County of Santa Clara
Behavioral Health Services

CPT/HCPCS Training
for
MD/DO
Nurse Practitioners (NP)
Physician Assistant (PA)

June 23, 2023

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Clara Valley Medical Center

PT Code Training MD/DO (MH & SUTS)"

June 23, 2023

None of the planners and speakers for this educational activity have relevant financial relationship(s) to disclose with ineligible companies whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

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AGENDA

- What's changing and what's not changing

- Review of applicable CPT/HCPCS codes for MD/DO NP PA
  - Specialty Mental Health Services (SMHS)
    - Billing Manual Version 1.4
  - Drug Medi-Cal Organized Delivery System (DMC-ODS)
    - Billing Manual Version 1.3

SMHS BH Service Groups

1. Assessment
2. Crisis Intervention
3. Medication Support Services
4. Peer Support Services
5. Plan Development
6. Referral
7. Rehabilitation
8. Supplemental Services
9. Therapeutic Behavioral Services
10. Therapy

DMC-ODS BH Service Groups

1. Assessment
2. SUD Crisis Intervention
3. Medication Services
4. Treatment Planning
5. Individual Counseling
6. Group Counseling
7. Care Coordination
8. Recovery Services
9. Supplemental Services
10. Discharge Services
11. Family Therapy
12. Peer Support Specialist Services

CalAIM Regulatory Changes Effective 7/1/2023

CalAIM Behavioral Health Payment Reform

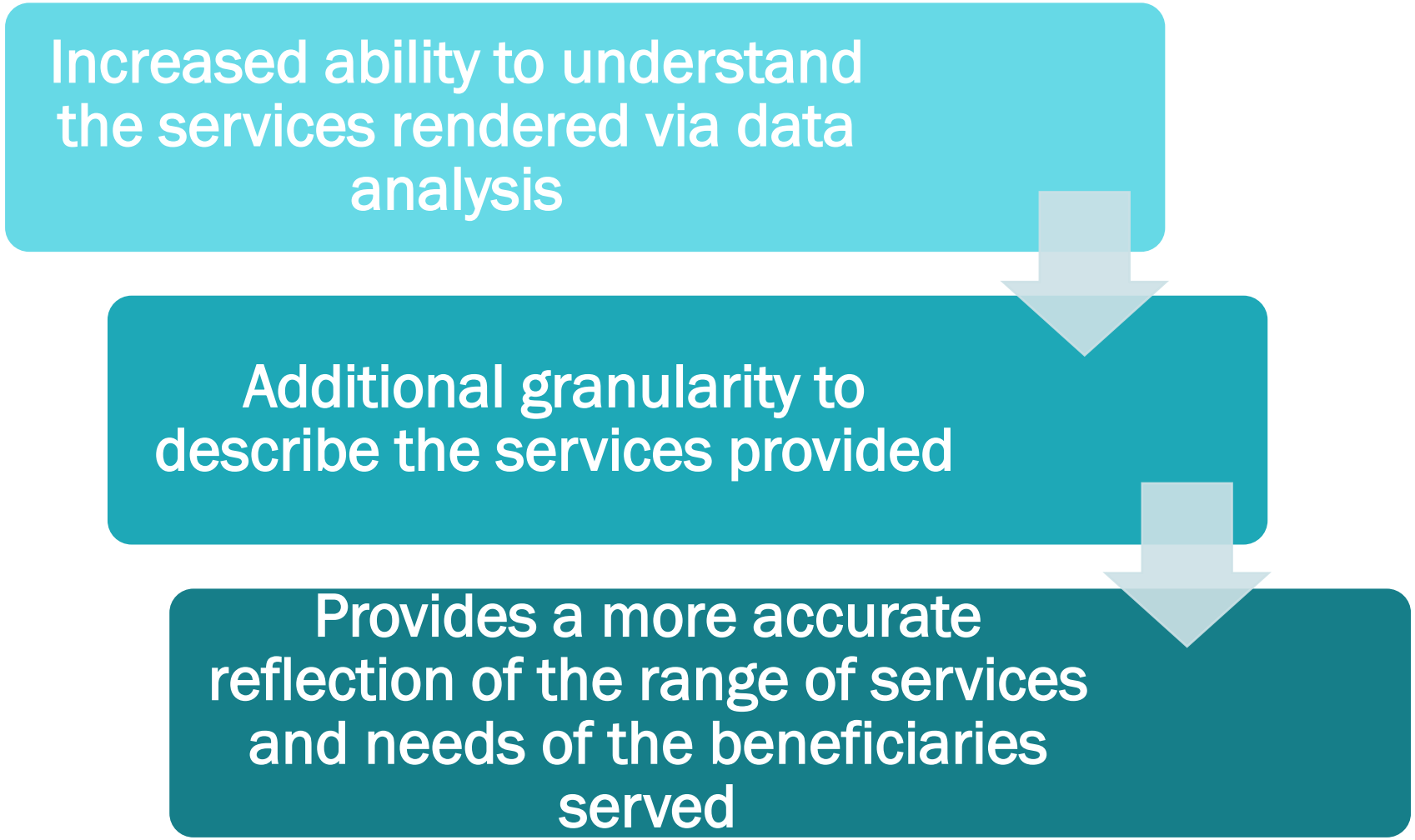
- CalAIM – California Advancing and Innovating Medi-Cal
- Payment reform goals:
  - Simplify county BH plan payments and reduce administrative burden for the State, counties, and providers.
- The payment reform initiative will enable counties and providers to deliver value-based care that improved quality of life fore Medi-Cal beneficiaries
- Ending cost-based reimbursement and simplifying payments to county BH plans are foundational first steps toward future development of more innovative value-based payment models
- The CalAIM Behavioral Health Payment Reform initiative consists of three different transitions, effective July 1, 2023
- Documentation link: CalAIM BH Payment Reform Fact Sheet DHCS Letterhead

CPT Coding Transition

Goals: Improve reporting and support data-driven decision making. Align with other healthcare delivery systems and comply with CMS requirements for all state Medicaid programs to adopt CPT codes where appropriate.

Present HCPCS Level II – All Services	Future CPT/HCPCS Level I – Where Applicable
HCPCS Level II codes are highly flexible; a variety of activities may be captured by the same code, making detailed analysis of services rendered a challenge	CPT codes: more detailed and nationally standardized definitions for each code.
HCPCS Level II codes can be used by any provider (licensed or non-licensed)	Some HCPCS Level II codes will be retained, for those behavioral health providers and services not captured by CPT codes.

Benefits of the Transition



Things that are NOT Changing

24-hour and Day Services
HCPCS codes utilized for non-clinical staff and non-clinical services (e.g., Rehabilitation, Targeted Case Management
Scope of practice (What a provider is permitted to do within their given discipline)
Scope of competence (skills or services a provider can offer based on experience and training)
County-defined supervision practices

Things that ARE Changing

Service/procedure code names
Billing by units vs. minutes
Direct patient care requirements
Selecting codes based on direct service time
Modifiers
Add-on Codes
Lockouts
Duplicate services
Recording documentation and travel time

Minutes vs. Units

NOTE: Your agency EHR configuration will determine whether to enter minutes or units.

- Claims will be based on units of service rather than total number of minutes.
- Direct services providers will still document service time, the finalized claim will be based on units of service dependent on the number of minutes
- A unit of time is considered ‘met’ when the midpoint of the given time or time range is exceeded
- *Example #1:*
  - An AOD Counselor meets with a client and provides 60 minutes of Targeted Case Management. This service would be noted as 4 units of Targeted Case Management (60 minutes of service/15 minutes per unit)
- *Example #2:*
  - An AOD Counselor meets with a client and provides 4 minutes of Targeted Case Management. This service does not pass the midpoint of 15 minutes and cannot be billed. If the service was 8 minutes, then 1 unit of Targeted Case Management could be billed.

Direct Patient Care

- Only direct patient care should be counted toward selection of service time when documenting a service
- Direct patient care can include time spent meeting directly with the beneficiary as well as with caregivers, significant support persons and other professionals
- 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 beneficiary visit.

Behavioral Health Services

Assessment
MD/DO NP PA

SMHS Assessment Codes

- Assessment means a service activity designed to evaluate the current status of a beneficiary's mental, emotional, or behavioral health.
- Assessment includes one or more of the following:
  - Mental status determination
  - Analysis of the beneficiary's clinical history
  - Analysis of relevant biopsychosocial and cultural issues and history
  - Diagnosis and the use of testing procedures

SMHS Assessment Codes

Code	Description	Code Guidance	Documentation
90791	Psychiatric diagnostic evaluation, 15 minutes	Diagnostic interview performed when the provider initially sees a patient. May be reported once per day and not on the same day as an E/M service performed by the same individual for the same patient.	• Documentation must include a complete medical and psychiatric history, a mental status exam, ordering of laboratory and other diagnostic studies with interpretation, and communication with of sources or informants. • Documentation must include total time Provider: MD/DO, PA, NP
90792	Psychiatric diagnostic evaluation with medical services, 15 minutes	Used for medical services provided in conjunction with the psychiatric diagnostic evaluation	• Documentation must include a complete medical and psychiatric history, a mental status exam, ordering of laboratory and other diagnostic studies with interpretation, and communication with of sources or informants. • Documentation must include total time Provider: MD/DO, PA, NP
90885	Psychiatric evaluation of hospital records and other accumulated data for medical diagnostic purposes, 15 minutes	Evaluation includes: hospital records, other psychiatric reports, psychometric and/or projective tests and other accumulated data May be separately reported on the same date of service as psychotherapy codes (90832-90838)	• Includes evaluation of results of psychometric tests or other evaluations. • Records can be from inpatient or outpatient hospitalization, drug or alcohol rehabilitation programs or facilities • Documentation must include total time Provider: MD/DO, PA, NP

SMHS Assessment Codes

Code	Description	Code Guidance	Documentation
96105	Assessment of aphasia, per hour	Includes assessment of expressive and receptive speech and language function, language comprehension, speech production, ability, reading, writing	• Includes face-to-face time with the patient and non-face-to-face time for results interpretation and report preparation. • Documentation must include total time Provider: MD/DO, PA, NP
96110	Development screening, per standardized instrument	Includes developmental milestone survey, speech and language delay screen with scoring and documentation	• Documentation should include the specific screening instrument used Provider: MD/DO, PA, NP
96112 96113	Developmental testing administration, by a physician or other QHP	96112: first hour 96113: each additional 30 minutes Includes assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments	• When testing exceeds 60 minutes, codes 96112 and 96113 should be utilized for correct billing • Documentation must include total time Provider: MD/DO, PA, NP

SMHS Assessment Codes

Code	Description	Code Guidance	Documentation
96116 96121	Neurobehavioral status exam, by a physician or other QHP	96116: first hour 96121: each additional 30 minutes Clinical assessment of thinking, reasoning and judgement. Includes acquired knowledge, attention, language, memory, planning and problem solving and visual spatial abilities	• This exam includes both face-to-face time with the patient and time interpreting test results and preparing the report • When testing exceeds 60 minutes, codes 96116 and 96121 should be utilized for correct billing • Documentation must include total time Provider: MD/DO, PA, NP
96125	Standardized cognitive performance testing, per hour	Includes the Ross Information Processing Assessment	• This testing includes both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report • Documentation must include total time Provider: MD/DO, PA, NP
96127	Brief emotional/ behavioral assessment, per standardized instrument	Includes depression inventory, attention-deficit/hyperactivity disorder (ADHD) scale with scoring	• Documentation should include the specific screening instrument used. Provider: MD/DO, PA, NP

SMHS Assessment Codes

Code	Description	Code Guidance	Documentation
96130 96131	Psychological testing evaluation by physician or QHP	96130: first hour 96131: each additional hour Includes face-to-face time with the patient as well as time spent integrating and interpreting the data These codes do not include time for testing administration and scoring services (96136, 96137, 96138, 96139)	• Document evaluation services, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed • Documentation must include total time of the evaluation Provider: MD/DO, PA, NP
96132 96133	Neuropsychological testing evaluation by physician or QHP	96132: first hour 96133: each additional hour Includes face-to-face time with the patient as well as time spent integrating and interpreting the data These codes do not include time for testing administration and scoring services (96136, 96137, 96138, 96139)	• Document evaluation services, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed • Documentation must include total time for the evaluation Provider: MD/DO, PA, NP

SMHS Assessment Codes

Code	Description	Code Guidance	Documentation
96136 96137	Psychological or neuropsychological testing administration by physician or QHP	96136: first 30 minutes 96137: each additional 30 minutes Includes administration and scoring of two or more tests by any method These codes do not include time for testing evaluation (96130, 96131, 96132, 96133)	• Document the specific tests administered and scoring • Documentation must include total time Provider: MD/DO, PA, NP
96146	Psychological or neuropsychological test administration, 15 minutes	Test administered via a computer providing an automated result, which is interpreted by a QHP	• Document the specific test administered via a computer and the automated results • Documentation must include total time Provider: MD/DO, PA, NP

