INTRODUCTION TO NEW SERVICE CODES FOR DIRECT SERVICE PROVIDERS

Specialty Mental Health Services (SMHS)

June 2023

Welcome

SIGN-IN

HANDOUTS

PLEASE HOLD QUESTIONS
UNTIL QUESTION BREAK

BREAK

TRAINING OBJECTIVES

Participants will walk away with:

- Knowledge of key CalAIM Payment Reform terms & definitions
- A basic understanding of what Payment Reform is, why it is happening and what it means for counties
- Information about how Payment Reform impacts direct service providers and the service codes that they utilize

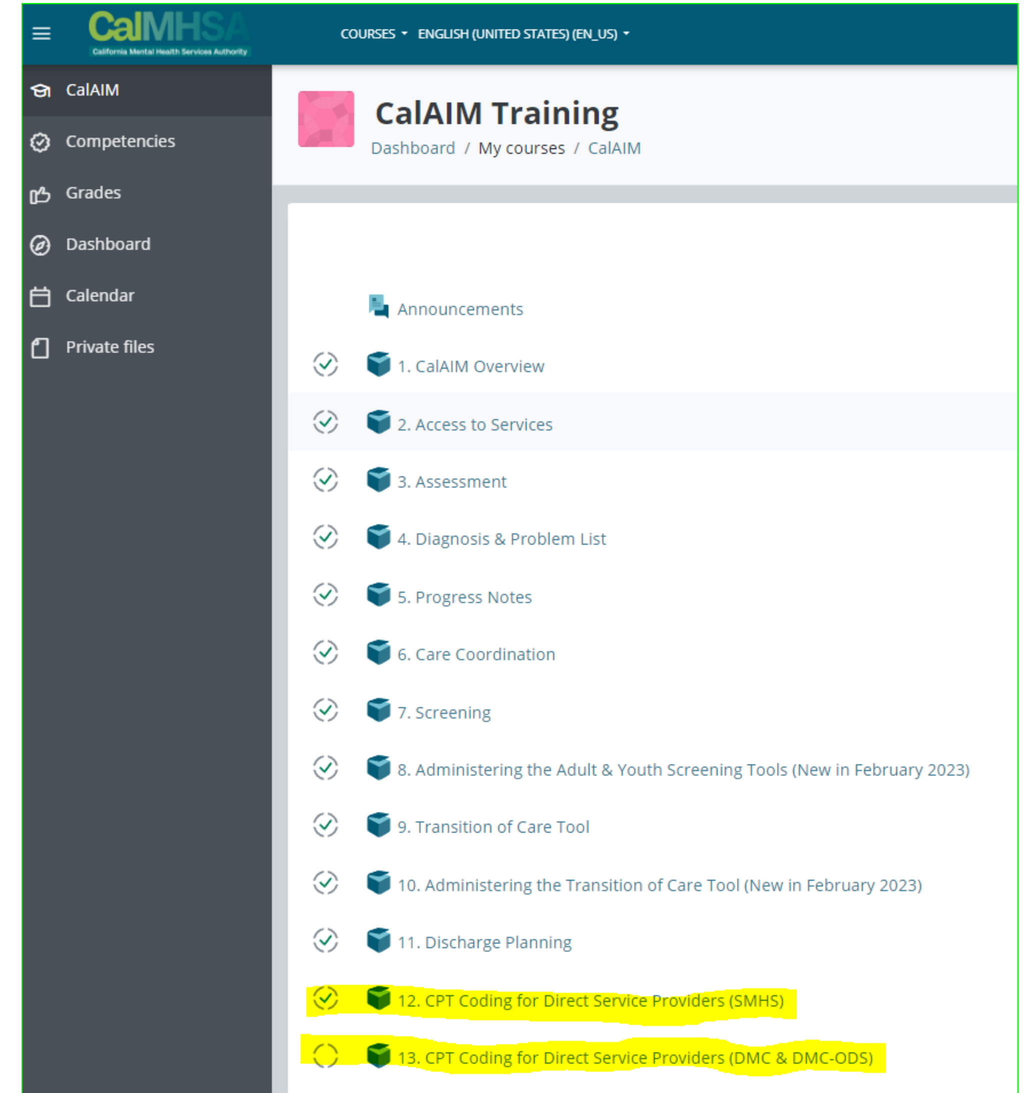
PLEASE NOTE:

- Santa Cruz County Avatar electronic health record (EHR) will automatically manage many of the changes to coding brought about by Payment Reform.
- We have minimized the impact that these changes have on direct service providers as much as possible.
- There is value in direct service providers having a general understanding of coding and the related requirements to ensure services are documented appropriately and in alignment with Payment Reform.
- It is also important to point out that this training is specific to state Medi-Cal claiming requirements and **does not address Medicare / FQHC specific coding requirements**.

