



**Behavioral Health
Department**
Alameda County Health

FREQUENTLY ASKED QUESTIONS HCPCS /CPT CODES

Alameda County Behavioral Health Department, Quality Assurance
Updated: October 2026

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General

1. What are HCPCS and CPT codes?

Behavioral Health Medi-Cal (DMC-ODS and SMHS) utilizes the Healthcare Common Procedure Coding System (HCPCS) Level I and Level II code set.

HCPCS Level I are CPT codes. CPT stands for Current Procedural Terminology. CPT codes are five digit numerical codes (e.g., 99202). CPT codes are maintained by the [American Medical Association \(AMA\)](#).

HCPCS Level II are commonly just referred to as HCPCS. HCPCS Level II codes are maintained by CMS and are a single alphabetical letter followed by 4 numeric digits. (e.g., T1017).

More information about the Healthcare Common Procedure Coding System (HCPCS) can be found on the [CMS website](#).

2. Will providers 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 behavioral health Medi-Cal delivery systems (SMHS and DMC-ODS).

3. Will ACBHD continue to use HCPCS after 7/1/23? *Updated October 2026*

Yes, both HCPCS Level I (CPT) and Level II codes will be available in each delivery system after 7/1/23. CPT codes will be used for outpatient clinical services provided by licensed professionals within their scope of practice. HCPCS Level II will continue to be used for non-clinical services (e.g., rehabilitation) and by non-licensed staff.

Except for a few specific cases, CPT codes must follow the rules and requirements as specified in the American Medical Association (AMA) CPT Codebook. Additional rules and requirements for procedure codes can be found in the DHCS billing manual for their respective delivery system.

4. How can providers best prepare for the transition to CPT Codes? *Updated October 2026*

There are multiple coding resources available for providers. Note, many of the questions in this document are covered in the training programs noted in the resources below. Providers are encouraged to listen to the 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 basics of payment reform coding and how procedure codes will be set up in SmartCare.¹
- Review the ACBHD SmartCare procedure code tables in Section 13 of the [ACBHD QA Manual](#). Refer to the corresponding procedure code table based on delivery system and date of service (e.g., DMC-ODS, FY25-26).
- Review [CalMHSA's](#) training modules in their [learning platform](#). Procedure code trainings are in the *Clinical Practice* section.
- Review the DHCS billing manuals for SMHS and DMC-ODS posted on the [MedCCC Library](#) page. The billing manuals are differentiated by delivery system and fiscal year (FY) and are in the *Short Doyle Medi-Cal Billing Manuals* section.
- Review the DHCS service tables for SMHS and DMC-ODS, available in the *Service Tables* section on the [MedCCC Library](#) page.
- The [American Medical Association's \(AMA\) CPT Codebook](#) can be purchased on the AMA website and is the official rule book for use of CPT codes.
- Attend [QA Brown Bags](#) or send questions to QATA@acgov.org. This FAQ is the result of questions asked by providers.

5. Will Community Based Organization (CBO) staff enter their services into SmartCare using CPT codes, or will there be some sort of crosswalk? *Updated April 2024*

CBOs will enter services into SmartCare or Clinician's Gateway using SmartCare procedure codes. ACBHD has published SmartCare procedure code tables in Section 13 of the [QA Manual](#), that include all procedure codes available in SmartCare and relevant details for each code. Services that bill Medi-Cal must follow DHCS rules set forth in the DHCS billing manual and services table for the corresponding delivery system. Due to the scope of the coding changes, a crosswalk is not advised.

6. Will ACBHD provide a list of code descriptions along with role type? *Updated April 2024*

Yes. The ACBHD SmartCare procedure code tables include information about which provider types can use the code. ACBHD provided these lists as excel documents with filtering capabilities to assist providers in navigating those tables. Additional information about disciplines can be found in both the DHCS SMHS and DMC-ODS billing manuals and service tables.

¹ As of publication of this version of the FAQ, the ACBHD CPT Code Training is slightly out of date. Some guidance may not reflect current information.

7. Will all codes on the DHCS service tables be available for all providers? *Updated April 2024*

No. Currently, only certain codes are available for each program. Program specific codes will continue to be consistent with the agency's provider contract. If there are codes on the service table 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 April 2024*

Providers should still enter non-billable time for activities or events (e.g., no shows) that ACBHD has procedure codes for and have been 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. Does ACBHD use any non-DHCS codes? *Updated October 2026*

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.). Both the MH and SUD ACBHD SmartCare procedure code tables contain non-Medi-Cal billable codes.

10. Do providers still need to follow CMS and AMA documentation standards for CPT/HCPCS codes, including E/M codes? *New October 2026*

Yes. DHCS and ACBHD guidance does not supersede CMS or AMA CPT and HCPCS documentation standards, including E/M codes.

