Drug Medi-Cal Organized Delivery System

California Advancing and Innovating Medi-Cal (CalAIM)

Payment Reform CPT Guide 2024

Version 2

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Purpose

This guide is intended to be used for educational purposes only. It reflects the most recent updates to the Department of Health Care Services (DHCS) Drug Medi-Cal Organized Delivery System (DMC-ODS) Billing Manual. Information is provided on the allowable billing codes for claiming substance use disorder treatment services to Medi-Cal. This guide can be used as a reference tool for programs and providers in discerning the appropriate billing code needed to claim for the services provided. Details include the County's current understanding regarding the description of each billing code, how or what types of activities it is used for, as well as its limitations for their use across programs and provider types.

For specific questions or clarification, contact the Quality Management Services, Substance Use Disorder (SUD) Support Team at aqissudsupport@ochca.com.

What is payment reform?

Effective July 1, 2023, the State has moved away from cost-based reimbursement and implemented fee-for-service payments. This has resulted in an increase in the number of Current Procedural Terminology (CPT) codes that are more specific to the type of services, the rendering provider's credentials, and the location where the service is provided.

Is this part of CalAIM?

Yes. Payment reform is part of the implementation of CalAIM. It is, however, distinct from the documentation standards that have changed with CalAIM.

What does this mean for me in working with clients in a substance use disorder program?

There are no changes to how or what services are provided. There is no impact on how services are documented or what is required for completing a progress note. What is different is how we code the service we provide for the purpose of billing. It requires us to be more specific in identifying what type of activity we are providing so that the appropriate billing code can be attached to that service or session for reimbursement.

This has not impacted residential day rate services, withdrawal management day rate services, and Narcotic Treatment Program (NTP) dosing services, which have remained the same with no changes.

Are there other changes besides the billing codes?

One big change that came with payment reform was that documentation and travel time is no longer billable. Although it is not billed to the State, we continue to note the minutes spent on documentation and travel in progress notes and enter the minutes into the billing system to monitor for potential fiscal implications.

The time we can claim must be direct client care, which is the time spent with the client. This time cannot 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 an encounter with a client.

What are lockout codes?

Depending on the regulations, there are some services that are prohibited from being provided to the same client on the same day as well as some procedure codes that should not be billed on the same day for the same client unless certain conditions are met. What this means is that there are some services that are "locked out" from being able to be claimed if a particular service has already been claimed. In some of these cases, there will be a modifier that may be used to override the lockout to allow for both services to be billed. Those services are identified on the Version 2 (v2) Service Table with an asterisk * in the lockout column. In other cases, there is no way to bill for both services and we will need to be aware of not falling into a situation where one claim will be denied. Existing lockout rules still apply regarding outpatient services during a residential stay only allowed on date of admission or discharge.

How do we select billing codes based on time?

Billing codes that do not have a defined time range should be selected based on the midpoint rule. This means that a unit associated with a code is attained when the midpoint is passed. For example, if one unit of a code is one hour, one unit of that code is attained when 31 minutes (or the midpoint) of direct patient care has been provided. It is important to note that a disruption in the service does not create a new, initial service. For example, if a client receives 31 minutes of an assessment in the morning and 20 minutes of an assessment in the afternoon, the provider will claim the number of units allowable for that billing code based on the total number of service minutes (or 51 minutes). If the assessment service is most appropriately described as a psychiatric diagnostic evaluation, this code has a maximum unit of one that can be claimed. One unit of the psychiatric diagnostic evaluation code is 60 minutes, which means that the midpoint of 31 minutes must be attained to utilize this code. Therefore, a 51-minute service would be claimed as one unit.

Codes with a defined time range are not subject to the midpoint rule. When the lower bound of the time range is reached for the code, one unit may be claimed. For example, when selecting the alcohol and/or substance abuse structured assessment code G0396 with a time range of 15-30 minutes, a provider can bill for one unit of that code when the client is seen for 15 minutes.

The State has provided a spreadsheet of all available billing codes called the "Version 2 (v2) Service Table." Some key points about the Service Table:

- "Minimum Time Needed to Claim 1 Unit" column is the minimum amount of direct patient care time allowed with one unit of the code.
- "Time When Add-On Code or next Code in Series Can be Claimed" column is the number of minutes or the point at which an add-on code should be claimed, if applicable. Not all codes will have an available add-on code.
- "Can This Code be Extended?" column indicates whether the code can be extended and if so, the appropriate HCPCS code (i.e., T2021 or T2024) that should be used instead at the specified time.
- "Medicare Coordination of Benefits (COB) Required?" identifies the specific services that may be billed directly to Medi-Cal and which must be submitted to Medicare first. If this column has a "Yes," the corresponding CPT or HCPCS code is covered by Medicare. If this column has a "No," the service is not covered by Medicare.

New Expansion of Eligible Providers

The following are the new provider qualifications:

- Medical Assistants
- Clinical Trainees
- Licensed Vocational Nurses
- Licensed Psychiatric Technicians
- Licensed Occupational Therapists

Please note that the type of services that may be provided by these new eligible disciplines will also depend on scope of practice and each respective licensing board requirements.

Services claimed after July 1, 2023 by eligible providers will be reimbursed. Except for the programs that identified an early use in FY 23/24, the new provider groups and rates will be built for FY 24/25. However, they will not be ready in IRIS on July 1, 2024 as the build requires new taxonomies, rates and associated services, therefore, services will need to be held. More information will be provided as it becomes available. Currently, new provider disciplines may be part of the team that provides services for day services claims (e.g., NTP dosing, Withdrawal Management and Residential treatment days).

Medicare

There are some provider types that are eligible to render DMC-ODS services, however, are not eligible to render Medicare services. Medi-Cal is the payer of last resort. Providers must submit claims to Medicare for Medi-Cal eligible services performed by Medicare-recognized providers before submitting a claim to Medi-Cal. If the rendering provider is not eligible to provide Medicare services, billing to Medi-Cal directly is permitted.

Medicare eligible provider types are as follows:

- Physician
- Physician Assistant
- Nurse Practitioner
- Licensed Clinical Social Worker
- Clinical Psychologist
- Licensed Marriage and Family Therapists*
- Licensed Professional Clinical Counselors*

*Effective January 1, 2024, MFTs and LPCCs can bill Medicare. However, Medicare has established requirements for MFTs and LPCCs that are more stringent than California. If MFTs and LPCCs have not achieved all required hours or two years of clinically supervised experience *after* obtaining the applicable doctor's or master's degree (e.g., if part of the MFTs 3,000 hours or two years of clinically supervised experienced were accrued *before* the individual obtained their degree). In such cases, the MFT/LPCC should claim Medi-Cal directly and use the HL modifier. Providers in this situation should coordinate with IRIS to ensure that their profile is built with the HL modifier.

*****DISCLAIMER*****
This guide is a living document and will be amended as needed, based on changes made by the State as well as any internal program requirements implemented. This current version is based on the current understanding and will be updated or revised as more information and guidance becomes available.

Service Codes

Assessment Services

Assessment is an activity to evaluate or monitor the status of a client's behavioral health and determine the appropriate level of care and course of treatment for that client. Assessment pertains to the initial assessment as well as any subsequent re-assessments.
Assessment may include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the client.
Some examples of assessment activities:

- Collecting information needed to evaluate and analyze the cause or nature of the substance use disorder.
- Establishing a diagnosis of substance use disorder(s) utilizing the DSM-5-TR and assessment of treatment needs for medically necessary treatment services. A physical examination and laboratory testing (e.g., body specimen screening) necessary for treatment and evaluation may also be included, provided within scope of practice.
- Gathering information in regard to the client's needs and corresponding interventions for the purposes of working towards developing or updating the client's course of treatment as well as monitoring a client's progress.

Billing Codes:

Charge Description	CPT/HCPCS Code(s)	CDM Code
Psych Diagnostic Eval, 60 min	90791	90791-1
Psych Eval of Hospital Record, 60 Min	90885	90885-1
Psychological Testing Eval, First Hour	96130	96130-1
Psychological Testing Eval, Each Add'l Hour	96131	96131-1
Telephone Assmt and Mgmt Service, 5-10 Min	98966	98966-1
Telephone Assmt and Mgmt Service, 11-20 Min	98967	98967-1
Telephone Assmt and Mgmt Service, 21-30 Min	98968	98968-1
SUD Structured Assmt, 15-30 Min	G0396	70899-100
SUD Structured Assmt, 30+ Min	G0397	70899-101
SUD Structured Assmt, 5-14 Min	G2011	70899-102
SUD Assmt	H0001	70899-103
SUD Screening	H0049	70899-105
Assessment Substitute	T2024	TBD
SUD Drug Testing POC Tests	H0048	70899-104

Non Billable Code:

Charge Description	CPT/HCPCS Code(s)	CDM Code
Non Billable SUD Assessment	n/a	70899-300*

** This non-billable code is applicable for all services identified under Assessment.*

Assessment Services codes are not available for use at the Withdrawal Management or Residential Treatment Services levels of care. Assessment activities are considered part of the daily bundle of services. There is no separate billing permitted.

In those rare instances where a client receives only an assessment service at Withdrawal Management or Residential Treatment Services levels of care because the client decides to leave

the program on the date of admission, the appropriate assessment code may be claimed (see SUD Screening code section below).

SUD Assessment (70899-103) H0001

Available for use by non-LPHA and LPHA in accounting for the time spent administering assessment activities, such as the ASAM-based assessment. There are no limitations on provider disciplines permitted to use this code. All activities/interventions must be within the scope of practice of the rendering provider.
At this time, this can include direct client care or non-face-to-face time without the client's presence when it is for the purpose of assessing the client for appropriateness for ODS services.

Examples of when to use the SUD Assessment code:

- ✓ Conducting the initial ASAM-based assessment (i.e., meeting with the client in person, via telehealth, or telephone) to gather information needed to determine access criteria or level of care placement. For non-LPHA and certain LPHA who are not qualified to diagnose or determine level of care, this would mean gathering information to be presented to or synthesized for the qualified LPHA.
- ✓ Conducting re-assessments with the client (in person, via telehealth, or telephone) as clinically necessary throughout the treatment episode of care (i.e., determining readiness for discharge, need for higher/lower level of care, justifying continued stay at the residential level of care, etc.).
- ✓ Non-face-to-face time spent consolidating and synthesizing clinical information that is part of the ASAM-based assessment (i.e., determining the risk ratings for dimensions 1-6 of the ASAM Criteria, formulating the rationales for the dimensions of the ASAM Criteria).
- ✓ Collateral sessions/services for the purpose of gathering pertinent information about the client for assessment and determination of meeting the access criteria and/or level of care placement.

There is no maximum number of minutes that can be claimed for this service. The actual number of minutes spent providing this service should be captured and appropriately justified by the documentation. Service minutes less than 8 minutes in duration should be coded using the corresponding non-billable code.

There are no lockout codes for this service. Therefore, it is permissible to use this code when other services have been provided on the same day by the same or a different provider.

This code is locked out for use at the Withdrawal Management or Residential Treatment Services levels of care. Assessment activities are considered part of the daily bundle of services. There is no separate billing permitted in addition to the treatment day.

This code is locked out for use at the OTP/NTP level of care. Assessment is considered part of the dosing service. Assessment services cannot be claimed in addition to the dosing service.

Emphasis on Direct Client Care

The State's policy is that only direct client care should be counted toward the selection of time and "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 client visit" (DHCS Drug Medi-Cal ODS Billing Manual, May 2024). At this time, the one area of exception is for activities related to the assessment. As a result, the non-LPHA and/or LPHA's non-face-to-face time (or time spent outside of an encounter with the client) to develop the components of the ASAM based assessment that involves consolidating and synthesizing clinical information to make recommendations for treatment or to make a diagnosis (i.e., Dimensions 1-6, risk ratings, rationales) is billable. The SUD Assessment (70899-103) code should be used to account for this time.

Review of documents received from outside entities, such as legal court documents, psychiatric/psychological evaluations, hospital records, etc.) is only billable by the LPHA and must be for the purpose of informing the client's diagnosis (see Psychiatric Evaluation of Hospital Record code below). Review of such documents by non-LPHA is not billable.

SUD Screening (70899-105) H0049

Available for use by non-LPHA and LPHA (except Licensed Occupational Therapists and Occupational Therapist Clinical Trainees) for the purposes of screening a client for appropriateness to receive DMC-ODS services.

Some examples of when to use the SUD Screening code:

- ✓ Intake services/sessions – Until further clarification, this code may also be used to claim the time spent conducting an intake service/session where there is a brief screening for the purposes of admission to treatment, but the significant portion of the time is utilized towards reviewing and signing intake paperwork. In cases where the intake session also involves a significant portion devoted to the ASAM Assessment, the SUD Assessment (70899-103) H0001 code may be used instead.
- ✓ Aside from the intake service/session, this code may also be utilized for conducting the SUD Brief LOC Screening Tool or other brief screening. Also applicable for the brief assessment permitted for Withdrawal Management levels of care.
- ✓ A client presenting to an intake or assessment service/session and deciding that they do not wish to stay/participate (i.e., "open/close," admit and discharge on the same day). Also applicable for the Withdrawal Management or Residential Treatment Services levels of care if the daily rate is not claimed because the client did not stay.

There is no maximum number of minutes that can be claimed for this service. The actual number of minutes spent providing this service should be captured and appropriately justified by the documentation. Service minutes less than 8 minutes in duration should be coded using the corresponding non-billable code.

This code cannot be used on the same day as the following services:

- **SUD Structured Assessment, 15-30 Min (70899-100)**
- **SUD Structured Assessment, 30+ Min (70899-101)**

The following supplemental codes cannot be used with this code:

- **Sign Language or Oral Interpretation Services, 15 Min (70899-132)**
- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

This code is locked out for use at the Withdrawal Management or Residential Treatment Services levels of care. Assessment activities are considered part of the daily bundle of services. There is no separate billing permitted in addition to the treatment day.

This code is locked out for use at the OTP/NTP level of care. Assessment is considered part of the dosing service. Assessment services cannot be claimed in addition to the dosing service.

Transitions between the Residential and Outpatient levels of care:
The lockouts between outpatient and inpatient/24-hour services do not apply for the date of admission or discharge. This means that there are no concerns about same-day billing for those clients transitioning between the two levels of care for the date of admission or discharge. For example, when a client is leaving a residential program to enter an outpatient program, the residential program may claim the treatment day (if applicable) even when the outpatient program claims the intake/assessment service/session. It is important to remember that the residential program can only claim the treatment day when all requirements are met for claiming a treatment day and the documentation supports this.

SUD Structured Assessment, 5-14 Min (70899-102) G2011

Available for use by non-LPHA (except Medical Assistants) and LPHA (except Licensed Occupational Therapists and Occupational Therapist Clinical Trainees) for administering a brief screening, such as the required evidence-based assessment for MAT (i.e., COWS, CIWA-AR, DAST, AUDIT, etc.), according to each program's MAT Policies and Procedures.
This code is restricted to use only one time per day. Use this code when the total service minutes are 5-14 minutes.

This code cannot be used on the same day as the following services:

- **SUD Structured Assessment, 15-30 Min (70899-100)**
- **SUD Structured Assessment, 30+ Min (70899-101)**

This code may be used on the same day with the following service, if the appropriate modifiers are used:

- **Administration of Patient-Focused Health Risk Assessment Instrument (96160-1)**

SUD Structured Assessment, 15-30 Min (70899-100) G0396

Available for use by non-LPHA (except Medical Assistants) and LPHA (except Licensed Occupational Therapists and Occupational Therapist Clinical Trainees) for administering a brief screening, such as the required evidence-based assessment for MAT (i.e., COWS, CIWA-AR, DAST,

AUDIT, etc.), according to each program's MAT Policies and Procedures. This code is restricted to use only one time per day. Use this code when the total service minutes are 15-30 minutes.

This code cannot be used on the same day as the following services:

- **SUD Structured Assessment, 5-14 Min (70899-102)**
- **SUD Structured Assessment, 30+ Min (70899-101)**
- **SUD Screening (70899-105)**
- **SUD Brief Intervention, 15 Min (70899-117)**

This code may be used on the same day with the following services, if the appropriate modifiers are used:

- **Administration of Patient-Focused Health Risk Assessment Instrument (96160-1)**
- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

The following supplemental code cannot be used with this code:

- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

SUD Structured Assessment, 30+ Min (70899-101) G0397

Available for use by non-LPHA (except Medical Assistants) and LPHA (except Licensed Occupational Therapists and Occupational Therapist Clinical Trainees) for administering a brief screening, such as the required evidence-based assessment for MAT (i.e., COWS, CIWA-AR, DAST, AUDIT, etc.), according to each program's MAT Policies and Procedures. This code is restricted to use only one time per day. Use this code when the total service minutes are 31 minutes or more.