PAYMENT REFORM KEY TERMS/DEFINITIONS

HCPCS AND CPT CODES

If you are interested in the details, view the CalMHSA version of this training in the CalMHSA Learning Management System: https://moodle.calmhsalearns.org/



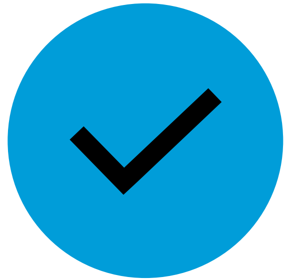
WHAT ARE HCPCS CODES?

HCPCS = Healthcare Common Procedure Coding System (Commonly pronounced as "hick picks")

- Maintained and administered by the Centers for Medicare and Medicaid Services (CMS).
- HCPCS divided into two subsystems (Level I and Level II).
- Level 1 = CPT codes
- Level 2 = codes used to identify a variety of items and services not included in the Level I code set (HCPCS codes we utilize fall under Level 2)
- Prior to the changes brought about by Payment Reform, HCPCS codes made up the majority of codes utilized by county plans.
- HCPCS codes will continue to be used in some instances, but CPT codes will now be used for many of the services provided by clinical staff, allowing for services to be identified with more specificity on claims.

WHAT ARE CPT CODES?

CPT = Current Procedural Terminology



* Created by American Medical Association (AMA)

* Updated annually

* CPT codes generally specify the billing increment or a range of time in the code description

* Used by physicians and clinical providers

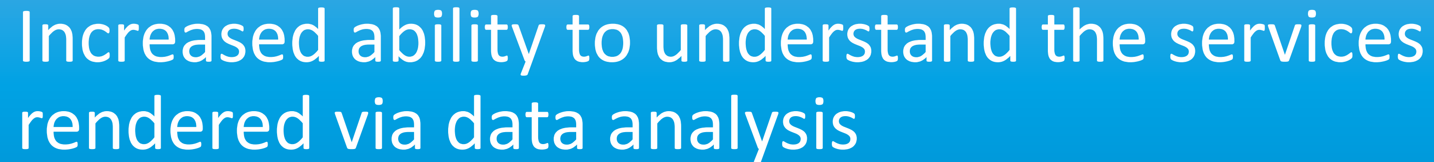
* Provide detailed definitions for codes that are standardized nationwide - this common language streamlines reporting and helps increase efficiency and accuracy

* All CPT codes are five-digits and can be either numeric or alphanumeric, depending on the category

CALAIM PAYMENT REFORM OVERVIEW

What is changing, when is it changing and what are the benefits?

WHAT ARE SOME BENEFITS OF THIS TRANSITION?



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

MANY THINGS ARE CHANGING BUT A LOT REMAINS THE SAME!

THINGS THAT REMAIN THE SAME

Providers still choose from the same Avatar Service Code field in the Avatar Progress Note

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)

24-hour and Day Service Codes (Telos, EDC, Casa P)

WHAT IS CHANGING?

- Payment Reform will transition counties from cost-based reimbursement funded via Certified Public Expenditures (CPEs) to fee-for-service reimbursement funded via Intergovernmental Transfers (IGTs), eliminating the need for reconciliation to actual costs.
- Rather than being paid for the cost of providing services, counties will be paid for the services rendered.
- All counties are expected to align with other healthcare delivery systems and utilize CPT codes where appropriate to improve reporting and support data-driven decision making.

THINGS THAT WILL CHANGE

(WE WILL DISCUSS THESE IN MORE DETAIL IN THE NEXT SECTION)

- Service code names
- Units vs. Minutes
- Claiming for direct care only
- Not claiming for documentation and travel time
- Add-On Codes
- Lockouts by location code, not service code
- Taken care of by Avatar:
  - Selecting codes based on direct service time
  - Modifiers
  - Duplicate services

WHEN IS IT CHANGING?

CalAIM Payment Reform changes go into effect July 1, 2023

Service date June 30th or before --→ Progress Notes Finalized by Friday, July 7th, 11:59pm

Service date July 1st or after -----→ Leave Progress Notes in Draft until Monday, July 10th

QUESTIONS?

AVATAR CHANGES

SERVICE CODE NAMES

- Even though the service activities you are providing to individuals are not changing under Payment Reform, you do need to familiarize yourself with some new service code names that describe these services activities.

