A GUIDE TO
PROCEDURE CODES
FOR
CLAIMING MENTAL HEALTH SERVICES

County of Los Angeles – Department of Mental Health
Quality Assurance Division

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INTRODUCTION

This Guide, prepared by DMH, lists and defines the compliant codes that the DMH believes reflects the services it provides throughout its system, whether by directly-operated or contracted organizational providers or individual, group, or organizational network providers. This analysis does not, however, absolve Providers, whether individuals or agencies from their responsibility to be familiar with nationally compliant codes and to inform and dialogue with the DMH should they believe differences exist.

Brief History

Since the inception of the DMH's first computer system in 1982, DMH directly-operated and contract staff have reported services using Activity Codes. These Activity Codes were then translated into the types of mental health services for which DMH could be reimbursed through a variety of funding sources. On April 14, 2003, health care providers throughout the Country implemented the HIPAA Privacy rules. This brought many changes to the DMH's way of managing Protected Health Information (PHI), but did not impact the reporting/claiming codes. On October 16, 2003, all health care providers throughout the USA are required to implement the HIPAA Transaction and Codes Sets rules or be able to demonstrate good faith efforts to that end. These rules require that providers of health care services anywhere in the USA must use nationally recognized Procedure Codes to claim services.

HIPAA Objectives and Compliant Coding Systems

One of the objectives of HIPAA is to enable providers of health care throughout the country to be able to be conversant with each other about the services they were providing through the use of a single coding system that would include any service provided. In passing HIPAA, Legislators were also convinced that a single national coding system would simplify the claims work of insurers of health. Two nationally recognized coding systems were approved for use: the Current Procedural Terminology (CPT) codes and the Level II Health Care Procedure Coding System (HCPCS). The CPT codes are five digit numeric codes, such as 90804 and the HCPCS are a letter followed by four numbers, such as H2012.

Definitions found in this Guide are from the following resources: CPT code definitions come from the CPT Codes Manual; HCPCS codes are almost exclusively simply code titles absent definition so these definitions were established either exclusively or in combination from one of these sources – 1) Title 9 California Code of Regulations, Chapter 11, Specialty Mental Health Services, 2) State DMH Letters and Informational Notices, or 3)program definitions such as the Clubhouse Model. Reference citations follow all of the State code definitions.

Implications for Service Delivery

These changes are being made in conjunction with the much larger implementation of a new Management Information System known simply as the Integrated System (IS). In light of all these very extensive changes in the way the DMH reports and claims it's services, it is important to note that, while the DMH will continue to examine its service delivery system and implement creative programs as appropriate, the change from Activity Codes to Procedure Codes is NOT about a change in the services provided by the DMH nor the reimbursement rates for those services. In fact, DMH staff have been diligent in their efforts to ensure that all services that are currently provided have found a place in the new (to the DMH) HIPAA compliant coding system. This will ensure that revenues after October 16, 2003, the implementation date of the new HIPAA compliant Integrated System (IS), will continue to flow into the DMH unchanged from revenues prior to October 16, 2003.

HELPFUL HINTS FOR USING THE GUIDE

DMH directly-operated and contract staff should address **questions and issues** to their supervisors/managers, who may, as needed, contact their Services Area Procedure Codes Liaisons for clarifications. Network Providers should contact Provider Relations.

- Readers will quickly note that, except for those services funded entirely by CGF, there are no codes that identify payer information, such as PATH. Payer information will be maintained by providers in the administrative part of the new IS and when claims are being prepared, will match the service code on the clinical side of the IS with the payer information on the administrative side of the IS. Therefore, if claims are to go to the correct payer source, it is imperative that the Administrative side of the system be maintained.
- The codes have been categorized into types of services similar to those now in use in order to facilitate the transition to Level I (CPT) and Level II (HCPCS) codes.
- Medicare does not reimburse for travel and documentation time, so in order to appropriately claim to both Medicare and Medi-Cal total service time for the Rendering Provider must be broken out into face-to-face and other time for most services. Both of these times need to be entered into the IS and documented in the clinical record.
- While the basic structure of the tables is the same, many vary in their content because the requirements of different sets of codes are so different.
- The "Scope of Practice" column that used to define who could report the code is now headed "Rendering Provider". This is HIPAA language that the DMH is embracing, but the information in the column provides the same information regarding usage of the code. The categories of staff the DMH will continue to recognize are these: physician (MD or DO); licensed or waivered clinical psychologist (PhD or PsyD); licensed or registered Social Worker; licensed or registered MFT; registered nurse (RN); nurse practitioner (NP); clinical nurse specialist (CNS); psychiatric technician (PT); licensed vocational nurse (LVN); and mental health rehabilitation specialist (MHRS). See Page vi, Reporting and Documentation Notes, for documentation comments.
- The table heading on each page indicates whether the codes on that page may be used by Network and/or SD/MC Providers. Individual, Group, and Organizational Network Providers may only use lined or shaded Services and shaded codes and only the disciplines as noted under the Network header. SD/MC Organizational Providers may use shaded codes on pages 1-2, 7-9, and 27 & 28 AND any unshaded codes. The Table of Contents also indicates whether the codes on a page are applicable to Network, SD/MC, or both.

LIST OF ABBREVIATIONS

- **CGF** – County General Funds
- **CPT** – Current Procedural Terminology; codes established by the American Medical Association to uniquely identify services for reporting and claiming purposes.
- **Disciplines:**
  - **CNS** – Clinical Nurse Specialist
  - **DO** - Doctors of Osteopathy
  - **LCSW** – Licensed Clinical Social Worker
  - **MD** – Medical Doctor
  - **MFT** – Marriage & Family Therapist
  - **NP** – Nurse Practitioner
  - **PhD** – Doctor of Philosophy, clinical psychologist
  - **PsyD** – Doctor of Psychology, clinical psychologist
  - **PT** – Psychiatric Technician
  - **RN** – Registered Nurse
  - **LVN** – Licensed Vocational Nurse
  - **MHRS** – Mental Health Rehabilitation Specialist
- **DMH** – Los Angeles County Department of Mental Health or Department; also known as the Local Mental Health Plan (LMHP)
- **ECT** – Electroconvulsive Therapy
- **FFS** – Fee-For-Service
- **HCPCS** – Health Care Procedure Coding System
- **IMD** – Institutions for Mental Disease
- **IS** – Integrated Systems (formerly known as the MIS, Management Information System)
- **LMHP** – Local Mental Health Plan (in Los Angeles County, the Department of Mental Health)
- **PHI** – Protected Health Information
- **SD/MC** – Short-Doyle/Medi-Cal *(Terminology carried forward from pre-Medi-Cal Consolidation: Medi-Cal Organizational Providers who can be reimbursed for a full range of rehabilitation staff)*
- **SFC** – Service Function Code
- **STP** – Special Treatment Patch
- **TCM** – Targeted Case Management

REPORTING AND DOCUMENTATION NOTES

DMH directly-operated and contract staff should address **questions and issues** to their supervisors/managers, who may, as needed, contact their Service Area QA Liaison for clarifications. Network Providers should contact Provider Relations.

- **Telephone Service**: When using the Daily Service Log to report telephone services, the telephone box next to the Service Location Code must be checked. When telephone services are entered into the IS, the "telephone" box on the "Outpatient – Add Service" screen must be checked. This is the only way to ensure that telephone services are claimed to the appropriate payer. Face-to-Face time is always "0" for telephone contacts. Some procedure codes are not telephone allowable meaning they may not be used for telephone services (see "Face to Face time" below); only those procedure codes specifically identified as telephone allowable may be claimed as a telephone service. For Contract providers submitting electronic claims, the SC modifier must be placed on the procedure code for all telephone services.

