San Francisco
Behavioral Health Services

DMC-ODS HCPCS Training
for AOD Counselors (registered and certified)
& Peer Providers

June, 2023

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Housekeeping

- Welcome!
  - All participants will be muted upon entry.
  - Use the chat box in the bottom right hand corner to ask a question of the presenters or to communicate with the organizers.
    - Questions will be collected and answered at the end of the presentation.
  - Closed captioning and language assistance are both available in the bottom left hand corner of the screen.

AGENDA

- CalAIM Payment Reform
- What is Changing; Billing Rules
- Review of applicable HCPCS codes for Non-LPHA Providers

- HCPCS review based on 2023 billing manuals
  - Drug Medi-Cal Organized Delivery System (DMC-ODS)
    - Billing Manual Version 1.3
    - Version 1.4 published Friday, 6/23/23 – currently working on updates based on the new version

CalAIM Payment Reform Effective 7/1/2023

CalAIM Behavioral Health Payment Reform

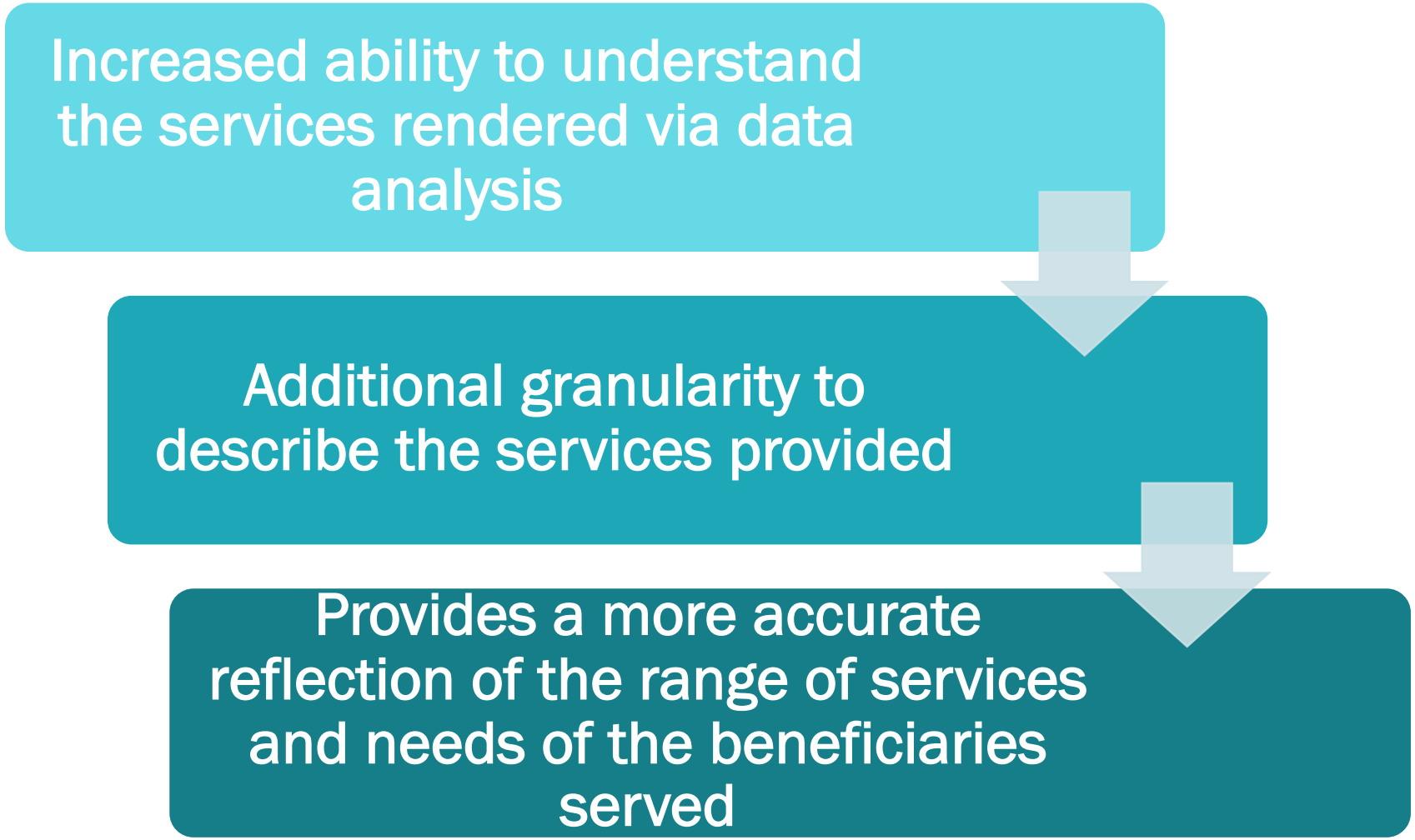
- CalAIM – California Advancing and Innovating Medi-Cal
- Payment reform goals:
  - Simplify county BH plan payments and reduce administrative burden for the State, counties, and providers.
- The payment reform initiative will enable counties and providers to deliver value-based care that improved quality of life for 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