SMHS Assessment Codes

Code	Description	Code Guidance	Documentation
98966 98967 98968	Telephone assessment and management service by a non-physician health care professional	98966: 5-10 minutes 98967: 11-20 minutes 98968: 21-30 minutes Code is not reported if phone call refers to a service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment	• These calls involve obtaining a patient's history, assessing the patient's condition, medical decision making and communicating the decision via phone call with the patient • Document the date, participant(s) on the call, notation that the phone call was patient-initiated, nature of the service and other pertinent information • Document the assertation that the call was not related to a service performed and reported within previous 7 days • Documentation must include total time of the phone call assessment Provider: PA, NP
99441 99442 99443	Telephone evaluation and management services by a physician or other QHP who may report evaluation and management services	99441: 5-10 minutes 99442: 11-20 minutes 99443: 21-30 minutes Used by physician or QHP for medical discussion via telephone call Code is not reported if phone call refers to a service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment	• These calls involve obtaining a patient's history, assessing the patient's condition, medical decision making and communicating the decision via phone call with the patient • Document the date, participant(s) on the call, notation that the phone call was patient-initiated, nature of the service and other pertinent information • Document the assertation that the call was not related to a service performed and reported within previous 7 days • Documentation must include total time of the phone call assessment Provider: MD/DO, PA, NP

SMHS Assessment Codes

Code	Description	Code Guidance	Documentation
99234 99235 99236	Observation or inpatient hospital care	99234: 45 minutes met or exceeded 99235: 70 minutes met or exceeded 99236: 85 minutes met or exceeded	• Document total face-to-face (direct patient care) time on date of the encounter • Includes admission and discharge on the same date Provider: MD/DO, PA, NP
H0031	Mental health assessment by non-physician, 15 minutes	In-depth mental health assessment One in-depth assessment per recipient, per year	• Document the findings of the in-depth mental health assessment, including treatment plan/goals • Documentation must include total time of the assessment Provider: PA, NP
H2000	Comprehensive multidisciplinary evaluation, 15 minutes	Comprehensive evaluation by a multidisciplinary team	• Document the findings of the comprehensive evaluation and multidisciplinary team members involved in the evaluation • Documentation must include total time of the evaluation Provider: MD/DO, PA, NP
T1001	Nursing assessment, evaluation, 15 minutes	Assessment/evaluation conducted by a nurse	• Document the evaluation of the patient by the nurse • Documentation must include total time of the evaluation Provider: NP

DMC-ODS Assessment Codes

- Consists of activities to evaluate or monitor the status of a beneficiary's behavioral health and determine the appropriate level of care and course of treatment for that beneficiary.
- Assessments shall be conducted in accordance with applicable State and Federal laws, and regulations, and standards.
- Assessment may be initial and periodic, and may include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the beneficiary.

DMC-ODS Assessment Codes

Code	Description	Code Guidance	Documentation
90865	Nacrosynthesis for psychiatric diagnostic and therapeutic purposes, 15 minutes	Used for sodium amobarbital (Amytal) interview to monitor the effect of the drug	• Patient's medical record must contain documentation that fully supports the medical necessity for the services provided • Document specific pharmacological agent, dosage administered and whether the technique was effective or non-effective • Documentation must include total time Provider: LP, PA, NP
90791	Psychiatric diagnostic evaluation, 15 minutes	The diagnostic interview exam is done when the provider first sees a patient. May be reported once per day and not on the same day as an E/M service performed by the same individual for the same patient.	• Documentation must include a complete medical and psychiatric history, a mental status exam, ordering of laboratory and other diagnostic studies with interpretation, and communication with of sources or informants. • Documentation must include total time Provider: LP, PA, NP
90792	Psychiatric diagnostic evaluation with medical services, 15 minutes	Used for medical services provided in conjunction with the psychiatric diagnostic evaluation	• Documentation must include a complete medical and psychiatric history, a mental status exam, ordering of laboratory and other diagnostic studies with interpretation, and communication with of sources or informants. • Documentation must include total time Provider: LP, PA, NP

DMC-ODS Assessment Codes

Code	Description	Code Guidance	Documentation
90885	Psychiatric evaluation of hospital records and other accumulated data for medical diagnostic purposes, 15 minutes	Evaluation includes: hospital records, other psychiatric reports, psychometric and/or projective tests and other accumulated data May be separately reported on the same date of service as psychotherapy codes (90832-90838)	• Includes evaluation of results of psychometric tests or other evaluations. • Records can be from inpatient or outpatient hospitalization, drug or alcohol rehabilitation programs or facilities • Documentation must include total time Provider: LP, PA, NP
96130 96131	Psychological testing evaluation	96130: 1st hour 96131: each additional hour	• Document evaluation services, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed • Documentation must include total time of the evaluation Provider: LP, PA, NP
98966 98967 98968	Telephone assessment and management service by a non-physician health care professional	98966: 5-10 minutes 98967: 11-20 minutes 98968: 21-30 minutes Code is not reported if phone call refers to a service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment	• These calls involve obtaining a patient's history, assessing the patient's condition, medical decision making and communicating the decision via phone call with the patient • Document the date, participant(s) on the call, notation that the phone call was patient-initiated, nature of the service and other pertinent information • Document the assertation that the call was not related to a service performed and reported within previous 7 days • Documentation must include total time of the phone call assessment Provider: PA, NP

DMC-ODS Assessment Codes

Code	Description	Code Guidance	Documentation
99202 99203 99204 99205	Office or Other Outpatient Visit, New Patient	99202: 15-29 minutes 99203: 30-44 minutes 99204: 45-59 minutes 99205: 60-74 minutes	• Document total face-to-face (direct patient care) time on date of the encounter Provider: LP, PA, NP
99212 99213 99214 99215	Office or Other Outpatient Visit, Established Patient	99212: 10-19 minutes 99213: 20-29 minutes 99214: 30-29 minutes 99215: 40-54 minutes	• Document total face-to-face (direct patient care) time on date of the encounter Provider: LP, PA, NP
99234 99235 99236	Observation or inpatient hospital care with admission and discharge on the same date	99234: 45 minutes met or exceeded 99235: 70 minutes met or exceeded 99236: 85 minutes met or exceeded	• Document total face-to-face (direct patient care) time on date of the encounter • Includes admission and discharge on the same date Provider: LP, PA, NP
99304 99305 99306	Initial nursing facility care per day for new or established patient	99304: 25 minutes met or exceeded 99305: 35 minutes met or exceeded 99306: 45 minutes met or exceeded	• Document total face-to-face (direct patient care) time on date of the encounter Provider: LP, PA, NP

DMC-ODS Assessment Codes

Code	Description	Code Guidance	Documentation
99307 99308 99309 99310	Subsequent nursing facility care per day for new or established patient	99307: 10 minutes met or exceeded 99308: 15 minutes met or exceeded 99309: 30 minutes met or exceeded 99310: 45 minutes met or exceeded	• Document total face-to-face (direct patient care) time on date of the encounter Provider: LP, PA, NP
99341 99342 99344 99345	Home or residence visit of a new patient	99341: 15 minutes met or exceeded 99342: 30 minutes met or exceeded 99344: 60 minutes met or exceeded 99345: 75 minutes met or exceeded	• Document specific place of home or residence visit • Document total face-to-face (direct patient care) time on date of the encounter Provider: LP, PA, NP
99347 99348 99349 99350	Home or residence visit of an established patient	99347: 20 minutes met or exceeded 99348: 30 minutes met or exceeded 99349: 40 minutes met or exceeded 99350: 60 minutes met or exceeded	• Document specific place of home or residence visit • Document total face-to-face (direct patient care) time on date of the encounter Provider: LP, PA, NP

DMC-ODS Assessment Codes

Code	Description	Code Guidance	Documentation
99441 99442 99443	Telephone evaluation and management services by a physician or QHP who may report evaluation and management services	99441: 5-10 minutes 99442: 11-20 minutes 99443: 21-30 minutes Used by physician or QHP for medical discussion via telephone call Code is not reported if phone call refers to a service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment	• These calls involve obtaining a patient's history, assessing the patient's condition, medical decision making and communicating the decision via phone call with the patient • Document the date, participant(s) on the call, notation that the phone call was patient-initiated, nature of the service and other pertinent information • Document the assertation that the call was not related to a service performed and reported within previous 7 days • Documentation must include total time of the phone call assessment Provider: LP, PA, NP

DMC-ODS Assessment Codes

Code	Description	Code Guidance	Documentation
H0001	Alcohol and/or Drug Assessment	Time spent completing drug and/or alcohol assessments with patients in the course of treatment Determines appropriate delivery system for patient seeking services	• Document why the assessment is being completed and preliminary findings or observations of the client's behaviors during the assessment process. Note involvement of family or other collaterals included. • It is not acceptable to simply note that an assessment was completed • Staff should only provide and document assessment services within their scope of practice • One assessment equals one unit of service, regardless of length of time or if it takes multiple sessions to complete the initial assessment • Document the course of treatment recommended Provider: LP, PA, NP
H0003	Alcohol and/or Drug Screening	Laboratory analysis of specimens for presence of alcohol and/or drugs	• Documentation of order(s) for the screening, including symptom or diagnosis to support medical necessity Provider: LP, PA, NP

DMC-ODS Assessment Codes

Code	Description	Code Guidance	Documentation
H0048	Alcohol and/or other drug testing	Used for collection and handling only, specimens other than blood	• Document collection and specimen type, other than blood Provider: LP, PA, NP
H0049	Alcohol and/or Drug Screening	Miscellaneous drug and alcohol services	• Documentation of order(s) for screening • Tool and scoring must be recorded in record • Valid brief questionnaire for screening that includes questions about the frequency and amount of alcohol/drugs used Provider: LP, PA, NP

DMC-ODS Assessment Codes

Code	Description	Code Guidance	Documentation
G2011	Alcohol and/or substance (other than tobacco) abuse structured assessment, 5-14 minutes	Use codes G2011, G0396 and G0397 to determine the ASAM criteria	• Used for reporting of alcohol and substance abuse assessment and intervention services that are not provided as screening services, but are performed in the context of the diagnosis or treatment of an illness • Do not report separately with an E/M, psychiatric diagnostic, or psychotherapy service code for the same work/time. • Use of this code is for 5-14 minutes of treatment and start/stop or total time must be documented. Provider: LP, PA, NP

DMC-ODS Assessment Codes

Code	Description	Code Guidance	Documentation
G0396	Alcohol and/or substance misuse structured assessment and brief intervention 15 to 30 minutes	Use codes G2011, G0396, and G0397 to determine the ASAM criteria	• Used for reporting of alcohol and substance abuse assessment and intervention services that are not provided as screening services, but are performed in the context of the diagnosis or treatment of an illness • Do not report separately with an E/M, psychiatric diagnostic, or psychotherapy service code for the same work/time. • Use of this code is limited to 30 minutes of treatment and start/stop or total time must be documented. If greater than 30 minutes, see G0397. • If an intervention is not required on the basis of screening results the work effort is included in E/M or preventative service. Provider: LP, PA, NP
G0397	Alcohol and/or substance abuse structured assessment, 30+ minutes	Use codes G2011, G0396, and G0397 to determine the ASAM criteria	• Used for reporting of alcohol and substance abuse assessment and intervention services that are not provided as screening services, but are performed in the context of the diagnosis or treatment of an illness • Do not report separately with an E/M, psychiatric diagnostic, or psychotherapy service code for the same work/time. • Use of this code is for more than 30 minutes of treatment and start/stop or total time must be documented. If less than 30 minutes, see G0396. Provider: LP, PA, NP

Clinical Assessment Example

Document link: [Psychiatric Assessment Report Sample - Mental Health Evaluation Example (icanotes.com)]

Name: Aimee

History

Current Symptoms

Problem Pertinent Review of Symptoms

Past Psychiatric History

Social/Developmental History

Family History

Medical History

Diagnosis

Instructions/Recommendations/Plan

Clinical Assessment Example

- Document link: initial-assessment-sample.pdf (pathmentalhealth.com)
- Name: Jordan
- Initial Info
- Demographics
- Social History
- History of Present Illness
- Psychosocial History
- Health History
- Mental Status
- Substance Use History
- Mental Health Treatment History
- Clinical Summary

Clinical Assessment Example

Name: Marie

Contributions to the Assessment:

- Diagnostic interview with Maria on 2/18, 2/22 and 3/1/2021
- Review of available records from Mercy Hospital
- Collateral information obtained from Marie's mother

Assessment components:

- Current life situation:
  - Age/living situation/basic needs/education
  - Significant personal relationships
  - Strengths
  - Health and spiritual beliefs
  - Current medications

Clinical Assessment Example

- Reasons for Extended Assessment:
  - Perception of condition
  - Description of symptoms
  - Reason for referral
  - Client mental health and treatment history
  - Developmental incidents
  - Trauma history
  - Substance use history
  - Health history
  - Family history
  - Cultural impact and influence
  - Communication style

Clinical Assessment Example

- Mental Status Examination
- Screening Measures
  - GAIN-SS CD Screener
  - Trauma checklist
- Assessment Measures
  - Substance Abuse Treatment Scale-Revised (SATS-R)
  - Alcohol Use Scale-Revised (AUS-R) and Drug Use Scale-Revised (DUS-R)
  - Comprehensive Longitudinal Assessment
  - Contextual Assessment
- Assessment of Client Needs
- Summary and Recommendations

Clinical Assessment Example

- Diagnosis
  - Axis I: Bipolar I Disorder, most recent episode manic, in partial remission
  - Axis II: No diagnosis
  - Axis III: Closed head injury at age 5, secondary to a fall
  - Axis IV: Unemployment, family conflict, limited supports, few sober friends
  - Axis V: GAF = 60

Behavioral Health Services

Medication Support Services
Medication Services
MD/DO NP PA

SMHS Medication Support Services Codes

- Medication Support Services include one or more of the following: prescribing, administering, dispensing and monitoring drug interactions and contraindications of psychiatric medications or biologicals that are necessary to alleviate the suffering and symptoms of mental illness.
- This service may also include assessing the appropriateness of reducing medication usage when clinically indicated.
- Medication Support Services are individually tailored to address the beneficiary's need and are provided by a consistent provider who has an established relationship with the beneficiary.
- Services may include: providing detailed information about how medications work; different types of medications available and why they are used; anticipated outcomes of taking a medication; the importance of continuing to take a medication even if the symptoms improve or disappear (as determined to be clinically appropriate); how the use of the medication may improve the effectiveness of other services a beneficiary is receiving (e.g., group or individual therapy); possible side effects of medications and how to manage them; information about medication interactions or possible complications related to using medications with alcohol or other medications or substances; and the impact of choosing not to take medications.