For additional resources on CPT and HCPCS coding and documentation, please see:

- [American Medical Association CPT and HCPCS Resources](#)
- [Centers for Medicare and Medicaid Services HCPCS Resources](#)

11. How should providers manage conflicting information between ACBHD guidance, CMS Medicare standards, and AMA CPT Codebook guidance? *Updated October 2026*

Generally, CPT code rules are determined by the AMA (as described in the CPT Codebook). However, DHCS has applied more restrictive rules, such as only using direct patient care to determine time/units, even when the CPT Codebook indicates differently. DHCS also determines which codes are allowable based on CMS Medicare standards, though their specific rules may not always align with CMS. Therefore, the CPT codebook should be used in conjunction with the billing manuals. For further clarification, please contact QATA@acgov.org.

12. What activities are not billable to Medi-Cal/Medicare? *Updated October 2026*

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

13. Why is ACBHD's list of locations different from DHCS/CMS's Place of Service (POS) code set? *Updated October 2026*

HCPSC 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 corresponding [CMS POS code](#) when the claim is submitted.

14. Will the daily rate increase if more than the minimum number of hours for full and half-day Day Rehab (DR)/Day Treatment Intensive (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.

15. Do SUD residential programs have to use CPT codes? *Updated October 2026*

Both HCPSC and CPT codes are available to SUD residential programs. SUD residential programs will continue to use HCPSC code H0019 for day claims. To report care coordination, recovery services, MAT, clinician consultation, and peer services, SUD residential programs must use the appropriate HCPSC or CPT code and document those services in CG using the *Progress Note Single Service*.

See memo [2023-06](#) for more information.

16. Can ACBHD provide concrete definitions of what can be billed under case management, assessment, and plan development? *Updated October 2026*

CalAIM payment reform did not change SMHS or DMC-ODS service definitions; however, the code set used to claim to those delivery systems significantly changed. Definitions of services for each delivery system can be found in the [CA Medicaid State Plan](#) and [Short Doyle Medi-Cal Manuals](#). The DHCS service tables includes a code category column that can help to identify codes available for specific service types.

17. What are standalone SUD services?

Standalone SUD services can be provided when no other SUD services are provided. Only Recovery Services, Peer Support Services, Care Coordination, and MAT/Medication Services may be provided as a standalone service, when clinically appropriate. If standalone services are clinically appropriate for a member, providers should admit the member to the assessed ASAM Level of Care (LOC) and use procedure codes for that LOC. Standalone services are only available at non-OTP outpatient programs at this time. If a member 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.

Diagnoses

18. What is the relationship between a CPT/HCPCS code, an ICD-10-CM diagnosis code, and a DSM diagnosis? *New October 2026*

Per state and federal Medicaid requirements, a procedure code and diagnosis code are required on all Medicaid claim submissions. The diagnosis code specifies the behavioral health challenge being treated. The diagnosis code must be a HIPAA-compliant ICD-10-CM code and allowed by CMS on the date of service. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) provides the criteria for the mental health or substance use diagnosis. The procedure code indicates the specific activity or intervention provided to treat an allowable diagnosis in a particular delivery system (e.g., H0004 Individual Counseling to treat F10.10 Alcohol Use Disorder Mild, in DMC-ODS).

ACBHD has developed a document with additional information on this subject, *ACBHD Diagnosis and Code Guidance*, that can be found in Section 13 of the [ACBHD QA Manual](#).

19. What will happen if an invalid code/diagnosis is used on a claim? *New October 2026*

The answer depends on the reason for the invalid code.

- 1) If the code is not an allowed ICD-10-CM code based on the date of service, DHCS's Short-Doyle Medi-Cal claiming system (SDMC) will deny ACBHD's entire claim submission.

Eating disorders provide a recent example. ICD-10-CM recently expanded codes used to report eating disorders. Up until 9/30/2024 F50.01 was a CMS allowed and HIPAA compliant claiming code. After 10/1/2024, CMS no longer allowed F50.01 for claiming as more specific ICD-10-CM eating disorder diagnoses became effective ([link](#)). Claims with F50.01 after 9/30/2024 will be denied by SDMC.

- 2) The ICD-10-CM code is allowed by CMS on the date of service, but the code is not associated with any diagnoses in the current edition of DSM.

In this situation, the claim will not be denied by SDMC; however, Medi-Cal requires providers to use the current edition of the DSM to diagnosis mental and substance use disorders. Using codes not found in the DSM at the time of the service may result in non-compliance during chart review.

- 3) The SUD residential/inpatient program uses a code that is not listed in Appendix 5 of the DMC-ODS billing manual.

Per DHCS, the service will be denied. See *Section 5.2.35 Covered Diagnosis* section of the [DHCS DMC-ODS billing manual](#)

General Procedure Code Information

20. 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 training courses available, such as www.aapc.com (not an official recommendation) and ACBHD recommends providers utilize all available resources.

21. May different services on the same day or different days for the same member be combined and claimed at the same time? *Updated October 2026*

No. One of the major changes with CalAIM Payment Reform is the expansion of the specificity of codes available to report Medi-Cal activities. CPT code rules are very detailed and may only be used to report the specific activity.

