County of Santa Clara
Behavioral Health Services

CPT/HCPCS Training
for
Licensed Psychiatric Technician (LPT)
Licensed Vocational Nurse (LVN)
Occupational Therapist (OT)

June 21, 2023

W W W . U A S I S O L U T I O N S . C O M

insight. innovation. impact.

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AGENDA

- What's changing and what's not changing
- Review of applicable CPT/HCPCS codes for LPT LVN OT
  - Specialty Mental Health Services (SMHS)
    - Billing Manual Version 1.4

SMHS BH Service Groups

1. Assessment
2. Crisis Intervention
3. Medication Support Services
4. Peer Support Services
5. Plan Development
6. Referral
7. Rehabilitation
8. Supplemental Services
9. Therapeutic Behavioral Services
10. Therapy

CalAIM Regulatory Changes Effective 7/1/2023

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CalAIM Behavioral Health Payment Reform

- CalAIM – California Advancing and Innovating Medi-Cal
- Payment reform goals:
  - Simplify county BH plan payments and reduce administrative burden for the State, counties, and providers.
- The payment reform initiative will enable counties and providers to deliver value-based care that improved quality of life fore Medi-Cal beneficiaries
- Ending cost-based reimbursement and simplifying payments to county BH plans are foundational first steps toward future development of more innovative value-based payment models
- The CalAIM Behavioral Health Payment Reform initiative consists of three different transitions, effective July 1, 2023
- Documentation link: CalAIM BH Payment Reform Fact Sheet DHCS Letterhead

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CPT Coding Transition

Goals: Improve reporting and support data-driven decision making. Align with other healthcare delivery systems and comply with CMS requirements for all state Medicaid programs to adopt CPT codes where appropriate.

Present HCPCS Level II – All Services	Future CPT/HCPCS Level I – Where Applicable
HCPCS Level II codes are highly flexible; a variety of activities may be captured by the same code, making detailed analysis of services rendered a challenge	CPT codes: more detailed and nationally standardized definitions for each code.
HCPCS Level II codes can be used by any provider (licensed or non-licensed)	Some HCPCS Level II codes will be retained, for those behavioral health providers and services not captured by CPT codes.

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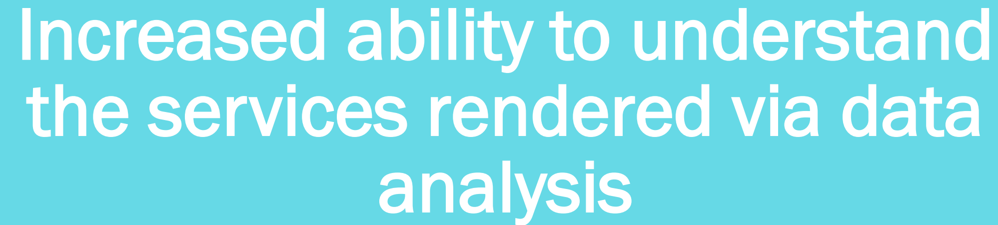
Benefits of the Transition



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

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Things that are NOT Changing

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24-hour and Day Services
HCPCS codes utilized for non-clinical staff and non-clinical services (e.g., Rehabilitation, Targeted Case Management
Scope of practice (What a provider is permitted to do within their given discipline)
Scope of competence (skills or services a provider can offer based on experience and training)
County-defined supervision practices

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Things that ARE Changing

Service/procedure code names
Billing by units vs. minutes
Direct patient care requirements
Selecting codes based on direct service time
Modifiers
Add-on Codes
Lockouts
Duplicate services
Recording documentation and travel time

Minutes vs. Units

NOTE: Your agency EHR configuration will determine whether to enter minutes or units.

- Claims will be based on units of service rather than total number of minutes.
- Direct services providers will still document service time, the finalized claim will be based on units of service dependent on the number of minutes
- A unit of time is considered 'met' when the midpoint of the given time or time range is exceeded
- *Example #1:*
  - An AOD Counselor meets with a client and provides 60 minutes of Targeted Case Management. This service would be noted as 4 units of Targeted Case Management (60 minutes of service/15 minutes per unit)
- *Example #2:*
  - An AOD Counselor meets with a client and provides 4 minutes of Targeted Case Management. This service does not pass the midpoint of 15 minutes and cannot be billed. If the service was 8 minutes, then 1 unit of Targeted Case Management could be billed.

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Direct Patient Care

- Only direct patient care should be counted toward selection of service time when documenting a service
- Direct patient care can include time spent meeting directly with the beneficiary as well as with caregivers, significant support persons and other professionals
- Direct patient care <u>does not</u> include travel time, administrative activities, chart review, documentation, utilization review and quality assurance activities or other activities a provider engages in either before or after a beneficiary visit.