- **Telepsychiatric Service:** When using the Daily Service Log to report telepsychiatric services, the telepsychiatric box next to the telephone box must be checked for all telepsychiatric services. When telepsychiatric services are entered in the IS, the "telepsychiatric" box on the "Outpatient – Add Service" screen must be checked. This is the only way to ensure that telepsychiatric services are appropriately claimed. For Contract providers submitting electronic claims, the GT modifier must be placed on the procedure code for all telepsychiatric services.

- **Combined Services**: In those instances where two or more significant and distinct services (e.g. assessment and collateral) or service types (e.g. MHS and TCM) are delivered within a single contact, each service must be documented in a separate progress note that meets all documentation requirements. It is not appropriate to combine multiple significant and distinct services under a single progress note that simply reflects the predominant service. Per the Organizational Providers Manual, plan development activities are an exception and may be combined into a single progress note with another service.

- **Penal facilities, including Juvenile Halls**: Services delivered in these facilities are not Medi-Cal reimbursable unless delivered to a youth who has been adjudicated for suitable placement and is awaiting placement.

- **More than one staff participating in a single direct service**: Anytime more than one staff participate in a service, each must be identified in the note indicating the time spent by each in providing the service, and the specific interventions performed by each. Except for group, the **Rendering provider** must indicate both face-to-face time and other time. Other participating staff need only report his/her total time.

REPORTING AND DOCUMENTATION NOTES (continued)

- **Claiming Payers**: Not all staff listed in the Rendering Provider column who can report the service may claim to all payer sources. The DMH will keep its employees informed, and, as appropriate, its contractors, regarding rules and regulations for service delivery and reimbursement.

- **Scope of Practice**: A Rendering Provider may only provide services within his/her job specification and scope of practice. Staff without credentials that meet a category's requirements may deliver rehabilitation services to the extent that they function within the job specification with commensurate training and skill development in accord with the services s/he may be rendering. The DMH will also continue to require that students and staff without two years mental health experience or a bachelor's degree in a mental health related field must have all documentation co-signed until these minimum requirements have been met and his/her supervisor believes him/her to be competent to document services independently. **Please note that co-signature does NOT allow any level staff to provide services that are outside his/her scope of practice and job specification.** Staff at all levels must have appropriate supervision.

- **Face-to-Face time**: Note that for SD/MC Providers, only the psychotherapy codes on pages 3 and 4 indicate Face-to-Face time. This is because, for the same service, different codes are available and must be selected based on the Face-to-Face time. The absence of Face-to-Face times for other codes only means that time is not a determinant in selecting the code; it does not mean that the code has no Face-to-Face time requirement. Assessment, Psychological Testing, and Individual Medication all require Face-to-Face time that must be both documented in the clinical record and entered into the IS. No other Mental Health, Medication Support, or Targeted Case Management Services require Face-to-Face time, but if it occurs, it should be both noted in the clinical record and entered into the IS. All groups, except Collateral Group, require Face-to-Face time, but that time does not need to be documented in the clinical record or entered into the IS separate from the total time of the contact. Collateral, Team Conference/Case Consultations and No-Contact – Report Writing should always be reported with "0" Face-to-Face time.

ASSESSMENT – SD/MC & NETWORK PROVIDERS (MODE 15)

Assessment services are a required component of Day Treatment Intensive and Day Rehabilitation. These services will not be separately authorized for clients in one of these programs.

This is an activity that may include a clinical analysis of the history and current status of a client's mental, emotional, or behavioral disorder; relevant cultural issues and history; and diagnosis (§1810.204). These codes should be used when completing an Initial Assessment form or when performing subsequent assessment activities that are documented on an assessment form..

Service	Code	Network MC Rendering Provider	Cost Report SFC	SD/MC Rendering Provider
Psychiatric diagnostic interview	90801	MD/DO PhD/PsyD LCSW MFT NP/CNS	**42**	Licensed, registered, waivered: MD/DO PhD/PsyD LCSW MFT NP/CNS RN and student professionals in these disciplines with co-signature
Interactive psychiatric diagnostic interview using play equipment, physical devices, or other non- verbal mechanism of communication	90802			

Notes:

- These services are recorded in the clinical record and reported into the IS in hours/minutes.
- When working with children or other clients with limited verbal ability, claim in accord with the predominant intervention modality – 90802 for non-verbal, 90801 for verbal.
- Not all staff listed who can report the service may claim to all payer sources. The Department will keep its employees informed, and, as appropriate, its agencies, regarding rules and regulations for service delivery and reimbursement.

PSYCHOLOGICAL TESTING – SD/MC & NETWORK PSYCHOLOGISTS & PHYSICIANS (MODE 15)

All psychological testing performed by Network Providers and claimed to Medi-Cal must have prior authorization.

Service (effective 1/1/06)		New Codes 1/1/06	Network MC Rendering Provider	Cost Report SFC	SD/MC Rendering Provider
Psychological Testing Scoring time is not reimbursable. Psychodiagnostic assessment of personality, development assessment and cognitive functioning. For children, referrals are made to clarify symptomology, rule out diagnoses and help delineate emotional from learning disabilities.	**Face-to-face administration time by Psychologist or Physician**	96101	Licensed PhD/PsyD Trained MD/DO	**34**	Licensed PhD/PsyD Trained MD/DO
	Face-to-face administration time by Technician	96102	NA		Waivered PhD/PsyD, & student professionals in these disciplines with co-signature
	Administered by Computer	96103	NA		Licensed, waivered PhD/PsyD, & trained MD/DO & student professionals in these disciplines with co-signature
Psychological Test Interpretation and Report Writing		90889	Licensed PhD/PsyD Trained MD/DO	**42**	Licensed PhD/PsyD Trained MD/DO
Computer Scoring		90889	Licensed PhD/PsyD Trained MD/DO	Not Applicable	

Notes:

- Testing is recorded in the clinical record and reported into the IS in hours:minutes.
- Providers must document and submit a claim for the administration of tests on the day of the administration indicating which tests were administered. On the day interpretation and report writing is performed a separate claim must be submitted; documentation for the claim can simply reference the report.
- Not all staff listed who can report the service may claim to all payer sources. The Department will keep its employees informed, and, as appropriate, its agencies, regarding rules and regulations for service delivery and reimbursement.

INDIVIDUAL PSYCHOTHERAPY (NON-FAMILY) – SD/MC & NETWORK PROVIDERS (MODE 15)

Individual Psychotherapy services that a provider wishes to deliver in conjunction with Day Treatment Intensive or Day Rehabilitation must have authorization from the Department's Central Authorization Unit prior to delivery.

	Short-Doyle/Medi-Cal (SD/MC)			Network Medi-Cal		
Service	**Duration of Face-to-Face**	**Code**	**Rendering Provider**	**Duration of Face-to-Face**	**Code**	**Rendering Provider**
Insight oriented, behavior modifying, and/or supportive psychotherapy delivered to one client.	0-19 minutes	H0046** (former code H2015)	MD/DO: Licensed PhD/PsyD: Licensed or Waivered LCSW & MFT: Licensed or registered or waivered NP or CNS: Certified RN: Masters in Psychiatric Mental Health Nursing & listed as a psychiatric-mental health nurse with the BRN and student professionals in these disciplines with co-signature	**Ind, Gp, & Org** 1-19 minutes	Not Reimbursed	MD/DO: Licensed PhD/PsyD: Licensed LCSW & MFT: Licensed NP or CNS: Certified RN: Masters level within Scope of Practice
	20-44 minutes	90804		**Ind, Gp, & Org** 20-39 minutes	90804	
	45-74 minutes	90806		**Indiv & Group** 40-74 minutes **Org** 40-50 minutes	90806	
	75+ minutes	90808		**Indiv & Group** 75+ minutes **Org**: NA	**Indiv & Group** 90808 **Org**: Not Reim	
Interactive psychotherapy using play equipment, physical devices, or other mechanisms of non-verbal communication delivered to one client.	0-19 minutes	H0046** (former code H2015)		**Ind, Gp, & Org** 1-19 minutes	Not Reimbursed	
	20-44 minutes	90810		**Ind, Gp, & Org** 20-39 minutes	90810	
	45-74 minutes	90812		**Indiv & Group** 40-74 minutes **Org** 40-50 minutes	90812	
	75+ minutes	90814		**Indiv & Group** 75+ minutes **Org**: NA	**Indiv & Group** 90814 **Org**: Not Reim	

** Telephone allowable: Contract providers submitting electronic claims must attach the SC modifier when service is via telephone.