22. What should providers do when a Medi-Cal billable activity has been performed but an exact code cannot be identified? *New October 2026*

Covered Medi-Cal services are described in the [California Medicaid State Plan](#). If you've provided a covered service to a Medi-Cal member, but there is not an obvious procedure code to use, just select the code most appropriate to report the activity.

23. Can providers complete one progress note if two or more services are provided to the same member on the same day? *Updated October 2026*

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 member**.
3. The **same provider** conducted all of the services.
4. All activities would be reported with the exact same **procedure code**.

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.

24. Should the Location code be “School” or “Office” when services are provided at a member’s school that is also a provider’s school site/office? *New April 2024*

The provider should use the Location code for “School” even if the provider’s office is at a school site.

25. 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. These codes are all HCPCS Level II.

Medi-Medi

26. What does “Medicare COB” mean? *Updated October 2026*

In the DHCS service tables, 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.

27. How are services claimed for members who have both Medicare and Medi-Cal?

Updated October 2026

Often referred to as having Medi-Medi, claiming for these members has not changed because of CalAIM or payment reform. Because Medi-Cal is the payer of last resort, it may not be known at the time of documentation which insurance will be billed. In these cases, the higher standard between Medicare and Medi-Cal should be followed. This means that for members who have Medi-Medi, treatment plans and other Medicare documentation requirements should continue to be completed.

Direct Patient Care

28. What is considered *direct patient care*? *Updated October 2026*

Below is the definition of *direct patient care* from the DHCS SMHS and DMC-ODS billing manuals:

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. Counties should only consider direct patient care time, as defined in the billing manual, when choosing the most appropriate code to bill. However, this does not mean that counties would not be reimbursed for activities such as chart review, documentation, and other activities associated with preparing to see a patient or post service time. The rates DHCS pays to counties are adjusted to incorporate the cost for staff time not spent on direct patient care, which includes activities the provider engages in before and after seeing a patient, and "no shows".

29. 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 they spent with the patient or collateral person for applicable codes.

Documentation and Travel Time

30. Will documentation and travel time continue to be reimbursed? *Updated October 2026*

At least through FY26-27, 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 Total Duration for direct service (“face-to-face”), 2) Travel time, and 3) Documentation time.
- Receive a monthly report from ACBHD, mimicking InSyst invoicing reports, 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.

31. How is travel and documentation time entered in SmartCare?

Travel time and documentation time must be maintained in the EHR or member’s chart documentation. There are distinct fields in SmartCare and Clinician’s Gateway to enter travel and documentation time, along with the service time when entering services directly into SmartCare. That information is 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.

32. 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 member’s medical record.

33. In the CPT codebook, certain E/M codes clearly allow billing for documentation time as part of the service. Are these an exception to the rule to not bill documentation time? *New October 2026*

This is a known issue. DHCS has stated that generally the CPT codebook should be followed; however, there are areas where DHCS’ rules may be different or even stricter than what is in the CPT codebook. DHCS has addressed this in their [CaAIM Payment Reform FAQ](#) (on page 6).

From all we have heard, DHCS has clearly indicated that documentation time is being reimbursed as part of the rate of the code and cannot be included in the time used to determine the number of units. Doing so would be double billing for that activity. Regardless, at the time this FAQ’s publication, ACBHD is continuing to pay providers separately for travel and documentation time.

34. What is the difference between travel time and transportation? *Updated April 2024*

Travel time is the time the staff spends traveling to meet the member in the community and back to the office. Traveling between agency offices is not travel time. If a staff member travels 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 member from one location to another.

35. Is transportation a billable activity? *New April 2024*

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. Also, time spent connecting a member to transportation services (such as paratransit) is billable as care coordination.

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

If documentation is occurring collaboratively, concurrent 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

37. In SmartCare what is the difference between *Total Duration* (service tab), *Duration* (add-on tab), and *Face-to-Face Time*? *Updated October 2026*

The service entry screen has several tabs used to enter services into SmartCare.

Total Duration (located in the main service entry tab) is the [direct patient care](#) time that SmartCare uses to calculate the number of units billed to Medi-Cal for the primary code.

Duration located on the *Add-On Codes* tab, 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* = 45 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 and designated as prolonged (e.g., Psychotherapy for Crisis, 90839-90840), *Total Duration* and *Face-to-Face Time* will be the same.

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

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

The goal is 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 or codes based on the time entered.

39. Can we always use the midpoint rule for code selection? *Updated October 2026*

No. Midpoint rule applies to some codes and not others and to both HCPCS Level I and II codes.

CPT codes that begin with 90* follow the midpoint rule, meaning that they can only be reported once the time threshold is reached. Another example of a code that uses the midpoint rule is T1017 Targeted Case Management. This code is billable once 8 minutes of direct (face-to-face) service has been 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. The *Time Range in Minutes* column provides the range of time associated with the code.