Provider Billing - CPT Code 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



Provider Billing – What is Changing

What is Changing

- Changes to procedure codes:
  - For LPHAs providers, addition of CPT codes to both SMHS and DMC-ODS delivery systems.
  - More codes with more specific usage.
  - HCPCS will continue to be used by LPHAs and non-LHPAs and for Existing Day/24-hour services.
- Change from minutes to units
- Duplicate service changes
- Modifier changes
- Expansion of code lockouts

**HCPCS: Health Care Common Procedure Coding System*
**CPT: Current Procedural Terminology*

CPT Code Categories

CPT Category I Codes

- Some of the 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

Minutes vs. Units

- Claims will be based on units of service rather which is based on the number of direct service 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.
    - Regardless of total direct patient care time, a progress note should be completed to document the interaction

Time Associated with CPT Codes

Per DHCS, providers must be familiar with and follow the guidelines in the CPT code manual.

Some services can be claimed once they reach the mid point of the time associated with code.

For example, *Targeted Case Management* has a 15-minute time associated with the code. The service cannot be claimed unless it lasts at least 8 minutes (midpoint).

Other codes, have a time range associated with the service and the service can be claimed as long as it fits within the designated time range.

For example, code 99202 is claimed for services that last anywhere from 15-29 minutes.

Code Type	Service	Code	SD/MC Allowable Disciplines
Assessment Codes	Office or Other Outpatient Visit of New Patient, 15-29 Minutes	99202	LP, PA, NP
Assessment Codes	Office or Other Outpatient Visit of a New patient, 30- 44 Minutes	99203	LP, PA, NP
Assessment Codes	Office or Other Outpatient Visit of a New Patient, 45- 59 Minutes	99204	LP, PA, NP
Assessment Codes	Office or Other Outpatient Visit of a New Patient, 60- 74 Minutes	99205	LP, PA, NP

Targeted Case Management, Each 15 Minutes	T1017	LP, PA, Pharma, Psy, LCSW, MFT,	96

Direct Patient Care Time

- The DHCS definition of Direct Patient Care is different from the CMS definition of total time. The table below compares the 2 definitions.

	DHCS	CMS
Includes	<u>Direct Patient Care time:</u> • Means time spent with the patient for the purpose of providing healthcare. • If the service code billed is a medical consultation/care coordination, it means time spent with the consultant/members of the beneficiary's care team	Includes the following activities on the date of the encounter: • preparing to see the patient (e.g., review of tests), obtaining and/or reviewing separately obtained history, performing a medically appropriate examination and/or evaluation, counseling and educating the patient/family/caregiver, ordering medications, tests, or procedures, referring and communicating with other health care professionals, documenting clinical information in the electronic or other health record, independently interpreting results and communicating results to the patient/ family/caregiver, care coordination
Does Not Include	<u>Does not include:</u> • 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. • Time spend preparing for a session, time thinking about or reviewing assessment notes .	<u>Does not include</u> time spent on the following: • the performance of other services that are reported separately, travel. teaching that is general and not limited to discussion that is required for the management of a specific patient

Dependent Codes

Dependent Codes:

- These are codes that either indicate:
  - Time has been added to a primary procedure (i.e., add-on codes – G2212); 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.