Notes:

- All of these services are classified as Individual Mental Health Services and are reported under Service Function 42.
- These services are recorded in the clinical record and reported into the IS in hours:minutes.
- Not all staff listed who can report the service may claim to all payer sources. The Department will keep its employees informed, and, as appropriate, its agencies, regarding rules and regulations for service delivery and reimbursement.
- When doing telephone therapy, face to face time is always zero and the code used is H0046.

Documentation Notes:

- Clinical interventions must be included in the progress note and must be consistent with the client's goals/desired results identified in the Service Plan.
- The service focuses primarily on symptom reductions as a means of improving functional impairments.

INDIVIDUAL PSYCHOTHERAPY (NON-FAMILY) WITH EVALUATION AND MANAGEMENT SD/MC & NETWORK PHYSICIANS AND NURSE PRACTITIONERS (MODE 15)

Individual Psychotherapy services that a provider wishes to deliver in conjunction with Day Treatment Intensive or Day Rehabilitation must have authorization from the Department's Central Authorization Unit prior to delivery.

This service should be used by Physicians and Nurse Practitioners when providing medication prescription services in association with more than minimal therapy.

	Short-Doyle/Medi-Cal (SD/MC)			Network Medi-Cal		
Service	**Duration of Face-to-Face**	**Code**	**Rendering Provider**	**Duration of Face-to-Face**	**Code**	**Rendering Provider**
Insight oriented, behavior modifying, and/or supportive psychotherapy delivered to one client **WITH** evaluation and management.	0-19 minutes	H0046** (former code H2015)	MD/DO: Licensed NP: Certified and student professionals in these disciplines with co-signature	**Ind, Gp, & Org** 1-19 minutes	Not Reimbursed	MD/DO: Licensed NP: Certified
	20-44 minutes	90805		**Ind, Gp, & Org** 20-39 minutes	90805	
	45-74 minutes	90807		**Indiv & Group** 40-74 minutes **Org** 40-50 minutes	90807	
	75+ minutes	90809		**Indiv & Group** 75+ minutes **Org**: NA	**Indiv & Group** 90809 **Org**: Not Reim	
Interactive psychotherapy using play equipment, physical devices, or other mechanisms of non-verbal communication delivered to one client **WITH** evaluation and management,	0-19 minutes	H0046** (former code H2015)		**Ind, Gp, & Org** 1-19 minutes	Not Reimbursed	
	20-44 minutes	90811		**Ind, Gp, & Org** 20-39 minutes	90811	
	45-74 minutes	90813		**Indiv & Group** 40-74 minutes **Org** 40-50 minutes	90813	
	75+ minutes	90815		**Indiv & Group** 75+ minutes **Org**: NA	**Indiv & Group** 90815 **Org**: Not Reim	

** Telephone allowable: Contract providers submitting electronic claims must attach the SC modifier when service is via telephone.

Notes:

- All of these services are classified as Individual Mental Health Services and are reported under Service Function 42.
- These services are recorded in the clinical record and reported into the IS in hours:minutes.

INDIVIDUAL REHABILITATION (NON-FAMILY) – SD/MC ONLY (MODE 15)

Individual Rehabilitation services that a provider wishes to deliver in conjunction with Day Treatment Intensive or Day Rehabilitation must have authorization from the Department's Central Authorization Unit prior to delivery.

Service	Code	Cost Report SFC	Rendering Provider
Individual Rehabilitation Service Service delivered to one client to provide assistance in improving, maintaining, or restoring the client's functional, daily living, social and leisure, grooming and personal hygiene, or meal preparation skills, or his/her support resources. §1810.243 "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.	H2015**	**42**	Any staff operating within his/her scope of practice.
On-going support to maintain employment (This service requires the client be currently employed, paid or unpaid; school is not considered employment.)	H2025**		

** Telephone allowable: Contract providers submitting electronic claims must attach the SC modifier when service is via telephone.

Notes:

- These services are recorded in the clinical record and reported into the IS as hours:minutes.
- A collateral/significant support person is, in the opinion of the client or the staff providing the service, a person who has or could have a significant role in the successful outcome of treatment, including, but not limited to, parent, spouse, or other relative, legal guardian or representative, or anyone living in the same household as the client. Agency staff, including Board & Care operators are not collaterals.

SERVICES TO SPECIAL POPULATIONS – SD/MC ONLY (MODE 15)

Service	Code	Rendering Provider
Multi-Systemic Therapy **(inactive)**	H2033	Any staff operating within his/her scope of practice
Community-based Wrap Around **(inactive)**	H2021	
MAT - Case Conference Attendance MAT Team Meeting time that cannot be claimed to Medi-Cal	G9007**	
Wraparound – Team Plan Development Discussion with the client and/or family focused on plan development which includes development of client plans and services and/or monitoring a client's progress during Wraparound Child and Family Team (CFT) meetings.	H0032**	

** Telephone allowable: Contract providers submitting electronic claims must attach the SC modifier when service is via telephone.

Notes:

- All of these services are classified as Individual Mental Health Services and are reported under Service Function 42.
- These services are recorded in the clinical record and reported into the IS in hours:minutes.

Service	Code, (Modifier*)	Rendering Provider
Therapeutic Behavior Services	H2019** (HE*)	Any staff operating within his/her scope of practice

*Contract providers submitting electronic claims to the Department must attach the letter modifiers in the claims transmission.
** Telephone allowable: Contract providers submitting electronic claims must attach the SC modifier when service is via telephone.

Notes:

- This service is classified as Therapeutic Behavior Services and is reported under Service Function 58.
- These services are recorded in the clinical record and reported into the IS in hours:minutes.

FAMILY AND GROUP SERVICES (except Med Support Group) – SD/MC & NETWORK MC PROVIDERS (MODE 15)

Family and group services that a provider wishes to deliver in conjunction with Day Treatment Intensive or Day Rehabilitation must have authorization from the Department's Central Authorization Unit prior to delivery.

Service	Code (Modifiers*)	Network MC Rendering Provider	Cost Report SFC	SD/MC Rendering Provider
Family Psychotherapy with One Client Present Psychotherapy delivered to a family with the intent of improving or maintaining the mental health status of the client. Only one claim will be submitted. **Note:** Family Psychotherapy without the Client Present (90846) is not a reimbursable service through the LAC LMHP – Psychotherapy can only be delivered to an enrolled client. Services to collaterals of clients that fall within the "Collateral" service definition below may be claimed to 90887.	90847	MD/DO: Licensed PhD/PsyD: Licensed LCSW & MFT: Licensed NP or CNS: Certified RN: Masters level within Scope of Practice	**42**	MD/DO: Licensed PhD/PsyD: Licensed or waivered LCSW & MFT: Licensed or registered or waivered NP or CNS: Certified RN: Masters in Psychiatric Mental Health Nursing & listed as a psychiatric-mental health nurse with the BRN and student professionals in these disciplines with co-signature
Family Psychotherapy with More than One Client Present Psychotherapy delivered to a family with the intent of improving or maintaining the mental health status of the client. One claim will be submitted for each client present or represented. **Note:** Family Psychotherapy without the Client Present (90846) is not a reimbursable service through the LAC LMHP – Psychotherapy can only be delivered to an enrolled client. Services to collaterals of clients that fall within the "Collateral" service definition below may be claimed to 90887.	90847 (HE, HQ*)		**52**	
Collateral (one or more clients represented) 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 client.	90887**	MD/DO PhD/PsyD LCSW MFT NP/CNS RN	**10**	Any staff operating within his/her scope of practice.