SMHS Medication Support Services Codes

- The service includes one or more of the following service components:
  - Evaluation of the need for medication
  - Evaluation of clinical effectiveness and side effects
  - The obtaining of informed consent
  - Medication education including instruction in the use, risks, and benefits of and alternatives for medication
  - Collateral
  - Plan Development

- Title 9, CCR, § 1840.372 states that “the maximum amount claimable for Medication Support Services in a 24-hour period is 4 hours.”

SMHS Medication Support Services Codes

Code	Description	Code Guidance	Documentation
90865	Narcosynthesis for psychiatric diagnostic and therapeutic purposes, 15 minutes	Used for sodium amobarbital (Amytal) interview to monitor the effect of the drug	• Patient's medical record must contain documentation that fully supports the medical necessity for the services provided • Document specific pharmacological agent, dosage administered and whether the technique was effective or non-effective • Documentation must include total time Provider: MD/DO, PA, NP

SMHS Medication Support Services Codes

Code	Description	Code Guidance	Documentation
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis, 1-60 minutes	Initial IV infusion up to 1 hour Performed for infusions (other than hydration) Do not report with codes for which IV push or infusion is an inherent part of the procedure (e.g., administration of contrast for a diagnostic imaging study)	• Documentation must include the specific reason (symptom or diagnosis) for which the infusion is administered • Documentation must include start/stop times Provider: MD/DO, PA, NP
96366	Intravenous infusion, for therapy, prophylaxis, each additional 30-60 minutes past 96365	Each additional IV infusion 30-60 minutes beyond initial IV infusion (96365) Performed for infusions (other than hydration)	• Documentation must include the specific reason (symptom or diagnosis) for which the infusion is administered • Documentation must include start/stop times for the infusion Provider: MD/DO, PA, NP
96367	Intravenous infusion, for therapy, prophylaxis, or diagnosis; additional sequential infusion, 1-60 minutes after 96365	Additional sequential IV infusion 1-60 minutes beyond initial IV infusion (96365) Performed for infusions (other than hydration)	• Documentation must include the specific reason (symptom or diagnosis) for which the infusion is administered • Documentation must include start/stop times for the infusion Provider: MD/DO, PA, NP

SMHS Medication Support Services Codes

Code	Description	Code Guidance	Documentation
96368	Intravenous infusion, for therapy, prophylaxis, or diagnosis; concurrent infusion, 15 minutes	Concurrent IV infusion 15 minutes beyond initial IV infusion up to 1 hour (96365) or additional IV infusion (96366) Performed for infusions (other than hydration)	• Documentation must include the specific reason (symptom or diagnosis) for which the infusion is administered • Documentation must include start/stop times for the infusion Provider: MD/DO, PA, NP
96369	Subcutaneous infusion for therapy or prophylaxis, initial, 15 - 60 minutes	Initial subcutaneous infusion 15-60 minutes For infusions of 15 minutes of less use 96372 Includes pump set-up and establishment of subcutaneous infusion site(s)	• Documentation must include the specific reason (symptom or diagnosis) for which the infusion is administered • Documentation must include start/stop times for the infusion Provider: MD/DO, PA, NP
96370	Subcutaneous infusion for therapy or prophylaxis, each additional 30-60 minutes after 96369	Each additional 30-60 minutes subcutaneous infusion beyond initial subcutaneous infusion (96369)	• Documentation must include the specific reason (symptom or diagnosis) for which the infusion is administered • Documentation must include start/stop times for the infusion Provider: MD/DO, PA, NP
96371	Subcutaneous infusion for therapy or prophylaxis, additional pump set-up, 15 minutes	Additional pump set-up with establishment of subcutaneous infusion site(s) beyond initial subcutaneous infusion (96369)	• Documentation must include the specific reason (symptom or diagnosis) for which the infusion is administered • Documentation must include start/stop times for the infusion Provider: MD/DO, PA, NP

SMHS Medication Support Services Codes

Code	Description	Code Guidance	Documentation
96372	Therapeutic, prophylactic, or diagnostic injection; subcutaneous or intramuscular, 15 minutes	Do not use this code to indicate administration of vaccines/toxoids or intradermal cancer immunotherapy injection	• Documentation must include the specific reason (symptom or diagnosis) for which the injection is administered • Documentation must include start/stop times for the injection Provider: MD/DO, PA, NP
96373	Therapeutic, prophylactic, or diagnostic injection; intra-arterial, 15 minutes	Intra-arterial injection	• Documentation must include the specific reason (symptom or diagnosis) for which the injection is administered • Documentation must include start/stop times for the injection Provider: MD/DO, PA, NP

SMHS Medication Support Services Codes

Code	Description	Code Guidance	Documentation
96374	Therapeutic, prophylactic, or diagnostic injection; intravenous push, single or initial substance/drug, 15 minutes	IV push injection, single or initial substance/drug	• Documentation must include the specific reason (symptom or diagnosis) for which the injection is administered • Documentation must include start/stop times for the injection Provider: MD/DO, PA, NP
96375	Therapeutic, prophylactic, or diagnostic injection; each additional sequential intravenous push of a new substance/drug, 15 minutes	Each additional sequential IV push of a **new** substance/drug beyond initial IV push (96374) or IV infusion (96365)	• Documentation must include the specific reason (symptom or diagnosis) for which the injection is administered • Documentation must include start/stop times for the injection Provider: MD/DO, PA, NP
96376	Therapeutic, prophylactic, or diagnostic injection; each additional sequential intravenous drug provided in a facility, 1-14 minutes	Each additional sequential IV push of the **same** substance/drug beyond initial IV push (96374) or IV infusion (96365) Used for more than 30 minutes after a reported push of the same drug	• Documentation must include the specific reason (symptom or diagnosis) for which the injection is administered • Documentation must include start/stop times for the injection Provider: MD/DO, PA, NP

SMHS Medication Support Services Codes

Code	Description	Code Guidance	Documentation
96377	Application of on-body injector for timed subcutaneous injection, 15 minutes	Used to report the work of preparing and applying an on-body injector that includes the insertion of a cannula for a timed subcutaneous injection	Documentation must include the specific reason (symptom or diagnosis) for which the on-body injection is applied Documentation must include total time Provider: MD/DO, PA, NP

SMHS Medication Support Services Codes

Code	Description	Code Guidance	Documentation
99202 99203 99204 99205	Office or Other Outpatient Visit, New Patient	99202: 15-29 minutes 99203: 30-44 minutes 99204: 45-59 minutes 99205: 60-74 minutes	• Document total face-to-face (direct patient care) time on date of the encounter Provider: MD/DO, PA, NP
99212 99213 99214 99215	Office or Other Outpatient Visit, Established Patient	99212: 10-19 minutes 99213: 20-29 minutes 99214: 30-39 minutes 99215: 40-54 minutes	• Document total face-to-face (direct patient care) time on date of the encounter Provider: MD/DO, PA, NP
99341 99342 99344 99345	Home or residence visit, new patient	99341: 15 minutes met or exceeded 99342: 30 minutes met or exceeded 99344: 60 minutes met or exceeded 99345: 75 minutes met or exceeded	• Document specific place of home or residence visit • Document total face-to-face (direct patient care) time on date of the encounter Provider: MD/DO, PA, NP

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SMHS Medication Support Services Codes

Code	Description	Code Guidance	Documentation
99347 99348 99349 99350	Home or residence visit, established patient	99347: 20 minutes met or exceeded 99348: 30 minutes met or exceeded 99349: 40 minutes met or exceeded 99350: 60 minutes met or exceeded	• Document specific place of home or residence visit • Document total face-to-face (direct patient care) time on date of the encounter Provider: MD/DO, PA, NP

SMHS Medication Support Services Codes

Code	Description	Code Guidance	Documentation
G2212	Prolonged office or other outpatient evaluation and management service(s) beyond the maximum time, each additional 15 minutes	Each additional 15 minutes for E/M services provided beyond maximum time for primary procedure, e.g., 74 minutes (99205) or 54 minutes (99215) Do not report for any time unit less than 15 minutes	• Document total face-to-face (direct patient care) time on date of the encounter Provider: MD/DO, PA, NP
H0033	Oral medication administration, direct observation, 15 minutes	Direct observation for oral medication administration	• Documentation must include direct observation for oral medication administration • Documentation must include the specific reason (symptom or diagnosis) for which the oral medication is administered • Documentation must include total time Provider: MD/DO, PA, NP
H0034	Medication training and support, per 15 minutes	Provide medication and support	• Documentation must include training and support provided • Documentation must include the specific reason (symptom or diagnosis) for which the on-body injection is applied • Documentation must include total time Provider: MD/DO, PA, NP

DMC-ODS Medication Services Codes

- Medication Services includes prescription or administration of medication related to substance use disorder services, or the assessment of the side effects or results of the medication.
- Medication Services does not include MAT for Opioid Use Disorders(OUD)or MAT for Alcohol Use Disorders (AUD) and Other Non-Opioid Substance Use Disorders.

DMC-ODS Medication Services Codes

Code	Description	Code Guidance	Documentation
G2212	Prolonged office or other outpatient evaluation and management service(s) beyond the maximum time; each additional 15 minutes	Use this code in conjunction with the primary evaluation and management service	• The primary evaluation and management code must be selected based on total time on the specific date of service. • In addition to total time for the primary procedure, documentation for the prolonged service(s) must also have documentation of total time. Provider: LP, PA, NP
H0033	Oral medication administration, direct observation	Directly observed oral medication administration; do not bill for services rendered by family members or be reimbursed for family member time	• Document observed ingestion of prescribed medication • Include the reason for DOT (Directly Observed Therapy) services, including treatment course as indicated in the treatment plan Provider: LP, PA, NP
H0034	Medication training and support, per 15 minutes	Time spent providing medication training and support	• Time documentation for the use of this code is each 15 minutes. Specific documentation of time must be included. • Document the specific prescribed medication and the reason the patient is taking the medication Provider: LP, PA, NP

Behavioral Health Services

Plan Development Treatment Planning for MD/DO NP PA

Plan Development/Treatment Planning

Per *California Mental Health Services Authority (CalMHSA); Clinical Documentation Guide; 2022*

- Effective treatment planning involves a dynamic process since the person's needs are dynamic and can change rapidly.
- As part of CalAIM, treatment plans for many types of services are moving from standalone documents to be embedded in progress notes.
- Document link: CalMHSA-MHP-LPHA-Documentation-Guide-05182022.pdf

SMHS Plan Development Codes

- Plan Development means a service activity that consists of one or more of the following:
  - Development of client plans
  - Approval of client plans
  - Monitoring of a beneficiary's progress

SMHS Plan Development Codes

Code	Description	Code Guidance	Documentation
99366	Medical team conference with interdisciplinary team of health care professionals, 30 minutes or more	Participation by non-physician. Face-to-face conference with patient and/or family. Face-to-face participation by a minimum of three qualified health care professionals from different specialties or disciplines. Participants shall have performed face-to-face evaluations or treatments of the patient, independent of any team conference, within the previous 60 days Team conference services of less than 30 minutes duration are not reported separately	• Reporting participants in the team conference shall document their participation as well as their contributed information and subsequent treatment recommendations • Treatment plan should be updated accordingly based on the team conference Provider: PA, NP

SMHS Plan Development Codes

Code	Description	Code Guidance	Documentation
99367	Medical team conference with interdisciplinary team of health care professionals, 30 minutes or more	Participation by physician. Patient and/or family not present at conference. Face-to-face participation by a minimum of three qualified health care professionals from different specialties or disciplines. Participants shall have performed face-to-face evaluations or treatments of the patient, independent of any team conference, within the previous 60 days Team conference services of less than 30 minutes duration are not reported separately	• Participants actively involved in the development, revision, coordination, and implementation of health care services needed by the patient • Documentation should include all attendees at the team conference and specify to context of the conversation. Evaluation of the current treatment plan and applicable changes should be included in the documentation. • Requires minimum of 30 minutes with participation by physicians • Physicians or other qualified health care professionals who may report evaluation and management services should report their time spent in a team conference with the patient and/or family/caregiver present using evaluation and management (E/M) codes Provider: MD

SMHS Plan Development Codes

Code	Description	Code Guidance	Documentation
99368	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more	Participation by non-physician. Patient and/or family not present at conference. Face-to-face participation by a minimum of three qualified health care professionals from different specialties or disciplines. Participants shall have performed face-to-face evaluations or treatments of the patient, independent of any team conference, within the previous 60 days	• Documentation should note the team members present and reflect the recommendation of the team • Treatment plan should be updated accordingly based on the team conference Provider: PA, NP

SMHS Plan Development Codes

Code	Description	Code Guidance	Documentation
99484	Care management services for behavioral health conditions, directed by physician. At least 20 minutes	Reported for at least 20 minutes of clinical staff time, directed by a physician or other QHP, per calendar month	Documented services must encompass the required elements listed in the code descriptor. Required elements for reporting are: • initial assessment or follow-up monitoring, including the use of applicable validated rating scales; • behavioral health care planning in relations to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; • facilitating and coordination treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and • continuity of care with a designated member of the care team Provider: MD/DO, PA, NP

SMHS Plan Development Codes

Code	Description	Code Guidance	Documentation
H0032	Mental health service plan development by non-physician, 15 minutes	Reported for selection of treatment targets in collaboration with family members and other stakeholders	• Document the development of written protocols for treating and measuring all treatment targets Provider: PA, NP

DMC-ODS Treatment Planning Codes

- Treatment planning, a service activity that consists of development and updates to documentation needed to plan and address the beneficiary's needs, planned interventions and to address and monitor a beneficiary's progress and restoration of a beneficiary to their best possible functional level.

