

A GUIDE TO  
PROCEDURE CODES  
FOR  
CLAIMING MENTAL HEALTH SERVICES



**County of Los Angeles – Department of Mental Health**

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March 2010

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## INTRODUCTION

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

### Brief History

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

### HIPAA Objectives and Compliant Coding Systems

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

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

### Implications for Service Delivery

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

## HELPFUL HINTS FOR USING THE GUIDE

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

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

## LIST OF ABBREVIATIONS

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

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**REPORTING AND DOCUMENTATION NOTES**

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

- **Telephone Service:** When using the Daily Service Log to report services, the telephone box next to the Service Location Code must be checked. When telephone services are entered into the IS, the “telephone” box on the “Outpatient – Add Service” screen must be checked. This is the only way to ensure that telephone services are claimed to the appropriate payer. Face-to-Face time is always “0” for telephone contacts.
- **Combined Services:** When more than one type of service is delivered in a session, a single claim may be submitted for the predominant service as long as the chart documentation predominantly reflects that service. Example #1: use 90812 for a therapy session of 60 minutes in which both play therapy and talk therapy are used, with play therapy being the predominant interactive mode (as indicated in the clinical note). Example #2: use H2015 when targeted case management and individual rehabilitation are combined into a single session with individual rehabilitation being documented as the predominant service. If case management was documented as the predominant service, T1017 would be the appropriate code. With Example #2, if the staff believes that services to the client would be best represented if each services were documented separately, it is permissible to write two notes, one for case management and one for individual rehabilitation **and** claim two services.
- **Penal facilities, including Juvenile Halls:** Services delivered in these facilities are not Medi-Cal reimbursable unless delivered to a youth who has been adjudicated and waiting placement.
- **More than one staff participating in a single direct service:** Anytime more than one staff participate in a service, each must be identified in the note indicating the time spent by each in providing the service, and the specific interventions performed by each. Except for group, the **Rendering provider** must indicate both face-to-face time and other time. Other participating staff need only report his/her total time.
- **Claiming Payers:** Not all staff listed in the Rendering Provider column who can report the service may claim to all payer sources. The DMH will keep its employees informed, and, as appropriate, its contractors, regarding rules and regulations for service delivery and reimbursement.
- **Scope of Practice:** A Rendering Provider may only provide services within his/her job specification and scope of practice. Staff without credentials that meet a category’s requirements may deliver rehabilitation services to the extent that they function within the job specification with commensurate training and skill development in accord with the services s/he may be rendering. The DMH will also continue to require that students and staff without two years mental health experience or a bachelor’s degree in a mental health related field must have all documentation co-signed until these minimum requirements have been met and his/her supervisor believes him/her to be competent to document services independently. **Please note that co-signature does NOT allow any level staff to provide services that are outside his/her scope of practice and job specification.** Staff at all levels must have appropriate supervision.
- **Face-to-Face time:** Note that for SD/MC Providers, only the psychotherapy codes on pages 3 and 4 indicate Face-to-Face time. This is because, for the same service, different codes are available and must be selected based on the Face-to-Face time. The absence of Face-to-Face times for other codes only means that time is not a determinant in selecting the code; it does not mean that the code has no Face-to-Face time requirement. Assessment, Psychological Testing, and Individual Medication all require Face-to-Face time that must be both documented in the clinical record and entered into the IS. No other Mental Health, Medication Support, or Targeted Case Management Services require Face-to-Face time, but if it occurs, it should be both noted in the clinical record and entered into the IS. All groups, except Collateral Group, require Face-to-Face time, but that time does not need to be documented in the clinical record or entered into the IS separate from the total time of the contact. Collateral, Team Conference/Case Consultations and No-Contact – Report Writing should always be reported with “0” Face-to-Face time.

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**ASSESSMENT – SD/MC & NETWORK PROVIDERS**

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

This is an activity that may include a clinical analysis of the history and current status of a client’s mental, emotional, or behavioral disorder; relevant cultural issues and history; and diagnosis (§1810.204). These codes should be used when completing an Initial Assessment form or when performing subsequent assessment activities that are documented on an assessment form. An “Evaluation by Physician” form MH504, when completed as part of an evaluation for medication, should be claimed as Medication Support (see page 9).

Service	Code	Former FFS Codes	Network MC Rendering Provider	Cost Report SFC	Former ClinServ ActCodes	Former OutptHospSv ActCodes	SD/MC Rendering Provider
Psychiatric diagnostic interview	90801	<b><u>Ind, Gp, &amp; Org</u></b> 20-39 minutes 90805 X9500	MD/DO PhD/PsyD LCSW MFT NP/CNS	42	040 800 1718 8000 9011 9092 9113	161 802 1738 8002 9113	Licensed, registered, waived: MD/DO PhD/PsyD LCSW MFT NP/CNS RN and student professionals in these disciplines with co-signature
Interactive psychiatric diagnostic interview using play equipment, physical devices, or other non-verbal mechanism of communication	90802	<b><u>Indiv &amp; Group</u></b> 40+ minutes 90807 X 9502 <b><u>Organizational</u></b> 40-50 minutes 90807 X 9502					

**Notes:**

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

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**PSYCHOLOGICAL TESTING – SD/MC & NETWORK PSYCHOLOGISTS & PHYSICIANS**

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

Service (effective 1/1/06)		New Codes 1/1/06	Former FFS Code	Network MC Rendering Provider	Cost Report SFC	Former ClinServ ActCodes	Former OutptHospSv ActCodes	SD/MC Rendering Provider
<b>Psychological Testing</b> Scoring time is not reimbursable.  Psychodiagnostic assessment of personality, development assessment and cognitive functioning.  For children, referrals are made to clarify symptomology, rule out diagnoses and help delineate emotional from learning disabilities.	<b>Face-to-face administration time by Psychologist or Physician</b>	96101	<u>Ind. Gp. Org</u> 60-1200 min 96100 X9514	Licensed PhD/PsyD Trained MD/DO	<b>34</b>	<b>034</b> 043 857 877 1717 1704 8035 8037 9002 9005 9126 9127	<b>738</b> 044 858 878 1737 1736 8036 8038 9004 9006 9126 9127	Licensed PhD/PsyD Trained MD/DO
	<b>Face-to-face administration time by Technician</b>	96102	NA	NA				Registered, waived PhD/PsyD, & student professionals in these disciplines with co-signature
	<b>Administered by Computer</b>	96103	NA	NA				Licensed, registered, waived PhD/PsyD, & trained MD/DO & student professionals in these disciplines with co-signature
<b>Psychological Test Interpretation and Report Writing</b>		90889	<u>Ind. Gp. Org</u> 60-1200 min. 96100 X9514	Licensed PhD/PsyD Trained MD/DO	<b>42</b>	<b>1220</b> 870 1721 8040 9114	<b>1221</b> 871 1740 8041 9114	Licensed PhD/PsyD Trained MD/DO
<b>Computer Scoring</b>		90889	<u>Indiv -Group Org</u> : 1-30 min X9536	Individual & Group PhD/PsyD & trained MD/DO	Not Applicable			

