Fresno County DBH Training: Introduction to CPT/HCPCS Procedural Codes

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California Advancing & Innovating Medi-Cal (CalAIM)

CalAIM –A multi-year initiative by DHCS to improve the quality of life and health outcomes of Medi-Cal persons served.

A set of CalAIM behavioral health policies are being rolled out in phases starting with the criteria to access SMHS and DMC-ODS (January 1, 2022)

These policies are designed to:

- ✓ Improve access to care
- ✓ Streamline administrative requirements
- ✓ Modernize the Medi-Cal payment methodology

CalAIM Behavioral Health Policy	Go-Live Date
Criteria to Access Specialty Mental Health Services (SMHS)	January 2022
Documentation Redesign for SMHS	July 2022
Co-Occurring Treatment	July 2022
No Wrong Door	July 2022
Standardized Screening & Transition Tools	January 2023
Behavioral Health CPT Coding Transition (Payment Reform)	July 2023

Here is what we hope to cover today…

- **CalAIM – Payment Reform - Transition to CPT procedural codes**
- **Know your resources, e.g. the SMHS Medi-Cal Billing Manual and the DMC-ODS Medi-Cal Billing Manual**
- **Getting familiar with CPT code charts and spreadsheets in the Medi-Cal Billing Manuals and the MedCCC Library**
- **Key parts of CPT Coding e.g. Modifiers, Location codes and Add-on Codes**
- **Introduction to some familiar services and the corresponding CPT codes for both SMHS and DMC-ODS**
- **More learning opportunities to come, as we prepare for July 1, 2023!**

As we go through this training let's think on these words.

Progress is impossible without change. Those who cannot change their mind, cannot change anything.

George Bernard Shaw

Medi-Cal Manuals & Navigation Reference Pages

- Specialty Mental Health Medi-Cal Billing Manual V 1.4 (Revised 04/2023)
- Drug Medi-Cal ODS – Medi-Cal Billing Manual V 1.3 (Revised 01/2023)
- **There are Navigation pages to various CPT/HCPCS Codes with procedures to help you on this journey**
- MedCCC - Library (ca.gov) – The state will update these as necessary so it is best to reference the latest manual located on the state's webpage. Do not print or save the manual to your computer.

Behavioral Health Payment Reform

What will not change:

- Monitoring for any Medi-Cal fraud, waste, or abuse
- For Providers
  - Funding sources used to reimburse providers
  - The providers will continue to receive monthly payments

What will change:

- List of CPT and HCPCS codes, add-on codes and modifiers
- For Providers
  - Allowing multiple services per claim (only for primary and add-on services)
  - Denial rules for lockouts, duplicates, duration and places of services
  - Services will be billed to State before payment to vendor is processed

So Why Are We Preparing for This?

- DBH and Contractor systems and procedures are impacted, such as EHRs and progress noting, invoicing, billing and utilization review.
- Directly impacts provider payment
- Federal matching funds increase when we can efficiently and effectively provide and claim the full scope of the much needed services to the individuals we serve.

When utilizing your agency's EHR billing system

You must:

- Learn the billing scope of each clinical discipline, and therefore understand the proper procedural codes to utilize.
- Set up the EHR system's capability and controls to ensure proper coding.
- Coding errors might delay the billing and claiming process, therefore proper set ups on the front-end are important.

Errors in Procedural codes, add-ons, modifiers and/or location codes may lead to a denial of claims. Correcting errors takes added staff time and delays the process.

Provider submits billing data to Fresno DBH → Fresno DBH submits service claims to the state.

- Learn the documentation rules for the procedural code utilized, since this will be subject to audit by Fresno County Managed Care and DHCS.

CPT Coding Transition: Key Changes

CPT Codes

HCPCS Level II codes

Add-on codes

- Prolonged Time
- Interactive Complexity

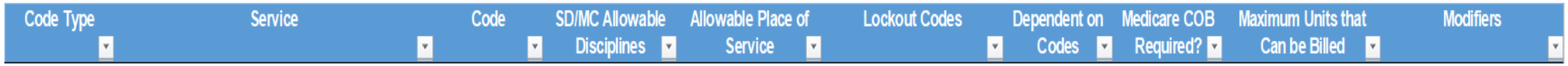
Location Codes

Modifiers

Coding Transitions the difference between CPT & HCPCS

- CPT stands for current procedural terminology. Consists of 5 characters and can include both numeric and alphanumeric characters. Are defined by the AMA American Medical Assoc. (uniform language used by insurances). Codes are used to describe tests, surgeries, evaluations, and any other medical procedure performed by a doctor and other healthcare provider of a person served.
- HCPCS stands for Healthcare Common Procedure Coding System. Consist of 5 characters (1 Alpha character and 4 numerical digits) Are defined by CMS (Medicare and Medic-Aid Services and are basically use the HCPCS level 2 codes which deal with services. These codes can be used by any entity (licensed or non-licensed.) to include SUD Counselors, Nurses, Case Managers, Peer Support Services, etc. will continue to use many of these codes.

