CalAIM Behavioral Health Payment Reform

Frequently Asked Questions (FAQs) | Last update 2/27/24

The Department of Health Care Services (DHCS) is implementing a Behavioral Health Payment Reform initiative on July 1, 2023. The initiative will change the way DHCS reimburses counties for Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS) services. Behavioral Health Payment Reform includes many changes relating to CPT coding, Intergovernmental Transfers, updated reimbursement methodologies and a new fee schedule.

DHCS developed these FAQs to provide more detailed clarification on multiple topics relating to Behavioral Health Payment Reform.

Administrative Services and Utilization Review/Quality Assurance (UR/QA)

1. **How will counties claim for Administrative Services and Utilization Review and Quality Assurance?**
   Claiming for administrative services and UR/QA will remain under the current Certified Public Expenditure (CPE) process while DHCS continues discussions with the Center for Medicare and Medicaid Services (CMS) about updating this process. Counties will submit claims for administrative and UR/QA services that will be reconciled to cost after submission of a cost report. Although this process will remain cost reconciled, DHCS is committed to improving the efficiency of this process to reduce the administrative burden on counties. DHCS has published BHIN 23-049 Administration and Utilization Review/Quality Assurance (UR/QA) Reimbursement Under Payment Reform and will publish further guidance on this topic as it becomes available.

2. **Will counties have to complete cost reports for Administrative Services and UR/QA?**
   Yes, counties will need to submit a final invoice that reflects actual costs by December 31st following the close of the fiscal year. The final invoice will be subject to audit. Please see BHIN 23-049 for more information.

3. **What will audits look like under the new cost reporting process?**
   DHCS is currently working to finalize an audit process that is less burdensome to counties than previous audits. DHCS will publish an Information Notice on this topic with guidance on this process which is likely to retain most of the current claiming process.

4. **Will Administrative Services and URQA be funded by the Intergovernmental Transfers (IGTs)?**

No. IGTs will only be used to fund direct services. DHCS will continue to certify the public expenditures consistent with current practices. DHCS will publish an Information Notice to give guidance on this procedure.

Acute Psychiatric Inpatient Rates

1. **Why aren't professional fees included in the inpatient rate?**
   Beginning July 1, 2023, Short-Doyle Medi-Cal (SD/MC) and Fee for Service Medi-Cal (FFS) hospitals will be reimbursed a bundled rate for routine and ancillary services. MHPs will reimburse professional services provided in both SD/MC and FFS hospitals and submit claims for federal reimbursement to the SD/MC claiming system using the 837P.

   DHCS deployed a system change in SD/MC on May 9, 2023 that allows counties to claim for professional services provided in SD/MC hospitals as outpatient services in addition to routine and ancillary services. The SMHS Billing Manual v1.5 will reflect this update.

   Professional fees are reimbursed under the outpatient services fee schedule. This is a CMS requirement in approval of the DHCS State Plan Amendment 23-015, not DHCS policy. Counties will be paid for professional services using the outpatient rates published here.

2. **How will Fee-For-Service (FFS) and Short-Doyle Medi-Cal (SD/MC) Hospital Administrative Day rates for inpatient be reimbursed?**
   For FFS hospitals, the development of the administrative day rate and its current methodology will not change beginning July 1, 2023. DHCS will continue publishing this rate annually. The current rates are published here.

   As of July 1, 2023, the same administrative day rates apply to SD/MC hospitals.

Narcotic Treatment Program (NTP) Rates

1. **What does the NTP Dosing Bundle include?**
   Cost factors included in the NTP dosing calculations are:
   - Physical Exam
   - Drug Screening
   - Intake Assessment
   - Medical Director Supervision
   - TB Test
   - Syphilis Test
   - HIV Test
   - Hepatitis C Test

- Drug Screening
- LVN Dosing
- RN Dosing
- Ingredient Costs

For components included in the NTP dosing rate such as the physical exam, providers and counties cannot bill those separate and apart from the bundled rate. NTP rates can be found here.

Substance Use Disorder (SUD) Residential Rates

1. **Are Care Coordination, Recovery Services, and MAT included in the DMC Residential Rate?**
DHCS is allowing separate billing for Care Coordination, Recovery Services and MAT in addition to the per diem residential rate for two years. During that time, DHCS will gather data to incorporate these services into the per diem rate thereafter. DHCS anticipates recalculation of the residential rate along with new care coordination, recovery services and MAT rates in June 2025.