This code cannot be used on the same day as the following services:

- **SUD Structured Assessment, 5-14 Min (70899-102)**
- **SUD Structured Assessment, 15-30 Min (70899-100)**
- **SUD Screening (70899-105)**
- **SUD Brief Intervention, 15 Min (70899-117)**

This code may be used on the same day with the following services, if the appropriate modifiers are used:

- **Administration of Patient-Focused Health Risk Assessment Instrument (96160-1)**

The following supplemental codes cannot be used with this code:

- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

The **SUD Structured Assessment, 5-14/15-30/30+ Min (70899-102/70899-100/70899-101)** codes are locked out for use at the Withdrawal Management or Residential Treatment Services

levels of care. Assessment activities are part of the daily bundle of services to be provided. Therefore, there is no separate billing permitted for time spent on screening activities in addition to the treatment day.

This code is locked out for use at the OTP/NTP level of care. Assessment is considered part of the dosing service. Assessment services cannot be claimed in addition to the dosing service.

These codes require a Medicare COB.

Psychiatric Diagnostic Evaluation, 60 minutes (90791-1)

Only available for LPHA (except Pharmacists, Pharmacist Clinical Trainees, Registered Nurses, Registered Nurse Clinical Trainees, Licensed Vocational Nurses, Vocational Nurse Clinical Trainees, Licensed Psychiatric Technicians, Psychiatric Technician Clinical Trainees, Licensed Occupational Therapists, and Occupational Therapist Clinical Trainees) to use to claim an assessment activity. This may be face-to-face or non-face-to-face time. This code is restricted to use only one time per day. The minimum number of minutes required to use this code is 31 minutes. Service minutes that are 30 minutes or less should use an alternative assessment code (i.e., SUD Assessment [70899-103]). This code should be used for services up to 67 minutes. For services 68 minutes or more, the Assessment Substitute (T2024 – CDM code TBD) code should be used instead. For example, if the total service time was 100 minutes, the Assessment Substitute (T2024 – CDM code TBD) code would be used to account for all 100 minutes of the assessment service. Until the T2024 code can be built in IRIS, it is advised that services of 68 minutes or more be claimed using the SUD Assessment 70899-103 H0001 code.

When this code should be used:

- ✓ Time spent by the LPHA conceptualizing the Case Formulation or narrative necessary to establish the client's DSM-5-TR substance use disorder diagnosis and/or the justification for the level of care that is needed.
- ✓ If LPHA (instead of a non-LPHA) is meeting with the client directly and completing all components of the assessment, such as all 6 dimensions of the ASAM Criteria, this code may be used to capture the time spent. If the time spent is 68 minutes or more, it is advised that the SUD Assessment (70899-103) code be claimed until the Assessment Substitute T2024 code is built in IRIS.

This code cannot be used on the same day as the following services:

- **Family Psychotherapy (w/o Pt Present), 50 Min (90846-1)** and **Family Psychotherapy (w/ Pt Present), 50 Min (90847-1)**
- **Assessment Substitute (T2024** – CDM code TBD)
- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

This code may be used on the same day as the following services, if the appropriate modifiers are used:

- **Multiple-Family Group Psychotherapy, 15 Min (90849-1)**
- **Environmental Intervention for Medical Management Purposes (90882-1)**

- **Psychiatric Evaluation of Hospital Record, 15 Min (90885-1)**
- **Interpretation of Psychiatric Results to Family, 15 Min (90887-1)**
- **Preparation of Report of Patient's Psychiatric Status (90889-1)**
- **Administration of Patient-Focused Health Risk Assessment Instrument (96160-1)**
- **Office Outpatient Visit of New Patient, 15-29/30-44/45-59/60-74 Min (99202-1/99203-1/99204-1/99205-1)**
- **Office Outpatient Visit of an Established Patient, 10-19/20-29/30-39/40-54 Min (99212-1/99213-1/99214-1/99215-1)**
- **Home Visit of a New Patient, 15-29/30-59/60-74/75-89 Min (99341-1/99342-1/99344-1/99345-1)**
- **Home Visit of an Established Patient, 20-29/30-39/40-59/60-74 Min (99347-1/99348-1/99349-1/99350-1)**
- **Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Physician, Patient and/or Family not Present, 30 Min+ (99367-1)**
- **Medical Team Conference by non-MD, Patient/Family not present, 30 Min+ (99368-1)**
- **Prolonged clinical staff service during an evaluation and management service in the office or outpatient setting, first hour (99415 – CDM code TBD)**
- **Prolonged clinical staff service during an evaluation and management service in the office or outpatient setting, each additional 30 min (99416 – CDM code TBD)**
- **Telephone Evaluation & Management Service, 5-10/11-20/21-30 Min (99441-1/99442-1/99443-1)**
- **Inter-Professional Telephone/Internet/Electronic Health Record Assessment Provided by a Consultative Physician, 5-30 Min (99451-1)**
- **Transitional Care Management Services: Communication (direct contact, telephone, electronic) within 14 calendar days (99495-1)** and **Transitional Care Mgmt Services: Communication (direct contact, telephone, electronic) within 7 calendar days (99496-1)**
- **SUD Structured Assessment 15-30/30+/5-14 min (70899-100/70899-101/70899-102)**

The following supplemental codes cannot be used with this code:

- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

This code is locked out for use at the Withdrawal Management or Residential Treatment Services levels of care. Assessment activities are part of the daily bundle of services to be provided. Therefore, there is no separate billing permitted in addition to the treatment day.

This code is locked out for use at the OTP/NTP level of care. Assessment is considered part of the dosing service. Assessment services cannot be claimed in addition to the dosing service.

This code requires a Medicare COB.

Assessment Substitute, 15 Min (CDM code TBD) T2024

May be used by non-LPHA and LPHA (except for Licensed Psychiatric Technicians, Psychiatric Technician Clinical Trainees, Licensed Vocation Nurses, Vocational Nurse Clinical Trainees, Pharmacists, and Pharmacist Clinical Trainees) to claim for service time that exceeds the allowable number of minutes for the assessment code.

This code may be used to substitute for the following assessment codes:

- **Psychiatric Diagnostic Evaluation, 60 minutes (90791-1)** and **Psychiatric Diagnostic Evaluation with Medical Services, 60 min (90792-1)**
- **Environmental Intervention for Medical Management Purposes (90882-1)**
- **Psychiatric Evaluation of Hospital Record, 15 Min (90885-1)**

The following supplemental codes cannot be used with this code:

- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

This code is locked out for the OTP/NTP level of care. Assessment is part of the dosing service. There is no separate billing permitted in addition to the dosing service.

This code is locked out for Withdrawal Management and Residential levels of care. Assessment is part of the daily bundle of services. There is no separate billing permitted in addition to the treatment day.

This code cannot be submitted to Medicare.

Psychiatric Evaluation of Hospital Record, 60 Min (90885-1)

May only be used by LPHA (except Pharmacists, Pharmacist Clinical Trainees, Registered Nurses, Registered Nurse Clinical Trainees, Licensed Vocational Nurses, Vocational Nurse Clinical Trainees, Licensed Psychiatric Technicians, Psychiatric Technician Clinical Trainees, Licensed Occupational Therapists, and Occupational Therapist Clinical Trainees) to claim for review of documents that are specific to psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes. This code may only be used once per day.
The minimum number of minutes required to use this code is 31 minutes. Service minutes that are 30 minutes or less should be coded using the non-billable code. This code should be used for services up to 67 minutes. For services 68 minutes or more, the Assessment Substitute (T2024 – CDM code TBD) code should be used instead. For example, if the total service time was 100 minutes, the Assessment Substitute (T2024 – CDM code TBD) code would be used to account for all 100 minutes of the assessment service. Be sure that the documentation clearly substantiates the amount of time that is claimed for reviewing documents to prevent any appearance of potential fraud, waste, and/or abuse. Until the Assessment Substitute (T2024 – CDM code TBD) code is built in IRIS, there is no way to claim for services 68 minutes or more.

Therefore, the maximum number of minutes that can be claimed as this time is 67 minutes for this code.

Review of documents by the non-LPHA is not billable.

The following are the ways in which this code may be used by the LPHA:

- ✓ Review of documents from outside entities (i.e., legal court documents, psychiatric/psychological evaluations, hospital records, etc.) to inform the assessment for establishing, confirming, or changing the diagnosis.
- ✓ Review of the ASAM-based assessment completed by the non-LPHA in preparation for the consultation and conceptualization of the Case Formulation or required write-up to establish the diagnosis.
- ✓ Review of any assessment documents received from other providers (e.g., clients transferring or transitioning from another program or level of care) to confirm or amend/update the diagnosis.

This code cannot be used on the same day as the following services:

- **Assessment Substitute (T2024 – CDM code TBD)**

This code may be used on the same day as the following services, if the appropriate modifiers are used:

- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

The following supplemental codes cannot be used with this code:

- **Sign Language or Oral Interpretation Services, 15 Min (70899-132)**
- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

This code is locked out for use at the Withdrawal Management or Residential Treatment Services levels of care. Unfortunately, this means that an LPHA's time spent reviewing the non-LPHA's completion of the ASAM-based assessment or the receipt of an assessment document from another provider is not billable at these levels of care in addition to the treatment day.

This code is locked out for use at the OTP/NTP level of care. Review of documents by the LPHA is considered part of the dosing service. Review of documents by the LPHA cannot be claimed in addition to the dosing service.

Psychological Testing Evaluation, First Hour (96130-1)

May only be used by a Licensed Psychologist, Psychologist Clinical Trainee, Licensed Physician, Medical Student in Clerkship, Physician Assistant, Physician Assistant Clinical Trainee, Nurse Practitioner, and Nurse Practitioner Clinical Trainee to conduct a psychological and/or neuropsychological testing evaluation services. Psychological evaluation domains: emotional and interpersonal functioning, intellectual function, thought processes, personality, and psychopathology. Neuropsychological testing evaluation domains: intellectual function,

attention, executive function, language and communication, memory, visual-spatial function, sensorimotor function, emotional and personality features, and adaptive behavior. This code may be used for claiming time spent on integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour. Please be sure the documentation clearly supports the medical necessity for this service as it relates to substance use disorder treatment. Service time of 30 minutes or less, or the midpoint, in duration should be coded using the corresponding non-billable code. This code may only be used once per day.

This code may be used on the same day as the following service, if the appropriate modifiers are used:

- **Interactive Complexity (90785-1)**
- **Administration of Patient-Focused Health Risk Assessment Instrument (96160-1)**

This code is locked out for use at the Withdrawal Management or Residential Treatment Services levels of care. Any psychological testing performed at these levels of care are considered part of the daily bundle of services. There is no separate billing permitted in addition to the treatment day.

This code is locked out for use at the OTP/NTP level of care. Psychological testing performed at this level of care is considered part of the dosing service. Psychological testing cannot be claimed in addition to the dosing service.

This code requires a Medicare COB.

Psychological Testing Evaluation, Each Additional Hour (96131-1) may be used for each additional hour. This means that services that are 91 minutes or more would use this code to account for the additional time.

Telephone Assessment and Management Service, 5-10 Min (98966-1)

May only be used by a Physician Assistant, Physician Assistant Clinical Trainee, Nurse Practitioner, Nurse Practitioner Clinical Trainee, Licensed Psychologist, Psychologist Clinical Trainee, Licensed Clinical Social Worker, Social Worker Clinical Trainee, Licensed Marriage and Family Therapist, Marriage and Family Therapist Clinical Trainee, Licensed Professional Clinical Counselor, and Professional Clinical Counselor Clinical Trainee to provide contact with a client or collateral for the purpose of assessment and management of the client's substance use disorder treatment, only if not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment. This code may only be used once per day for services that range from 5-10 minutes in duration.

Telephone Assessment and Management Service, 11-20 Min (98967-1)

To be used for services that range from 11-20 minutes in duration. This code can only be used once per day.

Telephone Assessment and Management Service, 21-30 Min (98968-1)

To be used for services that range from 21-30 minutes in duration. This code can only be used once per day.

The Telephone Assessment and Management Service codes are locked out for use at the Withdrawal Management or Residential Treatment Services levels of care. Assessment activities are part of the daily bundle of services to be provided. Therefore, there is no separate billing permitted at these levels of care in addition to the treatment day.

These codes are locked out for use at the OTP/NTP level of care. Assessment is considered part of the dosing service. There is no separate billing permitted in addition to the dosing service.

These codes require a Medicare COB.

SUD Drug Testing Point of Care Tests (70899-104) H0048

May only be used by a Licensed Physician, Medical Student in Clerkship, Pharmacist, Pharmacist Clinical Trainee, Physician Assistant, Physician Assistant Clinical Trainee, Nurse Practitioner, Nurse Practitioner Clinical Trainee, Registered Nurse, Registered Nurse Clinical Trainee, Licensed Vocational Nurse, Vocational Nurse Clinical Trainee, Licensed Psychiatric Technician, Psychiatric Technician Clinical Trainee, or Medical Assistant to claim for providing point of care alcohol and/or other drug testing.

Due to the history of fraud, waste, and/or abuse related to drug testing in substance use disorder treatment programs, it is very important to make sure that the need for drug testing and frequency of testing is clearly documented. The chart documentation must support the medical necessity or "why" the specific client needs testing to be done at the frequency it is performed. It should be part of the treatment planning for the client's treatment episode where consideration is given for the types of services, potential interventions, and expected course of treatment necessary to address the client's particular issues. If, during the treatment episode, there is a change that necessitates increasing the frequency of the drug tests performed, there must be documentation to support this.

There is no maximum number of minutes that can be claimed for this service. The actual number of minutes spent providing this service should be captured and appropriately justified by the documentation. Service minutes less than 8 minutes, or the midpoint, in duration should be coded using the corresponding non-billable code.

There are no lockout codes for this service. Therefore, it is permissible to use this code when other services have been provided on the same day by the same or a different provider.

The following supplemental codes cannot be used with this code:

- **Sign Language or Oral Interpretation Services, 15 Min (70899-132)**
- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

This code is locked out for use at the Withdrawal Management and Residential Treatment Services levels of care. Drug testing is considered part of the daily bundle of services. Therefore, there is no separate billing permitted for drug testing in addition to the treatment day.

This code is locked out for use at the OTP/NTP level of care. Drug testing is considered part of the dosing service. There is no separate billing for administering drug tests in addition to the dosing service.

Individual Counseling Services

Individual Counseling consists of contacts with a client focusing on the specific treatment needs. It can also include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on supporting the client's achievement of treatment goals.

Billing Codes:

Charge Description	CPT/HCPCS Code(s)	CDM Code
SUD Brief Intervention, 15 Min	H0050	70899-117
Skills Training and Dev, Indv, per 15 Min	H2014	70899-113
Psychoeducational Svc, per 15 Min	H2027	70899-115
SUD Family Counseling	T1006	70899-116
Family Psychotherapy (w/o Pt Present), ~~26-~~50 Min	90846	90846-1
Family Psychotherapy (w/ Pt Present), ~~26-~~50 Min	90847	90847-1
Multiple-Family Group Psychotherapy, 84 Min	90849	90849-1
Therapy Substitute	T2021	TBD
SUD Individual Counseling, 15 Min	H0004	70899-130
SUD Treatment Plan Development/Modification	T1007	70899-125

~~New~~ Non Billable Codes:

Charge Description	CPT/HCPCS Code(s)	CDM Code
Non Billable SUD Individual Counseling	n/a	70899-309
Non Billable SUD Family Therapy	n/a	70899-307

Non Billable SUD Treatment Planning	n/a	70899-303
Non Billable SUD Discharge Svcs	n/a	70899-306

SUD Brief Intervention, 15 Min (70899-117) H0050

May be used by Peer Support Specialists, non-LPHA (except for Medical Assistants), and LPHA. It is primarily for use in Recovery Incentives programs, however, it is available for use at the outpatient levels of care. There is limited information from the State on the use of this code outside of the Recovery Incentives program. More information will be provided as it becomes available.

There is no maximum number of minutes that can be claimed for this service. The actual number of minutes spent providing this service should be captured and appropriately justified by the documentation. Service minutes less than 8 minutes, or the midpoint, in duration should be coded using the corresponding non-billable code.

This code cannot be used on the same day as the following services:

- **SUD Structured Assessment, 15-30 Min (70899-100)**
- **SUD Structured Assessment, 30+ Min (70899-101)**

The following supplemental codes cannot be used with this code:

- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

This code is locked out for use at the Withdrawal Management or Residential Treatment Services levels of care. Individual counseling activities are considered part of the daily bundle of services. There is no separate billing permitted in addition to the treatment day.

This code is locked out for use at the OTP/NTP level of care.

SUD Individual Counseling, 15 Min (70899-130) H0004

May be used by non-LPHA (except for Medical Assistants) and LPHA (except for Pharmacists, Pharmacist Clinical Trainees, Licensed Vocational Nurses, Vocational Nurse Clinical Trainees, Licensed Psychiatric Technicians, and Psychiatric Technician Clinical Trainees) and is the equivalent to what was previously used for all behavioral health counseling and therapy services/sessions. Now, this code will be solely for sessions with the client (in person, via telehealth, or telephone) to address the client's specific treatment needs related to the substance use disorder.

