Fiscal Year 24-25 Service Codes and Rates Matrix Updates

Updated: 2/13/2025

The information below outlines changes for Fiscal Year (FY) 2024-2025. This information should be used in conjunction with the Rates and Standards Matrix as well as the DHCS DMC-ODS Billing Manual to inform billing for the fiscal year. Providers should note that these changes are for FY 24-25 only and are not applicable for FY 23-24. Refer to the FY 23-24 Rates and Standards Matrix and Information Notice for information applicable to that FY.

Rates and Standards Matrix Tab Formatting Changes

- The following changes have been made to the Rates and Standards Matrix tabs to align the columns and add additional information present on the DHCS DMC-ODS Service Table. For descriptions on what information is within each column, providers should refer to the DHCS DMC-ODS Billing Manual.
    - **NEW Tier 1/Tier 2/Tier 3 Tabs**
        - The tabs for the rates by service code and level of care have been consolidated into one tab per tier which will include all service codes and levels of care.
        - This change was made to allow for a comprehensive view of all services in one tab vs. having to navigate into multiple tabs for information on service codes and rates.
        - The Rates and Standards Matrix remains filterable to allow for ease of filtering by level of care, code type, and/or specific code.
        - NEW column added – Code+ LOC U Code – which identifies the service code and level of care U code combination as the base code prior to adding any additional needed modifiers.
    - **REMOVED Outpatient/Residential/Withdrawal Management/OTP/ASAM 3.7WM & 4.0WM/Non-DMC Services/Perinatal/CENS Tabs**
        - These tabs were consolidated into the new Tier 1/Tier 2/Tier 3 tabs as noted in the item above.
    - **NEW NDC Codes Tab**
        - New tab added to break out the NDC code listing from the rates for the MAT medications.
        - The NDC listing has been updated with the most current information SAPC has received from DHCS as of April 2024.
    - **UPDATED Billing Rules Tab**
        - **Relabeled/Changed columns:**
            - Service column changed to Service (Brief Definition)
            - Lockout Codes column broken out to the following columns:
                - Outpatient Non-Overridable Lockout Codes
                - Outpatient Overridable Lockouts with Appropriate Modifiers

        - Locked Out Against ASAM OTP/NTP (UA:HG)?
        - Locked Out Against ASAM 3.1 (U1)?
        - Locked Out Against ASAM 3.3 (U2)?
        - Locked Out Against ASAM 3.5 (U3)?
        - Locked Out Against ASAM 3.2 WM (U9)?
        - Locked Out Against ASAM 3.7 WM?
        - Locked Out Against ASAM 4.0 WM?
      - Dependent on Codes changed to Dependent on Codes (Primary Code)
      - Exempt from Medicare COB? Column changed to Medicare COB Required
    - **Added columns:**
      - Minimum Time Needed to Claim 1 Unit
      - Minimum Time When Add-On Code or Next Code in Series Can Be Claimed
      - Can This Code Be Extended with an Add-on or Prolonged Code?
      - Example Calculation
      - Is this an Add-On Code
      - Units of T1013 Associated with 1 Unit of Code
      - Units of 96170 associated with 1 Unit of Code
      - Units of 96171 associated with 1 Unit of Code
      - Medicare COB Required
      - Justice Informed (JI) Warm Linkage Code?
  - **NEW CPT Add On Codes Tab**
    - New tab added to help quickly identify which primary codes are associated with which add on codes.

CENS Available Codes

- The following codes are no longer billable for FY 24-25:
  - 90846-CN
  - H0004-CN
  - H0005-CN
  - H2017-CN
  - H0001-CN
  - T1017-CN
- Services for CENS should be billed under H2015-CN with the exception of screening.
- For screening, CENS locations can still bill for H0049-CN or H0049-N depending on whether or not the person was admitted to care or not.

G2212 Removal & New Add-on Codes

- DHCS has removed G2212 as an applicable add-on code.
- DHCS has added the following prolonged service codes to replace G2212: 991415, 99416, 99417, and 99418. Refer to the Rates and Standards Matrix for the associated primary codes with which these new add-on codes can be utilized.
- T2021 and T2024 are new substitution codes associated with 90791, 90792, 90885, or 90849

when the service extends beyond the maximum for those codes. Note that substitution codes are not the same as prolonged duration and are not add-on codes. More information on how to utilize these two codes is in the following "T2021 and T2024 Substitution Codes" section.