DMC-ODS Treatment Planning Codes

Code	Description	Code Guidance	Documentation
H2014	Skills training and development, per 15 minutes	Patient education services claims	• Documentation should include specific skills address and the associated training plan. • Time documentation for the use of this code is each 15 minutes. Specific documentation of time must be included. For example, an occurrence of 30 minutes would use code H2014 with 2 units to account for each 15 minutes. Provider: LP, PA, NP

DMC-ODS Treatment Planning Codes

Code	Description	Code Guidance	Documentation
H2021	Community-based wrap-around services, per 15 minutes	Services provided through wrap-around programs can include: -Case management (service coordination) -Counseling (individual, family, group, youth, and vocational) -Crisis care and outreach -Education/special education services, tutoring -Family support, independent living supports, self-help, or support groups.	• Documentation should address all components included in each client's wrap-around program. • Time documentation for the use of this code is each 15 minutes. Specific documentation of time must be included. For example, an occurrence of 30 minutes would use code H2021 with 2 units to account for each 15 minutes. Provider: LP, PA, NP
H2027	Psychoeducational service, per 15 minutes	Combines the elements of cognitive-behavior therapy, group therapy, and education to provide the client knowledge about various facets of the illness and its treatment	• Include the specifics of the service provided to address the psychoeducational needs of the client. • Time documentation for the use of this code is each 15 minutes. Specific documentation of time must be included. For example, an occurrence of 30 minutes would use code H2027 with 2 units to account for each 15 minutes. Provider: LP, PA, NP

Treatment Planning/Plan Development Case Example

S: Client with significant history of thought disorder, including auditory hallucinations and paranoid delusions continues to be symptomatic, although relatively stable for the last three months. Affect is blunted, insight is limited, although has recently been more medication adherent than in the past. Continues to need support to remain on meds, remain in stable structured housing, and maintain adequate health.

I: Spoke with client to review and renew annual client plan. Reviewed previous objectives for relevance. Suggested changes based on his more stable situation. Supported his remaining compliant with medication, and we agreed that we should keep an objective related to this important area. Discussed whether having objective relating to obtaining stable housing was still relevant, or whether we should revise as ‘maintain stable housing,’ given that he has remained at current place for most of year. Also discussed whether we need to meet as frequently during the upcoming year as we have been.

Treatment Planning/Plan Development Case Example

R: Client was engaged in revising objective on plan. Agreed that focus on maintain housing was more appropriate than obtain housing. Continued to express some ambivalence re meds but acknowledges that they have benefitted him. Agreed that keeping an objective re this is appropriate. Appeared to have mixed feelings about possible decreased frequency of contact. Was more comfortable with compromise language that we would 'explore' decreased frequency of contact.

P: Will write up renewed Client Plan based on our discussion and present to him for approval/signature.

Behavioral Health Services

Care Coordination Codes for MD/DO NP PA

DMC-ODS Care Coordination Codes

- Care Coordination consists of activities to provide coordination of SUD care, mental health care, and primary care, and to support the beneficiary with linkages to services and supports designed to restore the beneficiary to their best possible functional level.
- Care Coordination can be provided in clinical or non-clinical settings.
- Please note that codes 99367, 99368, and 99451 can also be used for Clinical Consultation.

DMC-ODS Care Coordination Codes

Code	Description	Code Guidance	Documentation
90882	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions	Work done with agencies, employers, or institutions on a psychiatric patient's behalf in order to achieve environmental changes and interventions for managing the patient's medical condition	• Document interventions performed for medical management purposes on behalf of the patient and the agency involved in the work Provider: LP, PA, NP
90889	Preparation of report of patient's psychiatric status, history, treatment, or progress for other individuals, agencies, or insurance carriers	Excludes those for legal or consultative purpose	• Document preparation of psychiatric status report for other physicians, other QHPs (eg, dietician), agencies or insurance carriers Provider: LP, PA, NP

DMC-ODS Care Coordination Codes

Code	Description	Code Guidance	Documentation
96160	Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument	Used to collect health information in conjunction with biometric testing to help determine an individual's health status and health risks and formulate a healthy lifestyle plan to promote wellness.	• Face-to-face interview with a standardized questionnaire, recorded by interviewer and scored with the standardized tool • The score is used to estimate the level of health risk • A health plan is implemented or modified to provide clinical preventive care, health promotion, and disease management Provider: LP, PA, NP
99339 99340	Individual physician supervisory of a patient (patient not present) in home	99339: 15-29 minutes 99340: each additional 30 minutes Patient is not present and resides in a domiciliary or rest home (e.g., assisted living facility) Codes are reported within one calendar month and are classified according to place of service	Keep a CPO (Care Plan Oversight) services monthly log (calendar month) that documents the date, total time and brief description of services provided, including provider signature, such as: • Revision of care plans • Review of subsequent reports of patient status • Review of related laboratory and other studies • Communication (including telephone calls) for purposes of assessment or care decision with QHPs, family members, surrogate decision makers and/or key caregivers involved in patient's care • Integration of new information into the medical treatment plan • Adjustment of medical therapy Provider: LP, PA, NP

DMC-ODS Care Coordination Codes

Code	Description	Code Guidance	Documentation
99367	Medical team conference with interdisciplinary team of health care professionals, participation by physician. 30 minutes or more	Participation by physician. Patient and/or family not present at conference. Face-to-face participation by a minimum of three qualified health care professionals from different specialties or disciplines. Participants shall have performed face-to-face evaluations or treatments of the patient, independent of any team conference, within the previous 60 days Team conference services of less than 30 minutes duration are not reported separately	• Participants actively involved in the development, revision, coordination, and implementation of health care services needed by the patient. • Documentation should include all attendees at the team conference and specify to context of the conversation. Evaluation of the current treatment plan and applicable changes should be included in the documentation. • Requires minimum of 30 minutes with participation by physicians • Physicians or other qualified health care professionals who may report evaluation and management services should report their time spent in a team conference with the patient and/or family/caregiver present using evaluation and management (E/M) codes Provider: LP

DMC-ODS Care Coordination Codes

Code	Description	Code Guidance	Documentation
99368	Medical team conference with interdisciplinary team of health care professionals, participation by non-physician. 30 minutes or more	Participation by non-physician. Patient and/or family not present at conference. Face-to-face participation by a minimum of three qualified health care professionals from different specialties or disciplines. Participants shall have performed face-to-face evaluations or treatments of the patient, independent of any team conference, within the previous 60 days Team conference services of less than 30 minutes duration are not reported separately	• Reporting participants in the team conference shall document their participation as well as their contributed information and subsequent treatment recommendations • Treatment plan should be updated accordingly based on the team conference Provider: PA, NP

DMC-ODS Care Coordination Codes

Code	Description	Code Guidance	Documentation
99451	Interprofessional telephone/internet/ electronic, health record assessment and management service provided by a consultative physician or other qualifier health care professional, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time	An assessment and management service in which a patient's treating physician requests the opinion and/or treatment advice of a physician or other qualified health care professional with specific specialty expertise to assist the treating physician in the diagnosis and/or management of the patient's problem without patient face-to-face contact with the consultant.	• A written report of the consultative interaction is required in the documentation and has to include documentation of time. • Face-to-face time from the consultant is not required. • The code requires a minimum of 5 minutes of consultative time. • The patient for whom the interprofessional telephone/Internet/electronic health record consultation is requested may be either a new patient to the consultant or an established patient with a new problem or an exacerbation of an existing problem. • The consultant should not have seen the patient in a face-to-face encounter within the last 14 days. • When the telephone/Internet/electronic health record consultation leads to a transfer of care or other face-to-face service (e.g., a surgery, a hospital visit, or a scheduled office evaluation of the patient) within the next 14 days or next available appointment date of the consultant, these codes are not reported. Provider: LP

DMC-ODS Care Coordination Codes

Code	Description	Code Guidance	Documentation
H1000	Prenatal care, at risk assessment		• Documentation should include all elements of the assessment related to the client's prenatal care. • This could include the development of a care plan, referral to or consultation with an appropriate specialist, individualized counseling and services designed to address the risk factor(s) involved. Provider: LP, PA, NP
T1017	Targeted case management, each 15 minutes	Targeted case management services are aimed specifically at special groups, such as those with developmental disabilities or chronic mental illness	• Documentation should include the reasons for the targeted case management and include the components of the services provided and/or recommended • Time documentation for the use of this code is each 15 minutes. Specific documentation of time must be included. Provider: LP, PA, NP

Behavioral Health Services

Individual Counseling for MD/DO NP PA

DMC-ODS Individual Counseling Codes

- Individual Counseling consists of contacts with a beneficiary.
- Individual counseling can include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the beneficiary by supporting the achievement of the beneficiary's treatment goals.

DMC-ODS Individual Counseling Codes

Code	Description	Code Guidance	Documentation
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15-30 minutes	Billing for 99408 is limited to once per day	• Provider spends 15-30 minutes screening a patient for abuse of alcohol or another non-tobacco substance • Provider performs a brief intervention at the same session • Should be utilized for screening and intervention lasting no more than 30 minutes Provider: LP, PA, NP
99409	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15-30 minutes	Billing for 99409 is limited to once per day	• Should be utilized for screening and intervention lasting more than 30 minutes Provider: LP, PA, NP

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DMC-ODS Individual Counseling Codes

Code	Description	Code Guidance	Documentation
H0004	Behavioral health counseling and therapy, per 15 minutes	Time spent providing individual counseling and therapy. One-on-one session does not involve family or friends of the individual during the therapy provided.	• Time documentation for the use of this code is each 15 minutes. Specific documentation of time must be included • Individual counseling can include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the beneficiary by supporting the achievement of the beneficiary's treatment goals • Document assessment of readiness for change as well as barriers to change Provider: LP, PA, NP
H0050	Alcohol and/or drug services, brief intervention, per 15 minutes	Time spent providing individual SBI (screening and brief intervention) for alcohol and drug use problems	• Time documentation for the use of this code is each 15 minutes. Specific documentation of time must be included. • Document brief intervention(s) performed in relation to alcohol and/or drug use, such as education, consequences of use and behavior changes Provider: LP, PA, NP

DMC-ODS Individual Counseling Codes

Code	Description	Code Guidance	Documentation
T1006	Alcohol and/or substance abuse services; family/couple counseling	Time spent providing family/couple counseling	• Time documentation for the use of this code is each 15 minutes. Specific documentation of time must be included. Provider: LP, PA, NP

Clinical Example Individual Counseling

S: Clinician met with client in the community for a one-on-one session to improve client's relaxation skills. Client continues to exhibit impaired judgement, low frustration tolerance, and highly reactive when faced with frustrating situations. Appeared subdued, although anxious.

I: In order to help client decrease angry outbursts, clinician encouraged the client to utilize coping skills such as deep breathing relaxation exercises and taking quick time-outs instead of reacting to situations. Practiced coping skills to manage anger, clinician and client role-played a recent situation where client reacted to the situation in angry manner. Clinician and client practiced different responses the client could have had. Client was encouraged to use relaxation exercises at least 2x during the following week.

Clinical Example Individual Counseling

R: Client reports feelings frustrated when people ‘don’t understand me…they ask me the same question over and over…they make me mad.’ During role-play, client was able to identify a couple of areas where taking a breath and a quick time-out may have been helpful. Client reported participation in role-play was beneficial and agreed to practice coping skill at least 2 times during the next week, if the situation arises.

P: Clinician to meet with client in one week and process if the use of the practiced coping skills was helpful or not helpful during stressful situations.

Behavioral Health Services

Group Counseling for MD/DO NP PA

DMC-ODS Group Counseling Codes

- Face-to-face contacts in which one or more therapists or counselors treat two or more clients at the same time with a maximum of 12 in the group, focusing on the needs of the individuals served.
- Units for group counseling should be calculated using the following formula:
  - Number of minutes for the group counseling session/15minute increments = Total Units to submit using code H0005
  - For example: 120 minutes/15 minutes = 8 Units which is equivalent to 8 units of code H0005*
  - *DHCS will divide the rate by 4.5. Counties should submit claims separately for each beneficiary receiving group counseling.