CHANGES TO AVATAR CODE FIELDS

Service Charge Code:

Add-On Services:

Service Charge Code

m

Results

90791 Psychiatric Diagnostic Evaluation (M90791)
90792 Psych Diag Eval with Medical Svc (M90792)
90832-90837 Psychotherapy (M90832S)
90839 Psychotherapy for Crisis 1st hour (M90839)
90847 Family Psychotherapy with Patie
90849 Multiple-Family Group Psychothp
90853 Group Psychotherapy (M90853)
90885 Pych Eval of Med Records and Te
96130 Psych Testing Evaluation - 1st hr
99202-99205 Office Visit of New Patient
99212-99215 Office Visit Established Pt

H0025 BH Prevention Education (MH0025)
H0031 MH Assessment by Non- Physician (MH0031)
H0032 MH Svc Plan by Non-Physician (MH0032)
H0033 Oral Med Admin, Direct Observation (MH0033)
H0034 Medication Training and Support (MH0034)
H0038 Peer Service (MH0038)
H2011 Crisis Intervention Service (MH2011)
H2017 Group Psychosocial Rehabilitation (MH2017G)
H2017 Psychosocial Rehabilitation (MH2017)
H2019 Therapeutic Behavioral Service (MH2019)
H2021 Community Wrap-Around (MH2021)

Add-On Service

90785 Interactive Complexity (M90785)
90887 Interpretation of Results (M90887)
G2212 Prolonged Office Outpatient visit (MG2212)
T1013 Interpretive Service (MT1013)

Add-On Duration

UNITS VS. MINUTES

- For all codes, claims will be based on units of service and not the total number of minutes. While **direct service providers will still document service time in minutes when writing progress notes**, the finalized claim will be based on units of service dependent on the number of minutes.

- For example, for the service called Psychosocial Rehabilitation, per 15 minutes (HCPCS H2017) each 15 minutes of service is considered one unit.

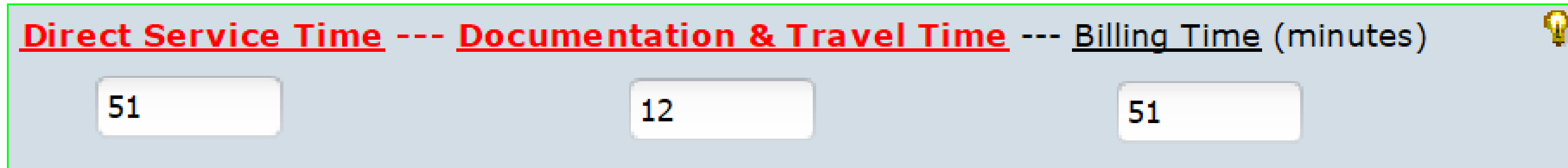
Example 1:
If a Mental Health Rehabilitation Specialist (MHRS) meets with an individual and provides 60 minutes of Psychosocial Rehabilitation the service would be claimed as 4 units of Psychosocial Rehabilitation (60 minutes of service / 15 minutes per unit = 4 units).

- Also, a unit of time is considered “met” when the midpoint of the given time or time range of a service is passed.

Example 2:
If a MHRS meets with an individual and provides 4 minutes of Psychosocial Rehabilitation, then the service does not pass the midpoint of 15 minutes and will not be claimed (though should still be documented). However, if the service was 8 minutes [exceeds the midpoint of 15 minutes] then the service would be claimed as 1 unit of Psychosocial Rehabilitation.

Avatar will automatically manage all calculations. Staff will need to enter the correct number of minutes for each service provided and Avatar will perform all necessary calculations.

CHANGES TO AVATAR PROGRESS NOTE TIME FIELDS



Face to Face and Other times have changed

Now:
Direct Service Time &
Documentation and Travel Time
(Total Duration label will be changing)

New lightbulb

DIRECT SERVICE REQUIREMENTS

- Direct services include time spent:
  - Meeting directly with the beneficiary
  - Meeting with caregivers, significant support persons and other professionals, even without the beneficiary present.
- This is captured in Avatar **Direct Service Time**.
- It is important to accurately record Direct Service Time vs. Documentation and Travel Time.
- Direct patient care does not include travel time, administrative activities, chart review*, documentation, utilization review and quality assurance activities or other activities a provider engages in either before or after a beneficiary visit.
  (*except for LPHA review of records for assessment purposes)

ADD-ON/SUPPLEMENTAL SERVICES

- Per CMS, an add-on code describes a service that is performed in conjunction with the primary service by the same practitioner.
- These codes are performed *in addition to* another primary service and must never be billed as a stand-alone service.
- Add-on codes allow for noting treatment complexity, adding extra time to a service when a time range maximum is met, noting when interpretation services were utilized, etc.
- We will go into more depth about specific add-on codes throughout this training.
- Add-On codes = $
- Important to utilize add-on codes when fitting

RECORDING DOCUMENTATION & TRAVEL TIME

- DHCS policy states that we can only claim for direct patient care when providing a service.
- Under Payment Reform, reimbursement rates account for the average costs of travel and documentation time.
- However, travel time and documentation time should still be documented separately from direct care in progress notes to support future rate setting efforts

QUESTIONS?