*Contract providers submitting electronic claims to the Department must attach the letter modifiers in the claims transmission.
** Telephone allowable: Contract providers submitting electronic claims must attach the SC modifier when service is via telephone.

See bottom of next page for Family and Group Notes.

(Continued)

FAMILY AND GROUP SERVICES (except Med Support Group) – SD/MC & NETWORK PROVIDERS (MODE 15)

Family and group services that a provider wishes to deliver in conjunction with Day Treatment Intensive or Day Rehabilitation must have authorization from the Department's Central Authorization Unit prior to delivery.

Service	Code (Modifiers*)	Network MC Rendering Provider	Cost Report SFC	SD/MC Rendering Provider
Multi-family Group Psychotherapy Psychotherapy delivered to more than one family unit each with at least one enrolled client. Generally clients are in attendance.	90849	MD/DO: Licensed PhD/PsyD: Licensed LCSW & MFT: Licensed NP or CNS: Certified RN: Masters level within Scope of Practice	**52**	MD/DO: Licensed PhD/PsyD: Licensed or waivered LCSW & MFT: Licensed or registered or waivered NP or CNS: Certified RN: Masters in Psychiatric Mental Health Nursing & listed as a psychiatric-mental health nurse with the BRN and student professionals in these disciplines with co-signature
Group Psychotherapy Insight oriented, behavior modifying, supportive services delivered at the same time to more than one non-family client.	90853			
Interactive Group Psychotherapy Interactive service using non-verbal communication techniques delivered at the same time to more than one non-family client.	90857			
Group Rehabilitation (family and non-family) Service delivered to more than one client at the same time to provide assistance in improving, maintaining, or restoring his/her support resources or his/her functional skills - daily living, social and leisure, grooming and personal hygiene, or meal preparation. §1810.243	H2015 (HE, HQ*)	Not Applicable		Any staff operating within his/her scope of practice.

*Contract providers submitting electronic claims to the Dept must attach the letter modifiers in the claims transmission.

**Maximum reimbursement for Family Therapy or Collateral for Network Organizational Providers is 90 minutes. Maximum reimbursement for any Group for Network Individual & Group Providers is $15/client for MD/OD and $14/per client for all other staff.

Notes:

- These services are recorded in the clinical record and reported into the IS as hours:minutes.
- Not all staff listed who can report the service may claim to all payer sources. The Department will keep its employees informed, and, as appropriate, its agencies, regarding rules and regulations for service delivery and reimbursement.

MEDICATION SUPPORT – SD/MC & NETWORK PHYSICIANS & NURSE PRACTITIONERS (MODE 15)

	Short-Doyle/Medi-Cal (SD/MC)		Network Medi-Cal	
Service	**Code (Modifier*)**	**Rendering Provider**	**Code (Modifier*)**	**Rendering Provider**
Individual Medication Service (Face-to-Face) This service requires expanded problem-focused or detailed history and medical decision-making of low to moderate complexity for prescribing, adjusting, or monitoring meds. **Note:** If more than minimal, supportive psychotherapy is provided, the service must be claimed as an E&M Individual Psychotherapy service (see pg 4).	90862	MD/DO & NP	90862 **Indiv & Group** 15+ minutes **Organizational** 15-50 minutes	MD/DO & NP
Brief Medication Visit (Face-to-Face) This service typically requires only a brief or problem-focused history including evaluation of safety & effectiveness with straightforward decision-making regarding renewal or simple dosage adjustments. The client is usually stable.	M0064		M0064 **I&G**: 7+ min **Org**: 7-50 min	
Intramuscular Injections Used for administering intramuscular injections as ordered by an MD, DO or NP.	96372	MD/DO, NP/CNS, RN, LVN, PT, Pharmacist***, & student professionals in these disciplines with co-signature	N/A	N/A
Oral Medication Administration Used for single or multiple administration at one time of oral medications as ordered by an MD, DO or NP.	H0033		N/A	N/A
Comprehensive Medication Service Prescription services by phone or with collateral, medication education, medication group services, and other non- prescription, non-face-to-face activities pertinent to medication	H2010** (HE*)		N/A	N/A

*Contract providers submitting electronic claims to the Department must attach the letter modifiers in the claims transmission.
** Telephone allowable: Contract providers submitting electronic claims must attach the SC modifier when service is via telephone.
***Per the Pharmacist laws and regulations, an agency must have policies and procedures in place in order for a pharmacist to administer injections.

Notes:

- These services are recorded in the clinical record and reported into the IS in hours:minutes.
- Not all staff listed who can report the service may claim to all payer sources. The Department will keep its employees informed, and, as appropriate, its agencies, regarding rules and regulations for service delivery and reimbursement.
- When a physician and a nurse provide Medication Support Services to a client, the time of both staff should be claimed. If both staff are providing the same service, one note is written covering both staff and one claim is submitted that includes the time of both staff. If the two staff provide different services during the contact, two notes should be written with each staff submitting his/her own claim. If a staff person ineligible to claim Medication Support participates in the contact, then each staff present must write a separate note documenting service time with the non-eligible staff claiming as either TCM or Individual or Group in accord with the service provided.
- In the unusual circumstance in which medication support plan development occurs when neither the client nor a significant other is present, the service may be claimed as a Comprehensive Medication Service.
- **Medi-Cal Lockout:** Medication Support Services are reimbursable up to a maximum of 4 hours a day per client.
- All Medication Support Services are claimed as Service Function Code 62 and are thus all reimbursed at a Legal Entity's Medication Support Service rate.

OTHER SERVICES – SD/MC & NETWORK PROVIDERS (MODE 15)

	Short-Doyle/Medi-Cal (SD/MC)		Network Medi-Cal Organizational Providers ONLY	
Service	**Code**	**Rendering Provider**	**Code**	**Rendering Provider**
Behavioral Health Screening – Triage Service to determine eligibility for admission to a treatment program	H0002**	Any staff operating within his/her scope of practice.	**Not Reimbursed**	MD/DO or RN: Licensed PhD/PsyD: Licensed LCSW & MFT: Licensed NP or CNS: Certified
Review of Records Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for: • Assessment and/or diagnostic purposes • Continuity of care when receiving a transferred or new client • Plan Development (development of client plans and services and/or monitoring a client's progress) when not in the context of another service	90885		**Not Reimbursed**	
Targeted Case Management (TCM) Services needed to access medical, educational, social, prevocational, vocational, rehabilitative, or other community services. These services, whether face-to-face, by telephone, or through correspondence, provide for the continuity of care within the mental health system and related social service systems. Services include linkage and consultation, placement, and plan development in the context of targeted case management services.	T1017** (HE, HS*)		**T1017** (HE, HS*)	
No contact – Report Writing Preparation of reports of client's psychiatric status, history, treatment, or progress for other physicians, agencies, insurance carriers, or for clinical discharge summaries when not part of another service	90889		**Not Reimbursed**	

*Contract providers submitting electronic claims to the Department must attach the letter modifiers in the claims transmission.
** Telephone allowable: Contract providers submitting electronic claims must attach the SC modifier when service is via telephone.

Notes:

- All of these services, except TCM, are classified as Individual Mental Health Services and are reported under Service Function 42.
- TCM services are classified as Targeted Case Management Services and are reported under Service Function 04.
- These services are recorded in the clinical record and reported into the IS in hours:minutes.
- **TCM Medi-Cal Lockout:** Except for the day of admission or for placement services provided during the 30 calendar days immediately prior to the day of discharge for a maximum of three nonconsecutive periods of 30 days, TCM may not be reimbursed by Medi-Cal on the same day as any of the following services are claimed – psychiatric inpatient hospital services, Psychiatric Health Facility services, or Psychiatric Nursing Facility services. (These facilities include Institutions for Mental Disease - IMDs.)