2. **Are medication services billed separately or included in the bundled rate?**
Yes, medication services are included in the bundled rate for Residential services.

3. **Do these services (Care Coordination, Recovery Services, and MAT) meet the minimum daily service requirements for the residential day rate?**

   To receive the residential day rate, a residential provider has to provide at least one of the following service components: Assessment, counseling, family therapy, medication service, patient education, or SUD crisis intervention service.

   Care Coordination, Peer Support Specialist services, MAT for OUD and MAT for AUD are reimbursed separate from the per diem rate.

4. **When provided by an SUD residential program, can these services (Care Coordination, Recovery Services, and MAT) be documented in the daily note as long as separate claims are made for those services?**

   DHCS requires at minimum one progress note for services that are billed daily or as a bundled service. The progress note must support the services rendered and include all progress note requirements outlined in BHIN 22-019. For example, Therapeutic Foster Care (TFC) is claimed based on 24-hour increments, and a progress note is required for each unit of service delivered. Weekly or periodic progress notes cannot be used in lieu of individual progress notes for each unit of

service.

There are some (relatively rare) scenarios where a bundled service may be delivered concurrently with a second service that is not included in the bundled rate and may be claimed separately. In these cases, there must also be a progress note to support the second, unbundled service. For example, Medi-Cal Peer Support Specialist services may be claimed on the same day as, and separately from, residential or day services. In this scenario, DHCS would require one progress note for the bundled residential or day service, and a separate progress note to support the additional, unbundled claim for Medi-Cal Peer Support Specialist services.

These requirements apply regardless of whether the bundled and unbundled services are delivered by the same provider or by different providers.

Reference BHIN 22-019 & SMHS, DMC, and DMC-ODS billing manuals

Mobile Crisis Rates

1. **What variables were used to develop the encounter rate?**
   DHCS referenced both the Crisis Resource Need Calculator developed from the National Association of State Mental Health Directors (NASMHPD) and a DHCS report titled “Assessing the Continuum of Care for Behavioral Health Services in California” to develop the Mobile Crisis rates.

   Variables considered in the rate calculation include: the estimated number of Mobile Crisis teams needed based on the Crisis Resource Need Calculator, estimated travel time, estimated number of encounters, County hourly rate for Mobile Crisis teams and average County rate for Mobile Crisis teams – both from the FY 2023/24 MH/DMC Outpatient County Rate, direct service time, follow up and standby time.

   More information on the data sources that contributed to rate development can be found here in BHIN 23-017 Specialty Mental Health Services and Drug Medi-Cal Services Rates.pdf.

2. **How are mileage and transportation accounted for?**
   Time and transportation for the mobile crisis team is built into the mobile crisis rate. For mobile crisis encounters, mileage is billable when the Mobile Crisis team arranges for the patient to be transported to a higher level of care using HCPCS code A0140 (Transportation, mileage). The time it takes for this transport and warm handoff can be billed under HCPCS code T2007 (Transportation, staff time).

More information on billing codes related to Mobile Crisis can be found in the [MedCCC - Library (ca.gov)](#).

3. **Will rates for EMT and paramedics be added to the current rate?**

   No, the current rates for transportation mileage (A0140) and transportation staff time (T2007) are not based on provider type. For these codes, there is a single rate per county and all provider types who are part of the mobile crisis team may use these codes.

Rates

1. **Why does DHCS publish rates for expanded DMS-ODS Services for all DMC (State Plan) counties?**
   In accordance with BHIN 22-003, "Beneficiaries under age 21 are entitled to receive all medically necessary services coverable under 42 U.S.C. § 1396d(a) whether or not the services are in the state's Medicaid Plan, including all DMC-ODS services, even if they reside in a DMC county." Therefore, DMC-State Plan counties are obligated to provide DMC-ODS services to EPSDT beneficiaries (i.e., beneficiaries under 21 enrolled in a full scope aid code).

2. **Are rates paid to counties inclusive of travel and documentation time?**
   In development of the CalAIM Behavioral Health Payment Reform Fee Schedule Outpatient rates, DHCS collected cost information from direct SMHS outpatient providers in each county for SFY 2020-21. Information includes employee benefits costs, clinic supervision and support staff costs, clinic operating costs, and clinic indirect costs. DHCS used this data as the base of fully loaded rates for outpatient services. A fully loaded rate accounts for staff time spent on direct patient care; staff time not spent on direct patient care (e.g., time spent on documentation, travel, and paid time off); total staff compensation (e.g., salaries and wages, benefits, bonuses, and other incentives); and any direct and indirect overhead and operating costs.