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Behavioral Health Services

Assessment
LPT LVN OT

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SMHS Assessment Codes

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- Assessment means a service activity designed to evaluate the current status of a beneficiary's mental, emotional, or behavioral health.
- Assessment includes one or more of the following:
  - Mental status determination
  - Analysis of the beneficiary's clinical history
  - Analysis of relevant biopsychosocial and cultural issues and history
  - Diagnosis and the use of testing procedures

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SMHS Assessment Codes

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Code	Description	Code Guidance	Documentation
96138 96139	Psychological or neuropsychological test administration by technician	96138: first 30 minutes 96139: <u>each additional</u> 30 minutes Includes administration and scoring of two or more tests by any method These codes do not include time for testing evaluation (96130, 96131, 96132, 96133)	• Document the specific tests administered and scoring • Documentation must include total time Provider: PT

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SMHS Assessment Codes

Code	Description	Code Guidance	Documentation
H0031	Mental health assessment by non-physician, 15 minutes	In-depth mental health assessment One in-depth assessment per recipient, per year	• Document the findings of the in-depth mental health assessment, including treatment plan/goals • Documentation must include total time of the assessment Provider: Psychiatric Technician, LVN, OT
H2000	Comprehensive multidisciplinary evaluation, 15 minutes	Comprehensive evaluation by a multidisciplinary team	• Document the findings of the comprehensive evaluation and multidisciplinary team members involved in the evaluation • Documentation must include total time of the evaluation Provider: LVN, OT
T1001	Nursing assessment, evaluation, 15 minutes	Assessment/evaluation conducted by a nurse	• Document the evaluation of the patient by the nurse • Documentation must include total time of the evaluation Provider: Psychiatric Technician, LVN

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Clinical Assessment Example

Name: Marie

Contributions to the Assessment:

- Diagnostic interview with Maria on 2/18, 2/22 and 3/1/2021
- Review of available records from Mercy Hospital
- Collateral information obtained from Marie's mother

Assessment components:

- Current life situation:
  - Age/living situation/basic needs/education
  - Significant personal relationships
  - Strengths
  - Health and spiritual beliefs
  - Current medications

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Clinical Assessment Example

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- Reasons for Extended Assessment:
  - Perception of condition
  - Description of symptoms
  - Reason for referral
  - Client mental health and treatment history
  - Developmental incidents
  - Trauma history
  - Substance use history
  - Health history
  - Family history
  - Cultural impact and influence
  - Communication style

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Clinical Assessment Example

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- Mental Status Examination
- Screening Measures
  - GAIN-SS CD Screener
  - Trauma checklist
- Assessment Measures
  - Substance Abuse Treatment Scale-Revised (SATS-R)
  - Alcohol Use Scale-Revised (AUS-R) and Drug Use Scale-Revised (DUS-R)
  - Comprehensive Longitudinal Assessment
  - Contextual Assessment
- Assessment of Client Needs
- Summary and Recommendations

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Clinical Assessment Example

- Diagnosis
  - Axis I: Bipolar I Disorder, most recent episode manic, in partial remission
  - Axis II: No diagnosis
  - Axis III: Closed head injury at age 5, secondary to a fall
  - Axis IV: Unemployment, family conflict, limited supports, few sober friends
  - Axis V: GAF = 60

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Behavioral Health Services

Medication Support Services
LPT LVN OT

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SMHS Medication Support Services Codes

- Medication Support Services include one or more of the following: prescribing, administering, dispensing and monitoring drug interactions and contraindications of psychiatric medications or biologicals that are necessary to alleviate the suffering and symptoms of mental illness.
- This service may also include assessing the appropriateness of reducing medication usage when clinically indicated.
- Medication Support Services are individually tailored to address the beneficiary's need and are provided by a consistent provider who has an established relationship with the beneficiary.
- Services may include: providing detailed information about how medications work; different types of medications available and why they are used; anticipated outcomes of taking a medication; the importance of continuing to take a medication even if the symptoms improve or disappear (as determined to be clinically appropriate); how the use of the medication may improve the effectiveness of other services a beneficiary is receiving (e.g., group or individual therapy); possible side effects of medications and how to manage them; information about medication interactions or possible complications related to using medications with alcohol or other medications or substances; and the impact of choosing not to take medications.

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SMHS Medication Support Services Codes

- The service includes one or more of the following service components:
  - Evaluation of the need for medication
  - Evaluation of clinical effectiveness and side effects
  - The obtaining of informed consent
  - Medication education including instruction in the use, risks, and benefits of and alternatives for medication
  - Collateral
  - Plan Development

- Title 9, CCR, § 1840.372 states that "the maximum amount claimable for Medication Support Services in a 24-hour period is 4 hours."

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SMHS Medication Support Services Codes

Code	Description	Code Guidance	Documentation
G2212	Prolonged office or other outpatient evaluation and management service(s) beyond the maximum time, each additional 15 minutes	Each additional 15 minutes for E/M services provided beyond maximum time for primary procedure, e.g., 74 minutes (99205) or 54 minutes (99215) Do not report for any time unit less than 15 minutes	• Document total face-to-face (direct patient care) time on date of the encounter Provider: LVN
H0033	Oral medication administration, direct observation, 15 minutes	Direct observation for oral medication administration	• Documentation must include direct observation for oral medication administration • Documentation must include the specific reason (symptom or diagnosis) for which the oral medication is administered • Documentation must include total time Provider: LPT, LVN, OT
H0034	Medication training and support, per 15 minutes	Provide medication and support	• Documentation must include training and support provided • Documentation must include the specific reason (symptom or diagnosis) for which the on-body injection is applied • Documentation must include total time Provider: LVN, PT