T2021 and T2024 Substitution Codes

- DHCS has provided two codes – T2021 and T2024 – which act as replacement/substitution codes if extended service time is needed beyond the allowable maximums for services that previously used G2212 as an add-on code. Both new codes are billed in 15-minute unit increments.
- T2024 is used to replace/substitute for 90791, 90792, and 90885 if more than 67 minutes of the service is delivered.
- T2021 is used to replace/substitute for 90849 if more than 91 minutes of the service is delivered and for 90846 and 90847 when more than 59 minutes of service is delivered.
- Example T2024 Replacement/Substitution: A provider delivers a service that would typically be billed as 90791 with a service duration of 90 minutes. For FY 24-25, 90791 has a maximum duration of 67 minutes, any service duration of 68 minutes or more needs to be billed as T2024 instead of 90791. The provider would bill 6 units of T2024 and not bill 90791 at all for that service.

Clarification on Use of HL Modifier

- DHCS has clarified in the DMC-ODS Billing Manual version 1.5: *"For services that require Medicare COB and are performed by registrants/interns who are working in clinical settings under supervision to obtain licensure, use this modifier to bypass the Medicare COB requirement. Also use this modifier to indicate that the service was performed by a fully licensed MFT or LPCC who does not meet the requirements of Section 4121, Division F of the federal Consolidated Appropriations Act and are therefore not Medicare-recognized providers. Medicare does not reimburse for services rendered by registrants/interns or by non-Medicare recognized providers. For claims that do not require Medicare COB and are performed by registrant(s)/intern(s) or MFTs/LPCCs who are not Medicare-recognized, use of the HL modifier is not required. When using this modifier, if the pre-licensed professional has an NPI, they may report their own NPI. If they do not, the supervising clinician's NPI would be reported with modifier HL after the service to indicate that the service was performed by a pre-licensed professional. If the service was performed by a resident, use the GC modifier."*
- No configuration changes are necessary with this clarification; however, it does inform providers of which service code and modifier combination is required for the service.
- The HL modifier is only used when Medicare COB is required for the procedure code. If the procedure code is required to be billed to Medicare, however, the performing provider is not Medicare recognized, then the HL modifier must be used on the claim to bypass the Medicare COB requirement.
- The HL modifier should be included on services provided by Licensed Eligible LPHA's, LCSW, LPCC and LMFT if the patient is a Medi-Medi patient and the Medicare COB column is marked yes for the service. This will exempt the service from the Medicare COB requirement when DHCS adjudicates the claim.

90785 and T1013

- 90785 and T1013 have been right-sized to follow SAPC's standardized rate determination process.

H2010M/N/S

- H2010M and H2010N have been revised to $0 services, applicable to all levels of care except 3.7-WM, 4.0-WM, and RBH, and must be claimed for incentives tracking.
- The units for the time spent delivering the service billed under H2010M or N can be rolled up into either H2015 or H2017 based on the service where the MAT education or naloxone handling/distribution was delivered.
- H2010S is a billable service that has a flat rate per service delivered to the patient, only applicable for residential levels of care.
- Refer to the H2010M/N/S Guidance document for more information.

99441, 99442, 99443

- DHCS has discontinued service codes 99441, 99442, and 99443 after 12/31/2024.
- The codes can still be used for services on or prior to 12/31/2024; however, if billed to SAPC for services rendered on or after 1/1/2025, the services will be denied.
- Per DHCS guidance, providers are instructed to utilize code H0001 to bill for these services delivered on or after 1/1/2025.

Removal of Fees for Residential and Outpatient WM Assessment Codes

- SAPC incorrectly associated fees to assessment codes for residential and outpatient withdrawal management levels of care.
- The impacted codes include 96160, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99416, 99418, and H0049-N.
- These services can be billed as a $0 service to be captured for tracking towards clinical standard hours.
- SAPC previously had issued guidance to utilize these codes for medication/MAT services, but providers are instructed to utilize H0034R for medication/MAT services instead.
- For assessment services billed under these codes, unless the service included a medication or MAT discussion, or the purpose was assessment for medications, they may not be rebillable under H0034R.

