Behavioral Health Department
Alameda County Health

FREQUENTLY ASKED QUESTIONS
HCPC/CPT Codes

Alameda County Behavioral Health Department, Quality Assurance
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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) AC Health, Behavioral Health Department (ACBHD) 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 ACBHD continue to use HCPCs after 7/1/23?

   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 in 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 3/28/24*

   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 training sessions.

   - Begin by reviewing the ACBHD CPT Code Training recording and/or reviewing the presentation deck. The recording is on the QA Training page of the ACBHD 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, ACBHD has provided two SmartCare Procedure Code Tables that list all available CPT codes in SmartCare, their descriptions and specific rules related to each. 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. The ABCH procedure code tables should be used in tandem with DHCS Service Tables for the respective delivery system.
   - 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 MedCCC Library page. Scroll to CalAIM Manuals and References Effective July 1, 2023, to find the Short Doyle Medi-Cal Manuals for SMHS and DMC-ODS.
- Review the DHCS Service Tables for DMC-ODS and SMHS, also posted on the MedCCC Library page.
- 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 3/28/24*

   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. ACBHD has created two procedure code tables on either the QA Training page or on the QA Manual page (see Section 13 Service and Billing Resources), that include all CPT codes available in SmartCare and relevant details for each code.

5. Will ACBHD provide a list of code descriptions along with role type? *Updated 3/28/24*

   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 DHCS SMHS and DMC-ODS Billing Manual and Service Tables.

6. Where can I find the DHCS billing manuals and service tables online? *Updated 3/28/24*

   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? *Updated 3/28/24*

   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 your ACBHD contract manager for discussion.

8. Should non-billable procedure codes be entered into SmartCare? *Updated 3/28/24*

   Providers should still enter non-billable time for activities or events ACBHD has procedure codes for (e.g., no show) and are added to their specific program (aka RU). Please refer to the ACBHD SmartCare procedure code tables on the QA Manual website, as it contains a list of the most common non-billable service and tracking codes.

9. Can providers use any codes not listed in the SMHS Billing Manual (i.e., will ACBHD create any non-DHCS codes)?

   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), ACBHD special non-billable codes, etc. The *Additional Service Code List* sheet on the SmartCare MH Procedure Code Table lists these codes.

10. What do we do if there is conflicting information between ACBHD guidance, CMS Medicare standards, and what is in the CPT Codebook? *Updated 3/28/24*

    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. Please note that DHCS' rules may be more restrictive than the rules described in the CPT codebook. As a result, the CPT codebook should be used in conjunction with the billing manuals. Except in certain situations, the information provided by ACBHD does not supersede AMA CPT coding rules.

    Additionally, please note that DHCS determines which CPT codes are allowable or not, based on CMS Medicare standards, however, rules for CPT codes may not always match between CMS and DHCS. Please contact QATA@acgov.org to discuss confusing or conflicting information.

11. Why is ACBHD'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. ACBHD calls these Locations and has developed a county specific list. ACBHD providers must use ACBHD's list. SmartCare will automatically map ACBHD locations to the official POS list when the claim is submitted.

12. 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.

13. Do SUD residential programs have to use CPT codes?

When ACBHD 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 ACBHD'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.

General Procedure Code Information

14. 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.

15. Can ACBHD provide clear and definitive descriptions for CPT codes that are unclear?

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

16. May different services on the same day or different days for the same beneficiary be combined and claimed at the same time?

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.

17. What current InSyst codes do not have clear replacements?

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.

18. May we complete one progress note if two or more services are provided to the same beneficiary on the same day?

Possibly. Providers may optionally complete a single progress note when ALL of the following conditions are met:

1. All activities occur on the same calendar day.
2. All services are for the same beneficiary.
3. The same provider conducted all of the services.
4. All activities would be reported with the exact same procedure code.
5. All activities have the same location.

If ALL the above conditions are not met, then separate documentation must be completed.

When reporting time, add up the time of each time category (direct patient time, travel, and documentation) and enter each total in their respective SmartCare fields. For start time in SmartCare, use the start time of the first service.

19. Should the Location Code be "School" or "Office" when services are provided at a beneficiary's school that is also a provider's school site/office? *New 3/28/24*

The provider should use the Location Code for "School" even if the provider's office is at a school site.