SELECTING SERVICE CODES BASED ON DIRECT SERVICE TIME

NOTE: AVATAR will do this automatically for majority of codes, below is just an example of what avatar is doing in the background.

Most services have a time or time range associated with them and the time/time range is included in the description of the service (When a time or time range is not specifically noted, DHCS has assigned a time of 15 minutes).

Service	Code	Disciplines
Telephone Evaluation and Management Service, 5-10 Minutes	99441	MD/DO, PA, NP or CNS
Telephone Evaluation and Management Service, 11-20	99442	MD/DO, PA, NP or CNS
Telephone Evaluation and Management Service, 21-30 Minutes	99443	MD/DO, PA, NP or CNS
Psychiatric Diagnostic Evaluation, 15 minutes	90791	MD/DO, PA, PhD/PsyD, LCSW, MFT, LPCC, NP or CNS
Psychosocial Rehabilitation, per 15 Minutes	H2017	All disciplines

MODIFIERS

- **Most Modifiers will be managed by Avatar; it is unlikely that providers will need to enter modifiers manually when documenting services.**
- Two-character codes (sometimes two numbers sometimes two letters) that are added to a CPT or HCPCS code in order to provide additional detail about the service that was provided.
- Modifiers have always existed, but the number of modifiers has been expanded under Payment Reform.
- Modifiers are not always used, but there are a few instances where they will be required.
- Examples of modifiers for MH include: “HK”: Identifies that an Intensive Home-Based Services (IHBS) or Intensive Care Coordination (ICC) service was provided and “93” clarifies that a service was provided via telephone.

LOCKOUTS - LOCATION

- The same locations as prior to payment reform continue to be **Lockouts** for billing purposes
- The previous **M6xx** codes will be removed from Avatar. **M001** remains.
- When a client is in a lockout location, you will now use the Progress Note **Location Code** to indicate to Avatar that the service is not billable.
  - Use Location Codes "09- Jail" or "51- Inpatient Psychiatric Facility"
  - Use the location ***where the client is***, even if speaking with someone else on behalf of the client, i.e. speaking on the phone with client's sister.
  - If the service is billable even in a lockout location, use Location Code "Non-Traditional Location" rather than "09- Jail" or "51- Inpatient Psychiatric Facility" (e.g., TCM for **discharge planning up to 30-days prior to discharge** from a psychiatric hospital).

LOCKOUTS – OTHER THAN LOCATION

- **Most lockouts will be managed by Avatar; it is unlikely that providers will need to enter lockouts manually when documenting services (other than Location).**
- Some codes cannot be billed together with other codes and others can only be billed together in extraordinary or very specific circumstances (This was the case even prior to Payment Reform).
- Lockout codes are outlined in the DHCS SMHS Billing Manual and will be managed by Avatar.
- In some cases, service lockouts can be overridden with modifiers and Avatar will be set up to manage that for any applicable codes.

DUPLICATE SERVICES

Duplicate Services will be managed by Avatar; it is unlikely that providers will need to address duplicate services directly.

- A claim for an outpatient service is considered a duplicate if ***all the following data elements*** are the same:
    - Client
    - Provider
    - Service code(s)/modifier(s)
    - Date of Service(s)
- If all of the elements above apply, and the duplicate services are both valid, then a county must roll up the total number of minutes for the day.
- **Avatar will "roll up" the services that meet all elements above automatically.** Providers may continue to document services in one or multiple progress notes.

QUESTIONS?

REVIEW OF THE MOST COMMONLY UTILIZED SERVICES CODES

NOTE:

- The following slides do not include an exhaustive list of service code descriptions.
- This training is focused on the most commonly utilized codes.
- Throughout this training the terms client, beneficiary, patient and individual are all used interchangeably.

DISCIPLINES

- The following slides will refer to the disciplines that are able to provide each service type (these disciplines are taken directly from the DHCS SMHS Billing Manual).
- Wherever MFT, LCSW, LPCC and Psychologist is noted, this includes AMFT, ASW, APCC and Waivered Psychologist.

ASSESSMENT

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.