Unit Maximum Caps for Service Codes

- All service codes will now have a maximum unit cap allowable for the service, based on the number on the Billing Rules tab of the Rates and Standards Matrix. Services with units submitted over the maximum will be denied locally.
- The number of units is in the "Maximum Units That Can Be Billed per Rendering Provider per Beneficiary per Day" field as designated by DHCS. All services are subject to audit and if the units billed are deemed excessive, the services may be recouped.

Time Associated with Code

- DHCS has aligned the times associated with many service codes to 2024 AMA guidelines which

are effective for FY 24-25. The times associated with the code for services delivered in FY 23-24 still apply as described on the FY 23-24 Rates and Standards Matrix. It is important that providers review these changes to ensure accurate billing for services based on the updated service duration times.

- The table on the following page provides the updated service code descriptions for FY 24-25. The details regarding the minimum and maximum times and maximum units allowed to be billed are on the Billing Rules tab of the Rates and Standards Matrix. Providers must review these codes to understand the changes. For Secondary Providers, this is necessary to ensure the agency's Electronic Health Record is correct configured to be able to bill the services differently for FY 23-24 and FY 24-25.
    - Column descriptions:
        - **Code:** This is the service code.
        - **FY 23-24 SAPC Matrix Description:** This is the description of the code based on DHCS FY 23-24 code descriptions.
        - **Updated FY 24-25 SAPC Matrix Descriptions:** This is the updated description of the service code based on DHCS FY 24-25 code descriptions.
        - **Sage Configuration Descriptions:** The description of the code that will be visible in Sage when using the Fast Service Entry Submission form to select a service code to bill.

Service Code Description Updates

Code	FY 23-24 SAPC Matrix Description	Updated FY 24-25 SAPC Matrix Descriptions	Sage Configuration Descriptions
90791	Psychiatric Diagnostic Evaluation, 15 Minutes	Psychiatric Diagnostic Evaluation, 60 mins	Psychiatric diagnostic evaluation
90792	Psychiatric Diagnostic Evaluation with Medical Services, 15 Minutes	Psychiatric Diagnostic Evaluation with Medical Services, 60 mins	Psychiatric diagnostic evaluation with medical services
90885	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 60 mins	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes
99205	Office or Other Outpatient Visit of a New Patient, 60- 74 Minutes	Office or Other Outpatient Visit of a New Patient, 60+ mins	Office or Other Outpatient Visit of a New Patient
90889	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purpose) for other individuals, agencies, or insurance carries.	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purpose) for other individuals, agencies, or insurance carriers; 15 mins	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purpose) for other individuals, agencies, or insurance carriers; 15 mins
96160	Administration of patient-focused health risk assessment instrument.	Administration of patient-focused health risk assessment instrument; 15 mins	Administration of patient-focused health risk assessment instrument; 15 mins
99212	Office or Other Outpatient Visit of an Established Patient, 10-19 Minutes	Office or Other Outpatient Visit of an Established Patient, 10-19 mins	Office or Other Outpatient Visit of an Established Patient, 10-19 mins
H0001	Alcohol and/or drug assessment. (Note: Use this code for screening to determine the appropriate delivery system for beneficiaries seeking services)	Alcohol and/or drug assessment; 15 mins (Note: Use this code for the ASAM assessment to determine the appropriate delivery system for beneficiaries seeking services)	Alcohol and/or drug assessment; 15 mins (Note: Use this code for screening to determine the appropriate delivery system for beneficiaries seeking services)
H0007	Alcohol and/or drug services; crisis intervention (outpatient)	Alcohol and/or drug services; crisis intervention (outpatient); 15 mins	Alcohol and/or drug services; crisis intervention (outpatient); 15 mins
H0048	Alcohol and/or other drug testing. (Note: Use this code to submit claims for point of care tests)	Alcohol and/or other drug testing; 15 mins (Note: Use this code to submit claims for point of care tests)	Alcohol and/or other drug testing; 15 mins (Note: Use this code to submit claims for point of care tests)
H1000	Prenatal Care, at risk assessment.	Prenatal Care, at risk assessment, 15 mins	Prenatal Care, at risk assessment, 15 mins

