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 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 CPT Codes.

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] 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 60 minutes 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?

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 external 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. The documentation should note the type(s) of documentation 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?

A: That is correct.

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 team based intensive service and typically occurs in the community or home.

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 July 1, 2023, 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.

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?

A: Psychotherapy is claimed using a series of codes (e.g., 90832-90838) that have specific time ranges built into each code. Note, providers will enter the direct service, travel, and documentation time and Avatar will automatically apply the correct psychotherapy code using the primary local code.

- INDPTY/90832 (30 minutes) = 15 – 36 minutes of direct patient care
- INDPTY/90834 (45 minutes) = 37 – 52 minutes of direct patient care
- INDPTY/90837 (60 minutes) = 53 – 67 minutes of direct patient care

To extend the psychotherapy service beyond 67 minutes, the add-on code G2212 code must be used. Unfortunately, Avatar cannot automatically apply the add-on code for prolonged time.

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.

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.

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 Billing 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.

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 same claim, for the beneficiary

Q: Does interactive complexity 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 be HCPCS code T1013 along with the code for the therapy provided. The health worker providing the interpretation services does not bill anything.

Q: For the T1013 and the provider is bilingual, will interpretation be coded separately?

A: No, if the provider is bilingual interpreter services are not being used.

Q: If the T1013 is only apply to the therapist, what will the health worker use to bill, ADM99?

A: The health worker may use ADM99. This is not a billable service to Medi-Cal.

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: That is correct. In order to claim one unit of G2212, you must have provided at least 8 minutes of service.

ICC and IHBS Codes

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

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. The following table provides information on the following codes:

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. ***Note:*** 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.

CalAIM Billing Code	SF Local Code	Service Description	Services Provided
T1017-HK	ICC	Targeted Case Management, per 15 minutes (local code for Intensive Care Coordination)	ICCC service components include assessing, service planning and implementation, monitoring and adapting, and transition. ICC services are provided through the establishment of the Child and Family Team (CFT) to ensure facilitation of a collaborative relationship among a child, their family, and involved child-serving systems. All service team members use this code to claim for Intensive Care Coordination services.
T1017-HK	CFTICC	Targeted Case Management, per 15 minutes (local code for Child and Family Team)	Participation in the Child and Family Team Meeting. All service team members use this code to claim for participation in a CFT meeting.
90791-HK	IHBSASMT	Psychiatric Diagnostic Evaluation, 15 Minutes	Meeting with individual/caregiver/significant support person to gather information to inform an assessment/re-assessment. All service team members use this code to claim for relevant assessment services when a client meets criteria and is authorized for IHBS.
H2017-HK	IHBSREHAB (formerly KTAIHBS)	Psychosocial Rehabilitation, per 15 minutes (local code for IHBS rehab-type)	Meeting with individual person for the purpose of coaching, skill development to support the individual with managing behavioral health needs. Note: BHS is waiting on DHCS decision regarding whether Rehab may be provided to a significant support without the client present. We will update the document as information is published.
H0031-HK	IHBSH0031	Mental Health Assessment by Non-Physician, 15 Minutes	Meeting with individual/caregiver/significant support person to gather information to inform an assessment/re-assessment
H0032-HK	IHBSPlan	Mental Health Service Plan Developed by Non-Physician, 15 Minutes	Meeting with individual/caregiver/significant support person to develop a care plan/client plan

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?

A: The following codes encompass collateral type activities when the service is provided to a caregiver or significant support person to support the client's needs and goals. The client may or may not be present for the following activities:

CalAIM Billing Code	SF Local Code	Service Description	Services Provided
90791	90791	Psychiatric Diagnostic Evaluation, 15 Minutes	Meeting w/individual/ caregiver/significant support person to gather information to inform a client assessment
90887	90887	Interpretation or explanation of results of psychiatric or other medical procedures to family or other responsible persons **15 Min.**	Meeting with caregiver/significant support person on the same day as a covered. Maximum claimable time is 15 minutes.
H0031	H0031	Mental Health Assessment by Non-Physician, 15 Minutes	Meeting with individual/caregiver/significant support person to gather information to inform a client assessment
H0032	H0032	Mental Health Service Plan Developed by Non-Physician, 15 Minutes	Meeting w/individual/caregiver/significant support person to develop a care plan/client plan
TBD	ICOLL, GCOLL	Individual and Group Collateral	A service activity to a significant support person or persons in a beneficiary's life for the purpose of providing support to the beneficiary in achieving client goals (e.g., consultation, coaching, skill building).

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.

Care Coordination Codes

Q: 96160 is for DMC only?

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

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 in the group is between 2 or more clients at the same time with a maximum of 12 is group. For this specific code, please send it to BHS for review and we will follow-up.

Q: is there a code to use for planning for topic for a group?

A: No. Currently there is not a specific CPT/HCPCS code to capture planning services.

Supplemental Service Codes

Q: T1013 cannot be used by Counselors?

A: The code can be billed by an AOD counselor. Please review the DMC-ODS Billing Manual posted on the MedCCC Library.

Treatment Planning Codes

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

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

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.

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.

Direct Patient Care Questions

Q: What is considered Direct Patient Care?

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 Page 63 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.

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 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 licensed or registered with their professional licensing board cannot provide certain codes, including individual and group psychotherapy. What services can students provide?

A: Students 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 note that BHS Leadership is discussing the delivery of psychotherapy by students and will provide further information.

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 BHS for discussion.

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 BHIS Website.

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?

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 any documentation.

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 BHS 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 will 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 activities do not need to be documented in nonbillable notes.