DMC-ODS Group Counseling Codes

Code	Description	Code Guidance	Documentation
H0005	Alcohol and/or drug services group counseling by a clinician, 15 minutes	Time spent providing face to face group counseling. Maximum of 12 in the group.	• Time documentation for the use of this code is each 15 minutes. Specific documentation of time must be included. • 1 unit equals 15 minutes of group counseling • Length of group sessions are not specified or dictated by DCJ/DCHA Provider: LP, PA, NP

Clinical Example Group Counseling

S: Client participated in group session with 5 peers. The purpose of the group was to provide emotional support, encourage the use of positive coping strategies, reinforce interpersonal skills and use of peer support in a safe environment.

I: Facilitator led check-in by asking client to report on his week. Facilitator gave positive reinforcement to client for identifying use of positive strategy in dealing with a difficult situation. Facilitator also provided positive feedback for client's listening to suggestions by other group members. Facilitator provided redirection as necessary to facilitate group process.

R: Client participated well in group, able to report on difficult situation and listen to suggestions from peers. Client responded well to receiving redirection when straying off topic. Client reported feeling good about being able to use strategy.

P: Continue to provide safe and encouraging environment for group members. Continue to encourage use of peer supports and practice coping strategies.

Behavioral Health Services

Family Therapy for MD/DO NP PA

DMC-ODS Family Therapy Codes

- Family Therapy is a rehabilitative service that includes family members in the treatment process, providing education about factors that are important to the beneficiary's recovery as well as the holistic recovery of the family system.
- Family members can provide social support to the beneficiary and help motivate their loved one to remain in treatment.
- There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of this service, but the service is for the direct benefit of the beneficiary.
- DHCS will divide the rate for group therapy (90849) rate by 4.5. Counties should submit claims separately for each beneficiary receiving group therapy.

DMC-ODS Family Therapy Codes

Code	Description	Code Guidance	Documentation
90846	Family psychotherapy (without the patient present), 50 minutes	May be used on the same day as an individual psychotherapy service when the services are separate and distinct for the patient.	• The session is for 50 minutes and the time range is 26 minutes or more. • May involve all family members, only those who are experiencing difficulties, or only those who are willing and able to participate. • The therapist works with the family the help identify challenges in the recovery process and recommendations to support the patient. Provider: LP, PA, NP
90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	May be used on the same day as an individual psychotherapy service when the services are separate and distinct for the patient.	• The session is for 50 minutes and the time range is 26 minutes or more. Provider: LP, PA, NP
90849	Multiple-family, group psychotherapy	Therapy sessions typically last between 1-2 hours. 90849 should be reported separately for each family group participating.	• This involved working with families that have a member who has similar developmental or mental disorders • Treatment is focused on the family unit, rather than on the individual Provider: LP, PA, NP

Clinical Example Family Therapy

S: Clinician traveled to client's home to meet with the client and his maternal grandparents. Client and family are experiencing high level of stress and need support with helping the client manage anxiety, threats of self-harm and feeling overwhelmed. Client and family were open to process feelings/concerns.

I: Clinician facilitated communication between family members and allowed time for all the express self and concerns. Reinforced use of healthy communication and modeled such when interacting with all individuals present. Clinician used gently confrontation, active listening, support, and encouragement when an individual struggled with expressing their feelings and assisting them with communicating in a positive manner. Clinician educated the client's grandparents about parenting techniques and ways to set consistent and healthy boundaries for client. Identified previous adaptive coping skill used by each family member in the past. Clinician wrapped up the meeting by identifying the family's strengths to encourage future participation in family therapy sessions and encouraged the family to contact the clinician should they need assistance with addressing their frustration.

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Clinical Example Family Therapy

R: Client tried to control the family session, interrupting conversations and displaying his temperament. Client responded to redirection by clinician. Client identified a difficult day at school, as he was unable to participate in field trip, due to previous behavioral issues. Grandparents reported desire to help client feel better, however, when client does not listen to directives or do chores, it is difficult to get along. Grandmother was open to allowing clinician to confront her responses to client's behaviors. Grandmother had some difficulty with staying on topic and wanting to continue to discuss her frustration, instead of focusing on coping skills and interventions. Family in agreement to take time out, when feeling frustrated in order to avoid conflict and also agreed to contact the clinician should they need assistance with managing frustration related to communicating with the client.

P: Clinician will continue to work with client and family to assist them with improving communication, parenting skills, and coping skills to help client attain goal of managing anxiety, decreasing threats of self-harm and managing feelings of overwhelm,

Behavioral Health Services

Therapy
for MD/OD NP PA

SMHS Therapy Codes

- Therapy means a service activity that is a therapeutic intervention that focuses primarily on symptom reduction and restoration of functioning as a means to improve coping and adaptation and reduce functional impairments.
- Therapeutic intervention includes the application of cognitive, affective, verbal or nonverbal strategies based on the principles of development, wellness, adjustment to impairment, recovery and resiliency to assist a beneficiary in acquiring greater personal, interpersonal and community functioning or to modify feelings, thought processes, conditions, attitudes or behaviors which are emotionally, intellectually, or socially ineffective.
- These interventions and techniques are specifically implemented in the context of a professional clinical relationship.
- Therapy may be delivered to a beneficiary or group of beneficiaries and may include family therapy directed at improving the beneficiary's functioning and at which the beneficiary is present.

SMHS Therapy Codes

Code	Description	Code Guidance	Documentation
90832	Psychotherapy, 30 minutes with patient	Represents insight oriented, behavior modifying, supportive and/or interactive psychotherapy Report 90833 if a separate E/M service is performed during the same encounter	Documentation should include, but is not limited to the following: • Modalities and frequency • Clinical notes for each encounter that summarizes the diagnosis, symptoms, functional status, focused MSE, treatment plan, prognosis and progress • Face-to-face service that may include involvement of family members, patient must be present for all or some of the time • Documentation must include total time of psychotherapy Provider: MD/DO, PA, NP
90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service	Represents insight oriented, behavior modifying, supportive and/or interactive psychotherapy	Documentation should include, but is not limited to the following: • Modalities and frequency • Clinical notes for each encounter that summarizes the diagnosis, symptoms, functional status, focused MSE, treatment plan, prognosis and progress • Face-to-face service that may include involvement of family members, patient must be present for all or some of the time • Documentation must include total time of psychotherapy • Documentation must support a separately identifiable E/M service with total time of the E/M service documented Provider: MD/DO, PA, NP

SMHS Therapy Codes

Code	Description	Code Guidance	Documentation
90834	Psychotherapy, 45 minutes with patient	Represents insight oriented, behavior modifying, supportive and/or interactive psychotherapy Report 90836 if a separate E/M service is performed during the same encounter	Documentation should include, but is not limited to the following: • Modalities and frequency • Clinical notes for each encounter that summarizes the diagnosis, symptoms, functional status, focused MSE, treatment plan, prognosis and progress • Face-to-face service that may include involvement of family members, patient must be present for all or some of the time • Documentation must include total time of psychotherapy Provider: MD/DO, PA, NP
90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service	Represents insight oriented, behavior modifying, supportive and/or interactive psychotherapy	Documentation should include, but is not limited to the following: • Modalities and frequency • Clinical notes for each encounter that summarizes the diagnosis, symptoms, functional status, focused MSE, treatment plan, prognosis and progress • Face-to-face service that may include involvement of family members, patient must be present for all or some of the time • Documentation must include total time of psychotherapy • Documentation must support a separately identifiable E/M service with total time of the E/M service documented Provider: MD/DO, PA, NP

SMHS Therapy Codes

Code	Description	Code Guidance	Documentation
90837	Psychotherapy, 60 minutes with patient	Represents insight oriented, behavior modifying, supportive and/or interactive psychotherapy Report 90838 if a separate E/M service is performed during the same encounter	Documentation should include, but is not limited to the following: • Modalities and frequency • Clinical notes for each encounter that summarizes the diagnosis, symptoms, functional status, focused MSE, treatment plan, prognosis and progress • Face-to-face service that may include involvement of family members, patient must be present for all or some of the time • Documentation must include total time of psychotherapy Provider: MD/DO, PA, NP
90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service	Represents insight oriented, behavior modifying, supportive and/or interactive psychotherapy	Documentation should include, but is not limited to the following: • Modalities and frequency • Clinical notes for each encounter that summarizes the diagnosis, symptoms, functional status, focused MSE, treatment plan, prognosis and progress • Face-to-face service that may include involvement of family members, patient must be present for all or some of the time • Documentation must include total time of psychotherapy • Documentation must support a separately identifiable E/M service with total time of the E/M service documented Provider: MD/DO, PA, NP

SMHS Therapy Codes

Code	Description	Code Guidance	Documentation
90845	Psychoanalysis, 15 minutes	Includes follow-up work of documentation, content review and peer consultation	• Document the indication for psychoanalysis • Documentation must include total time of psychoanalysis Provider: MD/DO, PA, NP
90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	May be used on the same day as an individual psychotherapy service when the services are separate and distinct for the patient	• Session is for 50 minutes; time range is 26 minutes or more • Documentation must include total time of psychotherapy Provider: MD/DO, PA, NP
90849	Multiple-family, group psychotherapy, 15 minutes	Therapy sessions typically last between 1-2 hours. 90849 should be reported separately for each family group participating.	• Involves working with families that have a member who has similar developmental or mental disorders • Treatment is focused on the family unit, rather than on the individual • Documentation must include total time of psychotherapy Provider: MD/DO, PA, NP

SMHS Therapy Codes

Code	Description	Code Guidance	Documentation
90853	Group psychotherapy, 15 minutes	Does not include a multiple-family group	• Involves working in a group setting that may include several patients • Documentation must include total time of group psychotherapy Provider: MD/DO, PA, NP
90867	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial	Includes cortical mapping, motor threshold determination, delivery and management Report only once per course of treatment	• Document medical necessity for TMS treatment, including the symptom or diagnosis • Documentation must include total time of TMS treatment Provider: MD/DO, PA, NP
90868	Subsequent delivery and management of TMS, per session	Includes cortical mapping, motor threshold determination, delivery and management	• Document medical necessity for TMS treatment, including the symptom or diagnosis • Documentation must include total time of TMS treatment Provider: MD/DO, PA, NP

SMHS Therapy Codes

Code	Description	Code Guidance	Documentation
90869	TMS treatment subsequent motor threshold re-determination with delivery and management	Includes cortical mapping, motor threshold re-determination, delivery and management	• Document medical necessity for TMS treatment, including the symptom or diagnosis • Documentation must include total time of TMS treatment Provider: MD/DO, PA, NP
90870	Electroconvulsive therapy	Includes necessary monitoring	• Document medical necessity for electroconvulsive therapy, including the symptom or diagnosis Provider: MD/DO, PA, NP
90880	Hypnotherapy	Used as a modality for psychotherapy	• Document medical necessity for hypnotherapy, including the symptom or diagnosis Provider: MD/DO, PA, NP

SMHS Therapy Codes

Code	Description	Code Guidance	Documentation
99221 99222 99223	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient.	99221: 40 minutes met or exceeded 99222: 55 minutes met or exceeded 99223: 75 minutes met or exceeded	• Document total face-to-face (direct patient care) time on date of the encounter Provider: MD/DO, PA, NP
99231 99232 99233	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient.	99231: 25 minutes met or exceeded 99232: 35 minutes met or exceeded 99233: 50 minutes met or exceeded	• Document total face-to-face (direct patient care) time on date of the encounter Provider: MD/DO, PA, NP
99242 99243 99244 99245	Office or other outpatient consultation for a new or established patient.	99242: 20 minutes met or exceeded 99243: 30 minutes met or exceeded 99244: 40 minutes met or exceeded 99245: 55 minutes met or exceeded	• Document total face-to-face (direct patient care) time on date of the encounter Provider: MD/DO, PA, NP

SMHS Therapy Codes

Code	Description	Code Guidance	Documentation
99252 99253 99254 99255	Inpatient or observation for a new or established patient.	99252: 35 minutes met or exceeded 99253: 45 minutes met or exceeded 99254: 60 minutes met or exceeded 99255: 80 minutes met or exceeded	• Document total face-to-face (direct patient care) time on date of the encounter Provider: MD/DO, PA, NP
99304 99305 99306	Initial nursing facility care, per day, for a new or established patient.	99304: 25 minutes met or exceeded 99305: 35 minutes met or exceeded 99306: 45 minutes met or exceeded	• Document total face-to-face (direct patient care) time on date of the encounter Provider: MD/DO, PA, NP
99307 99308 99309 99310	Subsequent nursing facility care, per day, for a new or established patient.	99307: 10 minutes met or exceeded 99308: 15 minutes met or exceeded 99309: 30 minutes met or exceeded 99310: 45 minutes met or exceeded	• Document total face-to-face (direct patient care) time on date of the encounter Provider: MD/DO, PA, NP

Behavioral Health Services

Crisis Intervention
SUD Crisis Intervention
for MD/DO NP PA

SMHS Crisis Intervention Codes

- Crisis Intervention is an unplanned, expedited service, to or on behalf of a beneficiary to address a condition that requires more timely response than a regularly scheduled visit.
- Crisis intervention is an emergency response service enabling the beneficiary to cope with a crisis, while assisting the beneficiary in regaining their status as a functioning community member.
- The goal of crisis intervention is to stabilize an immediate crisis within a community or clinical treatment setting.
- This service includes one or more of the following service components:
  - Assessment
  - Collateral
  - Therapy
  - Referral
- Title 9, CCR, § 1840.366 states that “the maximum amount claimable for Crisis Intervention in a 24-hour period is 8 hours.”