Some examples of when to use the SUD Individual Counseling code:

- ✓ Processing the client's addiction history and factors impacting or impacted by use
- ✓ Relapse prevention activities
- ✓ Skill building

There is no maximum number of minutes that can be claimed for this service. The actual number of minutes spent providing this service should be captured and appropriately justified by the documentation. Service minutes less than 8 minutes, or the midpoint, in duration should be coded using the corresponding non-billable code.

There are no lockout codes for this service. Therefore, it is permissible to use this code when other services have been provided on the same day by the same or different provider.

The following supplemental codes cannot be used with this code:

- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

This code is locked out for use at the Withdrawal Management or Residential Treatment Services levels of care. Individual counseling activities are considered part of the daily bundle of services. There is no separate billing permitted in addition to the treatment day.

For OTP/NTP and MAT levels of care: Medicare COB required.

SUD Treatment Plan Development/Modification (70899-125) T1007

May be used by non-LPHA (except for Medical Assistants) and LPHA (except Pharmacists and Pharmacist Clinical Trainees) for services/sessions addressing the creation of a new treatment plan or problem list or change to an existing treatment plan or problem list. Treatment planning is an activity that consists of developing and updating the plans or interventions for addressing the client's needs and monitoring a client's progress. Due to the State's focus on direct client care, the time spent by the non-LPHA or LPHA in developing, creating, or modifying the treatment plan or problem list should only be billed when it takes place within the context of a direct encounter with the client. This code may be used at any point during a client's episode of care.

Recommendation: If, during an individual counseling service/session, there is discussion that leads to an update or change in the client's course of treatment (i.e., resulting in a change to the treatment plan or problem list), the code used for that service/session should be the SUD Treatment Plan Development/Modification (70899-125) code.

There is no maximum number of minutes that can be claimed for this service. The actual number of minutes spent providing this service should be captured and appropriately justified by the documentation. Service minutes less than 8 minutes in duration should be coded using the corresponding non-billable code.

There are no lockout codes for this service. Therefore, it is permissible to use this code when other services have been provided on the same day by the same or different provider.

The following supplemental codes cannot be used with this code:

- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

This code is locked out for use at the Withdrawal Management or Residential Treatment Services levels of care. Treatment planning activities are considered part of the daily bundle of services. There is no separate billing permitted in addition to the treatment day.

This code is locked out for use at the OTP/NTP level of care. This code cannot be claimed if a dosing service has been claimed on the same day.

Non-Billable Treatment Plan Development/Modification: When providing a non-billable Treatment Plan Development/Modification service, the appropriate code to use is the **Non Billable SUD Discharge Services (70899-306)** code. This is due to the State's classification of Treatment Plan Development/Modification under the Discharge Services activity type.

Skills Training and Development, Individual, per 15 Min (70899-113) H2014
May be used by non-LPHA or LPHA (except Pharmacists and Pharmacist Clinical Trainees) and is specific to services/sessions where Patient Education is provided in an individual setting.

There is no maximum number of minutes that can be claimed for this service. The actual number of minutes spent providing this service should be captured and appropriately justified by the documentation. Service minutes less than 8 minutes, or the midpoint, in duration should be coded using the corresponding non-billable code.

There are no lockout codes for this service. Therefore, it is permissible to use this code when other services have been provided on the same day by the same or different provider.

The following supplemental codes cannot be used with this code:

- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

This code is locked out for use at the Withdrawal Management and Residential levels of care. Patient education in an individual counseling setting is considered part of the daily bundle of services. No separate billing is permitted in addition to the treatment day.

This code is locked out for use at the OTP/NTP level of care. This code cannot be claimed if a dosing service has been claimed on the same day.

Non-Billable Skills Training and Development: When providing a non-billable Skills Training and Development Individual service, the appropriate code to use is the **Non Billable SUD Treatment Planning (70899-303)** code. This is due to the State's classification of Skills Training and Development under the Treatment Planning activity type.

Psychoeducational Service, per 15 Min (70899-115) H2027

May be used by non-LPHA or LPHA (except Pharmacists and Pharmacist Clinical Trainees) and is to be utilized for those one-on-one services/sessions where psychoeducation regarding substance use is provided. Topics may include, but are not limited to, physiological and/or psychological effects of substance use, withdrawal, factors that may support or hinder recovery or contribute to return to use.

Recommendation: For those services/sessions where there may be some elements of a regular individual counseling as well as some psychoeducation that is provided, utilize the billing code for the predominant service activity. In other words, if most of the session involved psychoeducation, use the psychoeducational services code.

There is no maximum number of minutes that can be claimed for this service. The actual number of minutes spent providing this service should be captured and appropriately justified by the documentation. Service minutes less than 8 minutes, or the midpoint, in duration should be coded using the corresponding non-billable code.

There are no lockout codes for this service. Therefore, it is permissible to use this code when other services have been provided on the same day by the same or different provider.

This code is locked out for use at the Withdrawal Management and Residential levels of care. Psychoeducation in an individual counseling setting is considered part of the daily bundle of services. No separate billing is permitted in addition to the treatment day.

This code is locked out for use at the OTP/NTP level of care. This code cannot be claimed if a dosing service has been claimed on the same day.

The following supplemental codes cannot be used with this code:
- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

Non-Billable Psychoeducational Service: When providing a non-billable Psychoeducational Service, the appropriate code to use is the **Non Billable SUD Treatment Planning (70899-303)** code. This is due to the State's classification of Psychoeducational Services under the Treatment Planning activity type.

Family Psychotherapy (w/o Pt Present), 50 Min (90846-1) and Family Psychotherapy (w/ Pt Present), 50 Min (90847-1)

May only be used by LPHA (except Pharmacists, Pharmacist Clinical Trainees, Registered Nurses, Registered Nurse Clinical Trainees, Licensed Vocational Nurses, Vocational Nurse Clinical Trainees, Licensed Psychiatric Technicians, Psychiatric Technician Clinical Trainees, Licensed Occupational Therapists, and Occupational Therapist Clinical Trainees). The definition of family therapy remains the same in that it is a rehabilitative service that includes family members in the treatment process, providing education about factors that are important to the client's recovery as well as the holistic recovery of the family system. The client may or may

not be present, but the service/session will revolve around the client and their treatment needs. Therefore, there is a code for when the client is present and another code for when the client is not present. This code may only be used once per day. Family therapy services/sessions must, at minimum, be 26 minutes (the midpoint) in duration for these codes. In those rare instances where a family therapy service/session is 25 minutes or less, the SUD Family Counseling (70899-116) should be used. Family therapy services that are 58 minutes or more should be claimed using the Therapy Substitute (T2021 - CDM code TBD) code. For example, if the service is 100 minutes, the Therapy Substitute (T2021 – CDM code TBD) code would be used instead of the 90846-1/90847-1. Until the Therapy Substitute (T2021 – CDM code TBD) code is built in IRIS, services that are 58 minutes or more should be claimed using the SUD Family Counseling (70899-116) code to account for the entire duration.

These codes are locked out for use at the Withdrawal Management and Residential levels of care. Family therapy is considered part of the daily bundle of services. No separate billing is permitted in addition to the treatment day.

These codes are locked out for use at the OTP/NTP level of care. This code cannot be claimed if a dosing service has been claimed on the same day.

These codes cannot be used on the same day as the following services:

- **Psychiatric Diagnostic Evaluation, 60 min (90791-1)** and **Psychiatric Diagnostic Evaluation with Medical Services, 60 min (90792-1)**
- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**
- **Therapy Substitute (T2021 – CDM code TBD)**

Family Psychotherapy (w/o Pt Present), 50 Min (90846-1) may be used on the same day as the following services, if the appropriate modifiers are used:

- **Family Psychotherapy (w/ Pt Present), 50 Min (90847-1)**
- **Office Outpatient Visit of New Patient, 15-29/30-44/45-59/60-74 Min (99202-1/99203-1/99204-1/99205-1)**
- **Office Outpatient Visit of an Established Patient, 10-19/20-29/30-39/40-54 Min (99212-1/99213-1/99214-1/99215-1)**
- **Home Visit of a New Patient, 15-29/30-59/60-74/75-89 Min (99341-1/99342-1/99344-1/99345-1)**
- **Home Visit of an Established Patient, 20-29/30-39/40-59/60-74 Min (99347-1/99348-1/99349-1/99350-1)**
- **Prolonged clinical staff service during an evaluation and management service in the office or outpatient setting, first hour (99415 – CDM code TBD)**
- **Prolonged clinical staff service during an evaluation and management service in the office or outpatient setting, each additional 30 min (99416 – CDM code TBD)**
- **SUD Structured Assessment, 5-14/15-30/30+ Min (70899-102/70899-100/70899-101)**
- **SUD Screening (70899-105)**

- **SUD Brief Intervention, 15 Min (70899-117)**

Family Psychotherapy (w Pt Present), 50 Min (90847-1) may be used on the same day as the following services, if the appropriate modifiers are used:

- **Office Outpatient Visit of New Patient, 15-29/30-44/45-59/60-74 Min (99202-1/99203-1/99204-1/99205-1)**
- **Office Outpatient Visit of an Established Patient, 10-19/20-29/30-39/40-54 Min (99212-1/99213-1/99214-1/99215-1)**
- **Home Visit of a New Patient, 15-29/30-59/60-74/75-89 Min (99341-1/99342-1/99344-1/99345-1)**
- **Home Visit of an Established Patient, 20-29/30-39/40-59/60-74 Min (99347-1/99348-1/99349-1/99350-1)**
- **Prolonged clinical staff service during an evaluation and management service in the office or outpatient setting, first hour (99415 – CDM code TBD)**
- **Prolonged clinical staff service during an evaluation and management service in the office or outpatient setting, each additional 30 min (99416 – CDM code TBD)**
- **SUD Structured Assessment, 5-14/15-30/30+ Min (70899-102/70899-100/70899-101)**
- **SUD Screening (70899-105)**
- **SUD Brief Intervention, 15 Min (70899-117)**

The following supplemental codes cannot be used with these codes:

- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

These codes require a Medicare COB.

Non-Billable Family Therapy Service: When providing a non-billable Family Psychotherapy Service, the appropriate code to use is the **Non Billable SUD Family Therapy (70899-307)** code.

Therapy Substitute, 15 Min (T2021 – CDM code TBD)

May be used by LPHA (except Pharmacists, Pharmacist Clinical Trainees, Registered Nurses, Registered Nurse Clinical Trainees, Licensed Vocational Nurses, Vocational Nurse Clinical Trainees, Licensed Psychiatric Technicians, Psychiatric Technician Clinical Trainees, Licensed Occupational Therapists, and Occupational Therapist Clinical Trainees) to account for family therapy services that exceed the maximum number of minutes allowed for the code. For service time of 58 minutes or more of the Family Psychotherapy (90846-1/90847-1) codes and 92 minutes or more of the Multi-Family Group Psychotherapy (90849-1) code, the Therapy Substitute (T2021 – CDM code TBD) code is used in place of the family therapy code.

This code is locked out for the OTP/NTP level of care. This code cannot be claimed if a dosing service has been provided on the same day.

This code is locked out for Withdrawal Management and Residential levels of care. Family therapy services are part of the daily bundle of services. There is no separate billing permitted in addition to the treatment day.

This code cannot be used on the same day as the following services:

- **Family Psychotherapy (w/o Pt Present), 50 Min (90846-1)**
- **Family Psychotherapy (w/ Pt Present), 50 Min (90847-1)**
- **Multiple-Family Group Psychotherapy, 84 Min (90849-1)**

The following supplemental codes cannot be used with these codes:

- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

This code cannot be submitted to Medicare.

SUD Family Counseling (70899-116) T1006

May be used by non-LPHA (except Medical Assistants) and LPHA (except Pharmacists, Pharmacist Clinical Trainees, Licensed Vocational Nurses, Vocational Nurse Clinical Trainees, Licensed Psychiatric Technicians, Psychiatric Technician Clinical Trainees, Licensed Occupational Therapists, and Occupational Therapist Clinical Trainees) for services/sessions working with the client's family, with or without the client's presence. The focus of the service/sessions must be around the client's substance use disorder treatment needs. Collateral services/sessions as well as couples work may also be claimed using this code. This code may also be used by the LPHA for family therapy services/sessions that are less than 26 minutes.

There is no maximum number of minutes that can be claimed for this service. The actual number of minutes spent providing this service should be captured and appropriately justified by the documentation. Service minutes less than 8 minutes, or the midpoint, in duration should be coded using the corresponding non-billable code.

There are no lockout codes for this service. Therefore, it is permissible to use this code when other services have been provided on the same day by the same or different provider.

This code is locked out for use at the Withdrawal Management and Residential levels of care. Family counseling is considered part of the daily bundle of services. No separate billing is permitted in addition to the treatment day.

This code is locked out for use at the OTP/NTP level of care. This code cannot be claimed if a dosing service has been provided on the same day.

The following supplemental codes cannot be used with these codes:

- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

Non-Billable Family Counseling Service: When providing a non-billable Family Counseling Service, the appropriate code to use is the **Non Billable SUD Individual Counseling (70899-309)** code. This is due to the State's classification of Family Counseling Services under the Individual Counseling activity type.

Multiple-Family Group Psychotherapy, 84 Min (90849-1)

May only be used by LPHA (except Pharmacists, Pharmacist Clinical Trainees, Registered Nurses, Registered Nurse Clinical Trainees, Licensed Vocational Nurses, Vocational Nurse Clinical Trainees, Licensed Psychiatric Technicians, Psychiatric Technician Clinical Trainees, Licensed Occupational Therapists, and Occupational Therapist Clinical Trainees) for services/sessions where multiple families are involved to address particular themes and common experiences related to substance use and its impact on the family unit. This code can only be used once per day. Non-LPHA may work with multiple families together using the SUD Family Counseling (70899-116). A progress note should be completed for each client whose family is participating in the encounter. Each progress note should account for the total duration of the group, the number of clients/client families in attendance, and the number of therapists. For example, if the Multiple-Family Group was a 64-minute session with five client families and one provider, each of the progress notes will reflect the total service minutes of 64 minutes, a total of 5 participants, and 1 provider. For service time of 92 minutes or more, the Therapy Substitute (T2021 – CDM code TBD) code should be used instead. This means that if the service is 100 minutes, the Therapy Substitute (T2021 – CDM code TBD) code is used to account for all 100 minutes of the multi-family group service. However, until the Therapy Substitute (T2021 – CDM code TBD) code is built in IRIS, services that are 92 minutes are more should be coded using the SUD Family Counseling (70899-116) code. Service minutes less than 43 minutes, or the midpoint, in duration should be coded using the SUD Family Counseling (70899-116) code. Service minutes less than 8 minutes will need to be coded using the corresponding non-billable code.

This code is locked out for use at the Withdrawal Management and Residential levels of care. Multi-family counseling is considered part of the daily bundle of services. No separate billing is permitted in addition to the treatment day.

This code is locked out and not available for use at the OTP/NTP level of care. This code cannot be claimed if a dosing service has been provided on the same day.

This code cannot be used on the same day as the following services:

- **Therapy Substitute (T2021 – CDM code TBD)**

This code may be used on the same day as the following services, if the appropriate modifiers are used:

- **Family Psychotherapy (w/o Pt Present), 50 Min (90846-1)** and **Family Psychotherapy (w/ Pt Present), 50 Min (90847-1)**
- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**
- **Office Outpatient Visit of New Patient, 15-29/30-44/45-59/60-74 Min (99202-1/99203-1/99204-1/99205-1)**

- **Office Outpatient Visit of an Established Patient, 10-19/20-29/30-39/40-54 Min (99212-1/99213-1/99214-1/99215-1)**
- **Home Visit of a New Patient, 15-**29/30-59/60-74/75-89 Min **(99341-1/99342-1/99344-1/99345-1)**
- **Home Visit of an Established Patient,** 20-29/30-39/40-59/60-74 **Min (99347-1/99348-1/99349-1/99350-1)**
- **Prolonged clinical staff service during an evaluation and management service in the office or outpatient setting, first hour (99415 – CDM code TBD)**
- **Prolonged clinical staff service during an evaluation and management service in the office or outpatient setting, each additional 30 min (99416 – CDM code TBD)**
- **SUD Structured Assessment, 5-14/15-30/30+ Min (70899-102/70899-100/70899-101)**
- **SUD Screening (70899-105)**
- **SUD Brief Intervention, 15 Min (70899-117)**

The following supplemental codes cannot be used with these codes:

- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

This code requires a Medicare COB.

Non-Billable Multi-Family Group Service: When providing a non-billable Multi-Family Group Service, the appropriate code to use is the **Non Billable SUD Family Therapy (70899-307)** code. This is due to the State's classification of Multi-Family Group Services under the Family Therapy activity type.

Mobile Crisis Services

Only available for those programs designated to provide this service.

Billing Codes:

Charge Description	CPT/HCPCS Code(s)	CDM Code
Mobile Crisis Intervention Svcs	H2011	70899-108

Non Billable Code:

Charge Description	CPT/HCPCS Code(s)	CDM Code
Non Billable SUD Crisis Intervention	n/a	70899-301

Mobile Crisis services cannot be billed with 24-hour services except on the date of admission and date of discharge.