PLAN DEVELOPMENT – SD/MC & NETWORK PROVIDERS (MODE 15)

	Short-Doyle/Medi-Cal (SD/MC)		Network Medi-Cal	
Service	**Code**	**Rendering Provider**	**Code**	**Rendering Provider**
Plan Development A stand-alone service that includes developing Client Care Plans, approval of Client Care Plans and/or monitoring of a client's progress. Plan development may be done as part of a interdisciplinary inter/intra-agency conference and/or consultation in order to develop and/or monitor the client's mental health treatment. Plan development may also be done as part of a contact with the client in order to develop and/or monitor the client's mental health treatment.	H0032**	Any staff operating within his/her scope of practice.	H0032	MD/DO or RN: Licensed PhD/PsyD: Licensed LCSW & MFT: Licensed NP or CNS: Certified

*Contract providers submitting electronic claims to the Department must attach the letter modifiers in the claims transmission.
** Telephone allowable: Contract providers submitting electronic claims must attach the SC modifier when service is via telephone.

Notes:

- This service is classified as an Individual Mental Health Service and is reported under Service Function 42.
- This service is recorded in the clinical record and reported into the IS in hours:minutes.
- For Team Conferences: Claimable time should only include the actual time a staff person participated in the conference and any other time a staff person actually spent related to the conference, such as travel or documentation. Participation includes time when information was shared that can be used in planning for client care or services to the client.

CRISIS INTERVENTION (MODE 15) AND CRISIS STABILIZATION (MODE 10) – SD/MC ONLY

Service	Code (Modifiers*) Place of Service (POS)	Cost Report Mode/SFC	Rendering Provider
Crisis Intervention A service lasting less than 24 hours which requires more timely response than a regularly scheduled visit and is delivered at a site other than a Crisis Stabilization program. (§1810.209)	H2011** (HE*)	Mode 15 SFC **77**	Any staff operating within his/her scope of practice.
Crisis Stabilization – Emergency Room A package program lasting less than 24 hours delivered to clients which requires more timely response than a regularly scheduled visit and is provided on-site at one of the facilities indicated in the "Notes" below. (§1810.210)	S9484 (HE, TG*) POS - 23	Mode 10 SFC **24**	Bundled service not claimed by individual staff. Specific staffing requirements are in §1840.348
Crisis Stabilization – Urgent Care Facility A package program lasting less than 24 hours delivered to clients which requires more timely response than a regularly scheduled visit and is provided on-site at one of the facilities indicated in the "Notes" below. (§1810.210)	S9484 (HE, TG*) POS - 20	Mode 10 SFC **25**	Bundled service not claimed by individual staff. Specific staffing requirements are in §1840.348

*Contract providers submitting electronic claims to the Department must attach the letter modifiers in the claims transmission.
** Telephone allowable: Contract providers submitting electronic claims must attach the SC modifier when service is via telephone.

Notes:

- **Crisis Intervention activities:** may include but are not limited to assessment, therapy, and collateral. (§1810.209)
- **Crisis Intervention services** are recorded in the clinical record and reported into the IS as hours:minutes.
- **Medi-Cal Crisis Intervention Lockouts** (§1840.366)**:**
  - This service is not reimbursable on days when Crisis Residential Treatment Services, psychiatric inpatient hospital services, Psychiatric Health Facility services, or Psychiatric Nursing Facility services are reimbursed, except for the day of admission to these services.
  - The maximum number of hours claimable for this service is 8 within a 24-hour period.
- **Crisis Stabilization activities:** must include a physical and mental health assessment and may additionally include, but is not limited to, therapy and collateral. (§1810.210 & §1840.338)
- **Crisis Stabilization services** are recorded in the clinical record and reported into the IS in hours.
- **Medi-Cal Crisis Stabilization Lockouts** (§1840.368)**:**
  - This service is not reimbursable on days when psychiatric inpatient hospital services, Psychiatric Health Facility services, or Psychiatric Nursing Facility services are reimbursed, except for the day of admission to these services.
  - No other specialty mental health services except Targeted Case Management are reimbursable during the same time period this service is claimed.
  - The maximum number of hours claimable for this service is 20 within a 24-hour period.

DAY REHABILITATION AND DAY TREATMENT INTENSIVE – SD/MC ONLY (MODE 10)

All of these services must be authorized by the Department prior to delivery and claiming.
The requirement for prior authorization also extends to outpatient mental health services planned for delivery on the same day the client is in one of these day programs.

Service	Program Duration	Code (Modifiers*)	Cost Report SFC	Rendering Provider
Day Rehabilitation A structured program of rehabilitation and therapy provided to a distinct group of beneficiaries in a therapeutic milieu to improve, maintain, or restore personal independence and functioning, consistent with requirements for learning and development. (§1810.212)	**Half Day:** exceeds 3 continuous hrs but less than 4/day	H2012 (HQ*)	**92**	Bundled service not claimed by individual staff. Any staff operating within his/her scope of practice may provide services. One of these disciplines must be included in the staffing: MD/DO, RN, PhD/PsyD, LCSW, MFT.
	Full Day: exceeds 4 continuous hrs/day	H2012 (HE*)	**98**	
Day Treatment Intensive A structured, multi-disciplinary program of therapy provided to a distinct group of clients in a therapeutic milieu that may: be an alternative to hospitalization, avoid placement in a more restrictive setting, or maintain the beneficiary in a community setting. (§1810.213)	**Half Day:** exceeds 3 continuous hrs but less than 4/day	H2012 (HQ TG*)	**82**	
	Full Day: exceeds 4 continuous hrs/day	H2012 (HE, TG*)	**85**	

*Contract providers submitting electronic claims to the Department must attach the letter modifiers in the claims transmission.

Notes:

- These services are recorded in the clinical record and reported into the IS as either full day or half day.
- **Service activities** for any of the programs must minimally include: assessment, plan development, crisis intervention, therapy including process groups, rehabilitation including skill-building groups, and adjunctive therapies. Intensive programs must include psychotherapy. Collateral contacts, travel, and documentation are a part of all day programs, but may occur outside the continuous hours of the program.
- **Medication services** are not included and must be claimed separately.
- For children, these services may focus on social and functional skills necessary for appropriate development and social integration. It may not be integrated with an educational program. Contact with families of these clients is expected.
- **Clients are expected to be in attendance** all the scheduled hours of the program, but a service may be claimed in unusual situations if the client has been in attendance at least 50% of the hours of operation of the program.
- Staff to client ratio for Day Treatment Intensive is 1:8 and for Day Rehabilitation is 1:10. When more than 12 clients are in the program, there must be staff from at least 2 of these disciplines: MD/DO, RN, PhD/PsyD, LCSW, MFT, LPT, Mental Health Rehabilitation Specialist (MHRS).

SOCIALIZATION SERVICES – SD/MC ONLY (MODE 10)

These services are neither Medicare nor SD/MC reimbursable.

Service	Code, (Modifier*)	Cost Report Mode/SFC	Rendering Provider
Socialization Day Services This service is a bundled activity service designed for clients who require structured support and the opportunity to develop the skills necessary to move toward more independent functioning. The activities focus on recreational and/or socialization objectives and life enrichment. The activities include but are not limited to outings, recreational activities, cultural events, linkages to community social resources, and other social supportive maintenance efforts. Services may be provided to clients with a mental disorder who might otherwise lose contact with social or treatment systems.	H2030 (HX*)	Mode 10 SFC **41**	Bundled service not claimed by individual staff. Any staff operating within his/her scope of practice may provide services.
Clubhouse (inactive) A particular type of Comprehensive Community Support program.	H2030		

*Contract providers submitting electronic claims to the Department must attach the letter modifiers in the claims transmission.

VOCATIONAL SERVICES – SD/MC ONLY (MODE 10)

These services are neither Medicare nor SD/MC reimbursable.

