Behavioral Health Department
Alameda County Health

The Behavioral Health Collaborative of Alameda County

Clinical Services TIPS

Treatment, Interventions, Protocols, and Suggestions

Assessment Coding for Specialty Mental Health Services

1. General Guidelines

CPT codes must follow requirements as specified in the CPT codebook. Nothing in this TIPS document supersedes American Medical Association (AMA) or Department of Health Care Services (DHCS) guidance.

As a general rule, the code used should always be the most specific code available.

2. Purpose of Assessment Services

Assessment is a service activity designed to collect information and evaluate the current status of a member's mental, emotional, or behavioral health to determine whether mental health services are medically necessary and to recommend or update a course of treatment for that member. Assessment activities must be conducted and documented in accordance with applicable State and Federal statutes, regulations, and standards.

3. Common Codes for Assessment Billing

There are many codes available to report assessment activities. This section includes information about codes that are commonly used. Staff should select the CPT or HCPCS code that best reflects the service rendered, based on time, scope, and type of provider. See section 13 of the QA Manual of the Provider Website for helpful resources, including procedure code tables.

- **90791 – Psychiatric Diagnostic Evaluation (without medical services)**

  Use this code to report a behavioral health diagnostic assessment activity that does not include a medication evaluation. The service may include gathering client history, assessing behavioral or clinical concerns, conducting a mental status exam, diagnostic formulation, and making treatment recommendations. 90791 can be used when gathering of assessment information from collateral contacts (e.g., parent). When billing 90791 and 90792 or 90832/34/27 (individual therapy) by the same provider, on the same day, to the same member, an override modifier must be manually added in SmartCare on the service entry screen. 90791 cannot be billed

on the same day as Psychotherapy for Crisis (90839/40), Family Therapy (90847) or Group Therapy (90853).

- **90792 – Psychiatric Diagnostic Evaluation (with medical services)**

  This code includes all the elements of 90791 but is used when the psychiatric diagnostic evaluation includes a medication evaluation. This code can only be used by staff with the scope of practice to prescribe medications (e.g., MD/DOs, NPs, CNSs, PAs).

- **H0031 – Mental Health Assessment**

  This code is used for psychosocial assessment or reassessment conducted by clinician non-prescribers. This code can be used for initial and ongoing assessment activities and is not limited to diagnostic evaluation. It can also be used for administration of the CANS. It does not have the service lockouts or require modifiers, such as those with 90791. The member is not required to be present to use this code.

- **90885 – Psychiatric Evaluation of Records and Reports**

  Code 90885 is a billing code for a "Psychiatric evaluation of records, reports, and/or other information sources" without direct patient contact, used by mental health professionals to document the time and expertise spent reviewing patient histories, medical records, and other data to inform diagnosis and treatment planning. Use of this code is not for routine review of records prior to treatment sessions, but for case transfers or review of external reports. The member is not required to be present to use this code. If using the code without the member present, document justification in the chart.

- **96127 – Brief Emotional or Behavioral Assessment**

  Code 96127 refers to the administration and scoring of a brief standardized instrument that measures emotional or behavioral functioning, such as the Beck or PHQ-9 for depression, the GAD-7 for anxiety, or the PSC-35 for general psychosocial screening. This code may also be used for administration of the CANS. The code requires a minimum service time of 31 minutes before it can be claimed. The member is not required to be present to use this code. If using this code without the member present, document justification in the chart.

- **T1001 – Nursing Assessment, Evaluation**

  This code is for nursing intake or health-related evaluations and can only be used by PTs, RNs, CNSs, NPs, and LVNs. The member is not required to be present to use

this code. If using the code without the member present, document justification in the chart.

4. **Documentation Requirements**

Staff must clearly document the purpose of the assessment and link it to medical necessity. For 90791 and 90792, documentation should include presenting problems, relevant history, mental status examination, diagnostic impressions (or rule-outs), and initial treatment recommendations.

DHCS has indicated that time spent "**consolidating and synthesizing**" clinical information to make treatment recommendations or establish a medical diagnosis may be considered service time and is claimable using the appropriate assessment code [1] (such as CPT code 90791 or 90885). This activity does not require direct contact to be billable to Medi-Cal. Refer to Documentation TIPS for more details.

5. When in Doubt

There will be times when it is unclear which assessment code is most appropriate. Consult with a supervisor, QA staff, or ACBH before finalizing the note.

Resources

- AMA CPT Code Book. Always use the CPT codebook that corresponds with the date of service.
- DHCS Medi-Cal Billing Manuals and Service Tables
- Supplemental Documentation Guide- SMHS- see section 7
- Mental Health Individual Handbook- see section 7
- HCPC/CPT Codes FAQs – see section 19
- SmartCare Procedure Code Tables- See section 13

***Disclaimer**: This document complements, but does not replace, CBO-specific policies. Staff must comply with evolving standards, laws, and organizational requirements. Guidance may change to reflect regulatory or contractual updates.*

[1] CALAIM Behavioral Health Payment Reform FAQ, updated 9/20/24, page 8 notes: "If consolidating and synthesizing clinical information which is a part of the member's medical record to make recommendations for treatment or to make a medical diagnosis, then the activity would count as service time and is claimable even in the event the member is not present."