Lockout Codes

Lockout codes:

- Codes that typically cannot be billed together.
  - For example: When an adult is in ASAM level 3.5 residential setting, their outpatient ASAM level 1 clinician cannot bill for case management services.
- 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.
  - Potential modifiers include (but are not limited to) 59, 93,95
    - Modifiers can be used as appropriate in lockout situations.
- Dependent codes and lockout codes are listed in the SMHS or DMC-ODS billing manual tables.

DMC-ODS (SUDS) Services

Drug Medi-Cal ODS (DMC-ODS) Billing Manual, January 2023; V1-3; Found at:
DMC-ODS-Billing-Manual-v-1-3.pdf
June 2023; V1-4; Found at:
DMC-ODS Billing Manual v 1.4.pdf (ca.gov)

DMC-ODS BH Service Types

1. Assessment
2. SUD Crisis Intervention
3. Medication Services
4. Mobile Crisis
5. Treatment Planning
6. Individual Counseling
7. Group Counseling
8. Care Coordination
9. Recovery Services
10. Supplemental Services
11. Discharge Services
12. Family Therapy
13. Peer Support Specialist Services
14. Existing 24-hour and Day Services

SUDS Services

Assessment Codes

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.

Assessment Codes

Local Code	Code	Description	Code Guidance	Documentation
H0001	**H0001**	Alcohol and/or Drug Assessment	Use this code for completing drug and/or alcohol assessments to determine the 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. Not acceptable to simply note that an Assessment was completed • Note involvement of family or other collaterals included. • Document the course of treatment recommended. • **AOD**
H0049	**H0049**	Alcohol and/or Drug Screening	Use this code for 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. • **AOD**
G2011	**G2011**	Alcohol and/or substance abuse misuse structured assessment and brief intervention, 5-14 min	Use this code for alcohol or substance abuse assessment. This code can be used to determine ASAM criteria and includes a brief intervention of 5 – 14 minutes	• Document significant findings from the assessment such as identified risks, level of care required, patient insight regarding substance use and initial treatment plan. • Document total time for the assessment • Do not report separately with an E/M, psychiatric diagnostic, or psychotherapy service code for the same work/time. • If an intervention is not required on the basis of screening results the work effort is included in E/M or preventative service. CPT Asst. May 2008 • **AOD**

Assessment Codes

Local Code	Code	Description	Code Guidance	Documentation
G0396	**G0396**	Alcohol and/or substance misuse structured assessment and brief intervention 15 to 30 minutes	Use this code for alcohol or substance abuse assessment. This code can be used to determine ASAM criteria and includes a brief intervention of 15-30 minutes	• Document significant findings from the assessment such as identified risks, level of care required, patient insight regarding substance use and initial treatment plan. • Document total time for the assessment • Do not report separately with an E/M, psychiatric diagnostic, or psychotherapy service code for the same work/time. • If an intervention is not required on the basis of screening results the work effort is included in E/M or preventative service. CPT Asst. May 2008 • **AOD**
G0397	**G0397**	Alcohol and/or substance abuse structured assessment, 30+ minutes	Use this code for alcohol or substance abuse assessment. This code can be used to determine ASAM criteria and includes intervention of 30 or more minutes	• Document significant findings from the assessment such as identified risks, level of care required, patient insight regarding substance use and initial treatment plan. • Document total time for the assessment • Do not report separately with an E/M, psychiatric diagnostic, or psychotherapy service code for the same work/time. • If an intervention is not required on the basis of screening results the work effort is included in E/M or preventative service. CPT Asst. May 2008 • **AOD**

SUDS Services

Treatment Planning Codes

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.
- Treatment planning consist 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.
- Document link: CalMHSA-MHP-LPHA-Documentation-Guide-05182022.pdf