Let's familiarize ourselves with the headers on a spreadsheet



- **Code Type**- This describes the family procedure codes associated with each service type.
- **Service**- What do you call this service? This column provides a brief description of the procedure, e.g. "Psychiatric Diagnostic Evaluation", "Alcohol and/or Drug Services; Group Counseling by a clinician, 15 minutes"
- **Code** - This is normally the numerical/alphanumeric primary procedural code e.g. 99213, 90791, G2212, 90832
- **Allowable disciplines**- This column lists the disciplines that are allowed to bill and perform each procedure.
- **Allowable Place of Service**- CPT codes must be reported in allowable places of service.
- **Lockout Codes**- These are Codes that cannot be billed with the primary procedure listed in column Code.
- **Dependent Codes**- Some codes can only be billed after certain other primary codes. If there are codes listed in the Dependent on Codes column, those **codes must be billed before** the procedure in question
- **Medicare COB Required**- If your person served also has Medicare, then Coordination of Benefits is required. The service must always be billed to Medicare first, then Medi-Cal or other insurance companies. Lots of insurance but who gets billed first.
- **Maximum Units that Can Be Billed**- This column lists the maximum number of units that the procedure may be billed for in a 24-hour period. 1 unit= 15 minutes or so how many units or how many minutes.
- **Modifiers**- This column lists the modifiers that are allowed with a particular procedure.

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** The below **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission.	Dependent on Codes	Medicare COB Required?	Maximum Units that Can be Billed	Allowable Modifiers
Psychotherapy, 30 Minutes with Patient	90832	• MD/DO • PA • PhD/PsyD (Licensed or Waivered) • LCSW (Licensed, Registered or Waivered) • MFT (Licensed, Registered or Waivered) • NP or CNS (Certified) and • PCC (Licensed or Registered)	All except 09	Cannot be billed with 90791 90792 90833-90834 90836-90840 90845 90847 90849 90853 90865 90867-90869* 90870 90880 96112-96113 96116* 96127* 96161* 99202-99205** 99212-99215** 99217-99223** 99231-99236** 99241-99245** 99251-99255** 99304-99310** 99324-99328** 99334-99337** 99341-99345** 99347-99350** 99366-99368** 99441-99443** 99451** 99605-99606**	None	Yes	1	59 93 95 GC HK HL HV XE XP XU

Rules Around Certain Codes & How They May be Used

Supplemental (Add-on) Codes:

Add-on procedures (an associated procedure) cannot be billed unless the provider first bills the **primary (main issue) procedure** (to the same person served by the same provider on the same date and same claim) Such as:

- i.e. if a provider renders a 30 minute psychotherapy service (primary procedure) 90832 (concentration on therapy with a person to help identify and change troubling emotions, thoughts, & behaviors) but wants to add a supplemental code such as +90785 (i.e. interactive complexity, 90785). Coded like this 90832+90785

Roll-up Services:

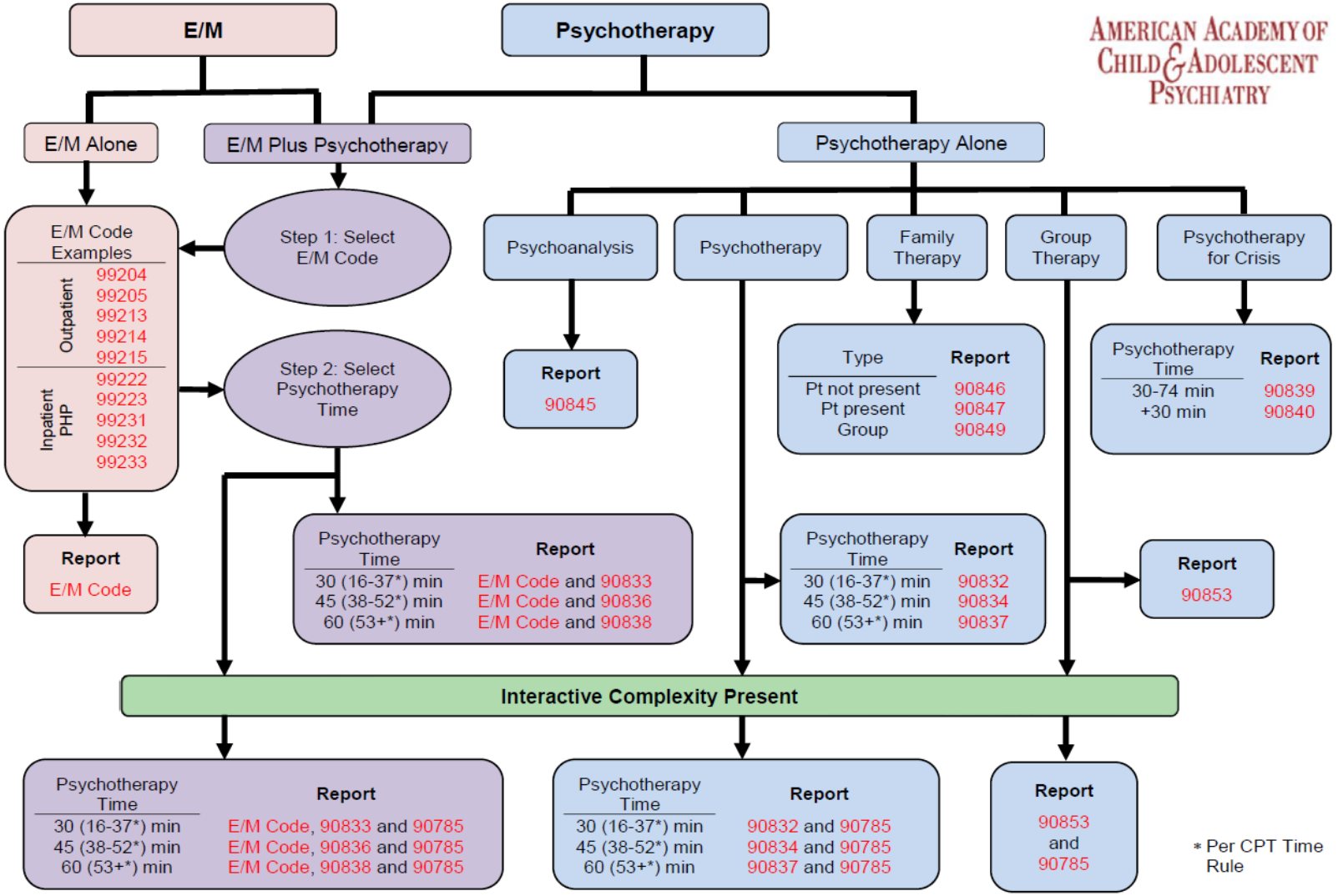
If provider renders 2 sessions of the same service to the same person served on the same day, all encounters must be claimed as 1 service (**to avoid denial for duplicate services).**

- i.e. if provider renders psychotherapy for crisis to a person served for 30 minutes in the morning and provided the same service to the same person served for 30 minutes in the afternoon, the claim submitted would be for 60 minutes of psychotherapy of crisis (90839).

- Code 90839 is crisis code = 30-74 min.
- Code 90840 is crisis code for **each additional 30 minutes 90839+90840**

E/M and Psychotherapy Coding Algorithm

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY



Popular Add-On Procedure Code Interactive Complexity 90785

- Used when there is **communicative difficulty during the visit** (caregivers and others involved in care during the visit/interpreter). Required when involvement with child welfare, parole, probation.
- Can apply to both children and adult.
- If you need to use the following:
  Play therapy equipment
  Translators needed
  Mandated reports of events
  Caregivers emotions and behaviors that interfere with treatment
  Needing to manage maladaptive communications/behaviors
- Not with Crisis 90839 equals 30-74 minutes -90840 for each additional 30 minutes past the first 74 minutes.