Code	FY 23-24 SAPC Matrix Description	Updated FY 24-25 SAPC Matrix Descriptions	Sage Configuration Descriptions
T1007	Alcohol and/or substance abuse services, treatment plan development and/or modification.	Alcohol and/or substance abuse services, treatment plan development and/or modification; 15 mins	Alcohol and/or substance abuse services, treatment plan development and/or modification; 15 mins
99345	Home Visit of a New Patient, 66-80 Minutes	Home Visit of a New Patient, 75+ mins	Home Visit of a New Patient
99344	Home Visit of a New Patient, 51-65 Minutes	Home Visit of a New Patient, 60-74 mins	Home Visit of a New Patient
99350	Home Visit of an Established Patient, 51-70 Minutes	Home Visit of an Established Patient, 60+ mins	Home Visit of an Established Patient
99204	Office or Other Outpatient Visit of a New Patient, 45- 59 Minutes	Office or Other Outpatient Visit of a New Patient, 45-59 mins	Office or Other Outpatient Visit of a New Patient, 45-59 mins
90887	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 50 mins	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons
99349	Home Visit of an Established Patient, 36-50 Minutes	Home Visit of an Established Patient, 40-59 mins	Home Visit of an Established Patient
99215	Office or Other Outpatient Visit of an Established Patient, 40-54 Minutes	Office or Other Outpatient Visit of an Established Patient, 40+ mins	Office or Other Outpatient Visit of an Established Patient
99342	Home Visit of a New Patient, 26-35 Minutes	Home Visit of a New Patient, 30-59 mins	Home Visit of a New Patient
99203	Office or Other Outpatient Visit of a New patient, 30- 44 Minutes	Office or Other Outpatient Visit of a New Patient, 30-44 mins	Office or Other Outpatient Visit of a New Patient, 30-44 mins
99214	Office or Other Outpatient Visit of an Established Patient, 30-39 Minutes	Office or Other Outpatient Visit of an Established Patient, 30-39 mins	Office or Other Outpatient Visit of an Established Patient, 30-39 mins
99348	Home Visit of an Established Patient, 21-35 Minutes	Home Visit of an Established Patient, 30-39 mins	Home Visit of an Established Patient
96170	Health behavior intervention, family (without the patient present), face-to-face. 16-30 minutes	Health behavior intervention, family (without the patient present), face-to-face; 16-46 mins	Health behavior intervention, family (without the patient present), face-to-face
99347	Home Visit of an Established Patient, 10-20 Minutes	Home Visit of an Established Patient, 20-29 mins	Home Visit of an Established Patient
99213	Office or Other Outpatient Visit of an Established Patient, 20-29 Minutes	Office or Other Outpatient Visit of an Established Patient, 20-29 mins	Office or Other Outpatient Visit of an Established Patient, 20-29 mins
99202	Office or Other Outpatient Visit of New Patient, 15-29 Minutes	Office or Other Outpatient Visit of New Patient, 15-29 mins	Office or Other Outpatient Visit of New Patient, 15-29 mins

Code	FY 23-24 SAPC Matrix Description	Updated FY 24-25 SAPC Matrix Descriptions	Sage Configuration Descriptions
99341	Home Visit of a New Patient, 15-25 Minutes	Home Visit of a New Patient, 15-29 mins	Home Visit of a New Patient
90849	Multiple-Family Group Psychotherapy, 15 Minutes	Multiple-Family Group Psychotherapy, 84 mins	Multiple-Family Group Psychotherapy
99451	Inter-Professional Telephone/Internet/ Electronic Health Record Assessment Provided by a Consultative Physician, 5-15 Minutes	Inter-Professional Telephone/Internet/ Electronic Health Record Assessment Provided by a Consultative Physician, 5-30 mins	Inter-Professional Telephone/Internet/ Electronic Health Record Assessment Provided by a Consultative Physician