Partners bill for this service?



# Resources and Next Steps

# Reference Guides and Resources

<p>American Medical Association (AMA) CPT Codebook  <a href="#">AMA/CPT site</a></p>	<p><a href="#">Short Doyle Medi-Cal References</a>  <b>CALAIM References and Manuals</b></p> <ul style="list-style-type: none"> <li>• CalAIM Reference Guide for CPT Codes -Specialty Mental Health</li> <li>• CalAIM Reference Guide for CPT Codes - Drug Medi-Cal Organized Delivery System</li> </ul>
<p><a href="#">Short Doyle Medi-Cal Manuals</a>  <b>CALAIM References and Manuals</b></p> <ul style="list-style-type: none"> <li>• Specialty Mental Health Billing Manual</li> <li>• Drug Medi-Cal ODS Billing Manual</li> </ul>	<p><b>ACBHD Reference Guides on <a href="#">QA Training Webpage</a></b></p> <ul style="list-style-type: none"> <li>• Detailed Preliminary DMC-ODS Codes in SmartCare</li> <li>• Detailed Preliminary SMHS CPT Codes in SmartCare</li> </ul>
<p><b>SmartCare Billing System Implementation and Payment Reform FAQ</b>          Section 19 of the <a href="#">QA Manual</a></p>	<p><b>CalMHSA Payment Reform <a href="#">Webinars</a></b></p> <ul style="list-style-type: none"> <li>• CPT Code 101- Introduction to CPT Codes</li> <li>• CPT Code 102- Optimization of CPT Codes for Majority of Behavioral Health Services</li> </ul>

**Note: Department of Health Care Services expects providers to be familiar with and follow the rules noted in the CPT Code Manual**

# Next Steps

- If you haven't done so already, please register for Part 2 of this training which will include information regarding:
  - Entering a claim into SmartCare
  - Location/Mode of Delivery
  - Telehealth
  - Supplemental Codes
  - Answers to commonly asked questions
  - More practice
- Before the next training, please review this deck again and familiar yourself with the Procedure Code Tables.
- If you have any questions that you would like answered at the next meeting, pls email them to: [QATA@acgov.org](mailto:QATA@acgov.org).



Slow and steady wins the race

**Thank you for attending.**