   Critically, to avoid disincentivizing the delivery of clinically appropriate field-based services, counties should consider implementing rate differentials/enhancements that account for lower productivity standards and the travel time and costs associated with in-home services, street-based services, and services delivered in other non-clinical settings in the community

General Billing & Coding

1. **What are the best sources of CPT Code information that counties should consult regularly for appropriate coding practices?**

The American Medical Association's (AMA) CPT codebooks provide a more complete description of the CPT codes and of the standard rules governing code use and selection. The CPT codebook will help answer questions such as: which services a code encompasses, how to select a unit of a particular code and which providers can claim for a particular service.

A common question that DHCS receives is when a unit of time for a specific code should be claimed. The 2024 CPT codebook, states: "The CPT code set contains many codes with a time basis for selection. The following standards shall apply to time measurement, unless there are code or code-range specific instructions in guidelines, parenthetical instructions, or code descriptions to the contrary. A unit of time is attained when the mid-point is passed. For example, an hour is attained when 31 minutes have elapsed (more than midway between zero and 60 minutes). A second hour is attained when a total of 91 minutes has elapsed." Similarly, there was an inquiry as to whether the services associated with evaluation and management CPT codes 99202-99215 could "include prescribing medication related to an alcohol use disorder." Page 14 of the 2024 CPT codebook lists the services that are included in each evaluation and management code when those codes are selected on the basis of time. "Ordering medications, tests, or procedures" is one of the services listed.

Please note that DHCS' rules may be more restrictive than the rules described in the CPT codebook. As a result, the CPT codebook should be used in conjunction with the billing manuals.

2. **Can providers bill for services when the member is not present?**
If the service code billed is a member care code claimable service time means time spent with the member for the purpose of providing healthcare. If the code billed specifies activities that are not direct member care but that are for the benefit of the member or the member's support persons, those activities are allowed, so long as activities are being conducted that would be billable if the member was present. For example, CPT code 99202 (office or other outpatient visit) includes "medically appropriate history and/or examination" as part of the services described by the code. According to the Evaluation and Management Services Guidelines in the 2024 CPT codebook, this means "the care team may collect information, e.g., by electronic health portal or questionnaire." If consolidating and synthesizing clinical information which is a part of the member's medical record to make recommendations for treatment or to make a medical diagnosis, then the activity would count as service time and is claimable even in the event the member is not present. If the service code billed specifies a case management service or a consulting service on behalf of the member, those activities are allowed. In those situations, claimable service time is time spent consulting on behalf of the member with specialist(s) and/or with the

member's support person(s). Claimable service time does not include travel time, administrative activities, chart review, documentation, utilization review and quality assurance activities or other activities a provider engages in that are either already included in the rate for the service code or are claimed separately by the county.

3. **Does DHCS provide or endorse an Electronic Health Records (EHR) system of billing platform?**
   County Behavioral Health Departments are responsible for selection and procurement of an EHR and other IT infrastructure. DHCS does not provide these resources and does not endorse nor recommend any specific product or vendor. Counties should select a vendor and product that best suits the needs and financial resources of the county.

Graduate/Student Billing

1. **How can counties claim for clinical services provided by master's degree students and non-licensed PhD students (students who are not yet able to register with BBS) working in a field practicum?**
   In California, master's degree students and non-licensed PhD students who are working in a field practicum may provide clinical services within their scope of practice under the supervision of a licensed behavioral health professional. DHCS will be submitting a State Plan Amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS) to clarify the role of practicum students as SMHS and DMC/DMC-ODS providers. Once the SPA is approved, the effective date will be retroactive to July 1, 2023.

   DHCS will also deploy updates to the Short-Doyle Medi-Cal claiming system to allow master's degree students and non-licensed PhD students who are working in a field practicum to use appropriate Common Procedural Terminology (CPT) codes to claim for reimbursement and will assign county behavioral health fee schedule rates for students who are working in a field practicum. In the interim, counties have the option to hold claims for students or submit claims pursuant to the guidance below and then replace them after the SPA is approved and the claiming system is updated.

