CBO Bulletin

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BILLING T2024 & T2021 FOR PROLONGED SERVICES

Recently, the California Department of Health Care Services (DHCS) revised its guidance on claiming for prolonged assessment and therapy services. Previously, DHCS instructed specialty mental health providers to add one unit of G2212 for every 15 minutes over the time allotted for the primary assessment or therapy Current Procedural Terminology (CPT) code. Now, under the new guidance, providers are to use multiple units of T2024 for prolonged assessment services and multiple units of T2021 for prolonged therapy services. T2024 and T2021 are to be used without the G2212 add-on as a substitute for the primary assessment/therapy CPT code plus the G2212 add-on code.

T2024 can only be used for prolonged assessment services lasting longer than the time allotted by the State for the CPT code. Providers must submit a minimum of five (5) units of service when submitting T2024 claims for prolonged assessment services. T2024 claims with fewer than five (5) units of service will be denied. Assessment services that are not prolonged and would require fewer than five (5) units of service should be billed the same as before, with the appropriate assessment CPT code. T2021 can only be used for prolonged therapy services. There is no minimum number of units required for T2021. For more information on the appropriate use of T2024 and T2021, please refer to the Guide to Procedure Codes available on the Department of Mental Health website: https://file.lacounty.gov/SDSInter/dmh/1135788_GuidetoProcedureCodesFinal.pdf.

The new T2024 and T2021 codes have been added to the Integrated Behavioral Health Information System (IBHIS). These codes are effective for dates of service July 1, 2023, forward. Providers may use these codes for all prolonged assessment and therapy services rendered under CalAIM.

Using T2024 and T2021 on replacement claims

The T2024 and T2021 substitute codes can be used to replace claims for prolonged services that were previously approved or denied by DHCS including claims where IBHIS disassociated the add-on from the primary code before sending it to the State.

Claims must have two (2) or more of the following elements the same on the replacement claim (Claim Type 7) as on the original claim:

- Procedure code
- Date of service
- Place of service
- Service Facility NPI

If more than two of the above elements on the replacement claim are different from the original, then the original claim must be voided, and a new original must be submitted.

For more information on replacements: CBO Bulletin NGA 24-006: Replacement Claims in IBHIS Under CalAIM.

Submitting T2024 and T2021 to Original Medicare and Commercial Insurance

When clients are enrolled in the Original Medicare program or have Commercial Insurance in addition to Medi-Cal, services must be approved or denied by Medicare or the insurance prior to billing Medi-Cal. T2024 and T2021 represent services that are billable to these other payers and DHCS expects to see the approval or denial information on the claim even when using the T2024 and T2021 substitute codes.

Whenever clients have coverage in addition to Medi-Cal, providers must bill the primary insurance using the appropriate code that is accepted by that payer. DHCS is aware that Original Medicare and commercial insurance will not accept T2024 and T2021. Do not send T2024 or T2021 to Medicare or commercial insurance. All providers are expected to bill the primary payer using the appropriate CPT code that is accepted by that payer.

Once the primary payer approves or denies the appropriate CPT code, DHCS expects to see T2024 for prolonged assessment services and T2021 for prolonged therapy services.