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Behavioral Health Services

Plan Development
LPT LVN OT

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Plan Development/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.
- As part of CalAIM, treatment plans for many types of services are moving from standalone documents to be embedded in progress notes.
- Document link: CalMHSA-MHP-LPHA-Documentation-Guide-05182022.pdf

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SMHS Plan Development Codes

- Plan Development means a service activity that consists of one or more of the following:
  - Development of client plans
  - Approval of client plans
  - Monitoring of a beneficiary’s progress

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SMHS Plan Development Codes

Code	Description	Code Guidance	Documentation
99484	Care management services for behavioral health conditions, directed by physician. At least 20 minutes	Reported for at least 20 minutes of clinical staff time, directed by a physician or other QHP, per calendar month	Documented services must encompass the required elements listed in the code descriptor. Required elements for reporting are: • initial assessment or follow-up monitoring, including the use of applicable validated rating scales; • behavioral health care planning in relations to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; • facilitating and coordination treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and • continuity of care with a designated member of the care team Provider: PT

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SMHS Plan Development Codes

Code	Description	Code Guidance	Documentation
H0032	Mental health service plan development by non-physician, 15 minutes	Reported for selection of treatment targets in collaboration with family members and other stakeholders	• Document the development of written protocols for treating and measuring all treatment targets Provider: PT, LVN, OT

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Plan Development Case Example

S: Client with significant history of thought disorder, including auditory hallucinations and paranoid delusions continues to be symptomatic, although relatively stable for the last three months. Affect is blunted, insight is limited, although has recently been more medication adherent than in the past. Continues to need support to remain on meds, remain in stable structured housing, and maintain adequate health.

I: Spoke with client to review and renew annual client plan. Reviewed previous objectives for relevance. Suggested changes based on his more stable situation. Supported his remaining compliant with medication, and we agreed that we should keep an objective related to this important area. Discussed whether having objective relating to obtaining stable housing was still relevant, or whether we should revise as 'maintain stable housing,' given that he has remained at current place for most of year. Also discussed whether we need to meet as frequently during the upcoming year as we have been.

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Plan Development Case Example

R: Client was engaged in revising objective on plan. Agreed that focus on maintain housing was more appropriate than obtain housing. Continued to express some ambivalence re meds but acknowledges that they have benefitted him. Agreed that keeping an objective re this is appropriate. Appeared to have mixed feelings about possible decreased frequency of contact. Was more comfortable with compromise language that we would ‘explore’ decreased frequency of contact.

P: Will write up renewed Client Plan based on our discussion and present to him for approval/signature.

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Behavioral Health Services

Crisis Intervention
LPT LVN OT

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SMHS Crisis Intervention Codes

- Crisis Intervention is an unplanned, expedited service, to or on behalf of a beneficiary to address a condition that requires more timely response than a regularly scheduled visit.
- Crisis intervention is an emergency response service enabling the beneficiary to cope with a crisis, while assisting the beneficiary in regaining their status as a functioning community member.
- The goal of crisis intervention is to stabilize an immediate crisis within a community or clinical treatment setting.
- This service includes one or more of the following service components:
  - Assessment
  - Collateral
  - Therapy
  - Referral
- Title 9, CCR, § 1840.366 states that "the maximum amount claimable for Crisis Intervention in a 24-hour period is 8 hours."

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SMHS Crisis Intervention Codes

Code	Description	Code Guidance	Documentation
H2011	Crisis intervention service, per 15 minutes	Mental health crisis assessment, intervention and stabilization	• Time documentation for the use of this code is each 15 minutes. Specific documentation of time must be included. • Document medical necessity for crisis intervention • Document the actual intervention performed linked to the symptoms/impairments of the patient's diagnosis Provider: LVN, OT, LPT

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Crisis Intervention Case Example

S: Received a call from manager of client's residence. Manager reported that client was yelling repeatedly, although not at any particular person. Manager stated that client's behavior is frightening other residents, although she was unsure whether there was any direct threat. Client has a history of stopping meds and substance use, which have resulted in decompensation and hospitalization due to similar behavior in past.

I: Visited client at his residence and spoke with manager. Client was extremely agitated, with considerable delusional content expressed. Appeared to be responding to internal stimuli. Client admitted that he has not been taking meds – states that they are poison. Was only able to redirect to coherent interaction from brief periods before client would return to somewhat incoherent rambling speech, containing ideas of reference and delusional material. Manager state that she can't keep him in the residence in his current state, although said that she would accept him back if her gets back on his medication and his behavior stabilizes. Writer initiated 5150 based on grave disability, as done not meet danger to self or others criteria but cannot provider for shelter in current state. Called for transport and police assistance in 5150 to XXX for evaluation and stabilization. Provided reassurance to client while waiting for police.

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Crisis Intervention Case Example

R: Client became slightly more subdued when officers arrived and when told that he was going to hospital. Was reassured that he was not being arrested, only being taken to hospital on a hold to help him get re-stabilized. Was not resisting assistance into ambulance.

P: Will check with XXX after they have evaluated to see whether they will admit to inpatient, or restart meds and discharge back to residence. Will inform XXX that unless client clears considerably, residence will not accept back. Will keep residence manager informed of client's state in terms of discharge.