Medi-Medi

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 service is rendered by a Medicare eligible provider.

21. 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.

22. 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 clerical 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 information to a client's record based on discussions during supervision.
    - Any activity that occurs after the client is deceased, including services to family members of deceased.

Direct Patient Care

23. What is considered Direct Patient Care?

    From SMHS Billing Manual:

    - 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:

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.

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?

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

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

Documentation and Travel Time

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

    At least through FY23-24, ACBHD 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 ACBHD for all services (including documentation, travel, and face-to-face time) for the previous month.
    - Use the report to bill ACBHD for documentation and travel time.

26. How will travel and documentation time 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.

27. What activities are considered documentation time?

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

28. What is the difference between travel time and transportation? *Updated 3/28/24*

    Travel time is the time the staff spends traveling to meet the beneficiary in the community and back to the office. Traveling between agency offices is not travel time. If a staff is traveling from their residence to a community location, claiming travel time is possible as long as they subtract their commute time. Transportation refers to transporting a client from one location to another.

29. Is transportation a billable activity? *New 3/28/24*

    Time spent transporting a beneficiary from one location to another is not claimable. However, if a clinical activity takes place while transporting a client, the time can be reported as the clinical activity provided. Also, time spent connecting a beneficiary to transportation services (such as paratransit) is claimable as care coordination.

30. Is concurrent documentation (therapy + documentation completed in a session as a clinical intervention) considered documentation time or service time?

    If documentation is occurring concurrently with therapy as a clinical intervention, 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

31. What time is considered when reporting or selecting a code?

    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.

32. In SmartCare what is the difference between *Total Duration* (service tab), *Duration* (add-on tab), and *Face-to-Face Time*? *Updated 4/22/24*

    The service entry screen has several tabs used to enter services into SmartCare. On the main *Service* tab *Total Duration* is the *direct patient care* time that SmartCare uses to calculate the number of units billed to Medi-Cal for the primary code. Similarly, on the *Add-On Codes* tab, *Duration* is the time used to calculate the number of Medi-Cal billable units for the add-on code(s).

    Face-to-Face Time is the combined time of the service and includes the total time for the primary code and any add-on codes (when applicable). For example, a 45-

minute psychiatric diagnostic evaluation with an interpreter for the whole session would be entered into SmartCare like this: 90791 *Total Duration* = 15 mins., G2212 *Duration* = 30 mins., T1013 *Duration* = 45 mins., *Face-to-Face Time* = 90 minutes.

For services reported with only a primary code (no add-on codes) and for codes in a series that SmartCare has combined designated prolonged (e.g., Psychotherapy for Crisis, 90839-90840) *Total Duration* and *Face-to-Face Time* will be the same.

For codes not combined in SmartCare, when an add-on code is used *Total Duration* is dropped back down to its base time (e.g., 90791 = 15 mins.). For a 22-minute 90791 service, enter 22 mins. Into *Total Duration*. For a 23-minute 90791 service, enter 15 minutes into *Total Duration* and 8 minutes into *Duration* for G2212.

Travel, documentation, and other non-billable time should never be included in *Total Duration, Duration,* or *Face-to-Face Time*.

33. 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 (total duration and face-to-face) and SmartCare will choose the correct code based on the time entered.

34. Can we always use the midpoint rule for code selection?

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 (in Section 13 of the QA Manual) were set up to assist with this. Column K provides the range of time associated with the code.

35. Does the midpoint rule apply to HCPCs?

Yes, midpoint rules apply to HCPCs as well.

36. What are "Maximum Units"?

Although CPT codes are entered into SmartCare using minutes of time, they are claimed to Medi-Cal by ACBHD 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.

37. What happens if we add a Procedure Code and Total Duration that exceeds the maximum allowed time for that code? *New 3/28/24*

    SmartCare will not allow users to enter procedure codes that exceed the maximum limit without an Add-On Code. It will alert the user to correct their entry.

38. What is changing for billing data entry in CG-SmartCare to match requirements from SmartCare? *New 3/28/24*

    To align the billing data entry fields in CG-SC with the SC system, users will notice changes to the duration field entries for some procedure codes.

