San Francisco Health Network
Behavioral Health Services

Frequently Asked Questions: CalAIM Payment Reform

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Behavioral Health Services CalAIM Payment Reform FAQs

The following specific questions were sent from providers and administrators across the various system of care. This document can be used as a tool that summarizes frequently asked questions related to Payment Reform and the coding transition.

Code Questions

SMHS Services

Assessment Codes

Q: If it is on the same date of service and one part is by phone or telehealth and one part is in person, does this need separate documentation?

A: Currently, there is no requirement to document these two situations separately. As a best practice it is recommended providers document the total time, the time spent face-to-face, and time spent via phone/telehealth.

Example: A total of 60 minutes of Direct Patient Care was provided with 45 minutes face-to-face and 15 minutes via telehealth.

Q: What is the maximum allowed time unit for 90791 and 90792?

A: According to the DHCS Billing Manuals, CPT code 90791 [Psychiatric Diagnostic Evaluation] and 90792 [Psychiatric Diagnostic Evaluation with Medical Services] and 90791 has maximum time allowed of 15 minutes (1 unit). Note that G2212 [Prolonged Office or Other Outpatient Evaluation and Management Service(s) beyond the Maximum Time] can be utilized for additional time beyond the 15 minutes for both 90791 and 90792.

Q: If I spend 60min on Psych Assessment, I code 90792 + G2212 + G2212 + G2212?

A: You would enter 90792 for the first 15 minutes (1 unit) and then choose G2212 for the remaining 45 minutes (3 units). Providers will only need to select the add-on code G2212 once and enter the additional time.

Q: Can you walk through the use of medical records review (90885) once more? Can we use CPT 90885 to bill for reviewing a chart prior to a session? Revised 07/14/2023

A: No, chart reviews are not considered a direct service. 90885 is an Assessment Code as defined in the State Plan Amendment (SPA 22-0023) and should be used when reviewing records for the purpose of making a diagnosis and/or treatment plan. This is a 15-minute service (1 unit) and can be billed without the client present. This is a separate note and documentation should identify the type(s) of information reviewed.

Q: If an assessment does not include a diagnosis and the other 7 domains altogether, we cannot call that an assessment. May be just a screening? Revised 07/14/2023

A: That is correct. DHCS requires all clients to be assessed. The finalized required assessment must cover 7 domains, including diagnostic impressions.

Q: Will there be a way to bill for time spent completing the Child and Adolescent Needs and Strengths (CANS), not in the presence of the client/caregiver?

A: The time spent completing the CANS/ANSA can be added as documentation time to the assessment session where the provider gathered the relevant information. After July 1st, documentation time on its own cannot be claimed.

Q: Can MHRS and MHW staff provide Assessment services?

A: Yes. Both MHRS and MHW staff may use H0031 to claim for assessment services. This code has been added to the BHS Provider Crosswalk.

Q: Can you clarify what H2000 Comprehensive Multidisciplinary Evaluation is used for?

A: This code can be used by all disciplines, including unlicensed staff. This code is used for multidisciplinary team meetings. Only one member of the meeting may claim for the service.

Q: Can you clarify what the H2021 Community-Based Wrap-Around Services is for?

A: This is a wrap-around service that refers to coordination of care between providers in the mental health system and providers outside of the system. This service is a team based intensive service and typically occurs in the community or home.

Q: Would the Patient Health Questionnaire-9 (PHQ9) and General Anxiety Disorder-7 (GAD7) be considered psychological testing? Added 07/14/2023

A: These instruments may be included in the battery of tests completed during psychological testing, but this service must be conducted by a psychologist (or other allowable professional) as part of a comprehensive psychological evaluation. The allowable disciplines for Psychological Testing Evaluation codes include MD/DO, Ph.D./Psy.D., PA, NP or CNS (certified).

However, time spent reviewing responses or results of a self-administered instrument with a client for the purposes of diagnosing, monitoring, planning may be claimed as an assessment service (ASMT1 or H0031) if it meets criteria per the SMHS Billing Manual.

Q: How should we code for time in court (such as testifying in a conservatorship hearing)? How to code for evaluation time of patient in prepare for court? Often, we need to see patient while they are in hospital to do this evaluation and court is scheduled during their hospital admission; how is this billed since they also saw their inpatient team that day? Added 07/14/2023

A: While these are important activities, time in court and time to prepare for court are not Specialty Mental Health Services and cannot be claimed to Medi-Cal.

Q: Are there Dependent Codes associated with each Assessment services or only Psychological Testing? Added 07/14/2023

A: Dependent procedure codes are not just applicable to Psychological Testing. For example, additional time may be added to ASMT1 (90791) using G2212 for each additional 15 minutes of time spent on assessment activities. Please review the BHS Crosswalk on the BHS Provider Resource Page for a complete list of additional dependent procedure codes.

Q: Is it appropriate to bill the Psychological Testing Evaluation Codes (96130 and 96131) for the time spent integrating and interpreting the data for the initial CANS? Added 07/14/2023

A: No, Psychological Testing Evaluation or psychological testing, is a thorough process of assessment and screening typically administered by a Psychologist. The allowable disciplines for Psychological Testing Evaluation codes include MD/DO, PH.D./Psy.D., PA, NP or CNS (certified).

