



**Drug Medi-Cal Organized Delivery System
California Advancing and Innovating Medi-Cal (CalAIM)**

Payment Reform CPT Guide 2026

Version 3

DMC-ODS PAYMENT REFORM 2026

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Purpose

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

As an additional resource for providers, there are now [Quick Guides by provider type](#) available. These spreadsheets are provider-specific to make it easy for each provider type to see what codes are allowable, where they may be used, and helpful reminders about the use of each code.

Access the Quick Guides here: [DMC-ODS For Providers | Orange County California - Health Care Agency](#)

****Disclaimer****

The Quality Management Services (QMS) Quality Assurance (QA) and Quality Improvement (QI) Division develops and distributes this guide to all DMC-ODS providers as a tool to assist with various QA/QI regulatory requirements. It is NOT an all-encompassing document. Programs and providers are responsible for ensuring their understanding and adherence with all local, state, and federal regulatory requirements.

DHCS' Medi-Cal County Customer Services (MedCCC) aids with the Short Doyle Medi-Cal (SDMC) claiming process and publishes the billing manuals and service tables of the available billing codes. Access the DMC-ODS Service Tables here: [MedCCC - Library](#)

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

For specific questions or clarification, contact the Quality Management Services, [Technical Assistance and Training Support \(TATS\) Team](#) at BHPSUDSupport@ochca.com.

Updates

The following is a summary of the main changes since the last version of the CPT Guide, based on the most recent DHCS Billing Manual v4.0 (April 2026) and corresponding Service Table for the fiscal year 2025-2026:

Expansion of Eligible Provider Types

- Other Qualified Providers
- Community Health Workers*

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New Codes

- Charge Description Master (CDM) codes for the Assessment Substitute (T2024) and Therapy Substitute (T2021) codes
- CDM codes for the Prolonged Clinical Staff Service codes (Evaluation and Management)
- Traditional Healer Services (CDM TBD) H0051 code
- Natural Helper Services (CDM TBD) T1016 code
- Education and Training for Patient Self-Management by Community Health Worker, face-to-face, each 30 minutes individual/2-4 clients/5-8 clients (CDM TBD) 98960/98961/98962*
- Support Employment Monthly Service (CDM TBD) H2023*

**More information will be forthcoming!*

Deleted/Removed Codes or Provider Types

- Telephone Evaluation & Management Service, 5-10/11-20/21-30 Min (99441-1/99442-1/99443-1) have been deleted effective January 1, 2025. These codes may be replaced with the Office Outpatient Evaluation and Management code series 99202-99205/99212-99215.
- Removal of Psychologists and Psychologist Clinical Trainees as eligible providers for Community Support Services, per 15 Min (70899-121) H2015
- Removal of Psychologists, Psychologist Clinical Trainees, Registered Nurses, Registered Nurse Clinical Trainees as eligible providers for Psychosocial Rehabilitation, Individual, per 15 Min (70899-122) and Psychosocial Rehabilitation, Group, per 15 Min (70899-123) H2017
- Removal of Registered Nurses and Registered Nurse Clinical Trainees as eligible providers from Recovery Services, 1 Hr (70899-124) H2035
- Removal of Psychologist Clinical Trainees as eligible providers for Skills Training and Development, Individual, per 15 Min (70899-113) and Skills Training and Development, Group, per 15 Min (70899-114) H2014
- Removal of Registered Nurses and Registered Nurse Clinical Trainees as eligible providers for Psychoeducational Service, per 15 Min (70899-115) H2027

Other Changes

- Telehealth place of service codes (02 and 10) and modifier SC added to the SUD Crisis Intervention (70899-107) H0007 code
- Prenatal Care, At Risk Assessment (70899-119) H1000 now categorized as an assessment activity type (previously categorized as care coordination)
- Drug lockouts for NTP/OTP medications
- Expanded or modified descriptions for the following codes:
 - Psychiatric Diagnostic Evaluation, 60 minutes (90791-1) and Psychiatric Diagnostic Evaluation with Medical Services, 60 min (90792-1)
 - Telephone Assessment and Management Service, 5-10/11-20/21-30 Min (98966-1/98967-1/98968-1)

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- Prenatal Care, At Risk Assessment (70899-119) H1000
- Skills Training and Development, Individual/Group, per 15 Min (70899-113/70899-114) H2014
- Psychoeducational Service, per 15 Min (70899-115) H2027
- Environmental Intervention for Medical Management Purposes (90882-1)
- Medical Team Conference by Non-MD, Patient/Family not Present, 30 Min+ (99368-1)
- Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Physician, Patient and/or Family not Present, 30 Min+ (99367-1)
- Recovery Services, 1 Hr (70899-124) H2035
- Behavioral Health Prevention Education Service (70899-128) H0025
- SUD Recovery Incentives, 15 Min (70899-118) H0050
- Sign Language or Oral Interpretation Services, 15 Min (70899-132) T1013
- Medication Training and Support- Individual per 15 Min (70899-110) and Medication Training and Support-Group per 15 Min (70899-111) H0034
- Office Outpatient Visit of New Patient, 15-29/30-44/45-59/60-74 Min (99202-1/99203-1/99204-1/99205-1) and Office Outpatient Visit of an Established Patient, 10-19/20-29/30-39/40-54 Min (99212-1/99213-1/99214-1/99215-1)
- Home Visit of a New Patient, 15-29/30-59/60-74/75-89 Min (99341-1/99342-1/99344-1/99345-1) and Home Visit of an Established Patient, 20-29/30-39/40-59/60-74 Min (99347-1/99348-1/99349-1/99350-1)
- Inter-Professional Telephone/Internet/Electronic Health Record Assessment Provided by a Consultative Physician, 5-30 Min (99451-1)
- Requirement for claiming Oral Medication Administration, Direct Observation, 15 Min (70899-109) H0033 with a National Drug Code (NDC)
- Added allowable modifiers to each service billing code section
- Added as an appendix:
 - Modifiers table with all applicable modifiers and their definitions
 - Reference sheet for substitute codes
 - Reference sheet for prolonged codes
 - Reference sheet for non-overrideable lockouts and overrideable lockouts with appropriate modifiers

Non-Billable Locations

DMC-ODS added Place of Service 09 (Prison/Correctional Facility) as an allowable place of service to various outpatient procedure codes for Medi-Cal covered individuals who are not institutionalized but are in jail/juvenile detention center/in holding.

Outpatient services are locked out against inpatient and 24-hour services except for the date of admission and discharge. The following are some exceptions:

- Peer Support services, MAT, NTP, Recovery Services, and care coordination are not locked out against residential or inpatient;

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- Services provided to individuals who are not institutionalized but are in jail/juvenile hall detention centers or in holding;
- Behavioral Health Links provided to individuals who are Justice Involved (JI) Medi-Cal.

There is no exception for the Institutes for Mental Disease (IMD).

Reminder about Medicare

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

Medicare eligible provider types are as follows:

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

*Effective January 1, 2024, MFTs and LPCCs can bill Medicare. However, Medicare has established requirements for MFTs and LPCCs that are more stringent than California. If MFTs and LPCCs have not achieved all required hours or two years of clinically supervised experience *after* obtaining the applicable doctor's or master's degree (e.g., if part of the MFTs 3,000 hours or two years of clinically supervised experience were accrued *before* the individual obtained their degree). In such cases, the MFT/LPCC should claim Medi-Cal directly and use the HL modifier. Providers in this situation should coordinate with IRIS to ensure that their profile is built with the HL modifier. [To bill Medicare for DMC-ODS services provided to clients who have Medicare or both Medicare and Medi-Cal \("Medi-Medi"\), it is important to ensure that the rendering providers are Provider Transaction Access Number \(PTAN\) Providers. DMC-ODS services can only be billed for a Medicare or Medi-Medi client by a PTAN provider. Medi-Cal cannot be billed for any claims delivered to a Medi-Medi client by a non-PTAN Medicare-eligible provider.](#)

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Service Codes

Assessment Services

Assessment is an activity to evaluate or monitor the status of a client’s behavioral health and determine the appropriate level of care and course of treatment for that client. Assessment pertains to the initial assessment as well as any subsequent re-assessments.

Assessment may include contact with family members or other collaterals if the purpose of the collateral’s participation is to focus on the treatment needs of the client.

Some examples of assessment activities:

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

Assessment Service Codes:

Charge Description	CPT/HCPCS Code	CDM Code	Non-Billable Code
Psych Diagnostic Eval, 60 min	90791	90791-1	70899-300
Psychiatric Diagnostic Eval, 68+ min	T2024	90791-7	70899-300
Psych Eval of Hospital Record, 60 Min	90885	90885-1	70899-300
Psych Eval of Hospital Record, 68+ Min	T2024	90885-7	70899-300
Psychological Testing Eval, First Hour	96130	96130-1	70899-300
Psychological Testing Eval, Each Add'l Hour	96131	96131-1	70899-300
Telephone Assmt and Mgmt Service, 5-10 Min	98966	98966-1	70899-300
Telephone Assmt and Mgmt Service, 11-20 Min	98967	98967-1	70899-300
Telephone Assmt and Mgmt Service, 21-30 Min	98968	98968-1	70899-300
SUD Structured Assmt, 15-30 Min	G0396	70899-100	70899-300
SUD Structured Assmt, 30+ Min	G0397	70899-101	70899-300
SUD Structured Assmt, 5-14 Min	G2011	70899-102	70899-300
SUD Assmt	H0001	70899-103	70899-300
SUD Screening	H0049	70899-105	70899-300
SUD Drug Testing POC Tests	H0048	70899-104	70899-300
Prenatal Care, At Risk Assmt	H1000	70899-119	70899-304

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

In those rare instances where a client receives only an assessment service at Withdrawal Management or Residential Treatment Services levels of care because the client decides to leave the program on the date of admission, the **treatment day can be claimed**. It is not required for the client to stay overnight to claim a treatment day, as long as there is at least one qualifying service provided to justify the treatment day. An assessment service with the client is considered a qualifying service. All services provided to justify the treatment day claim must be properly documented.

Psychiatric Diagnostic Evaluation, 60 minutes (90791-1)

Only available for LPHA and their respective Clinical Trainees (except Pharmacists, Pharmacist Clinical Trainees, Registered Nurses, Registered Nurse Clinical Trainees, Licensed Vocational Nurses, Vocational Nurse Clinical Trainees, Licensed Psychiatric Technicians, Psychiatric Technician Clinical Trainees, Licensed Occupational Therapists, and Occupational Therapist Clinical Trainees) to use to claim an assessment activity. It is an integrated biopsychosocial assessment, including history, mental status, and recommendations. The evaluation may include communication with family or other sources and review and ordering of diagnostic studies. This may be face-to-face or non-face-to-face time and can be provided in-person, via telehealth, or telephone (use the appropriate modifier). This code is restricted to use only one time per day per provider per client. The minimum number of minutes required to use this code is 31 minutes. Service minutes that are 30 minutes or less should use an alternative assessment code (i.e., SUD Assessment [70899-103]). This code should be used for services up to 67 minutes. For services 68 minutes or more, the **Psychiatric Diagnostic Evaluation, 68+ Min (90791-7) T2024** code should be used instead. For example, if the total service time was 100 minutes, the **Psychiatric Diagnostic Evaluation, 68+ Min (90791-7) T2024** code would be used to account for all 100 minutes of the assessment service. The total service minutes should be entered into IRIS and the number of units will be calculated for the Assessment Substitute code.

When this code should be used:

- ✓ Time spent by the LPHA conceptualizing the Case Formulation or narrative necessary to establish the client's DSM-5-TR substance use disorder diagnosis and/or the justification for the level of care that is needed.
- ✓ If LPHA (instead of a non-LPHA) is meeting with the client directly and completing all components of the assessment, such as all 6 dimensions of the ASAM Criteria, this code may be used to capture the time spent.

Due to the more stringent guidance from the Centers for Medicare and Medicaid Services (CMS) that the psychiatric diagnostic evaluation may be covered once and be repeated if there is an extended break in treatment (of 6 months or more) or for a significant change requiring further assessment, it is advised that this code only be used one time for the initial assessment.

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Non-Overridable Lockouts

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

- Family Psychotherapy (w/o Pt Present), 50 Min (90846-1)
- Family Psychotherapy (w/ Pt Present), 50 Min (90847-1)
- Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 30 Min (96170-1)
- Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)

See [Appendix V](#) for a quick reference sheet on all non-overridable lockouts and overridable lockouts with appropriate modifiers

Overridable Lockouts with Appropriate Modifiers

This code may be used on the same day as the following services, if the appropriate modifiers are used (* = 59, XE, XP, or XU; ** = 27, 59, XE, XP, XU):

- SUD Structured Assessment 15-30/30+/5-14 min (70899-100/70899-101/70899-102) G2011/G0396/G0397*
- Multiple-Family Group Psychotherapy, 84 Min (90849-1)*
- Environmental Intervention for Medical Management Purposes (90882-1)*
- Psychiatric Evaluation of Hospital Record, 60 Min (90885-1)*
- Interpretation of Psychiatric Results to Family, 50 Min (90887-1)*
- Preparation of Report of Patient's Psychiatric Status (90889-1)*
- Administration of Patient-Focused Health Risk Assessment Instrument (96160-1)*
- Office Outpatient Visit of New Patient, 15-29/30-44/45-59/60-74 Min (99202-1/99203-1/99204-1/99205-1)**
- Office Outpatient Visit of an Established Patient, 10-19/20-29/30-39/40-54 Min (99212-1/99213-1/99214-1/99215-1)**
- Home Visit of a New Patient, 15-29/30-59/60-74/75-89 Min (99341-1/99342-1/99344-1/99345-1)**
- Home Visit of an Established Patient, 20-29/30-39/40-59/60-74 Min (99347-1/99348-1/99349-1/99350-1)**
- Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Physician, Patient and/or Family not Present, 30 Min+ (99367-1)**
- Medical Team Conference by non-MD, Patient/Family not present, 30 Min+ (99368-1)**
- Prolonged clinical staff service during an evaluation and management service in the office or outpatient setting, first hour (99415-1)**
- Prolonged clinical staff service during an evaluation and management service in the office or outpatient setting, each additional 30 min (99416-1)**

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- **Inter-Professional Telephone/Internet/Electronic Health Record Assessment Provided by a Consultative Physician, 5-30 Min (99451-1)****
- **Transitional Care Management Services: Communication (direct contact, telephone, electronic) within 14 calendar days (99495-1) and Transitional Care Mgmt Services: Communication (direct contact, telephone, electronic) within 7 calendar days (99496-1)****

Allowable [modifiers](#) for this code:

- 59, 93, 95, AH, AJ, GC, HD, HG, HL, HP, U1, U2, U3, U7, U8, U9, UA, UB, XE, XP, XU

This code is locked out for use at the Withdrawal Management or Residential Treatment Services levels of care. Assessment activities are part of the daily bundle of services to be provided. Therefore, there is no separate billing permitted in addition to the treatment day. [An assessment service with the client, if properly documented, may be considered a qualifying service to claim the treatment day.](#)

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

This code requires a Medicare COB.

Assessment Substitute, 15 Min (XXXXX-7) T2024

Psychiatric Diagnostic Evaluation, 68+ Min (90791-7) T2024

Psychiatric Evaluation of Hospital Record, 68+ Min (90885-7) T2024

May be used by LPHA (except for Licensed Psychiatric Technicians, Psychiatric Technician Clinical Trainees, Licensed Vocational Nurses, Vocational Nurse Clinical Trainees, Pharmacists, and Pharmacist Clinical Trainees) to claim for service time that exceeds the allowable number of minutes for the assessment code. [The CDM code will be the CPT code for the primary service \(e.g., 90791, 90792, 90885\) followed by "-7" \("-8" for perinatal\). The total service time of the primary service should be entered into IRIS and the units will be calculated to reflect the Assessment Substitute code.](#)

See [Appendix III](#) for a reference tool on all assessment substitute codes available and when they may be used.

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

- **Psychiatric Diagnostic Evaluation, 60 minutes (90791-1)**
- **Psychiatric Diagnostic Evaluation with Medical Services, 60 min (90792-1)**
- **Psychiatric Evaluation of Hospital Record, 60 Min (90885-1)**

Allowable [modifiers](#) for this code:

- AH, AJ, CO, GC, HD, HG, HL, HM, HP, TD, TE, SC, U1, U2, U3, U7, U8, U9, UA, UB

The following supplemental codes CANNOT be used with this code:

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

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

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

This code **does not** require a Medicare COB, however **if the code being substituted requires a Medicare COB, then Medicare must be billed first.**

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

May only be used by LPHA (except Pharmacists, Pharmacist Clinical Trainees, Registered Nurses, Registered Nurse Clinical Trainees, Licensed Vocational Nurses, Vocational Nurse Clinical Trainees, Licensed Psychiatric Technicians, Psychiatric Technician Clinical Trainees, Licensed Occupational Therapists, and Occupational Therapist Clinical Trainees) to claim for review of documents that are specific to psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes. This code may only be used once per day per provider per client. The minimum number of minutes required to use this code is 31 minutes. Service minutes that are 30 minutes or less should be coded using the non-billable code. This code should be used for services up to 67 minutes. For services 68 minutes or more, the **Psychiatric Evaluation of Hospital Record, 68+ Min (90885-7)** T2024 code should be used instead. For example, if the total service time was 100 minutes, the **Psychiatric Evaluation of Hospital Record, 68+ Min (90885-7)** T2024 code would be used to account for all 100 minutes of the assessment service. Be sure that the documentation clearly substantiates the amount of time that is claimed for reviewing documents to prevent any appearance of potential fraud, waste, and/or abuse. **The total service minutes should be entered into IRIS and the number of units will be calculated for the Assessment Substitute code.**

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

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

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

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Overridable Lockouts with Appropriate Modifiers

This code may be used on the same day as the following services, if the appropriate modifiers are used (59, XE, XP, or XU):

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

See [Appendix V](#) for a quick reference sheet on all non-overridable lockouts and overridable lockouts with appropriate modifiers

Allowable [modifiers](#) for this code:

- 59, GC, HD, HL, HP, U1, U2, U3, U7, U8, UB, XE, XP, XU

The following supplemental codes CANNOT be used with this code:

- **Sign Language or Oral Interpretation Services, 15 Min (70899-132) T1013**
- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 30 Min (96170-1)**
- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

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

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

Psychological Testing Evaluation, First Hour (96130-1)

May only be used by a Licensed Psychologist, Psychologist Clinical Trainee, Licensed Physician, Medical Student in Clerkship, Physician Assistant, Physician Assistant Clinical Trainee, Nurse Practitioner, and Nurse Practitioner Clinical Trainee to conduct a psychological and/or neuropsychological testing evaluation services. Psychological evaluation domains: emotional and interpersonal functioning, intellectual function, thought processes, personality, and psychopathology. Neuropsychological testing evaluation domains: intellectual function, attention, executive function, language and communication, memory, visual-spatial function, sensorimotor function, emotional and personality features, and adaptive behavior. This code may be used for claiming time spent on integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour. Please be sure the documentation clearly supports the medical necessity for this service as it relates to substance use disorder treatment. [The minimum number of service minutes required to use this code is 31 minutes.](#) Service time of 30 minutes or less, or the midpoint, in duration should be coded using the corresponding non-billable code. [Service may be conducted in-](#)

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person, via telehealth, or telephone (use the appropriate modifier). This code may only be used once per day per provider per client.

Overridable Lockouts with Appropriate Modifiers

This code may be used on the same day as the following service, if the appropriate modifiers are used (59, XE, XP, or XU):

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

See [Appendix V](#) for a quick reference sheet on all non-overridable lockouts and overridable lockouts with appropriate modifiers

Allowable [modifiers](#) for this code:

- 59, 93, 95, AH, GC, HD, HG, HL, HP, U1, U2, U3, U7, U8, U9, UA, UB, XE, XP, XU

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

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

This code requires a Medicare COB.

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

Allowable [modifiers](#) for this code:

- 93, 95, AH, GC, HD, HG, HL, HP, U1, U2, U3, U7, U8, U9, UA, UB

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

May only be used by a Physician Assistant, Physician Assistant Clinical Trainee, Nurse Practitioner, Nurse Practitioner Clinical Trainee, Licensed Psychologist, Psychologist Clinical Trainee, Licensed Clinical Social Worker, Social Worker Clinical Trainee, Licensed Marriage and Family Therapist, Marriage and Family Therapist Clinical Trainee, Licensed Professional Clinical Counselor, and Professional Clinical Counselor Clinical Trainee to provide contact [initiated by](#) a client or collateral for the purpose of assessment and management of the client's substance use disorder treatment, only if not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment. [Telephone calls taking place within 24 hours or the next available urgent visit appointment when the client is seen, the encounter is considered part of the preservice work of the subsequent assessment and management service. Likewise, if the telephone call refers to a service](#)

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performed and reported within the previous seven days or within the postoperative period of the previously completed procedure, then the service(s) are considered part of that previous service. This code may only be used once per day per provider per client for services that range from 5-10 minutes in duration.

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

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

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

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

The Telephone Assessment and Management Service codes are locked out for use at the Withdrawal Management or Residential Treatment Services levels of care. Assessment activities are part of the daily bundle of services to be provided. Therefore, there is no separate billing permitted at these levels of care in addition to the treatment day. [An assessment service with the client, if properly documented, may be considered a qualifying service to claim the treatment day.](#)

Allowable [modifiers](#) for this code series:

- 59, 93, AH, AJ, HD, HL, HP, U7, U8, UB, XE, XP, XU

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

These codes require a Medicare COB.

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

Available for use by non-LPHA (except Medical Assistants [and Peer Support Specialists](#)) and LPHA (except Licensed Occupational Therapists and Occupational Therapist Clinical Trainees) for administering a brief screening, such as the required evidence-based assessment for MAT (i.e., COWS, CIWA-AR, DAST, AUDIT, etc.), according to each program's MAT Policies and Procedures.

[Service may be provided in-person, via telehealth, or telephone \(use the appropriate modifier\).](#)

This code is restricted to use only one time per day per provider per client. Use this code when the total service minutes are 5-14 minutes.

Non-Overridable Lockouts

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

- SUD Structured Assessment, 15-30 Min (70899-100) G0396
- SUD Structured Assessment, 30+ Min (70899-101) G0397

See [Appendix V](#) for a quick reference sheet on all non-overridable lockouts and overridable lockouts with appropriate modifiers

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Overridable Lockouts with Appropriate Modifiers

This code may be used on the same day with the following service, if the appropriate modifiers are used (59, XE, XP, or XU):

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

Allowable [modifiers](#) for this code:

- 59, 93, 95, AH, AJ, GC, HD, HG, HL, HM, HO, HP, TD, TE, U1, U2, U3, U7, U8, U9, UA, UB, XE, XP, XU

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

Available for use by non-LPHA (except Medical Assistants [and Peer Support Specialists](#)) and LPHA (except Licensed Occupational Therapists and Occupational Therapist Clinical Trainees) for administering a brief screening, such as the required evidence-based assessment for MAT (i.e., COWS, CIWA-AR, DAST, AUDIT, etc.), according to each program's MAT Policies and Procedures.

[Service may be provided in-person, via telehealth, or telephone \(use the appropriate modifier\).](#)

This code is restricted to use only one time per day. Use this code when the total service minutes are 15-30 minutes.

Non-Overridable Lockouts

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

- **SUD Structured Assessment, 5-14 Min (70899-102) G2011**
- **SUD Structured Assessment, 30+ Min (70899-101) G0397**
- **SUD Screening (70899-105) H0049**
- **SUD Brief Intervention, 15 Min (70899-117) H0050**
- **SUD Recovery Incentives, 15 Min (70899-118) H0050**

See [Appendix V](#) for a quick reference sheet on all non-overridable lockouts and overridable lockouts with appropriate modifiers

Overridable Lockouts with Appropriate Modifiers

This code may be used on the same day with the following services, if the appropriate modifiers are used (59, XE, XP, or XU):

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

Allowable [modifiers](#) for this code:

- 59, 93, 95, AH, AJ, GC, HD, HG, HL, HM, HO, HP, TD, TE, U1, U2, U3, U7, U8, U9, UA, UB, XE, XP, XU

The following supplemental code CANNOT be used with this code:

- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 30 Min (96170-1)**

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

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

Available for use by non-LPHA (except Medical Assistants and Peer Support Specialists) and LPHA (except Licensed Occupational Therapists and Occupational Therapist Clinical Trainees) for administering a brief screening, such as the required evidence-based assessment for MAT (i.e., COWS, CIWA-AR, DAST, AUDIT, etc.), according to each program's MAT Policies and Procedures.

Service may be provided in-person, via telehealth, or telephone (use the appropriate modifier).

This code is restricted to use only one time per day per provider per client. Use this code when the total service minutes are 31 minutes or more.

Non-Overridable Lockouts

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

- **SUD Structured Assessment, 5-14 Min (70899-102) G2011**
- **SUD Structured Assessment, 15-30 Min (70899-100) G0396**
- **SUD Screening (70899-105) H0049**
- **SUD Brief Intervention, 15 Min (70899-117) H0050**
- **SUD Recovery Incentives, 15 Min (70899-118) H0050**

See [Appendix V](#) for a quick reference sheet on all non-overridable lockouts and overridable lockouts with appropriate modifiers

Overridable Lockouts with Appropriate Modifiers

This code may be used on the same day with the following services, if the appropriate modifiers are used (59, XE, XP, or XU):

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

Allowable [modifiers](#) for this code:

- 59, 93, 95, AH, AJ, GC, HD, HG, HL, HM, HO, HP, TD, TE, U1, U2, U3, U7, U8, U9, UA, UB, XE, XP, XU

The following supplemental codes CANNOT be used with this code:

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

The SUD Structured Assessment, 5-14/15-30/30+ Min (70899-102/70899-100/70899-101) G2011/G0396/G0397 codes are locked out for use at the Withdrawal Management or Residential Treatment Services levels of care. Assessment activities are part of the daily bundle of services to be provided. Therefore, there is no separate billing permitted for time spent on screening activities in addition to the treatment day. [An assessment service with the client, if properly documented, may be considered a qualifying service to claim the treatment day.](#)

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

These codes require a Medicare COB.

SUD Assessment (70899-103) H0001

Available for use by non-LPHA (except Peer Support Specialists) and LPHA (except Pharmacist Clinical Trainees) in accounting for the time spent administering assessment activities, such as the ASAM-based assessment. There are no limitations on provider disciplines permitted to use this code. All activities/interventions must be within the scope of practice of the rendering provider. It is the responsibility of the rendering provider to understand and adhere to scope of practice limitations in accordance with their respective licensing/credentialing/certification board or organization. Service may be provided in-person, via telehealth, or telephone (use the appropriate modifier).

At this time, this can include direct client care or non-face-to-face time without the client's presence when it is for the purpose of assessing the client for appropriateness for ODS services.

Examples of when to use the SUD Assessment code:

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

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

Allowable [modifiers](#) for this code:

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- AH, AJ, CO, HD, HG, HM, HP, SC, TD, TE, U1, U2, U3, U7, U8, U9, UA, UB

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

This code is locked out for use at the Withdrawal Management or Residential Treatment Services levels of care. Assessment activities are considered part of the daily bundle of services. There is no separate billing permitted in addition to the treatment day. [An assessment service with the client, if properly documented, may be considered a qualifying service to claim the treatment day.](#)

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

Emphasis on Direct Client Care

The State's policy is that only direct client care should be counted toward the selection of time and "does not include travel time, administrative activities, chart review, documentation, utilization review and quality assurance activities or other activities a provider engages in either before or after a client visit" (DHCS Drug Medi-Cal ODS Billing Manual, July 2025). At this time, the one area of exception is for activities related to the assessment. As a result, the non-LPHA and/or LPHA's non-face-to-face time (or time spent outside of an encounter with the client) to develop the components of the ASAM-based assessment that involves consolidating and synthesizing clinical information to make recommendations for treatment or to make a diagnosis (i.e., Dimensions 1-6, risk ratings, rationales) is billable. The SUD Assessment (70899-103) code should be used to account for this time.

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

SUD Screening (70899-105) H0049

Available for use by non-LPHA ([except Peer Support Specialists](#)) and LPHA (except Licensed Occupational Therapists and Occupational Therapist Clinical Trainees) for the purposes of screening a client for appropriateness to receive DMC-ODS services. [Service may be provided in-person, via telehealth, or telephone \(use the appropriate modifier\).](#)

Some examples of when to use the SUD Screening code:

- ✓ Intake services/sessions – Until further clarification, this code may also be used to claim the time spent conducting an intake service/session where there is a brief screening for the purposes of admission to treatment, but the significant portion of the time is utilized towards reviewing and signing intake paperwork. [If the administration of the evidence-based MAT assessment is part of the intake service/session, it is acceptable to include this time.](#) In cases where the intake session also involves a significant portion devoted to the ASAM Assessment, the SUD

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Assessment (70899-103) H0001 code may be used instead. In cases where the intake session/service solely involves review of intake paperwork and obtaining the necessary signatures (no screening or assessment activities), the Targeted Case Management (70899-120) T1017 code may be used.

- ✓ Aside from the intake service/session, this code may also be utilized for conducting the SUD Brief LOC Screening Tool or other brief screening.
- ✓ A client presenting to an intake or assessment service/session and deciding that they do not wish to stay/participate (i.e., “open/close,” admit and discharge on the same day).

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

Non-Overridable Lockouts

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

- SUD Structured Assessment, 15-30 Min (70899-100) G0396
- SUD Structured Assessment, 30+ Min (70899-101) G0397

See [Appendix V](#) for a quick reference sheet on all non-overridable lockouts and overridable lockouts with appropriate modifiers

Allowable [modifiers](#) for this code:

- AH, AJ, HD, HG, HM, HO, HP, SC, TD, TE, U1, U2, U3, U7, U8, U9, UA, UB, XE, XP, XU

The following supplemental codes CANNOT be used with this code:

- Sign Language or Oral Interpretation Services, 15 Min (70899-132) T1013
- Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 30 Min (96170-1)
- Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)

This code is locked out for use at the Withdrawal Management or Residential Treatment Services levels of care. Assessment activities are considered part of the daily bundle of services. There is no separate billing permitted in addition to the treatment day. An assessment service with the client, if properly documented, may be considered a qualifying service to claim the treatment day.

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

Transitions between the Residential and Outpatient levels of care:

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

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

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

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

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

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

[Allowable modifiers for this code:](#)

- [HD, HG, HM, HO, HP, TD, TE, U1, U2, U3, U7, U8, U9, UA, UB](#)

The following supplemental codes CANNOT be used with this code:

- **Sign Language or Oral Interpretation Services, 15 Min (70899-132) T1013**
- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 30 Min (96170-1)**

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

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

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

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

May be used by a non-LPHA (except Medical Assistants [and Peer Support Specialists](#)) or LPHA (except Licensed Occupational Therapists and Occupational Therapist Clinical Trainees) and [is indicated for high-risk pregnancies where comprehensive coordination of services is necessary for pregnant individuals with elevated medical or obstetric risks. Activities can include an assessment to identify risk factors and needs, including access to prenatal care, that places the client in the “high-risk” pregnancy category. Service may be provided in-person, via telehealth, or telephone \(use the appropriate modifier\).](#)

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

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

[This code is available for use at the OTP/NTP, Residential, and Withdrawal Management levels of care.](#)

Allowable [modifiers](#) for this code:

- AH, AJ, HD, HG, HM, HO, HP, SC, TD, TE, U1, U2, U3, U7, U8, U9, UA, UB

The following supplemental codes CANNOT be used with this code:

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

[Non-Billable Prenatal Care, At Risk Assessment:](#) When providing a non-billable Prenatal Care, At Risk Assessment service, the appropriate code to use is the **Non-Billable SUD Care Coordination (70899-304)** code. The State has made a change in their classification of Prenatal Care, At Risk Assessment from the Care Coordination to Assessment activity type, however, no change was made in IRIS and it remains associated with the non-billable code for care coordination.

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Individual Counseling Services

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

Individual Counseling Service Codes:

Charge Description	CPT/HCPCS Code	CDM Code	Non-Billable Code
SUD Individual Counseling, 15 Min	H0004	70899-130	70899-309
SUD Treatment Plan Development/Modification	T1007	70899-125	70899-306
SUD Brief Intervention, 15 Min	H0050	70899-117	70899-309
Skills Training and Dev, Indv, per 15 Min	H2014	70899-113	70899-309
Psychoeducational Svc, per 15 Min	H2027	70899-115	70899-309
SUD Family Counseling	T1006	70899-116	70899-309
Family Psychotherapy (w/o Pt Present), 50 Min	90846	90846-1	70899-307
Family Psychotherapy (w/o Pt Present), 58+ Min	T2021	90846-7	70899-307
Family Psychotherapy (w/ Pt Present), 50 Min	90847	90847-1	70899-307
Family Psychotherapy (w/ Pt Present), 58+ Min	T2021	90847-7	70899-307
Multiple-Family Group Psychotherapy, 84 Min	90849	90849-1	70899-307
Multiple-Family Group Psychotherapy, 92+ Min	T2021	90849-7	70899-307

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

May be used by non-LPHA (except for Medical Assistants, [Peer Support Specialists](#), and [Other Qualified Providers](#)) and LPHA (except for Pharmacists, Pharmacist Clinical Trainees, Licensed Vocational Nurses, Vocational Nurse Clinical Trainees, Licensed Psychiatric Technicians, and Psychiatric Technician Clinical Trainees) and is the equivalent to what was previously used for all behavioral health counseling and therapy services/sessions. [Service may be provided in-person, via telehealth, or telephone \(use the appropriate modifier\).](#) [Collateral may be part of individual counseling, as long as the service/session centers around addressing the client’s specific treatment needs related to the substance use disorder.](#)

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

- ✓ “Talk therapy” or insight-oriented
- ✓ Processing the client’s addiction history and factors impacting or impacted by use
- ✓ Implementing evidence-based practices
- ✓ Relapse prevention activities

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✓ Skill building

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

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

Allowable [modifiers](#) for this code:

- AH, AJ, CO, GC, HD, HG, HL, HP, SC, TD, U1, U2, U3, U7, U8, U9, UA, UB

The following supplemental codes CANNOT be used with this code:

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

This code is locked out for use at the Withdrawal Management or Residential Treatment Services levels of care. Individual counseling activities are considered part of the daily bundle of services. There is no separate billing permitted in addition to the treatment day. **An individual counseling service with the client, if properly documented, may be considered a qualifying service to claim the treatment day.**

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

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

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

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

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

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the documentation. [The minimum number of service minutes required to use this code is 8 minutes.](#) Service minutes less than 8 minutes in duration should be coded using the corresponding non-billable code.

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

Allowable [modifiers](#) for this code:

- AH, AJ, CO, HD, HG, HM, HP, SC, TD, TE, U1, U2, U3, U7, U8, U9, UA, UB

The following supplemental codes CANNOT be used with this code:

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

This code is locked out for use at the Withdrawal Management or Residential Treatment Services levels of care. Treatment planning activities are considered part of the daily bundle of services. There is no separate billing permitted in addition to the treatment day. [A treatment planning service with the client, if properly documented, may be considered a qualifying service to claim the treatment day.](#)

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

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

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

May be used by Peer Support Specialists, non-LPHA (except for Medical Assistants), and LPHA. It is primarily for use in Recovery Incentives programs, however, it is available for use at the outpatient levels of care. [Service must be provided in-person. Telehealth and telephone are not permitted for this code.](#) There is limited information from the State on the use of this code outside of the Recovery Incentives program. More information will be provided as it becomes available. [At this time, outside of Recovery Incentives, this code will most likely be utilized by the Certified Peer Support Specialist or Other Qualified Provider to conduct encounters with clients and collateral that are in their scope of practice \(i.e., coaching, mentoring, etc.\).](#)

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

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Non-Overridable Lockouts

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

- **SUD Structured Assessment, 15-30 Min (70899-100) G0396**
- **SUD Structured Assessment, 30+ Min (70899-101) G0397**

See [Appendix V](#) for a quick reference sheet on all non-overridable lockouts and overridable lockouts with appropriate modifiers

Allowable [modifiers](#) for this code:

- HD, HF, HG, U7, U8, UA, UB, XE, XP, XU

The following supplemental codes CANNOT be used with this code:

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

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

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

Skills Training and Development, Individual, per 15 Min (70899-113) H2014

May be used by non-LPHA (except [Peer Support Specialists](#)) or LPHA (except [Psychologist Clinical Trainees](#), [Pharmacists](#), and [Pharmacist Clinical Trainees](#)). [Service may be provided in-person, via telehealth, or telephone \(use the appropriate modifier\).](#)

[This code can be used for individual, one-on-one services with the client that involves teaching and reinforcing adaptive life skills necessary to function independently in the community. Areas of focus can include life skills like social and interpersonal skills, enhancing problem-solving and decision-making abilities, and self-care techniques such as improving stress management and coping strategies, and promoting medication management and treatment adherence. The sessions are geared towards providing structured, goal-oriented teaching and demonstration of targeted skills, offering supervised practice to reinforce learned skills necessary for a client in recovery to reintegrate back into the larger community.](#)

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

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

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Allowable [modifiers](#) for this code:

- AJ, CO, HD, HM, HP, HQ, SC, TD, TE, U1, U2, U3, U7, U8, U9, UB

The following supplemental codes CANNOT be used with this code:

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

This code is locked out for use at the Withdrawal Management and Residential levels of care. Patient education in an individual counseling setting is considered part of the daily bundle of services. No separate billing is permitted in addition to the treatment day. [A one-on-one patient education service with the client, if properly documented, may be considered a qualifying service to claim the treatment day.](#)

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

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

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

May be used by non-LPHA ([except Peer Support Specialists](#)) or LPHA (except Pharmacists, Pharmacist Clinical Trainees, [Registered Nurses, and Registered Nurse Clinical Trainees](#)) and is to be utilized for those one-on-one services/sessions where psychoeducation regarding substance use is provided. Topics may include, but are not limited to, physiological and/or psychological effects of substance use, withdrawal, factors that may support or hinder recovery or contribute to return to use. [General information about addiction and recovery is layered with client-specific information to make it relatable. The focus is on presenting information that will help support the client's understanding of their SUD diagnosis and thereby enhance or promote change in alignment with sobriety and recovery. Service may be provided in-person, via telehealth, or telephone \(use the appropriate modifier\).](#)

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

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

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

This code is locked out for use at the Withdrawal Management and Residential levels of care. Psychoeducation in an individual counseling setting is considered part of the daily bundle of services. No separate billing is permitted in addition to the treatment day. [A psychoeducational service with the client, if properly documented, may be considered a qualifying service to claim the treatment day.](#)

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

Allowable [modifiers](#) for this code:

- AH, AJ, CO, HD, HG, HM, HP, SC, TE, U1, U2, U3, U7, U8, U9, UA, UB

The following supplemental codes CANNOT be used with this code:

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

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

SUD Family Counseling (70899-116) T1006

May be used by non-LPHA (except Medical Assistants, [Peer Support Specialists, and Other Qualified Providers](#)) and LPHA (except Pharmacists, Pharmacist Clinical Trainees, Licensed Vocational Nurses, Vocational Nurse Clinical Trainees, Licensed Psychiatric Technicians, Psychiatric Technician Clinical Trainees, Licensed Occupational Therapists, and Occupational Therapist Clinical Trainees) for services/sessions working with the client's family, with or without the client's presence. The focus of the service/sessions must be around the client's substance use disorder treatment needs. Collateral services/sessions as well as couples work may also be claimed using this code. This code may also be used by the LPHA for family therapy services/sessions that are less than 26 minutes. [Service may be provided in-person, via telehealth, or telephone \(use the appropriate modifier\).](#)

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

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

This code is locked out for use at the Withdrawal Management and Residential levels of care. Family counseling is considered part of the daily bundle of services. No separate billing is permitted in addition to the treatment day. [A family counseling service with the client, if properly documented, may be considered a qualifying service to claim the treatment day.](#)

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

Allowable [modifiers](#) for this code:

- AH, AJ, CO, HD, HG, HP, SC, TD, U1, U2, U3, U7, U8, U9, UA, UB

The following supplemental codes CANNOT be used with this code:

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

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

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

May only be used by LPHA (except Pharmacists, Pharmacist Clinical Trainees, Registered Nurses, Registered Nurse Clinical Trainees, Licensed Vocational Nurses, Vocational Nurse Clinical Trainees, Licensed Psychiatric Technicians, Psychiatric Technician Clinical Trainees, Licensed Occupational Therapists, and Occupational Therapist Clinical Trainees). The definition of family therapy remains the same in that it is a rehabilitative service that includes family members in the treatment process, providing education about factors that are important to the client's recovery as well as the holistic recovery of the family system. The client may or may not be present, but the service/session will revolve around the client and their treatment needs. Therefore, there is a code for when the client is present and another code for when the client is not present. [This service may be conducted in-person, via telehealth, or telephone \(use the appropriate modifier\).](#) This code may only be used once per day. Family therapy services/sessions must, at minimum, be 26 minutes (past the midpoint) in duration for these codes. In those rare instances where a family therapy service/session is 25 minutes or less, the SUD Family Counseling (70899-116) should be used. Family therapy services that are 58 minutes or more should be claimed using the [Family Psychotherapy \(w/o Pt Present\), 58+ Min \(90846-7\) T2021](#) or [Family Psychotherapy \(w/ Pt Present\), 58+ Min \(90847-7\) T2021](#) code. For example, if the service is 100 minutes (with the client present), the [Family Psychotherapy \(w/ Pt Present\), 58+ Min \(90847-7\) T2021](#) code would be used instead of the 90846-1/90847-1. The

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total service minutes should be entered into IRIS and the number of units will be calculated for the Therapy Substitute code.

These codes are locked out for use at the Withdrawal Management and Residential levels of care. Family therapy is considered part of the daily bundle of services. No separate billing is permitted in addition to the treatment day. [A family therapy service with the client, if properly documented, may be considered a qualifying service to claim the treatment day.](#)

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

Non-Overridable Lockouts

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

- **Psychiatric Diagnostic Evaluation, 60 min (90791-1)**
- **Psychiatric Diagnostic Evaluation with Medical Services, 60 min (90792-1)**
- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 30 Min (96170-1)**
- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

See [Appendix V](#) for a quick reference sheet on all non-overridable lockouts and overridable lockouts with appropriate modifiers

Overridable Lockouts with Appropriate Modifiers

Family Psychotherapy (w/o Pt Present), 50 Min (90846-1) may be used on the same day as the following services, if the appropriate modifiers are used (* = 59, XE, XP, or XU; ** = 27, 59, XE, XP, or XU):

- **SUD Structured Assessment, 5-14/15-30/30+ Min (70899-102/70899-100/70899-101) G2011/G0396/G0397***
- **SUD Screening (70899-105) H0049***
- **SUD Brief Intervention, 15 Min (70899-117) H0050***
- **SUD Recovery Incentives, 15 Min (70899-118) H0050***
- **Family Psychotherapy (w/ Pt Present), 50 Min (90847-1)***
- **Office Outpatient Visit of New Patient, 15-29/30-44/45-59/60-74 Min (99202-1/99203-1/99204-1/99205-1)****
- **Office Outpatient Visit of an Established Patient, 10-19/20-29/30-39/40-54 Min (99212-1/99213-1/99214-1/99215-1)****
- **Home Visit of a New Patient, 15-29/30-59/60-74/75-89 Min (99341-1/99342-1/99344-1/99345-1)****
- **Home Visit of an Established Patient, 20-29/30-39/40-59/60-74 Min (99347-1/99348-1/99349-1/99350-1)****
- **Prolonged clinical staff service during an evaluation and management service in the office or outpatient setting, first hour (99415-1)****

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- **Prolonged clinical staff service during an evaluation and management service in the office or outpatient setting, each additional 30 min (99416-1)****

Family Psychotherapy (w Pt Present), 50 Min (90847-1) may be used on the same day as the following services, if the appropriate modifiers are used (* = 59, XE, XP, or XU; ** = 27, 59, XE, XP, or XU):

- **SUD Structured Assessment, 5-14/15-30/30+ Min (70899-102/70899-100/70899-101) G2011/G0396/G0397***
- **SUD Screening (70899-105) H0049***
- **SUD Brief Intervention, 15 Min (70899-117) H0050***
- **SUD Recovery Incentives, 15 Min (70899-118) H0050***
- **Office Outpatient Visit of New Patient, 15-29/30-44/45-59/60-74 Min (99202-1/99203-1/99204-1/99205-1)****
- **Office Outpatient Visit of an Established Patient, 10-19/20-29/30-39/40-54 Min (99212-1/99213-1/99214-1/99215-1)****
- **Home Visit of a New Patient, 15-29/30-59/60-74/75-89 Min (99341-1/99342-1/99344-1/99345-1)****
- **Home Visit of an Established Patient, 20-29/30-39/40-59/60-74 Min (99347-1/99348-1/99349-1/99350-1)****
- **Prolonged clinical staff service during an evaluation and management service in the office or outpatient setting, first hour (99415-1)****
- **Prolonged clinical staff service during an evaluation and management service in the office or outpatient setting, each additional 30 min (99416-1)****

Allowable modifiers for these codes:

- 59, 93, 95, AH, AJ, GC, HD, HG, HL, HP, U1, U2, U3, U7, U8, U9, UA, UB, XE, XP, XU

These codes require a Medicare COB.

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

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

May only be used by LPHA (except Pharmacists, Pharmacist Clinical Trainees, Registered Nurses, Registered Nurse Clinical Trainees, Licensed Vocational Nurses, Vocational Nurse Clinical Trainees, Licensed Psychiatric Technicians, Psychiatric Technician Clinical Trainees, Licensed Occupational Therapists, and Occupational Therapist Clinical Trainees) for services/sessions where multiple families are involved to address particular themes and common experiences related to substance use and its impact on the family unit. **This service may be conducted in-person, via telehealth, or telephone (use the appropriate modifier).** This code can only be used once per day per provider per client. Non-LPHA may work with multiple families together using the SUD Family Counseling (70899-116). A progress note should be completed for each client whose family is participating in the encounter. Each progress note should account

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for the total duration of the group, the number of clients/client families in attendance, and the number of therapists/providers. For example, if the Multiple-Family Group was a 64-minute session with five client families and one provider, each of the progress notes will reflect the total service minutes of 64 minutes, a total of 5 participants, and 1 provider. For service time of 92 minutes or more, the [Multiple-Family Group Psychotherapy, 92+ Min \(90849-7\) T2021](#) code should be used instead. This means that if the service is 100 minutes, the [Multiple-Family Group Psychotherapy, 92+ Min \(90849-7\) T2021](#) code is used to account for all 100 minutes of the multi-family group service. [The total service minutes should be entered into IRIS and the number of units will be calculated for the Therapy Substitute code. The minimum number of service minutes required to use this code is 43 minutes.](#) Service minutes less than 43 minutes, or the midpoint, in duration should be coded using the SUD Family Counseling (70899-116) code. Service minutes less than 8 minutes will need to be coded using the corresponding non-billable code.

This code is locked out for use at the Withdrawal Management and Residential levels of care. Multi-family counseling is considered part of the daily bundle of services. No separate billing is permitted in addition to the treatment day. [A multi-family group therapy service with the client, if properly documented, may be considered a qualifying service to claim the treatment day.](#)

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

Overridable Lockouts with Appropriate Modifiers

This code may be used on the same day as the following services, [if the appropriate modifiers are used](#) (* = 59, XE, XP, or XU; ** = 27, 59, XE, XP, or XU):

- **Family Psychotherapy (w/o Pt Present), 50 Min (90846-1) and Family Psychotherapy (w/ Pt Present), 50 Min (90847-1)***
- **SUD Structured Assessment, 5-14/15-30/30+ Min (70899-102/70899-100/70899-101) G2011/G0396/G0397***
- **SUD Screening (70899-105) H0049***
- **SUD Brief Intervention, 15 Min (70899-117) H0050***
- **SUD Recovery Incentives, 15 Min (70899-118) H0050***
- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)***
- **Office Outpatient Visit of New Patient, 15-29/30-44/45-59/60-74 Min (99202-1/99203-1/99204-1/99205-1)****
- **Office Outpatient Visit of an Established Patient, 10-19/20-29/30-39/40-54 Min (99212-1/99213-1/99214-1/99215-1)****
- **Home Visit of a New Patient, 15-29/30-59/60-74/75-89 Min (99341-1/99342-1/99344-1/99345-1)****
- **Home Visit of an Established Patient, 20-29/30-39/40-59/60-74 Min (99347-1/99348-1/99349-1/99350-1)****

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- **Prolonged clinical staff service during an evaluation and management service in the office or outpatient setting, first hour (99415-1)****
- **Prolonged clinical staff service during an evaluation and management service in the office or outpatient setting, each additional 30 min (99416-1)****

See [Appendix V](#) for a quick reference sheet on all non-overridable lockouts and overridable lockouts with appropriate modifiers

Allowable [modifiers](#) for this code:

- 59, 93, 95, AH, AJ, GC, HD, HG, HL, HP, U1, U2, U3, U7, U8, U9, UA, UB, XE, XP, XU

The following supplemental codes CANNOT be used with this code:

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

This code requires a Medicare COB.

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

Therapy Substitute, 15 Min (XXXXX-7) T2021

Family Psychotherapy (w/o Pt Present), 58+ Min (90846-7) T2021

Family Psychotherapy (w Pt Present), 58+ Min (90847-7) T2021

Multiple-Family Group Psychotherapy, 92+ Min (90849-7) T2021

May be used by LPHA (except Pharmacists, Pharmacist Clinical Trainees, Registered Nurses, Registered Nurse Clinical Trainees, Licensed Vocational Nurses, Vocational Nurse Clinical Trainees, Licensed Psychiatric Technicians, Psychiatric Technician Clinical Trainees, Licensed Occupational Therapists, and Occupational Therapist Clinical Trainees) to account for family therapy services that exceed the maximum number of minutes allowed for the code. The CDM code will be the CPT code for the primary service (e.g., 90846, 90847, 90849) followed by "-7" ("-8" for perinatal). The total service time of the primary service should be entered into IRIS and the units will be calculated to reflect the Therapy Substitute code.

See [Appendix III](#) for a reference tool on all therapy substitute codes available and when they may be used.

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

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

Allowable [modifiers](#) for these codes:

- AH, AJ, GC, HD, HG, HL, HP, HQ, SC, U1, U2, U3, U7, U8, U9, UA, UB

The following supplemental codes CANNOT be used with these codes:

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

This code **does not** require a Medicare COB, however **if the code being substituted requires a Medicare COB, then Medicare must be billed first.**

Mobile Crisis Services

Only available for those programs designated to provide this service.

Mobile Crisis Service Codes:

Charge Description	CPT/HCPCS Code	CDM Code	Non-Billable Code
Mobile Crisis Intervention Svcs	H2011	70899-108	70899-301

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

Mobile Crisis Intervention Services (70899-108) H2011

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

Crisis Services

Crisis Intervention consists of contacts with a client in crisis. A crisis means an actual relapse or an unforeseen event or circumstance, which presents to the client an imminent threat of relapse. The focus of the service is on alleviating the crisis problem and limited to the stabilization of the client's immediate situation. It is intended to be provided in the least intensive level of care that is medically necessary to treat the client's condition.

Crisis Intervention Service Codes:

Charge Description	CPT/HCPCS Code	CDM Code	Non-Billable Code
SUD Crisis Intervention (outPt)	H0007	70899-107	70899-301

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

May be used by non-LPHA (except Medical Assistants, [Peer Support Specialists, and Other Qualified Providers](#)) and LPHA (except Pharmacists and Pharmacist Clinical Trainees) to address a client experiencing an SUD crisis. [Service may be provided in-person, telehealth, or telephone \(use the appropriate modifier\).](#)

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

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

This code is locked out for use at the Residential or Withdrawal Management levels of care. Crisis intervention is considered part of the daily bundle of services. There is no separate billing permitted in addition to the treatment day. [A crisis intervention service with the client, if properly documented, may be considered a qualifying service to claim the treatment day.](#)

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

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

Allowable [modifiers](#) for this code:

- [AH, AJ, CO, HD, HG, HM, HP, TD, SC, TE, U1, U2, U3, U7, U8, U9, UA, UB](#)

The following supplemental codes CANNOT be used with this code:

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

Group Counseling Services

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

Group Counseling Service Codes:

Charge Description	CPT/HCPCS Code	CDM Code	Non-Billable Code
Skills training and dev, Group, per 15 Min	H2014	70899-114	70899-310

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SUD Group Counseling	H0005	70899-131	70899-310
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Skills Training and Development, Group, per 15 Min (70899-114) H2014

May be used by non-LPHA (except [Peer Support Specialists](#)) and LPHA (except [Psychologist Clinical Trainees](#), Pharmacists, and Pharmacist Clinical Trainees) to specifically bill for Patient Education groups. The definition of Patient Education remains the same: it is research-based education for the client on addiction, treatment, recovery, and associated health risks. Patient Education groups may be billed even if the total number of participants exceeds twelve (12). [This code can also be used to provide services with clients in a group setting that involves teaching and reinforcing adaptive life skills necessary to function independently in the community. Areas of focus can include life skills like social and interpersonal skills, enhancing problem-solving and decision-making abilities, and self-care techniques such as improving stress management and coping strategies, and promoting medication management and treatment adherence. The sessions are geared towards providing structured, goal-oriented teaching and demonstration of targeted skills, offering supervised practice to reinforce learned skills necessary for a client in recovery to reintegrate back into the larger community. Use the appropriate modifier for any group services conducted via telehealth.](#)

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

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

This code is locked out for use at the Withdrawal Management and Residential levels of care. Patient Education is considered part of the daily bundle of services. No separate billing is permitted in addition to the treatment day. [A Patient Education group service with the client, if properly documented, may be considered a qualifying service to claim the treatment day.](#)

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

Allowable [modifiers](#) for this code:

- AJ, CO, HD, HM, HP, HQ, SC, TD, TE, U1, U2, U3, U7, U8, U9, UB

The following supplemental codes CANNOT be used with this code:

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

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

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SUD Group Counseling (70899-131) H0005

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

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

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

This code is locked out for use at the Withdrawal Management and Residential levels of care. Group counseling is considered part of the daily bundle of services. No separate billing is permitted in addition to the treatment day. [A group counseling service with the client, if properly documented, may be considered a qualifying service to claim the treatment day.](#)

Allowable [modifiers](#) for this code:

- AH, AJ, CO, GC, HD, HG, HL, HP, SC, TD, U1, U2, U3, U7, U8, U9, UA, UB

The following supplemental codes CANNOT be used with this code:

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

OTP/NTP or MAT: Medicare COB required.

Care Coordination Services

Care Coordination may include:

- Coordinating with primary care and mental health care providers to monitor and support comorbid health conditions;
- Discharge planning, including coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and referrals to primary/ specialty medical providers;

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- Ancillary services, including individualized connection, referral, and linkages to community-based services and supports including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, childcare, child development, family/marriage education, and mutual aid support groups.

Due to the State’s policy that only direct client care should be counted toward the selection of time and “does not include travel time, administrative activities, chart review, documentation, utilization review and quality assurance activities or other activities a provider engages in either before or after a client visit” (DHCS Drug Medi-Cal ODS Billing Manual, [July 2025](#)), billing is not allowed for review of documents. The exception to this is in relation to diagnosing the client by the LPHA (see the Psychiatric Evaluation of Hospital Record code section above).

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

Care Coordination Service Codes:

Charge Description	CPT/HCPCS Code	CDM Code	Non-Billable Code
Environmental Intervention for Med Mgmt Purposes	90882	90882-1	70899-304
Preparation of Report of Pt’s Psych Status	90889	90889-1	70899-304
Admin of Pt-Focused Health Risk Assmt Instrument	96160	96160-1	70899-304
Med Team Conf by Non-MD, Pt/Fam not Present, 30 Min+	99368	99368-1	70899-304
Targeted Case Management, Each 15 Min	T1017	70899-120	70899-304

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Environmental Intervention for Medical Management Purposes (90882-1)

May be used by a non-LPHA (except [Peer Support Specialists](#)) and LPHA (except Pharmacists and Pharmacist Clinical Trainees). It is to be used for coordinating with agencies, employers, or institutions on behalf of the client for the purpose of medical management. [Environmental intervention pertains to addressing issues or conditions in the client's physical environment that impacts SUD treatment. An example includes situations where a provider needs to visit the client's work site or collaborate with their employer to address environmental factors or work conditions that affect the client's SUD diagnosis. This service can be conducted in-person, via telehealth, or telephone \(use the appropriate modifier\).](#) This code may only be used once per day per provider per client.

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

Allowable [modifiers](#) for this code:

- 59, AH, AJ, CO, HD, HM, HP, TD, TE, U1, U2, U3, U7, U8, U9, UB, XE, XP, XU, 93, 95, UA, HG

The following supplemental codes CANNOT be used with this code:

- **Sign Language or Oral Interpretation Services, 15 Min (70899-132) T1013**
- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 30 Min (96170-1)**
- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

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

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

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

Allowable [modifiers](#) for this code:

- 59, AH, AJ, CO, HD, HM, HP, TD, TE, U1, U2, U3, U7, U8, U9, UB, XE, XP, XU

The following supplemental codes CANNOT be used with this code:

- **Sign Language or Oral Interpretation Services, 15 Min (70899-132) T1013**
- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 30 Min (96170-1)**
- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

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

May be used by a Medical Assistant or an LPHA (except Pharmacists and Pharmacist Clinical Trainees). This code can only be used ONE TIME PER YEAR BY ANY PROVIDER WITHIN THE NETWORK. It is intended to be used for an annual wellness visit. [Service can be provided in-person, via telehealth, or telephone \(use the appropriate modifier\)](#). If it is found to have been used by another provider or another county within the calendar year, the claim will be denied.

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

Non-Overridable Lockouts

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

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

See [Appendix V](#) for a quick reference sheet on all non-overridable lockouts and overridable lockouts with appropriate modifiers

Overridable Lockouts with Appropriate Modifiers

This code may be used on the same day as the following services, if the appropriate modifiers are used (59, XE, XP, or XU):

- **SUD Screening (70899-105) H0049**
- **SUD Brief Intervention, 15 Min (70899-117) H0050**
- **SUD Recovery Incentives, 15 Min (70899-118) H0050**

Allowable [modifiers](#) for this code:

- 59, 93, 95, AH, AJ, CO, GC, HD, HL, HM, HP, TD, TE, U1, U7, U8, UB, XE, XP, XU

This code requires a Medicare COB.

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

May be used by Medical Assistants and non-MD LPHA (except Licensed Vocational Nurses, Vocational Nurse Trainees, Licensed Psychiatric Technicians, Psychiatric Technician Clinical Trainees, Licensed Occupational Therapists, and Occupational Therapist Clinical Trainees) for a Clinician Consultation service to elicit additional expertise on complex cases pertaining to a client's medication or level of care placement. [Clinician consultations must be face-to-face and involve, at minimum, three \(3\) qualified LPHA from different specialties or disciplines \(each of whom provide direct care to the client\)](#). The State has clarified that consulting parties must be certified DMC-ODS providers. Consultations can be with providers within the same agency or outside the agency so long as both are DMC-ODS providers. It is permissible for the qualified LPHA of the same discipline to be involved, as long as their treatment specialty or role in the

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client's treatment is distinct. For example, in a consultation between two LMFTs and an RN, each of the two LMFTs must play a distinct and separate role in the client's treatment (e.g., one provides individual therapy while the other provides family therapy). Documentation must make clear who each of the LPHA involved in the consultation were as well as each provider's distinct role in the client's care. The consultation is intended to involve development, revision, coordination, and implementation of health care services needed by the client. Only the rendering provider for the client who is initiating the consultation can claim the time. The rendering provider must have performed a face-to-face encounter with the client within the previous sixty (60) days.

This code can only be used once per day per provider per client. The minimum number of service minutes required to claim this code is 30 minutes. For claiming services less than 30 minutes, the Targeted Case Management (70899-120) should be used. This code cannot be extended.

Overridable Lockouts with Appropriate Modifiers

This code may be used on the same day as the following services, if the appropriate modifiers are used (* = 59, XE, XP, or XU; ** = 27, 59, XE, XP, or XU):

- **SUD Screening (70899-105) H0049***
- **SUD Brief Intervention, 15 Min (70899-117) H0050***
- **SUD Recovery Incentives, 15 Min (70899-118) H0050***
- **Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Physician, Patient and/or Family not Present, 30 Min+ (99367-1)****

See [Appendix V](#) for a quick reference sheet on all non-overridable lockouts and overridable lockouts with appropriate modifiers

Allowable [modifiers](#) for this code:

- 27, 59, 93, 95, AH, AJ, CO, HD, HG, HO, HP, TD, U1, U2, U3, U7, U8, U9, UA, UB, XE, XP, XU

The following supplemental codes CANNOT be used with this code:

- **Sign Language or Oral Interpretation Services, 15 Min (70899-132) T1013**
- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 30 Min (96170-1)**
- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

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

May be used by a non-LPHA (except [Peer Support Specialists](#)) or LPHA. This is the equivalent to what was previously Care Coordination. The service/session can be with or without the presence of the client. Service may be provided in-person, via telehealth, or telephone ([use the appropriate modifier](#)).

Some examples of when to use Targeted Case Management:

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- ✓ Educating and connecting the client to community resources
- ✓ Coordinating with other providers to assist in a smooth transition for clients moving from one level of care or program to another
- ✓ Discharge planning to help ensure success post-discharge with regards to internal and external resources
- ✓ Time spent consulting with other providers
- ✓ Coordinating care with other professionals at external entities, agencies, or organizations (i.e., social workers, probation officers, teachers, etc.)
- ✓ **Solely reviewing intake paperwork and obtaining the necessary signatures (no screening or assessment activities)**

The following activities cannot be billed:

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

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

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

Allowable modifiers for this code:

- AH, AJ, CO, HD, HG, HM, HO, HP, SC, TD, TE, U1, U2, U3, U7, U8, U9, UA, UB

The following supplemental codes CANNOT be used with this code:

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

Recovery Services

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

Recovery Services Codes:

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Charge Description	CPT/HCPCS Code	CDM Code	Non-Billable Code
Community Support Svcs, per 15 Min	H2015	70899-121	70899-305
Psychosocial Rehabilitation, Indv, per 15 Min	H2017	70899-122	70899-305
Psychosocial Rehabilitation, Group, per 15 Min	H2017	70899-123	70899-305
Recovery Svcs, 1 Hr	H2035	70899-124	70899-305

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

May be used by non-LPHA (except Medical Assistants and Peer Support Specialists) and LPHA (except Pharmacists, Pharmacist Clinical Trainees, Psychologists, and Psychologist Clinical Trainees) for care coordination activities at the recovery services level of care. See the care coordination section above for examples that are also applicable to recovery services. Service may be provided in-person, via telehealth, or telephone (use the appropriate modifier).

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

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

Allowable [modifiers](#) for this code:

- AJ, CO, HD, HG, HM, HP, SC, TD, TE, U1, U2, U3, U6, U7, U8, U9, UA, UB

The following supplemental codes CANNOT be used with this code:

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

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

May be used by non-LPHA (except Peer Support Specialists) and LPHA (except Registered Nurses, Registered Nurse Clinical Trainees, Psychologists, and Psychologist Clinical Trainees), within scope of practice, for assessment, counseling, family therapy, recovery monitoring, and relapse prevention services/sessions provided individually and the group setting. Service may be provided in-person, via telehealth, or telephone (use the appropriate modifier).

There is no maximum number of minutes that can be claimed for this service. The actual number of minutes spent providing this service should be captured and appropriately justified by the documentation. The minimum number of required service minutes to use this code is 8

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[minutes](#). Service minutes less than 8 minutes in duration should be coded using the corresponding non-billable code.

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

Allowable [modifiers](#) for this code:

- AJ, CO, HD, HG, HM, HO, HP, HQ, SC, TE, U1, U2, U3, U6, U7, U8, U9, UA, UB, AH, TD

The following supplemental codes CANNOT be used with this code:

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

Recovery Services, 1 Hr (70899-124) H2035

May be used by non-LPHA (except Medical Assistants [and Peer Support Specialists](#)) and LPHA (except [Registered Nurses, Registered Nurse Clinical Trainees](#), Licensed Occupational Therapists, and Occupational Therapist Clinical Trainees) for services at this level of care that are a minimum of at least 31 minutes in duration in a one-on-one setting with a client. Service minutes 30 minutes or less in duration should be coded using the **Psychosocial Rehabilitation, Individual, per 15 Min (70899-122)** code [instead of this code](#). (Note, this does not mean that the [Psychosocial Rehabilitation, Individual, per 15 Min \[70899-122\]](#) code can only be used for services less than 30 minutes). This code should be used by Psychologists and their respective Clinical Trainees for claiming Recovery Services as they are ineligible to use the [Psychosocial Rehabilitation, Individual, per 15 Min \(70899-122\)](#) code. Service may be provided in-person, via telehealth, or telephone (use the appropriate modifier).

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

Allowable [modifiers](#) for this code:

- AH, AJ, HD, HG, HM, HO, HP, SC, TE, U1, U2, U3, U6, U7, U8, U9, UA, UB

The following supplemental codes CANNOT be used with this code:

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

Important note about Recovery Services: Recovery services may be provided as a standalone service or part of the treatment level of care. However, the provision of recovery services to clients who are also receiving a treatment level of care is not a common scenario and must be clinically appropriate. At the residential levels of care, in most cases, recovery services will

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likely be provided as part of the bundle of services for the treatment day, in which case there is no additional billing of recovery services permitted. Once a client is no longer receiving the residential levels of care (i.e., no treatment days are being claimed), recovery services may be billable as a standalone service. In such cases, the client's episode of care would be closed at the residential level and opened under a recovery services episode of care.

Peer Support Specialist Services Codes

Peer Support Services consist of individual and group coaching to promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths. Services are intended to prevent relapse, empower clients through strength-based coaching, support linkages to community resources, and educate clients and their families about SUD and the recovery process. Peer Support Services can be delivered and claimed as a standalone service or provided in conjunction with other DMC-ODS services, including inpatient and residential services. **Providers must be mindful to coordinate with other treatment providers to ensure there is no duplicative billing. Services may be provided in-person, via telehealth, or telephone. Peer Support Services Groups must adhere to the same requirements for group counseling of a minimum of two (2) and maximum of twelve (12) clients.**

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

Peer Support Services include the following service components:

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

Peer Support Specialist Service Codes:

Charge Description	CPT/HCPCS Code	CDM Code	Non-Billable Code
Behavioral Health Prevention Education, Group	H0025	70899-128	70899-308
Self-Help/Peer Svcs, Individual, per 15 Min	H0038	70899-129	70899-308

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

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

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

Allowable [modifiers](#) for this code:

- HD, HG, SC, U1, U2, U3, U7, U8, U9, UA, UB

The following supplemental codes CANNOT be used with this code:

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

Behavioral Health Prevention Education Service (70899-128) H0025

This code may only be used by Certified Peer Support Specialists to claim Educational Skill Building Groups. [Areas that may be addressed include socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and a maintenance of skills learned in other support services. The focus is on helping clients and their families learn coping mechanisms and problem-solving skills within scope of practice and in accordance with the Certified Peer Support Specialist Certification program training. Services may be provided in-person, via telehealth, or telephone \(use the appropriate modifier\).](#)

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

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

Allowable [modifiers](#) for this code:

- HD, HG, SC, U1, U2, U3, U7, U8, U9, UA, UB

The following supplemental codes CANNOT be used with this code:

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

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Contingency Management (Recovery Incentives) Services

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

Contingency Management Service Codes:

Charge Description	CPT/HCPCS Code	CDM Code	Non-Billable Code
SUD Recovery Incentives, 15 Min	H0050	70899-118	70899-309

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

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

[Service must be provided in-person.](#)

[For the Recovery Incentives programs, this code should be used to capture all direct service time with the client receiving Recovery Incentives services. This includes the required visit components as well as any additional issues that may arise within the context of a Recovery Incentives visit. For example, the visit goes beyond the typical 15 minutes because individual counseling is also provided to address the client’s concern about a new stressor that may potentially compromise the client’s recovery efforts and additional intervention such as motivational interviewing or relapse prevention is necessary. We do not need to separate out the service between RI and the individual counseling portion in the documentation or billing. It is acceptable to include that additional time into the RI service using the SUD Recovery Incentives, 15 Min \(70899-118\) H0050 code and complete one progress note.](#)

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

Non-Overridable Lockouts

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

- **SUD Structured Assessment, 15-30 Min (70899-100) G0396**
- **SUD Structured Assessment, 30+ Min (70899-101) G0397**

See [Appendix V](#) for a quick reference sheet on all non-overridable lockouts and overridable lockouts with appropriate modifiers

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Allowable [modifiers](#) for this code:

- HD, HF, HG, U7, U8, UA, UB, XE, XP, XU

The following supplemental codes CANNOT be used with this code:

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

Supplemental Codes

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

Supplemental Billing Codes:

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

Interactive Complexity (90785-1)

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

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

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

- **Psychiatric Diagnostic Evaluation, 60 min (90791-1)**
- **Psychiatric Diagnostic Evaluation, 68+ min (90791-7)**
- **Psychiatric Diagnostic Evaluation with Medical Services, 60 min (90792-1)**
- **Psychiatric Diagnostic Evaluation with Medical Services, 68+ min (90792-7)**
- **Family Psychotherapy (w/o Pt Present), 50 Min (90846-1)**
- **Family Psychotherapy (w/o Pt Present), 58+ Min (90846-7)**
- **Family Psychotherapy (w/ Pt Present), 50 Min (90847-1)**
- **Family Psychotherapy (w/ Pt Present), 58+ Min (90847-7)**

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- **Multiple-Family Group Psychotherapy, 84 Min (90849-1)**
- **Multiple-Family Group Psychotherapy, 92+ Min (90849-7)**
- **Office Outpatient Visit of New Patient, 15-29/30-44/45-59/60-74 Min (99202-1/99203-1/99204-1/99205-1)**
- **Office Outpatient Visit of an Established Patient, 10-19/20-29/30-39/40-54 Min (99212-1/99213-1/99214-1/99215-1)**
- **Home Visit of a New Patient, 15-29/30-59/60-74/75-89 Min (99341-1/99342-1/99344-1/99345-1)**
- **Home Visit of an Established Patient, 20-29/30-39/40-59/60-74 Min (99347-1/99348-1/99349-1/99350-1)**

Non-Overridable Lockouts

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

- **Sign Language or Oral Interpretation Services, 15 Min (70899-132) T1013**
- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 30 Min (96170-1)**
- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

See [Appendix V](#) for a quick reference sheet on all non-overridable lockouts and overridable lockouts with appropriate modifiers

Allowable [modifiers](#) for this code:

- 59, 93, 95, AH, AJ, CO, GC, HD, HG, HL, HM, HO, HP, TD, TE, U1, U2, U3, U7, U8, U9, UA, UB, XE, XP, XU

This code requires a Medicare COB.

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

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

May be used by Medical Assistants and LPHA (except Pharmacists and Pharmacist Clinical Trainees). Health behavior intervention services are used to address the psychological, behavioral, emotional, cognitive, and interpersonal factors important to the assessment, treatment, or management of physical health problems. It is to be used when the primary focus of the service/session is related to the client's physical health care/condition, using psychological and/or psychosocial interventions designed to ameliorate specific disease-related problems. Health behavior intervention includes promotion of functional improvement, minimizing psychological and/or psychosocial barriers to recovery, and management of and improved coping

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with medical conditions. This service emphasizes active patient/family engagement and involvement in a session with the family but not including the client. [Service can be provided in-person, via telehealth, or telephone \(use the appropriate modifier\).](#)

[Health Behavioral Intervention, Family \(without the Patient present\) Face-to-Face, Additional 15 Min \(96171-1\)](#) may only be used after 38 minutes of service for [Health Behavioral Intervention, Family \(without the Patient present\) Face-to-Face, 30 Min \(96170-1\)](#) has been reached.

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

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

- **Psychological Testing Evaluation, First Hour (96130-1)**
- **Telephone Assessment and Management Service, 5-10/11-20/21-30 Min (98966-1/98967-1/98968-1)**
- **Office Outpatient Visit of New Patient, 15-29/30-44/45-59/60-74 Min (99202-1/99203-1/99204-1/99205-1)**
- **Office Outpatient Visit of an Established Patient, 10-19/20-29/30-39/40-54 Min (99212-1/99213-1/99214-1/99215-1)**
- **Home Visit of a New Patient, 15-29/30-59/60-74/75-89 Min (99341-1/99342-1/99344-1/99345-1)**
- **Home Visit of an Established Patient, 20-29/30-39/40-59/60-74 Min (99347-1/99348-1/99349-1/99350-1)**
- **SUD Structured Assessment 5-14 Min (70899-102) G2011**
- **SUD Assessment (70899-103) H0001**

Non-Overridable Lockouts

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

- **Interactive Complexity (90785-1)**
- **Psychiatric Diagnostic Evaluation, 60 min (90791-1)**
- **Psychiatric Diagnostic Evaluation with Medical Services, 60 min (90792-1)**
- **Family Psychotherapy (w/o Pt Present), 50 Min (90846-1)**
- **Family Psychotherapy (w/ Pt Present), 50 Min (90847-1)**
- **Administration of Patient-Focused Health Risk Assessment Instrument (96160-1)**

See [Appendix V](#) for a quick reference sheet on all non-overridable lockouts and overridable lockouts with appropriate modifiers

Overridable Lockouts with Appropriate Modifiers

The **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 30 Min (96170-1)** code may be used on the same day as the following services, if the appropriate modifiers are used (59, XE, XP, or XU):

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- **Multiple-Family Group Psychotherapy, 84 Min (90849-1)**
- **Environmental Intervention for Medical Management Purposes (90882-1)**
- **Psychiatric Evaluation of Hospital Record, 60 Min (90885-1)**
- **Interpretation of Psychiatric Results to Family, 15 Min (90887-1)**
- **Preparation of Report of Patient's Psychiatric Status (90889-1)**
- **SUD Structured Assessment, 15-30/30+ Min (70899-100/70899-101) G0396/G0397**

The **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)** code may be used on the same day as the following services, if the appropriate modifiers are used (59, XE, XP, or XU):

- **Environmental Intervention for Medical Management Purposes (90882-1)**
- **Preparation of Report of Patient's Psychiatric Status (90889-1)**
- **SUD Structured Assessment, 30+ Min (70899-101) G0397**

Allowable modifiers for these codes:

- 59, 93, 95, AH, AJ, CO, HD, HM, HP, TD, TE, U1, U2, U3, U7, U8, U9, UB, XE, XP, XU

The following supplemental code CANNOT be used with these codes:

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

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

May be used by non-LPHA (except Peer Support Specialists) and LPHA (except Pharmacist Clinical Trainees) when an oral interpreter is necessary for a client who is unable to speak or speak the same language as the provider. This supplemental code is not to be used when the provider is speaking the client's preferred language and only when an oral interpreter is utilized. It is permissible for the other provider in these cases to be another staff member who is not certified as an interpreter. This occurs along with another primary service, such as individual counseling. It is important to note, however, that when another provider from your program is used, there is no billing for that provider as this code must be attached to the primary service. It is available for use with all services, including treatment planning, family therapy, and discharge services/sessions.

The number of units that can be claimed is dependent on the total service time for the primary service. Interpretation time cannot exceed the time spent providing a primary service.

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

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

Non-Overridable Lockouts

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

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

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See [Appendix V](#) for a quick reference sheet on all non-overrideable lockouts and overrideable lockouts with appropriate modifiers

Allowable [modifiers](#) for this code:

- AH, AJ, CO, HD, HG, HM, HP, SC, TD, TE, U1, U2, U3, U6, U7, U8, U9, UA, UB

The following supplemental codes CANNOT be used with this code:

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

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

May only be used by LPHA (except Licensed Vocational Nurses, Vocational Nurse Clinical Trainees, Licensed Psychiatric Technicians, and Psychiatric Technician Clinical Trainees) when an interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data is provided to family or other responsible persons or advising them how to assist client. [This can be provided in-person, via telehealth, and telephone \(use the appropriate modifier\)](#). Only one unit per service may be claimed per provider per client per day. The minimum number of service minutes required to use this code is 26 minutes.

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

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

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

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

Overridable Lockouts with Appropriate Modifiers

This code may be used on the same day as the following service, if the appropriate modifiers are used (59, XE, XP, or XU):

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

See [Appendix V](#) for a quick reference sheet on all non-overridable lockouts and overridable lockouts with appropriate modifiers

Allowable [modifiers](#) for this code:

- 59, 93, 95, AH, AJ, CO, HD, HG, HO, HP, TD, U1, U2, U3, U6, U7, U8, U9, UA, UB, XE, XP, XU

The following supplemental codes CANNOT be used with this code:

- **Sign Language or Oral Interpretation Services, 15 Min (70899-132) T1013**
- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 30 Min (96170-1)**
- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

Medication Services

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

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

Some examples of E/M activities include:

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

Do not count time spent on the following:

- The performance of other services that are reported separately
- Travel

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- Teaching that is general and not limited to discussion that is required for the management of a specific patient
- Review of documents to prepare for or as follow up from an E/M encounter

Medication Service Codes:

Charge Description	CPT/HCPCS Code	CDM Code	Non-Billable Code
Psych Diagnostic Eval w/ Med Svcs, 60 Min	90792	90792-1	70899-300
Psychiatric Diagnostic Eval w/ Med Services, 68+ Min	T2024	90792-7	70899-300
Oral Medication Admin, Direct Observation, 15 Min	H0033	70899-109	70899-302
Medication Training and Support-Indv per 15 Min	H0034	70899-110	70899-302
Medication Training and Support-Group per 15 Min	H0034	70899-111	70899-302
Office OutPt Visit of New Pt, 15-29 Min	99202	99202-1	70899-302
Office OutPt Visit of a New Pt, 30- 44 Min	99203	99203-1	70899-302
Office OutPt Visit of a New Pt, 45- 59 Min	99204	99204-1	70899-302
Office OutPt Visit of a New Pt, 60- 74 Min	99205	99205-1	70899-302
Office OutPt Visit of an Established Pt, 10-19 Min	99212	99212-1	70899-302
Office OutPt Visit of an Established Pt, 20-29 Min	99213	99213-1	70899-302
Office OutPt Visit of an Established Pt, 30-39 Min	99214	99214-1	70899-302
Office OutPt Visit of an Established Pt, 40-54 Min	99215	99215-1	70899-302
Prolonged Clinical Staff Service, first hour	99415	99415-1	70899-302
Prolonged Clinical Staff Service, additional 30 min	99416	99416-1	70899-302
Home Visit of a New Pt, 15-29 Min	99341	99341-1	70899-302
Home Visit of a New Pt, 30-59 Min	99342	99342-1	70899-302
Home Visit of a New Pt, 60-74 Min	99344	99344-1	70899-302
Home Visit of a New Pt, 75-89 Min	99345	99345-1	70899-302
Home Visit of an Established Pt, 20-29 Min	99347	99347-1	70899-302
Home Visit of an Established Pt, 30-39 Min	99348	99348-1	70899-302
Home Visit of an Established Pt, 40-59 Min	99349	99349-1	70899-302
Home Visit of an Established Pt, 60-74 Min	99350	99350-1	70899-302
Prolonged Outpatient E&M, each 15 min	99417	99417-1	70899-302
Med Team Conf by MD, Pt/Fam not Present, 30 Min+	99367	99367-1	70899-304
Transitional Care Mgmt Svcs: Comm. w/in 14 days	99495	99495-1	70899-304

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Transitional Care Mgmt Svcs: Comm. w/in 7 days	99496	99496-1	70899-304
Inter-Prof Phone/EHR Assmt-Consult. MD 5-30 Min	99451	99451-1	70899-304

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

May only be used by a Licensed Physician, Medical Student in Clerkship, Physician Assistant, Physician Assistant Clinical Trainee, Nurse Practitioner, or Nurse Practitioner Clinical Trainee for performing a MAT or OTP/NTP evaluation. An integrated biopsychosocial and medical assessment that can include history, mental status, other physical examination elements as indicated, and recommendations. May include communication with family or other sources, prescription of medications, and review and ordering of laboratory or other diagnostic services. [This service may be conducted in-person, via telehealth, or telephone \(use the appropriate modifier\).](#) This code is restricted to use only one time per day per provider per client. The minimum number of service minutes required to claim this code is 31 minutes. Services that are 30 minutes or less may be claimed using an alternative **Office Outpatient Visit of New Patient, 15-29/30-44/45-59/60-74 Min (99202-1/99203-1/99204-1/99205-1)** or **Office Outpatient Visit of an Established Patient, 10-19/20-29/30-39/40-54 Min (99212-1/99213-1/99214-1/99215-1)** code. For services that are 68 minutes or more, the [Psychiatric Diagnostic Eval w/ Med Services, 68+ Min \(90792-7\) T2024](#) code should be used instead. For example, if the total service time was 100 minutes, the T2024 code would be used to account for all 100 minutes of the assessment service. [The total service minutes should be entered into IRIS and the number of units will be calculated for the Assessment Substitute code.](#)

For Outpatient programs that may offer physical exams conducted by the Medical Director of the program, the service may be claimed using this code [or the Office Outpatient Visit of New or Established Patient \(99202-1/99203-1/99204-1/99205-1/99212-1/99213-1/99214-1/99215-1\)](#) codes.

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

Non-Overridable Lockouts

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

- **Family Psychotherapy (w/o Pt Present), 50 Min (90846-1)**
- **Family Psychotherapy (w/ Pt Present), 50 Min (90847-1)**
- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 30 Min (96170-1)**
- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

See [Appendix V](#) for a quick reference sheet on all non-overridable lockouts and overridable lockouts with appropriate modifiers

Overridable Lockouts with Appropriate Modifiers

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This code may be used on the same day as the following services, if the appropriate modifiers are used (* = 59, XE, XP, or XU; ** = 27, 59, XE, XP, XU):

- **SUD Structured Assessment 15-30/30+/5-14 min (70899-100/70899-101/70899-102) G2011/G0396/G0397***
- **Psychiatric Diagnostic Evaluation, 60 min (90791-1)***
- **Multiple-Family Group Psychotherapy, 84 Min (90849-1)***
- **Environmental Intervention for Medical Management Purposes (90882-1)***
- **Psychiatric Evaluation of Hospital Record, 60 Min (90885-1)***
- **Interpretation of Psychiatric Results to Family, 50 Min (90887-1)***
- **Preparation of Report of Patient's Psychiatric Status (90889-1)***
- **Administration of Patient-Focused Health Risk Assessment Instrument (96160-1)***
- **Office Outpatient Visit of New Patient, 15-29/30-44/45-59/60-74 Min (99202-1/99203-1/99204-1/99205-1)****
- **Office Outpatient Visit of an Established Patient, 10-19/20-29/30-39/40-54 Min (99212-1/99213-1/99214-1/99215-1)****
- **Home Visit of a New Patient, 15-29/30-59/60-74/75-89 Min (99341-1/99342-1/99344-1/99345-1)****
- **Home Visit of an Established Patient, 20-29/30-39/40-59/60-74 Min (99347-1/99348-1/99349-1/99350-1)****
- **Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Physician, Patient and/or Family not Present, 30 Min+ (99367-1)****
- **Medical Team Conference by non-MD, Patient/Family not present, 30 Min+ (99368-1)****
- **Prolonged clinical staff service during an evaluation and management service in the office or outpatient setting, first hour (99415-1)****
- **Prolonged clinical staff service during an evaluation and management service in the office or outpatient setting, each additional 30 min (99416-1)****
- **Inter-Professional Telephone/Internet/Electronic Health Record Assessment Provided by a Consultative Physician, 5-30 Min (99451-1)****
- **Transitional Care Management Services: Communication (direct contact, telephone, electronic) within 14 calendar days (99495-1) and Transitional Care Mgmt Services: Communication (direct contact, telephone, electronic) within 7 calendar days (99496-1)****

Allowable [modifiers](#) for this code:

- **93, 95, GC, HD, HG, HL, HP, U1, U2, U3, U7, U8, U9, UA, UB**

The following supplemental codes CANNOT be used with this code:

- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 30 Min (96170-1)**

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

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

This code is locked out for use at the Withdrawal Management and Residential levels of care as assessment is considered part of the daily bundle of services. There is no separate billing permitted in addition to the treatment day. [A medication service with the client, if properly documented, may be considered a qualifying service to claim the treatment day.](#)

This code requires a Medicare COB.

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

Oral Medication Administration, Direct Observation, 15 Min (70899-109) H0033

May be used by a Licensed Physician, Medical Student in Clerkship, Physician Assistant, Physician Assistant Clinical Trainee, Nurse Practitioner, Nurse Practitioner Clinical Trainee, Pharmacist, Pharmacist Clinical Trainee, Registered Nurse, Registered Nurse Clinical Trainee, Licensed Vocational Nurse, Vocational Nurse Clinical Trainee, Licensed Psychiatric Technician, Psychiatric Technician Clinical Trainee, Licensed Occupational Therapist, Occupational Therapist Clinical Trainee, and Medical Assistant for a MAT program when claiming a medication administration service (including injections) [outside of the NTP](#).

MAT services at Withdrawal Management and Residential levels of care can be claimed using this code. [This code can only be claimed at the 3.2 Withdrawal Management level of care if there is a National Drug Code \(NDC\) on the claim. The State's NDC List can be accessed on the \[MedCCC website\]\(#\).](#)

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

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

[This code requires that the corresponding National Drug Code \(NDC\) for the medication utilized be attached to the claim. The State's NDC List can be accessed on the \[MedCCC website\]\(#\).](#)

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

Allowable [modifiers](#) for this code:

- CO, HD, HG, HM, HO, HP, TD, TE, U1, U2, U3, U7, U8, U9, UA, UB, SC

The following supplemental codes CANNOT be used with this code:

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

Medication Training and Support- Individual per 15 Min (70899-110) and Medication Training and Support-Group per 15 Min (70899-111) H0034

May be used by a Licensed Physician, Medical Student in Clerkship, Physician Assistant, Physician Assistant Clinical Trainee, Nurse Practitioner, Nurse Practitioner Clinical Trainee, Pharmacist, Pharmacist Clinical Trainee, Registered Nurse, Registered Nurse Clinical Trainee, Licensed Vocational Nurse, Vocational Nurse Clinical Trainee, Licensed Psychiatric Technician, Psychiatric Technician Clinical Trainee, and Medical Assistant for a MAT program when providing psychoeducation, training, and/or support related to MAT medication, either in a one-on-one or group setting. [Service may be provided in-person, via telehealth, or telephone \(use the appropriate modifier\).](#) Note that this does not include Narcan distribution, education, and training. Please remember that it is expected that all SUD programs make Narcan readily available. It is not considered a MAT service. For outpatient programs, providing Narcan education on its own, if it meets the minimum 8 minutes, can be billed as a Psychoeducational Service. In most cases, it likely would not take 8 minutes, therefore, it can be part of or folded into another clinical service. For the residential and withdrawal management levels of care, it can be included as part of the individual counseling service that can count towards meeting the requirement for a qualifying service to bill the treatment day and the required five clinical hours for the week.

MAT services at Withdrawal Management and Residential levels of care can be claimed using this code. [Note the distinction between medication services that are a standard component of the daily rate at Withdrawal Management and Residential levels of care.](#) This code can only be used for activities relevant to the client's MAT medications.

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

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

Allowable [modifiers](#) for this code:

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- HD, HG, HM, HO, HP, HQ, TD, TE, U1, U2, U3, U7, U8, U9, UA, UB, SC

The following supplemental codes CANNOT be used with this code:

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

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

May only be used by medical LPHA (Licensed Physician, Medical Student in Clerkship, Physician Assistant, Physician Assistant Clinical Trainee, Nurse Practitioner, and Nurse Practitioner Clinical Trainee) when office or other outpatient visit for the evaluation and management of a new or established patient is provided. The service requires a medically appropriate history and/or examination and straightforward/low level/moderate level/high level of medical decision making. [Services can be provided in-person, via telehealth, or telephone \(use the appropriate modifier\).](#) This code can only be used once per day per provider per client. “New” patient means an individual who has not received services from any provider within the same provider (or legal entity) in the past three (3) years. “Established” patient means an individual who has received any services with a provider (or legal entity) in the past three (3) years. [This means checking to see within your organization/agency whether there are records of the client within the last three \(3\) years that can be reviewed and used to inform the evaluation for the current episode of care.](#)

[For Outpatient programs that may offer physical exams conducted by the Medical Director of the program, the service may be claimed using these codes or the Psychiatric Diagnostic Evaluation with Medical Services, 60 Min \(90792-1\) code.](#)

Non-Overridable Lockouts

These codes (for both New and Established Patient) CANNOT be used on the same day as the following services:

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

See [Appendix V](#) for a quick reference sheet on all non-overridable lockouts and overridable lockouts with appropriate modifiers

Overridable Lockouts with Appropriate Modifiers

These codes (for both New and Established Patient) may only be used on the same day as the following services, [if the appropriate modifiers are used \(59, XE, XP, or XU\)](#):

- **Psychological Testing Evaluation, First Hour (96130-1)***
- **SUD Structured Assessment 15-30/30+/5-14 min (70899-100/70899-101/70899-102) G2011/G0396/G0397***
- **SUD Screening (70899-105) H0049***

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- SUD Brief Intervention, 15 Min (70899-117) H0050*
- SUD Recovery Incentives, 15 Min (70899-118) H00508*

The Office Outpatient Visit of New Patient codes may only be used on the same day as the following services, [if the appropriate modifiers are used \(27, 59, XE, XP, or XU\)](#):

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

The Office Outpatient Visit of Established Patient codes may only be used on the same day as the following services, [if the appropriate modifiers are used \(27, 59, XE, XP, or XU\)](#):

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

Allowable [modifiers](#) for these code series:

- 27, 59, 93, 95, GC, HD, HL, HP, U1, U2, U3, U7, U8, UB, XE, XP, XU

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

This code is locked out for use at the Withdrawal Management and Residential levels of care as medication services is considered part of the daily bundle of services. There is no separate billing permitted in addition to the treatment day. [A medication service with the client, if properly documented, may be considered a qualifying service to claim the treatment day.](#)

These codes require a Medicare COB.

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

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Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office of outpatient setting, direct patient contact with physician supervision, first hour (99415-1)

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

For example, if the service was 110 minutes for an Office Outpatient E/M, the primary procedure code (99205) allows up to 74 minutes. 110 minutes – 74 minutes = 36 minutes. The minimum number of minutes beyond the maximum of the highest range that is needed to use the prolonged code is 30 minutes. Therefore, one unit of 99205 and one unit of 99415 would be claimed.

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

Office or Other Outpatient Visit of a New Patient				
99202-1	99203-1	99204-1	99205-1	99415-1* <small>(add on to 99205-1)</small>
15-29 minutes	30-44 minutes	45-59 minutes	60-103 minutes	104-148 minutes

Office or Other Outpatient Visit of an Established Patient				
99212-1	99213-1	99214-1	99215-1	99415-1* <small>(add on to 99215-1)</small>
10-19 minutes	20-29 minutes	30-39 minutes	40-54 minutes	84-128 minutes

See also [Appendix IV](#) for a reference tool on the prolonged codes.

This code requires a Medicare COB.

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

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

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Non-Overridable Lockouts

This code CANNOT be used on the same day as the following service:

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

See [Appendix V](#) for a quick reference sheet on all non-overridable lockouts and overridable lockouts with appropriate modifiers

Overridable Lockouts with Appropriate Modifiers

This code may be used on the same day with the following services, if the appropriate modifiers are used (* = 59, XE, XP, or XU; ** = 27, 59, XE, XP, or XU):

- **Psychological Testing Evaluation, First Hour (96130-1)***
- **Prolonged Outpatient Evaluation and Management Service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (99417-1)****
- **SUD Structured Assessment 15-30/30+/5-14 min (70899-100/70899-101/70899-102) G2011/G0396/G0397***

Allowable [modifiers](#) for this code:

- 27, 59, 93, 95, GC, HD, HL, HP, U1, U2, U3, U7, U8, UB, XE, XP, XU

The following supplemental codes CANNOT be used with this code:

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

Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; each additional 30 minutes (99416-1)

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

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

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

Office or Other Outpatient Visit of a New Patient					
99202-1	99203-1	99204-1	99205-1	99415-1* <small>(add on to 99205-1)</small>	99416-1* <small>(add on to 99205-1 and 99415)</small>
15-29 minutes	30-44 minutes	45-59 minutes	60-103 minutes	104-148 minutes	149 minutes or more

Office or Other Outpatient Visit of an Established Patient					
99212-1	99213-1	99214-1	99215-1	99415-1* <small>(add on to 99215-1)</small>	99416-1* <small>(add on to 99215-4 and 99415)</small>
10-19 minutes	20-29 minutes	30-39 minutes	40-54 minutes	84-128 minutes	129 minutes or more

See also [Appendix IV](#) for a reference tool on the prolonged codes.

The Prolonged Clinical Staff Service codes are locked out for use at the OTP/NTP, Withdrawal Management, and Residential levels of care.

This code requires a Medicare COB.

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

- Office Outpatient Visit of New Patient, 15-29/30-44/45-59/60-74 Min (99202-1/99203-1/99204-1/99205-1)
- Office Outpatient Visit of an Established Patient, 10-19/20-29/30-39/40-54 Min (99212-1/99213-1/99214-1/99215-1)
- Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office of outpatient setting, direct patient contact with physician supervision, first hour (99415-1)

Non-Overridable Lockouts

This code CANNOT be used on the same day as the following service:

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

See [Appendix V](#) for a quick reference sheet on all non-overridable lockouts and overridable lockouts with appropriate modifiers

Overridable Lockouts with Appropriate Modifiers

This code may be used on the same day with the following services, if the appropriate modifiers are used (* = 59, XE, XP, or XU; ** = 27, 59, XE, XP, or XU):

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- **SUD Structured Assessment 15-30/30+/5-14 min (70899-100/70899-101/70899-102) G2011/G0396/G0397***
- **Psychological Testing Evaluation, First Hour (96130-1)***
- **Prolonged Outpatient Evaluation and Management Service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (99417-1)****

Allowable [modifiers](#) for this code:

- 27, 59, 93, 95, GC, HD, HL, HP, U1, U2, U3, U7, U8, UB, XE, XP, XU

The following supplemental codes CANNOT be used with this code:

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

Home Visit of a New Patient, 15-29/30-59/60-74/75-89 Min (99341-1/99342-1/99344-1/99345-1) and Home Visit of an Established Patient, 20-29/30-39/40-59/60-74 Min (99347-1/99348-1/99349-1/99350-1)

May only be used by medical LPHA (Licensed Physician, Medical Student in Clerkship, Physician Assistant, Physician Assistant Clinical Trainee, Nurse Practitioner, and Nurse Practitioner Clinical Trainee) when E/M services provided in the home of a new or established patient, with patient and/or family. Home may be defined as a private residence, temporary lodging, or short-term accommodation (e.g., hotel, campground, hostel, or cruise ship). [These codes are also used when the residence is an assisted living facility, group home \(that is not licensed as an intermediate care facility for individuals with intellectual disabilities\), custodial care facility, or residential substance abuse treatment facility. **For the residential programs, this code cannot be claimed in addition to the treatment day. It may be used if the treatment day is not claimed**](#) These codes can only be used once per day per provider per client.

For new Patients - When presenting problems are of low severity, the 15-minute service requires 3 key components: problem focused history, problem focused examination, and straightforward medical decision making. When presenting problems are of moderate severity, the 30-minute service requires 3 key components: expanded problem focused history, expanded problem focused examination, and medical decision making of low complexity. When presenting problems are of high severity, the 60-minute service requires 3 key components: comprehensive history, comprehensive examination, and medical decision making of moderate complexity. When the patient is unstable or has developed a significant new problem requiring immediate physician attention, the 75-minute service requires 3 key components: comprehensive history, comprehensive examination, and medical decision making of high complexity.

For established patients – When presenting problems are self-limited or minor, the 20-minute service requires at least 2 of 3 key components: problem focused interval history, problem focused examination, and straightforward medical decision making. When presenting problems

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are of low to moderate severity, the 30-minute service requires at least 2 of 3 key components: expanded problem focused interval history, expanded problem focused examination, and medical decision making of low complexity. When presenting problems are of moderate to high severity, the 40-minute service requires at least 2 of 3 key components: detailed interval history, detailed examination, and medical decision making of moderate complexity. When presenting problems are of moderate to high severity, patient may be unstable or may have developed a significant new problem requiring immediate physician attention, the 60-minute service requires at least 2 of 3 key components: comprehensive interval history, comprehensive examination, and medical decision making of high complexity.

Non-Overridable Lockouts

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

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

See [Appendix V](#) for a quick reference sheet on all non-overridable lockouts and overridable lockouts with appropriate modifiers

Overridable Lockouts with Appropriate Modifiers

Home Visit of a New Patient, 15-29/30-59/60-74/75-89 Min (99341-1/99342-1/99344-1/99345-1) may be used on the same day as the following services, if the appropriate modifiers are used (* = 59, XE, XP, or XU; ** = 27, 59, XE, XP, or XU):

- **Psychological Testing Evaluation, First Hour (96130-1)***
- **SUD Structured Assessment 15-30/30+/5-14 min (70899-100/70899-101/70899-102) G2011/G0396/G0397***
- **SUD Screening (70899-105) H0049***
- **SUD Brief Intervention, 15 Min (70899-117) H0050***
- **SUD Recovery Incentives, 15 Min (70899-118) H0050***
- **Home Visit of a New Patient, 30-59 Min (99342-1)** can be used with **Home Visit of a New Patient, 15-29 Min (99341-1)** with the appropriate modifiers**
- **Home Visit of a New Patient, 60-74 Min (99344-1)** can be used with **Home Visit of a New Patient, 15-29/30-59 Min (99341-1/99342-1)** with the appropriate modifiers**
- **Home Visit of a New Patient, 75-89 Min (99345-1)** can be used with **Home Visit of a New Patient, 15-29/30-59/60-74 Min (99341-1/99342-1/99344-1)** with the appropriate modifiers**

Non-Overridable Lockouts

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

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

See [Appendix V](#) for a quick reference sheet on all non-overridable lockouts and overridable lockouts with appropriate modifiers

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Overridable Lockouts with Appropriate Modifiers

Home Visit of an Established Patient, 20-29/30-39/40-59/60-74 Min (99347-1/99348-1/99349-1/99350-1) may be used on the same day as the following services, if the appropriate modifiers are used (* = 59, XE, XP, or XU; ** = 27, 59, XE, XP, or XU):

- **Psychological Testing Evaluation, First Hour (96130-1)***
- **SUD Structured Assessment 15-30/30+/5-14 min (70899-100/70899-101/70899-102) G2011/G0396/G0397***
- **SUD Screening (70899-105) H0049***
- **SUD Brief Intervention, 15 Min (70899-117) H0050***
- **SUD Recovery Incentives, 15 Min (70899-118) H0050***
- **Home Visit of an Established Patient, 30-39 Min (99348-1)** can be used with **Home Visit of an Established Patient, 20-29Min (99347-1)** with the appropriate modifiers**
- **Home Visit of an Established Patient, 40-59 Min (99349-1)** can be used with **Home Visit of an Established Patient, 20-29/30-39 Min (99347-1/99348-1)** with the appropriate modifiers**
- **Home Visit of an Established Patient, 60-74 Min (99350-1)** can be used with **Home Visit of an Established Patient, 20-29/30-39/40-59 Min (99347-1/99348-1/99349-1)** with the appropriate modifiers**

Allowable modifiers for these code series (for both New and Established Patient):

- 27, 59, GC, HD, HL, HP, U7, U8, UB, XE, XP, XU, 93, 95

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

These codes require a Medicare COB.

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

Prolonged Outpatient Evaluation and Management Service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (99417-1)

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

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

For example, if 110 minutes of a home visit evaluation and management service (99345) was provided: 110 minutes – 89 minutes (upper bound of the range for 99345-1) = 21 minutes. 21

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minutes / 15 minutes (99417) = 1.4 rounded down is 1 unit of 99417. The claim would be for one unit of 99345-1 and one unit of 99417.

See also [Appendix IV](#) for a reference tool on the prolonged codes.

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

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

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

Allowable [modifiers](#) for this code:

- **HD, U7, U8, UB, 27, 59, XE, XP, XU, HP, 93, 95**

The following supplemental codes CANNOT be used with this code:

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

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

Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Physician, Patient and/or Family not Present, 30 Min+ (99367-1)

May only be used by a Licensed Physician or Medical Student in Clerkship and is the equivalent to the Physician Consultation that was previously available. This code can only be used once per day per provider per client.

Physician consultations must be face-to-face and involve, at minimum, three (3) qualified LPHA from different specialties or disciplines (each of whom provide direct care to the client).

Consultations can be with providers within the same agency or outside the agency so long as the consulting parties are certified DMC-ODS providers. It is permissible for qualified Health Care Professional of the same discipline to be involved, as long as their treatment specialty or role in the client's treatment is distinct. For example, in a consultation between 3 MDs, each of the MDs must play a distinct and separate role in the client's treatment (e.g., psychiatry, primary care physician, endocrinologist). Documentation must make clear who each of the providers involved in the consultation were as well as each provider's distinct role in the client's care. The consultation is intended to involve development, revision, coordination, and implementation of health care services needed by the client.

Minimum number of service minutes required to use this code is 30 minutes.

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Only the rendering provider connected to the client being consulted about may claim for the service.

Overridable Lockouts with Appropriate Modifiers

This code may be used on the same day as the following services, if the appropriate modifiers are used (59, XE, XP, or XU):

- **SUD Screening (70899-105) H0049**
- **SUD Brief Intervention, 15 Min (70899-117) H0050**
- **SUD Recovery Incentives, 15 Min (70899-118) H0050**

See [Appendix V](#) for a quick reference sheet on all non-overridable lockouts and overridable lockouts with appropriate modifiers

Allowable [modifiers](#) for this code:

- 27, 59, 93, 95, HD, HG, U1, U2, U3, U7, U8, U9, UA, UB, XE, XP, XU

The following supplemental codes CANNOT be used with this code:

- **Sign Language or Oral Interpretation Services, 15 Min (70899-132) T1013**
- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 30 Min (96170-1)**
- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)**

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

Transitional Care Management Services: Communication (direct contact, telephone, electronic) within 14 calendar days, 54 Min (99495-1)

May only be used by a Licensed Physician, Medical Student in Clerkship, Physician Assistant, Physician Assistant Clinical Trainee, Nurse Practitioner, and Nurse Practitioner Clinical Trainee. It is to be used for a new or established patient whose medical and/or psychosocial problems require moderate or high complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient's community setting (home, domiciliary, rest home or assisted living). Transitional Care Management commences upon the date of discharge and continues for the next 29 days.

Services may be provided in-person, via telehealth, or telephone (use the appropriate modifier). Comprised of one face-to-face visit within the specified time frames, in combination with non-face-to-face services that may be performed by the physician or other qualified health care professional and/or licensed clinical staff under his/her direction. **This code can only be used once per day per provider per client.**

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Non-face-to-face services provided by clinical staff, under the direction of the physician or other qualified health care professional may include: communication regarding aspects of care (with patient, family members, guardians/caretakers, surrogate decision makers, and/or other professionals), communication with home health agencies and other community services utilized by the patient, patient and/or family/caretaker education to support self-management, independent living, and activities of daily living, assessment and support for treatment.

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

Overridable Lockouts with Appropriate Modifiers

This code may be used on the same with the following services, if the appropriate modifiers are used (* = 59, XE, XP, or XU; ** = 27, 59, XE, XP, or XU):

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

See [Appendix V](#) for a quick reference sheet on all non-overridable lockouts and overridable lockouts with appropriate modifiers

Allowable [modifiers](#) for this code:

- 27, 59, 93, 95, GC, HD, HG, HL, HP, U1, U2, U3, U7, U8, U9, UA, UB, XE, XP, XU

The following supplemental codes CANNOT be used with this code:

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

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

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

This code requires a Medicare COB.

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

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

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The minimum number of service minutes required to use this code is 38 minutes (the midpoint).
This code can only be used once per day per provider per client.

Overridable Lockouts with Appropriate Modifiers

This code may be used on the same day with the following services, if the appropriate modifiers are used (* = 59, XE, XP, or XU; ** = 27, 59, XE, XP, or XU):

- **Telephone Assessment and Management Service, 5-10/11-20/21-30 Min (98966-1/98967-1/98968-1)***
- **Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Physician, Patient and/or Family not Present, 30 Min+ (99367-1)****
- **Medical Team Conference by Non-MD, Patient/Family not Present, 30 Min+ (99368-1)****
- **Transitional Care Management Services: Communication (direct contact, telephone, electronic) within 14 calendar days, 54 Min (99495-1)****

See [Appendix V](#) for a quick reference sheet on all non-overridable lockouts and overridable lockouts with appropriate modifiers

Allowable [modifiers](#) for this code:

- 27, 59, 93, 95, GC, HD, HG, HL, HP, U1, U2, U3, U7, U8, U9, UA, UB, XE, XP, XU

The following supplemental codes CANNOT be used with this code:

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

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

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

This code requires a Medicare COB.

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

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

May only be provided by a Licensed Physician or Medical Student in Clerkship and may include a written report to the patient's treating/requesting physician or other qualified health care

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professional; 5 minutes or more of medical consultative time. This can only be used once per day per provider per client. This code should not be reported more than once within a seven-day interval. The consultant should not have seen the client in a face-to-face encounter within the last 14 days. If the telephone/Internet/electronic health record consultation service leads to a transfer or care of other face-to-face service within the next 14 days, this code should not be reported. Review of pertinent medical records, laboratory studies, imaging studies, medication profile, pathology specimens, etc. is included in the telephone/Internet/electronic health record consultation service and should not be reported separately. The majority of the service reported (greater than 50%) must be devoted to the medical consultative verbal or Internet discussion. The service time is based on total review and interprofessional-communication time. The written or verbal request for telephone/Internet/electronic health record advice by the treating/requesting physician or other qualified health care professional should be documented in the patient's medical record, including the reason for the request. Use the appropriate modifier for telephone or telehealth service.

Non-Overridable Lockouts

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

- **Office Outpatient Visit of New Patient, 15-29/30-44/45-59/60-74 Min (99202-1/99203-1/99204-1/99205-1)**
- **Office Outpatient Visit of an Established Patient, 10-19/20-29/30-39/40-54 Min (99212-1/99213-1/99214-1/99215-1)**
- **Home Visit of a New Patient, 15-29/30-59/60-74/75-89 Min (99341-1/99342-1/99344-1/99345-1)**
- **Home Visit of an Established Patient, 20-29/30-39/40-59/60-74 Min (99347-1/99348-1/99349-1/99350-1)**
- **Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office of outpatient setting, direct patient contact with physician supervision, first hour (99415-1)**
- **Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; each additional 30 minutes (99416-1)**

See [Appendix V](#) for a quick reference sheet on all non-overridable lockouts and overridable lockouts with appropriate modifiers

Allowable [modifiers](#) for this code:

- 27, 59, 93, 95, GC, HD, HL, U7, U8, U9, UB, XE, XP, XU

The following supplemental codes CANNOT be used with this code:

- **Sign Language or Oral Interpretation Services, 15 Min (70899-132) T1013**
- **Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 30 Min (96170-1)**

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

These codes require a Medicare COB.

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

Residential Treatment Services

There are no changes to the residential day rate services. In addition to the treatment day, MAT, care coordination, and recovery services may be claimed. Please note that, as was the case previously, Residential 3.3 and Perinatal services codes are only permitted to be used by programs that have been designated by the State. **To receive the residential day rate, at least one of the following service components must be provided: assessment, counseling (individual/group), family therapy, medication service, patient education, or SUD crisis intervention service.** There must be supporting documentation in the clinical record to justify the billing of the treatment day.

Residential Treatment Services Codes:

Charge Description	CPT/HCPCS Code	CDM Code	Non-Billable Code
Residential 3.1	H0019	90899-638	90899-639
Residential 3.3	H0019	90899-844	90899-845
Residential 3.5	H0019	90899-674	90899-675

The treatment day is claimed under the residential program (as the daily rate reflects all clinical services provided by a variety of staff) and not one specific, rendering provider. Therefore, it does not matter whether the “assigned clinician” in IRIS for the treatment day claim entry is a non-LPHA or LPHA.

24-Hour Service & Outpatient Lockout:

No outpatient services may be claimed with a residential service except on the days of admission or discharge. For example, the residential treatment day may be claimed (provided that at least one qualifying service was rendered) on the same day as an outpatient intake/assessment service **ONLY IF** it is the client’s date of discharge from the residential level of care.

The only exceptions to billing services on the same day as a residential treatment day are Care Coordination, Peer Support Specialist Services, Recovery Services, and MAT.

MAT Services at Residential

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

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Care Coordination at Residential

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

Recovery Services at Residential

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

Unbundled Services

If a treatment day is not being claimed, services may be claimed separately so long as there is appropriate documentation to support the provision of the service. Please see the sections above for information on billing per service. However, it is expected that services are predominantly claimed by the treatment day at the residential levels of care. In order to claim a treatment day, there must be at least one qualifying service that is provided. A qualifying service is an assessment, counseling (individual or group), family therapy, medication service, patient education, or SUD crisis intervention service. There must be documentation of the provision of the qualifying service(s) on file to justify the claim.

Withdrawal Management Services

There are no changes to the withdrawal management day rate services. In addition to the treatment day, MAT, care coordination, and recovery services may be claimed. To claim a treatment day at the withdrawal management level of care, including on the date of discharge, there must be at least one qualifying service that is provided. A qualifying service is assessment, counseling (individual or group), family therapy, patient education, or SUD crisis intervention service. There must be documentation of the provision of the qualifying service(s) on file to justify the claim.

WM 3.2 Service Codes:

Charge Description	CPT/HCPCS Code	CDM Code	Non-Billable Code
WM Residential Withdrawal Mgmt 3.2	H0012	90899-779	90899-780

The treatment day is claimed under the withdrawal management program (as the daily rate reflects all clinical services provided by a variety of staff) and not one specific, rendering provider. Therefore, it does not matter whether the “assigned clinician” in IRIS for the treatment day claim entry is a non-LPHA or LPHA.

24-Hour Service & Outpatient Lockout:

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No outpatient services may be claimed with a withdrawal management service except on the days of admission or discharge. For example, the withdrawal management treatment day may be claimed (provided that at least one qualifying service was rendered) on the same day as an outpatient intake/assessment service ONLY IF it is the client's date of discharge from the withdrawal management level of care.

The only exceptions to billing services on the same day as a withdrawal management treatment day are Care Coordination, Peer Support Specialist Services, Recovery Services, MAT, and Methadone dosing.

MAT Services at Withdrawal Management

At this time, the State allows for the use of two codes, Medication Training and Support-Individual per 15 Min (70899-110) H0034 and Oral Medication Admin, Direct Observation, 15 Min (70899-109) H0033 for MAT services at the withdrawal management levels of care. The Withdrawal Management treatment day can only be claimed with Oral Medication Admin, Direct Observation, 15 Min (70899-109) H0033 if there is a National Drug Code (NDC) on the claim. DHCS' NDC List can be accessed on the [MedCCC website](#). For further information on the specific use of these codes, please refer to the MAT Documentation Manual.

Medication Services vs. MAT services at Withdrawal Management:

Medication services are part of the daily bundle of services to be provided at the withdrawal management levels of care. Therefore, it is important to distinguish between medication services and MAT services. Services for prescribing, ordering, administering, and monitoring medications for the purposes of stabilizing the client physically to address the client's withdrawals, would be part of the withdrawal management day rate and not separately billable as a MAT service. If the physician deems that additional or other medications for addiction are necessary, this could be considered a separate MAT service and billed as such. Additionally, if the physician is going to address the client's mental health as it relates to the client's SUD through medication management, this would not be a MAT service and cannot be claimed separately. A client already receiving MAT services, whose physician determines the need to address concurrently the mental health component with medication can fold this in as part of the MAT services provided.

Care Coordination at Withdrawal Management

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

Recovery Services at Withdrawal Management

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

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

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

Charge Description	CPT/HCPCS Code	CDM Code	Non-Billable Code
Psych Diagnostic Eval w/ Med Svcs, 60 Min*	90792	90792-1	70899-300
Psychiatric Diagnostic Eval w/ Med Services, 68+ Min*	T2024	90792-7	70899-300
SUD Assessment*	H0001	70899-103	70899-300
SUD Screening*	H0049	70899-105	70899-300
SUD Structured Assmt, 15-30 Min*	G0396	70899-100	70899-300
SUD Structured Assmt, 30+ Min*	G0397	70899-101	70899-300
SUD Structured Assmt, 5-14 Min*	G2011	70899-102	70899-300
Targeted Case Management, Each 15 Min	T1017	70899-120	70899-304
Environmental Intervention for Med Management Purposes	90882	90882-1	70899-304
Preparation of Report of Pt's Psych Status	90889	90889-1	70899-304
Admin of Pt-Focused Health Risk Assmt Instrument	96160	96160-1	70899-304
Prenatal Care, At Risk Assmt	H1000	70899-119	70899-304
Med Team Conf by MD, Pt/Fam not Present, 30 Min+	99367	99367-1	70899-304
Med Team Conf by Non-MD, Pt/Fam not Present, 30 Min+	99368	99368-1	70899-304
Inter-Prof Phone/EHR Assmt-Consult. MD 5-30 Min	99451	99451-1	70899-304
SUD Individual Counseling, 15 Min	H0004	70899-130	70899-309
SUD Group Counseling	H0005	70899-131	70899-310
OTP/NTP Methadone Dosing	H0020	90899-632	90899-633
OTP/NTP Courtesy Methadone Dosing	H0020	90899-786	90899-787
OTP/NTP MAT Antabuse Administration	S5001	90899-719	90899-720
OTP/NTP MAT Narcan (2-pack Nasal Spray)	S5001	90899-722	90899-723
OTP/NTP MAT Suboxone Administration	S5001	90899-728	90899-729
OTP/NTP MAT Subutex Administration	S5001	90899-731	90899-732
OTP/NTP MAT Courtesy Subutex Administration	S5001	90899-838	90899-839
OTP/NTP MAT Suboxone (Film) Administration	S5001	90899-862	90899-863
OTP/NTP MAT Sublocade Injectable Administration	S5001	90899-865	90899-866

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OTP/NTP MAT Vivitrol Injectable Administration	S5001	90899-868	90899-869
OTP/NTP MAT Disulfiram Administration	S5000	90899-635	90899-636
OTP/NTP MAT Buprenorphine (oral) Administration	S5000	90899-734	90899-735
OTP/NTP MAT Courtesy Buprenorphine (oral) Administration	S5000	90899-841	90899-842
OTP/NTP MAT Buprenorphine w/ Naloxone (oral) Administration	S5000	90899-737	90899-738
OTP/NTP MAT Naloxone (2-pack Nasal Spray)	S5000	90899-743	90899-744
OTP/NTP MAT Buprenorphine w/ Naloxone (Film) Administration	S5000	90899-871	90899-872
OTP/NTP MAT Buprenorphine Injectable Administration	S5000	90899-874	90899-875
OTP/NTP MAT Naltrexone Injectable Administration	S5000	90899-877	90899-878

Drug Lockouts:

- Buprenorphine is locked out against Vivitrol, Methadone, Buprenorphine-Naloxone: Sublingual Film, Buprenorphine Combo.
- Naloxone is locked out against Naloxone-Generic
- Vivitrol is locked out against Buprenorphine, Methadone
- Methadone is locked out against Buprenorphine, Vivitrol, Buprenorphine-Naloxone: Sublingual Film, Buprenorphine Combo
- Buprenorphine-Naloxone: Sublingual Film is locked out against Buprenorphine, Vivitrol, Methadone, Buprenorphine Combo
- Buprenorphine Combo is locked out against Buprenorphine, Vivitrol, Methadone, Buprenorphine-Naloxone: Sublingual Film
- Naloxone-Generic is locked out against Naloxone

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

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

The **Psychiatric Diagnostic Evaluation with Medical Services, 60 Min (90792-1)** may only be used by a Licensed Physician, Medical Student in Clerkship, Physician Assistant, Physician Assistant Clinical Trainee, Nurse Practitioner, and Nurse Practitioner Clinical Trainee for conducting the Physical Exam at the time of a patient's admission to the NTP. This may be face-to-face or non-face-to-face time. **However, note that the Physical Exam must be conducted in-person.** This code is restricted to using only one time per day per provider per client. The minimum number of service minutes required to claim this code is 31 minutes (the midpoint). The **Psychiatric Diagnostic Eval w/ Med Services, 68+ Min (90792-7) T2024** code can be used

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when the duration is 68 minutes or more if a dosing service was provided on that day. If the LPHA write up or narrative documentation that is required is also completed on the same day by the same LPHA, this code may capture both activities. The Physical Exam at the time of a patient's admission is only separately billable when there is no dosing on the same day.

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

Individual Counseling Services at NTP

The **SUD Individual Counseling, 15 Min (70899-130)** code, may be used to claim for the required 45-minute individual sessions/services. **This code may be claimed on the same day as a dosing service**. For further information on individual counseling, see the Individual Counseling section above.

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

- **SUD Crisis Intervention (outPt) (70899-107) H0007**
- **Psychoeducational Svc, per 15 Min (70899-115) H2027**
- **SUD Family Counseling (70899-116) T1006**
- **SUD Brief Intervention, 15 Min (70899-117) H0050**
- **SUD Treatment Plan Development and Modification (70899-125) T1007**

Group Counseling Services at NTP

The **SUD Group Counseling (70899-131) H0005** code, which may be used by non-LPHA and LPHA to claim for group sessions/services. **This code may be claimed on the same day as a dosing service**. For further information on groups, see the Group Counseling section above.

Care Coordination Services at NTP

The following care coordination services are permitted at the NTP:

- **Targeted Case Management, Each 15 Min (70899-120) T1017**
- **Environmental Intervention for Medical Management Purposes (90882-1)**
- **Preparation of Report of Patient's Psychiatric Status (90889-1)**
- **Administration of Patient-Focused Health Risk Assessment Instrument (96160-1)**
- **Inter-Professional Telephone/Internet/Electronic Health Record Assessment Provided by a Consultative Physician, 5-30 Min (99451-1)**
- **Clinician consultation or the Medical Team Conference by non-MD, Patient/Family not present, 30 Min+ (99368-1)**
- **Physician consultation or Medical Team Conference by MD, Patient/Family not present, 30 Min+ (99367-1)**

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

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Natural Helper Services Codes

For services provided by or through Indian Health Service or tribal facilities only. Natural Helper services may assist with navigational support, psychosocial skill building, self-management, and trauma support to individuals aimed at restoring the health of American Indian/Alaska Native individuals as well as Non-American Indian/Alaska Native individuals. A Natural Helper is a health advisor contracted or employed by the Indian Health Care Provider (IHCP) who deliver health, recovery, and social support in the context of Tribal cultures and may be spiritual leaders, elected officials, paraprofessionals and others who are trusted members of his/her/their Native American Tribe, Nation, Band, or Rancheria.

Natural Helper Code:

Charge Description	CPT/HCPCS Code	CDM Code	Non-Billable Code
Natural Helper services	T1016	TBD	TBD

Service may be provided in-person, via telehealth, or telephone (use the appropriate modifier). This code is claimed by encounter, not minutes of service. One unit is claimed for one natural helper encounter.

Allowable modifiers for this code:

- UA, HG, HQ, U1, U2, U3, U7, U8, U9, UB, SC

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

Traditional Health Care Practices Codes

For services provided by or through Indian Health Service or tribal facilities only. Traditional Healer services may use a variety of interventions such as music therapy (e.g., traditional music and songs, dancing, drumming, etc.), spirituality (e.g., ceremonies, rituals, herbal remedies, etc.), and other integrative approaches to American Indian/Alaska Native individuals as well as Non-American Indian/Alaska Native individuals.

A Traditional Healer is an individual currently recognized as a spiritual leader and in good standing with his/her/their Native American Tribe, Nation, Band, or Rancheria, and has two years of experience as a recognized Native American spiritual leader practicing in a setting recognized by his/her/their Native American Tribe, Nation, Band or Rancheria who is contracted or employed by the Indian Health Care Provider (IHCP). Traditional Healers have knowledge, skills and practices based on the theories, beliefs, and experiences which are accepted by that Indian community as handed down through the generations and which can be established through the collective knowledge of that Indian community.

Natural Helper Code:

Charge Description	CPT/HCPCS Code	CDM Code	Non-Billable Code
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Traditional Healer services	H0051	TBD	TBD
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Service may be provided in-person, via telehealth, or telephone (use the appropriate modifier). This code is claimed by encounter, not minutes of service. One unit is claimed for one traditional healer encounter.

Allowable modifiers for this code:

- UA, HG, HQ, U1, U2, U3, U7, U8, U9, UB, SC

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

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Appendix I: Perinatal Codes

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

Perinatal Assessment Codes:

Charge Description	CPT/HCPCS Code	CDM Code	Non-Billable Code
Peri Psych Diagnostic Eval, 60 min	90791	90791-2	70899-300
Peri Psych Diagnostic Eval, 68+ Min	T2024	90792-8	70899-300
Peri Psych Eval of Hospital Record, 60 Min	90885	90885-2	70899-300
Peri Psych Eval of Hospital Record, 68+ Min	T2024	90885-8	70899-300
Peri Psychological Testing Eval, First Hour	96130	96130-2	70899-300
Peri Psychological Testing Eval, Each Add'l Hour	96131	96131-2	70899-300
Peri Telephone Assmt and Mgmt Service, 5-10 Min	98966	98966-2	70899-300
Peri Telephone Assmt and Mgmt Service, 11-20 Min	98967	98967-2	70899-300
Peri Telephone Assmt and Mgmt Service, 21-30 Min	98968	98968-2	70899-300
Peri SUD Structured Assmt, 15-30 Min	G0396	70899-200	70899-300
Peri SUD Structured Assmt, 30+ Min	G0397	70899-201	70899-300
Peri SUD Structured Assmt, 5-14 Min	G2011	70899-202	70899-300
Peri SUD Assmt	H0001	70899-203	70899-300
Peri SUD Screening	H0049	70899-205	70899-300
Peri SUD Drug Testing POC Tests	H0048	70899-204	70899-300
Peri Prenatal Care, At Risk Assmt	H1000	70899-219	70899-304

Perinatal Individual Counseling Codes:

Charge Description	CPT/HCPCS Code	CDM Code	Non-Billable Code
Peri Skills Training and Dev, Indv, per 15 Min	H2014	70899-213	70899-309
Peri Psychoeducational Svc, per 15 Min	H2027	70899-215	70899-309
Peri SUD Family Counseling	T1006	70899-216	70899-309
Peri SUD Brief Intervention, 15 Min	H0050	70899-217	70899-309
Peri Family Psychotherapy (w/o Pt Present), 50 Min	90846	90846-2	70899-307
Peri Family Psychotherapy (w/o Pt Present), 58+ Min	T2021	90846-8	70899-307
Peri Family Psychotherapy (w/ Pt Present), 50 Min	90847	90847-2	70899-307

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Peri Family Psychotherapy (w/ Pt Present), 58+ Min	T2021	90847-8	70899-307
Peri Multiple-Family Group Psychotherapy, 84 Min	90849	90849-2	70899-307
Peri Multiple-Family Group Psychotherapy, 92+ Min	T2021	90849-8	70899-307
Peri SUD Individual Counseling, 15 Min	H0004	70899-230	70899-309
Peri SUD Treatment Plan Dev/Mod	T1007	70899-225	70899-306

Perinatal Crisis Service Codes:

Charge Description	CPT/HCPCS Code	CDM Code	Non-Billable Code
Peri Mobile Crisis Intervention Svcs	H2011	70899-208	70899-301
Peri SUD Crisis Intervention (outPt)	H0007	70899-207	70899-301

Perinatal Group Counseling Codes:

Charge Description	CPT/HCPCS Code	CDM Code	Non-Billable Code
Peri Skills training and dev, Group, per 15 Min	H2014	70899-214	70899-310
Peri SUD Group Counseling	H0005	70899-231	70899-310

Perinatal Care Coordination Codes:

Charge Description	CPT/HCPCS Code	CDM Code	Non-Billable Code
Peri Environmental Intervention for Med Mgmt Purposes	90882	90882-2	70899-304
Peri Preparation of Report of Pt's Psych Status	90889	90889-2	70899-304
Peri Admin of Pt-Focused Health Risk Assmt Instrument	96160	96160-2	70899-304
Peri Med Team Conf by Non-MD, Pt/Fam not Present, 30 Min+	99368	99368-2	70899-304
Peri Targeted Case Management, Each 15 Min	T1017	70899-220	70899-304

Perinatal Recovery Services Codes:

Charge Description	CPT/HCPCS Code	CDM Code	Non-Billable Code
Peri Community Support Svcs, per 15 Min	H2015	70899-221	70899-305
Peri Psychosocial Rehabilitation, Indv, per 15 Min	H2017	70899-222	70899-305
Peri Psychosocial Rehabilitation, Group, per 15 Min	H2017	70899-223	70899-305

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Peri Recovery Svcs, 1 Hr	H2035	70899-224	70899-305
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Perinatal Peer Support Specialist Services Codes:

Charge Description	CPT/HCPCS Code	CDM Code	Non-Billable Code
Peri Behavioral Health Prevention Education, Group	H0025	70899-228	70899-308
Peri Self-Help/Peer Svcs, Individual, per 15 Min	H0038	70899-229	70899-308

Perinatal Contingency Management Services Codes:

Charge Description	CPT/HCPCS Code	CDM Code	Non-Billable Code
Peri SUD Recovery Incentives, 15 Min	H0050	70899-218	70899-309

Perinatal Medication Services Codes:

Charge Description	CPT/HCPCS Code	CDM Code	Non-Billable Code
Peri Oral Medication Admin, Direct Observation, 15 Min	H0033	70899-209	70899-302
Peri Medication Training and Support-Indv per 15 Min	H0034	70899-210	70899-302
Peri Medication Training and Support-Group per 15 Min	H0034	70899-211	70899-302
Peri Office OutPt Visit of New Pt, 15-29 Min	99202	99202-2	70899-302
Peri Office OutPt Visit of a New Pt, 30- 44 Min	99203	99203-2	70899-302
Peri Office OutPt Visit of a New Pt, 45- 59 Min	99204	99204-2	70899-302
Peri Office OutPt Visit of a New Pt, 60- 74 Min	99205	99205-2	70899-302
Peri Office OutPt Visit of an Established Pt, 10-19 Min	99212	99212-2	70899-302
Peri Office OutPt Visit of an Established Pt, 20-29 Min	99213	99213-2	70899-302
Peri Office OutPt Visit of an Established Pt, 30-39 Min	99214	99214-2	70899-302
Peri Office OutPt Visit of an Established Pt, 40-54 Min	99215	99215-2	70899-302
Peri Prolonged Clinical Staff Service, first hour	99415	99415-2	70899-302

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Peri Prolonged Clinical Staff Service, additional 30 min	99416	99416-2	70899-302
Peri Home Visit of a New Pt, 15-29 Min	99341	99341-2	70899-302
Peri Home Visit of a New Pt, 30-59 Min	99342	99342-2	70899-302
Peri Home Visit of a New Pt, 60-74 Min	99344	99344-2	70899-302
Peri Home Visit of a New Pt, 75-89 Min	99345	99345-2	70899-302
Peri Home Visit of an Established Pt, 20-29 Min	99347	99347-2	70899-302
Peri Home Visit of an Established Pt, 30-39 Min	99348	99348-2	70899-302
Peri Home Visit of an Established Pt, 40-59 Min	99349	99349-2	70899-302
Peri Home Visit of an Established Pt, 60-74 Min	99350	99350-2	70899-302
Peri Prolonged Outpatient E&M, each 15 min	99417	99417-2	70899-302
Peri Med Team Conf by MD, Pt/Fam not Present, 30 Min+	99367	99367-2	70899-304
Peri Transitional Care Mgmt Svcs: Comm. w/in 14 days	99495	99495-2	70899-304
Peri Transitional Care Mgmt Svcs: Comm. w/in 7 days	99496	99496-2	70899-304
Peri Inter-Prof Phone/EHR Assmt-Consult. MD 5-30 Min	99451	99451-2	70899-304

Perinatal Supplemental Codes:

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

Perinatal Residential Treatment Services Codes:

Charge Description	CPT/HCPCS Code	CDM Code	Non-Billable Code
Residential 3.1 Peri	H0019	90899-656	90899-657
Residential 3.3 Peri	H0019	90899-888	90899-889
Residential 3.5 Peri	H0019	90899-692	90899-693

Perinatal WM 3.2 Service Codes:

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Charge Description	CPT/HCPCS Code	CDM Code	Non-Billable Code
WM Residential Withdrawal Mgmt 3.2 Peri	H0012	90899-779	90899-780

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

Charge Description	CPT/HCPCS Code	CDM Code	Non-Billable Code
Peri Psych Diagnostic Eval w/ Med Svcs, 60 Min*	90792	90792-2	70899-300
Peri SUD Assessment*	H0001	70899-203	70899-300
Peri SUD Screening*	H0049	70899-205	70899-300
Peri SUD Structured Assmt, 15-30 Min*	G0396	70899-200	70899-300
Peri SUD Structured Assmt, 30+ Min*	G0397	70899-201	70899-300
Peri SUD Structured Assmt, 5-14 Min*	G2011	70899-202	70899-300
Peri Targeted Case Management, Each 15 Min	T1017	70899-220	70899-304
Peri Environmental Intervention for Med Mgmt Purposes	90882	90882-2	70899-304
Peri Preparation of Report of Pt's Psych Status	90889	90889-2	70899-304
Peri Admin of Pt-Focused Health Risk Assmt Instrument	96160	96160-2	70899-304
Peri Prenatal Care, At Risk Assmt	H1000	70899-219	70899-304
Peri Med Team Conf by MD, Pt/Fam not Present, 30 Min+	99367	99367-2	70899-304
Peri Med Team Conf by Non-MD, Pt/Fam not Present, 30 Min+	99368	99368-2	70899-304
Peri Inter-Prof Phone/EHR Assmt-Consult. MD 5-30 Min	99451	99451-2	70899-304
Peri SUD Individual Counseling, 15 Min	H0004	70899-230	70899-309
Peri SUD Group Counseling	H0005	70899-231	70899-310
OTP/NTP Peri Methadone Dosing	H0020	90899-804	90899-805
OTP/NTP Peri Courtesy Methadone Dosing	H0020	90899-808	90899-809
OTP/NTP Peri MAT Antabuse Administration	S5001	90899-811	90899-812
OTP/NTP Peri MAT Narcan (2-pack Nasal Spray)	S5001	90899-814	90899-815
OTP/NTP Peri MAT Suboxone Administration	S5001	90899-817	90899-818
OTP/NTP Peri MAT Subutex Administration	S5001	90899-820	90899-821
OTP/NTP Peri MAT Suboxone (Film) Administration	S5001	90899-880	90899-881
OTP/NTP Peri MAT Disulfiram Administration	S5000	90899-823	90899-824
OTP/NTP Peri MAT Buprenorphine (oral) Administration	S5000	90899-826	90899-827

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OTP/NTP Peri MAT Buprenorphine w/ Naloxone (oral) Administration	S5000	90899-829	90899-830
OTP/NTP Peri MAT Naloxone (2-pack Nasal Spray)	S5000	90899-832	90899-833
OTP/NTP Peri MAT Buprenorphine w/ Naloxone (Film) Administration	S5000	90899-883	90899-884
OTP/NTP Peri MAT Sublocade Injectable Administration	S5001	90899-890	90899-891
OTP/NTP Peri MAT Vivitrol Injectable Administration	S5001	90899-892	90899-893
OTP/NTP Peri MAT Buprenorphine Injectable Administration	S5000	90899-894	90899-895
OTP/NTP Peri MAT Naltrexone Injectable Administration	S5000	90899-896	90899-897

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Appendix II: Modifiers

A modifier gets added to a service billing code to essentially describe aspects of that specific service. More precisely, it is a way to report that the service was modified in some way without changing the integrity of service according to the code definition. Modifiers can impact how a service should be billed or who can bill. In some cases, if the appropriate modifier is not attached, this can cause a service to be denied. For example, there are modifiers that must be used when specific combinations of service codes are used on the same day (such as in the case of an overridable lockout). No more than four (4) modifiers can be used with a service billing code.

Ultimately, it is the responsibility of the rendering service provider to ensure that the applicable modifier is attached to the claim, based on the service provided and supporting documentation.

Modifier	Definition	When to Use
27	<p>Multiple Outpatient Hospital Evaluation and Management (E/M) Encounters on the Same Date: For hospital outpatient reporting purposes, utilization of hospital resources related to separate and distinct E/M encounters performed in multiple outpatient hospital settings on the same date may be reported by adding modifier 27 to each appropriate level of outpatient and/or emergency department E/M code(s). This modifier provides a means of reporting circumstances involving evaluation and management services provided by physician(s) in more than one (multiple) outpatient hospital setting(s) (e.g., hospital emergency department, clinic).</p>	<p>Use this modifier, as appropriate, to override those lockout codes that can be overridden with a modifier. The lockout codes that can be overridden are listed in Column K, "Outpatient Overridable Lockouts with Appropriate Modifiers" and have ** next to them in the Service Table. This modifier needs to be used even if the over-ridable lockout combinations were provided by that same provider to the same beneficiary in different settings because SDMC compares the service code billed only to previously approved service codes on the submitted claim and in the beneficiary's history. If two service codes cannot be billed together, whichever code is processed second will be denied.</p>
59	<p>Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive</p>	<p>Use this modifier, as appropriate, to override those lockout codes that can be overridden with a modifier. The codes that can be overridden have * or ** next to them.</p>

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	modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.	
93	<p>Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunication System: Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located away at a distant site from the physician or other qualified professional. The totality of the communication of information exchanged between the physician or other qualified health care professional during the course of the synchronous telemedicine service must be of an amount and nature that is sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction.</p>	Use this modifier when a health care professional is providing services and benefits via telephone. If using this modifier, indicate that the service was provided in Place of Service 02 or 10.
95	<p>Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunication System. Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction.</p>	Use this modifier when a health care professional is providing services and benefits via telehealth. If using this modifier, indicate that the service was provided in Place of Service 02 or 10.
AH	Clinical psychologist	Use this modifier when the service was provided by a Clinical Trainee (taxonomy code 3902) who is studying to become a psychologist.
AJ	Clinical social worker	Use this modifier when the service was provided by a Clinical Trainee (taxonomy code 3902) who is studying to become an LCSW, MFT, or LPCC.

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GC	This service has been performed in part by a resident under the direction of a teaching physician.	For services that require Medicare COB and are performed by physician residents, use this modifier to bypass the Medicare COB requirement. Medicare does not reimburse for services rendered by residents. For claims that do not require Medicare COB and are performed by residents, use of the GC 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 physician's NPI would be reported with modifier GC after the service to indicate that the service was performed by a resident. If the service was performed by a pre-licensed professional who is not a resident, use the HL modifier.
HD	Pregnant/ Parenting women's program	All claims must have an HD modifier when service is provided to a woman who is pregnant/postpartum.
HF	Identifies when Contingency Management Services was provided as part of a Substance Use Disorder Program	Use this modifier to bill for SUD Recovery Incentives, 15 minutes (70899-118) H0050.
HG	Opioid treatment program (OTP)/Narcotic Treatment Program (NTP).	Daily or several times weekly opioid agonist medication and counseling available to maintain multidimensional stability for those with severe opioid use disorder. All claims must have HG (and UA) modifier when the service is provided in NTP Setting
HL	Registered professional	For services that require Medicare COB and are performed by registered professionals 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 who does not meet the requirements of Section 4121, Division F of the federal Consolidated Appropriations Act and is therefore not a Medicare-recognized provider. Medicare does not reimburse for services rendered by registered professionals or by non-Medicare recognized providers. For claims that do not require Medicare COB and are performed by registered professionals or MFTs 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

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		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.
HM	Less than bachelor's degree level	Use this modifier when the service was provided by a Clinical Trainee (taxonomy code 3902) who is studying to become a Psychiatric Technician.
HP	Doctoral level	Use this modifier when the service was provided by a Clinical Trainee (taxonomy code 3902) who is studying to become an advanced practice nurse (Nurse Practitioner or Clinical Nurse Specialist).
HQ	Group setting	Use this modifier to indicate that a service was provided in a group setting.
HW	This service is provided as a result of a State mandate and the State covers 100 percent of the nonfederal share, as the service was determined to be covered under Proposition 30.	Use this modifier to identify services that the county provided as a result of a state mandate that are subject to Proposition 30.
SC	Valid for codes when the service was provided via telephone or audio-only systems.	Modifier SC is used only with HCPCs codes and to indicate that the service was provided via telephone or audio-only. If using the SC modifier, the place of service must be 02 or 10, unless the service is mobile crisis. With HCPCS codes, if the service is in POS 02 or 10 but does not have the SC modifier, the telehealth service is video/audio.
TD	Registered Nurse	Use this modifier when the service was provided by a Clinical Trainee (taxonomy code 3902) who is studying to be a Registered Nurse
TE	Licensed Vocational Nurse	Use this modifier when the service was provided by a Clinical Trainee (taxonomy code 3902) who is studying to be a Licensed Vocational Nurse
XE	Separate encounter, a service that is distinct because it occurred during a separate encounter.	Use this modifier, as appropriate, to override those lockout codes that can be overridden with a modifier. The codes that can be overridden are listed in column K, "Outpatient Overridable Lockouts with Appropriate Modifiers" and have * or ** next to them. These modifiers need to be used even if the over-ridable lockout combinations were provided by that same provider to the same

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		beneficiary in different settings because SDMC compares the service code billed only to previously approved service codes on the submitted claim and in the beneficiary's history. If two service codes cannot be billed together, whichever code is processed second will be denied.
XP	Separate practitioner, a service that is distinct because it was performed by a separate practitioner.	Use this modifier, as appropriate, to override those lockout codes that can be overridden with a modifier. The codes that can be overridden are listed in column K, "Outpatient Overridable Lockouts with Appropriate Modifiers" and have * or ** next to them. These modifiers need to be used even if the over-ridable lockout combinations were provided by that same provider to the same beneficiary in different settings because SDMC compares the service code billed only to previously approved service codes on the submitted claim and in the beneficiary's history. If two service codes cannot be billed together, whichever code is processed second will be denied.
XU	Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service.	Use this modifier, as appropriate, to override those lockout codes that can be overridden with a modifier. The codes that can be overridden are listed in column K, "Outpatient Overridable Lockouts with Appropriate Modifiers" and have * or ** next to them. These modifiers need to be used even if the over-ridable lockout combinations were provided by that same provider to the same beneficiary in different settings because SDMC compares the service code billed only to previously approved service codes on the submitted claim and in the beneficiary's history. If two service codes cannot be billed together, whichever code is processed second will be denied.
U1	ASAM 3.1 Residential (RES)	Clinically Managed Low - Intensity Residential Services: 24-hour structure with available trained personnel; at least 5 hours of clinical service/week and prepare for outpatient treatment.
U2	ASAM 3.3 Residential (RES)	Clinically Managed Population - Specific High Intensity Residential Services: 24-hour care with trained counselors to stabilize multidimensional imminent danger. Less

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		intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community and prepare for outpatient treatment.
U3	ASAM 3.5 Residential (RES)	Clinically Managed High Intensity Residential Services: 24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full milieu or therapeutic community.
U6	Recovery Services	Recovery services that can be provided in all settings (ODF, IOT, PH, OTP/NTP, RES 3.1 & 3.3, 3.5, 3.2 WM). This modifier does not represent a “level of care”. It represents classification of service for within one of the levels of care.
U7	Outpatient Services (ODF)	Less than 9 hours of service/week (adults); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/strategies.
U8	Intensive Outpatient Services (IOT)	Nine or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability
U9	Residential Withdraw Management, ASAM 3.2	Moderate withdrawal but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery.
UA	ASAM OTP/NTP	All claims must include an UA (and an HG) modifier when service is provided in NTP setting.

For the full list of modifiers, see the State’s Service Table at [MedCCC - Library](#).

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Appendix III: Assessment & Therapy Substitute Code Reference Tool

CDM	HCPC	Code Type	Service (Brief Definition)	Billing Unit of Svc	Minimum Time to Claim 1 Unit	When to Use
90846-7	T2021	Family Therapy	Family Psychotherapy (w/o Pt Present), 58+ Min 90846-7	1 unit = 15 minutes	58 minutes	Use when a family psychotherapy service (without the client) is 58 minutes or more. If service is 26-57 minutes, use 90846-1/90846-2.
90846-8	T2021	Family Therapy	Peri Family Psychotherapy (w/o Pt Present), 58+ Min 90846-8	1=15	58	
90847-7	T2021	Family Therapy	Family Psychotherapy (w/ Pt Present), 58+ Min 90847-7	1=15	58	Use when a family psychotherapy service (with the client) is 58 minutes or more. If service is 26-57 minutes, use 90847-1/90847-2.
90847-8	T2021	Family Therapy	Peri Family Psychotherapy (w/ Pt Present), 58+ Min 90847-8	1=15	58	
90849-7	T2021	Family Therapy	Multiple-Family Group Psychotherapy, 92+ Min 90849-7	1=15	92	Use when a multi-family group psychotherapy service is 92 minutes or more. If service is 43-91 minutes, use 90849-1/90849-2.
90849-8	T2021	Family Therapy	Peri Multiple-Family Group Psychotherapy, 92+ Min 90849-8	1=15	92	
90791-7	T2024	Assessment	Psychiatric Diagnostic Evaluation, 68+ Min 90791-7	1=15	68	Use when a psychiatric diagnostic eval service is 68 minutes or more. If service is 31-67 minutes, use 90791-1/90791-2.
90791-8	T2024	Assessment	Peri Psychiatric Diagnostic Evaluation, 68+ Min 90791-8	1=15	68	
90792-7	T2024	Assessment	Psychiatric Diagnostic Eval w/Med Services, 68+ Min 90792-7	1=15	68	Use when a psychiatric diagnostic eval with medical services is 68 minutes or more. If service is 31-67 minutes, use 90792-1/90792-2.
90792-8	T2024	Assessment	Peri Psychiatric Diagnostic Eval w/Med Services, 68+ Min 90792-8	1=15	68	
90885-7	T2024	Assessment	Psych Eval of Hospital Record, 68+ Min 90885-7	1=15	68	Use when a psychiatric eval of hospital record service is 68 minutes or more. If service is 31-67 minutes, use 90885-1/90885-2.
90885-8	T2024	Assessment	Peri Psych Eval of Hospital Record, 68+ Min 90885-8	1=15	68	

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Appendix IV: Prolonged Codes Reference Tool

Codes to prolong E&M services (for MDs and Physician extenders):

- **99415** Prolonged clinical staff service; first hour
 - For the first 60 minutes beyond the highest time in the range
 - Maximum of 1 unit per day
 - To use with 99205 (60-74 min) if duration is 104 min or more or 99215 (40-45 min); use once reach 84 min
- **99416** Prolonged clinical staff service; each additional 30 min
 - For each additional 30 min after the first 60 minutes beyond the highest time in the range
 - Maximum of 44 units per day
- Office E&M with New Patients:
 - 99205 (Office E&M new patient 60-74 min) to be used for services from 60-103 min
 - 99415 (prolonged 1st hour) from 104-148 min
 - 99416 (prolonged, each additional 30 min) 149 min+
- Office E&M with Established patients:
 - 99215 (Office E&M established patient (40-54 min) to be used for services from 40-83 min
 - 99415 (prolonged 1st hour) from 84-128 min
- 99416 (prolonged, each additional 30 min) 129 min+

- **99417** Prolonged outpatient E&M; each 15 min
 - To be used with 99345, 99350 (Home E&M codes, rarely used)

Code	CDM* <input type="checkbox"/>	Non-Alpha Charge Description* <input type="checkbox"/>
99415	99415-1	Prolonged clinical staff service, First Hour
99415	99415-2	Peri Prolonged clinical staff service, First Hour
99416	99416-1	Prolonged clinical staff service; each additional 30 Min
99416	99416-2	Peri Prolonged clinical staff service; each additional 30 Min
99417	99417-1	Prolonged Outpatient Home E&M; each 15 Min
99417	99417-2	Peri Prolonged Outpatient Home E&M; each 15 Min

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Appendix V: Modifiers & Lockouts Reference Tool

ALL OUTPATIENT SERVICES ARE LOCKED OUT FROM RESIDENTIAL AND WITHDRAWAL MANAGEMENT TREATMENT DAY SERVICES EXCEPT ON THE DAYS OF ADMISSION OR DISCHARGE The only exceptions are Care Coordination, Peer Support Specialist Services, Recovery Services, MAT			
ASSESSMENT			
Service Code:	Codes Requiring Modifier 59, XE, XP, or XU to Use on the Same Day:	Codes Requiring Modifier 27, 59, XE, XP, or XU to Use on the Same Day:	Codes that CANNOT be Used on the Same Day:
Psychiatric Diagnostic Evaluation, 60 Min (90791-1)	<ul style="list-style-type: none"> • SUD Structured Assessment, 5-14/15-30/30+ Min (70899-102/70899-100/70899-101) G2011/G0396/G0397 • Multiple-Family Group Psychotherapy, 84 Min (90849-1) • Psychiatric Evaluation of Hospital Record, 60 Min (90885-1) • Interpretation of Psychiatric Results to Family, 50 Min (90887-1) • Environmental Intervention for Medical Management Purposes (90882-1) • Preparation of Report of Patient's Psychiatric Status (90889-1) • Administration of Patient-Focused Health Risk Assessment Instrument (96160-1) 	<ul style="list-style-type: none"> • Medical Team Conference by non-MD, Patient/Family not present, 30 Min+ (99368-1) • Office Outpatient Visit of New Patient, 15-29/30-44/45-59/60-74 Min (99202-1/99203-1/99204-1/99205-1) • Office Outpatient Visit of an Established Patient, 10-19/20-29/30-39/40-54 Min (99212-1/99213-1/99214-1/99215-1) • Home Visit of a New Patient, 15-29/30-59/60-74/75-89 Min (99341-1/99342-1/99344-1/99345-1) • Home Visit of an Established Patient, 20-29/30-39/40-59/60-74 Min (99347-1/99348-1/99349-1/99350-1) • Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Physician, Patient and/or Family not Present, 30 Min+ (99367-1) • Prolonged clinical staff service during an evaluation and management service in the office or outpatient setting, first hour (99415-1) • Prolonged clinical staff service during an evaluation and management service in the office or outpatient setting, each additional 30 min (99416-1) • Inter-Professional Telephone/Internet/Electronic Health Record Assessment Provided by a Consultative Physician, 5-30 Min (99451-1) • Transitional Care Management Services: Communication (direct contact, telephone, electronic) within 14 calendar days (99495-1) and Transitional Care Mgmt Services: Communication (direct contact, telephone, electronic) within 7 calendar days (99496-1) 	<ul style="list-style-type: none"> • Family Psychotherapy (w/o Pt Present), 50 Min (90846-1) • Family Psychotherapy (w/ Pt Present), 50 Min (90847-1) • Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 30 Min (96170-1) • Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)
Psychiatric Diagnostic Evaluation, 68+ Min (90791-7) T2024	N/A – Do not use modifiers 59, XE, XP, XU	N/A – Do not use modifiers 27, 59, XE, XP, XU	N/A
Psychiatric Evaluation of Hospital Record, 60 Min (90885-1)	<ul style="list-style-type: none"> • Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1) 	N/A	N/A
Psychiatric Evaluation of Hospital Record, 68+ Min (90885-7) T2024	N/A – Do not use modifiers 59, XE, XP, XU	N/A – Do not use modifiers 27, 59, XE, XP, XU	N/A
Psychological Testing Evaluation, First Hour (96130-1)	<ul style="list-style-type: none"> • Interactive Complexity (90785-1) • Administration of Patient-Focused Health Risk Assessment Instrument (96160-1) 	N/A	N/A
Psychological Testing Evaluation, Each Additional Hour (96131-1)	<ul style="list-style-type: none"> • Interactive Complexity (90785-1) • Administration of Patient-Focused Health Risk Assessment Instrument (96160-1) 	N/A	N/A
Telephone Assessment and Management Service, 5-10/11-20/21-30 Min (98966-1/98967-1/98968-1)	N/A	N/A	N/A
SUD Structured Assessment, 5-14 Min (70899-102) G2011	<ul style="list-style-type: none"> • Administration of Patient-Focused Health Risk Assessment Instrument (96160-1) 	N/A	<ul style="list-style-type: none"> • SUD Structured Assessment, 15-30 Min (70899-100) G0396 • SUD Structured Assessment, 30+ Min (70899-101) G0397
SUD Structured Assessment, 15-30 Min (70899-100) G0396	<ul style="list-style-type: none"> • Administration of Patient-Focused Health Risk Assessment Instrument (96160-1) • Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1) 	N/A	<ul style="list-style-type: none"> • SUD Structured Assessment, 5-14 Min (70899-102) G2011 • SUD Structured Assessment, 30+ Min (70899-101) G0397 • SUD Screening (70899-105) H0049 • SUD Brief Intervention, 15 Min (70899-117) H0050 • SUD Recovery Incentives, 15 Min (70899-118) H0050
SUD Structured Assessment, 30+ Min (70899-101) G0397	<ul style="list-style-type: none"> • Administration of Patient-Focused Health Risk Assessment Instrument (96160-1) 	N/A	<ul style="list-style-type: none"> • SUD Structured Assessment, 5-14 Min (70899-102) G2011 • SUD Structured Assessment, 15-30 Min (70899-100) G0396 • SUD Screening (70899-105) H0049 • SUD Brief Intervention, 15 Min (70899-117) H0050 • SUD Recovery Incentives, 15 Min (70899-118) H0050
SUD Assessment (70899-103) H0001	N/A	N/A	N/A
SUD Screening (70899-105) H0049	N/A	N/A	<ul style="list-style-type: none"> • SUD Structured Assessment, 15-30 Min (70899-100) G0396 • SUD Structured Assessment, 30+ Min (70899-101) G0397
SUD Drug Testing Point of Care Tests (70899-104) H0048	N/A	N/A	N/A
Prenatal Care, At Risk Assessment (70899-119) H1000	N/A	N/A	N/A
INDIVIDUAL COUNSELING SERVICES			

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		<ul style="list-style-type: none"> Prolonged clinical staff service during an evaluation and management service in the office or outpatient setting, first hour (99415-1) Prolonged clinical staff service during an evaluation and management service in the office or outpatient setting, each additional 30 min (99416-1) 	
Family Psychotherapy (w/o Pt Present), 58+ Min (90846-7) T2021	N/A – Do not use modifiers 59, XE, XP, XU	N/A – Do not use modifiers 59, XE, XP, XU	N/A
Family Psychotherapy (w/ Pt Present), 58+ Min (90847-7) T2021	N/A – Do not use modifiers 59, XE, XP, XU	N/A – Do not use modifiers 59, XE, XP, XU	N/A
Multiple-Family Group Psychotherapy, 84 Min (90849-1)	<ul style="list-style-type: none"> Family Psychotherapy (w/o Pt Present), 50 Min (90846-1) and Family Psychotherapy (w/ Pt Present), 50 Min (90847-1) SUD Structured Assessment, 5-14/15-30/30+ Min (70899-102/70899-100/70899-101) G2011.G0396/G0397 SUD Screening (70899-105) H0049 SUD Brief Intervention, 15 Min (70899-117) H0050 SUD Recovery Incentives, 15 Min (70899-118) H0050 Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1) 	<ul style="list-style-type: none"> Office Outpatient Visit of New Patient, 15-29/30-44/45-59/60-74 Min (99202-1/99203-1/99204-1/99205-1) Office Outpatient Visit of an Established Patient, 10-19/20-29/30-39/40-54 Min (99212-1/99213-1/99214-1/99215-1) Home Visit of a New Patient, 15-29/30-59/60-74/75-89 Min (99341-1/99342-1/99344-1/99345-1) Home Visit of an Established Patient, 20-29/30-39/40-59/60-74 Min (99347-1/99348-1/99349-1/99350-1) Prolonged clinical staff service during an evaluation and management service in the office or outpatient setting, first hour (99415-1) Prolonged clinical staff service during an evaluation and management service in the office or outpatient setting, each additional 30 min (99416-1) 	N/A
Multi-Family Group Psychotherapy, 92+ Min (90849-7) T2021	N/A – Do not use modifiers 59, XE, XP, XU	N/A – Do not use modifiers 59, XE, XP, XU	N/A
CRISIS INTERVENTION			
Service Code:	Codes Requiring Modifier 59, XE, XP, or XU to Use on the Same Day:	Codes Requiring Modifier 27, 59, XE, XP, or XU to Use on the Same Day:	Codes that CANNOT be Used on the Same Day:
SUD Crisis Intervention (outpatient) [70899-107] H0007	N/A	N/A	N/A
GROUP COUNSELING SERVICES			
Service Code:	Codes Requiring Modifier 59, XE, XP, or XU to Use on the Same Day:	Codes Requiring Modifier 27, 59, XE, XP, or XU to Use on the Same Day:	Codes that CANNOT be Used on the Same Day:
Skills Training and Development, Group, per 15 Min (70899-114) H2014	N/A	N/A	N/A
SUD Group Counseling (70899-131) H0005	N/A	N/A	N/A
CARE COORDINATION			
Service Code:	Codes Requiring Modifier 59, XE, XP, or XU to Use on the Same Day:	Codes Requiring Modifier 27, 59, XE, XP, or XU to Use on the Same Day:	Codes that CANNOT be Used on the Same Day:
Environmental Intervention for Medical Management Purposes (90882-1)	N/A	N/A	N/A
Preparation of Report of Patient's Psychiatric Status (90889-1)	N/A	N/A	N/A
Administration of Patient-Focused Health Risk Assessment Instrument (96160-1)	<ul style="list-style-type: none"> SUD Screening (70899-105) H0049 SUD Brief Intervention, 15 Min (70899-117) H0050 SUD Recovery Incentives, 15 Min (70899-118) H0050 	N/A	<ul style="list-style-type: none"> Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 30 Min (96170-1) Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)
Medical Team Conference by Non-MD, Patient/Family not Present, 30 Min+ (99638-1)	<ul style="list-style-type: none"> SUD Screening (70899-105) H0049 SUD Brief Intervention, 15 Min (70899-117) H0050 SUD Recovery Incentives, 15 Min (70899-118) H0050 	<ul style="list-style-type: none"> Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Physician, Patient and/or Family not Present, 30 Min+ (99367-1) 	N/A
Targeted Case Management, Each 15 Min (70899-120) T1017	N/A	N/A	N/A
RECOVERY SERVICES			
Service Code:	Codes Requiring Modifier 59, XE, XP, or XU to Use on the Same Day:	Codes Requiring Modifier 27, 59, XE, XP, or XU to Use on the Same Day:	Codes that CANNOT be Used on the Same Day:
Community Support Services, per 15 Min (70899-121) H2015	N/A	N/A	N/A
Psychosocial Rehabilitation, Individual, per 15 Min (70899-122)	N/A	N/A	N/A
Psychosocial Rehabilitation, Group, per 15 min (70899-123) H2017	N/A	N/A	N/A
Recovery Services, 1 Hr (70899-124) H2035	N/A	N/A	N/A
PEER SUPPORT SERVICES			
Service Code:	Codes Requiring Modifier 59, XE, XP, or XU to Use on the Same Day:	Codes Requiring Modifier 27, 59, XE, XP, or XU to Use on the Same Day:	Codes that CANNOT be Used on the Same Day:
Self-Help/Peer Services (70899-129) H0038	N/A	N/A	N/A
Behavioral Health Prevention Education Service (70899-128) H0025	N/A	N/A	N/A
RECOVERY INCENTIVES			
Service Code:	Codes Requiring Modifier 59, XE, XP, or XU to Use on the Same Day:	Codes Requiring Modifier 27, 59, XE, XP, or XU to Use on the Same Day:	Codes that CANNOT be Used on the Same Day:

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SUD Recovery Incentives, 15 Min (70899-118) H0050	N/A	N/A	<ul style="list-style-type: none"> SUD Structured Assessment, 15-30 Min (70899-100) G0396 SUD Structured Assessment, 30+ Min (70899-101) G0397
SUPPLEMENTAL CODES			
Service Code:	Codes Requiring Modifier 59, XE, XP, or XU to Use on the Same Day:	Codes Requiring Modifier 27, 59, XE, XP, or XU to Use on the Same Day:	Codes that CANNOT be Used on the Same Day:
Interactive Complexity (90785-1)	N/A	N/A	<ul style="list-style-type: none"> Sign Language or Oral Interpretation Services, 15 Min (70899-132) T1013 Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 30 Min (96170-1) Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)
Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 30 Min (96170-1)	<ul style="list-style-type: none"> Multiple-Family Group Psychotherapy, 84 Min (90849-1) Environmental Intervention for Medical Management Purposes (90882-1) Psychiatric Evaluation of Hospital Record, 60 Min (90885-1) Interpretation of Psychiatric Results to Family, 15 Min (90887-1) Preparation of Report of Patient's Psychiatric Status (90889-1) SUD Structured Assessment, 15-30/30+ Min (70899-100/70899-101) G0396/G0397 	N/A	<ul style="list-style-type: none"> Interactive Complexity (90785-1) Psychiatric Diagnostic Evaluation, 60 min (90791-1) Psychiatric Diagnostic Evaluation with Medical Services, 60 min (90792-1) Family Psychotherapy (w/o Pt Present), 50 Min (90846-1) Family Psychotherapy (w/ Pt Present), 50 Min (90847-1) Administration of Patient-Focused Health Risk Assessment Instrument (96160-1)
Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)	<ul style="list-style-type: none"> Environmental Intervention for Medical Management Purposes (90882-1) Preparation of Report of Patient's Psychiatric Status (90889-1) SUD Structured Assessment, 30+ Min (70899-101) G0397 	N/A	<ul style="list-style-type: none"> Interactive Complexity (90785-1) Psychiatric Diagnostic Evaluation, 60 min (90791-1) Psychiatric Diagnostic Evaluation with Medical Services, 60 min (90792-1) Family Psychotherapy (w/o Pt Present), 50 Min (90846-1) Family Psychotherapy (w/ Pt Present), 50 Min (90847-1) Administration of Patient-Focused Health Risk Assessment Instrument (96160-1)
Sign Language or Oral Interpretation Services, 15 Min (70899-132) T1013	N/A	N/A	<ul style="list-style-type: none"> Interactive Complexity (90785-1)

Interpretation of Psychiatric Results to Family, 50 Min (90887-1)	<ul style="list-style-type: none"> Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1) 	N/A	N/A
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MEDICATION SERVICES

Service Code:	Codes Requiring Modifier 59, XE, XP, or XU to Use on the Same Day:	Codes Requiring Modifier 27, 59, XE, XP, or XU to Use on the Same Day:	Codes that CANNOT be Used on the Same Day:
Psychiatric Diagnostic Evaluation with Medical Services, 60 Min (90792-1)	<ul style="list-style-type: none"> SUD Structured Assessment, 5-14/15-30/30+ Min (70899-102/70899-100/70899-101) G2011/G0396/G0397 Psychiatric Diagnostic Evaluation, 60 min (90791-1) