CalAIM FAQs

Quality Management & Compliance Coding

August-October 2024

New Provider Types

Question: What is a Clinical Trainee?

Answer: *A Clinical Trainee is an unlicensed individual who is enrolled in a post-secondary educational degree program in the State of California that is required for the individual to obtain licensure as a Licensed Mental Health Professional or Licensed Practitioner of the Healing Arts; is participating in a practicum, clerkship, or internship approved by the individual's program; and meets all relevant requirements of the program and/or applicable licensing board to participate in the practicum, clerkship or internship and provides rehabilitative mental health services or substance use disorder treatment services, including, but not limited to, all coursework and supervised practice requirements. See DBH Discipline and Taxonomy List for Clinical Trainee disciplines and associated taxonomy codes.*

Question: What are the requirements when claiming for services rendered by a Clinical Trainee?

Answer: *Claims for services provided by Clinical Trainees that do not report a supervisor's NPI will be denied. DBH and contract agencies must ensure that the clinician supervising the Clinical Trainee meets the minimum qualifications described by the applicable licensing board. The supervisor's NPI will be validated against the data in the National Plan & Provider Enumeration System (NPPES). Claims for Clinical Trainees that do not contain a valid supervisor's NPI will be denied. Note, upon DBH Staff Master Worksheet submission, Clinical Trainees must include their respective clinical supervisor's information, including NPI.*

Question: At what rate will the services rendered by Clinical Trainees be reimbursed?

Answer: *Services rendered by Clinical Trainees will be reimbursed at the same rate as that of licensed or registered health care professionals within the respective Clinical Trainees' profession/discipline. To receive the appropriate rate for their profession, the below taxonomy and modifier combinations must be used:*

Discipline	Taxonomy	Modifier
LCSW, MFT or LPCC Clinical Trainee	390200000X	AJ
Psychologist Clinical Trainee	390200000X	AH
Registered Nurse Clinical Trainee	390200000X	TD
Nurse Practitioner Clinical Trainee	390200000X	HP

Assessment Services

Question: How will Counties extend non-E&M assessment service codes for claims with dates of service after June 30, 2024?

Answer: *See below grid for response.*

Service Type	Code (s)	• DHCS Change	myAvatar's data entry
Assessment Codes	MH 90791, 90792, 90885, 96105, 96110, 96125, 96127 DMC-ODS 90791, 90792, 90885	• **Effective 7/1/2024, these codes can no longer be prolonged with G2212.** • Minimum duration for these codes was increased. • Maximum duration for these codes was increased. • If services provided exceed the maximum duration associated with the code, services can be claimed to MediCal using the Assessment Substitute code T2024.	**Manual Entry with Client Charge Input** Users entering services in myAvatar via *Client Charge Input*, will enter the appropriate Assessment code in the Service Code field, and the full face to face duration of the service in the *Face to Face* field. myAvatar is configured to use the appropriate code for the claims. **File Import** Files should contain the Assessment code in the *Service Code* field (column 2), and the full face to face duration of the service in the *Duration* field (column 9). myAvatar is configured to use the appropriate code for the claims. **CBO837** Provide the Assessment code and the full face to face duration (in minutes) of the service in the service line. myAvatar is configured to use the appropriate code for the claims. Once a service is recorded (*Client Charge Input* form submitted, confirmation of services from a file import posted, services from a CBO837 pushed to CalPM), users will see in the *Client Ledger* or the *Revenue report* only the Assessment code entered/provided in the file, even if the duration entered/provided exceeds the maximum time DHCS assigned to the Assessment code. Behind the scenes myAvatar will use the T2024 substitute code on the claims.

*****NOTE: The above graphic outlines configurations specific to myAvatar entries for San Bernardino County claims. This workflow may differ for providers who have contracts with other counties.***

Question: How should Assessment services be billed that are shorter than 31 minutes and/or provided by classifications unable to bill 90791?

Answer: *The HCPCS H0031 should be used to capture these services. The minimum billing time is 8 minutes and the maximum number of units for this code is 96 units.*

Care Planning/Client Recovery Plans

Question: Are treatment plans still required?

Answer: *Due to federal regulations, there are still some program services that require documentation of a Treatment Plan. This can be captured using a Care Plan document or Treatment Plan Progress Note. There should be documentation in the clinical record of client/support person's participation and agreement to the goals included on the Plan.*

Services requiring a Treatment Plan:

- *Targeted Case Management*
- *Intensive Home-Based Services/Intensive Care Coordination*
- *Therapeutic Behavioral Services*
- *Therapeutic Foster Care*
- *Peer Support Services*

Programs requiring a Treatment Plan (all services provided must be included on the plan):

- *Full Service Partnership*
- *Short-Term Residential Program*
- *Social Rehabilitation Programs (Adult Residential, Crisis Residential)*

Therapy Services

Question: How will Counties extend non-E&M therapy service codes for claims with dates of service after June 30, 2024?

Answer: *See below grid for response.*

Service Type	Code (s)	• DHCS Change	myAvatar's data entry
Therapy Services	MH 90837, 90845, 90847, 90849, 90853 DMC-ODS 90846, 90847, 90849	• **Effective 7/1/2024, these codes can no longer be prolonged with G2212.** • Minimum duration for some of these codes was increased. • Maximum duration associated with some of these codes was increased. • If services provided exceed the maximum duration associated with the code, services can be claimed to MediCal using the Therapy Substitute code T2021.	**Manual Entry with Client Charge Input** Users entering therapy services in myAvatar via *Client Charge Input*, will enter the Therapy code in the *Service Code* field, and the full face to face duration of the service in the *Face to Face* field. myAvatar is configured to use the appropriate code for the claims. **File Import** Records for Therapy services should contain the Therapy code in the *Service Code* field (column 2), and the full face to face duration of the service in the *Duration* field (column 9). myAvatar is configured to use the appropriate code for the claims. **CBO837** Provide the Therapy code and the full face to face duration (in minutes) of the service in the service line. myAvatar is configured to use the appropriate code for the claims. Once a service is recorded (*Client Charge Input* form submitted, confirmation of services from a file import posted, services from a CBO837 pushed to CalPM), users will see in the *Client Ledger* or the *Revenue report* only the Therapy code entered/provided in the file, even if the duration entered/provided exceeds the maximum time DHCS associated with the Therapy code. Behind the scenes, myAvatar will use the T2021 substitute code on the claims.

*****NOTE: The above graphic outlines configurations specific to myAvatar entries for San Bernardino County claims. This workflow may differ for providers who have contracts with other counties.***

Interpretation Services

Question: In what circumstances should a county claim for oral or sign language interpretation?

Answer: *A claim for interpretation should be submitted when the provider and the patient cannot communicate in the same language, and the provider uses an on-site interpreter and/or individual trained in medical interpretation to provide medical interpretation. Interpretation time may not exceed the time spent providing a primary service. For example, if a therapy session lasted 45 minutes, a maximum of three units of T1013 may be claimed.*

Interpretation may not be claimed during an inpatient or residential stay as the cost of interpretation is included in the residential rate in the Drug Medi-Cal (DMC) or Specialty Mental Health (SMH) systems. Interpretation also cannot be claimed for automated/digital translation or relay services. When using Interactive complexity (90785) interpretation (T1013) should not be claimed together.

Claim submission for interpretation should include the taxonomy code and NPI of the individual who provided the primary service. An additional service line should be included to reflect the oral interpretation/sign language. The NPI of the person providing oral/sign language interpretation is not necessary.

Licensed Vocational Nurses (LVNs) and Licensed Psychiatric Technicians (LPTs) in Specialty Mental Health Services

Question: Can Licensed Vocational Nurses (LVNs) and Licensed Psychiatric Technicians (LPTs) with the proper education and certification, under the supervision of a Registered Nurse or Physician, administer medications orally or intravenously to patients in the SMH delivery system?

Answer: *LVNs and LPTs are recognized provider types of SMH within their scope of practice. They can continue to administer medication and can claim for it using HCPCS code H0033. HCPCS code H0033 now includes all modes of medication administration. They can claim for providing medication training and support using HCPCS code H0034.*

Child and Family Team (CFT) Meetings

Question: What is a CFT?

Answer: *The CFT is comprised of-as appropriate, both formal supports, such as the care coordinator, providers, case managers from child-serving agencies, and natural supports, such as family members, neighbors, friends and clergy and all ancillary individuals who work together to develop and implement the client plan and are responsible for supporting the child and family in attaining their goals. For children/youth in the child welfare or probation systems, CFT composition always includes the child or youth, family members and/or current caregiver, a representative from the placing agency, and other individuals identified by the family as being important. A CFT shall also include a representative of the child or youth's tribe or Indian custodian, behavioral health staff, foster family agency social worker, or short-term residential therapeutic program (STRTP) representative, when applicable. The CFT should represent all important individuals involved; however, not all of them must be present at each CFT Meeting.*

Question: Does Department of Health Care Services (DHCS) have the same definition of what a CFT is as California Department of Social Services (CDSS)?

Answer: *Yes, the concept of CFT and CFT Meeting (CFTM) is the same for both entities. However, a meeting only qualifies as a "CFT Meeting" if decisions about goals and strategies to achieve them are made with involvement of the child, youth, and family members. For children/youth involved in the child welfare or probation system, the placing agency is responsible for convening and engaging members of the CFT. Therefore, the presence of placing agency representative and the act of making decisions about goals and strategies to achieve them are required to claim as a "CFT Meeting" using H2000 with HK modifier (see HCPCs question/answer below). If a CFT Meeting is convened without a placing agency (when relevant), activities will likely be coded as Intensive Care Coordination (ICC), as applicable (see HCPC ICC question/answer below).*

Question: Can CFT Meetings occur in conjunction with other processes or address other areas of need not already included in the CFT goals or objectives?