Mobile Crisis Intervention Services (70899-108) H2011

There are no allowable provider disciplines for this code. It is designated specifically the mobile crisis intervention program for mobile crisis encounters that include a face-to-face assessment, mobile crisis team response, crisis planning, and a follow-up check-in. This code can only be used once per day.

Crisis Services

Crisis Intervention consists of contacts with a client in crisis. There is no change in the definition of a crisis. A crisis means an actual relapse or an unforeseen event or circumstance, which presents to the client an imminent threat of relapse. The focus of the service is on alleviating the crisis problem and limited to the stabilization of the client's immediate situation. It is intended to be provided in the least intensive level of care that is medically necessary to treat the client's condition.

Billing Codes:

Charge Description	CPT/HCPCS Code(s)	CDM Code
SUD Crisis Intervention (outPt)	H0007	70899-107

Non Billable Code:

Charge Description	CPT/HCPCS Code(s)	CDM Code
Non Billable SUD Crisis Intervention	n/a	70899-301

SUD Crisis Intervention (outpatient) [70899-107] H0007

May be used by non-LPHA (except Medical Assistants) and LPHA (except Pharmacists and Pharmacist Clinical Trainees) to address a client experiencing a crisis situation.

There is no maximum number of minutes that can be claimed for this service. The actual number of minutes spent providing this service should be captured and appropriately justified by the documentation. Service minutes less than 8 minutes, or the midpoint, in duration should be coded using the corresponding non-billable code.

There are no lockout codes for this service. Therefore, it is permissible to use this code when other services have been provided on the same day by the same or different provider.

This code is locked out for use at the Residential or Withdrawal Management levels of care. Crisis intervention is considered part of the daily bundle of services. There is no separate billing permitted in addition to the treatment day.

This code is locked out for use at the OTP/NTP level of care. This code cannot be claimed if a dosing service has been provided on the same day.

Please remember that documentation for a crisis intervention progress note should be completed within 24 hours of the date of service. Date of service counts as day zero.

The following supplemental codes cannot be used with these codes:

- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

Group Counseling Services

Group Counseling consists of contacts with multiple clients at the same time, the focus of which is on the substance use disorder treatment needs of the participants as a whole.

Billing Codes:

Charge Description	CPT/HCPCS Code(s)	CDM Code
Skills training and dev, Group, per 15 Min	H2014	70899-114
SUD Group Counseling	H0005	70899-131

Non Billable Code:

Charge Description	CPT/HCPCS Code(s)	CDM Code
Non Billable SUD Group Counseling	n/a	70899-310
~~Non Billable SUD Treatment Planning~~	~~n/a~~	~~70899-303~~

Skills Training and Development, Group, per 15 Min (70899-114) H2014

May be used by non-LPHA and LPHA (except Pharmacists and Pharmacist Clinical Trainees) to specifically bill for Patient Education groups. The definition of Patient Education remains the same: it is education for the client on addiction, treatment, recovery and associated health risks. Patient Education groups may be billed even if the total number of participants exceeds twelve (12).

There is no maximum number of minutes that can be claimed for this service. The actual number of minutes spent providing this service should be captured and appropriately justified by

the documentation. Service minutes less than 8 minutes, or the midpoint, in duration should be coded using the corresponding non-billable code.

There are no lockout codes for this service. Therefore, it is permissible to use this code when other services have been provided on the same day by the same or different provider.

This code is locked out for use at the Withdrawal Management and Residential levels of care. Patient Education is considered part of the daily bundle of services. No separate billing is permitted in addition to the treatment day.

This code is locked out for use at the OTP/NTP level of care. This code cannot be claimed if a dosing service has been provided on the same day.

The following supplemental codes cannot be used with these codes:

- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

Non-Billable Skills Training and Development: When providing a non-billable Skills Training and Development Group, the appropriate code to use is the **Non-Billable Group Counseling (70899-310)** code.

SUD Group Counseling (70899-131) H0005

May be used by non-LPHA (except Medical Assistants) and LPHA (except Pharmacists, Pharmacist Clinical Trainees, Licensed Vocational Nurses, Vocational Nurse Clinical Trainees, Licensed Psychiatric Technicians, and Psychiatric Technician Clinical Trainees) and continues to apply to all clinical groups, except Patient Education, that address the substance use disorder treatment needs of its participants. The minimum number of clients is two (2) and the maximum number of clients is still twelve (12) in order to bill for a group service. A progress note for each participant in the group is needed with the total number of service minutes and total number of clients present.

There is no maximum number of minutes that can be claimed for this service. The actual number of minutes spent providing this service should be captured and appropriately justified by the documentation. Service minutes less than 8 minutes, or the midpoint, in duration should be coded using the corresponding non-billable code.

There are no lockout codes for this service. Therefore, it is permissible to use this code when other services have been provided on the same day by the same or different provider.

This code is locked out for use at the Withdrawal Management and Residential levels of care. Group counseling is considered part of the daily bundle of services. No separate billing is permitted in addition to the treatment day.

The following supplemental codes cannot be used with these codes:

- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

OTP/NTP or MAT: Medicare COB required.

Care Coordination Services

Care Coordination may include:

- Coordinating with primary care and mental health care providers to monitor and support comorbid health conditions;
- Discharge planning, including coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and referrals to primary/ specialty medical providers;
- Ancillary services, including individualized connection, referral, and linkages to community-based services and supports including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, child care, child development, family/marriage education, and mutual aid support groups.

Due to the State's policy that only direct client care should be counted toward the selection of time and "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 client visit" (DHCS Drug Medi-Cal ODS Billing Manual, May 2024), billing is not allowed for review of documents. The exception to this is in relation to diagnosing the client by the LPHA (see the Psychiatric Evaluation of Hospital Record code section above).

A separate progress note for every encounter (same day/provider/type of service) OR one progress note for all activities? The State expects that if a provider conducts the same type of service more than once for the same client on the same day, the provider should claim the service as one service rather than two separate services. For example, if a provider met with the client for a 16-minute care coordination service/session and then later that same day, provided another care coordination service/session for 23 minutes to the same client, the provider may complete one progress note rather than two separate progress notes. There would be one Financial Identification Number (FIN) for the one billing code (e.g., Targeted Case Management 70899-120) to capture the total number of service minutes (e.g., 39 minutes) provided on that day for that service type. The corresponding progress note documentation would demonstrate that there were two instances of the care coordination service/session with the client on that day. The reason that the two encounters can be combined is because it is the same type of service (or billing code) for the same provider and client on the same day. Services/sessions conducted on different days must be documented separately. Likewise, if the same provider conducted services/sessions of different service types in one day, then each service type needs to be documented in separate progress notes.

Billing Codes:

Charge Description	CPT/HCPCS Code(s)	CDM Code
Environmental Intervention for Med Mgmt Purposes	90882	90882-1
Preparation of Report of Pt's Psych Status	90889	90889-1
Admin of Pt-Focused Health Risk Assmt Instrument	96160	96160-1
Med Team Conf by Non-MD, Pt/Fam not Present, 30 Min+	99368	99368-1
Prenatal Care, At Risk Assmt	H1000	70899-119
Targeted Case Management, Each 15 Min	T1017	70899-120

Non Billable Codes:

Charge Description	CPT/HCPCS Code(s)	CDM Code
Non Billable SUD Care Coordination	n/a	70899-304

Environmental Intervention for Medical Management Purposes (90882-1)

May be used by a non-LPHA and LPHA (except Pharmacists and Pharmacist Clinical Trainees). It is to be used for coordinating with agencies, employers, or institutions on behalf of the client for the purpose of medical management. It is advised that this code be utilized specifically for coordination of care of medical or physical health care issues relevant to the client. This code may only be used once per day.

The minimum number of service minutes required to claim this code is 8 minutes. Services that are less than 8 minutes should be coded using the corresponding non-billable code. Since only one unit of this code is permitted, services that are 23 minutes or more should be coded using the Targeted Case Management (70899-120) code.

This code cannot be used on the same day as the following services:

- **Assessment Substitute (T2024** – CDM code TBD)

The following supplemental codes cannot be used with these codes:

- **Sign Language or Oral Interpretation Services, 15 Min (70899-132)**
- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

Preparation of Report of Patient’s Psychiatric Status (90889-1)

May only be used by an LPHA (except Pharmacists and Pharmacist Clinical Trainees) for claiming time spent in preparing reports on the client’s psychiatric status, history, treatment, or progress (other than for legal or consultative purpose) for other individuals, agencies, or insurance carriers. This code may only be used once per day.

The minimum number of service minutes required to claim this code is 8 minutes. Services that are less than 8 minutes should be coded using the corresponding non-billable code.

The following supplemental codes cannot be used with these codes:

- **Sign Language or Oral Interpretation Services, 15 Min (70899-132)**
- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

Administration of Patient-Focused Health Risk Assessment Instrument (96160-1)

May be used by a Medical Assistant or an LPHA (except Pharmacists and Pharmacist Clinical Trainees). This code can only be used ONE TIME PER YEAR BY ANY PROVIDER WITHIN THE NETWORK. It is intended to be used for an annual wellness visit. If it is found to have been used by another provider or another county within the calendar year, the claim will be denied.

The minimum number of service minutes required to claim this code is 8 minutes. Services that are less than 8 minutes should be coded using the corresponding non-billable code.

This code cannot be used on the same day as the following services:

- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

This code may be used on the same day as the following services, if the appropriate modifiers are used:

- **SUD Screening (70899-105)**
- **SUD Brief Intervention, 15 Min (70899-117)**

The following supplemental codes cannot be used with these codes:

- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

This code requires a Medicare COB.

Medical Team Conference by Non-MD, Patient/Family not Present, 30 Min+ (99368-1)

May be used by non-MD LPHA (except Licensed Vocational Nurses, Vocational Nurse Trainees, Licensed Psychiatric Technicians, Psychiatric Technician Clinical Trainees, Licensed Occupational Therapists, and Occupational Therapist Clinical Trainees) for a Clinician Consultation service to elicit additional expertise on complex cases pertaining to a client’s

medication or level of care placement. It is permitted to be used by Physician Assistants, Physician Assistant Clinical Trainees, Pharmacists, Pharmacist Clinical Trainees, Nurse Practitioners, Nurse Practitioner Clinical Trainees, Registered Nurses, and Registered Nurse Clinical Trainees. Medical Assistants, although not considered LPHA, may also utilize this code. This code can only be used once per day. The minimum number of service minutes required to claim this code is 30 minutes. For claiming services less than 30 minutes, the Targeted Case Management (70899-120) should be used. This code cannot be extended.

This code may be used on the same day as the following services, if the appropriate modifiers are used:

- **Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Physician, Patient and/or Family not Present, 30 Min+ (99367-1)**
- **SUD Screening (70899-105)**
- **SUD Brief Intervention, 15 Min (70899-117)**

The following supplemental codes cannot be used with these codes:

- **Sign Language or Oral Interpretation Services, 15 Min (70899-132)**
- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

Prenatal Care, At Risk Assessment (70899-119) H1000

May be used by a non-LPHA (except Medical Assistants) or LPHA (except Licensed Occupational Therapists and Occupational Therapist Clinical Trainees) when the service or session is related to assessing the client's access to prenatal care as well as in consideration of a possible referral to a perinatal-specific program.

There is no maximum number of minutes that can be claimed for this service. The actual number of minutes spent providing this service should be captured and appropriately justified by the documentation. Service minutes less than 8 minutes in duration should be coded using the corresponding non-billable code.

There are no lockout codes for this service. Therefore, it is permissible to use this code when other services have been provided on the same day by the same or different provider.

The following supplemental codes cannot be used with these codes:

- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

Targeted Case Management, Each 15 Min (70899-120) T1017

May be used by a non-LPHA or LPHA. This is the equivalent to what was previously Care Coordination. The service/session can be with or without the presence of the client.

Some examples of when to use Targeted Case Management:

- ✓ Educating and connecting the client to community resources
- ✓ Coordinating with other providers to assist in a smooth transition for clients moving from one level of care or program to another
- ✓ Discharge planning to help ensure success post-discharge with regards to internal and external resources
- ✓ Time spent consulting with other providers
- ✓ Coordinating care with other professionals at external entities, agencies, or organizations (i.e., social workers, probation officers, teachers, etc.)

Please note that most activities that are not considered direct client care that were previously billable are no longer billable. The following activities cannot be billed:

- Review of documents, such as
  - The physician's review of the physical exam,
  - Documents from outside entities for non-LPHA,
  - Review of past progress notes/assessment/treatment plan/problem list to prepare for upcoming services, etc.)
- Time spent completing the discharge summary for a client with an unplanned discharge

There is no maximum number of minutes that can be claimed for this service. The actual number of minutes spent providing this service should be captured and appropriately justified by the documentation. Service minutes less than 8 minutes in duration should be coded using the corresponding non-billable code.

There are no lockout codes for this service. Therefore, it is permissible to use this code when other services have been provided on the same day by the same or different provider.

The following supplemental codes cannot be used with these codes:

- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

Perinatal Codes

All billing codes have a corresponding Perinatal code that may be utilized by providers in a State-designated Perinatal program. Please remember that to claim services using the Perinatal code, there must be medical documentation on file that evidences the client's pregnant or postpartum status.

Perinatal Assessment Billing Codes:

Charge Description	CPT/HCPCS Code(s)	CDM Code
Peri Psych Diagnostic Eval, 60 min	90791	90791-2
Peri Psych Eval of Hospital Record, 60 Min	90885	90885-2
Peri Psychological Testing Eval, First Hour	96130	96130-2

Peri Psychological Testing Eval, Each Add'l Hour	96131	96131-2
Peri Assessment Substitute	T2024	TBD
Peri Telephone Assmt and Mgmt Service, 5-10 Min	98966	98966-2
Peri Telephone Assmt and Mgmt Service, 11-20 Min	98967	98967-2
Peri Telephone Assmt and Mgmt Service, 21-30 Min	98968	98968-2
Peri SUD Structured Assmt, 15-30 Min	G0396	70899-200
Peri SUD Structured Assmt, 30+ Min	G0397	70899-201
Peri SUD Structured Assmt, 5-14 Min	G2011	70899-202
Peri SUD Assmt	H0001	70899-203
Peri SUD Screening	H0049	70899-205
Peri SUD Drug Testing POC Tests	H0048	70899-204

Perinatal Individual Counseling Codes:

Charge Description	CPT/HCPCS Code(s)	CDM Code
Peri Skills Training and Dev, Indv, per 15 Min	H2014	70899-213
Peri Psychoeducational Svc, per 15 Min	H2027	70899-215
Peri SUD Family Counseling	T1006	70899-216
Peri SUD Recovery Incentives, 15 Min	H0050	70899-218
Peri Family Psychotherapy (w/o Pt Present), 50 Min	90846	90846-2
Peri Family Psychotherapy (w/ Pt Present), 50 Min	90847	90847-2
Peri Multiple-Family Group Psychotherapy, 84 Min	90849	90849-2
Peri Therapy Substitute	T2021	TBD
SUD Individual Counseling, 15 Min	H0004	70899-230

Perinatal Crisis Service Billing Codes:

Charge Description	CPT/HCPCS Code(s)	CDM Code
Peri Mobile Crisis Intervention Svcs	H2011	70899-208
Peri SUD Crisis Intervention (outPt)	H0007	70899-207
Peri SUD Individual Counseling, 15 Min	H0004	70899-230

Perinatal Group Counseling Billing Codes:

Charge Description	CPT/HCPCS Code(s)	CDM Code
Peri Skills training and dev, Group, per 15 Min	H2014	70899-214
Peri SUD Group Counseling	H0005	70899-231

Perinatal Care Coordination Billing Codes:

Charge Description	CPT/HCPCS Code(s)	CDM Code
Peri Environmental Intervention for Med Mgmt Purposes	90882	90882-2
Peri Preparation of Report of Pt's Psych Status	90889	90889-2
Peri Admin of Pt-Focused Health Risk Assmt Instrument	96160	96160-2
Peri Med Team Conf by Non-MD, Pt/Fam not Present, 30 Min+	99368	99368-2
Peri Prenatal Care, At Risk Assmt	H1000	70899-219
Targeted Case Management, Each 15 Min	T1017	70899-220

Perinatal Non Billable Codes (same as regular Non Billable Codes):

Charge Description	CPT/HCPCS Code(s)	CDM Code
Non Billable SUD Assessment	n/a	70899-300
Non Billable SUD Crisis Intervention	n/a	70899-301

Non Billable SUD Treatment Planning	n/a	70899-303
Non Billable SUD Care Coordination	n/a	70899-304
Non Billable SUD Discharge Svcs	n/a	70899-306
Non Billable SUD Family Therapy	n/a	70899-307
Non Billable SUD Individual Counseling	n/a	70899-309
Non Billable SUD Group Counseling	n/a	70899-310

Recovery Services

Recovery Services are designed to support recovery and prevent relapse with the objective of restoring the client to their best possible functional level. Recovery Services emphasize the client's central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to clients.

