County of Santa Clara
Behavioral Health Services

CPT/HCPCS Training
for
County Contracted Providers (CCPs) Peers

June 23, 2023

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AGENDA

- What's changing and what's not changing

- Review of applicable CPT/HCPCS codes for Peers
  - 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

Increased ability to understand the services rendered via data analysis

Additional granularity to describe the services provided

Provides a more accurate reflection of the range of services and needs of the beneficiaries served

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.

CPT/HCPCS Codes for Peers SMHS

SMHS Peer Support Services

- Culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals.
- Services aim to prevent relapse, empower beneficiaries through strength-based coaching, support linkages to community resources, and to educate beneficiaries and their families about their conditions and the process of recovery.
- Services may be provided with the beneficiary or significant support person(s) and may be provided in a clinical or non-clinical setting.
- Services 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.
- Peer support may be provided as a group service or a one-on-one service.

SMHS Peer Support Services Codes

H0025 – Behavioral health prevention education service

- Delivery of services with target population to affect knowledge, attitude and/or behavior
- If providing peer support services as a group service, use code H0025
- Include documentation of activities completed, such as group and individual coaching to set recovery goals and identify steps to reach the goals

H0038 – Self-help/peer services, per 15 minutes

- If providing peer support services for an individual, use code H0038
- Include documentation of activities completed, such as group and individual coaching to set recovery goals and identify steps to reach the goals.
- Include total time of services provided in the documentation

SMHS Assessment

- 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

H0031 – Mental health assessment by non-physician, 15 minutes

- Document findings of the in-depth mental health assessment, including treatment plan/goals.
- One in-depth assessment per recipient, per year.
- Documentation must include total time of the assessment.

H2000 – Comprehensive multidisciplinary evaluation, 15 minutes

- Document findings of the comprehensive evaluation and multidisciplinary team members involved in the evaluation.
- Documentation must include total time of the evaluation.

SMHS Crisis Intervention Code

- 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.
- 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.
- Goal of crisis intervention is to stabilize an immediate crisis within a community or clinical treatment setting.
- Service includes one or more of the following service components:
  - Assessment, Collateral, Therapy, Referral

H2011 – Crisis intervention service, per 15 minutes

- Mental health crisis assessment, intervention and stabilization
- Document medical necessity
- Document the actual intervention performed linked to the symptoms/impairments of the patient's diagnosis.
- Documentation must include total time of the service provided.

SMHS Referral Code

- Linkage to other needed services and supports
- Targeted case management services aimed specifically at special groups, such as those with developmental disabilities or chronic mental illness

T1017 – Targeted case management, each 15 minutes

- Documentation should include the reasons for the targeted case management and include the components of the services provided and/or recommended.
- Documentation must include total time of the service provided.

SMHS Rehabilitation

- 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

H2017 – Psychosocial rehabilitation, per 15 minutes

- Document and describe the specific activities performed to enhance/support the patient's skills related to their specific rehabilitation needs and goals.
- Time spent providing PSR (psychosocial rehabilitation) services; individual or group services
- Documentation must include total time of the rehabilitation provided.

H2021 – Community-based wrap-around services, per 15 minutes

- Documentation should address all components included in each client's wrap-around program.
- 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 must include total time of the services provided.

SMHS Supplemental Services

- 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, 90785 indicates that certain factors increase the complexity of a patient's treatment.
- Supplemental codes cannot be billed independently and must be billed with a/another (primary) procedure.

SMHS Supplemental Services Codes

90785 – Interactive complexity (psychotherapy complex interactive)

- 90785 is an add on code that may only be reported in conjunction with an appropriate primary service for psychiatric diagnostic evaluation or psychotherapy service
- 90785 is dependent on reporting with codes:
  - 90791, 90792 – diagnostic psychiatric evaluation
  - 90832-90838 – psychotherapy
  - 90853 – group psychotherapy

Note: Peers are not allowable disciplines to bill for diagnostic psychiatric evaluation, psychotherapy or group psychotherapy, therefore, CPT 90785 would not be utilized by Peers

SMHS Supplemental Services Codes

T1013 – Sign language or oral interpretive services, 15 minutes

- Facilitate effective communication with deaf or hearing-impaired patients
- Documentation must include total time of the services provided.