SMHS Crisis Intervention Codes

Code	Description	Code Guidance	Documentation
90839 90840	Psychotherapy for crisis services and procedures	90839: first 30-74 minutes on a given date 90840: each additional up to 30-minute blocks of time on a given date, beyond the first 74 minutes Psychotherapy for crisis of less than 30 minutes total duration on a given date should be reported with code 90832 or code 90833 (when provided with E&M services)	• Psychotherapy for crisis is an urgent assessment and history of a crisis state, a mental status exam, and a disposition. • Treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma. • The presenting problem is typically life threatening or complex and requires immediate attention to patient in high distress. • Document medical necessity for psychotherapy provided for a patient in a crisis state. • Document services provided linked to the symptoms/impairments of the patient's diagnosis. • Report the total duration of time face-to-face with the patient and/or family spent by the physician or other qualified healthcare professional providing psychotherapy for crisis, even if the time spent on that date is not continuous. • For any given period of psychotherapy for crisis state, the provider must devote his or her full attention and, therefore, cannot provide services to any other patient during the same time period. • The patient must be present for all or some of the service. • 90839 is used to report the first 30-74 minutes of psychotherapy for crisis on a given date. Add on code 90840 is reported for each additional increment of up to 30 minutes after the first 74 minutes. Specific documentation of time must be included. Provider: MD/DO, PA, NP

SMHS Crisis Intervention Codes

Code	Description	Code Guidance	Documentation
H2011	Crisis intervention service, per 15 minutes	Mental health crisis assessment, intervention and stabilization	• Time documentation for the use of this code is each 15 minutes. Specific documentation of time must be included. • Document medical necessity for crisis intervention • Document the actual intervention performed linked to the symptoms/impairments of the patient's diagnosis Provider: MD/DO, PA, NP

DMC-ODS SUD Crisis Intervention Codes

- SUD Crisis Intervention Services consists of contacts with a beneficiary in crisis.
- A crisis means an actual relapse or an unforeseen event or circumstance, which presents to the beneficiary an imminent threat of relapse.
- SUD Crisis Intervention Services shall focus on alleviating the crisis problem, be limited to the stabilization of the beneficiary's immediate situation, and be provided in the least intensive level of care that is medically necessary to treat their condition.

DMC-ODS SUD Crisis Intervention Codes

Code	Description	Code Guidance	Documentation
H0007	Alcohol and/or drug services, crisis intervention (outpatient)	Crisis assessment, intervention and stabilization related to substance use disorders	• Document medical necessity for crisis intervention including actual relapse or imminent threat of relapse • Document the actual intervention performed to alleviate the crisis problem and stabilize the situation. Provider: LP, PA, NP

Crisis Intervention Case Example

S: Received a call from manager of client's residence. Manager reported that client was yelling repeatedly, although not at any particular person. Manager stated that client's behavior is frightening other residents, although she was unsure whether there was any direct threat. Client has a history of stopping meds and substance use, which have resulted in decompensation and hospitalization due to similar behavior in past.

I: Visited client at his residence and spoke with manager. Client was extremely agitated, with considerable delusional content expressed. Appeared to be responding to internal stimuli. Client admitted that he has not been taking meds – states that they are poison. Was only able to redirect to coherent interaction from brief periods before client would return to somewhat incoherent rambling speech, containing ideas of reference and delusional material. Manager state that she can't keep him in the residence in his current state, although said that she would accept him back if her gets back on his medication and his behavior stabilizes. Writer initiated 5150 based on grave disability, as done not meet danger to self or others criteria but cannot provider for shelter in current state. Called for transport and police assistance in 5150 to XXX for evaluation and stabilization. Provided reassurance to client while waiting for police.

Crisis Intervention Case Example

R: Client became slightly more subdued when officers arrived and when told that he was going to hospital. Was reassured that he was not being arrested, only being taken to hospital on a hold to help him get re-stabilized. Was not resisting assistance into ambulance.

P: Will check with XXX after they have evaluated to see whether they will admit to inpatient, or restart meds and discharge back to residence. Will inform XXX that unless client clears considerably, residence will not accept back. Will keep residence manager informed of client's state in terms of discharge.

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Behavioral Health Services

Recovery Services for MD/DO NP PA

DMC-ODS Recovery Services Codes

- Recovery Services are designed to support recovery and prevent relapse with the objective of restoring the beneficiary to their best possible functional level.
- Recovery Services emphasize the beneficiary's central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to beneficiaries.

DMC-ODS Recovery Services Codes

Code	Description	Code Guidance	Documentation
H0008	Alcohol and/or drug services: Subacute detoxification	Hospital inpatient Subacute detoxification may be appropriate for patients who are in overall better health, use less harmful substances and in smaller doses	• Document medical necessity for subacute detoxification services • Document services provided and intervention performed for subacute detoxification Provider: LP, PA, NP
H0009	Alcohol and/or drug services: Acute detoxification	Hospital inpatient Acute detoxification may be used for patients who may be prone to life-threatening or critical conditions during the withdrawal process	• Document medical necessity for acute detoxification services • Document services provided and intervention performed for acute detoxification Provider: LP, PA, NP

DMC-ODS Recovery Services Codes

Code	Description	Code Guidance	Documentation
H2015	Comprehensive community support services, per 15 minutes	Time spent providing community support services	• Time documentation for the use of this code is each 15 minutes. Specific documentation of time must be included. • Document medical necessity for support services and description of the services provided • Document assessment of the effectiveness of the services and progress towards the patient's goals • Identify specific community support recommended for patient. Provider: LP, PA, NP
H2017	Psychosocial rehabilitation services, per 15 minutes	Time spent providing PSR (psychosocial rehabilitation) services; individual or group services	• Time documentation for the use of this code is each 15 minutes. Specific documentation of time must be included. • Document and describe the specific activities performed to specifically enhance/support the patient's skills related to their specific rehabilitation needs and goals Provider: LP, PA, NP

DMC-ODS Recovery Services Codes

Code	Description	Code Guidance	Documentation
H2035	Alcohol and/or other drug treatment program, per hour	Time spent providing alcohol/other drug treatment program services	• Time documentation for the use of this code is each 15 minutes. Specific documentation of time must be included. • Document medical necessity for SUD (Substance Use Disorder) services Provider: LP, PA, NP

Behavioral Health Services

Supplemental Services for MD/DO NP PA

SMHS Supplemental Services Codes

- Supplemental Codes are codes that describe additional and simultaneous services that were provided to the beneficiary during the visit or codes that describe the additional severity of the patient's condition.
  - For example, T1013 indicates that interpretation was provided during the visit while 90785 indicates that certain factors increase the complexity of a patient's treatment.
- Supplemental codes cannot be billed independently. They must be billed with a/another (primary) procedure.

SMHS Supplemental Services Codes

Code	Description	Code Guidance	Documentation
90785	Interactive complexity	Add on code reported in conjunction with an appropriate primary service for psychiatric diagnostic evaluation or psychotherapy service Used for situations beyond simply standard verbal communication Common factors include more difficult communication with discordant or emotional family members and engagement of young and verbally undeveloped or impaired patients Typical patients are those who have third parties involved in their psychiatric care.	Document at least one of the following: • Need to manage maladaptive communication (related to, eg, high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicates delivery of care • Caregiver emotions or behavior that interferes with the caregiver's understanding and ability to assist in the implementation of the treatment plan • Evidence of disclosure of a sentinel event and mandated report to third party (eg, abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants • Use of play equipment or other physical devices to communicate with the patient to overcome barriers to therapeutic or diagnostic interaction between the provider and a patient who has not developed, or has lost, either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the provider if he/she were to use typical language for communication Provider: MD/DO, PA, NP

SMHS Supplemental Services Codes

Code	Description	Code Guidance	Documentation
90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	Explanation of results to family or others involved in support of the patient, such as employers, in order to obtain their permission, participation and/or support for the patient's treatment. Supplemental codes cannot be billed independently. They have to be billed with a/another (primary) procedure.	• Document the specific results or other accumulated data utilized in explanation to family or others • Include a narrative indicating there was another individual in addition to the physician and patient present at the time of this service Provider: MD/DO, PA, NP

SMHS Supplemental Services Codes

Code	Description	Code Guidance	Documentation
96161	Caregiver assessment administration of care-giver focused risk assessment, 15 minutes	Health and behavior assessment (eg, depression inventory) of the patient's caregiver for the benefit of the patient Code is related only to practice expense, including clinical staff work, supplies and equipment expenses Code does not include physician work that is separately reported with an E/M service	• Document results from the standardized assessment • Document score per standardized scorable instrument • Time documentation for the use of this code is each 15 minutes. Specific documentation of time must be included. Provider: MD/DO, PA, NP
T1013	Sign language or oral interpretive services, 15 minutes	Facilitate effective communication with deaf or hearing-impaired patients	• Time documentation for the use of this code is each 15 minutes. Specific documentation of time must be included. Provider: MD/DO, PA, NP

DMC-ODS Supplemental Services Codes

- Supplemental Codes are codes that describe additional and simultaneous services that were provided to the beneficiary during the visit or codes that describe the additional severity of the patient's condition.
  - For example, T1013 indicates that interpretation was provided during the visit while 90785 indicates that certain factors increase the complexity of a patient's treatment.
- Supplemental codes cannot be billed independently. They must be billed with a/another (primary) procedure.

DMC-ODS Supplemental Services Codes

Code	Description	Code Guidance	Documentation
90785	Interactive complexity	Add on code reported in conjunction with an appropriate primary service for psychiatric diagnostic evaluation or psychotherapy service Used for situations beyond simply standard verbal communication Common factors include more difficult communication with discordant or emotional family members and engagement of young and verbally undeveloped or impaired patients. Typical patients are those who have third parties involved in their psychiatric care.	Document at least one of the following: • Need to manage maladaptive communication (related to, eg, high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicates delivery of care • Caregiver emotions or behavior that interferes with the caregiver's understanding and ability to assist in the implementation of the treatment plan • Evidence of disclosure of a sentinel event and mandated report to third party (eg, abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants • Use of play equipment or other physical devices to communicate with the patient to overcome barriers to therapeutic or diagnostic interaction between the provider and a patient who has not developed, or has lost, either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the provider if he/she were to use typical language for communication Provider: LP, PA, NP

DMC-ODS Supplemental Services Codes

Code	Description	Code Guidance	Documentation
90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	Explanation of results to family or others involved in support of the patient, such as employers, in order to obtain their permission, participation and/or support for the patient's treatment. Supplemental codes cannot be billed independently. They have to be billed with a/another (primary) procedure.	• Document the specific results or other accumulated data utilized in explanation to family or others • Include a narrative indicating there was another individual in addition to the physician and patient present at the time of this service Provider: LP, PA, NP

DMC-ODS Supplemental Services Codes

Code	Description	Code Guidance	Documentation
96170	Health behavior intervention, family (without the patient present), face-to-face, initial 30 minutes	Conduct face-to-face interaction with family members without the patient present. Facilitate family communication and provide education about the patient's illness or injury and resistance to change. Engage and mobilize family support and problem-solving regarding treatment adherence. Do not report for less than 16 minutes of service provided.	• Time documentation for the use of this code is each 30 minutes. Specific documentation of time must be included. • Document a description of the patient's status, family involvement, and progress toward and/or modification of treatment goals based on patient progress or other confounding factors that arise. • Document treatment recommendations for functional improvement, minimizing barriers to recovery and coping mechanisms. Provider: LP, PA, NP
96171	Health behavior intervention, family (without the patient present), face-to-face, each additional 15 minutes (List separately in addition to code for primary service)	+96171 is an add on code used in conjunction with 96170 for each additional 15 minutes beyond the initial 30 minutes of intervention provided Conduct face-to-face interaction with family members without the patient present. Facilitate family communication and provide education about the patient's illness or injury and resistance to change. Engage and mobilize family support and problem-solving regarding treatment adherence.	• Time documentation for the use of this add on code is each 15 minutes. Specific documentation of time must be included. • Document a description of the patient's status, family involvement, and progress toward and/or modification of treatment goals based on patient progress or other confounding factors that arise. Provider: LP, PA, NP

DMC-ODS Supplemental Services Codes

Code	Description	Code Guidance	Documentation
T1013	Sign language or oral interpretive services, 15 minutes	Facilitate effective communication with deaf or hearing-impaired patients	• Time documentation for the use of this code is each 15 minutes. Specific documentation of time must be included. Provider: LP, PA, NP

Behavioral Health Services

Rehabilitation for MD/DO NP PA

SMHS Rehabilitation Codes

- Rehabilitation means a recovery- or resiliency-focused service activity identified to address a mental health need in the client plan.
- This service activity provides assistance in restoring, improving, and/or preserving a beneficiary's functional, social, communication, or daily living skills to enhance self-sufficiency or self-regulation in multiple life domains relevant to the developmental age and needs of the beneficiary.
- Rehabilitation also includes support resources, and/or medication education.
- Rehabilitation may be provided to a beneficiary or a group of beneficiaries.