Service	Code	Cost Report Mode/SFC	Rendering Provider
Vocational Day Services (Skill Training and Development) This bundled service is designed to encourage and facilitate individual motivation and focus upon realistic and attainable vocational goals. To the extent possible, the intent of these services is to maximize individual client involvement in skill seeking enhancement with an ultimate goal of self-support. These vocational services shall be bundled into a milieu program for chronically and persistently mentally ill clients who are unable to participate in competitive employment. These programs include, but are not limited to vocational evaluation, pre-vocational, vocational, work training, sheltered workshop, and job placement. The program stresses development of sound work habits, skills, and social functioning for marginally productive persons who ultimately may be placed in work situations ranging from sheltered work environments to part or full-time competitive employment.	H2014	Mode 10 SFC **31**	Bundled service not claimed by individual staff. Any staff operating within his/her scope of practice may provide services.

Notes:

- These services are recorded in the clinical record and reported into the IS in units of 4 hour blocks of time.

COMMUNITY OUTREACH SERVICES (MODE 45) AND CASE MANAGEMENT SUPPORT (MODE 60) - SD/MC ONLY

These non-client services are neither Medicare nor SD/MC reimbursable.
Services should NOT be claimed in these activities for any client who has an open episode within a Provider number with the exception of peer services.

Service	Code	SFC	Rendering Provider
Community Outreach Service - Mental Health Promotion Services delivered in the community-at-large to special population groups, human service agencies, and to individuals and families who are not clients of the mental health system. Services shall be directed toward: 1) enhancing and/or expanding agencies' or organizations' knowledge and skills in the mental health field for the benefit of the community-at-large or special population groups, and 2) providing education and/or consultation to individuals and communities regarding mental health service programs in order to prevent the onset of mental health problems.	200**	**10**	Any staff operating within his/her scope of practice.
Community Outreach Service - Community Client Services Services delivered in the community-at-large to special population groups, human service agencies, and to individuals and families who are not clients of the mental health system. Services shall be directed toward: 1) assisting individuals and families for whom no case record can be opened to achieve a more adaptive level of functioning through a single contact or occasional contacts, such as suicide prevention or other hotlines, and 2) enhancing or expanding the knowledge and skills of human services agency staff in meeting the needs of mental health clients.	231**	**20**	
Case Management Support System-oriented services that supplement direct case management services such as: developing the coordination of systems and communications concerning the implementation of a continuum of care, establishing systems of monitoring and evaluating the case management system, and facilitating the development and utilization of appropriate community resources.	6000**	60	

** Services may be provided via telephone. Because services are not claimed electronically, no modifier is required.

Notes:

- These services are recorded in the clinical record and reported into the IS in units of 15 minute increments.

OUTPATIENT HOME MEDICAL SERVICES FOR MEDICARE BILLING ONLY (MODE 15)

(DMH GENESIS physician only)

Service	Components	Severity of Presenting Problem(s)	Duration of Face-to-Face with Client and/or Family and Code		Rendering Provider
			New Client	EstabClient	
Evaluation and management of a client that includes at least the three components noted in the next column. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	• problem focused history • problem focused examination • straightforward medical decision making	Low	20-29 minutes 99341	15-24 minutes 99347	DMH GENESIS MD only
	• expanded problem focused history . expanded problem focused exam • Medical decision making of low complexity	Moderate	30-44 minutes 99342	25-39 minutes 99348	
	• detailed history • detailed examination • medical decision making of moderate complexity	Moderate to high	45-59 minutes 99343	40-59 minutes 99349	
	• comprehensive history • comprehensive examination medical decision making of moderate complexity	High	60-74 minutes 99344	60+ minutes 99350	
	• comprehensive history • comprehensive examination • medical decision making of high complexity	Patient usually unstable	75+ minutes 99345		

Notes:

- These services are recorded in the clinical record and reported into the IS in hours:minutes.

RESIDENTIAL & OTHER SUPPORTED LIVING SERVICES – SD/MC ONLY (MODE 05)

Service	Code (Modifiers*)	Facility Type	Cost Report Mode 05	Medi-Cal Mode	Rendering Provider
			SFC		
Psychiatric Health Facility	H2013	11	**20**	05	Per diem service not claimed by individual staff
Crisis Residential	H0018	86	**43** 44	05	
Transitional Residential – Non-Medi-Cal	H0019 (HC*)	86	**60** 61 64	05	
Transitional Residential – Transitional	H0019	86	**65** 67	05	
Transitional Residential – Long Term	H0019 (HE*)	86	**70** 71	05	
Residential Pass Day	0183 (HB*)	86	**62**	NA	
Semi-Supervised Living	H0019 (HX*)	86	**80** 81 85 86	NA	
Life Support/Interim Funding	0134	86	**40**	NA	

*Contract providers submitting electronic claims to the Department must attach the letter modifiers in the claims transmission.

Notes:

- These services are recorded in the clinical record and reported into the IS as days.

STATE HOSPITAL, IMD, & MH REHABILITATION CENTER SERVICES – SD/MC ONLY (MODE 05)

Service		Code (Modifiers*)	Facility Type	Cost Report Mode 05 SFC	Medi-Cal Mode	Rendering Provider
State Hospital Facility		0100	89	**01**	NA	Per diem service not claimed by individual staff
Skilled Nursing Facility – Acute Intensive		0100 (HB*)	21	**30**	NA	
Institutions for Mental Disease (IMD) **WITHOUT** Special Treatment Patch (STP)	under 60 beds (Laurel Park. Provider #0058)	0100 (HE*)	89	**35**	NA	
	60 beds & over (Olive Vista, Provider #0061)	0100 (HE, GZ*)		**35**		
	Indigent	0100 (HX*)		**36**		
Institutions for Mental Disease (IMD) **WITH** Special Treatment Patch (STP)	Subacute, Forensic History (Olive Vista, Provider #0061),	0100 (HE, TG*)	89	**36**	NA	
	Non-MIO/Hearing Impaired (Sierra Vista, Provider #0066)	0100 (HK*)		**36**		
	MIO (Olive Vista, Provider #0061),	0100 (HB, HZ*)		**37**		
	Indigent MIO (Olive Vista, Provider #0061),	0100 (TG*)		**38**		
	Subacute, Forensic History, Indigent Olive Vista, Provider #0061),	0100 (HB, TG*)		**39**		
IMD Pass Day		0183	89	**39**	NA	
MH Rehabilitation Center		0100 (GZ*)	86	**90**	NA	

*Contract providers submitting electronic claims to the Department must attach the letter modifiers in the claims transmission.

Notes:

- These services are recorded in the clinical record and reported into the IS as days.

ACUTE INPATIENT FACILITY SERVICES (MODE 05)

Service	Code, (Modifiers*)	Facility Type	Cost Report Mode 05 SFC	SD/MC Mode	Rendering Provider
Acute Days					
Acute General Hospital	0100 (AT, HT*)	11	**10**	07	Per diem service not claimed by individual staff
Acute General Hospital – PDP	0100 (AT*)	11	**10**	NA	
Acute General Hospital - CGF	0100 (AT, HX*)	11	**10**	NA	
Local Psychiatric Hospital, age 21 or under	0100 (HA*)	11	**14**	08	
Local Psychiatric Hospital, age 22-64	0100 (HB*)	11	**15**	NA	
Local Psychiatric Hospital, age 65 or over	0100 (HC*)	11	**15**	09	
Local Psychiatric Hospital, Adult Forensic	0100 (HX)	11	**12**	NA	
Local Psychiatric Hospital, PDP	0100 (SC*)	11	**15**	NA	
Forensic Inpatient Unit	0100 (HZ*)	89	**50**	NA	
Administrative Days					
Acute General Hospital	0101 (HE*)	11	**19**	07	Per diem service not claimed by individual staff
Local Psychiatric Hospital, age 21 or under	0101 (HA*)	11		08	
Local Psychiatric Hospital, age 22-64	0101 (HB*)	11		NA	
Local Psychiatric Hospital, age 65 or over	0101 (HC*)	11		09	
Psych Hospital, PDP	0101	11		NA	
Acute Hospital, PDP	0101 (HX*)	11		NA	

*Contract providers submitting electronic claims to the Department must attach the letter modifiers in the claims transmission.