    Examples of these changes include the following:

    - For Residential Day codes, users will enter "1" day in the duration field instead of "24" hours.
    - Many zero-minute codes, such as the tracking codes, will change from requiring "0" minutes to "1" item in the duration field.
    - Some minimum and maximum duration values will be updated for specific codes. Error messages will alert users if they fall outside of the range.

    Existing notes in CG-SC will be automatically updated to reflect these changes and do not need to be altered by providers.

Modifiers and Lockouts

39. 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."

40. Can ACBHD provide a list of all the modifiers we are expected to use and how modifiers will be applied in SmartCare? *Updated 3/28/24*

    Most of the required modifiers have been built into SmartCare and are automatically added to codes (e.g. telehealth) behind the scenes. However, others will need to be manually entered. SmartCare will alert users when a duplicate modifier may be needed. The Modifier button will be activated in SmartCare and users will need to select from the modifier reason/code, per below:

- Distinct Procedural Service (59)
- Separate Encounter (XE)
- Separate Practitioner (XP)
- Unusual Non-overlapping Service (XU)

Other lockouts that have modifiers do not have alerts and providers will need to pay attention when entering the procedure codes and add a modifier if indicated. See the DHCS Billing Manuals for a full description of modifiers and their descriptions.

41. What are lockouts? *Updated 3/28/24*

    Lockouts happen when procedure codes are unable to be billed on the same day under certain conditions. There are a few kinds of lockouts. Some lockout rules only apply when procedure codes are being claimed for the same beneficiary on the same day by the same provider. If the rendering provider NPIs are different those lockout rules do not apply. In the billing manuals and ACBHD code tables, codes that cannot be billed on the same day as other codes are listed in the Lockout Codes column. Other lockouts are site specific, for example if a member is admitted to an inpatient psychiatric facility, all outpatient mental health services are locked out except the day of admission and day of discharge.

42. Does SmartCare include logic to enforce lockout rules?

    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?

    Dependent On codes are Add-On codes that indicate time has been added to a primary procedure or to 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? *Updated 3/28/24*

    No. G2212 may only be used to prolong time on some 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. Please refer to the DHCS Service Tables for specific G2212 usage.

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?

Yes, 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? *Updated 3/28/24*

As noted below, there are different ways that Add-Ons are used in SmartCare.

For procedures that have their own Add-On codes (e.g. Psychological Testing 96130 and Psychological Testing 96131) SmartCare will automatically insert the Add-On code based on the *Total Duration* that is entered by the provider. For example, if the provider enters a Total Duration of 2 hours for psychological testing using 96130, the system will automatically add the code 96131 in the Add-On field to account for the additional hour. As with all codes, the midpoint of the code, in this case 31 minutes, must be reached before the code can be used.

For procedures that have a time range associated with the code, SmartCare will select the correct code based on the *Total Duration* time. In these cases, the Add-On code of G2212 needs to be manually added only if the service time exceeds the maximum allowed for that procedure range. As with most procedure codes, the midpoint of G2212 (8 minutes) must be reached before it can be used to extend the time of a service.

For example, there are different codes associated with Psychotherapy, each indicating a different time range for that service:

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

If the service lasts at least 75 minutes (67 minutes for 90837 + 8 minutes for G2212), the provider will manually add the G2212 as an Add-On to account for the additional time of the service. Code G2212 only has to be added one time. The system will determine how many units of the code to claim based on the *Duration* entered next to the Add-On code.

For codes that can be extended by G2212, the G2212 code needs to be manually added by the user to indicate the additional service time. The G2212 only needs to be added one time to the service and the additional duration noted next to the code. Based on the *Duration* noted next to the code, SmartCare will determine how many units of G2212 to bill to Medi-Cal.

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

Yes, if the 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 these codes are HCPCs.

Specific Procedure Code Information

50. What procedure codes can be used when the beneficiary is not present for a service? *Updated 4/22/24*

    Please follow guidance from the DHCS CalAIM Payment Reform FAQ for information on providing services when a member is not present for some or all of a service.

51. 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, per the CPT codebook, direct patient care means time spent with the consultant/members of the beneficiary's care team.

52. 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 its own. You cannot do a CANS alone and claim it without a face-to-face service.

53. Can ACBHD 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 are the codes that are 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 Short Doyle Medi-Cal Manuals. See SMHS and DMC-ODS Billing Manuals for this information.

Providers may only claim SMHS and DMC-ODS for the defined services in each delivery system and choose 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.

54. The SMHS Billing Manual and the SMHS Service Table reference HCPCS Code H2011 as both Mobile Crisis and Crisis Intervention. What is the difference? *Updated 4/22/24*

The combination of HCPCS code H2011 with Place of Service Code 15 refers to a Mobile Crisis Encounter that meets the requirements outlined in BHIN 23-025 for the Mobile Crisis Services Benefit. The combination of HCPCS code H2011 with any other applicable Place of Service Code (e.g., 99) refers to Crisis Interventions that do not meet the requirements for the Mobile Crisis Services Benefit.

While the services rendered may mirror each other (e.g., assessment, safety planning, referrals, warm hand-offs, etc.), the Place of Service Code differentiates the service on the claim. Place of Service code 15 can only be used when all requirements are met per BHIN 23-025.

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

No. 90885 is an assessment code. According to the CMS Coding and Billing Guidelines, "CPT code 90885, *Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes*, is used when a provider is asked to do a review of records for psychiatric evaluation without direct patient contact. This may be accomplished at the request of an agency or peer review organization. It may also be employed as part of an overall evaluation of a patient's psychiatric illness or suspected psychiatric illness, to aid in the diagnosis and/or treatment plan."

56. How do we use the Psychotherapy for Crisis codes (90839 and 90840), do they follow the same rules regarding time as other codes?

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.

57. 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.

58. 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.

59. 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.

60. How will SUD providers distinguish between the two types of care coordination activities in the SUD system?

    Prior to 7/1/23, ACBHD 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 ACBHD SUD network. Case Management: Service Coordination was used when claiming for care coordination activities with a provider *outside* of the ACBHD SUD Network. After 7/1/23, outpatient SUD providers should use:

    - T1017 Targeted Case Management in place of Case Management: Care Coordination
    - 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.

61. 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 réhabilitation, per 15 minutes.

See this FAQ for information about standalone SUD services.

62. 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.

63. 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.

64. How do we bill for two separate assessment services completed by two different providers (MD and non-MD clinician) on the same day? *New 3/28/24*

The Billing Manual shows procedure codes 90791 "Psychiatric Diagnostic Evaluation, 15 Minutes" and 90792 "Psychiatric Diagnostic Evaluation with Medical Services, 15 Minutes" locked out against one another. Per DHCS MedCCC, “As long as the rendering provider NPIs are different, the lockout will not apply. Lockouts only apply when the same rendering provider NPI claims for both services. Even though the system will not lock these two services out from each other, this does not mean that it is necessarily clinically appropriate for these services to be

rendered to the same beneficiary on the same day. These services will be subject to audit."

65. Can the SUD Counselor bill for the time spent meeting with the LPHA to discuss a beneficiary's diagnosis? *New 3/28/24*

    While the LPHA can bill for the time spent meeting with the SUD counselor to gather information to conduct a diagnostic evaluation (e.g. 90791), the SUD counselor is not able to bill for that time as it is considered a post activity from direct service. Per DHCS, reimbursement for post service activities is included in the rate of the direct service code.

E/M Services

66. What are E/M codes? *New 3/28/24*

    E/M stands for Evaluation and Management and are CPT codes in the range 99202-99499. E/M codes are used by physicians or other qualified healthcare professionals. These medical codes apply to visits and services that involve evaluating and managing a patient's health. E/M codes are available in both SMHS and DMC-ODS delivery systems. E/M codes in ACBHD behavioral health systems typically are used for medication management activities related to the treatment of mental health or substance use concerns.

67. How can we claim Psychotherapy Services with Evaluation and Management (E/M)? *New 3/28/24*

    Psychotherapy with E/M codes are time-based dependent-on codes and need to be used alongside a primary E/M procedure code.

    - 90833: Psychotherapy, 30 minutes with patient when performed with an evaluation and management service = 16 – 37 minutes
    - 90836: Psychotherapy, 45 minutes with patient when performed with an evaluation and management service = 38 – 52 minutes
    - 90838: Psychotherapy, 60 minutes with patient when performed with an evaluation and management service = 53 minutes or longer

    Psychotherapy E/M codes when used together with E/M codes are intended to report a session where the provider performs an evaluation and management service and the psychotherapy session in the same visit. While there may not be definite start or end times for each activity, each code must report the total time spent in the session on each activity. To further clarify, 90838 does not extend the time of 99205 or 99215. Instead, G2212 should be used to extend the time for each activity.

    Let's consider three examples:

1. A psychiatrist meets with a new outpatient beneficiary for 50 minutes. In that session, both an E/M service and psychotherapy are provided. Approximately 20 minutes are spent doing a medication evaluation and 30 minutes providing psychotherapy. This should be reported like this: 99202 (1 unit) and 90833 (1 unit).
2. A psychiatrist has a long session with an established outpatient patient, total session time is 100 minutes. 20 minutes are spent on medication activities and the other 80 minutes is for psychotherapy. They would report this like this: 99213 (1 unit) and 90838 (1 unit) + G2212 (1 unit). In this case G2212 is added on to extend 90838.
3. A psychiatrist meets with a new outpatient patient for a very long session, 180 minutes in total. 90 minutes is for medication services and 90 minutes for psychotherapy. This would be reported like this: 99205 (1 unit) + G2212 (2 units) and 90838 (1 unit) + G2212 (2 units). In this situation, G2212 is used to extend each part of the activity.

For more information, please refer to this CMS guidance on how to use this code.

Collateral Services and Interactive Complexity

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

If the support to the caregiver meets the definition of Interactive Complexity as described in the billing manuals and AMA CPT Codebook, then 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.

69. 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. ACBHD strongly recommends all agencies purchase the official AMA CPT Codebook for specific guidance on CPT coding. Additionally, there are a number of resources on CPT coding, including from the APA and CMS that may be used as long as it is consistent with official guidance.

70. Can Interactive Complexity (90785) and Sign language or Oral Interpretation (T1013) be claimed together?

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

71. Can SUD providers continue to claim for services when working with a beneficiary's collateral supports? *Updated 3/28/24*

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 (see BHIN 23-001 and the DHCS CalAIM FAQ). 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, care coordination, and family therapy.

72. Can MH providers continue to claim for services when working with a beneficiary's collateral supports? *Updated 4/22/24*

Per CalAIM payment reform changes, collateral is no longer a distinct service activity. Instead, collateral refers to significant support persons in the beneficiary's life. Services provided to collaterals may only be for the purpose of the beneficiary's treatment. Services provided to collaterals include Assessment, Rehabilitation, Treatment Planning, Peer Support, Targeted Case Management, Crisis, or Therapeutic Foster Care.

When providing services to a beneficiary's significant support person, select the service code that most closely fits the intervention provided for the purposes of the beneficiary's treatment and make clear in a progress note that the service was provided to a collateral contact. For example, if a clinician gathers assessment information about a client from their caregiver, they will use a suitable assessment code to report that activity.

Per 9 CCR 1810.250, therapy codes require that the beneficiary be present for the service activity.

Note that some code descriptions clearly describe the service as occurring with the client present. Those codes should not be used to report services provided to collaterals. Most HCPCs, however, are silent as to whether the beneficiary is required to be present or not. It is appropriate to use these codes when the beneficiary is not there so long as they are the codes that describe the service provided. For specific CPT code usage, refer to the AMA CPT Codebook for 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 used for both individual and group services (e.g., H2017). If a code can be used for both individual and group services, modifier HQ needs to be applied to indicate that the code is being used for a group service. Group only codes do not require the HQ modifier. When indicated, group codes can be extended with G2212.

74. How do we enter travel time for group services in SmartCare? *Updated 4/22/24*

Group services are entered very similarly to individual services with the exception of travel time. Enter total travel time for the service on one of the client service records OR divide evenly between each group participant.

For example, a group with 5 participants where the clinician travelled 60 minutes round trip would be documented in one of two ways:

- Travel: 12 minutes (add to each beneficiary's claim)
- Travel: 60 minutes (only add to one beneficiary's claim)

Telehealth

75. What location should be selected when a service is provided via telehealth, but the beneficiary is not present for that service?

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

76. What Location Codes should be used if providing Collateral sessions remotely without the beneficiary present?

    Location/Place of Service Codes are allowable places where services can be performed. The DHCS Billing manual has a long list of Place of Service Codes and their descriptions. ACBHD 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 ACBHD 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.

77. In SmartCare, what is the purpose of "Mode of Delivery"? *New 3/28/24*

The purpose of "Mode of Delivery" is to apply the correct modifier to the different types of telehealth activities, either “audio only” (e.g. phone) or “audio/video” (e.g. zoom for healthcare). CG users will need to complete “Mode of Delivery” within CG.

78. 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.

Interpretation Services

79. 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.

80. When oral or sign language interpretation (T1013) be used?

    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.

81. Can residential and inpatient programs claim for T1013?

    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.

82. Can interpretation (T1013) be claimed when using a third party (e.g., language line, relay service) for interpretation?

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

83. Which taxonomy code should be included on a claim for interpretation services?

    A claim for interpretation, T1013 (sign language or oral interpretive services), should include the taxonomy code and NPI of the individual who provided the primary service.

Scope of Practice

84. 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.

85. Can a provider have multiple taxonomy codes in SmartCare?

    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 greatest number of services.

86. The billing manuals do not include taxonomy codes for all staff types, in those situations what should we do? *Updated 3/28/24*

    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 (e.g., ASW, AMFT, APCC): Use one of the taxonomy codes in the DHCS billing manual. An intern should use the taxonomy code most appropriate for the practitioner

    All Clinical Trainees (except Physician Clinical Trainees): Use taxonomy code 390200000X

    See ACBHD memo 2024-08 requiring providers to submit this change using an e-Form as soon as possible. Once the taxonomy code is changed in SmartCare, MH graduate students (clinical trainees) may use procedure codes consistent with others of their discipline (e.g. LCSW = ASW = SW clinical trainee) when claiming Medi-Cal.

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

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

    For specific codes and who can use them, please refer to the most recent DHCS SMHS Service Table on DHCS's MedCCC Library website.

88. 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.

89. What procedure codes can MHRS's use?

For specific codes allowable for MHRS's, please refer to the most recent DHCS SMHS Service Table on DHCS's MedCCC Library website and filter for "MHRS" in column titled "SD/MC Allowable Disciplines."

90. What procedure codes can Certified Peer Support Specialists use? *Updated 3/28/24*

Certified Peer Support Specialists must use taxonomy code 175T00000X and the following procedure codes:

- 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) – DMC-ODS ONLY

Certified Peer Support Specialists who meet the qualifications for another practitioner type (e.g., Other Qualified Provider) may submit a separate claim under a different taxonomy code for any non-Medi-Cal Peer Support Services.

91. Has the scope of practice changed for Certified Peer Support Specialists? *New 4/22/24*

No. Even though Certified Peer Support Specialists can only use specific codes when claiming for their services, the scope of practice for these provider types has not changed. The specified codes encompass all of the services that peer support specialists provide.

92. What procedure codes can Family Partners use? *New 3/28/24*

Family Partners with the Certified Peer Specialist credentials are considered "Certified Peer Support Specialists" and may only use procedure H0025 and H0038. Family Partners that are not Certified Peer Specialists are considered "Other Qualified Providers," and may use the procedure codes for "Other Qualified Providers."

93. What procedure codes can Clinical Trainees use to claim for MH services? *Updated 3/28/24*

Clinical trainee activities provided before their taxonomy code was updated in SmartCare per ACBHD memo 2024-08 should claim for student services per ACBHD Memo 2023-50. Clinical trainee activities after their taxonomy code is confirmed to have been updated in SmartCare per ACBHD memo 2024-08 should claim for activities using the same procedure codes as others in their discipline (e.g., a bachelor's level nursing student may use the same procedure codes as a Registered Nurse).

94. 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. ACBHD is currently working on implementing Clinical Trainees in DMC-ODS. As part of the implementation process, an ACBHD Clinical Trainee policy has been drafted and is going through the approval process.

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

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

96. How does a registered or waivered provider claim for services? *Updated 3/28/24*

    An unlicensed (but registered or waivered provider, e.g., AMFT) has the same scope of their licensed supervisor and the individual whose license they are working under, except when activities are outside the scope of practice of the license they are working towards. For example, if an AMFT is being supervised by a licensed PhD, they can only perform activities that are in scope for the MFT license. 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.

97. 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 (OTP)/Narcotic Treatment Programs (NTP)

98. 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.

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

ACBHD 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. Per the DHCS CalAIM Payment Reform FAQ, the NTP dosing rate includes the following activities:

- Physical Exam
- Drug Screening
- Intake Assessment
- Medical Director Supervision
- TB Test
- Syphilis Test
- HIV Test
- Hepatitis C Test
- LVN Dosing
- RN Dosing
- Ingredient Costs

For components included in the NTP dosing rate (e.g., drug screening, physical exam, intake assessment, etc.) providers cannot bill those separate and apart from the bundled rate. We expect additional clarification when DHCS's DMC-ODS billing manual is updated again.

100. 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.

101. 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.

102. 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.

103. May Licensed Vocational Nurses (LVNs) provide services at OTPs? *Updated 3/28/24*

Yes. ACBHD has updated SmartCare to accommodate the new behavioral health provider types per SPA 23-0026. Information about taxonomy codes for LVNs can be found in the CalAIM Payment Reform FAQ and information about what procedure codes LVNs can use can be found in the Codes for New Providers document on the DHCS BH-CalAIM website.

104. What codes can NTP/OTPs use for reporting medication activities? *New 3/28/24*

NTP/OTPs use codes H0020, S5000, and S5001 with a National Drug Code (NDC) to claim for dosing medications covered under the DMC-ODS formulary including methadone, buprenorphine (transmucosal and long-acting injectable), naltrexone (oral and long-acting injectable), disulfiram, and naloxone. The list of medication codes available in SmartCare can be found on the *NDC Code List* tab in the ACBH SUD SmartCare Procedure Code Table (see Section 13 of the QA Manual). Please contact ACBH BBSU if an allowable medication is not present in SmartCare and we will add it.

OTPs can additionally use H0033 (with a NDC) to report administering additional medications. Non-NTP/OTP providers can use H0033 to report medication administering and can optionally provide an NDC.

Additionally, ACBHD is in the process of reviewing and updating OTP/NTP codes to allow for the prescription of medications that will be fulfilled through the Medi-Cal pharmacy benefit. More information to follow.

Resources

- DHCS Medi-Cal Billing Manuals and Service Tables for SMHS and DMC-ODS https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx

  Look under CalAIM References and Manuals Effective July 1, 2023, Short Doyle Medi-Cal Manuals

- DHCS CalAIM BH Payment Reform Frequently Asked Questions (FAQ) https://www.dhcs.ca.gov/Documents/CalAIM-Payment-Reform-Frequently-Asked-Questions.pdf

- DHCS CalAIM FAQs https://www.dhcs.ca.gov/Pages/CalAIM-Behavioral-Health-Initiative-Frequently-Asked-Questions.aspx

- CalAIM Reference Guides for CPT Codes
  https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx
  See documents under Short Doyle Medi-Cal References:
  - *CalAIM Reference Guide for CPT Codes – Specialty Mental Health Services*
  - *CalAIM Reference Guide for CPT Codes – Drug Medi-Cal Counties*
  - *CalAIM Reference Guide for CPT Codes – Drug Medi-Cal Organized Delivery System*

- SmartCare Procedure Code Tables
  https://bhcsproviders.acgov.org/providers/QA/qa_manual.htm
  See Section 13: Service and Billing Resources
  - *MH SmartCare Procedure Code Table*
  - *SUD SmartCare Procedure Code Table*

- DHCS Professional Licensing Waivers
  https://www.dhcs.ca.gov/services/MH/Pages/MHPLW.aspx

- CALMHSA Payment Reform Training
  https://www.calmhsa.org/calaim-support-for-counties/
  See:
  - *CPT Coding 101*
  - *CPT Coding 102*

- ACBHD Quality Assurance (QA) CPT Code Training
  https://bhcsproviders.acgov.org/providers/QA/Training.htm
  See training titled Current Procedural Terminology

- ACBHD QA Memos
  https://bhcsproviders.acgov.org/providers/QA/memos-2023.htm

- ACBHD QA Manual
  https://bhcsproviders.acgov.org/providers/QA/qa_manual.htm
  See Section 13, Service and Billing Resources

- AMA CPT Code Book
  https://www.ama-assn.org/practice-management/cpt/need-coding-resources