SMHS Rehabilitation Codes

Code	Description	Code Guidance	Documentation
H2017	Psychosocial rehabilitation, per 15 minutes	Time spent providing PSR (psychosocial rehabilitation) services; individual or group services	• Time documentation for the use of this code is each 15 minutes. Specific documentation of time must be included. • Document and describe the specific activities performed to specifically enhance/support the patient's skills related to their specific rehabilitation needs and goals Provider: MD/DO, PA, NP
H2021	Community-based wrap-around services, per 15 minutes	Services provided through wrap-around programs can include: -Case management (service coordination) -Counseling (individual, family, group, youth, and vocational) -Crisis care and outreach -Education/special education services, tutoring -Family support, independent living supports, self-help, or support groups.	• Time documentation for the use of this code is each 15 minutes. Specific documentation of time must be included. • Documentation should address all components included in each client's wrap-around program. Provider: MD/DO, PA, NP

Clinical Example - Rehabilitation

Rehabilitation Individual Rehabilitation Progress Note:

- In an effort to monitor client's moods and emotions, I engaged her in an open-ended conversation about her day and how she has been feeling. I praised her for her reported positive day. I validated her responses and responded with empathy, encouraging her to express her feelings. I discussed and reviewed her current coping skills (i.e., reading, listening to music, etc.,). I normalized her need to take a break from difficult situations and reminded her to take time outside. Assisted client in practicing how to let others know that she needs to use her safety plan by engaging in a role play. Client was verbal and engaged throughout the session. I will meet with client next week for an individual rehabilitation session to support her with developing and utilizing coping skills. Total time spent for this encounter – 45 minutes.
- CPT/HCPCS Coding: H2017 (x3 units)

Behavioral Health Services

Therapeutic Behavioral Services for MD/DO NP PA

SMHS Therapeutic Behavioral Services Codes

- Therapeutic Behavioral Services (TBS) is an adjunctive program that supports other services patients are currently receiving.
- TBS is an intensive, individualized, one-to-one behavioral health service available to children/youth with serious emotional challenges and their families, who are under 21 years old and have full-scope Medi-Cal.
- For guidance on how to use TBS (H2019), refer to section 5.28.0.

SMHS Therapeutic Behavioral Services Codes

Code	Description	Code Guidance	Documentation
H2019	Therapeutic behavioral services, per 15 minutes		• Documentation must include total time Provider: MD/DO, PA, NP,

Behavioral Health Services

Referral
for MD/DO NP PA

SMHS Referral Codes

- Referral means linkage to other needed services and supports.

SMHS Referral Codes

Code	Description	Code Guidance	Documentation
99451	Interprofessional telephone/internet/ electronic, health record assessment and management service provided by a consultative physician or other qualifier health care professional, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time	An assessment and management service in which a patient's treating physician requests the opinion and/or treatment advice of a physician or other qualified health care professional with specific specialty expertise to assist the treating physician in the diagnosis and/or management of the patient's problem without patient face-to-face contact with the consultant.	• A written report of the consultative interaction is required in the documentation and has to include documentation of time. • Face-to-face time from the consultant is not required • Requires a minimum of 5 minutes of consultative time • The patient for whom the interprofessional telephone/Internet/electronic health record consultation is requested may be either a new patient to the consultant or an established patient with a new problem or an exacerbation of an existing problem. • The consultant should not have seen the patient in a face-to-face encounter within the last 14 days. • When the telephone/Internet/electronic health record consultation leads to a transfer of care or other face-to-face service (eg, a surgery, a hospital visit, or a scheduled office evaluation of the patient) within the next 14 days or next available appointment date of the consultant, these codes are not reported. Provider: MD/DO

SMHS Referral Codes

Code	Description	Code Guidance	Documentation
T1017	Targeted case management, each 15 minutes	Targeted case management services are aimed specifically at special groups, such as those with developmental disabilities or chronic mental illness.	• Documentation should include the reasons for the targeted case management and include the components of the services provided and/or recommended. • Time documentation for the use of this code is each 15 minutes. Specific documentation of time must be included. For example, an occurrence of 30 minutes would use code T1017 with 2 units to account for each 15 minutes. Provider: MD/DO, PA, NP

Behavioral Health Services

Discharge Services for MD/DO NP PA

DMC-ODS Discharge Services Codes

- Discharge services includes coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and referrals to primary or specialty medical providers.

DMC-ODS Discharge Services Codes

Code	Description	Code Guidance	Documentation
99495	Transitional care management services within 14 calendar days	Includes direct contact, telephone, or electronic communication Services are for a new or established patient during transition of care from an inpatient hospital setting (acute hospital, rehabilitation, long-term acute hospital), partial hospital, observation status in hospital or SNF to the patient's community setting (home, hotel, campground, hostel, cruise ship, rest home, assisted living).	Required documentation elements: • Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge • At least moderate level of medical decision making during the service period • Face-to-face visit within 14 calendar days of discharge Address and document any needed coordination of care performed by multiple disciplines and community service agencies. The reporting individual provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs and activity of daily living support by providing first contact and continuous access. Provider: LP, PA, NP

DMC-ODS Discharge Services Codes

Code	Description	Code Guidance	Documentation
99496	Transitional care management services within 7 calendar days	Includes direct contact, telephone, or electronic communication Services are for a new or established patient during transition of care from an inpatient hospital setting (acute hospital, rehabilitation, long-term acute hospital), partial hospital, observation status in hospital or SNF to the patient's community setting (home, hotel, campground, hostel, cruise ship, rest home, assisted living).	Required documentation elements: • Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge • High level of medical decision making during the service period • Face-to-face visit within 7 calendar days of discharge Address and document any needed coordination of care performed by multiple disciplines and community service agencies. The reporting individual provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs and activity of daily living support by providing first contact and continuous access. Provider: LP, PA, NP

DMC-ODS Discharge Services Codes

Code	Description	Code Guidance	Documentation
T1007	Alcohol and/or substance abuse services; treatment plan development and/or modification	Treatment plan development and modification	• Should be used for both the initial treatment plan as well as the modification to an existing treatment plan. • Document any referrals to recovery resources and/or medical providers to support the patient's transition. Provider: LP, PA, NP

References

References

- California Advancing and Innovating Medi-Cal (CalAIM). Overview: Behavioral Health Payment Reform. Published December 2022. Found at: CalAIM BH Payment Reform Fact Sheet DHCS Letterhead
- Drug Medi-Cal ODS (DMC-ODS) Billing Manual, January 2023; V1-3; Found at: DMC ODS Billing Manual v 1.3 (ca.gov)
- Specialty Mental Health Services (SMHS) Medi-Cal Billing Manual; V1.4; Found at: SMHS-Billing-Manual-v-1-4 (ca.gov)
- Clinical Documentation Guide 2022; revised 6/23/2022; California Mental Health Services Authority (CalMHSA). Found at: CalMHSA-MHP-LPHA-Documentation-Guide-06232022.pdf

Q&A Sessions

Q&A Session #1

- Tuesday, 6/27 @ 9:00am

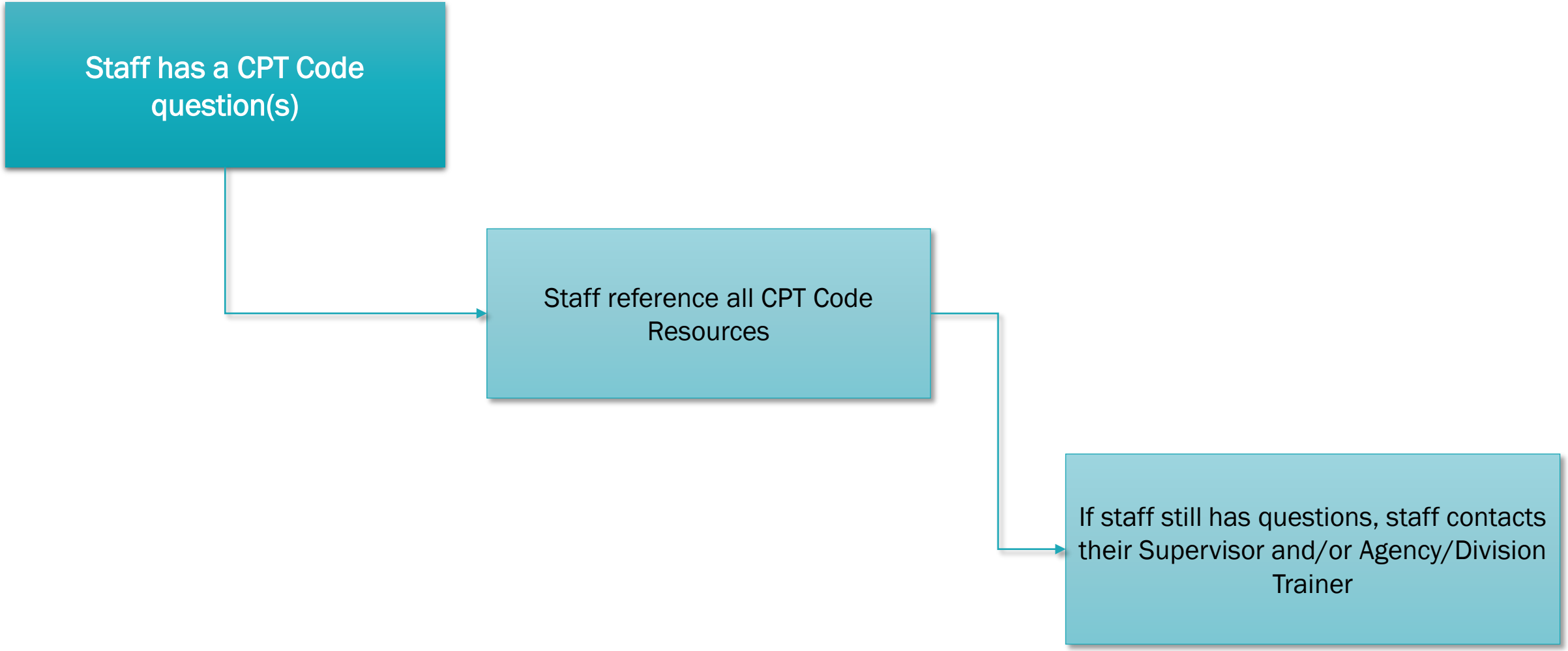
Q&A Session # 2

- Wednesday, 6/28 @ 3:00pm

Q&A Session # 3

- Thursday, 6/29 @ 11:00 am

Staff Support Flowchart



Appendix A
Acronym List

Acronym List

- ACE: Adverse childhood experience
- ASAM: American Society of Addiction Medicine
- BHIN: Behavioral health information notice
- CalAIM: California Advancing and Innovating Medi-Cal
- CMS: Center for Medicare and Medicaid Services
- CPT: Current Procedural Terminology
- DHCS: Department of Health Care Services
- DMC: Drug Medi-Cal
- DMC-ODS: Drug Medi-Cal Organized Delivery System
- HCPCS: Healthcare Common Procedural Code System
- ICD-10: International Classification of Diseases, 10th edition
- LOC: Level of care
- MAT: Medication for addiction treatment
- MCO: Managed care organization
- MCP: Managed care plan
- MHP: Mental health plan
- NSMHS: Non-specialty mental health services
- NTP: Narcotic treatment program
- SMHS: Specialty mental health services
- SUD: Substance use disorder
- TCM: Targeted case management

Appendix B
Documentation Best Practices*

***Disclaimer: This is general information only; please consult with your Agency's or County's Quality Team for specific information**

The Flow of Clinical Documentation

1. The Clinical Assessment is the first step in establishing Medical Necessity and the start of services
2. The Assessment supports staff in developing a clinical picture that informs the diagnostic process
3. The Treatment Planning process creates a framework for the services provided. This includes the development of goals and planned interventions to support clients in their recovery
4. Each service provided links back to an identified issue from the treatment planning process through the Assessment

All services are based on Medical Necessity – every service provided to the client/family is medically necessary to support the path to recovery

General Principles of Documentation

- Services provided by staff within the scope of practice of the individual delivering the service. Clinicians should follow specific scope of practice requirements
- Progress notes should provide enough detail to easily ascertain the client's status and needs and understand why the service was provided without having to refer to previous progress notes
- Each progress note must show the service was medically necessary
  - Documentation can include comments such as: 'it was reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain'
  - Progress notes should clearly identify the type of service provided and how the intervention addresses the client's presenting condition
  - Clinicians can support the medical necessity of a service by documenting how the intervention provided related to the clinical goals or mental health condition identified in the client plan

General Principles of Documentation

- Total time should be noted on each progress note. This is the direct patient care (face-to-face time) with the client
- Documentation should be completed in a timely manner, with minimal delay in finalizing all documentation
- Documentation must be readable and legible
- Copy and Paste: Do not copy and paste notes into a client's medical record. Each note should be specific to the service provided
- Clinician signature is required as part of the legal medical record, including an electronic signature

General Principles of Documentation

- Medical Necessity
  - Services provided to beneficiaries need to meet the standard of being 'medically necessary'
  - For individuals age 21 or older: a mental health service is considered medically necessary when it is "reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain."
  - For individuals under age 21: the medical necessity falls under the Early and Period Screening, Diagnostic and Treatment (EPSDT) services language under a specific section of Title 42.
    - Requires provision of all Medi-Cal coverable services necessary to correct or ameliorate a mental illness or condition discovered by a screening service, whether or not the service is covered under the State Plan.
    - These services need not be curative or restorative, and can be delivered to sustain, support, improve or make more tolerable a mental health condition