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Behavioral Health Services

Supplemental Services
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SMHS Supplemental Services Codes

- Supplemental Codes are codes that describe additional and simultaneous services that were provided to the beneficiary during the visit or codes that describe the additional severity of the patient's condition.
  - For example, T1013 indicates that interpretation was provided during the visit while 90785 indicates that certain factors increase the complexity of a patient's treatment.
- Supplemental codes cannot be billed independently. They must be billed with a/another (primary) procedure.

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SMHS Supplemental Services Codes

Code	Description	Code Guidance	Documentation
90785	Interactive complexity	Add on code reported in conjunction with an appropriate primary service for psychiatric diagnostic evaluation or psychotherapy service Used for situations beyond simply standard verbal communication Common factors include more difficult communication with discordant or emotional family members and engagement of young and verbally undeveloped or impaired patients Typical patients are those who have third parties involved in their psychiatric care.	Document at least one of the following: • Need to manage maladaptive communication (related to, eg, high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicates delivery of care • Caregiver emotions or behavior that interferes with the caregiver's understanding and ability to assist in the implementation of the treatment plan • Evidence of disclosure of a sentinel event and mandated report to third party (eg, abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants • Use of play equipment or other physical devices to communicate with the patient to overcome barriers to therapeutic or diagnostic interaction between the provider and a patient who has not developed, or has lost, either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the provider if he/she were to use typical language for communication Provider: LVN, OT, LPT

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SMHS Supplemental Services Codes

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Code	Description	Code Guidance	Documentation
90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	Explanation of results to family or others involved in support of the patient, such as employers, in order to obtain their permission, participation and/or support for the patient’s treatment. Supplemental codes cannot be billed independently. They have to be billed with a/another (primary) procedure.	• Document the specific results or other accumulated data utilized in explanation to family or others • Include a narrative indicating there was another individual in addition to the physician and patient present at the time of this service Provider: OT

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SMHS Supplemental Services Codes

Code	Description	Code Guidance	Documentation
96161	Caregiver assessment administration of care-giver focused risk assessment, 15 minutes	Health and behavior assessment (eg, depression inventory) of the patient's caregiver for the benefit of the patient Code is related only to practice expense, including clinical staff work, supplies and equipment expenses Code does not include physician work that is separately reported with an E/M service	• Document results from the standardized assessment • Document score per standardized scorable instrument • Time documentation for the use of this code is each 15 minutes. Specific documentation of time must be included. Provider: OT, LVN
T1013	Sign language or oral interpretive services, 15 minutes	Facilitate effective communication with deaf or hearing-impaired patients	• Time documentation for the use of this code is each 15 minutes. Specific documentation of time must be included. Provider: LVN, OT, LPT

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Behavioral Health Services

Rehabilitation
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SMHS Rehabilitation Codes

- Rehabilitation means a recovery- or resiliency-focused service activity identified to address a mental health need in the client plan.
- This service activity provides assistance in restoring, improving, and/or preserving a beneficiary's functional, social, communication, or daily living skills to enhance self-sufficiency or self-regulation in multiple life domains relevant to the developmental age and needs of the beneficiary.
- Rehabilitation also includes support resources, and/or medication education.
- Rehabilitation may be provided to a beneficiary or a group of beneficiaries.

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SMHS Rehabilitation Codes

Code	Description	Code Guidance	Documentation
H2017	Psychosocial rehabilitation, per 15 minutes	Time spent providing PSR (psychosocial rehabilitation) services; individual or group services	• Time documentation for the use of this code is <u>each 15 minutes</u>. Specific documentation of time must be included. • Document and describe the specific activities performed to specifically enhance/support the patient's skills related to their specific rehabilitation needs and goals Provider: LPT, LVN, OT
H2021	Community-based wrap-around services, per 15 minutes	Services provided through wrap-around programs can include: -Case management (service coordination) -Counseling (individual, family, group, youth, and vocational) -Crisis care and outreach -Education/special education services, tutoring -Family support, independent living supports, self-help, or support groups.	• Time documentation for the use of this code is <u>each 15 minutes</u>. Specific documentation of time must be included. • Documentation should address all components included in each client's wrap-around program. Provider: LPT, LVN, OT

Clinical Example - Rehabilitation

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Rehabilitation Individual Rehabilitation Progress Note:

- In an effort to monitor client's moods and emotions, I engaged her in an open-ended conversation about her day and how she has been feeling. I praised her for her reported positive day. I validated her responses and responded with empathy, encouraging her to express her feelings. I discussed and reviewed her current coping skills (i.e., reading, listening to music, etc.,). I normalized her need to take a break from difficult situations and reminded her to take time outside. Assisted client in practicing how to let others know that she needs to use her safety plan by engaging in a role play. Client was verbal and engaged throughout the session. I will meet with client next week for an individual rehabilitation session to support her with developing and utilizing coping skills. Total time spent for this encounter – 45 minutes.
- CPT/HCPCS Coding: H2017 (x3 units)

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Behavioral Health Services

Therapeutic Behavioral Services
LPT LVN OT

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SMHS Therapeutic Behavioral Services Codes

- Therapeutic Behavioral Services (TBS) is an adjunctive program that supports other services patients are currently receiving.
- TBS is an intensive, individualized, one-to-one behavioral health service available to children/youth with serious emotional challenges and their families, who are under 21 years old and have full-scope Medi-Cal.
- For guidance on how to use TBS (H2019), refer to section 5.28.0.