Q: Can we claim for time spent analyzing and consolidating information gathered during the assessment process? Added 01/18/2024

A: According to DHCS, if time spent consolidating and synthesizing clinical information is part of the assessment to make recommendations for treatment or to make a medical diagnosis, then the activity does count as service time and is claimable with ASMT1 (or another other code, as appropriate). This guidance is true for both DMC-ODS and SMHS services.

Please note, claimable service time 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 client visit. Progress notes must clearly describe the service being claimed and justify the use of the code when client not present.

Medication Support Codes

Q: Historically, it has been my understanding that CPT codes cannot be billed for (1) telepsychiatry services with a patient or (2) Medication Plan Development in person/telehealth/telephone with the parent alone but without the child patient present; therefore, I have been using HCPCS codes for these services. Starting 7/1/23, please confirm whether CPT codes can be used for these services (e.g., EEML3, EEML4) or if should continue to use the HCPCS code H0034 for these two services. I use CPT codes for in-person psychiatry appointments when the patient is present and will continue to do so.

A: Telepsychiatry can be billed with the E/M Office visit codes (EEML/99202-99205 and 99212-99215) by an applicable provider. When selecting the correct telehealth place of service, modifier 95 [Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunication system] will be added to the appropriate code. Please review the Avatar Place of Service list available on the BHS Provider Resource page. Note that E/M office visit codes cannot be used in the case of a telephone-only visit.

H0034 can be conducted with the client or significant support person. The services can be performed in person, by telephone or telehealth.

Q: Do we need to complete 15 minutes of Direct Patient Care to utilize G2212? Added 07/14/2023

A: G2212 can be used to add on time for certain CPT codes once the maximum time for the primary code is reached. The mid-point rule does apply to G2212 therefore a minimum of 8 minutes of Direct Patient Care must be provided before this code can be billed.

Q: What code or codes do we use when administering Intramuscular Medications? Added 07/14/2023

A: The appropriate code for IM injections is 96372. This code is being added into Avatar and to the BHS crosswalk.

Therapy Codes

Q: If the psychiatrist provides therapy/education in combination with a med visit and it is on the same day as a scheduled individual psychotherapy visit, can both be billed?

E.g. - A 90836 from the psychiatrist on the same day as a regular therapy visit with LCSW in same episode?

A: Both services should be billed for the same date of service. It may be necessary to add a modifier such as XP [Separate practitioner, a service that is distinct because it was performed by a separate practitioner] to one of the codes.

Q: Our MHWs have used T1017 in the past, is this changing? Are they still able to bill for TCM?

A: This is not changing. Other Qualified Providers (Mental Health Workers) can bill for TCM.

Q: How do we claim for a 90-minute psychotherapy session?

A: INDTPY/90837 for 60 minutes + G2212 for 30 minutes = 90 minutes

Q: How do we claim for psychotherapy session that is longer than 75 minutes? Revised 07/14/2023

A: Psychotherapy is claimed using a series of codes (e.g., 90832-90837) that have specific time ranges built into each code. Note, providers will enter the direct service time and select the local code INDPTY for the primary service. Avatar will automatically apply the correct psychotherapy code from that series.

- INDPTY/90832 (30 minutes) = 16 – 37 minutes of direct patient care
- INDPTY/90834 (45 minutes) = 38 – 52 minutes of direct patient care
- INDPTY/90837 (60 minutes) = 53- 67 minutes of direct patient care

To extend the psychotherapy service beyond 60 minutes, the add-on code G2212 code must be used. Unfortunately, Avatar cannot automatically apply the add-on code for prolonged time. Additional information on how to enter the add-on code can be found on the BHS Avatar User Support Page.

Q: CPT code 90839 (Psychotherapy for Crisis) is not allowed via telephone or telehealth. This service used to be allowed with telehealth/telephone. Is it an error?

A: No, this is not an error. In 2023, The American Medical Association provided guidance that this code may be delivered via audio. However, DHCS has determined that this code cannot be delivered via telephone or telehealth. When billing for a crisis intervention service that is provided via telehealth use CRISIS (H2011).

Q: How do we bill for group preparation and chart reviews in preparation for a session?

A: According to DHCS, preparation for therapy sessions is not a billable activity.

Q: During Covid BHS allowed providers to bill for psychotherapy when the service was less than 16 minutes. Is this still allowed?

A: The minimum reimbursable time for psychotherapy services is 16 minutes. While all services should be documented in the client record (using the relevant CPT or HCPC code), psychotherapy

services less than 16 minutes are not billable. The Covid relief policy that allowed for services under 16 minutes to be billed is no longer in effect.

Q: If a Psychotherapy session was 50 min, do we use the 45 min code or 60 min code? Added 07/14/2023

A: Until we move to Epic, providers will select the local code INDTPY, enter the direct patient care time and Avatar will crosswalk to the appropriate psychotherapy CPT code for billing purposes. For a 50-minute psychotherapy service, CPT code 90834 (the 45-minute code) would be billed.