Treatment Planning Codes

Local Code	Code	Description	Code Guidance	Documentation
IOPTEDUC ODSPTEDUC ODSPTEDUCG	**H2014**	Skills training and development, per 15 minutes	Use this code for Patient Education Services.	• 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. • **AOD**
H2021	**H2021**	Community-based wrap-around services, per 15 minutes	Use this to show that a delivery-system coordination of care has occurred.	• 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. • **AOD**
H2027	**H2027**	Psychoeducational service, per 15 minutes	Use this code when providing 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. • **AOD**

SUDS Services

Care Coordination Codes

Care Coordination

- These codes apply to those who can provide care coordination to the client and family, regardless of role. Your physician can do this work as well as your AOD counselor.
- Care coordination can be provided in clinical or non-clinical settings and includes one or more of the following components:
  - Coordination with primary care and mental health care providers to monitor and support comorbid health conditions.
  - Discharge planning, including 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/specialty medical providers.
  - Ancillary services, including individualized connection, referral, and linkages to community-based services and supports.

Care Coordination Codes

Local Code	Code	Description	Code Guidance	Documentation
H1000	**H1000**	Prenatal care, at risk assessment	Use this code when evaluating behaviors that can be dangerous for the mother and/or fetus	• 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. • **AOD**
T1017	**T1017**	Targeted case management, each 15 minutes	Use this code for targeted case management services	• 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. • **AOD**

SUDS Services

SUD Crisis Intervention

Crisis Intervention

- An immediate emergency response intended to help a client cope with a crisis
  - Potential danger to self or others, severe reactions that is above the client's normal baseline.
- Crisis Intervention progress notes describe:
  - The immediate emergency requiring crisis response
  - Interventions utilized to stabilize the crisis
  - Development of Safety Plan
  - Client response and outcome(s)
  - Follow-up plan and recommendations

Crisis Intervention Codes

Local Code	Code	Description	Code Guidance	Documentation
IOCRISIS ODFCRISIS ODSCRISIS	**H0007**	Alcohol and/or drug services, crisis intervention (outpatient)	Use this code for 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. • **AOD**

SUDS Services

Individual Counseling Codes

Individual Counseling

- Includes the application of strategies incorporating the principles of:
  - Development
  - Wellness
  - Adjustment to impairment
  - Recovery and resiliency
- Counseling should assist client in acquiring greater personal, interpersonal and community functioning **or**
  - To modify feelings, though processes, conditions, attitudes, or behaviors
- 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 beneficiary's treatment goals.

Individual Counseling Codes

Local Code	Code	Description	Code Guidance	Documentation
IINDCONS INDNTPCNS ODSINDCNS 31RCVIND OPRCVYIND	**H0004**	Behavioral health counseling and therapy, per 15 minutes	Time spent providing individual counseling.	• 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 • **AOD**
T1006	**T1006**	Alcohol and/or substance abuse services; family/couple counseling	Use code for time spent providing family/couple counseling	• Specific documentation of time must be included as this code per 15 minutes. • **AOD**
H0050	**H0050**	Alcohol and/or drug services, brief intervention, per 15 minutes	Use this code to report time spent providing individual SBI (screening and brief intervention) for alcohol and drug use problems	• Document brief intervention(s) performed in relation to alcohol and/or drug use. • Specific documentation of time must be included as this code per 15 minutes. • **AOD, Peers**

SUDS Services

Group Counseling

Group Counseling

- A group service provided to 2 or more clients at the same time.
- One or more practitioners may provide these services and the total time for intervention may be claimed, billing in 15-minute increments.
- Only one group progress note is written for each client.
- Documentation of group counseling should include:
  - A general statement about what the group counseling was for
  - Specific interventions.
  - Each group note must be individualized to the beneficiary and note specific responses/observations to intervention(s).

Group Counseling Codes

Local Code	Code	Description	Code Guidance	Documentation
IGRPCONS GRPNTPCNS ODSGRPCNS GRPOPRCVY	**H0005**	Alcohol and/or drug services' group counseling	Use this code to report time spent providing face to face group counseling. Minimum of 2 and maximum of 12 in the group. H0005 should be reported separately for each beneficiary receiving group therapy.	• Specific documentation of time must be included as this code per 15 minutes. • **AOD**

SUDS Service

Peer Support Services

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.
- Peer support may be provided as a group service or a one-on-one service.
- If providing peer support services as a group service, use HCPCS code H0025 (behavioral health education services, delivery of services with target population to affect knowledge, attitude and/or behavior).
- If claiming peer support services for an individual, use code H0038 (self-help/peer services).
- Peer support services are based on an approved plan of care.