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SMHS Therapeutic Behavioral Services Codes

Code	Description	Code Guidance	Documentation
H2019	Therapeutic behavioral services, per 15 minutes		• Documentation must include total time Provider: LVN, OT, LPT

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Behavioral Health Services

Referral
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SMHS Referral Codes

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Code	Description	Code Guidance	Documentation
T1017	Targeted case management, each 15 minutes	Targeted case management services are aimed specifically at special groups, such as those with developmental disabilities or chronic mental illness.	• 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. For example, an occurrence of 30 minutes would use code T1017 with 2 units to account for each 15 minutes. Provider: LVN, OT, LPT

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References

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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
- Specialty Mental Health Services (SMHS) Medi-Cal Billing Manual; V1.4; Found at: SMHS-Billing-Manual-v-1-4 (ca.gov)
- Clinical Documentation Guide 2022; revised 6/23/2022; California Mental Health Services Authority (CalMHSA). Found at: CalMHSA-MHP-LPHA-Documentation-Guide-05182022.pdf

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Q&A Sessions

Q&A Session #1

- Tuesday, 6/27 @ 9:00am

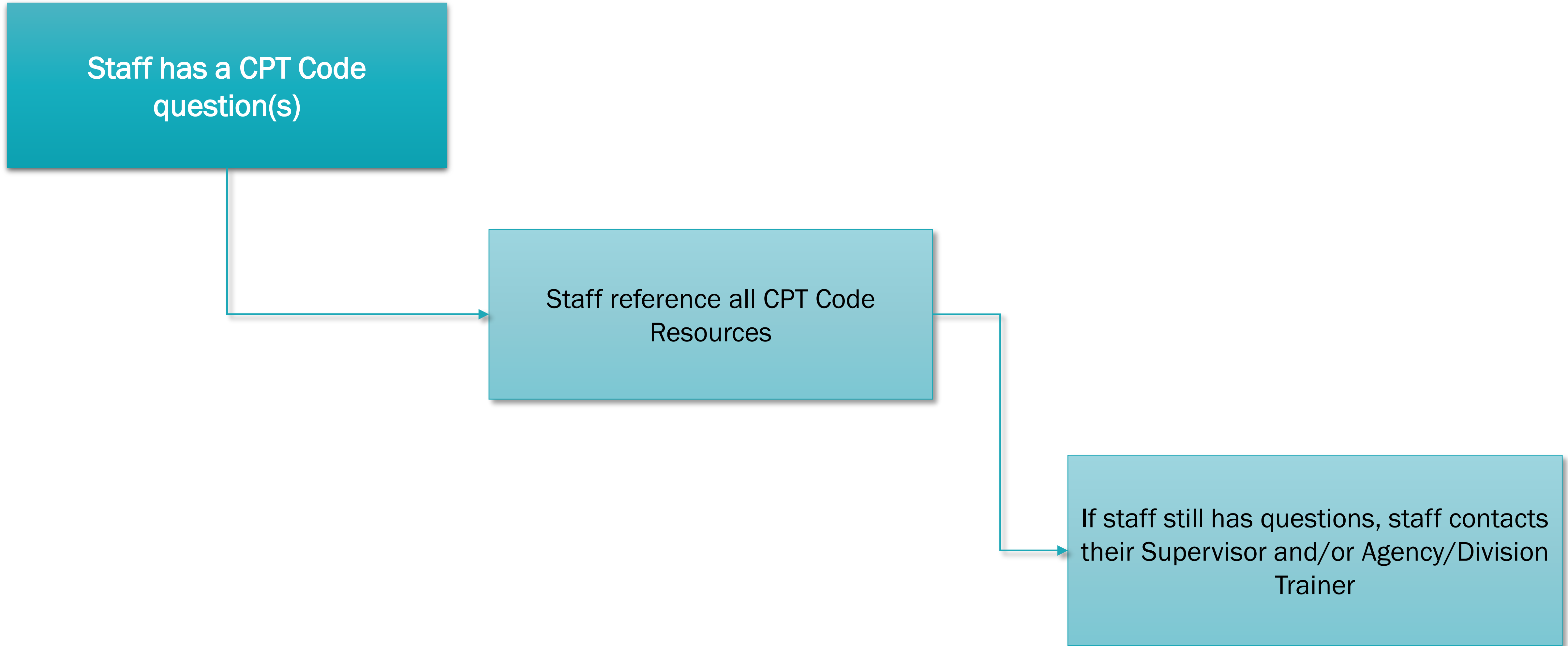
Q&A Session # 2

- Wednesday, 6/28 @ 3:00pm

Q&A Session # 3

- Thursday, 6/29 @ 11:00 am

Staff Support Flowchart



Appendix A
Acronym List

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Acronym List

- ACE: Adverse childhood experience
- ASAM: American Society of Addiction Medicine
- BHIN: Behavioral health information notice
- CalAIM: California Advancing and Innovating Medi-Cal
- CMS: Center for Medicare and Medicaid Services
- CPT: Current Procedural Terminology
- DHCS: Department of Health Care Services
- DMC: Drug Medi-Cal
- DMC-ODS: Drug Medi-Cal Organized Delivery System
- HCPCS: Healthcare Common Procedural Code System
- ICD-10: International Classification of Diseases, 10th edition
- LOC: Level of care
- MAT: Medication for addiction treatment
- MCO: Managed care organization
- MCP: Managed care plan
- MHP: Mental health plan
- NSMHS: Non-specialty mental health services
- NTP: Narcotic treatment program
- SMHS: Specialty mental health services
- SUD: Substance use disorder
- TCM: Targeted case management