Interactive Complexity Procedure Add-On Code

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** The below **outpatient** services are locked out against inpatient and 24-hour services except for f the date of admission.	Dependent on Codes	Medicare COB Required?	Maximum Units that Can be Billed	Allowable Modifiers
Interactive Complexity	90785	All disciplines found in Table 1, including non-licensed practitioners	All except 09	90839-90840 T1013	90791-90792 90832-90834 90836-90838 90853 99202-99205 99212-99215 99217-99220 99231-99236 99241-99245 99251-99255 99304-99310 99324-99328 99334-99337 99341-99345 99347-99350	Yes	1 per allowed procedure per provider per beneficiary	93 95 GC HK HL HV HW

Prolonged Service Code: **Key Changes**

G2212 - The office/outpatient Evaluation & Management (E/M) visit level, HCPCS code G2212 can be used when the maximum time for the highest level (level five) office/outpatient E/M visit (99205 or 99215) is **exceeded by at least 15 minutes** on the date of the service

Add-on Codes are utilized when time or complexity has been added to the primary procedure

> **Example:** 70 minute service of Evaluation & Management by a Psychiatrist would be coded as 99215 (40-54 min) + G2212 (prolonged code) since the service went beyond the 40-50 min range for that CPT code (by approx. 20 min beyond allotted time). 99215+G2212+1 unit

- **HCPCS codes are utilized when CPT codes are not accepted in some cases.** Some HCPCS codes will be used in place of existing HCPCS codes, i.e. H0034 (Medication training and support, per 15 minutes) instead of H2010 (Comprehensive medication services, per 15 minutes) **since it is a more specific procedural code.**

When the time of the reporting practitioner is used to select the office and other outpatient Evaluation and Management (E/M) visit level, HCPCS code G2212 is used when the maximum time for the highest level (level five) office/outpatient E/M visit (99205 or 99215) is exceeded by at least 15 minutes on the date of the service.

Prolonged office and other outpatient E/M visit reporting -- New patient

CPT/HCPCS code(s)	Total time required for reporting*
99205	60-74 minutes
99205 x 1 unit and G2212 x 1 unit	89-103 minutes
99205 x 1 unit and G2212 x 2 units	104-118 minutes
99205 x 1 unit and G2212 x 3 units	119 or more

Prolonged office and other outpatient E/M visit reporting -- Established patient

CPT/HCPCS code(s)	Total time required for reporting*
99215	40-54 minutes
99215 x 1 unit and G2212 x 1 unit	69-83 minutes
99215 x 1 unit and G2212 x 2 units	84-98 minutes
99215 x 1 unit and G2212 x 3 units	99 or more

Prolonged Times Cheat Sheet

New Patient Time Range	Reported Code(s)
60-88 mins	99205
89-103 mins	99205 and G2212
104-118 mins	99205 and G2212 X 2
119-133 mins	99205 and G2212 X 3
134 mins or more	99205 and G2212 X 4 or more for each additional 15 minutes
Est Patient Time Range	**Reported Code(s)**
40-68 mins	99215
69-83 mins	99215 and G2212
84-98 mins	99215 and G2212 X 2
99-113 mins	99215 and G2212 X 3
114 mins or more	99215 and G2212 X 4 or more for each additional 15 minutes

Collateral Coding

- In reference to collateral billing according to the V. 1.4 Billing Manual collateral billing can only be done when it accompanies another procedure. It can not be billed alone (there is no specific code for it) only with another service so documentation is important. Participation of collateral informants, such as family members, caregivers, etc. However, the patient must be present for all, or a majority, of the service.

- H0034
- H0031

They can use a G2212 which is for Outpatient Evaluation and Management or T1001 Nursing Evaluation and Management or H0031 Mental Health Assessment by Non Physicians

What are Modifier Codes?

Modifiers provides a way to **supplement the information or adjust care descriptions to provide extra details to or concerning a procedure or service without** changing its definition or person providing service.

(refer to Medi-Cal Billing Manuals)

- Modifiers for telehealth services
  - 93 Telephone 95 Telehealth (Video and voice)
- Modifiers for Interns/Residents
  - HL – (Intern: Registered, pre-licensed mental health professional who is working in a clinical setting under supervision)
  - GC – (Resident: issued a post graduate training license and enrolled in an Accreditation Council for Graduate Medical Education (ACGME)- accredited post graduate training program in California.
- Modifiers for over-riding a lock out.
  - These are waivers for code lock outs, for example, a modifier can override 2 codes that aren't allowed on the same day.
  - EXAMPLE: *Modifier XE - Separate encounter, a service that is distinct because it occurred during a separate encounter.*