SMHS Therapeutic Behavioral Services Code

- An adjunctive program that supports other services patients are currently receiving.
- 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.

H2019 – Therapeutic behavioral services, per 15 minutes

- Documentation must include total time of the services provided.

HCPCS Codes for Peers DMC-ODS

DMS-OCD Peer Support Specialist Services

- Culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals.

- Services aim to prevent relapse, empower beneficiaries through strength-based coaching, support linkages to community resources, and to educate beneficiaries and their families about their conditions and the process of recovery.

DMS-OCD Peer Support Specialist Services Codes

H0025 – Behavioral health prevention education service

- Delivery of services with target population to affect knowledge, attitude and/or behavior
- Include documentation of activities completed, such as group and individual coaching to set recovery goals and identify steps to reach the goals

H0038 – Self-help/peer services, per 15 minutes

- Include documentation of activities completed, such as group and individual coaching to set recovery goals and identify steps to reach the goals
- Include total time of services provided in the documentation

DMC-ODS Individual Counseling Code

- Individual counseling consists of contacts with a beneficiary
- 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.

H0050 – Alcohol and/or Drug Services, brief intervention, 15 minutes

- Code must be used to submit claims for Contingency Management Services.
- Documentation must include total time of the brief intervention.

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

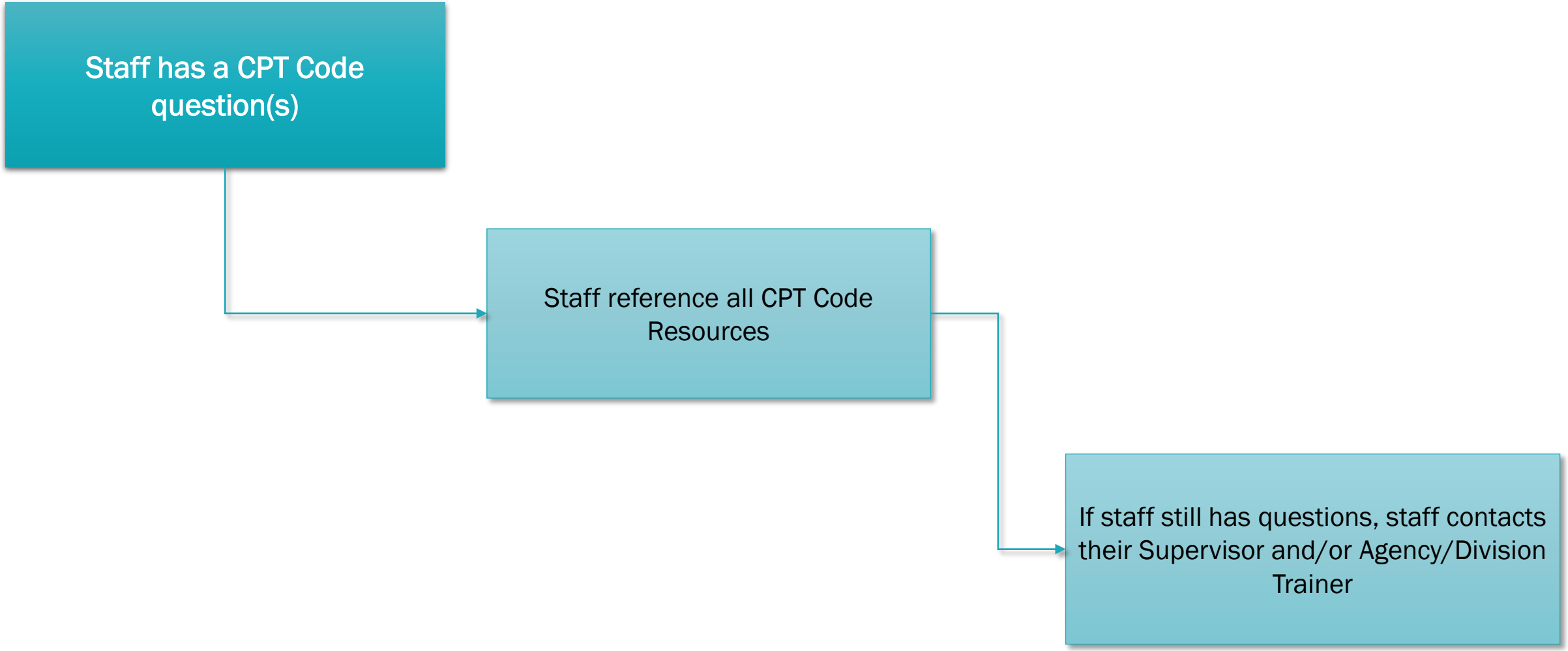
Q&A Session # 2

- 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

- Annual renewal of services:
  - On an annual basis, a reevaluation of the individual's status and needs must be completed in order to obtain continued authorization for services
  - It's a good practice to review the limits of confidentiality and risks and benefits with the individual as clinically relevant
  - When the service authorization period ends, the primary author is responsible for the completion of the Client Plan and Reassessment
    - Including collaboration and monitoring of goals/objectives among various service providers
  - Responsible for completion of the following items, which can be completed within 30 days prior to the end of the service authorization period:
    - Annual clinical reassessment
    - Annual client plan
    - Review/update medical necessity
    - Obtain signature of beneficiary

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

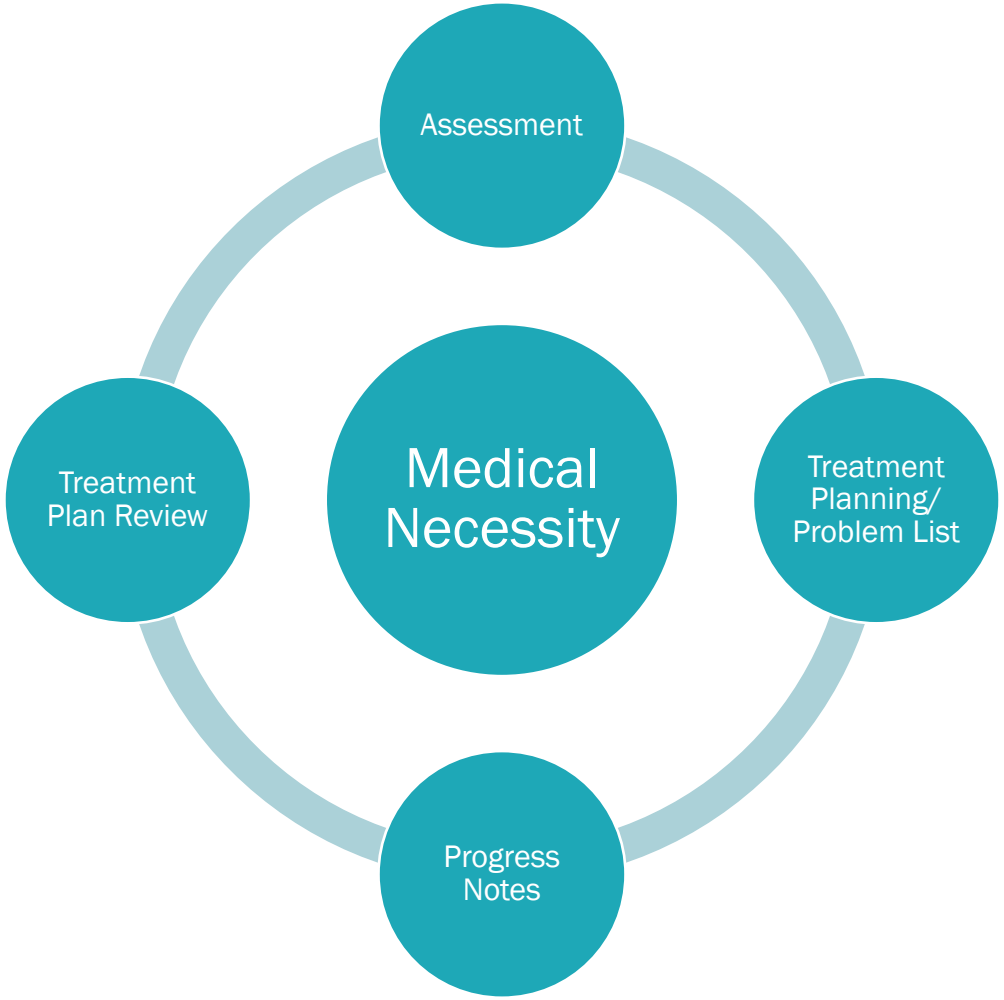
General Principles of Documentation

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

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

BHS captured mainly in these 2 subcategories

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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