   Students providing clinical interventions within their scope of practice should use appropriate CPT codes with an HL modifier to claim for reimbursement and include their NPI and the taxonomy code of their supervising clinician.

Interpretation Services

1. **In what circumstances should a county claim for oral or sign language interpretation?**

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.

2. **Which taxonomy code should be included on a claim for interpretation services?**
   A claim for interpretation, T1013 (sign language or oral interpretive services), should include the taxonomy code and NPI of the individual who provided the primary service. The standard rate per unit of oral or sign language interpretation is based on the Bureau of Labor Statistics data. One unit of T1013 will be reimbursed at $30. DHCS will clarify the claiming guidance in version 1.5 of the billing manuals.

Collateral Services

1. **Does Medi-Cal cover and reimburse for services provided to a beneficiary's supports when a beneficiary is not present?**
   Yes, depending on the covered service being performed. Supplement 3 to Attachment 3.1-A describes the Specialty Mental Health Services (SMHS), Substance Use Disorder Treatment Services (DMC), and Expanded Substance Use Disorder Treatment Services (DMC-ODS) that are available to Medicaid (Medi-Cal) beneficiaries. These covered services may include contact with significant support persons or other collaterals who participate in the planning for and treatment of the beneficiary. If the covered service requires that the beneficiary is present, then the collateral contact must occur when the beneficiary is present. If the covered service does not require the beneficiary to be present, the collateral contact may occur when the beneficiary is not present. The updated version of the Billing Manual reflect this.

Licensed Vocational Nurses (LVNs) and Licensed Psychiatric Technicians (LPTs) in Specialty Mental Health Services and Drug Medi-Cal

1. **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 Specialty Mental Health delivery system?
LVNs and LPTs are recognized provider types of SMHS within their scope of practice, as established in Supplement 3 to Attachment 3.1-A of California's Medicaid State Plan. They can continue to administer medication and can claim for it using HCPCS code H0033. They can claim for providing medication training and support using HCPCS code H0034. DHCS will clarify in version 1.5 of the SMHS billing manual that for DHCS behavioral health claiming purposes, H0033 includes all modes of medication administration.

2. **Can LVNs and LPTs claim for DMC and DMC-ODS services?**
   DHCS is in the process of submitting a State Plan Amendment (SPA) to CMS that will add LVNs and LPTs to the list of recognized provider types for DMC and DMC-ODS services. If approved, the SPA will be effective on July 1, 2023. DHCS is also updating the Short-Doyle Medi-Cal (SD/MC) claiming system to reimburse claims for outpatient DMC and DMC-ODS services provided by LVNs, in anticipation of a CMS SPA approval retroactive to July 1, 2023. Prior to the SPA approval and SD/MC updates, counties can submit claims for day services (e.g., NTP dosing) if an LVN was part of the team that provided the services.

   Until CMS SPA approval retroactive to July 1, 2023, counties will need to hold claims or submit claims and receive a denial for DMC and DMC-ODS outpatient services that were provided by an LVN or LPT. Currently in SD/MC, claims for outpatient services provided by an LVN or LPT will be denied because taxonomy codes associated with LVNs and LPTs are not recognized in SD/MC. Once the SPA is approved and the SD/MC claiming system is updated, counties can submit these claims or replace denied claims for dates of service effective July 1, 2023. DHCS will notify the counties when the SPA is approved and the system update has been made.

3. **Can medical Assistants (MAs) claim for SMHS, DMC, and DMC-ODS services?**
   DHCS is in the process of submitting a State Plan Amendment (SPA) to CMS that will add MAs to the list of recognized provider types for SMH, DMC, and DMC-ODS services. If approved, the SPA will be effective on July 1, 2023. DHCS is also updating the Short-Doyle Medi-Cal (SD/MC) claiming system to reimburse claims for outpatient SMH, DMC, and DMC-ODS services provided by MAs, in anticipation of a CMS SPA approval retroactive to July 1, 2023. Prior to the SPA approval and SD/MC updates, counties can submit claims for day services (e.g., NTP dosing) if an MA was part of the team that provided the services.

Non-Direct Patient Care Time

1. **Will counties be reimbursed for time spent preparing to see a patient and time spent on post service activities?**

   Counties should only consider direct patient care time, as defined in the billing manual, when choosing the most appropriate code to bill. However, this does not mean that counties would not be reimbursed for activities such as chart review, documentation, and other activities associated with preparing to see a patient or post service time. The rates DHCS pays to counties were adjusted to incorporate the cost for staff time not spent on direct patient care, which includes activities the provider engages in before and after seeing a patient, and "no shows".