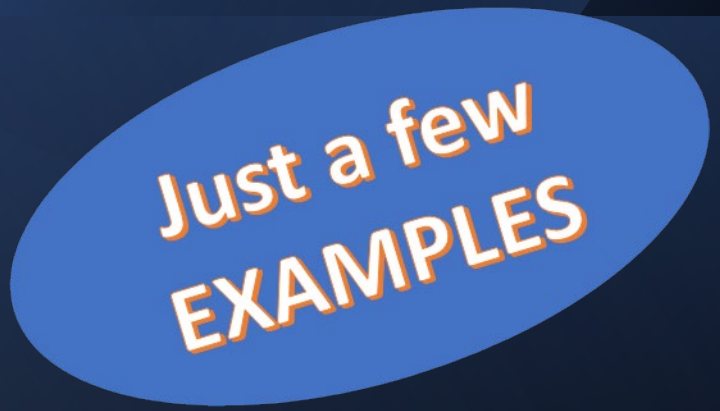
NOTE: The HE Modifier is no longer used for Outpatient Services as of 7-1-2023.

More Modifier examples for SMHS effective 7/1/23

Just a few EXAMPLES

SMHS		
Modifier	Definition	When to Use
SC	Valid for codes when the service was provided via telephone or audio-only systems	Modifier SC is used only with HCPCs codes and to indicate that the service was provided via telephone or audio-only. If using the SC modifier, the place of service must be 02 or 10, unless the service is mobile crisis. With HCPCS codes, if the service is in POS 02 or 10 but does not have the SC modifier, the telehealth service is video/audio
GT	Via telehealth in 24-hour or day facilities or as part of mobile crisis.	Use this modifier on day, 24-hour or mobile crisis, transportation mileage or transportation staff time claims when the service was provided via telehealth.
GC	This service has been performed in part by a resident under the direction of a teaching physician.	Use this modifier when the service was performed by a physician resident. If the pre-licensed professional has an NPI, they may report their own NPI. If they do not, the supervising physician's NPI would be reported with modifier GC after the service to indicate that the service was performed by a resident. If the service was performed by a pre-licensed professional who is not a resident, use modifier HL.
HQ	Group Setting	Use this modifier to indicate that a therapy service was provided in a group setting.

More Modifier examples for DMC-ODS effective 7/1/23



DMC-ODS		
Modifier	Definition	When to Use
HF	Identifies when Contingency Management Services was provided as part of a Substance Use Disorder Program	Use this modifier to bill for contingency Management Services, Code H0050 (Alcohol and/or Drug Services, brief intervention, 15 minutes contingency management)
HG	Opioid treatment program (OTP).	Daily or several times weekly opioid agonist medication and counseling available to maintain multidimensional stability for those with severe opioid use disorder. All Claims must have HG (and a UA) modifier when service is provided in NTP Setting
U1	ASAM 3.1 Residential (RES)	Clinically Managed Low - Intensity Residential Services: 24-hour structure with available trained personnel; at least 5 hours of clinical service/week and prepare for outpatient treatment.
U7	Outpatient Services (ODF	Less than 9 hours of service/week (adults); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/strategies.
U9	Residential Withdrawal Management, 3.2	Moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery

Location Codes (Places of Services, POS)- some examples

-Defined by CMS (Universal)
-Full list in Medi-Cal Billing Manuals

Place of Service Code	Place of Service Name	Place of Service Description
02	Telehealth Provided Other than in Patient's Home	The location, other than in patients' home, where health services and health related services are provided or received, through a telecommunication system
03	School	A facility whose primary purpose is education
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters)
10	Telehealth Provided in Patent's Home	Health services and health related services are provided or received, through a telecommunication system in the patient's home.
14	Group Home	A residence with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial services, and minimal services (e.g., medication administration).
53	Community Mental Health Center (CMHC)	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility….
55	Residential Substance Abuse Treatment Facility	A facility, which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care….
56	Psychiatric Residential Treatment Center	A facility or a distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professional staffed group living and learning environment.

Examples of what some disciplines can bill with CPT codes for SMHS.

For the full lists, check the charts located in the SMHS Medi-Cal Billing Manuals

Just a few EXAMPLES

Code Type	Service	Code	SD/MC Allowable Disciplines	Maximum Units that Can be Billed	Modifiers
Assessment Codes	**Psychiatric Diagnostic Evaluation, 15 Minutes**	90791	MD/DO, PA, PhD/PsyD (Licensed or Waivered), SW	1	59, 93, 95, GC, HK, HL, HV, HW, XE, XP, XU
Assessment Codes	**Psychiatric Diagnostic Evaluation with Medical Services, 15 Minutes**	90792	MD/DO, PA, NP or CNS (Certified)	1	59, 93, 95, GC, HK, HL, HV, HW, XE, XP, XU
Crisis Intervention Codes	**Psychotherapy for Crisis, First 30-74 Minutes 84**	90839	MD/DO, PhD/PsyD (Licensed or Waivered), SW (Licensed,	1	59, GC, HL, HV, XE, XP, XU
Medication Support Codes	**Office or Other Outpatient Visit of New Patient, 15-29 Minutes**	99202	MD/DO, PA, NP or CNS (Certified)	1	27, 59, 95, GC, HK, HL, HV, XE, XP, XU
Medication Support Codes	**Office or Other Outpatient Visit of an Established Patient, 10-19 Minutes**	99212	MD/DO, PA, NP or CNS (Certified)	1	27, 59, 95, GC, HK, HL, HV, XE, XP, XU
Therapy Codes	**Psychotherapy, 30 Minutes with Patient**	90832	MD/DO, PA, PhD/PsyD (Licensed or Waivered), SW	1	59, 93, 95, GC, HK, HL, HV, XE, XP, XU
Therapy Codes	**Group Psychotherapy (Other Than of a Multiple-Family Group), 15 Minutes**	90853	MD/DO, PA, PhD/PsyD (Licensed or Waivered), SW	1	59, 93, 95, GC, HK, HL, HV, XE, XP, XU

Examples of what some disciplines can bill with various CPT/HCPCS codes for DMC-ODS.

For the full lists, check the charts located in the **DMC-ODS** Medi-Cal Billing Manuals

Just a few EXAMPLES

Code Type	Service	Code	SD/MC Allowable Disciplines	Maximum Units that Can be Billed	Modifiers
Assessment Codes	**Psychiatric Diagnostic Evaluation, 15 Minutes**	90791	LP, PA, Psy, LCSW, MFT, NP, LPCC	1	HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, HL, GC, 59, 93, 95
Assessment Codes	**Psychiatric Diagnostic Evaluation with Medical Services, 15 Minutes**	90792	LP, PA, NP	1	HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, HL, GC, 59, 93, 95
Assessment Codes	**Telephone Assessment and Management Service, 5-10 Minutes**	98966	PA, Psy, LCSW, MFT, NP, LPCC	1	HD, U7, U8, UB, HL, 59, 93, XE, XP, XU
Treatment Planning Codes	**Psychoeducational Service, per 15 minutes**	H2027	LP, PA, Psy, LCSW, MFT, RN, NP, LPCC, AOD	96	HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, HL, GC, SC
Individual Counseling Codes	**Behavioral health counseling and therapy, 15 minutes.**	H0004	LP, PA, Psy, LCSW, MFT, RN, NP, LPCC, AOD	96	HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, HL, GC, SC
Group Counseling Codes	**Alcohol and/or drug services; group counseling by a clinician, 15 minutes.**	H0005	LP, PA, Psy, LCSW, MFT, RN, NP, LPCC, AOD	96	HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, HL, GC, SC
Care Coordination Codes	**Targeted Case Management, Each 15 Minutes**	T1017	LP, PA, Pharma, Psy, LCSW, MFT, RN, NP, LPCC, AOD	96	HD, U1, U2, U3, U7, U8, U9, UB, HL, GC, SC
Recovery Services Codes	**Psychosocial Rehabilitation, per 15 Minutes**	H2017	LP, PA, Psy, Pharma, LCSW, MFT, RN, NP, LPCC, AOD	96	HD, UA, HG, U1, U2, U3, U6, U7, U8, U9, UB, HL, GC, SC

To assist in navigating to the various areas for procedures and codes see link listed below

Code #	Procedure	Time Limits	Page
H0001	Alcohol/Drug Screening to determine appropriate service		DMC-ODS 85
H0003	Alcohol/Drug Screening-Lab Analysis		DMC-ODS 85
H0048 H0049	Alcohol Drug Testing Alcohol Drug Screening		DMC-ODS 86
H0396 H0397	Alcohol/Substance Use (other than tobacco) Alcohol/Substance Use (other than tobacco)	15-30 min. 30+ min	87 87-88
H2021	Community based Wrap Around	Per 15 min.	91
H2014	Skills training/development	Per 15 min.	91
H2027	Psychoeducation	Per 15 min.	94
H0004	Behav. Health Counseling Therapy	Per 15 min.	95
H0005 H0007	Alcohol/Drug Group Therapy Alcohol and/or drug services; crisis intervention (outpatient),	Per 15 min.	97 89