Q: What is the benefit of using the code for Group Psychotherapy, other than a Multi-Family Group (90853)? Does it add additional time? Added 07/14/2023

A: No, 90853 does not add additional time to a service. Both Group Psychotherapy (90853) and Multiple Family Group Psychotherapy (90849) are time based (per 15 minutes) services. These codes should be selected based on the composition of the group. Please note that add-on code G2212GRP may be used to extend both codes.

Plan Development Codes

Q: Can we bill for more than 1 increment of 15 minutes?

A: It depends on the specific CPT/HCPCS code you are referencing. Please review the BHS Provider Crosswalk or electronic page 129 of the SMHS Billing Manual.

Q: What code should be used for Plan Development?

A: All disciplines may use H0032 to claim for plan development services. This code is included in the BHS Provider Crosswalk.

Q Do all participants write notes for the medical team conference? Added 07/14/2023

A: According to DHCS, separate claims that use different rendering provider NPIs will not be denied on the same day for these services. The documentation should indicate which providers were present for the team conference.

Q: Does the patient need to be present for the CPT code 99366 [Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non- Physician. Face-to-face with Patient and/or Family. 30 Minutes or More]? Added 07/14/2023

A: Yes. Per the code description, the conference must include either the patient or the patient's family. One or the other must be present. It is also acceptable for both to be present during the service.

Referral Codes

Q: We are configuring our services and need some clarity on Direct Service time as it relates to TCM (T1017). Per the CMS definition of Direct Service Time; "means time spent with the consultant/members of the beneficiary's care team. If a provider meets with another professional for the coordination of care and/or referral (TCM) and the client is not present, is the time reimbursable as Direct Time?

A: Yes. The service definition for TCM has not changed. However, providers must follow the definitions and guidance of DHCS (see definition for TCM below).

Q: Could you clarify the definition of TCM?

A: The definition for TCM has not changed. Per the Electronic Page 22 of the SMHS Manual, Targeted Case Management is defined as a service that assists a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include but are not limited to communication, coordination, and referral; monitoring service delivery to ensure patient access to service and the service delivery system; monitoring the patient's progress; placement services and plan management.

TCM activities typically involve communication and collaboration ***with other professionals*** (e.g., teachers, counselors, social service providers, etc.) to coordinate care, assess individual needs for other services, monitor, or link the client to necessary community resources in order to stabilize, support, or make more tolerable the client's behavioral health condition.

Q: Can you clarify the difference between Targeted Case Management [T1017] and the Community-based wrap-around service [H2021]? Added 07/14/2023

A: CCR Title 9, 1810.249 defines Targeted Case Management [T1017] as a service that assists a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary's progress; placement services; and plan management.

Electronic Page 189 of the SMHS Billing Manual defines a community-based wrap-around service as service designated by HCPCS code H2021 and refers to coordination of care between providers in the Mental Health System and providers who are outside the Mental Health system. HCPCs code H2021 can only be used to show that a delivery-system coordination of care has occurred. For other kinds of coordination, other service codes must be used.

Q: If a clinician spends time completing a referral for a residential program for a client, can this be billed as case management? The forms take a considerable amount of time and are necessary to refer the client. Is this claimable time for Targeted Case Management (TCM)? Added 01/18/2024

A: If the service code billed specifies a case management service or a consulting service on behalf of the BHS client, those activities are allowed. In those situations, claimable service time is time spent consulting on behalf of the client with specialist(s) and/or with the member's support person(s). As an example, if a provider spends 20 minutes talking with a staff at a housing program and then spends 30 minutes completing a referral to the program on behalf of the program, the staff could claim for 50 minutes of TCM.

As a reminder, claimable service time 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 client visit. Progress Notes must clearly describe the service being claimed and justify the use of the code when client not present.

Supplemental Service Codes

Q: Can you clarify what it means that some codes are dependent on other codes?

A: These are procedures that either indicate that time has been added to a primary procedure (i.e., add-on codes) or modify a procedure (i.e., supplemental codes).

Dependent-On procedures cannot be billed unless the same provider first bills for a primary procedure, on the same day and the same claim, for the beneficiary.

Q: Does interactive complexity code include language interpretation needs of patient and family?

A: Interactive complexity, 90785, encompasses several factors including:

- Manage maladaptive communication
- Caregiver emotions or behavior that interferes with treatment
- Evidence of disclosure of a sentinel event and mandated reporting
- Use of devices to communication with the beneficiary

Use of an interpreter should be captured with HCPCs code T1013, Sign language or oral interpretive services, 15 minutes.

Q: For the T1013 Interpretation supplemental service, can it be used if provided when 2 separate staff are providing the service? For example: A therapist providing family therapy while the health worker helps with language interpretation?

A: Yes. The therapist would use HCPCS code T1013 along with the appropriate code for the therapy provided. The health worker providing the interpretation services does not bill anything.

Q: If the provider is bilingual, will interpretation be coded separately using T1013?

A: No, if the provider is bilingual interpreter services are not being used, because there is no need for translation

Q: If T1013 only applies to the primary provider, what will the health worker use to bill, ADM99?

A: The health worker would not need to write a separate note for their time.

Q: Can G2212 be used as an add-on code for any codes?