Billing Codes:

Charge Description	CPT/HCPCS Code(s)	CDM Code
Community Support Svcs, per 15 Min	H2015	70899-121
Psychosocial Rehabilitation, Indv, per 15 Min	H2017	70899-122
Psychosocial Rehabilitation, Group, per 15 Min	H2017	70899-123
Recovery Svcs, 1 Hr	H2035	70899-124

~~New~~ Non Billable Code:

Charge Description	CPT/HCPCS Code(s)	CDM Code
Non Billable SUD Recovery Svcs	n/a	70899-305

Community Support Services, per 15 Min (70899-121) H2015

May be used by non-LPHA (except Medical Assistants) and LPHA (except Pharmacists and Pharmacist Clinical Trainees) for care coordination activities at the recovery services level of

care. See the care coordination section above for examples that are also applicable to recovery services.

There is no maximum number of minutes that can be claimed for this service. The actual number of minutes spent providing this service should be captured and appropriately justified by the documentation. Service minutes less than 8 minutes in duration should be coded using the corresponding non-billable code.

There are no lockout codes for this service. Therefore, it is permissible to use this code when other services have been provided on the same day by the same or different provider.

The following supplemental codes cannot be used with these codes:

- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

Psychosocial Rehabilitation, Individual, per 15 Min (70899-122) and **Psychosocial Rehabilitation, Group, per 15 Min (70899-123) H2017**

May be used by non-LPHA and LPHA, within scope of practice, for assessment, counseling, family therapy, recovery monitoring, and relapse prevention services/sessions provided individually and the group setting.

There is no maximum number of minutes that can be claimed for this service. The actual number of minutes spent providing this service should be captured and appropriately justified by the documentation. Service minutes less than 8 minutes in duration should be coded using the corresponding non-billable code.

There are no lockout codes for this service. Therefore, it is permissible to use this code when other services have been provided on the same day by the same or different provider.

The following supplemental codes cannot be used with these codes:

- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

Recovery Services, 1 Hr (70899-124) H2035

May be used by non-LPHA (except Medical Assistants) and LPHA (except Licensed Occupational Therapists and Occupational Therapist Clinical Trainees) for services at this level of care that are at most one hour (minimum should be at least the midpoint or 30 minutes) in duration in a one-on-one setting with a client. Service minutes less than 30 minutes in duration should be coded using the **Psychosocial Rehabilitation, Individual, per 15 Min (70899-122)** code.

There are no lockout codes for this service. Therefore, it is permissible to use this code when other services have been provided on the same day by the same or different provider.

The following supplemental codes cannot be used with these codes:

- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

Important note about Recovery Services: Recovery services may be provided as a standalone service or part of the treatment level of care. However, the provision of recovery services to clients who are also receiving a treatment level of care is not a common scenario and must be clinically appropriate. At the residential levels of care, in most cases, recovery services will likely be provided as part of the bundle of services for the treatment day, in which case there is no additional billing of recovery services permitted. Once a client is no longer receiving the residential levels of care (i.e., no treatment days are being claimed), recovery services may be billable as a standalone service. In such cases, the client's episode of care would be closed at the residential level and opened under a recovery services episode of care.

Perinatal Recovery Services Billing Codes:

Charge Description	CPT/HCPCS Code(s)	CDM Code
Peri Community Support Svcs, per 15 Min	H2015	70899-221
Peri Psychosocial Rehabilitation, Indv, per 15 Min	H2017	70899-222
Peri Psychosocial Rehabilitation, Group, per 15 Min	H2017	70899-223
Peri Recovery Svcs, 1 Hr	H2035	70899-224

Perinatal Recovery Non Billable Code (same as regular Non Billable Code):

Charge Description	CPT/HCPCS Code(s)	CDM Code
Non Billable SUD Recovery Svcs	n/a	70899-305

Peer Support Specialist Services Codes

Peer Support Services consist of individual and group coaching to promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths. Services are intended to prevent relapse, empower clients through strength-based coaching, support linkages to community resources, and educate clients and their families about SUD and the recovery process. Peer Support Services can be delivered and claimed as a standalone service or provided in conjunction with other DMC-ODS services, including inpatient and residential services.

Peer Support Services can only be provided by certified peer specialists.

Peer Support Services include the following service components:

- Educational Skill Building Groups – A supportive environment where clients and their families learn coping mechanisms and problem-solving skills to help the client achieve desired outcomes. These groups should promote skill building for clients in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.
- Engagement – Activities and coaching that encourages and supports clients to participate in behavioral health treatment. This may include supporting clients in their transitions between levels of care and in developing their own recovery goals and processes.
- Therapeutic Activity – A structured non-clinical activity that promotes recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support the client's treatment to attain and maintain recovery within their communities. Activities may include, but are not limited to, advocacy on behalf of the client; promotion of self-advocacy; resource navigation; and collaboration with the clients and others providing care or support to the client, family members, or significant support persons.

Peer Support Specialist Services Billing Codes:

Charge Description	CPT/HCPCS Code(s)	CDM Code
Behavioral Health Prevention Education, Group	H0025	70899-128
Self-Help/Peer Svcs, Individual, per 15 Min	H0038	70899-129

Perinatal Peer Support Specialist Services Billing Codes:

Charge Description	CPT/HCPCS Code(s)	CDM Code
Peri Behavioral Health Prevention Education, Group	H0025	70899-228
Peri Self-Help/Peer Svcs, Individual, per 15 Min	H0038	70899-229

Non Billable Peer Support Specialist Services Billing Code:

Charge Description	CPT/HCPCS Code(s)	CDM Code
Non Billable SUD Peer Support Svcs	n/a	70899-308

Self-Help/Peer Services (70899-129) H0038

This code may only be used by Certified Peer Support Specialists to claim Engagement and Therapeutic Activity components described above. Services are to be conducted in a one-on-one setting (in person, by telephone, or telehealth).

There is no maximum number of minutes that can be claimed for this service. The actual number of minutes spent providing this service should be captured and appropriately justified by the documentation. Service minutes less than 8 minutes in duration should be coded using the corresponding non-billable code.

The following supplemental codes cannot be used with these codes:

- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

Behavioral Health Prevention Education Service (70899-128) H0025

This code may only be used by Certified Peer Support Specialists to claim Educational Skill Building Groups.

The following supplemental codes cannot be used with these codes:

- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

Contingency Management (Recovery Incentives) Services

Contingency Management Services is a pilot program for non-residential DMC-ODS providers that utilizes an evidence-based approach to reinforce individual positive behavior change for non-use or treatment/medication adherence in those with a stimulant use disorder. This benefit is only available for those programs that have been approved to provide this service.

Contingency Management Services Billing Codes:

Charge Description	CPT/HCPCS Code(s)	CDM Code
SUD Recovery Incentives, 15 Min	H0050	70899-118

Non Billable Codes:

Charge Description	CPT/HCPCS Code(s)	CDM Code
Non Billable SUD Individual Counseling	n/a	70899-309

SUD Recovery Incentives, 15 Min (70899-118) H0050

May be used by non-LPHA (except Medical Assistants), LPHA, and other trained staff under the supervision of an LPHA for only those programs designated by the State to provide a Contingency Management or Recovery Incentives program. Recovery Incentives activities include administering drug tests, informing clients of the results of the evidence/urine drug test, entering the results into the mobile or web-based application, providing educational information, and distributing motivational incentives.

There is no maximum number of minutes that can be claimed for this service. The actual number of minutes spent providing this service should be captured and appropriately justified by the documentation. Service minutes less than 8 minutes, or the midpoint, in duration should be coded using the corresponding non-billable code.

This code cannot be used on the same day as the following services:

- **SUD Structured Assessment, 15-30 Min (70899-100)**
- **SUD Structured Assessment, 30+ Min (70899-101)**

The following supplemental codes cannot be used with these codes:

- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

Perinatal Contingency Management Services Billing Codes:

Charge Description	CPT/HCPCS Code(s)	CDM Code
Peri SUD Recovery Incentives, 15 Min	H0050	70899-218

Non Billable Contingency Management Services Billing Codes:

Charge Description	CPT/HCPCS Code(s)	CDM Code
Non Billable SUD Individual Counseling	n/a	70899-309

Supplemental Codes

Supplemental Codes are codes that describe additional and simultaneous services that were provided to the client during the visit or codes that describe the additional severity of the client's condition. Supplemental codes cannot be billed independently. They must be billed with a/another (primary) service.

Supplemental Billing Codes:

Charge Description	CPT/HCPCS Code(s)	CDM Code
Health Bx Int, Fam wo Pt F2F, 16-30 Min	96170	96170-1
Health Bx Int, Fam wo Pt F2F, Add'l 15 Min	96171	96171-1
Sign Lang. or Oral Interp. Svcs, 15 Min	T1013	70899-132
Interactive Complexity	90785	90785-1
Interp. of Psych Results to Fam, 50 Min	90887	90887-1

Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1) and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

May be used by Medical Assistants and LPHA (except Pharmacists and Pharmacist Clinical Trainees). Health behavior intervention services are used to address the psychological, behavioral, emotional, cognitive, and interpersonal factors important to the assessment, treatment, or management of physical health problems. It is to be used when the primary focus of the service/session is related to the client's physical health care/condition, using psychological and/or psychosocial interventions designed to ameliorate specific disease-related problems. Health behavior intervention includes promotion of functional improvement, minimizing psychological and/or psychosocial barriers to recovery, and management of and improved coping with medical conditions. This service emphasizes active patient/family engagement and involvement in a session with the family, but not including the client.

This code is locked out for use at the OTP/NTP level of care, Withdrawal Management, and Residential levels of care.

In order to utilize the **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1),** one of the following services must have been provided as the primary service:

- **Psychological Testing Evaluation, First Hour (96130-1)**
- **Telephone Assessment and Management Service, 5-10/11-20/21-30 Min (98966-1/98967-1/98968-1)**
- **Office Outpatient Visit of New Patient, 15-29/30-44/45-59/60-74 Min (99202-1/99203-1/99204-1/99205-1)**
- **Office Outpatient Visit of an Established Patient, 10-19/20-29/30-39/40-54 Min (99212-1/99213-1/99214-1/99215-1)**
- **Home Visit of a New Patient, 15-29/30-59/60-74/75-89 Min (99341-1/99342-1/99344-1/99345-1)**
- **Home Visit of an Established Patient, 20-29/30-39/40-59/60-74 Min (99347-1/99348-1/99349-1/99350-1)**

- **Telephone Evaluation & Management Service, 5-10/11-20/21-30 Min (99441-1/99442-1/99443-1)**
- **SUD Structured Assessment 5-14 Min (70899-102)**
- **SUD Assessment (70899-103)**

These codes cannot be used on the same day as the following services:

- **Interactive Complexity (90785-1)**
- **Psychiatric Diagnostic Evaluation, 15 min (90791-1)** and **Psychiatric Diagnostic Evaluation with Medical Services, 15 min (90792-1)**
- **Family Psychotherapy (w/o Pt Present), 50 Min (90846-1)** and **Family Psychotherapy (w/ Pt Present), 50 Min (90847-1)**
- **Administration of Patient-Focused Health Risk Assessment Instrument (96160-1)**

The **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** code may be used on the same day as the following services, if the appropriate modifiers are used:

- **Multiple-Family Group Psychotherapy, 84 Min (90849-1)**
- **Environmental Intervention for Medical Management Purposes (90882-1)**
- **Psychiatric Evaluation of Hospital Record, 60 Min (90885-1)**
- **Interpretation of Psychiatric Results to Family, 15 Min (90887-1)**
- **Preparation of Report of Patient's Psychiatric Status (90889-1)**
- **SUD Structured Assessment, 15-30/30+ Min (70899-100/70899-101)**

The **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)** code may be used on the same day as the following services, if the appropriate modifiers are used:

- **Environmental Intervention for Medical Management Purposes (90882-1)**
- **Preparation of Report of Patient's Psychiatric Status (90889-1)**
- **SUD Structured Assessment, ~~15-30/~~30+ Min (~~70899-100/~~70899-101)**

The following supplemental codes cannot be used with these codes:

- **Sign Language or Oral Interpretation Services, 15 Min (70899-132)**

Sign Language or Oral Interpretation Services, 15 Min (70899-132) T1013

May be used by non-LPHA and LPHA when an oral interpreter is necessary for a client who is unable to speak or speak the same language as the provider. This supplemental code is not to be used when the provider is speaking the client's preferred language and only when an oral interpreter is utilized. This occurs along with another primary service, such as individual counseling. It is available for use with all services, including treatment planning, family therapy, and discharge services/sessions.

The number of units that can be claimed is dependent on the total service time for the primary service.

There are no lockout codes for this service. Therefore, it is permissible to use this code when other services have been provided on the same day by the same or different provider.

This code is locked out for use at the Withdrawal Management and Residential levels of care. The cost of interpretation is included in the daily bundled rate.

This code cannot be claimed together with **Interactive Complexity (90785-1).**

The following supplemental codes cannot be used with these codes:

- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

Interactive Complexity (90785-1)

May be used by non-LPHA and LPHA when there is a need to manage maladaptive communication related to high anxiety, high reactivity, repeated questions, or when the patient is under the influence of alcohol or other substances. The documentation must clearly explain what constituted the need for the use of this code. Can be billed in any given encounter. Only one unit per service may be claimed.

This code is locked out for use at the OTP/NTP, Withdrawal Management, and Residential levels of care.

This code can only be used with the following primary services:

- **Psychiatric Diagnostic Evaluation, 15 min (90791-1)** and **Psychiatric Diagnostic Evaluation with Medical Services, 15 min (90792-1)**
- **Family Psychotherapy (w/o Pt Present), 26-50 Min (90846-1)** and **Family Psychotherapy (w/ Pt Present), 26-50 Min (90847-1)**
- **Multiple-Family Group Psychotherapy, 15 84 Min (90849-1)**
- **Office Outpatient Visit of New Patient, 15-29/30-44/45-59/60-74 Min (99202-1/99203-1/99204-1/99205-1)**
- **Office Outpatient Visit of an Established Patient, 10-19/20-29/30-39/40-54 Min (99212-1/99213-1/99214-1/99215-1)**
- **Home Visit of a New Patient, 15-29/30-59/60-74/75-89 Min (99341-1/99342-1/99344-1/99345-1)**
- **Home Visit of an Established Patient, 20-29/30-39/40-59/60-74 Min (99347-1/99348-1/99349-1/99350-1)**

This code cannot be used on the same day as the following services:

- **Sign Language or Oral Interpretation Services, 15 Min (70899-132)**
- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

This code requires a Medicare COB.

For Outpatient only: In those cases where a service/session requires the sign language or oral interpretation, interactive complexity, or health behavior intervention supplemental codes, two different services (such as Psychiatric Diagnostic Evaluation and individual counseling) may be provided to the same client on the same day.

Interpretation of Psychiatric Results to Family, 50 Min (90887-1)

May only be used by LPHA (except Licensed Vocational Nurses, Vocational Nurse Clinical Trainees, Licensed Psychiatric Technicians, and Psychiatric Technician Clinical Trainees) when an interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data is provided to family or other responsible persons, or advising them how to assist client. Only one unit per service may be claimed. The minimum number of service minutes required to use this code is 26 minutes.

This code is locked out for use at the OTP/NTP, Withdrawal Management, and Residential levels of care.

This code can only be used with the following primary services:

- **Environmental Intervention for Medical Management Purposes (90882-1)**
- **Preparation of Report of Patient's Psychiatric Status (90889-1)**
- **Psychological Testing Evaluation, First Hour (96130-1)**
- **Administration of Patient-Focused Health Risk Assessment Instrument (96160-1)**
- **Office Outpatient Visit of New Patient, 15-29/30-44/45-59/60-74 Min (99202-1/99203-1/99204-1/99205-1)**
- **Office Outpatient Visit of an Established Patient, 10-19/20-29/30-39/40-54 Min (99212-1/99213-1/99214-1/99215-1)**
- **Home Visit of a New Patient, 15-29/30-59/60-74/75-89 Min (99341-1/99342-1/99344-1/99345-1)**
- **Home Visit of an Established Patient, 20-29/30-39/40-59/60-74 Min (99347-1/99348-1/99349-1/99350-1)**
- **Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Physician, Patient and/or Family not Present, 30 Min+ (99367-1)**
- **Medical Team Conference by non-MD, Patient/Family not present, 30 Min+ (99368-1)**
- **Transitional Care Management Services: Communication (direct contact, telephone, electronic) within 14 calendar days (99495-1) and Transitional Care Mgmt Services: Communication (direct contact, telephone, electronic) within 7 calendar days (99496-1)**

This code may be used on the same day as the following service, if the appropriate modifiers are used:

- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

The following supplemental codes cannot be used with these codes:

- **Sign Language or Oral Interpretation Services, 15 Min (70899-132)**
- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

Perinatal Supplemental Billing Codes:

Charge Description	CPT/HCPCS Code(s)	CDM Code
Peri Health Bx Int, Fam wo Pt F2F, 16-30 Min	96170	96170-2
Peri Health Bx Int, Fam wo Pt F2F, Add'l 15 Min	96171	96171-2
Peri Sign Lang. or Oral Interp. Svcs, 15 Min	T1013	70899-232
Peri Interactive Complexity	90785	90785-2
Peri Interp. of Psych Results to Fam, 50 Min	90887	90887-2

Residential Treatment Services

There are no changes to the residential day rate services. In addition to the treatment day, MAT, care coordination, and recovery services may be claimed. Please note that, as was the case previously, Residential 3.3 and Perinatal services codes are only permitted to be used by programs that have been designated by the State.

Billable Residential Treatment Services:

Charge Description	CPT/HCPCS Code(s)	CDM Code
Residential 3.1	H0019	90899-638
Residential 3.1 Peri	H0019	90899-656
Residential 3.3	H0019	90899-844
Residential 3.3 Peri	H0019	90899-888
Residential 3.5	H0019	90899-674
Residential 3.5 Peri	H0019	90899-692

Non-Billable Residential Treatment Services:

Charge Description	CPT/HCPCS Code(s)	CDM Code
NB Residential 3.1	n/a	90899-639
NB Residential 3.1 Peri	n/a	90899-657
NB Residential 3.3	n/a	90899-845

NB Residential 3.3 Peri	n/a	90899-889
NB Residential 3.5	n/a	90899-675
NB Residential 3.5 Peri	n/a	90899-693

MAT Services at Residential

At this time, the State allows for the use of two codes, Medication Training and Support-Individual per 15 Min (70899-110) and Oral Medication Admin, Direct Observation, 15 Min (70899-109) for MAT services at the Residential levels of care. For further information on the specific use of these codes, please refer to the MAT Documentation Manual.

Care Coordination at Residential

For all available care coordination services billing codes allowable at the residential levels of care, please see the Care Coordination Services section above.

Recovery Services at Residential

Although the State allows for clients to receive Recovery Services while receiving another treatment level of care, this is very rare. Clients at residential programs who are also appropriate for Recovery Services will likely be receiving it as part of their residential treatment episode of care. In such cases, there should be no additional billing of recovery services on top of the residential treatment day. It is most appropriate for clients to receive Recovery Services once they are no longer receiving residential treatment services. For such clients, a new episode of care is opened at recovery services and the billing codes outlined in the Recovery Services section above are applicable.

Unbundled Services

If a treatment day is not being claimed, services may be claimed separately so long as there is appropriate documentation to support the provision of the service. Please see the sections above for information on billing per service.

Withdrawal Management Services

There are no changes to the withdrawal management day rate services. In addition to the treatment day, MAT, care coordination, and recovery services may be claimed.

Billable WM 3.2 Service:

Charge Description	CPT/HCPCS Code(s)	CDM Code
WM Residential Withdrawal Mgmt 3.2	H0012	90899-779

Non-Billable WM 3.2 Service:

Charge Description	CPT/HCPCS Code(s)	CDM Code

NB WM Residential Withdrawal Mgmt 3.2	n/a	90899-780

MAT Services at Withdrawal Management

At this time, the State allows for the use of two codes, Medication Training and Support-Individual per 15 Min (70899-110) and Oral Medication Admin, Direct Observation, 15 Min (70899-109) for MAT services at the withdrawal management levels of care. For further information on the specific use of these codes, please refer to the MAT Documentation Manual.

Care Coordination at Withdrawal Management

For all available care coordination services billing codes allowable at the withdrawal management level of care, please see the Care Coordination Services section above.

Recovery Services at Withdrawal Management

Although the State allows for clients to receive Recovery Services while receiving another treatment level of care, this is very rare. Clients at withdrawal management who are also appropriate for Recovery Services will likely be receiving it as part of their withdrawal management episode of care. In such cases, there should be no additional billing of Recovery Services on top of the withdrawal management treatment day. It is most appropriate for clients to receive Recovery Services once they are no longer receiving withdrawal management services. For such clients, a new episode of care is opened under Recovery Services and the billing codes outlined in the Recovery Services section above are applicable.

Opioid Treatment Programs (OTP)/Narcotic Treatment Programs (NTP)

Billable OTP/NTP Regular Services (*part of the dosing service):

Charge Description	CPT/HCPCS Code(s)	CDM Code
Psych Diagnostic Eval w/ Med Svcs, 60 Min*	90792	90792-1
SUD Assessment*	H0001	70899-103
SUD Screening*	H0049	70899-105
SUD Structured Assmt, 15-30 Min*	G0396	70899-100
SUD Structured Assmt, 30+ Min*	G0397	70899-101
SUD Structured Assmt, 5-14 Min*	G2011	70899-102
Targeted Case Management, Each 15 Min	T1017	70899-120
Environmental Intervention for Med Management Purposes	90882	90882-1

Preparation of Report of Pt's Psych Status	90889	90889-1
Admin of Pt-Focused Health Risk Assmt Instrument	96160	96160-1
Prenatal Care, At Risk Assmt	H1000	70899-119
Med Team Conf by MD, Pt/Fam not Present, 30 Min+	99367	99367-1
Med Team Conf by Non-MD, Pt/Fam not Present, 30 Min+	99368	99368-1
Inter-Prof Phone/EHR Assmt-Consult. MD 5-15 Min	99451	99451-1
SUD Individual Counseling, 15 Min	H0004	70899-130
SUD Group Counseling	H0005	70899-131
OTP/NTP Methadone Dosing	H0020	90899-632
OTP/NTP Courtesy Methadone Dosing	H0020	90899-786
OTP/NTP MAT Antabuse Administration	S5001	90899-719
OTP/NTP MAT Narcan (2-pack Nasal Spray)	S5001	90899-722
OTP/NTP MAT Suboxone Administration	S5001	90899-728
OTP/NTP MAT Subutex Administration	S5001	90899-731
OTP/NTP MAT Courtesy Subutex Administration	S5001	90899-838
OTP/NTP MAT Suboxone (Film) Administration	S5001	90899-862
OTP/NTP MAT Sublocade Injectable Administration	S5001	90899-865
OTP/NTP MAT Vivitrol Injectable Administration	S5001	90899-868
OTP/NTP MAT Disulfiram Administration	S5000	90899-635
OTP/NTP MAT Buprenorphine (oral) Administration	S5000	90899-734
OTP/NTP MAT Courtesy Buprenorphine (oral) Administration	S5000	90899-841
OTP/NTP MAT Buprenorphine w/ Naloxone (oral) Administration	S5000	90899-737
OTP/NTP MAT Naloxone (2-pack Nasal Spray)	S5000	90899-743

OTP/NTP MAT Buprenorphine w/ Naloxone (Film) Administration	S5000	90899-871
OTP/NTP MAT Buprenorphine Injectable Administration	S5000	90899-874
OTP/NTP MAT Naltrexone Injectable Administration	S5000	90899-877

Billable OTP/NTP Perinatal Services (*part of the dosing service):

Charge Description	CPT/HCPCS Code(s)	CDM Code
Peri Psych Diagnostic Eval w/ Med Svcs, 60 Min*	90792	90792-2
Peri SUD Assessment*	H0001	70899-203
Peri SUD Screening*	H0049	70899-205
Peri SUD Structured Assmt, 15-30 Min*	G0396	70899-200
Peri SUD Structured Assmt, 30+ Min*	G0397	70899-201
Peri SUD Structured Assmt, 5-14 Min*	G2011	70899-202
Peri Targeted Case Management, Each 15 Min	T1017	70899-220
Peri Environmental Intervention for Med Mgmt Purposes	90882	90882-2
Peri Preparation of Report of Pt's Psych Status	90889	90889-2
Peri Admin of Pt-Focused Health Risk Assmt Instrument	96160	96160-2
Peri Prenatal Care, At Risk Assmt	H1000	70899-219
Peri Med Team Conf by MD, Pt/Fam not Present, 30 Min+	99367	99367-2
Peri Med Team Conf by Non-MD, Pt/Fam not Present, 30 Min+	99368	99368-2
Peri Inter-Prof Phone/EHR Assmt-Consult. MD 5-15 Min	99451	99451-2
SUD Individual Counseling, 15 Min	H0004	70899-230
Peri SUD Group Counseling	H0005	70899-231
OTP/NTP Peri Methadone Dosing	H0020	90899-804
OTP/NTP Peri Courtesy Methadone Dosing	H0020	90899-808

OTP/NTP Peri MAT Antabuse Administration	S5001	90899-811
OTP/NTP Peri MAT Narcan (2-pack Nasal Spray)	S5001	90899-814
OTP/NTP Peri MAT Suboxone Administration	S5001	90899-817
OTP/NTP Peri MAT Subutex Administration	S5001	90899-820
OTP/NTP Peri MAT Suboxone (Film) Administration	S5001	90899-880
OTP/NTP Peri MAT Disulfiram Administration	S5000	90899-823
OTP/NTP Peri MAT Buprenorphine (oral) Administration	S5000	90899-826
OTP/NTP Peri MAT Buprenorphine w/ Naloxone (oral) Administration	S5000	90899-829
OTP/NTP Peri MAT Naloxone (2-pack Nasal Spray)	S5000	90899-832
OTP/NTP Peri MAT Buprenorphine w/ Naloxone (Film) Administration	S5000	90899-883
OTP/NTP Peri MAT Sublocade Injectable Administration	S5001	90899-890
OTP/NTP Peri MAT Vivitrol Injectable Administration	S5001	90899-892
OTP/NTP Peri MAT Buprenorphine Injectable Administration	S5000	90899-894
OTP/NTP Peri MAT Naltrexone Injectable Administration	S5000	90899-896

Non-Billable OTP/NTP Regular Services:

Charge Description	CPT/HCPCS Code(s)	CDM Code
Non Billable SUD Assessment	n/a	70899-300
NB OTP/NTP Methadone Dosing	n/a	90899-633
NB OTP/NTP WM Methadone Dosing	n/a	90899-785
NB OTP/NTP Courtesy Methadone Dosing	n/a	90899-787
NB OTP/NTP MAT Antabuse Administration	n/a	90899-720
NB OTP/NTP MAT Narcan Administration	n/a	90899-723
NB OTP/NTP MAT Suboxone Administration	n/a	90899-729

NB OTP/NTP MAT Subutex Administration	n/a	90899-732
NB OTP/NTP MAT Courtesy Subutex Administration	n/a	90899-839
NB OTP/NTP MAT Suboxone (Film) Administration	n/a	90899-863
NB OTP/NTP MAT Sublocade Injectable Administration	n/a	90899-866
NB OTP/NTP MAT Vivitrol Injectable Administration	n/a	90899-869
NB OTP/NTP MAT Disulfiram Administration	n/a	90899-636
NB OTP/NTP MAT Buprenorphine (oral) Administration	n/a	90899-735
NB OTP/NTP MAT Courtesy Buprenorphine (oral) Administration	n/a	90899-842
NB OTP/NTP MAT Buprenorphine w/ Naloxone (oral) Administration	n/a	90899-738
NB OTP/NTP MAT Naloxone Administration	n/a	90899-744
NB OTP/NTP MAT Buprenorphine w/ Naloxone (Film) Administration	n/a	90899-872
NB OTP/NTP MAT Buprenorphine Injectable Administration	n/a	90899-875
NB OTP/NTP MAT Naltrexone Injectable Administration	n/a	90899-878

Non-Billable OTP/NTP Perinatal Services:

Charge Description	CPT/HCPCS Code(s)	CDM Code
Non Billable SUD Assessment	n/a	70899-300
NB OTP/NTP Peri Methadone Dosing	n/a	90899-805
NB OTP/NTP Peri WM Methadone Dosing	n/a	90899-807
NB OTP/NTP Peri Courtesy Methadone Dosing	n/a	90899-809
NB OTP/NTP Peri MAT Antabuse Administration	n/a	90899-812
NB OTP/NTP Peri MAT Narcan Administration	n/a	90899-815
NB OTP/NTP Peri MAT Suboxone Administration	n/a	90899-818

NB OTP/NTP Peri MAT Subutex Administration	n/a	90899-821
NB OTP/NTP Peri MAT Suboxone (Film) Administration	n/a	90899-881
NB OTP/NTP Peri MAT Disulfiram Administration	n/a	90899-824
NB OTP/NTP Peri MAT Buprenorphine (oral) Administration	n/a	90899-827
NB OTP/NTP Peri MAT Buprenorphine w/ Naloxone (oral) Administration	n/a	90899-830
NB OTP/NTP Peri MAT Naloxone Administration	n/a	90899-833
NB OTP/NTP Peri MAT Buprenorphine w/ Naloxone (Film) Administration	n/a	90899-884
NB OTP/NTP Peri MAT Sublocade Injectable Administration	n/a	90899-891
NB OTP/NTP Peri MAT Vivitrol Injectable Administration	n/a	90899-893
NB OTP/NTP Peri MAT Buprenorphine Injectable Administration	n/a	90899-895
NB OTP/NTP Peri MAT Naltrexone Injectable Administration	n/a	90899-897

***Dosing bundled rates at the NTP include the costs for physical exam; drug screening, intake assessment; medical director supervision; TB, syphilis, HIV and Hepatitis C tests; drug screening; dosing; and ingredient costs.**

Assessment Services at NTP *****May only be claimed separately from dosing if a dosing service is not provided on the same day *****

The **Psychiatric Diagnostic Evaluation with Medical Services, 60 Min (90792-1)** may only be used by a Licensed Physician, Medical Student in Clerkship, Physician Assistant, Physician Assistant Clinical Trainee, Nurse Practitioner, and Nurse Practitioner Clinical Trainee for conducting the Physical Exam at the time of a patient's admission to the NTP. This may be face-to-face or non-face-to-face time. This code is restricted to use only one time per day. The minimum number of service minutes required to claim this code is 31 minutes (the midpoint). The Assessment Substitute T2024 (CDM code TBD) code is not available for use at the OTP/NTP level of care to allow for claiming of services when the duration is 68 minutes or more. If the LPHA write up or narrative documentation that is required is also completed on the same day by the same LPHA, this code may capture both activities. The Physical Exam at the time of a patient's admission is only billable when there is no dosing on the same day.

If a dosing service has not been provided, the **SUD Assessment (70899-103) code** should be used by the non-LPHA to claim the time spent to complete the ASAM based assessment. If dosing has been provided, all assessment activities are included as part of that service.

Individual Counseling Services at NTP

The **SUD Individual Counseling, 15 Min (70899-130)** code, may be used to claim for the required 50-minute individual sessions/services. For further information on individual counseling, see the Individual Counseling section above.

The following services are permitted at the NTP (see descriptions in the Individual Counseling section above) when a dosing service has not been provided on that day:

- **SUD Crisis Intervention (outPt) 70899-107**
- **Psychoeducational Svc, per 15 Min 70899-115**
- **SUD Family Counseling 70899-116**
- **SUD Brief Intervention, 15 Min 70899-117**
- **SUD Treatment Plan Development and Modification (70899-125)**

Group Counseling Services at NTP

The **SUD Group Counseling (70899-131)** code, which may be used by non-LPHA and LPHA to claim for group sessions/services. For further information on groups, see the Group Counseling section above.

Care Coordination Services at NTP

The following care coordination services are permitted at the NTP:

- **Targeted Case Management, Each 15 Min (70899-120)**
- **Environmental Intervention for Medical Management Purposes (90882-1)**
- **Preparation of Report of Patient's Psychiatric Status (90889-1)**
- **Administration of Patient-Focused Health Risk Assessment Instrument (96160-1)**
- **Prenatal Care, At Risk Assessment (70899-119)**
- **Inter-Professional Telephone/Internet/Electronic Health Record Assessment Provided by a Consultative Physician, 5-15 Min (99451-1)**
- Clinician consultation or the **Medical Team Conference by non-MD, Patient/Family not present, 30 Min+ (99368-1)**
- Physician consultation or **Medical Team Conference by MD, Patient/Family not present, 30 Min+ (99367-1)**

For further information on care coordination services, see the Care Coordination section above.

Medication Services

For more information specific to MAT program providers, please refer to the MAT Documentation Manual.

Evaluation and Management (E/M) services may only be performed by medical LPHA (Licensed Physician, Physician Assistant, Nurse Practitioner).