Service	Code	Disciplines	Notes
Psychiatric Diagnostic Evaluation	**M90791** Psychiatric Diagnostic Evaluation -Previously M431	MD/DO, PA, **PhD/PsyD, LCSW, MFT, LPCC,** NP or CNS	Used to document assessments(initial, re-assessments) completed by non-physician licensed, license-eligible/waivered staff **(LPHA)**
Psychiatric Diagnostic Evaluation with Medical Services	M90792 Psych Diag Eval with Medical Svc	MD/DO, PA, NP or CNS	Used to document psychiatric evaluations completed by physicians
Mental Health Assessment by Non-Physician	**MH0031** MH Assessment by Non-Physician - previously M433	Pharmacist, PhD/PsyD, LCSW, MFT, LPCC, Psychiatric Technician, PA, NP or CNS, RN, LVN, **MHRS, Occupational Therapist, Other Qualified Practitioner**	Used to document assessment work completed by **non-LPHA** staff.

ASSESSMENT - CONTINUED

Service	Code	Disciplines	Notes
Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes	**M90885** Pych Eval of Med Records and Tests	MD/DO, PA, **PhD/PsyD, LCSW, MFT, LPCC**, NP or CNS	Used when a provider is asked to conduct a review of records for diagnostic purposes and when there is no direct patient contact. This may be at the request of an agency or peer review organization.
Psychological Testing Evaluation, First Hour	**M96130** Psych Testing Evaluation - 1st hr	MD/DO, **PhD/PsyD**, PA, NP or CNS	
Psychological Testing Evaluation, Each Additional Hour	**M96131** Psych Testing Evaluation Addtl hr	MD/DO, **PhD/PsyD**, PA, NP or CNS	THIS IS AN **ADD-ON CODE**. Utilized for each additional hour of Psychological Testing Evaluation

CRISIS INTERVENTION

The goal of crisis intervention is to stabilize an immediate crisis within a community or clinical treatment setting.

Service	Code	Disciplines	Notes
Psychotherapy for Crisis, First hour	**M90839** Psychotherapy for Crisis 1st hour – previously M471	MD/DO, **PhD/PsyD, LCSW, MFT, LPCC**, PA, NP or CNS	The individual must be present for all or part of the service. Urgent assessment and exploration of an individual in crisis. Includes mental status exam as well as a disposition and treatment includes therapy, mobilization of resources and implementation of interventions to address the crisis. **(LPHA)**
Psychotherapy for Crisis, Each Additional 30 Minutes (Avatar may be taking care of this)	**M90840** Psychthpy for Crisis Addtl 30min	MD/DO, **PhD/PsyD, LCSW, MFT, LPCC**, PA, NP or CNS	THIS IS AN **ADD-ON CODE.** Same as above, but this code adds additional time once you hit the maximum for Psychotherapy for Crisis, First 30-74 minutes
Crisis Intervention Service,	**MH2011** Crisis Intervention Service - previously M471	**All disciplines**	For **non-LPHA staff**, this Crisis Intervention Service remains as it was prior to Payment Reform.

MOBILE CRISIS

Mobile crisis services provide rapid response, individual assessment and community-based stabilization for Medi-Cal beneficiaries who are experiencing a mental health crisis.

Service	Code	Disciplines
Mobile Crisis	**MH2011M** Mobile Crisis Intervention Service – previously M471	All disciplines (LPHA and non-LPHA): **MERT and MH Liaison**

PLAN DEVELOPMENT

Plan Development means a service activity that consists of one or more of the following: development of client plans, approval of client plans and/or monitoring of a beneficiary's progress.

Service	Code	Disciplines	Notes
Mental Health Service Plan Developed by Non-Physician	**MH0032** MH Svc Plan by Non-Physician – previously M432	Pharm, **PhD/PsyD, LCSW, MFT, LPCC,** PA, NP or CNS, RN, PT, LVN, **MHRS, OT, Other**	Plan Development utilizes the same HCPCS code under Payment Reform.

PEER SUPPORT SERVICES

The following peer support service codes can only be utilized by certified peer support specialists.

Service	Code	Disciplines	Notes
Behavioral Health Prevention Education service, delivery of service with target population to affect knowledge, attitude, and/or behavior.	**MH0025**	Peer	Skill building groups
Self-Help/Peer Services, per 15 minutes	**MH0038** Peer Service	Peer	Engagement; therapeutic activity

QUESTIONS?

COLLATERAL SERVICES

IMPORTANT: Collateral services can **STILL BE BILLED** under Payment Reform. They simply no longer utilize a distinct service code called "Collateral". Collateral can be a component of many mental health services. When documenting a collateral contact, providers should **select the service code that most closely fits the service provided and it should be clear in the progress note that the service was provided to a collateral contact**.