A: G2212 may only be used for codes that do not have a designated add-on code. For codes that have a designated add-on code, only the designated add-on codes should be used. Please review the SMHS Billing Manual for codes that allow G2212.

Q: Do you have to provide at least 8 minutes of G2212 to be able to claim the code?

A: The mid-point rule does apply to G2212 therefore a minimum of 8 minutes of Direct Patient Care must be provided before this code can be billed.

ICC and IHBS Codes

Q: What codes should be used to claim for Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS)? Revised 07/14/2023

A: BHS has created six local codes for these services. The purpose of the local codes is to better understand services being provided across BHS *and* so that the EHR can automatically apply the required HK modifier each time these codes are selected.

Intensive Care Coordination (ICC): BHS will use two codes to capture ICC services.

- ICC: This code is used for all intensive care coordination services outside of the CFT meetings.
- CFTICC: This code is used for all services and participation during a CFT Meeting.

Intensive Home-Based Services (IHBS): The codes described below were identified as the most likely services to reflect IHBS. Providers may use any other allowable code as indicated in the SMHS Billing Manual. In instances where an additional code is used to reflect an IHBS service, the provider will need to add the HK modifier.

- IHBSASMT: This code is used for any assessment service provided by a LPHA for clients who meet criteria and are authorized for IHBS.
- IHBSH0031: This code is used for any assessment service provided by a non-LPHA for clients who meet criteria and are authorized for IHBS.
- IHBSPLAN: This code is used for any plan development service for clients who meet criteria and are authorized for IHBS.
- IHBSREHAB: This code is used for any rehabilitation service for clients who meet criteria and are authorized for IHBS.

Please review the Intensive Services CPT Code Tip Sheet for additional information and guidance.

Collateral-Type Codes

Q: There is no standalone collateral code in the SMHS Billing Manual. What codes can be used to provide services with a caregiver or significant support person when the client is not present?
Revised 07/14/2023

A: What has historically been called "collateral" is now viewed as a component of many different services. Providers can claim for collateral-type services and are encouraged to use the code that most accurately reflects the service provided.

Please review the SMHS Collateral Information Sheet for additional information and guidance.

DMC-ODS Services

Assessment Codes

Q: What procedure codes can SUD providers use to claim for completing the ASAM assessment?

A: According to the DHCS DMC-ODS Billing Manual, codes G2011, G0396, and G0397 can be used when completing an ASAM criteria assessment.

Q: Are there specific codes for Tobacco Use? Added 07/14/2023

A: Currently, Tobacco-Related Disorders are not covered under DMC-ODS, so there are no billing codes for Tobacco Use. If a client presents with a primary Substance-Related and Addictive Disorder in addition to the Tobacco-Related Disorder, you may address the tobacco use as you would other secondary concerns. However, if Tobacco-Related Disorder is primary or the only diagnosis, then client will need to be referred to their primary care provider or other entities that treat Tobacco.

Q: If it is on the same date of service and one part is by phone or telehealth and one part is in person, does this need separate documentation? Added 07/14/2023

A: Currently, there is no requirement to document these two situations separately. As a best practice it is recommended providers document the total time, the time spent face-to-face, and time spent via phone/telehealth.

Example: A total of 60 minutes of Direct Patient Care was provided with 45 minutes face-to-face and 15 minutes via telehealth.

Q: What is the maximum allowed time unit for 90791 and 90792? Added 07/14/2023

A: According to the DHCS Billing Manuals, CPT code 90791 [Psychiatric Diagnostic Evaluation] and 90792 [Psychiatric Diagnostic Evaluation with Medical Services] and 90791 has maximum time allowed of 15 minutes (1 unit). Note that G2212 [Prolonged Office or Other Outpatient Evaluation and Management Service(s) beyond the Maximum Time] can be utilized for additional time beyond the 15 minutes for both 90791 and 90792.

Q: If I spend 60min on Psych Assessment, I code 90792 + G2212 + G2212 + G2212? Added 07/14/2023

A: You would enter 90792 for the first 15 minutes (1 unit) and then choose G2212 for the remaining 45 minutes (3 units). Providers will only need to select the add-on code G2212 once and enter the additional time.

Q: Can we use CPT 90885 to bill for reviewing a chart prior to a session? Added 07/14/2023

A: No, chart reviews are not considered a direct service. 90885 is an Assessment Code as defined in the State Plan Amendment (SPA 21-0058) and should be used when reviewing records for the purpose of making a diagnosis and/or treatment plan. The service and documentation should identify the type(s) of information reviewed and the purpose of the review.

Q: Can you clarify what the H2021 Community-Based Wrap-Around Services is for? Added 07/14/2023

A: This is a wrap-around service that refers to coordination of care between providers in the Drug Medi-Cal system and providers outside of the system. This service is a team based intensive service and typically occurs in the community or home. For other kinds of coordination, other service code must be used.

Q: Can we claim for time spent analyzing and consolidating information gathered during the assessment process? Added 01/18/2024

A: According to DHCS, if time spent consolidating and synthesizing clinical information is part of the assessment to make recommendations for treatment or to make a medical diagnosis, then the activity does count as service time and is claimable with 90791 (or other code, as appropriate). This guidance is true for both DMC-ODS and SMHS services.