Some examples of E/M activities include:

- Performing a medically appropriate examination and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other health care professionals (when not separately reported)
- Interpreting (not separately reported) and communicating results to the patient/family/caregiver)
- Care coordination (not separately reported)

Do not count time spent on the following:

- The performance of other services that are reported separately
- Travel
- Teaching that is general and not limited to discussion that is required for the management of a specific patient
- Review of documents to prepare for or as follow up from an E/M encounter

Medication Services Billing Codes:

Charge Description	CPT/HCPCS Code(s)	CDM Code
Psych Diagnostic Eval w/ Med Svcs, 60 Min	90792	90792-1
Oral Medication Admin, Direct Observation, 15 Min	H0033	70899-109
Medication Training and Support-Indv per 15 Min	H0034	70899-110
Medication Training and Support-Group per 15 Min	H0034	70899-111
Office OutPt Visit of New Pt, 15-29 Min	99202	99202-1
Office OutPt Visit of a New Pt, 30-44 Min	99203	99203-1
Office OutPt Visit of a New Pt, 45-59 Min	99204	99204-1
Office OutPt Visit of a New Pt, 60-74 Min	99205	99205-1
Office OutPt Visit of an Established Pt, 10-19 Min	99212	99212-1
Office OutPt Visit of an Established Pt, 20-29 Min	99213	99213-1
Office OutPt Visit of an Established Pt, 30-39 Min	99214	99214-1
Office OutPt Visit of an Established Pt, 40-54 Min	99215	99215-1

Prolonged Clinical Staff Service, first hour	99415	TBD
Prolonged Clinical Staff Service, additional 30 min	99416	TBD
Home Visit of a New Pt, 29 Min	99341	99341-1
Home Visit of a New Pt, 30-59 Min	99342	99342-1
Home Visit of a New Pt, 60-74 Min	99344	99344-1
Home Visit of a New Pt, 75-89 Min	99345	99345-1
Home Visit of an Established Pt, 20-29 Min	99347	99347-1
Home Visit of an Established Pt, 30-39 Min	99348	99348-1
Home Visit of an Established Pt, 40-59 Min	99349	99349-1
Home Visit of an Established Pt, 60-74 Min	99350	99350-1
Prolonged Outpatient E&M, each 15 min	99417	TBD
Telephone E&M Service, 5-10 Min	99441	99441-1
Telephone E&M Service, 11-20 Min	99442	99442-1
Telephone E&M Service, 21-30 Min	99443	99443-1
Med Team Conf by MD, Pt/Fam not Present, 30 Min+	99367	99367-1
Transitional Care Mgmt Svcs: Comm. w/in 14 days	99495	99495-1
Transitional Care Mgmt Svcs: Comm. w/in 7 days	99496	99496-1
Inter-Prof Phone/EHR Assmt-Consult. MD 5-30 Min	99451	99451-1

New Medication Services Non Billable Code:

Charge Description	CPT/HCPCS Code(s)	CDM Code
Non Billable SUD Assessment	n/a	70899-300
Non Billable SUD Medication Services	n/a	70899-302
Non Billable SUD Discharge Svcs	n/a	70899-306
Non Billable SUD Care Coordination	n/a	70899-304

Psychiatric Diagnostic Evaluation with Medical Services, 60 Min (90792-1)

May only be used by a Licensed Physician, Medical Student in Clerkship, Physician Assistant, Physician Assistant Clinical Trainee, Nurse Practitioner, or Nurse Practitioner Clinical Trainee for performing a MAT or OTP/NTP evaluation. An integrated biopsychosocial and medical assessment that can include history, mental status, other physical examination elements as indicated, and recommendations. May include communication with family or other sources, prescription of medications, and review and ordering of laboratory or other diagnostic services. This code is restricted to use only one time per day. The minimum number of service minutes required to claim this code is 31 minutes. Services that are 30 minutes or less may be claimed using an alternative **Office Outpatient Visit of New Patient, 15-29/30-44/45-59/60-74 Min (99202-1/99203-1/99204-1/99205-1)** or **Office Outpatient Visit of an Established Patient, 10-19/20-29/30-39/40-54 Min (99212-1/99213-1/99214-1/99215-1)** code. For services that are 68 minutes or more, the Assessment Substitute T2024 (CDM code TBD) code should be used instead. For example, if the total service time was 100 minutes, the T2024 code would be used to account for all 100 minutes of the assessment service. Until the T2024 code can be built in IRIS, it is advised that services of 68 minutes or more be claimed using an alternative Office Outpatient Evaluation & Management Service code.

For Outpatient programs that may offer physical exams conducted by the Medical Director of the program, the service may be claimed using this code.

Review of a physical exam (either completed on-site or received from an outside provider) for the purpose of fulfilling the physical exam requirement for each DMC-ODS client is not billable.

This code cannot be used on the same day as the following services:

- **Family Psychotherapy (w/o Pt Present), 50 Min (90846-1)** and **Family Psychotherapy (w/ Pt Present), 50 Min (90847-1)**
- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**
- **Assessment Substitute T2024 –** CDM code TBD

This code may be used on the same day as the following services, if the appropriate modifiers are used:

- **Psychiatric Diagnostic Evaluation, 15 min (90791-1)**
- **Multiple-Family Group Psychotherapy, 15 Min (90849-1)**
- **Environmental Intervention for Medical Management Purposes (90882-1)**
- **Psychiatric Evaluation of Hospital Record, 15 Min (90885-1)**
- **Interpretation of Psychiatric Results to Family, 15 Min (90887-1)**
- **Preparation of Report of Patient's Psychiatric Status (90889-1)**
- **Administration of Patient-Focused Health Risk Assessment Instrument (96160-1)**
- **Office Outpatient Visit of New Patient, 15-29/30-44/45-59/60-74 Min (99202-1/99203-1/99204-1/99205-1)**

- **Office Outpatient Visit of an Established Patient, 10-19/20-29/30-39/40-54 Min (99212-1/99213-1/99214-1/99215-1)**
- **Home Visit of a New Patient, 15-29/30-59/60-74/75-89 Min (99341-1/99342-1/99344-1/99345-1)**
- **Home Visit of an Established Patient, 20-29/30-39/40-59/60-74 Min (99347-1/99348-1/99349-1/99350-1)**
- **Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Physician, Patient and/or Family not Present, 30 Min+ (99367-1)**
- **Medical Team Conference by non-MD, Patient/Family not present, 30 Min+ (99368-1)**
- **Prolonged clinical staff service during an evaluation and management service in the office or outpatient setting, first hour (99415 – CDM code TBD)**
- **Prolonged clinical staff service during an evaluation and management service in the office or outpatient setting, each additional 30 min (99416 – CDM code TBD)**
- **Telephone Evaluation & Management Service, 5-10/11-20/21-30 Min (99441-1/99442-1/99443-1)**
- **Inter-Professional Telephone/Internet/Electronic Health Record Assessment Provided by a Consultative Physician, 5-15 Min (99451-1)**
- **Transitional Care Management Services: Communication (direct contact, telephone, electronic) within 14 calendar days (99495-1) and Transitional Care Mgmt Services: Communication (direct contact, telephone, electronic) within 7 calendar days (99496-1)**
- **SUD Structured Assessment 15-30/30+/5-14 min (70899-100/70899-101/70899-102)**

The following supplemental codes cannot be used with this code:

- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

This code is locked out for use at the OTP/NTP level of care. Assessment is part of the dosing services. There is no separate billing permitted in addition to the dosing service.

This code is locked out for use at the Withdrawal Management and Residential levels of care as assessment is considered part of the daily bundle of services. There is no separate billing permitted in addition to the treatment day.
This code requires a Medicare COB.

Non-Billable Psychiatric Diagnostic Evaluation with Medical Services: When providing a non-billable Psychiatric Diagnostic Evaluation Service, the appropriate code to use is the **Non Billable SUD Assessment (70899-300)** code. This is due to the State's classification of Psychiatric Diagnostic Evaluation Services under the Assessment activity type.

Oral Medication Administration, Direct Observation, 15 Min (70899-109) H0033
May be used by a Licensed Physician, Medical Student in Clerkship, Physician Assistant, Physician Assistant Clinical Trainee, Nurse Practitioner, Nurse Practitioner Clinical Trainee, Pharmacist, Pharmacist Clinical Trainee, Registered Nurse, Registered Nurse Clinical Trainee, Licensed Vocational Nurse, Vocational Nurse Clinical Trainee, Licensed Psychiatric Technician, Psychiatric Technician Clinical Trainee, Licensed Occupational Therapist, Occupational Therapist Clinical Trainee, and Medical Assistant for a MAT program when claiming a medication administration service.

MAT services at Withdrawal Management and Residential levels of care can be claimed using this code.

There is no maximum number of minutes that can be claimed for this service. The actual number of minutes spent providing this service should be captured and appropriately justified by the documentation. Service minutes less than 8 minutes in duration should be coded using the corresponding non-billable code.

There are no lockout codes for this service. Therefore, it is permissible to use this code when other services have been provided on the same day by the same or different provider.

The following supplemental codes cannot be used with this code:

- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

Medication Training and Support- Individual per 15 Min (70899-110) and **Medication Training and Support-Group per 15 Min (70899-111) H0034**
May be used by a Licensed Physician, Medical Student in Clerkship, Physician Assistant, Physician Assistant Clinical Trainee, Nurse Practitioner, Nurse Practitioner Clinical Trainee, ~~or~~ Pharmacist, Pharmacist Clinical Trainee, Registered Nurse, Registered Nurse Clinical Trainee, Licensed Vocational Nurse, Vocational Nurse Clinical Trainee, Licensed Psychiatric Technician, Psychiatric Technician Clinical Trainee, and Medical Assistant for a MAT program when providing psychoeducation, training, and/or support related to medication, either in a one-on-one or group setting.

MAT services at Withdrawal Management and Residential levels of care can be claimed using this code.

There is no maximum number of minutes that can be claimed for this service. The actual number of minutes spent providing this service should be captured and appropriately justified by the documentation. Service minutes less than 8 minutes in duration should be coded using the corresponding non-billable code.

There are no lockout codes for this service. Therefore, it is permissible to use this code when other services have been provided on the same day by the same or different provider.

The following supplemental codes cannot be used with this code:

- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

Office Outpatient Visit of New Patient, 15-29/30-44/45-59/60-74 Min (99202-1/99203-1/99204-1/99205-1) and **Office Outpatient Visit of an Established Patient, 10-19/20-29/30-39/40-54 Min (99212-1/99213-1/99214-1/99215-1)**

May only be used by medical LPHA (Licensed Physician, Medical Student in Clerkship, Physician Assistant, Physician Assistant Clinical Trainee, Nurse Practitioner, and Nurse Practitioner Clinical Trainee) when office or other outpatient visit for the evaluation and management of a new or established patient is provided. The service requires a medically appropriate history and/or examination and straightforward/low level/moderate level/high level of medical decision making. This code can only be used once per day. *"New"* patient means an individual who has not received services from any provider within the same provider (or legal entity) in the past three (3) years. *"Established"* patient means an individual who has received any services with a provider (or legal entity) in the past three (3) years.

These codes cannot be used on the same day as the following services:

- **Inter-Professional Telephone/Internet/Electronic Health Record Assessment Provided by a Consultative Physician, 5-15 Min (99451-1)**

These codes may only be used on the same day as the following services, if the appropriate modifiers are used:

- **Psychological Testing Evaluation, First Hour (96130-1)**
- **SUD Structured Assessment 15-30/30+/5-14 min (70899-100/70899-101/70899-102)**
- **SUD Screening (70899-105)**
- **SUD Brief Intervention, 15 Min (70899-117)**

For the Office Outpatient Visit of New Patient codes:

- **Office Outpatient Visit of New Patient, 30-44 Min (99203-1) can be used with Office Outpatient Visit of New Patient, 15-29 Min (99202-1) with the appropriate modifiers**
- **Office Outpatient Visit of New Patient, 45-59 Min (99204-1) can be used with Office Outpatient Visit of New Patient, 15-29/30-44 Min (99202-1/99203-1) with the appropriate modifiers**
- **Office Outpatient Visit of New Patient, 60-74 Min (99205-1) can be used with Office Outpatient Visit of New Patient, 15-29/30-44/45-59 Min (99202-1/99203-1/99204-1) with the appropriate modifiers**

For the Office Outpatient Visit of Established Patient codes:

- **Office Outpatient Visit of an Established Patient, 20-29 Min (99213-1) can be used with Office Outpatient Visit of an Established Patient, 10-19 Min (99212-1) with the appropriate modifiers**
- **Office Outpatient Visit of an Established Patient, 30-39 Min (99214-1) can be used with Office Outpatient Visit of an Established Patient, 10-19/20-29 Min (99212-1/99213-1) with the appropriate modifiers**
- **Office Outpatient Visit of an Established Patient, 40-54 Min (99215-1) can be used with Office Outpatient Visit of an Established Patient, 10-19/20-29/30-39 Min (99212-1/99213-1/99214-1) with the appropriate modifiers**

The Office Outpatient Evaluation and Management codes are locked out for use at the OTP/NTP levels of care.

These codes require a Medicare COB.

Non-Billable Office Outpatient Visit Services: When providing a non-billable Office Outpatient Visit Service, the appropriate code to use is the **Non Billable SUD Assessment (70899-300)** code. This is due to the State's classification of Office Outpatient Visit Services under the Assessment activity type.

Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office of outpatient setting, direct patient contact with physician supervision, first hour (99415 – CDM code TBD)

May only be used by a Licensed Physician, Medical Student in Clerkship, Physician Assistant, Physician Assistant Clinical Trainee, Nurse Practitioner, or Nurse Practitioner Clinical Trainee for services that exceed the maximum number of minutes allowed for evaluation and management services.
For example, if the service was 110 minutes for an Office Outpatient E/M, the primary procedure code (99205) allows up to 74 minutes. 110 minutes – 74 minutes = 36 minutes. The minimum number of minutes beyond the maximum of the highest range that is needed to use the prolonged code is 30 minutes. Therefore, one unit of 99205 and one unit of 99415 would be claimed.

The minimum number of service minutes required for this prolonged code to be utilized is 104 minutes of the primary procedure code service of a new patient and 84 minutes of the primary procedure code service of an established patient.

In order to utilize this code, one of the following services must have been provided as the primary service:

- **Office Outpatient Visit of New Patient, 15-29/30-44/45-59/60-74 Min (99202-1/99203-1/99204-1/99205-1)**
- **Office Outpatient Visit of an Established Patient, 10-19/20-29/30-39/40-54 Min (99212-1/99213-1/99214-1/99215-1)**

This code cannot be used on the same day as the following services:

- **Inter-Professional Telephone/Internet/Electronic Health Record Assessment Provided by a Consultative Physician, 5-15 Min (99451-1)**

This code may be used on the same with the following services, if the appropriate modifiers are used:

- **Psychological Testing Evaluation, First Hour (96130-1)**
- **Prolonged Outpatient Evaluation and Management Service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (99417 – CDM code TBD)**
- **SUD Structured Assessment 15-30/30+/5-14 min (70899-100/70899-101/70899-102)**

The following supplemental codes cannot be used with this code:

- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; each additional 30 minutes (99416 – CDM code TBD)

May only be used by a Licensed Physician, Medical Student in Clerkship, Physician Assistant, Physician Assistant Clinical Trainee, Nurse Practitioner, or Nurse Practitioner Clinical Trainee for services that exceed the maximum number of minutes allowed for evaluation and management services.

This code is used once the "first hour" has been met with the use of 99415 above to account for the time beyond the maximum in the range for the primary procedure code. For example, for a service time of 200 minutes where the primary procedure code is 99215 with the upper bound of the range is 54 minutes. 200 minutes – 54 minutes (one unit of 99215) = 146 minutes. 146 minutes – 60 minutes (one unit of 99415) = 86 minutes. 86 minutes / 30 minutes (99416) = 2.8 to round up to 3 units of 99416.

The minimum number of service minutes required for this prolonged code to be utilized is 149 minutes of the primary procedure code service of a new patient and 129 minutes of the primary procedure code of an established patient.

In order to utilize this code, one of the following services must have been provided as the primary service:

- **Office Outpatient Visit of New Patient, 15-29/30-44/45-59/60-74 Min (99202-1/99203-1/99204-1/99205-1)**
- **Office Outpatient Visit of an Established Patient, 10-19/20-29/30-39/40-54 Min (99212-1/99213-1/99214-1/99215-1)**
- **Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office**

of outpatient setting, direct patient contact with physician supervision, first hour (99415 – CDM code TBD)

This code cannot be used on the same day as the following services:
- **Inter-Professional Telephone/Internet/Electronic Health Record Assessment Provided by a Consultative Physician, 5-15 Min (99451-1)**

This code may be used on the same with the following services, if the appropriate modifiers are used:
- **Psychological Testing Evaluation, First Hour (96130-1)**
- **Prolonged Outpatient Evaluation and Management Service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (99417 – CDM code TBD)**
- **SUD Structured Assessment 15-30/30+/5-14 min (70899-100/70899-101/70899-102)**

The following supplemental codes cannot be used with this code:
- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

Home Visit of a New Patient, 15-29/30-59/60-74/75-89 Min (99341-1/99342-1/99344-1/99345-1) and **Home Visit of an Established Patient, 20-29/30-39/40-59/60-74 Min (99347-1/99348-1/99349-1/99350-1)**
May only be used by medical LPHA (Licensed Physician, Medical Student in Clerkship, Physician Assistant, Physician Assistant Clinical Trainee, Nurse Practitioner, and Nurse Practitioner Clinical Trainee) when E/M services provided in the home of a new or established patient, face-to-face with patient and/or family. Home may be defined as a private residence, temporary lodging, or short-term accommodation (e.g., hotel, campground, hostel, or cruise ship). These codes can only be used once per day.