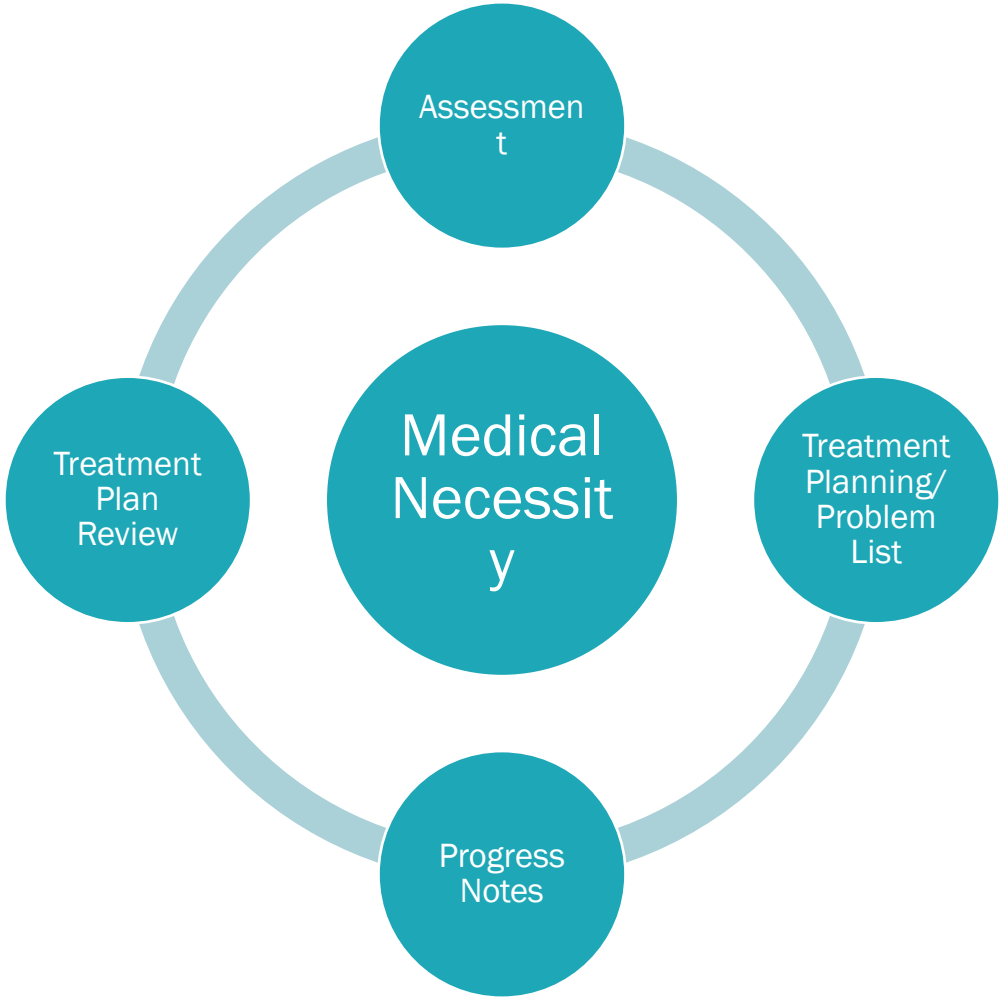
General Principles of Documentation

Overview of criteria for persons aged 21 years or older
The person has significant impairment in social, occupational, or other important life activities and/or there is reasonable probability of significant deterioration in important are of life functioning
AND the significant impairments listed above are due to a mental health disorder, Diagnostic Statistical Manual, Fifth Edition (DSM-5), either diagnosed or suspected, but not yet diagnosed

General Principles of Documentation

Overview of criteria for persons under 21 years of age
The person is experiencing homelessness and/or is interacting with the child welfare or criminal justice system
OR has scored high on the trauma screening tool, placing them at high risk for a mental health disorder
OR, the person has a significant impairment, a reasonable probability of significant deterioration in an important area of life functioning, a reasonable probability of not progressing as developmentally appropriate, or there is no presence of impairment
AND the significant impairments listed above are due to a mental health disorder, Diagnostic Statistical Manual, Fifth Edition (DSM-5), either diagnosed or suspected, but not yet diagnosed

Medical Necessity



Documentation of Diagnosis(es)

- The diagnosis for the patient's condition should be reported as specifically supported in the provider documentation
- In the absence of a definitive diagnosis, the documentation should support the sign or symptom being evaluated
- The diagnosis should be supported by the client's symptoms, impairments, and/or behaviors as documented on the most current Assessment
  - This should include documentation of significant impairments that have an impact on current or future functioning if not treated
- Documentation should include a thorough patient history that includes medical, surgical and family history that is pertinent to the patient's current condition

Diagnosis Documentation Tips

- Clarify specific type(s) of drug or substance, mode and usage
  - Use, abuse and dependence
- Specifically document “in remission” for any drug or substance, as appropriate
- Relationship between mental conditions and substance disorders
- Relationship between physical conditions and substance disorders
- Clarify mental health disorders by specific type, acuity, episode type and severity
- Comorbid/complicating medical conditions that affect treatment and/or are complicated by substance use, such as malnutrition or hypertension
- Socioeconomic and or psychosocial factors that complicate treatment and recovery
- Personal or family history that impacts substance use, treatment and/or recovery

Assessment Documentation

- The completion of an Assessment establishes the foundation for an included diagnosis and the resulting symptoms and impairments in life functioning.
- When conducting an Assessment, documentation should include:
  - Presenting problem(s)
  - Relevant conditions and psychosocial factors
  - Mental and physical health status and history
  - Medications
  - Past and present use of substances
  - Client and family strengths in achieving treatment plan goals
  - Identified risk factors for the patient to achieve treatment plan goals
- The Assessment, which includes one or more diagnoses, evaluates the current status of a client's mental, emotional or behavioral health
- The initial Clinical Assessment should be completed within 30 days and submitted with the client Plan
- An addendum should be completed when additional information is available or changes after the Initial Assessment, or between required re-assessments

Treatment Planning

- Treatment planning establishes treatment goals/objectives and the proposed clinical interventions that will address the diagnoses and impairments
- Each patient's treatment planning should include:
  - Current diagnosis(es)
  - Goals and objectives
  - Interventions and options
  - Treatment modality and frequency (specifically stated)
  - Methods for monitoring and measuring progress
- Documentation should include the client's participation in the development of and agreement with the plan
- Both compliance and non-compliance with the treatment planning should also be documented
- Treatment Planning should be updated annually or sooner if there is a significant change

Progress Note Documentation

- Document all facts relevant to an intervention, event, course of treatment, patient condition, response to treatment and progress toward objective each time a service is provided
- Record the date, location, duration and service provided, and include a brief narrative
- Document delivered services that are linked to an intervention identified on the Client Treatment & Recovery Plan
- Document progress the client is making toward their objectives
- Include test results/consultations in record as well as other notes that you reviewed
- Document rationale for deviating from standard treatment, when applicable
- Medication progress notes should document the client's response to medications, side effects, compliance and/or a plan to maintain or change the medication regimen

Progress Note Documentation

Progress notes should answer:

- Who did you see today?
  - *Client is a 26-year-old single Chilean female diagnosed with Schizophrenia, Paranoid Type*
- Why did you see the client? (Purpose of visit)
  - *Client came in for a scheduled appointment to continue learning ways to manage her auditory hallucinations*
- What did you do? (Intervention PN)
  - *Clinician worked with the client on developing reality testing techniques, such as asking a trusted individual if she also heard what the voices had said. Clinician also helped the client minimize the voices by discussing ways to reduce the intrusiveness of the voices*

Progress Note Documentation

Progress notes should answer:

- What was the client's response? (Response to Intervention PN)
  - *Client reported that she could try reality testing with her mom as she trusts her. Client also noted that it helps her to listen to music and could wear headphones to reduce the intrusiveness of the voices.*
- What is the plan for the next visit? (MHS and PN Plan)
  - *Clinician will meet with client again next week and will assess how the techniques discussed today have worked for the client.*

The Journey of Documentation

- Throughout the course of a beneficiaries treatment, all of the information in the documentation should be consistent.
- All documents in the record should tie together to give a clear clinical picture of the beneficiary and demonstrate strong clinical interventions that addresses the mental health problem with the beneficiary
- The Initial Assessment should relate to the Care Plan, and both should relate to all the progress notes that follow
- There is a relationship between the medical necessity established in the Initial Assessment, the Care Plan, and the planned services provided

Appendix C
CPT Coding Basics

Codes Sets for BH Services

Beginning July 1, 2023, behavioral health services will be billed using 2 code types

1. **Current Procedural Terminology (CPT) Codes**
2. **Healthcare Common Procedure Coding System (HCPCS) Level II codes**

CPT Coding Transition

GOALS

Improve reporting and support data-driven decision making

Align other healthcare delivery systems and comply with CMS requirements for Medicaid programs to adopt CPT codes, where appropriate

Present HCPCS Level II – All Services	Future CPT/HCPCS Level I – Where Applicable
HCPCS Level II codes are highly flexible; a variety of activities may be captured by the same code, making detailed analysis of services rendered a challenge	CPT codes: More detailed and nationally standardized definitions for each code
HCPCS Level II codes can be used by any provider (licensed or non-licensed)	Some HCPCS Level II codes will be retained for those behavioral health providers and services not captured by CPT codes

HCPCS Code Set

HCPCS Level I Codes

- Published and maintained by the American Medical Association (AMA), i.e., CPT codes
- Describe medical, surgical, and diagnostic services provided by physicians or providers

HCPCS Level II Codes

- Used for non-physician services or procedures, such as:
  - Drug screening or testing, family or group counseling and peer support services

HCPCS Level III Codes

- Local codes that are not nationally accepted
- Alphanumeric codes starting with an alpha character X or Z

Purpose of CPT

- Reimburse provider services
- Trending services provided nationally
- Future coding and reimbursement planning
- Benchmarking facilities, costs and services
- Measuring quality of care and patient outcomes nationally

CPT Code Set

- Published and maintained by the American Medical Association (AMA)
- CPT codes are updated yearly in October by the AMA and go into effect in January of the following year
  - New codes
  - Deleted codes
  - Revised codes

- Represent many healthcare services or procedures for medical billing, including:
  - Surgeries
  - Diagnostic tests
  - Evaluations
  - Other medical procedures or services performed

CPT Code Categories

CPT Category I Codes

- Most commonly used codes to report services and procedures
- Codes range from 00100 to 99499
- Codes are 5 digits long
- AMA CPT Manual includes parenthetical notes, instructions that verify the intent of the code(s)

- Codes are further divided into 6 sub-categories as follows:
  - 00100-01999 – Anesthesia
  - 10004-69990 – Surgery
  - 70010-79999 – Radiology Procedures
  - 80047-89398 – Pathology and Laboratory Procedures
  - 90281-99607 – Medicine Services and Procedures
  - 99091-99499 – Evaluation and Management Services

Level II HCPCS Codes

- In medical billing when the HCPCS code set is being discussed, it is refers to HCPCS Level II national code set.
- Composed of a single letter in the A to V range, followed by 4 digits
- Used for healthcare providers, physicians, and medical equipment suppliers
- While there are over 20 categories of HCPCS Level II services, CalAIM is only including 3 categories of codes for services such as:
  - G0008-G9360 – Procedures/Professional Services
  - H0001-H2037 – Alcohol and Drug Abuse Treatment
  - T1000-T5999 – National Codes Established for State Medicaid Agencies

Definitions/Descriptions

- New vs. established patients: Some evaluation and management E/M codes are described as being services for a new or an established patient, and should be billed accordingly.
  - New Patient: an individual who has not received any professional services from the physician/qualified healthcare professional; or another physician/qualified healthcare professional of the exact same specialty, and subspecialty who belongs to the same group practice within the past three years
  - Established Patient: an individual who has received professional services from the physician/qualified healthcare professional or another physician/qualified healthcare professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.
- Qualified healthcare professional (QHP): E/M services can be rendered by:
  - Physician, Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist
- Time: Each code is associated with a length of time or time range as part of the service description. Per policy, the only time considered is the time it takes to provide direct services associated with that code as part of time

Dependent Codes

Dependent Codes:

- These are codes that either indicate that time has been added to a primary procedure (i.e., add-on codes) or modifies a procedure (i.e., supplemental codes).
- Dependent codes cannot be billed unless the provider first bills the primary code to the same beneficiary by the same rendering provider on the same date on the same claim.

Example: Psychological Testing, 1 hour, 45 minutes

- Primary Code: 96130 Psychological Testing Evaluation, First Hour
- Dependent Code: 96131 Psychological Testing Evaluation, Each Additional Hour

A claim submitted with only 96131 will be denied unless the primary code 96130 is also on the claim

Lockout Codes

Lockout codes:

- Codes that typically cannot be billed together.
- However under certain circumstances, lockout codes can be billed together with the appropriate modifier, such as:
  - Separate practitioners or separate sessions on the same date of service.

- Dependent codes and lockout codes are indicated in the SMHS or DMC-ODS billing manual tables.

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