Please note, claimable service time 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 client visit. Progress notes must clearly describe the service being claimed and justify the use of the code when client not present.

Care Coordination Codes

Q: Is CPT code 96160 for DMC only?

A: Correct, CPT code 96160 is not a billable service code in the SMHS Billing Manual.

Q Do all participants write notes for the medical team conference? Added 07/14/2023

A: According to DHCS, separate claims that use different rendering provider NPIs will not be denied on the same day for these services. The documentation should indicate which providers were present for the team conference.

Group Counseling Codes

Q: There was a local code for groups greater than 12 participants. Is that no longer valid?

A: The number of participants has not changed under Payment Reform. The minimum number of participants in a group is 2 and the maximum is 12 participants.

Q: is there a code to use for planning for topic for a group? Revised 07/14/2023

A: No. Currently there is not a specific CPT/HCPCs code to capture planning services for group or individual services. That time is captured in the allotted administrative hours for each staff.

Q: For group services, does each therapist or counselor write a progress note and bill for the session? Added 07/14/2023

A: According to BHIN 22-019, only one group note will be written per client, regardless of how many providers were involved in that session. The progress note shall clearly document the specific involvement and the specific amount of time of involvement of each provider of the group activity, including travel and documentation time.

Q: How do we bill for group preparation and chart reviews in preparation for a session? Added 07/14/2023

A: According to DHCS, preparation for sessions is not a billable activity.

Supplemental Service Codes

Q: Is it accurate that T1013 cannot be used by Counselors? Revised 07/14/2023

A: Incorrect. The code can be billed by an AOD counselor as long as they are the individual providing the interpretive service. Please review the DMC-ODS Billing Manual posted on the MedCCC Library or the DMC-ODS Outpatient Code crosswalk on the BHS Provider Resource Page.

Q: For the T1013 Interpretation supplemental service, can it be used if provided when 2 separate staff are providing the service? For example: A LPHA providing family therapy while the health worker helps with language interpretation? Added 07/14/2023

A: Yes. The LPHA would use HCPCS code T1013 along with the appropriate code for the therapy provided. The health worker providing the interpretation services does not bill anything.

Q: Can you clarify what it means that some codes are dependent on other codes? Added 07/14/2023

A: These are procedures that either indicate that time has been added to a primary procedure (i.e., add-on codes) or modify a procedure (i.e., supplemental codes).

Dependent-On procedures cannot be billed unless the same provider first bills for a primary procedure, on the same day and the same claim, for the beneficiary.

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- A: Interactive complexity, 90785, encompasses several factors including: Manage maladaptive communication
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Use of an interpreter should be captured with HCPCs code T1013, Sign language or oral interpretive services, 15 minutes.

Q: Can G2212 be used as an add-on code for any codes? Added 07/14/2023

A: G2212 may only be used for codes that do not have a designated add-on code. For codes that have a designated add-on code, only the designated add-on codes should be used. Please review the SMHS Billing Manual for codes that allow G2212.

Q: Do you have to provide at least 8 minutes of G2212 to be able to claim the code? Added 07/14/2023

A: That is correct. In order to claim one unit of G2212, 8 minutes of direct service must be provided.

Treatment Planning Codes

Q: What procedure codes can SUD providers use to claim for patient education services?

A: Most work will include patient education embedded into whatever service being provided, whether it be individual counseling or medication management. However, below is a specific patient education service code identified in the DHCS DMC-ODS Billing Manual.

- IOPTEDUC/IOPTEDUCGP/ODSPTEDUC/ODSPTEDUCG for HCPCS code H2014: Skills Training and Development

As a reminder, providers will enter the direct service time and select the appropriate local code.

Collateral Codes

Q: Where is the collateral code under DMC-ODS? Are collateral services still covered? Added 07/14/2023

A: We continue to encourage providers to do collateral work, as contact with significant people in client's life is crucial to their recovery. "Collateral services" is no longer defined as a distinct service component of the DMC-ODS service modalities.

DHCS has identified several activities that could be utilized for collateral services, but they are integrated into other service codes without distinction. According to the DHCS Billing Manual and BHIN 21-075, the concept of including a collateral in a beneficiary's substance use disorder treatment has been incorporated into Assessment, Individual Counseling, and Family Therapy service types.

- Assessment services 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.
- Individual counseling 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.
- Family therapy 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.

As having data on collateral work is important to BHS and to your agency, BHS is also exploring whether to further distinguish the new activities identified above with collateral markers. Additional information will be published as soon as it is available.

General Coding Questions

Q: Can we always use the midpoint rule for code selection?

A: It depends. The midpoint rule applies to codes that have a set time limit. For example, Mental Health Service Plan Development by a Non-Physician (H0032) is listed with a 15-minute time limit. For that code, the service can only be claimed once the midpoint is reached. That means, once 8 minutes of direct (face-to-face) service is provided.

Other codes have a range of time associated with the code. For example, CPT code 99213 Office or Other Outpatient Visit of an Established Patient, has a time range of 20-29 minutes associated with code. In these situations, the code can be claimed if the Direct (face-to-face) service falls within that timeframe.

Q: Does the midpoint rule apply to HCPCS?