Service Provided to Collateral	Service to Select	Code	Disciplines	Notes
Meeting with caregiver/significant support person to gather information to inform an assessment/re-assessment	Psychiatric Diagnostic Evaluation	**M90791** Psychiatric Diagnostic Evaluation	MD/DO, PA, **PhD/PsyD, LCSW, MFT, LPCC,** NP or CNS	**Non-LPHA** providers would utilize "Mental Health Assessment by Non-Physician, (**MH0031**)
Meeting with caregiver/significant support person to develop a care plan/client plan / Problem List	Mental Health Service Plan Developed by Non-Physician	**MH0032** MH Svc Plan by Non-Physician	Pharm**, PhD/PsyD, LCSW, MFT, LPCC,** PA, NP or CNS, RN, PT, LVN, **MHRS, OT, Other**	
Meeting with caregiver/significant support person for the purpose of coaching, and/or skill development as a means to support the client with managing behavioral health needs.	Psychosocial Rehabilitation	**MH2017** Psychosocial Rehabilitation	All disciplines	

TARGETED CASE MANAGEMENT

Service	Code	Disciplines	Notes
Targeted Case Management	**MT1017** Targeted Case Management – previously M401	All disciplines	TCM is still what it has always been / no change to the description of this service. TCM can be with significant support people, or solely with the client. Meeting with caregiver/significant support person for the purpose of connecting them with resources/community supports to address the client's needs
Intensive Care Coordination (EPSDT)	**KT1017** Intensive Care Coordination - previously NK/K402	All disciplines	ICC is still what it has always been. It is an intensive form of TCM that facilitates assessment of, care planning for, and coordination of services for children and youth who meet certain criteria. **Katie A and Non-Katie A services now use the same "K" Codes**
Community-Based Wrap-Around Services	**MH2021** Community Wrap-Around	All disciplines	Refers to coordination of care between providers in the **Specialty Mental Health System** and providers who are **outside** Specialty Mental Health. **ONLY** used to show that delivery-system coordination of care has occurred. For other kinds of care coordination, other service codes must be used. Examples: Specialty Mental Health refers to the Managed Care System (mild to moderate mental health services) or the Drug Medi-Cal Organized Delivery System (DMC-ODS).

QUESTIONS?

REHABILITATION

Rehabilitation means a recovery-or resiliency-focused service activity identified to address a beneficiary's mental health needs. 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.

Service	Code	Disciplines
Psychosocial Rehabilitation	**MH2017** Psychosocial Rehabilitation - previously M445 / M448 / M411 / M412	All disciplines
Psychosocial Group Rehabilitation	**MH2017G** Psychosocial Group Rehabilitation - previously M455	All disciplines

INDIVIDUAL THERAPY

Therapy means a service activity that is a therapeutic intervention that focuses primarily on symptom reduction and restoration of functioning as a means to improve coping and adaptation and reduce functional impairments. Therapeutic intervention includes the application of cognitive, affective, verbal or nonverbal strategies based on the principles of development, wellness, adjustment to impairment, recovery and resiliency to assist a beneficiary in acquiring greater personal, interpersonal and community functioning or to modify feelings, thought processes, conditions, attitudes or behaviors which are emotionally, intellectually, or socially ineffective.

Service	Code	Disciplines
Psychotherapy	**M90832S** Psychotherapy – previously M441	MD/DO, PA, **PhD/PsyD, LCSW, MFT, LPCC,** NP or CNS

GROUP THERAPY/ FAMILY THERAPY CODES

Therapy may be delivered to a beneficiary or group of beneficiaries and may include family therapy directed at improving the beneficiary's functioning and at which the beneficiary is present.

Service	Code	Disciplines	Notes
Group Psychotherapy (Other than that of a multiple-family group)	**M90853** Group Psychotherapy – previously M451	MD/DO, PA, **PhD/PsyD, LCSW, MFT, LPCC,** NP or CNS	Code for "typical" general group therapy that includes multiple beneficiaries
Family Psychotherapy (Conjoint psychotherapy with Patient Present)	**M90847** Family Psychotherapy with Patient – previously M442	MD/DO, PA, **PhD/PsyD, LCSW, MFT, LPCC**, NP or CNS	
Multiple-Family Group Psychotherapy	**M90849** Multiple-Family Group Psychothpy – previously M451	MD/DO, PA, **PhD/PsyD, LCSW, MFT, LPCC**, NP or CNS	Allows for documentation of groups that include multiple families.

INTENSIVE HOME-BASED SERVICES (IHBS)

Similar to Collateral services, Intensive Home-Based Services (IHBS) are no longer documented utilizing a distinct "IHBS" service code. When documenting an IHBS service, providers should select the service code that most closely fits the service provided and the modifier "HK" will be utilized to indicate that a Katie A, IHBS or Intensive Care Coordination (ICC) service was provided – Avatar will manage modifiers for IHBS, ICC and other services to which modifiers apply.