Appendix B
Documentation Best Practices*

***Disclaimer: This is general information only; please consult with your Agency's or County's Quality Team for specific information**

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The Flow of Clinical Documentation

1. The Clinical Assessment is the first step in establishing Medical Necessity and the start of services
2. The Assessment supports staff in developing a clinical picture that informs the diagnostic process
3. The Treatment Planning process creates a framework for the services provided. This includes the development of goals and planned interventions to support clients in their recovery
4. Each service provided links back to an identified issue from the treatment planning process through the Assessment

All services are based on Medical Necessity – every service provided to the client/family is medically necessary to support the path to recovery

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General Principles of Documentation

- Services provided by staff within the scope of practice of the individual delivering the service. Clinicians should follow specific scope of practice requirements
- Progress notes should provide enough detail to easily ascertain the client's status and needs and understand why the service was provided without having to refer to previous progress notes
- Each progress note must show the service was medically necessary
  - Documentation can include comments such as: 'it was reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain'
  - Progress notes should clearly identify the type of service provided and how the intervention addresses the client's presenting condition
  - Clinicians can support the medical necessity of a service by documenting how the intervention provided related to the clinical goals or mental health condition identified in the client plan

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General Principles of Documentation

- Total time should be noted on each progress note. This is the direct patient care (face-to-face time) with the client
- Documentation should be completed in a timely manner, with minimal delay in finalizing all documentation
- Documentation must be readable and legible
- Copy and Paste: Do not copy and paste notes into a client's medical record. Each note should be specific to the service provided
- Clinician signature is required as part of the legal medical record, including an electronic signature

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General Principles of Documentation

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- Medical Necessity
  - Services provided to beneficiaries need to meet the standard of being ‘medically necessary’
  - For individuals age 21 or older: a mental health service is considered medically necessary when it is “reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.”
  - For individuals under age 21: the medical necessity falls under the Early and Period Screening, Diagnostic and Treatment (EPSDT) services language under a specific section of Title 42.
    - Requires provision of all Medi-Cal coverable services necessary to correct or ameliorate a mental illness or condition discovered by a screening service, whether or not the service is covered under the State Plan.
    - These services need not be curative or restorative, and can be delivered to sustain, support, improve or make more tolerable a mental health condition

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General Principles of Documentation

Overview of criteria for persons aged 21 years or older
The person has significant impairment in social, occupational, or other important life activities and/or there is reasonable probability of significant deterioration in important are of life functioning
AND the significant impairments listed above are due to a mental health disorder, Diagnostic Statistical Manual, Fifth Edition (DSM-5), either diagnosed or suspected, but not yet diagnosed

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General Principles of Documentation

Overview of criteria for persons under 21 years of age
The person is experiencing homelessness and/or is interacting with the child welfare or criminal justice system
OR has scored high on the trauma screening tool, placing them at high risk for a mental health disorder
OR, the person has a significant impairment, a reasonable probability of significant deterioration in an important area of life functioning, a reasonable probability of not progressing as developmentally appropriate, or there is no presence of impairment
AND the significant impairments listed above are due to a mental health disorder, Diagnostic Statistical Manual, Fifth Edition (DSM-5), either diagnosed or suspected, but not yet diagnosed

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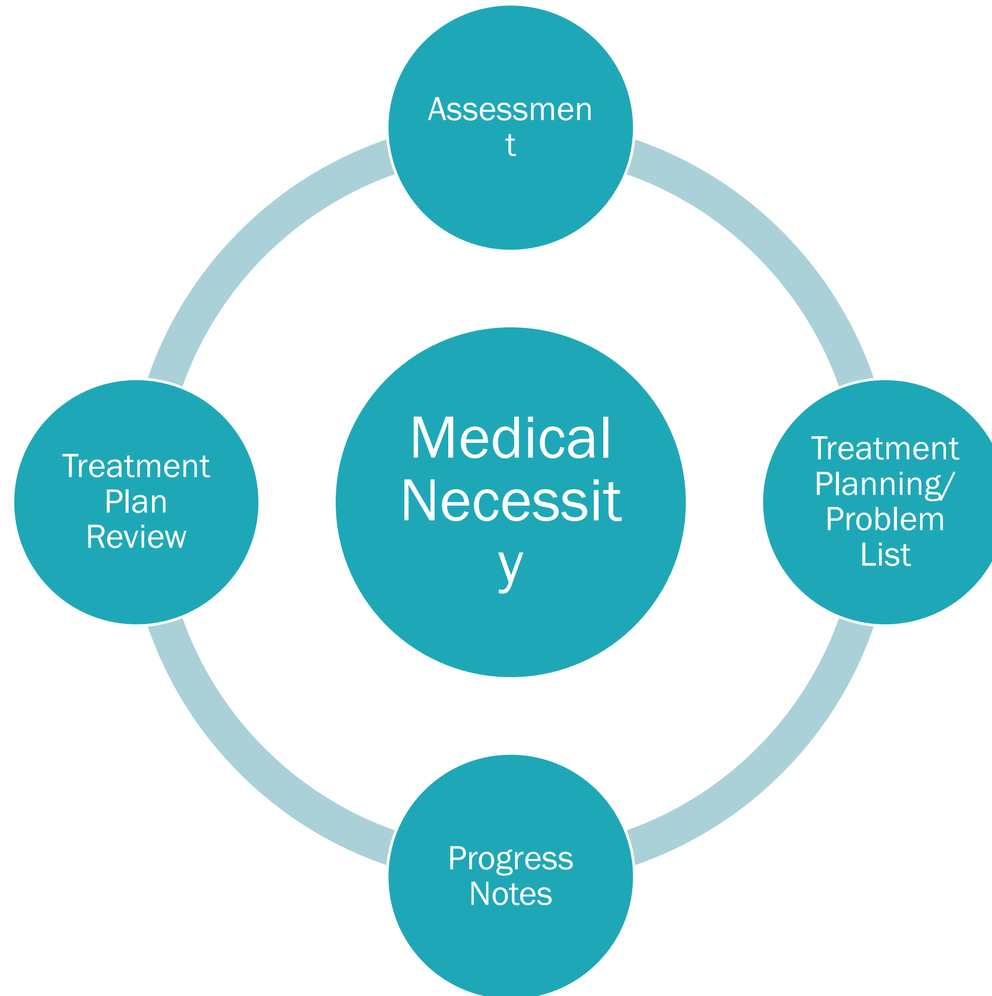
Medical Necessity