Navigation Journey continues

Code #	Procedure	Time limit	Page	
90791	Psychiatric Diagnostic Evaluation	15 minutes	60	
90792	Psych. Diag. Eval. w/Medical Assessment		61-62	
98966	Telephone Assess/Management	5-10 minutes	72-73	
		11-20 min.	73	
		21-30 min.	73-74	
99441	Telephone Assess/Management By MD/DO, PA, NP, CNS (Certified)	5-10 min.	82	
99442		11-20 min.	82	
99443		21-30 min.	82-83	
H0031	Mental Health Assess by Non-Physician	15 min.	83-84	

Navigation Journey continued

Code #	Procedure	Time Limit	Page
H2000	Comprehensive Multidisciplinary Evaluation	Every 15 min.	84
T1001	Nursing Assessment & Evaluation	Every 15 min.	84
90839	Crisis- Psychotherapy for Crisis	First 30-74 min.	85
90840		Each additional 30 min.	86
H2011	Crisis Intervention (all disciplines including non clinical practitioners) Use G0396, G0397 to determine ASAM Criteria	Per 15 min.	86
96372	Therapeutic, Prophylactic, or Diagnostic Injection; Subcutaneous or Intramuscular, (Do not use this code to indicate administration of vaccines/toxoids or intradermal cancer immunotherapy injections.)	15 Minutes.	93
99202	Evaluation & Management (E&M) Office visit New Person-served	15-29 min.	96
99203		30-44 min.	97
99204		45-59 min.	98
99205		60-74	99

Navigation Journey continued

Code #	Procedure	Time Limits	Page
99212	Evaluation & Management (E&M) Office visit Est. Person-served	10-19 min.	100
99213		20-29 min.	101
99214		30-39 min.	101-102
99215		40-54 min.	102-103
99341-99350	Home visits by licensed medical prescribers New and Est person-served	Various time limits	112-121
99605-99607	Medication Management by pharm New and Est. person-served Individual F/F	Various times	122-123
H0033 H0034	Oral Med. Admin. Direct Observation Medication training	First 15 min. 15 min.	125
H0050	Alcohol/Drug Brief Intervention	Per 15 min	97
99408 99409	Alcohol/Substance Use & Brief Intervention (DAST/AUDIT)	15-30 min. 30+	97-98

Navigations continued

Code #	Procedure	Time limits	Page
90832	Psychotherapy w/person-served	30 min.	142
90833 (MD/DO, PA, NP, CNS-certified)	Psychotherapy w/E&M w/person-served	30	143
90834	Psychotherapy w/person- served	45	144
90836 (MD/DO, PA, NP, CNS-certified)	Psychotherapy w/ E&M w/person-served	45	145
90837	Psychotherapy w/ person- served	60	146
90838 (MD/DO, PA, NP, CNS-certified)	Psychotherapy w E&M w/person-served	60	147
90847 90849	Family Therapy with person-served present Multi-Family Therapy	50 Each 15 min.	148 149
90853	Regular Group Therapy	Each 15 min.	150
T1017	Target Case Management	Each 15 min.	133
90889	Preparation of reports for Psych Hx, Treatment, etc. For ins. Agencies, other individuals		97

Here is what we have covered today…

- **CalAIM – Payment Reform - Transition to CPT procedural codes**
- **Know your resources, e.g. the SMHS Medi-Cal Billing Manual and the DMC-ODS Medi-Cal Billing Manual**
- **Key parts of CPT Coding e.g. Modifiers, Location codes and Add-on Codes**
- **Getting familiar with CPT code charts and spreadsheets in the Medi-Cal Billing Manuals and the MedCCC Library**
- **Introduction to some familiar services and the corresponding CPT codes for both SMHS and DMC-ODS**
- **More learning opportunities to come, as we prepare for July 1, 2023!**

Thank You

Any Questions?

Together, We Put the Puzzle Together

Please type your questions in the Chat section. Please know that we will respond with a formulated Q & A document.

Again thank you for your attendance.
Have a great rest of your day.

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