**Notes:**

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

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

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

Service	Short-Doyle/Medi-Cal (SD/MC)			Network Medi-Cal		
	Duration of Face-to-Face	Code	Rendering Provider	Duration of Face-to-Face	Code	Rendering Provider
Insight oriented, behavior modifying, and/or supportive psychotherapy delivered to one client.	0-19 minutes	H0046 (former code H2015)	<u>MD/DO or RN:</u> Licensed  <u>PhD/PsyD:</u> Licensed or registered <u>and</u> waived  <u>LCSW &amp; MFT:</u> Licensed or registered or waived	<u>Ind, Gp, &amp; Org</u> 0-19 minutes	Not Reimbursed	<u>MD/DO or RN:</u> Licensed  <u>PhD/PsyD:</u> Licensed  <u>LCSW &amp; MFT:</u> Licensed
	20-44 minutes	90804		<u>Ind, Gp, &amp; Org</u> 20-39 minutes	90804	
	45-74 minutes	90806		<u>Indiv &amp; Group Org</u> 40-74 minutes 40-50 minutes	90806	
	75+ minutes	90808		<u>Indiv &amp; Group Org: NA</u> 75+ minutes	<u>Indiv &amp; Group Org: Not Reim</u> 90808	
Interactive psychotherapy using play equipment, physical devices, or other mechanisms of non-verbal communication delivered to one client.	0-19 minutes	H0046 (former code H2015)	<u>NP or CNS:</u> Certified  and student professionals in these disciplines with co-signature	<u>Ind, Gp, &amp; Org</u> 0-19 minutes	Not Reimbursed	<u>NP or CNS:</u> Certified
	20-44 minutes	90810		<u>Ind, Gp, &amp; Org</u> 20-39 minutes	90810	
	45-74 minutes	90812		<u>Indiv &amp; Group Org</u> 40-74 minutes 40-50 minutes	90812	
	75+ minutes	90814		<u>Indiv &amp; Group Org: NA</u> 75+ minutes	<u>Indiv &amp; Group Org: Not Reim</u> 90814	

**Notes:**

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

**Documentation Notes:**

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

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

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

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

Service	Short-Doyle/Medi-Cal (SD/MC)			Network Medi-Cal		
	Duration of Face-to-Face	Code	Rendering Provider	Duration of Face-to-Face	Code	Rendering Provider
Insight oriented, behavior modifying, and/or supportive psychotherapy delivered to one client <b>WITH</b> evaluation and management.	0-19 minutes	H0046 (former code H2015)	<u>MD/DO:</u> Licensed  <u>NP:</u> Certified and student professionals in these disciplines with co-signature	<u>Ind, Gp, &amp; Org</u> 0-19 minutes	Not Reimbursed	<u>MD/DO:</u> Licensed
	20-44 minutes	90805		<u>Ind, Gp, &amp; Org</u> 20-39 minutes	90805	
	45-74 minutes	90807		<u>Indiv &amp; Group</u> 40-74 minutes <u>Org</u> 40-50 minutes	90807	
	75+ minutes	90809		<u>Indiv &amp; Group</u> 75+ minutes <u>Org:</u> NA	<u>Indiv &amp; Group</u> 90809 <u>Org:</u> Not Reim	
Interactive psychotherapy using play equipment, physical devices, or other mechanisms of non-verbal communication delivered to one client <b>WITH</b> evaluation and management.	0-19 minutes	H0046 (former code H2015)		<u>Ind, Gp, &amp; Org</u> 0-19 minutes	Not Reimbursed	
	20-44 minutes	90811		<u>Ind, Gp, &amp; Org</u> 20-39 minutes	90811	
	45-74 minutes	90813		<u>Indiv &amp; Group</u> 40-74 minutes <u>Org</u> 40-50 minutes	90813	
	75+ minutes	90815		<u>Indiv &amp; Group</u> 75+ minutes <u>Org:</u> NA	<u>Indiv &amp; Group</u> 90814 <u>Org:</u> Not Reim	

**Notes:**

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

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

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

Service	Code	Cost Report SFC	Former ClinServ ActCodes	Former OutptHospSv ActCodes	Rendering Provider
<b>Individual Rehabilitation Service</b> Service delivered to one client to provide assistance in improving, maintaining, or restoring the client’s functional, daily living, social and leisure, grooming and personal hygiene, or meal preparation skills, his/her support resources. §1810.243 The contact could include family or other collaterals/significant support person (see definition below).	H2015	42	<b>(040)</b> 062 800 1718 8000 9011 9092 9113	<b>161</b> 802 1738 8002 9113	Any staff operating within his/her scope of practice.
<b>On-going support to maintain employment</b> (This service requires the client be currently employed, paid or unpaid; school is not considered employment.)	H2025				

**Notes:**

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

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**SERVICES TO SPECIAL POPULATIONS – SD/MC ONLY**

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

**Notes:**

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

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

\*Contract agencies submitting electronic claims to the Department must use the letter modifiers in the claims transmission.

**Notes:**

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

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

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

Service	Code (Modifiers*)	Former FFS Code	Network MC Rendering Provider	Cost Report SFC	Former ClinServ ActCodes	Former OutptHospSv ActCodes	SD/MC Rendering Provider
<p><b>Family Psychotherapy with <u>One Client Present</u></b> Psychotherapy delivered to a family with the intent of improving or maintaining the mental health status of the client. Only one claim will be submitted. <b>Note:</b> Family Psychotherapy without the Client Present (90846) is not a reimbursable service through the LAC LMHP – Psychotherapy can only be delivered to an enrolled client. Services to collaterals of clients that fall within the “Collateral” service definition below may be claimed to 90887.</p>	90847	<p><b><u>Ind. Gp. &amp; Org</u></b> 20-39 minutes 90811 X9512</p>	MD/DO PhD/PsyD LCSW MFT NP/CNS RN	42	(040)	161	Licensed, registered, waivered: MD/DO PhD/PsyD LCSW MFT NP/CNS RN and student professionals in these disciplines with co-signature
<p><b>Family Psychotherapy with <u>More than One Client Present</u></b> Psychotherapy delivered to a family with the intent of improving or maintaining the mental health status of the client. One claim will be submitted for each client present or represented. <b>Note:</b> Family Psychotherapy without the Client Present (90846) is not a reimbursable service through the LAC LMHP – Psychotherapy can only be delivered to an enrolled client. Services to collaterals of clients that fall within the “Collateral” service definition below may be claimed to 90887.</p>		<p><b><u>Ind. Gp. &amp; Org</u></b> 40-59 minutes 90813 X9508</p> <p><b><u>Indiv &amp; Group</u></b> 60+ minutes 90813 X9510</p> <p><b><u>Organizational</u></b> 60-90 minutes 90813 X9510</p>		52	(065) 085 100 800 804 1718 1723 8000 8004 9011 9015 9092 9093 9113 9115	163 805 1741 8005 9115	
<p><b>Collateral (<u>one or more clients represented</u>)</b> Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist client.</p>	90887				10	099 815 9010 1716 9091 8015 9112	112 816 8016 1735 9112

See bottom of next page for Family and Group Notes.