A: Yes, the midpoint rule applies to HCPCS codes as well.

Q: What is the definition of group practice? Added 07/14/2023

A: Electronic Page 185 of the SMHS Billing Manual defines a group practice as "the entity that owns and is responsible for the beneficiary's medical record describing the services provided by a licensed or pre-licensed professional. If professional services are provided to the beneficiary by county-operated and/or county employed health care professionals, the MHP [Mental Health Plan] is considered to be the "group practice" because the MHP owns and is responsible for the beneficiary's medical record. If the beneficiary receives their specialty mental health services from a county-contracted provider (a community-based organization or other provider), then the clinic or the clinic's owner in that location owns and is responsible for the beneficiary's medical record. If a psychiatrist, advanced practice nurse and physician assistant all work for a practice at a discrete location, then that practice owns the medical record and is considered the group practice. If the psychiatrist owns the practice at a discrete location and the advanced practice nurse and physician assistant work for the psychiatrist, then the psychiatrist-owner is considered to be the group practice as he/she owns and is responsible for the beneficiary's medical record."

Electronic Page 133 of the DMC-ODS Billing Manual defines a group practice as "the entity that owns and is responsible for the beneficiary's medical record describing services provided by a licensed or intern/resident professional. If county-operated and/or county-employed health care professionals provide professional services to the beneficiary, the county is considered the "group practice" because the county owns and is responsible for the beneficiary's medical record. If the beneficiary receives their DMC services from a county-contracted provider (a community-based organization or other provider), then the clinic or the clinic's owner in that location owns and is responsible for the beneficiary's medical record. If a physician, advanced practice nurse and physician assistant all work for a practice at a discrete location, then that practice owns the medical record and is considered the group practice. If the physician owns the practice at a discrete location and the advanced practice nurse and physician assistant work for the physician, then the physician-owner is considered the group practice as he/she owns and is responsible for the beneficiary's medical record."

Modifier Questions

Q: What are modifiers?

A: According to DHCS, modifiers provide a way to report or indicate that a service or procedure performed was altered by a specific circumstance but does not change its definition. Modifiers will not impact how much a service is reimbursed but may impact how a service should be billed and/or who pays for the service. There are some instances (such as the lack of an overriding modifier) when missing a modifier will result in a service being denied.

Note that many modifiers will be automatically applied by Avatar. For a complete list, please contact the BHS Billing Department.

Q: Are we using the modifier HE?

A: This modifier will only be used when billing for 24-hour and day services. For additional information about when this modifier is required, refer to Service Table 11 in the SMHS Billing Manual. Do not use this modifier when claiming for Outpatient Services.

Q: Will the telephone modifier requirement that is in place now still be required as of July 1, 2023?

A: Yes, the telephone or audio-only services modifier will be required. For CPT codes the appropriate modifier is 93 and for HCPCs codes the appropriate modifier is SC. Avatar will automatically assign this modifier when place of service 98 is selected.

Q: What happens if we have more than 4 modifiers for a claim, especially now with all the modifier requirements?

A: For a transaction to be HIPAA-compliant, a procedure code cannot use more than 4 modifiers. DHCS recommends that, in the rare situations that MHPs exceed 4 modifiers per procedure code in each transaction, they not use modifiers that validate services, indicate that the service was provided as a result of a federal or state mandate or facilitate payment. Telehealth modifiers fit those criteria.

Q: What are Lockouts?

A: Lockouts are codes that cannot be billed on the same day, or others can only be billed on the same day when certain conditions are met, and the appropriate modifier(s) is used. Please see the SMHS and DMC-ODS Billing Manuals for details on lockouts for each code and the correct modifiers for each situation.

Q: How will 'Possible Duplicates' be handled? Will the BHS Billing Dept apply the appropriate modifiers, or the is the submitting agency required to make the change? Added 07/14/2023

A: The submitting agency will be responsible for making the change. Similar to the current Inpatient Lockout Report, BHS will be releasing an error report for Outpatient Lockouts for agencies to run every month and correct possible duplicates with the appropriate modifier(s). Additional information about this report will be released shortly.

Direct Patient Care Questions

Q: What is considered Direct Patient Care? Revised 07/14/2023

A: From Electronic Page 185 of the SMHS Billing Manual:

- If the service code billed is a patient care code, direct patient care means time spent with the patient for the purpose of providing healthcare.
- If the service code billed is a medical consultation code, then direct patient care means time spent with the consultant/members of the beneficiary’s care team.

Direct patient care does not include travel time, administrative activities, chart review, documentation, utilization review and quality assurance activities or other activities a provider engages in either before or after a patient visit.

From the Electronic Page133 of the DMC-ODS Billing Manual:

DHCS policy states that only direct patient care should be counted toward selection of time. Direct patient care does not include travel time, administrative activities, chart review, documentation, utilization review and quality assurance activities or other activities a provider engages in either before or after a patient visit.

Q: If someone does their documentation concurrent or collaborative with the service, does it count towards the duration?

A: Direct patient care time is defined as the time spent with the patient for the purpose of providing service.

Q: Are there codes for indirect services that go into making the direct service possible such as travel?

A: Per DHCS, providers can only claim for Direct Patient Care services through Short Doyle Medi-Cal. There is not a unique service code for travel. As previously communicated, information will still be entered in for documentation and travel time. That information will be monitored by BHS System of Care. Future rates are intended to cover the indirect costs associated with each service, including documentation and travel. It will be very important to accurately track your travel time.

Q: How do we capture time spent doing non-direct patient care activities like chart review and calling pharmacies? Do we put that under Documentation and Travel Time versus Face to Face? Added 07/14/2023

A: Time spent on non-direct patient care, such as chart reviews, is not a billable service and would not be documented in the client chart as it does not pertain to client's personal treatment history. Please see the Prescribers CPT Code Tip for more details related to activities considered direct patient care.

Q: Are providers allowed to bill for services when the client is not present? Added 01/18/2024

A: According to DHCS, if the service code billed is a direct patient care code billable service time means time spent with the client for the purpose of providing healthcare. If the code billed specifies activities that are not direct client care but that are for the benefit of the client or the client's support persons, those activities are allowed, *so long as activities are being conducted that would be billable if the member was present*. Billable service time does not include travel time, administrative activities, chart review, documentation, utilization review and quality assurance activities.

Scope of Practice Questions

Q: I notice that these codes all list licensed staff but not waivered staff, who have traditionally been able to bill these services as well. Will our waivered staff continue to be able to bill for assessment, plan development, etc.?

A: Whenever MFT, LCSW, LPCC and psychologist is noted, this includes AMFT, ASW, APCC and waivered psychologists. The DHCS CalAIM Billing Manual posted on the MedCCC Library defines an intern as someone who is registered with the appropriate professional licensing board. Interns

and residents are considered LPHAs and can use the applicable taxonomy code for their profession and use the HL or GC modifier on claims to identify that services were provided. Those who are not yet registered are not considered residents or interns. Those individuals must use the appropriate taxonomy code for their level of education and training.

Q: Are there any changes for Psychology Postdocs?

A: Psychology Postdocs, staff with a Ph.D./Psy.D. who are unlicensed and registered with the Board of Psychology, should use the Taxonomy for a licensed psychologist (103T00000X). All claims for registered Psychology Postdocs will use the HL modifier. Psychology Postdocs are able to use the CPT codes that are specified for licensed psychologists if the HL modifier is attached to the claim.

Q: The SMHS Billing Manual states that students who are not licensed or registered with their professional licensing board cannot provide certain codes, including individual and group psychotherapy. What services can students provide? Revised 07/14/2023

A: Students in SMHS programs should use the Taxonomy Code for MHRS, or Other Qualified Health Professional based on their education, training, and experience. Although MHRS and Other Qualified Health Professionals cannot bill for CPT codes, they can bill for HCPCs codes. The following Table outlines the allowable codes.

Codes Allowed for MHRS and Other Qualified Professionals

BHS Local Code	CalAIM Billing Code	Service Description
CRISIS	H2011	Crisis Intervention Service, per 15 Min.
H0033	H0033	Oral Medication Administration, Direct Observation, 15 Min.
H0031	H0031	Mental Health Assessment by Non-Physician, 15 Min.
H2000	H2000	Comprehensive Multidisciplinary Evaluation, 15 Min.
H0032	H0032	Mental Health Service Plan Developed by Non-Physician, 15 Min.
T1017	T1017	Targeted Case Management, Each 15 Min.
ICC	T1017-HK	Intensive Care Coordination, 15 Min.
IREHAB/GREHAB	H2017	Psychosocial Rehabilitation, per 15 Min.
IHBSREHAB	H2017- HK	Intensive Home-Based Services (Rehab), per 15 Min.
H2021	H2021	Community-Based Wrap-Around Services, per 15 Min.
T1013	T1013	Sign Language or Oral Interpretive Services, 15 Min.

Please review the Mental Health Graduate Student and Trainee Information Sheet for additional information.

Q: We have students using the taxonomy code 390200000X (student in an organized health care education/training program). Is this appropriate? Added 07/14/2023

A: For SMHS graduate students, the taxonomy code 390200000X is appropriate if it meets the individual's education, training, and experience.

Q: Can ASWs bill Psychiatric Diagnostic Evaluation, ASMT1 (90791)? Added 07/14/2023

A: Yes. As an intern who is registered with the appropriate professional licensing board, an ASW can bill a Psychiatric Diagnostic Evaluation (ASMT1).

Q: Can an MHRS use add on G2212 when a service exceeds 15 minutes? Added 07/14/2023

A: No, G2212 is out of scope for an MHRS.

Q: How is 'Peer' defined? Added 07/14/2023

A: Certified Medi-Cal Peer Support Specialists provide recovery-oriented, culturally appropriate services that promote engagement, socialization, self-sufficiency, self-advocacy, natural supports and are trauma aware. Senate Bill 803 (SB 803) provides the definition and outlines the certification criteria.

Contract Questions

Q: What is the process for including codes on our contract with BHS?

A: Codes available for each program will continue to be consistent with the agency's contract. If there are codes in the BHS Provider Crosswalk or in the DHCS CalAIM Billing Manuals your agency would like to add, please contact your CDTA or SOC manager for discussion.