Multiple Group Services

1. **How do counties claim for group services if the same beneficiary is seen in several group sessions on the same day?**

   Under CalAIM, if a provider renders two outpatient services to the same beneficiary on the same day in two or more separate encounters, all encounters must be claimed as one service to ensure the additional encounters are not denied as duplicate services.

   However, DHCS recognizes that it can be difficult to track when a beneficiary is seen in several group sessions on the same day. Therefore, DHCS is working on updating the Short-Doyle Medi-Cal claiming system to allow counties to claim reimbursement for more than one group service provided to the same beneficiary by the same provider on the same day. After the change is deployed in SD/MC, counties will be able to claim more than once for the same beneficiary, on the same day, for the respective group service. DHCS anticipates implementing this change in September or October and will notify the counties when the update has been made.

New Provider Types

1. **Which providers are newly eligible to claim for services in the Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC)-Organized Delivery System (ODS), and DMC delivery systems?**

   State Plan Amendment (SPA) 23-0026 added the rendering provider types listed below to the Short-Doyle claiming system, effective July 1, 2023.

Provider types newly eligible to claim for services in the SMHS delivery system are:

- Medical Assistant
- Nurse Practitioner/Clinical Nurse Specialist Clinical Trainee
- Psychologist Clinical Trainee
- Clinical Social Worker (LCSW) Clinical Trainee
- Marriage and Family Therapist (MFT) Clinical Trainee
- Professional Counselor (LPCC) Clinical Trainee
- Psychiatric Technician Clinical Trainee
- Registered Nurse Clinical Trainee
- Vocational Nurse Clinical Trainee
- Occupational Therapist Clinical Trainee
- Medical Student in Clerkship (Physician Clinical Trainee)

Provider types newly eligible to claim in the DMC and DMC-ODS delivery systems are:

- Medical Assistant
- Occupational Therapist
- Licensed Vocational Nurse
- Licensed Psychiatric Technician
- Nurse Practitioner Clinical Trainee
- Psychologist Clinical Trainee
- Clinical Social Worker (LCSW) Clinical Trainee
- Marriage and Family Therapist (MFT) Clinical Trainee
- Professional Clinical Counselor (LPCC) Clinical Trainee
- Psychiatric Technician Clinical Trainee
- Registered Nurse Clinical Trainee
- Vocational Nurse Clinical Trainee
- Occupational Therapist Clinical Trainee
- Pharmacist Clinical Trainee
- Physician Assistant Clinical Trainee
- Medical Student in Clerkship (Physician Clinical Trainee)

2. What is a Clinical Trainee?

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.

3. **When claiming for services rendered by Clinical Trainees, what taxonomy codes, modifiers and additional information should be reported on the 837P?**

   When claiming for clinical trainees, MHPs, DMC-ODS counites, DMC counties and trading partners should report taxonomy code with the first four characters 1774 for medical students in clerkship or 3902 for all other clinical trainees, along with the appropriate procedure code modifier as indicated below to identify the type of clinical trainee. For example, to claim for a psychiatric diagnostic evaluation (CPT code 90791), a Social Worker Clinical Trainee would use taxonomy code 3902 and claim for the psychiatric diagnostic evaluation, using the procedure code: modifier combination 90791:AJ.

   In addition to using the appropriate taxonomy and procedure code modifier, the supervisor's National Provider Identifier (NPI) will also be required on all claims for services rendered by Clinical Trainees.

No.	Profession(s) Type	Taxonomy	Modifier
1.	Medical Student in Clerkship	1744	None
2.	LCSW, MFT or LPCC Clinical Trainee	3902	AJ
3.	Psychologist Clinical Trainee	3902	AH
4.	Registered Nurse Clinical Trainee	3902	TD
5.	Vocational Nurse Clinical Trainee	3902	TE
6.	Psychiatric Technician Clinical Trainee	3902	HM
7.	Occupational Therapist Clinical Trainee	3902	CO
8.	Nurse Practitioner/Clinical Nurse Specialist Clinical Trainee	3902	HP
9.	Pharmacist Clinical Trainee	3902	HO
10.	Physician Assistant Clinical Trainee	3902	None

4. **When claiming for services rendered by a Clinical Trainee, where should the supervisor's NPI be reported?**

   When claiming for services provided by a Clinical Trainee, the supervisor's NPI must be reported at the claim level (loop 2310D) and/or at the service line level (loop 2420D). If the Clinical Trainee has an NPI, they should also report it.