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(Continued)

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

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

Service	Code (Modifiers*)	Former FFS Code	Network MC Rendering Provider	Cost Report SFC	Former ClinServ ActCodes	Former OutptHospSv ActCodes	SD/MC Rendering Provider
<b>Multi-family Group Psychotherapy</b> Psychotherapy delivered to more than one family unit each with at least one enrolled client. Generally clients are in attendance.	90849	90853 X9506  2 client minimum 9 client maximum	MD/DO PhD/PsyD LCSW MFT NP/CNS	52	(065) 115 804 9015 1723 9093 8004 9115	163 805 1741 8005 9115	Licensed, registered, waived: MD/DO PhD/PsyD LCSW MFT NP/CNS RN and student professionals in these disciplines with co-signature
<b>Group Psychotherapy</b> Insight oriented, behavior modifying, supportive services delivered at the same time to more than one non-family client.	90853	<b>Indiv &amp; Group**</b> 30+ minutes  <b>Organizational**</b> # of minutes divided by #of clients present from 2-9 clients			804 9015 1723 9093 8004 9115		
<b>Interactive Group Psychotherapy</b> Interactive service using non-verbal communication techniques delivered at the same time to more than one non-family client.	90857						
<b>Group Rehabilitation (family and non-family)</b> Service delivered to more than one client at the same time to provide assistance in improving, maintaining, or restoring his/her support resources or his/her functional skills - daily living, social and leisure, grooming and personal hygiene, or meal preparation. §1810.243	H2015 (HE, HQ*)	Not Applicable			(065) 105 804 9015 1723 9093 8004 9115		

\*Contract agencies submitting electronic claims to the Dept must use the letter modifiers in the claims transmission.

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

**Notes:**

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

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**MEDICATION SUPPORT – SD/MC & NETWORK PHYSICIANS & NURSE PRACTITIONERS**

Service	Code (Modifier*)	Former FFS Code	Network MC Rendering Provider	Cost Report SFC	Former ClinServ ActCodes	Former OutptHospSv ActCodes	SD/MC Rendering Provider
<b>Individual Medication Service (Face-to-Face)</b> This service requires expanded problem-focused or detailed history and medical decision-making of low to moderate complexity for prescribing, adjusting, or monitoring meds. <b>Note:</b> If more than minimal, supportive psychotherapy is provided, the service must be claimed as an E&M Individual Psychotherapy service (see pg 4).	90862  <u>Indiv &amp; Group</u> 15+ minutes  <u>Organizational</u> 15-50 minutes	90862	MD/DO	62	(035)  1319	164 812 8012 9009 9116	Physician Nurse Practitioner
	Effective 9/21/04 M0064  <u>I&amp;G:</u> 7+ min <u>Org:</u> 7-50 min						
<b>Brief Medication Visit (Face-to-Face)</b> This service typically requires only a brief or problem-focused history including evaluation of safety & effectiveness with straightforward decision-making regarding renewal or simple dosage adjustments. The client is usually stable.							
<b>Comprehensive Medication Service</b> Prescription services by phone or with collateral, medication administration, medication education, medication group services, and other non-prescription, non-face-to-face activities pertinent to medication support services.	H2010 (HE*)	N/A	MD/DO & NP				MD/DO, NP/CNS, RN, LVN, PT, Pharmacist, & student professionals in these disciplines with co-signature

\*Contract agencies submitting electronic claims to the Department must use the letter modifiers in the claims transmission.

**Notes:**

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

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**OTHER SERVICES – SD/MC & NETWORK PROVIDERS**

Service	Short-Doyle/Medi-Cal (SD/MC)		Network Medi-Cal	
	Code	Rendering Provider	Code	Rendering Provider
<b>Behavioral Health Screening – Triage</b> Service to determine eligibility for admission to a treatment program	H0002	Any staff operating within his/her scope of practice.	<b>Not Reimbursed</b>	<u>MD/DO or RN:</u> Licensed  <u>PhD/PsyD:</u> Licensed  <u>LCSW &amp; MFT:</u> Licensed  <u>NP or CNS:</u> Certified
<b>Review of Records</b> Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for: <ul style="list-style-type: none"> <li>• Assessment and/or diagnostic purposes</li> <li>• Continuity of care when receiving a transferred or new client</li> <li>• Plan Development (development of client plans and services and/or monitoring a client’s progress) when not in the context of another service</li> </ul>	90885		<b>Not Reimbursed</b>	
<b>Targeted Case Management (TCM)</b> Services needed to access medical, educational, social, prevocational, vocational, rehabilitative, or other community services. These services, whether face-to-face, by phone, or through correspondence, provide for the continuity of care within the mental health system and related social service systems. Services include linkage and consultation, placement, and plan development in the context of targeted case management services.	T1017 (HE, HS*)		<b>T1017</b> (HE, HS*)	
<b>No contact – Report Writing</b> Preparation of reports of client’s psychiatric status, history, treatment, or progress for other physicians, agencies, insurance carriers, or for discharge summary	90889		<b>Not Reimbursed</b>	

\*Contract agencies submitting electronic claims to the Department must use the letter modifiers in the claims transmission.

**Notes:**

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

**TEAM CONFERENCE/CASE CONSULTATION – SD/MC & NETWORK PROVIDERS**

Service	Short-Doyle/Medi-Cal (SD/MC)		Network Medi-Cal	
	Code	Rendering Provider	Code	Rendering Provider
<b>Team Conference/Case Consultation</b> Interdisciplinary inter/intra-agency conferences and consultations to coordinate activities of client care. Client may or may not be present.	1-59 minutes 99361	Any staff operating within his/her scope of practice.	1-59 minutes 99361	<u>MD/DO or RN:</u> Licensed  <u>PhD/PsyD:</u> Licensed
	60+ minutes 99362		60+ minutes 99362	<u>LCSW &amp; MFT:</u> Licensed  <u>NP or CNS:</u> Certified

\*Contract agencies submitting electronic claims to the Department must use the letter modifiers in the claims transmission.

**Notes:**

- Indiv=Individual Provider; Org=Organizational Provider
- These services are classified as Individual Mental Health Services and are reported under Service Function 42.
- These services are recorded in the clinical record and reported into the IS in hours:minutes.
- **The time of the conference determines the code, but that time should NOT be equated with claimable time.**
- **Face-to-face time must always be zero** because this is not a service directed toward the client and would distort the amount of appropriate reimbursable time; these codes are only used when the service is **directed towards** agency staff.
- For Team Conference: Other time should only include the actual time a staff person participated in the conference (listening and learning are not included) and any other time a staff person actually spent related to the conference, such as travel or documentation. Participation includes time when information was shared that can be used in planning for client care or services to the client.
- For Case Consultations (between two staff): All time spent during the consultation may be claimed as other time since each person must be actively participating for the entire duration.