Q. How do we bill as cost reimbursement since we've historically billed as Fee-for-Service with an end of year cost-settlement report. Will there be a new template and what will that expectation look like? Added 07/14/2023

A. DPH will send out the invoice (MYE) templates based on the prior year's budget in late July or early August. Contractors should submit invoices based on actual costs. For Outpatient Service programs that have Fee-for-Service (FFS) invoices, contractors will enter the monthly actual costs/expenditures divided by the contract unit rate to come up with the units of services (which is not necessarily representative of the actual UOS delivered). Once the FY23-24 contract is completed, a new invoice template for cost reimbursement will be issued.

Q. How many Level of Effort (LOE) Targets will there be for each program? Added 07/14/2023

A. One LOE will be required per program will be required for invoicing. There is no need to break down the LOE by funding source.

Q. Will monthly reimbursement be limited to only delivered direct service reflected in Avatar/Epic? If yes, there will be a significant cashflow gap (timing of incurred expenses with year-end settlement payment, which now occurs 10-12 months after fiscal year end). Added 07/14/2023

A. For SMHS and DMC ODS Outpatient services, reimbursement will be based on monthly incurred costs as invoiced. Direct service billing targets will be monitored via monthly LOE reporting.

Q. Does this impact the Mode 55 pilot and the move to start utilizing mode 55? Added 07/14/2023

A. No, Mode 55 will continue to be reported separately from Mode 15.

Q. Does that mean there won't be a delineation between Case Management Services vs Mental Health/Collateral Services etc.? Added 07/14/2023

A. Correct, for all outpatient programs (SMH & DMC ODS inclusive) service function code distinctions are no longer budgeted or invoiced separately.

Avatar Questions

Q: How will this look in Avatar. Will these codes be accepted into Avatar starting July?

A: Codes reviewed in these trainings will be effective on July 1, 2023.

Q: When we are billing for multiple units, will Avatar handle this "behind the scenes," or will we have to bill these as "Add on" codes?

A: For people who enter services directly in Avatar, there is add-on section in the Progress Note to select the appropriate code and enter the corresponding duration. For people who send services to BHS via Service Uploads, add-ons will need to be entered in Edit Service Information. Additional guidance on these forms can be found in a PowerPoint on the BHS Avatar User Support Page.

Q: Will Avatar assign the number of units automatically based on the time entered, or will we be responsible for determining the number of units when billing?

A: Avatar will automatically calculate the number of units based on the Direct Patient Care (face-to-face) time entered.

Q: When you say use an add-on does that mean there will be a place to put two codes on the one note or do we have to do two notes with each code? Revised 07/14/2023

A: There is an add-on section in the Progress Note section at the bottom. This would be used to select the appropriate code and add additional any documentation.

For example, if a clinician provides 75 minutes of psychotherapy, 60 minutes of direct service would be entered in the FTF field to capture the total time allowed for psychotherapy (INDTPY). The additional 15 minutes would be entered as the duration in the Add-On section of the Progress Note. Additional guidance on how to enter information in these forms can be found in a PowerPoint on the BHS Avatar User Support Page.

Q: Are the local codes in Avatar going away and will staff be required to use the new HCPCS/CPT codes starting 7/1? Added 07/14/2023

A: BHS has retained the local codes where appropriate and added select new local codes to assist with the Payment Reform transition.

Please review Column B of the SMHS and DMC-ODS outpatient code crosswalks on the BHS Provider Resource Page for further information. The local codes listed in Column B will be the code you select for entry in Avatar.

Q: In Avatar, we currently enter travel and documentation time. Is this no longer be needed? Do we only need to enter FTF time? Added 07/14/2023

A: Information will be entered for both documentation and travel time separate from the direct patient care (FTF) time. Please review the BHIS CalAIM Bulletin for additional details.

General Questions

Q: How can we access this slide deck for review?

A: All finalized slide decks will be posted to the BHS Provider Resource Page.

Q: Would it be possible to get a summary of which codes have changed vs what has stayed the same from what we were using previously?

A: BHS has posted the Outpatient Code crosswalks and Training Tip Sheets on the BHS Provider Resource Page. We will review this specific request and follow-up.

Q: Are all the DMC-ODS codes also available at NTPs?

A: Not all codes reviewed are available at the NTP Level of Care. Please review the DMC-ODS Provider Crosswalk for additional information and contact your System of Care Representative if you have any questions.

Q: When will this take effect?

A: These changes begin July 1, 2023.

Q: Do providers need to create ADM99 notes for all documentation time? For example, if a staff spends 45 minutes entering an Assessment, should this time be entered into as a nonbillable note?

A: The purpose of nonbillable notes is to document activities that are client specific and important to be included in a clinical and legal record. Non-Billable notes should be used to capture important information relevant to the treatment of the client. When documenting assessment services, any associated time spent on documentation should be entered on the same progress note. Additional time spent typing or entering data does not need to be documented in a separate ADM99 note. While the CPT Codes are intended to cover the cost of the additional work required to deliver services (e.g., typing an assessment, entering CANS scores, reviewing notes, etc.), these types of activities do not need to be documented in nonbillable notes.

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