For new Patients - When presenting problems are of low severity, the 20-minute service requires 3 key components: problem focused history, problem focused examination, and straightforward medical decision making. When presenting problems are of moderate severity, the 30-minute service requires 3 key components: expanded problem focused history, expanded problem focused examination, and medical decision making of low complexity. When presenting problems are of high severity, the 60-minute service requires 3 key components: comprehensive history, comprehensive examination, and medical decision making of moderate complexity. When the patient is unstable or has developed a significant new problem requiring immediate physician attention, the 75-minute service requires 3 key components: comprehensive history, comprehensive examination, and medical decision making of high complexity.

For established patients – When presenting problems are self-limited or minor, the 15-minute service requires at least 2 of 3 key components: problem focused interval history, problem focused examination, and straightforward medical decision making. When presenting problems

are of low to moderate severity, the 25-minute service requires at least 2 of 3 key components: expanded problem focused interval history, expanded problem focused examination, and medical decision making of low complexity. When presenting problems are of moderate to high severity, the 40-minute service requires at least 2 of 3 key components: detailed interval history, detailed examination, and medical decision making of moderate complexity. When presenting problems are of moderate to high severity, patient may be unstable or may have developed a significant new problem requiring immediate physician attention, the 60-minute service requires at least 2 of 3 key components: comprehensive interval history, comprehensive examination, and medical decision making of high complexity.

Home Visit of a New Patient, 15-29/30-59/60-74/75-89 Min (99341-1/99342-1/99344-1/99345-1) cannot be used on the same day as the following services:

- **Inter-Professional Telephone/Internet/Electronic Health Record Assessment Provided by a Consultative Physician, 5-15 Min (99451-1)**

Home Visit of a New Patient, 15-29/30-59/60-74/75-89 Min (99341-1/99342-1/99344-1/99345-1) may be used on the same day as the following services, if the appropriate modifiers are used:

- **Psychological Testing Evaluation, First Hour (96130-1)**
- **SUD Structured Assessment 15-30/30+/5-14 min (70899-100/70899-101/70899-102)**
- **SUD Screening (70899-105)**
- **SUD Brief Intervention, 15 Min (70899-117)**

- **Home Visit of a New Patient, 30-59 Min (99342-1)** can be used with **Home Visit of a New Patient, 15-29 Min (99341-1)** with the appropriate modifiers
- **Home Visit of a New Patient, 60-74 Min (99344-1)** can be used with **Home Visit of a New Patient, 15-29/30-59 Min (99341-1/99342-1)** with the appropriate modifiers
- **Home Visit of a New Patient, 75-89 Min (99345-1)** can be used with **Home Visit of a New Patient, 15-29/30-59/60-74 Min (99341-1/99342-1/99344-1)** with the appropriate modifiers

Home Visit of an Established Patient, 20-29/30-39/40-59/60-74 Min (99347-1/99348-1/99349-1/99350-1) cannot be used on the same day as the following services:

- **Inter-Professional Telephone/Internet/Electronic Health Record Assessment Provided by a Consultative Physician, 5-15 Min (99451-1)**

Home Visit of an Established Patient, 20-29/30-39/40-59/60-74 Min (99347-1/99348-1/99349-1/99350-1) may be used on the same day as the following services, if the appropriate modifiers are used:

- **Psychological Testing Evaluation, First Hour (96130-1)**
- **SUD Structured Assessment 15-30/30+/5-14 min (70899-100/70899-101/70899-102)**
- **SUD Screening (70899-105)**
- **SUD Brief Intervention, 15 Min (70899-117)**

- **Home Visit of an Established Patient, 30-39 Min (99348-1)** can be used with **Home Visit of an Established Patient, 20-29Min (99347-1)** with the appropriate modifiers
- **Home Visit of an Established Patient, 40-59 Min (99349-1)** can be used with **Home Visit of an Established Patient, 20-29/30-39 Min (99347-1/99348-1)** with the appropriate modifiers
- **Home Visit of an Established Patient, 60-74 Min (99350-1)** can be used with **Home Visit of an Established Patient, 20-29/30-39/40-59 Min (99347-1/99348-1/99349-1)** with the appropriate modifiers

The Home Visit Evaluation and Management codes are locked out for use at the OTP/NTP, Withdrawal Management, and Residential levels of care.

These codes require a Medicare COB.

Non-Billable Home Visit Services: When providing a non-billable Home Visit Service, the appropriate code to use is the **Non Billable SUD Assessment (70899-300)** code. This is due to the State's classification of Home Visit Services under the Assessment activity type.

Prolonged Outpatient Evaluation and Management Service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of *total time* (99417 – CDM code TBD)

May only be used by a Licensed Physician, Medical Student in Clerkship, Physician Assistant, Physician Assistant Clinical Trainee, Nurse Practitioner, or Nurse Practitioner Clinical Trainee for services that exceed the maximum number of minutes allowed for evaluation and management services.

This code does not follow the midpoint rule. A full 15 minutes must be met before one unit can be claimed.

For example, if 110 minutes of a home visit evaluation and management service (99345) was provided: 110 minutes – 89 minutes (upper bound of the range for 99345-1) = 21 minutes. 21 minutes / 15 minutes (99417) = 1.4 rounded down is 1 unit of 99417. The claim would be for one unit of 99345-1 and one unit of 99417.

The minimum number of service minutes required for this prolonged code to be utilized is 104 minutes of the primary procedure code service of a new patient and 89 minutes of the primary procedure code service of an established patient.

In order to utilize this code, one of the following services must have been provided as the primary service:

- **Home Visit of a New Patient, 75-89 Min (99345-1)**
- **Home Visit of an Established Patient, 60-74 Min (99350-1)**

The following supplemental codes cannot be used with this code:

- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

This code is locked out for use at the OTP/NTP, Withdrawal Management, and Residential levels of care.

Telephone Evaluation & Management Service, 5-10 Min (99441-1)
May only be used by a Licensed Physician, Medical Student in Clerkship, Physician Assistant, Physician Assistant Clinical Trainee, Nurse Practitioner, or Nurse Practitioner Clinical Trainee for an E/M service provided to a client using the telephone when the service duration is 5-10 minutes. This code can only be used once per day.
The Telephone E/M Service Codes are used to report service encounters initiated by an established client, parent, or guardian of an established client. If the telephone service ends with a decision to see the client within 24 hours of the next available urgent visit appointment, the code is not reported; rather the encounter is considered part of the preservice work of the subsequent E/M service, procedure, and visit. Likewise, if the telephone call refers to an E/M service performed and reported by that individual within the previous 7 days (either requested or unsolicited client follow-up) or within the postoperative period of the previously completed procedure, then the service(s) is considered part of that previous E/M service or procedure.

Telephone Evaluation & Management Service, 11-20 Min (99442-1)
May only be used by a Licensed Physician, Medical Student in Clerkship, Physician Assistant, Physician Assistant Clinical Trainee, Nurse Practitioner, or Nurse Practitioner Clinical Trainee for an E/M service provided to a client using the telephone when the service duration is 11-20 minutes. This code can only be used once per day.

Telephone Evaluation & Management Service, 21-30 Min (99443-1)
May only be used by a Licensed Physician, Medical Student in Clerkship, Physician Assistant, Physician Assistant Clinical Trainee, Nurse Practitioner, or Nurse Practitioner Clinical Trainee for an E/M service provided to a client using the telephone when the service duration is 21-30 minutes. This code can only be used once per day.

These codes may be used on the same day as the following services, if the appropriate modifiers are used:

- **SUD Screening (70899-105)**
- **SUD Brief Intervention, 15 Min (70899-117)**

These codes are not available for use at OTP/NTP, Withdrawal Management, and Residential levels of care.

These codes require a Medicare COB.

Non-Billable Telephone Evaluation and Management Services: When providing a non-billable Telephone Evaluation and Management Service, the appropriate code to use is the **Non Billable**

SUD Assessment (70899-300) code. This is due to the State's classification of Telephone Evaluation and Management Services under the Assessment activity type.

Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Physician, Patient and/or Family not Present, 30 Min+ (99367-1)
May only be used by a Licensed Physician or Medical Assistant in Clerkship and is the equivalent to the Physician Consultation that was previously available. This code can only be used once per day.

These codes may be used on the same day as the following services, if the appropriate modifiers are used:

- **SUD Screening (70899-105)**
- **SUD Brief Intervention, 15 Min (70899-117)**

The following supplemental codes cannot be used with these codes:

- **Sign Language or Oral Interpretation Services, 15 Min (70899-132)**
- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

Non-Billable Medical Team Conference Services: When providing a non-billable Medical Team Conference service, the appropriate code to use is the **Non Billable SUD Care Coordination (70899-304)** code. This is due to the State's classification of Medical Team Conference Services under the Care Coordination activity type.

Transitional Care Management Services: Communication (direct contact, telephone, electronic) within 14 calendar days, 54 Min (99495-1)
May only be used by a Licensed Physician, Medical Student in Clerkship, Physician Assistant, Physician Assistant Clinical Trainee, Nurse Practitioner, and Nurse Practitioner Clinical Trainee. It is to be used for a new or established patient whose medical and/or psychosocial problems require moderate or high complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient's community setting (home, domiciliary, rest home or assisted living). Transitional Care Management commences upon the date of discharge and continues for the next 29 days.
Comprised of one face-to-face visit within the specified time frames, in combination with non-face-to-face services that may be performed by the physician or other qualified health care professional and/or licensed clinical staff under his/her direction.
Non-face-to-face services provided by clinical staff, under the direction of the physician or other qualified health care professional may include: communication regarding aspects of care (with patient, family members, guardians/caretakers, surrogate decision makers, and/or other professionals), communication with home health agencies and other community services utilized

by the patient, patient and/or family/caretaker education to support self-management, independent living, and activities of daily living, assessment and support for treatment.

The minimum number of service minutes required to use this code is 28 minutes (the midpoint).

This code may be used on the same with the following services, if the appropriate modifiers are used:

- **Telephone Assessment and Management Service, 5-10/11-20/21-30 Min (98966-1/98967-1/98968-1)**
- **Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Physician, Patient and/or Family not Present, 30 Min+ (99367-1)** and **Medical Team Conference by Non-MD, Patient/Family not Present, 30 Min+ (99368-1)**
- **Telephone Evaluation & Management Service, 5-10 Min (99441-1), Telephone Evaluation & Management Service, 11-20 Min (99442-1),** and **Telephone Evaluation & Management Service, 21-30 Min (99443-1)**

The following supplemental codes cannot be used with these codes:

- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

This code is locked out for use at the OTP/NTP level of care. There is no separate billing permitted in addition to the dosing service.

This code is locked out for use at the Withdrawal Management level of care. There is no separate billing permitted in addition to the treatment day.

This code requires a Medicare COB.

Transitional Care Mgmt Services: Communication (direct contact, telephone, electronic) within 7 calendar days, 75 Min (99496-1)

May only be used by a Licensed Physician, Medical Student in Clerkship, Physician Assistant, Physician Assistant Clinical Trainee, Nurse Practitioner, and Nurse Practitioner Clinical Trainee. See description above for 99495-1.

The minimum number of service minutes required to use this code is 38 minutes (the midpoint).

This code may be used on the same with the following services, if the appropriate modifiers are used:

- **Telephone Assessment and Management Service, 5-10/11-20/21-30 Min (98966-1/98967-1/98968-1)**
- **Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Physician, Patient and/or Family not Present, 30 Min+ (99367-1)** and **Medical Team Conference by Non-MD, Patient/Family not Present, 30 Min+ (99368-1)**

- **Telephone Evaluation & Management Service, 5-10 Min (99441-1), Telephone Evaluation & Management Service, 11-20 Min (99442-1),** and **Telephone Evaluation & Management Service, 21-30 Min (99443-1)**
- **Transitional Care Management Services: Communication (direct contact, telephone, electronic) within 14 calendar days, 54 Min (99495-1)**

The following supplemental codes cannot be used with these codes:

- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

This code is locked out for use at the OTP/NTP level of care. There is no separate billing permitted in addition to the dosing service.

This code is locked out for use at the Withdrawal Management level of care. There is no separate billing permitted in addition to the treatment day.

This code requires a Medicare COB.

Non-Billable Transitional Care Management Services: When providing a non-billable Transitional Care Management Service, the appropriate code to use is the **Non Billable SUD Discharge Services (70899-306)** code. This is due to the State's classification of Transitional Care Management Services under the Discharge Services activity type.

Inter-Professional Telephone/Internet/Electronic Health Record Assessment Provided by a Consultative Physician, 5-30 Min (99451-1)

May only be provided by a Licensed Physician or Medical Student in Clerkship and may include a written report to the patient's treating/requesting physician or other qualified health care professional; 5 minutes or more of medical consultative time. This can only be used once per day.

These codes cannot be used on the same day as the following services:

- **Office Outpatient Visit of New Patient, 15-29/30-44/45-59/60-74 Min (99202-1/99203-1/99204-1/99205-1)**
- **Office Outpatient Visit of an Established Patient, 10-19/20-29/30-39/40-54 Min (99212-1/99213-1/99214-1/99215-1)**
- **Home Visit of a New Patient, 15-29/30-59/60-74/75-89 Min (99341-1/99342-1/99344-1/99345-1)**
- **Home Visit of an Established Patient, 20-29/30-39/40-59/60-74 Min (99347-1/99348-1/99349-1/99350-1)**
- **Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office of outpatient setting, direct patient contact with physician supervision, first hour (99415 – CDM code TBD)**

- **Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; each additional 30 minutes (99416 – CDM code TBD)**

The following supplemental codes cannot be used with these codes:

- **Sign Language or Oral Interpretation Services, 15 Min (70899-132)**
- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 16-30 Min (96170-1)** and **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

These codes require a Medicare COB.

Non-Billable Inter-Professional Service: When providing a non-billable Inter-Professional service, the appropriate code to use is the **Non Billable SUD Care Coordination (70899-304)** code. This is due to the State's classification of Inter-Professional Services under the Care Coordination activity type.

Perinatal Medication Services Billing Codes:

Charge Description	CPT/HCPCS Code(s)	CDM Code
Peri Psych Diagnostic Eval w/ Med Svcs, 60 Min	90792	90792-2
Peri Oral Medication Admin, Direct Observation, 15 Min	H0033	70899-209
Peri Medication Training and Support-Indv per 15 Min	H0034	70899-210
Peri Medication Training and Support-Group per 15 Min	H0034	70899-211
Peri Office OutPt Visit of New Pt, 15-29 Min	99202	99202-2
Peri Office OutPt Visit of a New Pt, 30- 44 Min	99203	99203-2
Peri Office OutPt Visit of a New Pt, 45- 59 Min	99204	99204-2
Peri Office OutPt Visit of a New Pt, 60- 74 Min	99205	99205-2
Peri Office OutPt Visit of Established Pt, 10-19 Min	99212	99212-2
Peri Office OutPt Visit of Established Pt, 20-29 Min	99213	99213-2
Peri Office OutPt Visit of Established Pt, 30-39 Min	99214	99214-2
Peri Office OutPt Visit of Established Pt, 40-54 Min	99215	99215-2

Peri Prolonged Clinical Staff Service, first hour	99415	TBD
Peri Prolonged Clinical Staff Service, additional 30 min	99416	TBD
Peri Home Visit of a New Pt, 15-29 Min	99341	99341-2
Peri Home Visit of a New Pt, 30-59 Min	99342	99342-2
Peri Home Visit of a New Pt, 60-74 Min	99344	99344-2
Peri Home Visit of a New Pt, 75-89 Min	99345	99345-2
Peri Home Visit of an Established Pt, 20-29 Min	99347	99347-2
Peri Home Visit of an Established Pt, 30-39 Min	99348	99348-2
Peri Home Visit of an Established Pt, 40-59 Min	99349	99349-2
Peri Home Visit of an Established Pt, 60-74 Min	99350	99350-2
Peri Telephone E&M Service, 5-10 Min	99441	99441-2
Peri Telephone E&M Service, 11-20 Min	99442	99442-2
Peri Telephone E&M Service, 21-30 Min	99443	99443-2
Peri Med Team Conf by MD, Pt/Fam not Present, 30 Min+	99367	99367-2
Peri Transitional Care Mgmt Svcs: Comm. w/in 14 days	99495	99495-2
Peri Transitional Care Mgmt Svcs: Comm. w/in 7 days	99496	99496-2
Peri Inter-Prof Phone/EHR Assmt-Consult. MD 5-30 Min	99451	99451-2

Perinatal Medication Services Non Billable Code (same as Regular Non Billable Code):

Charge Description	CPT/HCPCS Code(s)	CDM Code
Non Billable SUD Assessment	n/a	70899-300
Non Billable SUD Medication Services	n/a	70899-302
Non Billable SUD Discharge Svcs	n/a	70899-306

Non Billable SUD Care Coordination	n/a	70899-304