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**CRISIS INTERVENTION AND CRISIS STABILIZATION – SD/MC ONLY**

Service	Code (Modifiers*) Place of Service (POS)	Cost Report Mode/SFC	Former ClinServ ActCodes	Former OutptHospSv ActCodes	Rendering Provider
<b>Crisis Intervention</b> A service lasting less than 24 hours which requires more timely response than a regularly scheduled visit and is delivered at a site other than a Crisis Stabilization program. (§1810.209)	H2011 (HE*)	Mode 15  SFC 77	141 854 1745 8032 9117	175 875 1743 8033 9117	Any staff operating within his/her scope of practice.
<b>Crisis Stabilization – Emergency Room</b> A package program lasting less than 24 hours delivered to clients which requires more timely response than a regularly scheduled visit and is provided on-site at one of the facilities indicated in the “Notes” below. (§1810.210)	S9484 (HE, TG*)  POS - 23	Mode 10  SFC 24	1413	452	Bundled service not claimed by individual staff. Specific staffing requirements are in §1840.348
<b>Crisis Stabilization – Urgent Care Facility</b> A package program lasting less than 24 hours delivered to clients which requires more timely response than a regularly scheduled visit and is provided on-site at one of the facilities indicated in the “Notes” below. (§1810.210)	S9484 (HE, TG*)  POS - 20	Mode 10  SFC 25	1414	1415	Bundled service not claimed by individual staff. Specific staffing requirements are in §1840.348

\*Contract agencies submitting electronic claims to the Department must use the letter modifiers in the claims transmission.

**Notes:**

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

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**DAY REHABILITATION AND DAY TREATMENT INTENSIVE – SD/MC ONLY**

**All of these services must be authorized by the Department prior to delivery and claiming.**

The requirement for prior authorization also extends to outpatient mental health services planned for delivery on the same day the client is in one of these day programs.

Service	Program Duration	Code (Modifiers*)	Cost Report SFC	Former ClinServ ActCodes	Former OutptHospSv ActCodes	Rendering Provider
<b>Day Rehabilitation</b> A structured program of rehabilitation and therapy provided to a distinct group of beneficiaries in a therapeutic milieu to improve, maintain, or restore personal independence and functioning, consistent with requirements for learning and development. (§1810.212)	<b>Half Day:</b> exceeds 3 continuous hrs but less than 4/day	H2012 (HQ*)	<b>92</b>	<b>429</b> 840 9121	<b>403</b> 841 9121	Bundled service not claimed by individual staff.  Any staff operating within his/her scope of practice may provide services.
	<b>Full Day:</b> exceeds 4 continuous hrs/day	H2012 (HE*)	<b>98</b>	<b>434</b> 842 9122	<b>408</b> 843 9122	
<b>Day Treatment Intensive</b> A structured, multi-disciplinary program of therapy provided to a distinct group of clients in a therapeutic milieu that may: be an alternative to hospitalization, avoid placement in a more restrictive setting, or maintain the beneficiary in a community setting. (§1810.213)	<b>Half Day:</b> exceeds 3 continuous hrs but less than 4/day	H2012 (HQ TG*)	<b>82</b>	<b>430</b> 844	<b>405</b> 845	One of these disciplines must be included in the staffing: MD/DO, RN, PhD/PsyD, LCSW, MFT.
	<b>Full Day:</b> exceeds 4 continuous hrs/day	H2012 (HE, TG*)	<b>85</b>	<b>435</b> 846	<b>410</b> 847	

\*Contract agencies submitting electronic claims to the Department must use the letter modifiers in the claims transmission.

**Notes:**

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

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**SOCIALIZATION SERVICES – SD/MC ONLY**

**These services are neither Medicare nor SD/MC reimbursable.**

Service	Code, (Modifier*)	Cost Report Mode/SFC	Former ClinServ & OutptHospSv ActCode	Rendering Provider
<b>Socialization Day Services</b> This service is a bundled activity service designed for clients who require structured support and the opportunity to develop the skills necessary to move toward more independent functioning. The activities focus on recreational and/or socialization objectives and life enrichment. The activities include but are not limited to outings, recreational activities, cultural events, linkages to community social resources, and other social supportive maintenance efforts. Services may be provided to clients with a mental disorder who might otherwise lose contact with social or treatment systems.	H2030 (HX*)	Mode 10  SFC 41	460	Bundled service not claimed by individual staff.  Any staff operating within his/her scope of practice may provide services.
<b>Clubhouse (inactive)</b> A particular type of Comprehensive Community Support program.	H2030			

\*Contract agencies submitting electronic claims to the Department must use the letter modifiers in the claims transmission.

**VOCATIONAL SERVICES – SD/MC ONLY**

**These services are neither Medicare nor SD/MC reimbursable.**

Service	Code	Cost Report Mode/SFC	Former ClinServ & OutptHospSv ActCodes	Rendering Provider
<b>Vocational Day Services (Skill Training and Development)</b> This bundled service is designed to encourage and facilitate individual motivation and focus upon realistic and attainable vocational goals. To the extent possible, the intent of these services is to maximize individual client involvement in skill seeking enhancement with an ultimate goal of self-support. These vocational services shall be bundled into a milieu program for chronically and persistently mentally ill clients who are unable to participate in competitive employment. These programs include, but are not limited to vocational evaluation, pre-vocational, vocational, work training, sheltered workshop, and job placement. The program stresses development of sound work habits, skills, and social functioning for marginally productive persons who ultimately may be placed in work situations ranging from sheltered work environments to part or full-time competitive employment.	H2014	Mode 10  SFC 31	447 9120	Bundled service not claimed by individual staff. Any staff operating within his/her scope of practice may provide services.

**Notes:**

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

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**COMMUNITY OUTREACH SERVICES AND CASE MANAGEMENT SUPPORT - SD/MC ONLY**

**These non-client services are neither Medicare nor SD/MC reimbursable.**

**Services should NOT be claimed in these activities for any client who has an open episode within a Provider number.**

Service	Code	Cost Report Mode	SFC	Former ClinServ & OutptHospSv ActCodes	Rendering Provider
<b>Community Outreach Service - Mental Health Promotion</b> Services delivered in the community-at-large to special population groups, human service agencies, and to individuals and families who are not clients of the mental health system. Services shall be directed toward: 1) enhancing and/or expanding agencies' or organizations' knowledge and skills in the mental health field for the benefit of the community-at-large or special population groups, and 2) providing education and/or consultation to individuals and communities regarding mental health service programs in order to prevent the onset of mental health problems.	200	45	10	200 970 2210 9050 9119	Any staff operating within his/her scope of practice.
<b>Community Outreach Service - Community Client Services</b> Services delivered in the community-at-large to special population groups, human service agencies, and to individuals and families who are not clients of the mental health system. Services shall be directed toward: 1) assisting individuals and families for whom no case record can be opened to achieve a more adaptive level of functioning through a single contact or occasional contacts, such as suicide prevention or other hotlines, and 2) enhancing or expanding the knowledge and skills of human services agency staff in meeting the needs of mental health clients.	231		20	231 235 9066 9118	
<b>Case Management Support</b> System-oriented services that supplement direct case management services such as: developing the coordination of systems and communications concerning the implementation of a continuum of care, establishing systems of monitoring and evaluating the case management system, and facilitating the development and utilization of appropriate community resources.	6000	60	60	600 615 640 838 9081	

**Notes:**

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

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**OUTPATIENT HOME MEDICAL SERVICES FOR MEDICARE BILLING ONLY  
(DMH GENESIS physician only)**