Katie A and Non-Katie A services now use the same "K" Codes

IHBS Service Provided	Service to Select	Code	Disciplines	Notes
Meeting with individual/caregiver/significant support person to gather information to inform an assessment/re-assessment	Psychiatric Diagnostic Evaluation	**K90791** IHBS Psych Diagnostic Evaluation	MD/DO, PA, PhD/PsyD, LCSW, MFT, LPCC, NP or CNS	Non-LPHA providers would utilize "IHBS Mental Health Assessment by Non-Physician" (**K**H0031)
Meeting with individual/caregiver/significant support person to develop a care plan/client plan	Mental Health Service Plan Developed by Non-Physician	**KH0032** IHBS MH Svc Plan by Non-Physician	Pharm, PhD/PsyD, LCSW, MFT, LPCC, PA, NP or CNS, RN, PT, LVN, MHRS, OT, Other	

INTENSIVE HOME-BASED SERVICES (IHBS) [CONTINUED]

IHBS Service Provided	Service to Select	Code	Disciplines
Meeting with individual/caregiver/significant support person for the purpose of coaching, and/or skill development as a means to support the individual with managing behavioral health needs.	Psychosocial Rehabilitation	**KH2017** IHBS Psychosocial Rehabilitation - Previously NK414	All disciplines
Meeting with the individual for the purpose of symptom reduction and restoration of functioning as a means to improve coping and adaptation and reduce functional impairments.	Psychotherapy	**K90832S** IHBS Psychotherapy – previously NK415	MD/DO, PA, **PhD/PsyD, LCSW, MFT, LPCC,** NP or CNS
Family therapy directed at improving the beneficiary's functioning and at which the beneficiary is present	Family Psychotherapy (Conjoint psychotherapy with Patient Present)	**K90847** IHBS Family Psychotherapy with Pt – previously NK415	MD/DO, PA, **PhD/PsyD, LCSW, MFT, LPCC**, NP or CNS

QUESTIONS?

THERAPEUTIC BEHAVIORAL SERVICES (TBS)

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.

Service	Code	Disciplines
Therapeutic Behavioral Services, per 15 Minutes	**MH2019** - Previously M447	TBS Program only TBS is still what it has always been / no change to the description of this service, or the criteria to qualify for TBS.

ADD-ON/SUPPLEMENTAL SERVICES

Remember: Add-On codes are not billed independently—they supplement the primary service code that is utilized to document a service.

Staff will need to select appropriate add-on codes when appropriate.

Service	Code	Disciplines	Notes
Interactive Complexity	**M90785** Interactive Complexity	Same as disciplines for primary service	Can only be utilized **with assessment/psychiatric evaluation, therapy and group therapy codes**. Refers to communication difficulties during the psychiatric service. For example: • Managing maladaptive communications that complicate service delivery (high anxiety, confrontation/disagreement, reactivity, repeated questions, etc.). • Caregiver emotions or behavior that interferes with ability to support the treatment of the individual in care. • Evidence of disclosure of a sentinel event/mandated report. • Use of play equipment or other devices to overcome barriers to therapeutic interaction.

Add-On Service 90785 Interactive Complexity (...

Add-On Duration

Save Add-On Service

Selected Add-On Services

90785 Interactive Complexity (M90785)

ADD-ON/SUPPLEMENTAL SERVICES [CONTINUED]

Remember: Add-On codes are not billed independently—they supplement the primary service code that is utilized to document a service, and staff will need to select appropriate add-on codes when appropriate.

Some Add-On Codes will require Duration.

Service	Code	Disciplines	Notes
Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons	**M90887** Interpretation of Results	MD/DO, Pharm, **PhD/PsyD, LCSW, LMFT, LPCC**, PA, NP/CNS, OT	Utilized when a provider interprets or explains the results of psychiatric tests or other psychiatric/medical procedures to a family, caregiver or other significant support person.
Sign Language or Oral Interpretive Services	**MT1013** Interpretive Service	All disciplines	Utilized when interpretation services are used (only if another provide interpretation- **not for bilingual staff**).

Add-On Service T1013 Interpretive Service (MT...