Answer: *Yes. To reduce duplicative efforts, the CFT Meeting may occur in conjunction with other regularly scheduled meetings, when appropriate. However, the criteria for "CFT Meeting" as described herein must apply in order to bill the activity with the CFT Meeting applicable billable codes (e.g., placing agency presence, discussion and decisions on goals and strategies, etc.).*

Question: What HCPCS code should be used for the purposes of activities occurring within a CFT Meeting?
Answer: *H2000 with HK modifier would be used. See additional descriptions below for H2000 and HK modifier.*

H2000: Comprehensive, multidisciplinary health evaluation. A comprehensive multidisciplinary evaluation consists of a thorough investigation in several areas to provide an accurate representation of the individual's needs and strengths. This evaluates areas such as psychiatric, physical, psychosocial, family, recreational, and occupational therapy.

HK: Specialized mental health programs for high-risk populations. Use this modifier to indicate that an Intensive Home-Based Services (IHBS), Intensive Care Coordination (ICC), and/or CFT service was provided.

For children/youth involved with the child welfare and/or probation systems, the placing agency representative must be present to bill H2000 HK, and activities must qualify under "CFT Meeting" criteria as described herein.

Question: What HCPCS code should be used for the purposes of ICC?
Answer: *T1017 with HK modifier would be used. See additional descriptions below for T1017, HK modifier and activities that require T1017 HK use, including CFT activities that do not meet "CFT Meeting" criteria.*

T1017: Manage health care needs of an individual belonging to a target group, recorded in 15 minute increments. Case management is an effort to improve care and to contain costs by having one party manage or coordinate all care delivered to a patient that usually has certain complex illnesses or injuries, including mental and behavioral health issues. Case management may include, but is not limited to, the evaluation of a condition, the development and implementation of a plan of care, the coordination of medical resources, and the appropriate communication to all parties. Targeted case management is targeted to a specific population subgroup.

HK: Specialized mental health programs for high-risk populations. Use this modifier to indicate that an Intensive Home-Based Services (IHBS), ICC, and/or CFT service was provided.

If the placing agency representative is not present in the meeting (or it does not meet the description of a "CFT Meeting" as referenced above), then care coordination activities that meet the below referenced code description and as governed under Title 9 §1810.249, T1017 should be used.

***Targeted Case Management (TCM)**: CCR Title 9, § 1810.249 - Targeted case management is a service that assists a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative or other community services. The service activities may include but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure patient access to service and the service delivery system; monitoring the beneficiary's progress; placement services and plan management. TCM services may be face-to-face or by telephone/telehealth with the client or significant support persons and may be provided anywhere in the community. Additionally, services may be provided*

by any person determined by the MHP to be qualified to provide the service, consistent with the scope of practice and state law.

Intensive Care Coordination (ICC): *ICC is a* ***targeted case management*** *service that facilitates assessment of, care planning for, and coordination of services to beneficiaries under 21 who are eligible for full-scope Medi-Cal services and who meet medical necessity criteria to access SMH. ICC service components include: assessing, service planning and implementation, monitoring and adapting, and transition. ICC services are provided through the principles of the Integrated Core Practice Model (ICPM), including the establishment of the Child and Family Team (CFT) to ensure facilitation of a collaborative relationship among a child, their family, and involved child-serving systems. The CFT is comprised of-as appropriate, both formal supports, such as the care coordinator, providers, case managers from child-serving agencies, and natural supports, such as family members, neighbors, friends and clergy and all ancillary individuals who work together to develop and implement the client plan and are responsible for supporting the child and family in attaining their goals. ICC also provides an ICC coordinator who: ensures that medically necessary services are accessed; coordinated and delivered in a strength-based, individualized, family/child driven and culturally and linguistically competent manner and that services and supports are guided by the needs of the child; facilitates a collaborative relationship among the child, their family and systems involved in providing services to the child; supports the parent/caregiver in meeting their child's needs; helps establish the CFT and provides ongoing support; and organizes and matches care across providers and child serving systems to allow the child to be served in the community.*

Question: What staff can use H2000 HK for CFTM?
Answer: *All qualifying service providers can bill H2000 HK, if activities qualify as CFT Meeting related as described above, and placing agency representative is present when applicable (child/youth in child welfare and/or probation system). All notes/documentation must be specific to the role of the individual staff/service provider. Qualifying service providers within DBH system of care include: LCSW, ACSW, LCSW-CT, LMFT, AMFT, LMFT-CT, OT, LPCC, APCC, LPCC-CT, LPT, LVN, MD/DO, MD/DO-Clerks, LMFT, MHRS (Social Worker II, BSW Student Intern, OTA, Pre-licensed Clinical Therapist Trainee), NP, NP-CT, Other Qualified Provider (Case Manager/Care Coordinator, Community Health Worker, Parent Partner, Uncertified Peer and Family Advocate, Mental Health Specialist), PhD/PsyD-CT, PhD/PsyD, RN, RN-CT.*

For any additional service delivery or documentation questions, please contact the Quality Management Division at DBH-QualityManagementDivision@sbcounty.gov or (909) 386-8226.

For questions specific to HCPCS and/or CPT codes, please contact the Compliance Coding Team at DBH-ComplianceCodingQuestions@dbh.sbcounty.gov or (909) 388-0879.