Service	Components	Severity of Presenting Problem(s)	Duration of Face-to-Face with Client and/or Family and Code		Rendering Provider
			New Client	EstabClient	
Evaluation and management of a client that includes at least the three components noted in the next column. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	<ul style="list-style-type: none"> <li>▪ problem focused history</li> <li>▪ problem focused examination</li> <li>▪ straightforward medical decision making</li> </ul>	Low	20-29 minutes 99341	15-24 minutes 99347	DMH GENESIS MD only
	<ul style="list-style-type: none"> <li>▪ expanded problem focused history</li> <li>▪ expanded problem focused exam</li> <li>▪ medical decision making of low complexity</li> </ul>	Moderate	30-44 minutes 99342	25-39 minutes 99348	
	<ul style="list-style-type: none"> <li>▪ detailed history</li> <li>▪ detailed examination</li> <li>▪ medical decision making of moderate complexity</li> </ul>	Moderate to high	45-59 minutes 99343	40-59 minutes 99349	
	<ul style="list-style-type: none"> <li>▪ comprehensive history</li> <li>▪ comprehensive examination</li> <li>▪ medical decision making of moderate complexity</li> </ul>	High	60-74 minutes 99344	60+ minutes 99350	
	<ul style="list-style-type: none"> <li>▪ comprehensive history</li> <li>▪ comprehensive examination</li> <li>▪ medical decision making of high complexity</li> </ul>	Patient usually unstable	75+ minutes 99345		

**Notes:**

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

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**RESIDENTIAL & OTHER SUPPORTED LIVING SERVICES – SD/MC ONLY**

Place of Service Codes: 56-Psychiatric Residential Treatment Center; 99-Other Unlisted Facility

Service	Code (Modifiers*)	Place of Service	Cost Report Mode 05	Medi-Cal Mode	Former ActCodes	Rendering Provider
			ServFuncCode			
Psychiatric Health Facility	H2013	56	<b>20</b>	05	<b>526</b>	Per diem service not claimed by individual staff
Crisis Residential	H0018 (HE, HB*)	56	<b>43</b> 44	05	<b>577</b> 969	
Transitional Residential – Non-Medi-Cal	H0019 (HC*)	56	<b>60</b> 61 64	05	<b>536</b> 961 9100	
Transitional Residential – Transitional	H0019	56	<b>65</b> 67	05	<b>542</b> 541, 551, 996	
Transitional Residential – Long Term	H0019 (HE, HB*)	56	<b>70</b> 71	05	<b>545</b> 964	
Residential Pass Day	0183 (HB*)	56	<b>62</b>	NA	<b>579</b>	
Semi-Supervised Living	H0019 (HX*)	99	<b>80</b> 81 85 86	NA	<b>550, 556</b> 965 559 967	
Life Support/Interim Funding	0134	99	<b>40</b>	NA	<b>675</b> 680 682	

\*Contract agencies submitting electronic claims to the Department must use the letter modifiers in the claims transmission.

**Notes:** These services are recorded in the clinical record and reported into the IS as days.

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**STATE HOSPITAL, IMD, & MH REHABILITATION CENTER SERVICES – SD/MC ONLY**

Place of Service Codes: 31-Skilled Nursing Facility; 32-Nursing Facility;  
56-Psychiatric Residential Treatment Center; 99-Other Unlisted Facility

Service	Code (Modifiers*)	Place of Service	Cost Report Mode 05	Medi-Cal Mode	Former ActCodes	Rendering Provider
			ServFuncCode			
State Hospital Facility	0100	99	<b>01</b>	NA	<b>500</b>	Per diem service not claimed by individual staff
Skilled Nursing Facility – Acute Intensive	0100 (HB*)	31	<b>30</b>	NA	<b>532</b>	
Institutions for Mental Disease (IMD) <b>WITHOUT</b> Special Treatment Patch (STP)	under 60 beds	31	<b>35</b>	NA	<b>528, 578</b>	
	60 beds & over		<b>35</b>		<b>1513</b>	
	indigent		<b>36</b>		<b>1514</b>	
Institutions for Mental Disease (IMD) <b>WITH</b> Special Treatment Patch (STP)	Non-MIO	32	<b>36</b>	NA	<b>529</b>	
	MIO		<b>37</b>		<b>1515</b>	
	Indigent MIO		<b>38</b>		<b>1516</b>	
MH Rehabilitation Center	0100 (HE*)	56	<b>90</b>	NA	<b>880</b>	

\*Contract agencies submitting electronic claims to the Department must use the letter modifiers in the claims transmission.

**Notes:** These services are recorded in the clinical record and reported into the IS as days.

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**ACUTE INPATIENT FACILITY SERVICES**

Place of Service (POS) Codes: 21 - Inpatient Hospital; 33 - Custodial Care Facility; for SD/MC facilities only 51 – Inpatient Psychiatric Facility

Service	Code, (Modifiers*) Place of Service (POS)	Former Contract FFS Codes	Former No-contract LACo Codes	Former No-contract CA Codes	Former No-contract Outside CA Codes	Cost Report Mode 05	SD/MC Mode	Former ActCode	Rendering Provider
						SFC			
<b>Acute Days</b>									
Acute General Hospital	0100 (HE, HT*) POS - 21	518, 5000, 5001, 5002, 5003	5014, 5017, 5020, 5023	5015, 5018, 5021, 5024	5016, 5019, 5022, 5025	<b>10</b>	07	<b>505</b>	Per diem service not claimed by individual staff
Local Psychiatric Hospital, age 21 or under	0100 (HE, HA*) SD/MC POS - 51	518, 5000, 5001	5014, 5017	5015, 5018	5016, 5019	<b>14</b>	08	<b>508</b>	
Local Psychiatric Hospital, age 22-64	0100 (HE, HB*) SD/MC POS – 51	514, 5002	5020	5021	5022	<b>15</b>	NA	<b>514</b>	
Local Psychiatric Hospital, age 65 or over	0100 (HE, HC*) SD/MC POS – 51	518, 5003	5023	5024	5025	<b>15</b>	09	<b>511</b>	
Local Psychiatric Hospital, Adult Forensic	0100 (HX) POS - 51	NA				<b>12</b>	NA	<b>1512</b>	
Forensic Inpatient Unit	0100 (HE*) POS - 33	NA				<b>50</b>	NA	<b>530</b>	
<b>Administrative Days</b>									
Acute General Hospital	0101 (HE*) POS – 21	NA				19	07	<b>522</b>	Per diem service not claimed by individual staff
Local Psychiatric Hospital, age 21 or under	0101 (HE, HA*) SD/MC POS – 51						08	<b>523</b>	
Local Psychiatric Hospital, age 22-64	0101 (HX*) POS - 51						NA	<b>587</b>	
Local Psychiatric Hospital, age 65 or over	0101 (HE, HC*) SD/MC POS – 51						09	<b>524</b>	

\*Contract agencies submitting electronic claims to the Department must use the letter modifiers in the claims transmission.