Notes:

- These services are recorded in the clinical record and reported into the IS as days.

ELECTROCONVULSIVE THERAPY (ECT) (MODE 15)
NETWORK INDIVIDUAL & GROUP PHYSICIANS ONLY

This service may only be delivered in an Outpatient Hospital (Place of Service Code 22)

Service	Type	Code*	Rendering Provider
ECT including monitoring	Single seizure	90870	Network MD/DO only
	Multiple seizures/day	90871	

*Plus CPT modifiers, when appropriate

Notes:

- These services are categorized in the data system as Medication Support Services and are recorded in the clinical record and reported into the IS in hours:minutes.

INDIVIDUAL PSYCHOTHERAPY - HOSPITAL OR RESIDENTIAL CARE FACILITY (MODE 15)
NETWORK PHYSICIANS & ADMITTING PSYCHOLOGISTS ONLY

This service may be delivered at any of these locations: Inpatient Hospital (Place of Service Code 21), Skilled Nursing Facility (POS Code 31), Nursing Facility (POS Code 32), Custodial Care Facility (POS Code 33), Intermediate Care Facility/Mentally Retarded (POS Code 54), Residential Substance Abuse Treatment Facility (POS Code 55), or Psychiatric Residential Treatment Center (POS Code 56).

Service	Duration of Face-to-Face	Code*	Rendering Provider
Insight oriented, behavior modifying, and/or supportive services delivered to one client.	**Indiv, Group, & Organizational**: 20-39 minutes	90816	Network MD/DO & Admitting PhD/PsyD
	Indiv & Group: 40-74 minutes **Organizational**: 40-50 minutes	90818	
	Indiv & Group: 75+ minutes **Org**: NA	90821	
Insight oriented, behavior modifying, and/or supportive services delivered to one client **WITH** evaluation and management	**Indiv, Group, & Organizational**: 20-39 minutes	90817	
	Indiv & Group: 40-74 minutes **Organizational**: 40-50 minutes	90819	
	Indiv & Group: 75+ minutes **Org**: NA	90822	
Interactive service using play equipment, physical devices, or other mechanisms of non-verbal communication delivered to one client.	**Indiv, Group, & Organizational**: 20-39 minutes	90823	
	Indiv & Group: 40-74 minutes **Organizational**: 40-50 minutes	90826	
	Indiv & Group: 75+ minutes **Org**: NA	90828	
Interactive service using play equipment, physical devices, or other mechanisms of non-verbal communication delivered to one client **WITH** evaluation and management	**Indiv, Group, & Organizational**: 20-39 minutes	90824	
	Indiv & Group: 40-74 minutes **Organizational**: 40-50 minutes	90827	
	Indiv & Group: 75+ minutes **Org**: NA	90829	

Notes: *Plus CPT modifiers, when appropriate

- These services are categorized in the data system as Individual Services and are recorded in the clinical record and reported into the IS in hours:minutes.
- While physicians may use this code if they are providing psychotherapy to their patients, their service is probably more likely the evaluation and management services described on pages 20-23

EVALUATION AND MANAGEMENT - HOSPITAL INPATIENT SERVICES (MODE 15)

NETWORK PHYSICIANS ONLY

This service may only be delivered at one of these locations: Inpatient Hospital (Place of Service Code 21)

Service	Components	Severity of Condition	Duration of Face-to-Face or on Unit	Code*	Rendering Provider
Initial Care The first hospital encounter the admitting physician has with a client on the inpatient unit for the management and evaluation of a new client that requires three components. Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	• detailed history • detailed or comprehensive exam • straight-forward or low complexity decision-making	Low	**Ind, Gp, & Org** 1-29 minutes	99221	Network MD/DO only
	• comprehensive history • comprehensive examination • decision-making of moderate complexity	Moderate	**Indiv & Group** 30-69 minutes Org 30-45 minutes	99222	
	• comprehensive history • comprehensive examination • decision-making of high complexity	High	**Indiv & Group** 70+ minutes **Organizational** 30-45 minutes	99223	
Subsequent Care, per day, for the evaluation and management of a client that requires at least two of three components. Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	• Problem focused history • Problem focused examination • straight-forward or low complexity decision-making	Stable, recovering, or improving	**Ind, Gp, & Org** 1-24 minutes	99231	
	• expanded problem focused history • expanded problem focused exam • decision-making of moderate complexity	Inadequate response to therapy or minor complication	**Ind, Gp, & Org** 25-34 minutes	99232	
	• detailed history • detailed examination • decision making of moderate to high complexity	Unstable, Significant complication, or new problem	**Indiv & Group** 35+ minutes **Organizational** 35-45 minutes**	99233	
Discharge	All services on day of discharge	N/A	**Ind, Gp, & Org** 1-24 minutes	99238	
			I&G: 25+ min **Org**: 25-45 min**	99239	

*Plus CPT modifiers, when appropriate

** Maximum reimbursement is for 45 minutes of service

Notes:

- These services are categorized in the data system as Individual Services and are recorded in the clinical record and reported into the IS in hours:minutes.

EVALUATION & MANAGEMENT - NURSING FACILITY (MODE 15)

NETWORK PHYSICIANS ONLY

This service may be delivered at any of these locations: Skilled Nursing Facility (Place of Service Code 31), Nursing Facility (POS Code 32), Intermediate Care Facility/Mentally Retarded (POS Code 54), Residential Substance Abuse Treatment Facility (POS Code 55), or Psychiatric Residential Treatment Center (POS Code 56).

Service	Components	Severity of Condition and/or Plan Requirements	Duration of Face-to-Face or on Unit	Code*	Rendering Provider
Assessment Annual assessment for the evaluation and management of a new or established client that requires three components. Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	• detailed history • comprehensive examination • straight-forward or low complexity decision-making	Stable, recovering, or improving; Affirmation of plan of care required	**Ind, Gp, & Org** 20-39 minutes	99301	Network MD/DO only
	• detailed history • comprehensive examination • decision-making of moderate to high complexity	Significant complication or new problem; New plan of care required	**Ind, Gp, & Org** 40-49 minutes	99302	
	• comprehensive history • comprehensive examination • decision-making of moderate to high complexity	Creation plan of care required	**Indiv & Group** 50+ minutes **Organizational** 50 minutes**	99303	
Subsequent Care, per day, for the evaluation and management of a new or established client that requires three components. Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	• Problem focused history • Problem focused examination • straight-forward or low complexity decision-making	Stable, recovering, or improving	**Ind, Gp, & Org** 1-19 minutes	99311	
	• expanded history • expanded examination • decision-making of moderate complexity	Inadequate response to therapy or minor complication	**Ind, Gp, & Org** 20-39 minutes	99312	
	• detailed history • detailed examination • decision making of moderate to high complexity	Unstable, Significant complication or new problem	**Indiv & Group** 40+ minutes **Organizational** 41-50 minutes**	99313	
Discharge	All services on day of discharge	N/A	**Ind, Gp, & Org** 20-39 minutes	99315	
			I&G: 40+ min **Org**: 41-50 min**	99316	

*Plus CPT modifiers, when appropriate

** Maximum reimbursement is for 50 minutes of service.

Notes:

- These services are categorized in the data system as Individual Services and are recorded in the clinical record and reported into the IS in hours:minutes.

EVALUATION AND MANAGEMENT
DOMICILIARY, BOARD & CARE, OR CUSTODIAL CARE FACILITY (MODE 15)
NETWORK PHYSICIANS ONLY

This service may only be delivered at a Custodial Care Facility (Place of Service Code 33)
It will be categorized in the data system as an Individual Service.