SMHS Peer Support Services Codes

Local Code	Code	Description	Code Guidance	Documentation
H0025	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	• Documentation should include activities completed, such as group coaching to set recovery goals and identify steps to reach the goals. • **Peer**
H0038	H0038	Self-help/peer services, per 15 minutes	If providing peer support services for an individual, used code H0038	• Documentation should include activities completed, such as individual coaching to set recovery goals and identify steps to reach the goals. • Include total time of services provided in the documentation. • **Peer**

SUDS Service

Discharge Services

Discharge Services

- Discussion about discharge planning begins at the time of initial assessment (as clinically appropriate) and continues throughout the course of treatment
- Discharge planning must include the person in care and their social supports as full partners in the planning process and should be done as far in advance as practical
- Including other treatment providers, when applicable, paves the way to successful transitions to other levels of care and to recovery support, including linkage to other non-DMC services.
- Detailed information on discharge planning should be clear, concise, and accurately communicated and documented

Discharge Services Codes

Local Code	Code	Description	Code Guidance	Documentation
T1007	**T1007**	Alcohol and/or substance abuse services; discharge treatment plan development and/or modification	Use this code for discharge treatment plan development and modification	• Should be used to record discharge planning. • Should be used for both the initial discharge treatment plan as well as the modification to an existing discharge treatment plan. • Document any referrals to recovery resources and/or medical providers to support the patient's transition during treatment and discharge. • **AOD**

SUDS Services

Recovery Services

Recovery Services

- 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.

Recovery Services Codes

Local Code	Code	Description	Code Guidance	Documentation
H2015	**H2015**	Comprehensive community support services, per 15 minutes	Use this code for time spent providing community support services	• Specific documentation of time must be included as this code -per 15 minutes. • Document medical necessity for support services, identify specific community support recommended and include a description of the services provided • Document assessment of the effectiveness of the services and progress towards the patient's goals • **AOD**
IREHAB GREHAB	**H2017**	Psychosocial rehabilitation services, per 15 minutes	Use this code for time spent providing PSR (psychosocial rehabilitation) services. These include services designed to improve emotional, social and vocational wellbeing.	• Specific documentation of time must be included as this code per 15 minutes. • Document and describe the specific activities performed to specifically enhance/support the patient's emotional cognitive and social skills related to their specific rehabilitation needs and goals • **AOD**
H2035	**H2035**	Alcohol and/or other drug treatment program, per hour	Time spent providing alcohol/other drug treatment program services	• Document medical necessity for SUD (Substance Use Disorder) services. • Documentation must include the total time spent with the patient providing direct patient care. 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 • **AOD**

SUDS Services

Supplemental Services

Supplemental Services Codes

Supplemental Codes 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.

Cannot be billed independently; must be submitted on the same claim with a primary code.

For example: T1013 is a Supplemental code that can be used to indicate sign language or oral interpretative services.

It must be used on the same claim as one of the primary codes listed in the Dependent On Codes column of the Billing Manual.

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Supplemental Services Codes

Local Code	Code	Description	Code Guidance	Documentation
T1013	**T1013**	Sign language or oral interpretive services, 15 minutes	Use this code when necessary to facilitate effective communication with deaf or hearing-impaired patients. This supplemental code cannot be billed independently. They have to be billed with a/another (primary) procedure.	• Specific documentation of time must be included as this code is per each 15 minutes. • **AOD**

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, June 2023; V1-4; Found at: DMC-ODS-Billing-Manual-v-1-4.pdf
- Clinical Documentation Guide 2022; revised 6/23/2022; California Mental Health Services Authority (CalMHSA). Found at: CalMHSA-MHP-LPHA-Documentation-Guide-05182022.pdf

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

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