Add-On Duration 52

Save Add-On Service

Selected Add-On Services

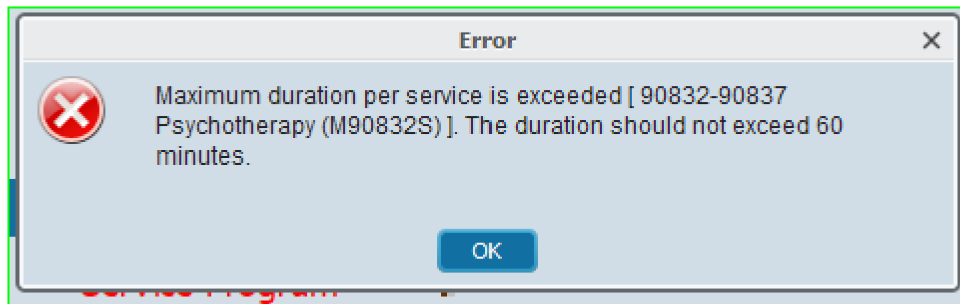
T1013 Interpretive Service (MT1013)

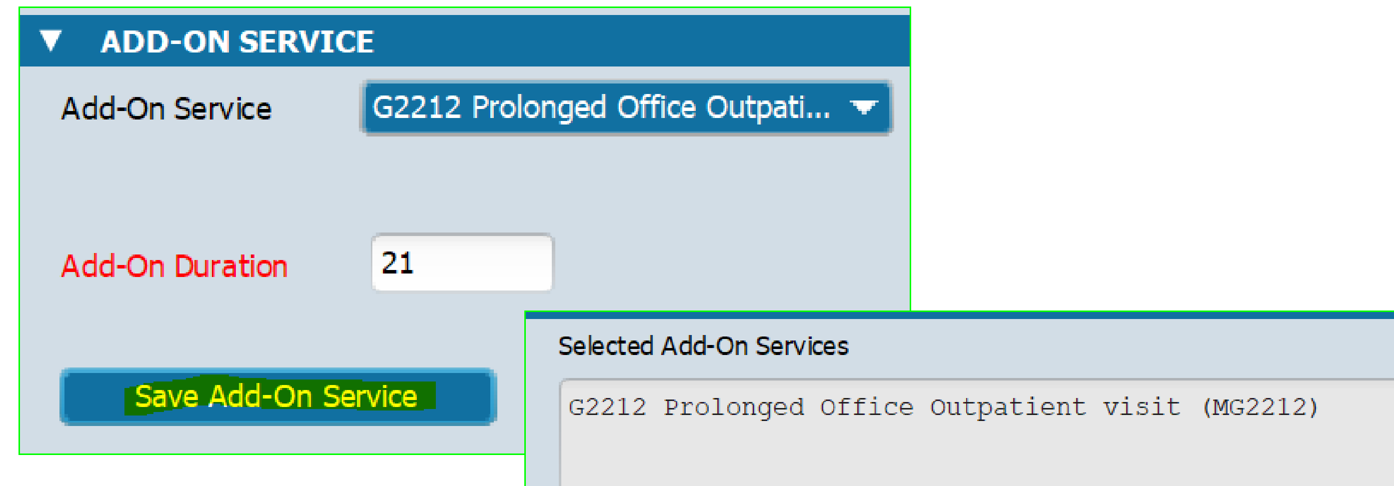
ADD-ON/SUPPLEMENTAL SERVICES [CONTINUED]

Add-On code MG2212 can be used to prolong a code that does not have a dedicated add-on code associated with it or an evaluation and management code that is at the end of a series (i.e., is associated with the longest time).

Duration = prolonged time

Service	Code	Disciplines
Prolonged Office or Other Outpatient Evaluation & Management Service(s) Beyond the Maximum Time; Each Additional 15 Minutes	**MG2212**	MD/DO, PA, **PhD/PsyD, LCSW, MFT, LPCC,** NP or CNS / Same as disciplines for primary service





WRAP UP & CODING REMINDERS

- **Many potential billing errors should be minimized as the CPT & HCPCS codes, modifiers, lockouts, etc. will be managed "behind the scenes" in Avatar.**
- Direct service time includes not only time spent with the individual in care, but can include contact with collateral sources and other service providers (even if the individual in care is not present). Some services do require that a client is present for the service to be claimed.
- Add-On codes cannot be utilized independently. They must be used in conjunction with a primary service code.
- Collateral services and IHBS services do still exist, and you can document and bill for them. They simply no longer have a distinct service code called "Collateral" or "IHBS".
- Travel and documentation time should be recorded separately in progress notes even though the time is not billable; this is important for future rate setting.

RESOURCES

- County BH QI Office Hours:
  2nd & 4th Friday of the Month, 9:00am. Email Ask.QI for invitation
- County BH QI CalAIM Guidance Page:
  https://www.santacruzhealth.org/HSAHome/HSADivisions/BehavioralHealth/AvatarResources/CalAIM.aspx
- CalMHSA Learning Management System:
  https://moodle.calmhsalearns.org/
- County BH QI:
  Ask.QI@santacruzcounty.us
- County BH QI CalAIM Questions MS form:
  CalAIM Question for Santa Cruz County
- Within the next couple of weeks, a recorded training will be available in Relias.

QUESTIONS?
FEEDBACK FORM