Service	Components	Severity of Presenting Problem	Code*	Rendering Provider
New Client Service for the evaluation and management of a new client that requires three components. Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	• Problem focused history • Problem focused examination • straight-forward or low complexity decision-making	Low	99321	Network MD/DO only
	• expanded history • expanded examination • decision-making of moderate	Moderate	99322	
	• detailed history • detailed examination • decision-making of high complexity	High	99323	
Established Client Services for the evaluation and management of an established client that requires at least two of three components. Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	• Problem focused history • Problem focused examination • straight-forward or low complexity decision-making	Stable, recovering, or improving	99331	
	• expanded history • expanded examination • decision-making of moderate complexity	Inadequate response to therapy or minor complication	99332	
	• detailed history • detailed examination • decision making of high complexity	Significant complication or new problem	99333	

*Plus CPT modifiers, when appropriate
** Maximum reimbursement for Network Organizational MD/DO is for 50 minutes of service.

Notes:

- These services are categorized in the data system as Individual Services and are recorded in the clinical record and reported into the IS in hours:minutes.

EVALUATION AND MANAGEMENT - OFFICE OR OTHER OUTPATIENT SERVICES (MODE 15)
NETWORK PHYSICIANS ONLY

This service may be only be delivered in an Office (Place of Service Code 11)

Service	Components	Severity of Presenting Problem(s)	New Client Duration of Face-to-Face with Client and/or Family and Code*	Established Client Duration of Face-to-Face with Client and/or Family and Code*	Rendering Provider
Evaluation and management of a client that includes at least the three components noted in the next column. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	• problem focused history • problem focused examination • straightforward medical decision making	Minor	**Ind, Gp, & Org** 1-19 minutes 99201	No Code	Network MD/DO only
	• expanded problem focused history • expanded problem focused exam • straightforward medical decision making	Low to Moderate	**Ind, Gp, & Org** 20-29 minutes 99202	**Ind, Gp, & Org** 1-19 min. 99212	
	• detailed history • detailed examination • medical decision making of low complexity	Moderate	**Ind, Gp, & Org** 30-39 minutes 99203	**Ind, Gp, & Org** 20-24 minutes 99213	
	• comprehensive history • comprehensive examination • medical decision making of moderate complexity	Moderate to High	**Indiv & Group** 40-59 minutes **Org**: 40-50 minutes 99204**	**Ind, Gp, & Org** 25-39 minutes 99214	
	• comprehensive history • comprehensive examination • medical decision making of high complexity	Moderate to High	**Indiv & Group** 60+ minutes 99205 **Org**: NA	**Indiv & Group** 40+ minutes 99215 **Org**:Not Reimbursed	

*Plus CPT modifiers, when appropriate

**Maximum reimbursement for Network Organizational MD/DO is for 50 minutes of service.

Notes:

- These services are categorized in the data system as Individual Services and are recorded in the clinical record and reported into the IS in hours:minutes.

EVALUATION AND MANAGEMENT – CONSULTATIONS, OFFICE OR OTHER OUTPATIENT (MODE 15)
DEPT OF HEALTH SERVICES & NETWORK PHYSICIANS & PSYCHOLOGISTS

This service may be delivered in any setting other than Inpatient Hospital: Office (Place of Service Code 11), Home (POS 12), Urgent Care (POS 20), Outpatient Hospital (POS 22), Hospital E (POS 23), Ambulatory Surgical Center (POS 24), Skilled Nursing Facility (POS31), Nursing Facility (POS 32), Custodial Care Facility (POS 33), Hospice (POS 34)

Service	Components	Presenting Problems	Duration of Face-to-Face, Client and/or Family	Code*	Rendering Provider
New or Established Client Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	• problem focused history • problem focused examination • straightforward decision-making	Self limited or Minor	**Ind, Gp, & Org** 20-29 minutes	99241	<u>SD/MC</u> MD/DO <u>Network</u> MD/DO & PhD/PsyD only
	• expanded problem focused history , expanded problem focused exam • straightforward decision-making	Low Severity	**Ind, Gp, & Org** 30-39 minutes	99242	
	• detailed history • detailed examination • decision-making of low complexity	Moderate Severity	**Indiv & Group** 40-59 minutes **Org**: 40-50 min	99243	
	• comprehensive history • comprehensive examination • decision-making of moderate complexity	Moderate to High Severity	**Indiv & Group** 60-79 minutes **Org**: NA	**Indiv & Group** 99244 **Org**: Not Reimbursed	
	• comprehensive history • comprehensive examination • decision-making of high complexity	Moderate to High Severity	**Indiv & Group** 80+ minutes **Org**: NA	**Indiv & Group** 99245 **Org**: Not Reimbursed	

*Plus CPT modifiers, when appropriate

<u>Notes:</u>

- These services are categorized in the data system as Individual Services and are recorded in the clinical record and reported into the IS in hours:minutes.

EVALUATION AND MANAGEMENT – CONSULTATIONS, INPATIENT (MODE 15)
DEPT OF HEALTH SERVICES & NETWORK PHYSICIANS AND ADMITTING PSYCHOLOGISTS

This service may only be delivered at one of these locations: Outpatient Hospital (Place of Service Code 22)

Service	Components	Severity of Presenting Problem	Initial Consultation Code*	Confirmatory Consult Code*	Rendering Provider
Initial Inpatient or Nursing Facility Service for the evaluation and management of a new or established client that requires three components.	• Problem focused history • Problem focused examination • straightforward decision making	Self limited or minor	20-39 min 99251	99271	SD/MC MD/DO Network MD/DO & Admitting PhD/PsyD
	• expanded problem focused history • expanded problem focused exam • straightforward decision making	Low	40-54 min 99252	99272	
Confirmatory Service to a new or established client to confirm an existing opinion regarding services. Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	• detailed history • detailed examination • decision-making of low complexity	Moderate	55-79 min 99253	99273	
	• comprehensive history • comprehensive examination • decision-making of moderate complexity	Moderate to high	80-109 min 99254	99274	
	• comprehensive history • comprehensive examination • decision-making of high complexity	high	110+ min 99255	99275	
Follow-up Inpatient Service to an established client to complete a consultation, monitor progress, or recommend modifications to management or a new plan of care based on changes in client status. At least two of three components are required. Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	• Problem focused history • Problem focused examination • straightforward or low complexity decision-making	Stable, recovering, or improving	1-19 minutes 99261	Not Reimbursed	
	• expanded problem focused history • expanded problem focused exam • decision-making of moderate complexity	Inadequate response to therapy or minor complication	20-29 minutes 99262	**Individual, Group, & Organizational** 20-39 minutes 90805	
	• detailed history • detailed examination • decision-making of high complexity	Significant complication or new problem	30-39 minutes 99263		

*Plus CPT modifiers, when appropriate

** Maximum reimbursement for Network Organizational MD/DO & Admitting PhD/PsyD is for 50 minutes of service.

Notes:

- These services are categorized in the data system as Individual Services and are recorded in the clinical record and reported into the IS in hours:minutes.

SERVICES BY COMMUNITY PARTNERS (MODE 15)

Service	Code	Rendering Provider
Comprehensive Community Support (Community Partner contract providers ONLY) Specialty Mental Health Services including assessment, individual therapy, and other emergent services provided to eligible HWLA Matched or Matched Program Pending clients by Community Partners; the duration of the visit must be at least 20 minutes, with at least 15 minutes of face-to-face time with the client. This service may also include psychiatric consultation provided to a primary care provider (PCP) by a licensed MD or DO who is a board-certified psychiatrist, which is an exception to the face-to-face requirement between a client and a mental health provider.	H2016	Any staff operating within the FQHC contract and his/her scope of practice

Notes:

- All of these services are classified as Individual Mental Health Services and are reported under Service Function 43.
- These services are recorded in the clinical record and reported into the IS as one unit.