Documentation of Diagnosis(es)

- The diagnosis for the patient's condition should be reported as specifically supported in the provider documentation
- In the absence of a definitive diagnosis, the documentation should support the sign or symptom being evaluated
- The diagnosis should be supported by the client's symptoms, impairments, and/or behaviors as documented on the most current Assessment
  - This should include documentation of significant impairments that have an impact on current or future functioning if not treated
- Documentation should include a thorough patient history that includes medical, surgical and family history that is pertinent to the patient's current condition

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Diagnosis Documentation Tips

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- Clarify specific type(s) of drug or substance, mode and usage
  - Use, abuse and dependence
- Specifically document “in remission” for any drug or substance, as appropriate
- Relationship between mental conditions and substance disorders
- Relationship between physical conditions and substance disorders
- Clarify mental health disorders by specific type, acuity, episode type and severity
- Comorbid/complicating medical conditions that affect treatment and/or are complicated by substance use, such as malnutrition or hypertension
- Socioeconomic and or psychosocial factors that complicate treatment and recovery
- Personal or family history that impacts substance use, treatment and/or recovery

Assessment Documentation

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- The completion of an Assessment establishes the foundation for an included diagnosis and the resulting symptoms and impairments in life functioning.
- When conducting an Assessment, documentation should include:
  - Presenting problem(s)
  - Relevant conditions and psychosocial factors
  - Mental and physical health status and history
  - Medications
  - Past and present use of substances
  - Client and family strengths in achieving treatment plan goals
  - Identified risk factors for the patient to achieve treatment plan goals
- The Assessment, which includes one or more diagnoses, evaluates the current status of a client's mental, emotional or behavioral health
- The initial Clinical Assessment should be completed within 30 days and submitted with the client Plan
- An addendum should be completed when additional information is available or changes after the Initial Assessment, or between required re-assessments

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Treatment Planning

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- Treatment planning establishes treatment goals/objectives and the proposed clinical interventions that will address the diagnoses and impairments
- Each patient's treatment planning should include:
  - Current diagnosis(es)
  - Goals and objectives
  - Interventions and options
  - Treatment modality and frequency (specifically stated)
  - Methods for monitoring and measuring progress
- Documentation should include the client's participation in the development of and agreement with the plan
- Both compliance and non-compliance with the treatment planning should also be documented
- Treatment Planning should be updated annually or sooner if there is a significant change

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Progress Note Documentation

- Document all facts relevant to an intervention, event, course of treatment, patient condition, response to treatment and progress toward objective each time a service is provided
- Record the date, location, duration and service provided, and include a brief narrative
- Document delivered services that are linked to an intervention identified on the Client Treatment & Recovery Plan
- Document progress the client is making toward their objectives
- Include test results/consultations in record as well as other notes that you reviewed
- Document rationale for deviating from standard treatment, when applicable
- Medication progress notes should document the client's response to medications, side effects, compliance and/or a plan to maintain or change the medication regimen

Progress Note Documentation

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Progress notes should answer:

- Who did you see today?
  - *Client is a 26-year-old single Chilean female diagnosed with Schizophrenia, Paranoid Type*
- Why did you see the client? (Purpose of visit)
  - *Client came in for a scheduled appointment to continue learning ways to manage her auditory hallucinations*
- What did you do? (Intervention PN)
  - *Clinician worked with the client on developing reality testing techniques, such as asking a trusted individual if she also heard what the voices had said. Clinician also helped the client minimize the voices by discussing ways to reduce the intrusiveness of the voices*

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Progress Note Documentation

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Progress notes should answer:

- What was the client's response? (Response to Intervention PN)
  - *Client reported that she could try reality testing with her mom as she trusts her. Client also noted that it helps her to listen to music and could wear headphones to reduce the intrusiveness of the voices.*
- What is the plan for the next visit? (MHS and PN Plan)
  - *Clinician will meet with client again next week and will assess how the techniques discussed today have worked for the client.*

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The Journey of Documentation

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- Throughout the course of a beneficiaries treatment, all of the information in the documentation should be consistent.
- All documents in the record should tie together to give a clear clinical picture of the beneficiary and demonstrate strong clinical interventions that addresses the mental health problem with the beneficiary
- The Initial Assessment should relate to the Care Plan, and both should relate to all the progress notes that follow
- There is a relationship between the medical necessity established in the Initial Assessment, the Care Plan, and the planned services provided

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Appendix C
CPT Coding Basics

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Codes Sets for BH Services

Beginning July 1, 2023, behavioral health services will be billed using 2 code types

1. **Current Procedural Terminology (CPT) Codes**
2. **Healthcare Common Procedure Coding System (HCPCS) Level II codes**

CPT Coding Transition

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GOALS

Improve reporting and support data-driven decision making

Align other healthcare delivery systems and comply with CMS requirements for Medicaid programs to adopt CPT codes, where appropriate

Present HCPCS Level II – All Services	Future CPT/HCPCS Level I – Where Applicable
HCPCS Level II codes are highly flexible; a variety of activities may be captured by the same code, making detailed analysis of services rendered a challenge	CPT codes: More detailed and nationally standardized definitions for each code
HCPCS Level II codes can be used by any provider (licensed or non-licensed)	Some HCPCS Level II codes will be retained for those behavioral health providers and services not captured by CPT codes

HCPCS Code Set

HCPCS Level I Codes

- Published and maintained by the American Medical Association (AMA), i.e., CPT codes
- Describe medical, surgical, and diagnostic services provided by physicians or providers

HCPCS Level II Codes

- Used for non-physician services or procedures, such as:
    - Drug screening or testing, family or group counseling and peer support services

HCPCS Level III Codes

- Local codes that are not nationally accepted
- Alphanumeric codes starting with an alpha character X or Z

Purpose of CPT

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- Reimburse provider services
- Trending services provided nationally
- Future coding and reimbursement planning
- Benchmarking facilities, costs and services
- Measuring quality of care and patient outcomes nationally

CPT Code Set

- Published and maintained by the American Medical Association (AMA)
- CPT codes are updated yearly in October by the AMA and go into effect in January of the following year
  - New codes
  - Deleted codes
  - Revised codes

- Represent many healthcare services or procedures for medical billing, including:
  - Surgeries
  - Diagnostic tests
  - Evaluations
  - Other medical procedures or services performed

CPT Code Categories

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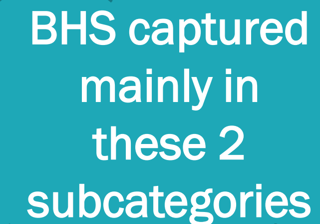
<u>CPT Category I Codes</u>

- 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



Level II HCPCS Codes

- In medical billing when the HCPCS code set is being discussed, it is refers to HCPCS Level II national code set.
- Composed of a single letter in the A to V range, followed by 4 digits
- Used for healthcare providers, physicians, and medical equipment suppliers
- While there are over 20 categories of HCPCS Level II services, CalAIM is only including 3 categories of codes for services such as:
  - G0008-G9360 – Procedures/Professional Services
  - H0001-H2037 – Alcohol and Drug Abuse Treatment
  - T1000-T5999 – National Codes Established for State Medicaid Agencies

Definitions/Descriptions

- New vs. established patients: Some evaluation and management E/M codes are described as being services for a new or an established patient, and should be billed accordingly.
  - New Patient: an individual who has not received any professional services from the physician/qualified healthcare professional; or another physician/qualified healthcare professional of the exact same specialty, and subspecialty who belongs to the same group practice within the past three years
  - Established Patient: an individual who has received professional services from the physician/qualified healthcare professional or another physician/qualified healthcare professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.
- Qualified healthcare professional (QHP): E/M services can be rendered by:
  - Physician, Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist
- Time: Each code is associated with a length of time or time range as part of the service description. Per policy, the only time considered is the time it takes to provide direct services associated with that code as part of time

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Dependent Codes

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Dependent Codes:

- These are codes that either indicate that time has been added to a primary procedure (i.e., add-on codes) or modifies a procedure (i.e., supplemental codes).
- Dependent codes cannot be billed unless the provider first bills the primary code to the same beneficiary by the same rendering provider on the same date on the same claim.

Example: Psychological Testing, 1 hour, 45 minutes

- Primary Code: 96130 Psychological Testing Evaluation, First Hour
- Dependent Code: 96131 Psychological Testing Evaluation, Each Additional Hour

A claim submitted with only 96131 will be denied unless the primary code 96130 is also on the claim

Lockout Codes

<u>Lockout codes:</u>

- Codes that typically cannot be billed together.
- However under certain circumstances, lockout codes can be billed together with the appropriate modifier, such as:
  - Separate practitioners or separate sessions on the same date of service.

- Dependent codes and lockout codes are indicated in the SMHS or DMC-ODS billing manual tables.

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