**Notes:**

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

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**ELECTROCONVULSIVE THERAPY (ECT)**  
**NETWORK INDIVIDUAL & GROUP PHYSICIANS ONLY**

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

Service	Type	Code*	Former FFS Code	Rendering Provider
ECT including monitoring	Single seizure	90870	20+ minutes 90870	Network MD/DO only
	Multiple seizures/day	90871		

\*Plus CPT modifiers, when appropriate

**Notes:**

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

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**EMERGENCY ROOM SERVICES  
NETWORK PHYSICIANS ONLY**

This service may only be delivered in a Hospital Emergency Room (Place of Service Code 23)

<b>Service</b>	<b>Components</b>	<b>Severity of Presenting Problem(s)</b>	<b>Code*</b>	<b>Former FFS Code</b>	<b>Rendering Provider</b>
A service for the evaluation and management of a client, which requires three components within the constraints of the client's clinical condition and/or mental status	<ul style="list-style-type: none"> <li>▪ problem focused history</li> <li>▪ problem focused examination</li> <li>▪ straightforward decision making</li> </ul>	Self-limited or minor	99281	99284  <b><u>Indiv &amp; Group</u></b> 20+ minutes <b><u>Organizational</u></b> 1-45 minutes	Network MD/DO only
	<ul style="list-style-type: none"> <li>▪ expanded history</li> <li>▪ expanded examination</li> <li>▪ decision making of low complexity</li> </ul>	Low to moderate	99282		
	<ul style="list-style-type: none"> <li>▪ expanded history</li> <li>▪ expanded examination</li> <li>▪ decision making of moderate complexity</li> </ul>	Moderate	99283		
	<ul style="list-style-type: none"> <li>▪ detailed history</li> <li>▪ detailed examination</li> <li>▪ decision making of moderate complexity</li> </ul>	High requiring urgent evaluation but do not pose an immediate significant threat to life or psychological function	99284		
	<ul style="list-style-type: none"> <li>▪ comprehensive history</li> <li>▪ comprehensive examination</li> <li>▪ decision making of high complexity</li> </ul>	High and poses an immediate significant threat to life or psychological function	99285		

\*Plus CPT modifiers, when appropriate

**Notes:**

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

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**INDIVIDUAL PSYCHOTHERAPY - HOSPITAL OR RESIDENTIAL CARE FACILITY**  
**NETWORK PHYSICIANS & ADMITTING PSYCHOLOGISTS ONLY**

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

Service	Duration of Face-to-Face	Code*	Former FFS Code	Rendering Provider
Insight oriented, behavior modifying, and/or supportive services delivered to one client.	<b><u>Indiv, Group, &amp; Organizational:</u></b> 20-39 minutes	90816	90805 or X9500	Network MD/DO & Admitting PhD/PsyD
	<b><u>Indiv &amp; Group:</u></b> 40-74 minutes <b><u>Organizational:</u></b> 40-50 minutes	90818	90807 or X9502	
	<b><u>Indiv &amp; Group:</u></b> 75+ minutes <b><u>Org:</u></b> NA	90821	<b><u>Indiv &amp; Group:</u></b> 90807 or X9502 <b><u>Org:</u></b> Not Reimbursed	
Insight oriented, behavior modifying, and/or supportive services delivered to one client <b>WITH</b> evaluation and management	<b><u>Indiv, Group, &amp; Organizational:</u></b> 20-39 minutes	90817	90805 or X9500	
	<b><u>Indiv &amp; Group:</u></b> 40-74 minutes <b><u>Organizational:</u></b> 40-50 minutes	90819	90807 or X9502	
	<b><u>Indiv &amp; Group:</u></b> 75+ minutes <b><u>Org:</u></b> NA	90822	<b><u>Indiv &amp; Group:</u></b> 90807 or X9502 <b><u>Org:</u></b> Not Reimbursed	
Interactive service using play equipment, physical devices, or other mechanisms of non-verbal communication delivered to one client.	<b><u>Indiv, Group, &amp; Organizational:</u></b> 20-39 minutes	90823	90805 or X9500	
	<b><u>Indiv &amp; Group:</u></b> 40-74 minutes <b><u>Organizational:</u></b> 40-50 minutes	90826	90807 or X9502	
	<b><u>Indiv &amp; Group:</u></b> 75+ minutes <b><u>Org:</u></b> NA	90828	<b><u>Indiv &amp; Group:</u></b> 90807 or X9502 <b><u>Org:</u></b> Not Reimbursed	
Interactive service using play equipment, physical devices, or other mechanisms of non-verbal communication delivered to one client <b>WITH</b> evaluation and management	<b><u>Indiv, Group, &amp; Organizational:</u></b> 20-39 minutes	90824	90805 or X9500	
	<b><u>Indiv &amp; Group:</u></b> 40-74 minutes <b><u>Organizational:</u></b> 40-50 minutes	90827	90807 or X9502	
	<b><u>Indiv &amp; Group:</u></b> 75+ minutes <b><u>Org:</u></b> NA	90829	<b><u>Indiv &amp; Group:</u></b> 90807 or X9502 <b><u>Org:</u></b> Not Reimbursed	

**Notes:**

\*Plus CPT modifiers, when appropriate

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

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**EVALUATION AND MANAGEMENT - HOSPITAL INPATIENT SERVICES**  
**NETWORK PHYSICIANS ONLY**

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

Service	Components	Severity of Condition	Duration of Face-to-Face or on Unit	Code*	Former FFS Code	Rendering Provider
<b><u>Initial Care</u></b> The first hospital encounter the admitting physician has with a client on the inpatient unit for the management and evaluation of a new client that requires <u>three</u> components. Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	<ul style="list-style-type: none"> <li>▪ detailed history</li> <li>▪ detailed or comprehensive exam</li> <li>▪ straight-forward or low complexity decision-making</li> </ul>	Low	<b><u>Ind, Gp, &amp; Org</u></b> 1-29 minutes	99221	Not Reimbursed	
	<ul style="list-style-type: none"> <li>▪ comprehensive history</li> <li>▪ comprehensive examination</li> <li>▪ decision-making of moderate complexity</li> </ul>	Moderate	<b><u>Indiv &amp; Group</u></b> 30-69 minutes <b><u>Org</u></b> 30-45 minutes	99222	99222	
	<ul style="list-style-type: none"> <li>▪ comprehensive history</li> <li>▪ comprehensive examination</li> <li>▪ decision-making of high complexity</li> </ul>	High	<b><u>Indiv &amp; Group</u></b> 70+ minutes <b><u>Organizational</u></b> 30-45 minutes	99223		
<b><u>Subsequent</u></b> Care, per day, for the evaluation and management of a client that requires at least <u>two of three</u> components. Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	<ul style="list-style-type: none"> <li>▪ Problem focused history</li> <li>▪ Problem focused examination</li> <li>▪ straight-forward or low complexity decision-making</li> </ul>	Stable, recovering, or improving	<b><u>Ind, Gp, &amp; Org</u></b> 1-24 minutes	99231	Effect 11/03 99231	Network MD/DO only
	<ul style="list-style-type: none"> <li>▪ expanded problem focused history</li> <li>▪ expanded problem focused exam</li> <li>▪ decision-making of moderate complexity</li> </ul>	Inadequate response to therapy or minor complication	<b><u>Ind, Gp, &amp; Org</u></b> 25-34 minutes	99232	99232	
	<ul style="list-style-type: none"> <li>▪ detailed history</li> <li>▪ detailed examination</li> <li>▪ decision making of moderate to high complexity</li> </ul>	Unstable, Significant complication, or new problem	<b><u>Indiv &amp; Group</u></b> 35+ minutes <b><u>Organizational</u></b> 35-45 minutes	99233		
<b><u>Discharge</u></b>	<u>All</u> services on day of discharge	N/A	<b><u>Ind, Gp, &amp; Org</u></b> 1-24 minutes	99238	Effect 11/03 99238	
			<b><u>I&amp;G:</u></b> 25+ min <b><u>Org:</u></b> 25-45 min	99239	99232	