40. 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.

41. What happens when a provider attempts to enter a service where *Total Duration* exceeds the maximum allowed time for that code? *Updated October 2026*

SmartCare will not allow users to enter a time in *Total Duration* that exceeds the code’s maximum limit. It will alert the user to correct their entry.

42. What is changing for billing data entry in CG-SmartCare to match requirements from SmartCare? *New 3/28/2024*

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 modified by providers.

43. Why do many code descriptions in the DHCS service table include time in minutes, but the corresponding codes in SmartCare do not include time? *New October 2026*

SmartCare codes do not include time because the time in the DHCS code name is not representative of the total time when prolonged service codes or multiple units are factored in. Since SmartCare automatically prolongs a primary code’s time based on *Total Duration*, it was confusing to have time in a code name, when the actual range is much different.

For example, SDMC allows *T1017 Targeted Case Management, 15 minutes* to be claimed up to 96 units (1440 minutes). On the Service Entry screen in SmartCare, a 45 minute case management service would be entered as *T1017 Targeted Case Management* with a *Total Duration* of 45 minutes. When claiming to DHCS SmartCare will automatically claim three units of T1017.

Modifiers and Lockouts

44. What are modifiers? *Updated October 2026*

According to DHCS:

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.

45. Can ACBHD provide a list of all modifiers providers are expected to use and how modifiers will be applied in SmartCare? *Updated October 2026*

Most of the required modifiers have been built into SmartCare and are automatically added to codes (e.g. telehealth, ASAM LOC, etc.) behind the scenes. However, a few require manual entry. 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 are responsible for adding a modifier when entering those procedure codes if indicated. See the [DHCS Billing Manuals](#) for a full description of modifiers and their descriptions.

As an example, for IHBS services, the HK modifier needs to be manually added to each IHBS service entry. Please see [QA Memo 2025-01](#) for full details. The ACBHD SMHS SmartCare procedure code table lists all the codes that can be used to report IHBS.

46. What are lockouts? *Updated October 2026*

Lockouts happen when procedure codes are unable to be billed on the same day under certain conditions. SDMC enforces two types of lockouts. Some lockout rules only apply when procedure codes are being claimed for the same member on the same day by the same provider. If the rendering provider NPIs are different, those lockout rules do not apply. 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 on the day of admission and day of discharge.

The [DHCS billing manuals and service tables](#) include a detailed overview of lockout rules and the lockout rules for each procedure code. Additionally, in [Section 13 of the QA Manual](#), ACBHD has created an SMHS Lockout Situations Grid to reference.

47. Does SmartCare include logic to enforce lockout rules?

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

48. What services are outpatient providers able to render/bill when members are receiving services at a 24/7 facility? *New April 2025*

24/7 facility (e.g., acute psychiatric hospital, psychiatric health facility, CRT, ART) services are bundled and have a Medi-Cal daily reimbursement rate. Medi-Cal lockouts are intended to prevent duplicative service delivery and billing. Therefore, the main lockout exceptions are the day of admission and discharge.

For members admitted to acute psychiatric hospitals or psychiatric health facilities, outpatient providers may render/bill Targeted Case Management (TCM) services. TCM services, “solely for the purpose of coordinating placement of the beneficiary on discharge...” can be billed 30 days prior to the day of discharge. Reference: [9 CCR 1840.374. Lockouts for Targeted Case Management Services](#). Since average lengths of stay are generally well under 30 days, TCM services to coordinate placement should begin upon admission.

Regardless of whether a facility is subject to the IMD Exclusion (i.e. Medi-Cal reimbursement prohibition), service duplication should not occur. Therefore, outpatient providers should only render/bill TCM services to coordinate placement while members are receiving 24/7 facility services. [ACBHD Specialty Mental Health Services \(SMHS\) Medi-Cal Lockout Grid](#) provides a few examples of the facility types but is not an exhaustive list. There are over 140 acute psychiatric hospitals and psychiatric health facilities in California.

Dependent-On Codes

49. What are *Dependent-On* codes?

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

50. How does SmartCare prolong or extend a primary code’s time? *New October 2026*

For most services, claiming rules have been set up in SmartCare to automatically add the appropriate add-on codes to extend time.

A few services, however, require multiple stacked add-on codes to prolong time and SmartCare cannot be configured to correctly automatically claim those codes. The table below provides guidance for those situations:

CPT Code	SDMC Time Range	SmartCare Time Range	Alternate Code If Time Exceeds SmartCare Max	Alternate Code Time Range
99202-99205	15-1440	15-134	90792	31-1440
99212-99215	10-1440	10-114	90792	31-1440
96170-96171	16-1440	16-38	None	N/A

51. What are supplemental codes? *New October 2026*

Supplemental codes are a type of Dependent-On code used to modify a service. DHCS has identified the following codes as supplemental codes. Refer to the [DHCS billing manuals and service tables](#) for specific usage and requirements.

SMHS

- 90785 Interactive Complexity
- 90887 Interpret or Explain Results of Psych/Other Med. Proc.
- 96161 96161 Caregiver Assessment Admin.
- T1013 Sign Language or Oral Interpretive Services

DMC-ODS

- 90785 Interactive Complexity
- 90887 Interpret or Explain Results of Psych/Other Med. Proc.
- 96170 Health Behavior Intervention, f/f- w/family w/out patient
- T1013 Sign Language or Oral Interpretive Services

52. Can multiple Add-On codes be used for the same service? *Updated October 2026*

Yes, if the conditions for all add-on codes are met.

53. What are the T2024 and T2021 substitution codes used for? *New October 2026*

T2024/T2021 are behavioral health Medi-Cal specific substitution codes used to extend the time of certain assessment and therapy codes, respectively. ACBHD providers do not have to use these codes because SmartCare has been configured to automatically substitute T2024 and T2021 when necessary.

54. How are supplemental codes added to a claim? *New October 2026*

In SmartCare, on the *Service Entry* screen, supplemental codes can be added to a claim from the *Add-On Codes* tab. More than one supplemental code can be added on to a service when allowed by DHCS.

In Clinician's Gateway (CG), supplemental codes are added on within the standard progress note template. There are two dropdowns in the *Billing Time* section to add supplemental codes. The *Add-On Codes* dropdown and *Add-On Time* allows one supplemental code to be added to the claim. The *Interactive Complexity* dropdown is only used for interactive complexity. IS/IT, QA, and BBSU are working on improving CG add-on code functionality to properly allow multiple add-on codes per Medi-Cal standards.

Specific Procedure Code Information

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

Updated April 2024

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.

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

Several 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 member or their family members are not present (see codes 99367, 99368). If the consultation is a service to refer, link, or monitor a member's use of additional services, 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 member's care team.

57. 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 InSyst code 326-90889 (CANS Evaluation, not face-to-face) code? *Updated October 2026*

Documentation time can no longer be claimed to Medi-Cal thus there are no codes to claim documentation time on its own. Time completing the CANS could be considered "consolidating and synthesizing" if it meets that definition, but the time spent entering CANS data into various systems is not billable because data entry is not a Medi-Cal billable activity.

To report billable CANS-related activities, please choose the most appropriate code based on the activity provided.

58. The SMHS billing manual and service table includes two crisis codes that use code H2011. What is the difference? *Updated October 2026*

Despite their similarities these two codes report distinct crisis activities and have different rules.

H2011 Crisis Intervention - Crisis intervention activities may be provided across the outpatient system and is billed in 15 minute units. This is the standard outpatient code to report outpatient mental health crisis interventions. It may be used at many locations throughout the system.

H2011 Medi-Cal Mobile Crisis Services – This code is only to be used by mobile crisis teams to report a mobile crisis encounter that meets the requirements outlined in [BHIN 23-025](#) for the Medi-Cal Mobile Crisis Services Benefit (MCB). *H2011 Medi-Cal Mobile Crisis Services* will be sent with Place of Service 15 per requirements from DHCS. This is how DHCS distinguishes MCB services from other types of crisis services including non-MCB qualifying mobile crisis services.

If a mobile crisis team provides a crisis service that does not meet the requirements of the MCB and BHIN 23-025, they must use *H2011 Crisis Intervention* to report the service.

59. Can providers use CPT 90885 to bill for reviewing a chart prior to a session?

No. This code is intended to be used for diagnostic and treatment planning purposes. 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.”

60. How can providers bill for chart reviews in preparation for an individual or group session?

According to DHCS, preparation for therapy sessions is not billable using HCPCS Level I or Level II codes.

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

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

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

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

63. How do SUD providers claim for recovery services?

The definition of recovery services has changed significantly from the DMC-ODS initial implementation in Alameda County in July of 2018 (see DHCS BHINs [21-020](#) and [23-001](#)). Namely, recovery services is no longer a distinct level of care (LOC), a SUD remission

diagnosis is no longer required, recovery services can be provided at all SUD LOCs, they can be provided as a standalone service, they can be provided concurrently with other SUD services, and they are no longer only an aftercare service. After 7/1/23, there are two primary codes for recovery services at outpatient LOCs:

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

Information about standalone SUD services are also available in other questions of this FAQ.

64. What are Community-Based Wrap-Around Services?

Community-based wrap around services (HCPSC H2021) refers to coordination of care between providers in the Drug Medi-Cal System and providers who are outside the Drug Medi-Cal System. H2021 can only be used to show that a delivery-system coordination of care has occurred. For other kinds of coordination, other service codes must be used.

65. How can providers bill for two separate assessment services completed by two different providers (MD and non-MD clinician) on the same day? *New April 2024*

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.”

66. Can a SUD Counselor bill for the time spent meeting with an LPHA to discuss a member’s diagnosis? *New April 2024*

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

E/M Services

67. What are E/M codes? *New April 2024*

E/M stands for Evaluation and Management. E/M codes 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.

68. How can providers claim Psychotherapy Services with Evaluation and Management?

Updated October 2026

For guidance on how to use this code series, please refer to [QA Memo 2025-37](#).

Collateral Services and Interactive Complexity

69. Can SUD providers continue to claim for services when working with a member's collateral supports? *Updated October 2026*

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 24-001](#) and the [DHCS CalAIM FAQ](#)). However, services provided to members' significant support persons (when related to their treatment), are still Medi-Cal reimbursable.

70. Can MH providers continue to claim for services when working with a member's collateral supports? *Updated October 2026*

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

Per [9 CCR § 1810.250](#), therapy codes require that the member be present for the service activity.

71. What procedure codes can providers use to claim for services to collateral supports? *New October 2026*

When providing services to a member's significant support person, select the service code that most closely fits the intervention provided related to the member'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 member from their caregiver, they will use a suitable assessment code to report that activity.

Note that some code descriptions clearly describe the service as occurring with the member present. Those codes should not be used to report services provided to collaterals.

Additionally, the [DHCS CalAIM Behavioral Health Initiative FAQ](#) includes several questions and answers related to code selection for services to collateral supports relevant to this question.

72. Can providers use *Interactive Complexity* for some collateral support at the end or beginning of a session? *Updated October 2026*

If the support rendered meets the definition of Interactive Complexity as described in the billing manuals and AMA CPT Codebook, then it may be used on allowable codes.

73. Can providers use the APA one-page guideline on *Interactive Complexity*?

Officially, the definition of *interactive complexity* (CPT 90875) comes from the AMA CPT Codebook. Guidance from other sources, such as the APA and CMS, may be used if it is consistent with official guidance.

74. 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 aligns with the service.

Group Services

75. What codes can be used to claim group services? *Updated October 2026*

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). When claiming to SDMC group only codes do not require the HQ modifier. If a code can be used for both individual and group services, SmartCare will automatically add modifier HQ to indicate that the code is being used for a group service.

76. How do providers enter travel time for group services in SmartCare? *Updated April 2024*

Group services are entered 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 member's claim)
- Travel: 60 minutes (only add to one member's claim)

Telehealth

77. What location should be selected when a service is provided via telehealth, but the patient is not present for that service? *Updated October 2026*

In SmartCare select *Phone-Pt not home/not present* or *Video-Pt not home/not present*. Selecting either of these locations will add Place of Service (POS) 02 to the claim line.

78. In SmartCare, what is the purpose of *Mode of Delivery*? *New April 2024*

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.

79. Can 90839 (w/90840 Add-on) *PsychThpy for Crisis* be provided via telehealth? *Updated October 2026*

Yes. DHCS added POS 02 and 10 to 90839 and 90840 effective 7/1/2023.

Interpretation Services

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

No. A claim for interpretation (T1013) should not be submitted for this scenario.

81. When can *T1013 Sign language or oral interpretive services* be used?

A claim for interpretation can be submitted when the provider and the member 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.

82. Can residential and inpatient programs claim for T1013?

No. Interpretation is included in the inpatient/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.

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

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

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

A claim for services under T1013 should include the taxonomy code and NPI number of the individual who provided the primary service.

Scope of Practice

85. How do providers determine who can use a particular procedure code? *New October 2026*

Please refer to the *SDMC Allowable Disciplines* column in the appropriate SMHS and DMC-ODS service table on the [MedCCC Library](#) website for this information.

The DHCS discipline may be a category that includes multiple provider types, for example LCSW means any of LCSW, ASW, MSW-Candidate, or SW-Clinical Trainee.

Taxonomy Codes

86. Why are taxonomy codes important?

In short, taxonomy codes help to ensure that providers have the scope of practice to claim a service. DHCS uses the first four (4) or five (5) 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.

87. Provider disciplines listed in the DHCS billing manuals are different from the SmartCare degree license types. How do we know what taxonomy number to select for the disciplines not listed? *New October 2026*

ACBHD degree license types are based on DHCS disciplines, but with more specificity. The full list of DHCS disciplines and taxonomy prefixes are listed in *Appendix 1- Taxonomy Codes* in the [DHCS billing manuals](#). A crosswalk of DHCS staff disciplines and the corresponding SmartCare degree license type is provided below.

DHCS / ACBHD Staff Discipline Crosswalk		
DHCS Discipline	ACBHD Degree License Type	Recommended Taxonomy Prefix*
Alcohol and Other Drug Counselor	- Registered SUD Counselor - Certified SUD Counselor - Licensed SUD Counselor	101YA
Clinical Nurse Specialist	Clinical Nurse Specialist	364S
Clinical Trainee	- Clinical Nurse Specialist Clinical Trainee - Marriage and Family Therapist Clinical Trainee - Occupational Therapist Clinical Trainee - Pharmacist Clinical Trainee - Physician Assistant Clinical Trainee - Professional Clinical Counselor Clinical Trainee - Psychiatric Technician Clinical Trainee - Psychologist (PhD) Clinical Trainee - Psychologist (PsyD) Clinical Trainee - Registered Nurse Clinical Trainee - Social Worker Clinical Trainee - Vocational Nurse Clinical Trainee	3902
Community Health Worker	Community Health Worker	172V
Licensed Clinical Social Worker	- LCSW - ASW - MSW-Candidate	1041
Licensed Psychiatric Technician	Licensed Psychiatric Technician	167G
Licensed Vocational Nurse	Licensed Vocational Nurse	164X

DHCS / ACBHD Staff Discipline Crosswalk		
DHCS Discipline	ACBHD Degree License Type	Recommended Taxonomy Prefix*
Marriage and Family Therapist or Licensed Professional Clinical Counselor	- Licensed Marriage and Family Therapist (LMFT) - Associate Marriage and Family Therapist (AMFT) - MFT-Candidate - Licensed Professional Clinical Counselor (LPCC) - Associate Professional Clinical Counselor (APCC) - PCC-Candidate	106H
Medical Assistant	Certified Medical Assistant	363AM
Medical Student in Clerkship	- Physician Clinical Trainee - Post-Graduate Physician Resident (PTL)	1744
Mental Health Rehabilitation Specialist	Mental Health Rehab Specialist	2254
Nurse Practitioner	- Nurse Practitioner - Nurse Practitioner Furnishing - Psychiatric Mental Health Nurse Practitioner	363L
Occupational Therapist	Occupational Therapist	225X
Other Qualified Provider	- Other/Adjunct - ACBHD Peer Partner - ACBHD Family Partner - TFC Parent	373H
Peer Specialist	- Certified Medi-Cal Peer Support Specialist - Certified Medi-Cal Peer Support Specialist-Family	175T
Pharmacist	- Registered Pharmacist - Advanced Practice Pharmacist	1835

DHCS / ACBHD Staff Discipline Crosswalk		
DHCS Discipline	ACBHD Degree License Type	Recommended Taxonomy Prefix*
Physician	- Licensed Psychiatrist/Physician (MD) - Licensed Psychiatrist/Physician (DO)	2084
Physician Assistant	Physician Assistant	363A
Psychologist	- Licensed Psychologist (-PhD) - Licensed Psychologist (-PsyD) - Waivered Psychologist- (PhD) - Waivered Psychologist- (PsyD)	103T
Registered Nurse	Registered Nurse	163W

The above table includes the ACBHD recommended taxonomy prefix for each discipline type. Providers may use other available taxonomy codes as appropriate for their specialty. To avoid billing errors, only use taxonomy prefixes that have been consistently allowed in the category.

88. Where can providers find a list of taxonomy codes and their descriptions? *New October 2026*

Taxonomy codes and their descriptions are determined by the National Uniform Claim Committee (NUCC.org) and can be found on their website.

89. Does a provider's SmartCare and NPPES NPI Registry taxonomy codes need to match? *New October 2026*

Yes. A provider's SmartCare taxonomy code should align with their [NPPES NPI Registry](#) profile. If a provider has multiple specialties, multiple taxonomies may be added to their NPI profile. ACBHD only verifies that the requested taxonomy is present on NPPES, it does not have to be primary.

90. What will happen if a provider's taxonomy code in SmartCare is incorrect? *New October 2026*

One of the SDMC's validations is between taxonomy and procedure code. If a claim is submitted with a taxonomy code that is not allowed for the procedure code Medi-Cal will

deny the claim. Staff taxonomy codes must be updated in both SmartCare and NPPES whenever there is change in discipline or if a taxonomy code is not correct.

91. 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 to which they were hired and/or the code that will allow the greatest number of services.

Clinical Trainees

92. What procedure codes can clinical trainees use? *Updated October 2026*

Clinical trainees can use the same procedure codes as others in their discipline.

For example, a bachelor's level nursing student (RN-CT) may use the same procedure codes as a Registered Nurse (RN). The difference between a RN and a RN-CT is the required level of oversight and supervision, but their scope of practice is the same.

93. How do MH graduate students claim for services with DMC-ODS? *Updated October 2026*

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. All ACBHD providers utilizing clinical trainees must follow [1603-3-3 ACBHD Clinical Trainee Policy](#).

94. Is a Post-Graduate Physician Resident (PTL) considered a physician clinical trainee? *New October 2026*

Yes. Per DHCS [PTLs](#) are considered clinical trainees. PTLs should use a taxonomy code prefix of 1744.

Registered/Waivered Providers

95. How does a registered or waived provider claim for services? *Updated October 2026*

An unlicensed but registered or waived provider (e.g., AMFT) has the same scope of practice as 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.

96. What staff designations/taxonomy codes should waived providers use?

Waivered providers 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](#).

97. Are waived psychologists required to register with the CA Board of Psychology as a psychological associate? *New October 2026*

Yes. Due to state credentialing, board oversight, and monitoring requirements ACBHD requires psychologists with a [DHCS professional licensing waiver \(PLW\)](#) to register with the CA Board of Psychology as a [Registered Psychological Associate \(RPA\)](#). In ACBHD's billing system RPA will be designated as a non-billing license/degree type and claims to SMHS will continue to be processed as waived psychologist. Additional information will be provided in a [QA Memo](#) shortly after publication of these FAQs.

Peers

98. What procedure codes can Certified Medi-Cal Peer Support Specialists (CMPSS/CMPSS-F) use? *Updated October 2026*

CMPSS/CMPSS-F must use taxonomy code 175T00000X and the following procedure codes:

- When providing peer support groups to members use *H0025 PSS Educational Skill Building Groups*.
- When facilitating group peer support services to family members or other significant support persons use *H0025 PSS Family Educational Skill Building Groups*. If the member is present, do not use this code.
- When providing individual peer support services and the member is present use *H0038 PSS Engagement/Therapeutic Activity*
- When providing individual peer support services to family members or other significant support persons use *H0038 PSS Family Engagement/Therapeutic Activity*. If the member is present, do not use this code.
- When providing Recovery Incentives/Contingency Management services use *H0050 Alcohol and/or Drug Services – DMC-ODS ONLY*

99. Has the scope of practice changed for Certified Peer Support Specialists? *New April 2024*

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 the services that peer support specialists provide.

100. What procedure codes can family partners use? *Updated October 2026*

Peer providers designated as *ACBHD Peer Partner (APP)* and *ACBHD Family Partner (AFP)* are considered *Other Qualified Providers* by Medi-Cal and may use any procedure codes for that discipline. In contrast, staff with a Certified Medi-Cal Peer Specialist (CMPSS/CMPSS-F) credential may only use procedure codes H0025, H0038, and H0050.

Opioid Treatment Programs (OTP)/Narcotic Treatment Programs (NTP)

101. Can OTP claims include documentation and travel time after 7/1/23? *Updated October 2026*

DHCS and ACBHD do not reimburse NTP/OTP programs for documentation or travel time.

102. After 7/1/23 how will OTP services be claimed? *Updated October 2026*

Per DHCS, 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

Providers cannot separately bill for components included in the NTP dosing rate (e.g., drug screening, physical exam, intake assessment, etc.) as they are part of the bundled rate.

Additional information about NTP/OTP services can be found in the [DHCS DMC-ODS billing manual](#).

103. 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 seem inconsistent with the definition of the NTP level of care. Is it accurate that all codes with UA or HG

modifiers can be used at OTP/NTPs or will those modifiers be removed from some of those codes in version 1.4 of the DMC-ODS 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.

104. Will the CPT change apply to OTP providers? *Updated October 2026*

As of publication of this FAQ, NTP/OTPs use mostly HCPCS Level II codes. DHCS has allowed a few HCPCS Level I (CPT) codes to report clinician consultation activities.

105. 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.

106. May Licensed Vocational Nurses (LVNs) provide services at OTPs? *Updated April 2024*

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](#).

107. What codes can NTP/OTPs use for reporting medication activities? *New April 2024*

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 ACBHD SUD SmartCare Procedure Code Table (see [Section 13 of the QA Manual](#)). Please contact ACBHD BBSU if an allowable medication is not present in SmartCare and we will add it.

OTPs can additionally use H0033 (with an 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 Resources

- [DHCS MedCCC Library](#)
 - DHCS website that includes SMHS and DMC-ODS billing manuals and service tables.
- [DHCS CalAIM BH Payment Reform Frequently Asked Questions](#)
- [DHCS CalAIM Behavioral Health Initiative FAQs](#)
- [DHCS Contingency Management / Recovery Incentives](#)
- [DHCS Medi-Cal Peer Support Services](#)
- [DHCS Narcotic Treatment Programs](#)
- [DHCS Professional Licensing Waivers \(PLWs\)](#)
- [DHCS Telehealth](#)

ACBHD Resources

- [ACBHD SmartCare procedure code tables](#)
 - See Section 13: Service and Billing Resources
- [ACBHD QA Training page](#)
 - For procedure code training, search for *Current Procedural Terminology*
- [ACBHD QA Memos](#)
- [ACBHD QA Manual](#)
 - See Section 13, *Service and Billing Resources*
 - See Section 19 *Frequently Asked Questions (FAQ)*
 - See Section 20 *TIPS Sheets (Treatment Interventions, Protocols, and Suggestions)*

Additional Resources

- [CalMHSA](#)
 - Use the *Training & Implementation* dropdown and select *Clinical Practice*.
- [American Medical Association \(AMA\) CPT Coding Resources](#)
 - Visit the [AMA Store](#) to purchase a CPT codebook.
- [American Psychological Association \(APA\) Diagnostic and Statistical Manual of Mental Disorders \(DSM-5-TR\)](#)

- [CMS ICD-10 Codes](#)