Specific details on how to report provider NPIs on 837P claims are documented in the ASCX12 5010 Implementation Guides available for purchase at http://www.wpc-edi.com/. Claims for services provided by Clinical Trainees that do not report a supervisor's NPI will be denied. The county must ensure that the clinician supervising the Clinical Trainee meets the minimum qualifications described by the applicable licensing board.

Short Doyle will validate the supervisor's NPI 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 with adjustment group, reason code, and remarks code CO/208/N297.

5. **When claiming for services rendered by Clinical Trainees, can anyone in a supervisory role be reported on the claim? (New 4/5/2024)**

   Wherever mentioned in this document, the "supervisor" refers to the licensed clinician co-signing the progress notes. The licensed clinician co-signing the progress notes accepts the responsibility for the services a clinical trainee has provided for that service date, and this individual's NPI should be the NPI reported in loop 2310D and/or loop 2420D on the 837P.

6. **How is a Medical Assistants defined?**

   State Plan Amendment (SPA) 23-0026 defines a Medical Assistant as an individual who is at least 18 years of age, meets all applicable education, training and/or certification requirements and provides administrative, clerical, and technical supportive services, according to their scope of practice, under the supervision of a licensed physician and surgeon, or to the extent authorized under state law, a nurse practitioner or physician assistant that has been delegated supervisory authority by a physician and surgeon. The licensed physician and surgeon, nurse practitioner, or physician assistant must be physically present in the treatment facility (medical office or clinic setting) during the provision of services by a medical assistant.

7. **What taxonomy codes should counties use to claim for services rendered by a Medical Assistant?**

   Short Doyle will utilize five-digit validation for the taxonomy code for Medical Assistants. Mental Health Plans (MHP), DMC-ODS counites, DMC counties and trading partners should use taxonomy codes in which the first five characters begins with 363A**M** for Medical Assistants. Please note that all taxonomy codes

beginning with 363A where the fifth character is not “M” will continue to map to the physician assistant provider type in Short Doyle.

8. **What taxonomy codes should DMC and DMC-ODS counties use to claim for services rendered by a licensed occupational therapist, licensed vocational nurse, and licensed psychiatric technicians in the DMC-ODS and DMC delivery system?**

   DMC-ODS counites, DMC counties and trading partners should use the same taxonomy codes for these provider types as are currently used by MHPs in the SMHS delivery system. The first four characters of the taxonomy codes associated with the licensed occupational therapist, licensed vocational nurse, and licensed psychiatric technician provider types are listed in the table below:

Profession Type	Taxonomy
Occupational Therapist	225X
Licensed Vocational Nurse	164X or 164W
Licensed Psychiatric Technician	106S, 167G or 3747

9. **Which procedure codes can the newly eligible providers added by SPA 23-0026 claim in the Specialty Mental Health Services, DMC-ODS, and DMC delivery systems**?

   The codes that each newly eligible provider type can claim are listed in Attachment A by delivery system and provider type.

10. **At what rate will the services rendered by Clinical Trainees be reimbursed?**

    Services rendered by Clinical Trainees will be reimbursed at the same rate as that of licensed or registered health care professionals within the Clinical Trainees’ profession. To receive the appropriate rate for their profession, Clinical Trainees should use the taxonomy and modifier combinations listed in the table below:

No.	Profession(s) Type	Taxonomy	Modifier
1.	Medical Student in Clerkship	1744	None
2.	LCSW, MFT or LPCC Clinical Trainee	3902	AJ
3.	Psychologist Clinical Trainee	3902	AH

4.	Registered Nurse Clinical Trainee	3902	TD
5.	Vocational Nurse Clinical Trainee	3902	TE
6.	Psychiatric Technician Clinical Trainee	3902	HM
7.	Occupational Therapist Clinical Trainee	3902	CO
8.	Nurse Practitioner/Clinical Nurse Specialist Clinical Trainee	3902	HP
9.	Pharmacist Clinical Trainee	3902	HO
10.	Physician Assistant Clinical Trainee	3902	None