\*Plus CPT modifiers, when appropriate

**Notes:**

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**EVALUATION & MANAGEMENT - NURSING FACILITY**  
**NETWORK PHYSICIANS ONLY**

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

<b>Service</b>	<b>Components</b>	<b>Severity of Condition and/or Plan Requirements</b>	<b>Duration of Face-to-Face or on Unit</b>	<b>Code*</b>	<b>Former FFS Code</b>	<b>Rendering Provider</b>
<b><u>Assessment</u></b> Annual assessment for the evaluation and management of a new or established client that requires <u>three</u> components. Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	<ul style="list-style-type: none"> <li>▪ detailed history</li> <li>▪ comprehensive examination</li> <li>▪ straight-forward or low complexity decision-making</li> </ul>	Stable, recovering, or improving; Affirmation of plan of care required	<b><u>Ind, Gp, &amp; Org</u></b> 20-39 minutes	99301	90805	Network MD/DO only
	<ul style="list-style-type: none"> <li>▪ detailed history</li> <li>▪ comprehensive examination</li> <li>▪ decision-making of moderate to high complexity</li> </ul>	Significant complication or new problem; New plan of care required	<b><u>Ind, Gp, &amp; Org</u></b> 40-49 minutes	99302	90807	
	<ul style="list-style-type: none"> <li>▪ comprehensive history</li> <li>▪ comprehensive examination</li> <li>▪ decision-making of moderate to high complexity</li> </ul>	Creation plan of care required	<b><u>Indiv &amp; Group</u></b> 50+ minutes <b><u>Organizational</u></b> 50 minutes	99303		
<b><u>Subsequent</u></b> Care, per day, for the evaluation and management of a new or established client that requires <u>three</u> components. Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	<ul style="list-style-type: none"> <li>▪ Problem focused history</li> <li>▪ Problem focused examination</li> <li>▪ straight-forward or low complexity decision-making</li> </ul>	Stable, recovering, or improving	<b><u>Ind, Gp, &amp; Org</u></b> 1-19 minutes	99311	Not Reimbursed	
	<ul style="list-style-type: none"> <li>▪ expanded history</li> <li>▪ expanded examination</li> <li>▪ decision-making of moderate complexity</li> </ul>	Inadequate response to therapy or minor complication	<b><u>Ind, Gp, &amp; Org</u></b> 20-39 minutes	99312	90805	
	<ul style="list-style-type: none"> <li>▪ detailed history</li> <li>▪ detailed examination</li> <li>▪ decision making of moderate to high complexity</li> </ul>	Unstable, Significant complication or new problem	<b><u>Indiv &amp; Group</u></b> 40+ minutes <b><u>Organizational</u></b> 41-50 minutes	99313	90807	
<b><u>Discharge</u></b>	<u>All</u> services on day of discharge	N/A	<b><u>Ind, Gp, &amp; Org</u></b> 20-39 minutes	99315	90805	
			<b><u>I&amp;G:</u></b> 40+ min <b><u>Org:</u></b> 41-50 min	99316	90807	

\*Plus CPT modifiers, when appropriate

**Notes:**

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

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**EVALUATION AND MANAGEMENT  
DOMICILIARY, BOARD & CARE, OR CUSTODIAL CARE FACILITY  
NETWORK PHYSICIANS ONLY**

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

<b>Service</b>	<b>Components</b>	<b>Severity of Presenting Problem</b>	<b>Code*</b>	<b>Former FFS Code</b>	<b>Rendering Provider</b>
<b><u>New Client</u></b> Service for the evaluation and management of a new client that requires <u>three</u> components.  Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	<ul style="list-style-type: none"> <li>▪ Problem focused history</li> <li>▪ Problem focused examination</li> <li>▪ straight-forward or low complexity decision-making</li> </ul>	Low	99321	90805 <b><u>Indiv, Group, &amp; Organizational</u></b> 20-39 min.	Network MD/DO only
	<ul style="list-style-type: none"> <li>▪ expanded history</li> <li>▪ expanded examination</li> <li>▪ decision-making of moderate</li> </ul>	Moderate	99322		
	<ul style="list-style-type: none"> <li>▪ detailed history</li> <li>▪ detailed examination</li> <li>▪ decision-making of high complexity</li> </ul>	High	99323		
<b><u>Established Client</u></b> Services for the evaluation and management of an established client that requires at least <u>two</u> of <u>three</u> components.  Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	<ul style="list-style-type: none"> <li>▪ Problem focused history</li> <li>▪ Problem focused examination</li> <li>▪ straight-forward or low complexity decision-making</li> </ul>	Stable, recovering, or improving	99331	90807 <b><u>Indiv &amp; Group Organizational</u></b> 40+ minutes 40-50 minutes	Network MD/DO only
	<ul style="list-style-type: none"> <li>▪ expanded history</li> <li>▪ expanded examination</li> <li>▪ decision-making of moderate complexity</li> </ul>	Inadequate response to therapy or minor complication	99332		
	<ul style="list-style-type: none"> <li>▪ detailed history</li> <li>▪ detailed examination</li> <li>▪ decision making of high complexity</li> </ul>	Significant complication or new problem	99333		

\*Plus CPT modifiers, when appropriate

**Notes:**

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**EVALUATION AND MANAGEMENT - OFFICE OR OTHER OUTPATIENT SERVICES**  
**NETWORK PHYSICIANS ONLY**

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

Service	Components	Severity of Presenting Problem(s)	New Client		Established Client		Rendering Provider
			Duration of Face-to-Face with Client and/or Family and Code*	Former FFS Code	Duration of Face-to-Face with Client and/or Family and Code*	Former FFS Code	
Evaluation and management of a client that includes at least the three components noted in the next column.	<ul style="list-style-type: none"> <li>▪ problem focused history</li> <li>▪ problem focused examination</li> <li>▪ straightforward medical decision making</li> </ul>	Minor	<u>Ind, Gp, &amp; Org</u> 10-19 minutes 99201	No Reimbursement	No Code	Not Reimbursed	Network MD/DO only
	<ul style="list-style-type: none"> <li>▪ expanded problem focused history</li> <li>▪ expanded problem focused exam</li> <li>▪ straightforward medical decision making</li> </ul>	Low to Moderate	<u>Ind, Gp, &amp; Org</u> 20-29 minutes 99202	90805	<u>Ind, Gp, &amp; Org</u> 10-19 min. 99212		
Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	<ul style="list-style-type: none"> <li>▪ detailed history</li> <li>▪ detailed examination</li> <li>▪ medical decision making of low complexity</li> </ul>	Moderate	<u>Ind, Gp, &amp; Org</u> 30-39 minutes 99203		<u>Ind, Gp, &amp; Org</u> 20-24 minutes 99213	90805	
	<ul style="list-style-type: none"> <li>▪ comprehensive history</li> <li>▪ comprehensive examination</li> <li>▪ medical decision making of moderate complexity</li> </ul>	Moderate to High	<u>Indiv &amp; Group</u> 40-59 minutes <u>Org:</u> 40-50 minutes 99204	90807	<u>Ind, Gp, &amp; Org</u> 25-39 minutes 99214		
	<ul style="list-style-type: none"> <li>▪ comprehensive history</li> <li>▪ comprehensive examination</li> <li>▪ medical decision making of high complexity</li> </ul>	Moderate to High	<u>Indiv &amp; Group</u> 60+ minutes 99205 <u>Org:</u> NA		<u>Indiv &amp; Group</u> 40+ minutes 99215 <u>Org:</u> Not Reimbursed	90807	

\*Plus CPT modifiers, when appropriate

**Notes:**

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**EVALUATION AND MANAGEMENT – CONSULTATIONS, OFFICE OR OTHER OUTPATIENT  
DEPT OF HEALTH SERVICES & NETWORK PHYSICIANS ONLY**

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

Service	Components	Presenting Problems	Duration of Face-to-Face, Client and/or Family	Code*	Former FFS Code	Rendering Provider
<b><u>New or Established Client</u></b>  Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client's and/or family's needs.	<ul style="list-style-type: none"> <li>▪ problem focused history</li> <li>▪ problem focused examination</li> <li>▪ straightforward decision-making</li> </ul>	Self limited or Minor	<b><u>Ind, Gp. &amp; Org</u></b> 20-29 minutes	99241	90805	SD/MC MD/DO  Network MD/DO only
	<ul style="list-style-type: none"> <li>▪ expanded problem focused history</li> <li>▪ expanded problem focused exam</li> <li>▪ straightforward decision-making</li> </ul>	Low Severity	<b><u>Ind, Gp. &amp; Org</u></b> 30-39 minutes	99242		
	<ul style="list-style-type: none"> <li>▪ detailed history</li> <li>▪ detailed examination</li> <li>▪ decision-making of low complexity</li> </ul>	Moderate Severity	<b><u>Indiv &amp; Group</u></b> 40-59 minutes <b><u>Org:</u></b> 40-50 min	99243	90807	
	<ul style="list-style-type: none"> <li>▪ comprehensive history</li> <li>▪ comprehensive examination</li> <li>▪ decision-making of moderate complexity</li> </ul>	Moderate to High Severity	<b><u>Indiv &amp; Group</u></b> 60-79 minutes <b><u>Org:</u></b> NA	<b><u>Indiv &amp; Group</u></b> 99244 <b><u>Org:</u></b> Not Reimbursed		
	<ul style="list-style-type: none"> <li>▪ comprehensive history</li> <li>▪ comprehensive examination</li> <li>▪ decision-making of high complexity</li> </ul>	Moderate to High Severity	<b><u>Indiv &amp; Group</u></b> 80+ minutes <b><u>Org:</u></b> NA	<b><u>Indiv &amp; Group</u></b> 99245 <b><u>Org:</u></b> Not Reimbursed		

\*Plus CPT modifiers, when appropriate

**Notes:**

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**EVALUATION AND MANAGEMENT – CONSULTATIONS, INPATIENT**  
**DEPT OF HEALTH SERVICES & NETWORK PHYSICIANS AND ADMITTING PSYCHOLOGISTS**

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

Service	Components	Severity of Presenting Problem	Initial Consultation		Confirmatory Consult		Rendering Provider
			Code*	Former FFS Code	Code*	Former FFS Code	
<p><b><u>Initial Inpatient or Nursing Facility</u></b> Service for the evaluation and management of a new or established client that requires <u>three</u> components.</p> <p><b><u>Confirmatory</u></b> Service to a new or established client to confirm an existing opinion regarding services.</p> <p>Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client’s and/or family’s needs.</p>	<ul style="list-style-type: none"> <li>▪ Problem focused history</li> <li>▪ Problem focused examination</li> <li>▪ straightforward decision making</li> </ul>	Self limited or minor	20-39 min 99251	<b><u>Ind, Gp, &amp; Org</u></b> 90805 X9500	99271	<b><u>Ind, Gp, &amp; Org</u></b> 90805 X9500	<p>SD/MC MD/DO</p> <p>Network MD/DO &amp; Admitting PhD/PsyD</p>
	<ul style="list-style-type: none"> <li>▪ expanded problem focused history</li> <li>▪ expanded problem focused exam</li> <li>▪ straightforward decision making</li> </ul>	Low	40-54 min 99252	<b><u>Indiv &amp; Group</u></b> 40+ min 90807 X9502	99272	<b><u>Indiv &amp; Group</u></b> 40+ min 90807 X9502	
	<ul style="list-style-type: none"> <li>▪ detailed history</li> <li>▪ detailed examination</li> <li>▪ decision-making of low complexity</li> </ul>	Moderate	55-79 min 99253	<b><u>Organizational</u></b> 40-50 min 90807 X9502	99273	<b><u>Organizational</u></b> 40-50 min 90807 X9502	
	<ul style="list-style-type: none"> <li>▪ comprehensive history</li> <li>▪ comprehensive examination</li> <li>▪ decision-making of moderate complexity</li> </ul>	Moderate to high	80-109 min 99254	<b><u>Indiv &amp; Group</u></b> 80+ min 90807 X9502	99274	<b><u>Indiv &amp; Group</u></b> 80+ min 90807 X9502	
	<ul style="list-style-type: none"> <li>▪ comprehensive history</li> <li>▪ comprehensive examination</li> <li>▪ decision-making of high complexity</li> </ul>	high	110+ min 99255	<b><u>Organizational</u></b> Not Reimbursed	99275	<b><u>Organizational</u></b> Not Reimbursed	
	<ul style="list-style-type: none"> <li>▪ Problem focused history</li> <li>▪ Problem focused examination</li> <li>▪ straightforward or low complexity decision-making</li> </ul>	Stable, recovering, or improving	1-19 minutes 99261	Not Reimbursed			
<p><b><u>Follow-up Inpatient</u></b> Service to an established client to complete a consultation, monitor progress, or recommend modifications to management or a new plan of care based on changes in client status. At least <u>two of three</u> components are required. Counseling or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the client’s and/or family’s needs.</p>	<ul style="list-style-type: none"> <li>▪ expanded problem focused history</li> <li>▪ expanded problem focused exam</li> <li>▪ decision-making of moderate complexity</li> </ul>	Inadequate response to therapy or minor complication	20-29 minutes 99262	<b><u>Individual, Group, &amp; Organizational</u></b> 20-39 minutes 90805 X9500			
	<ul style="list-style-type: none"> <li>▪ detailed history</li> <li>▪ detailed examination</li> <li>▪ decision-making of high complexity</li> </ul>	Significant complication or new problem	30-39 minutes 99263				

\*Plus CPT modifiers, when appropriate

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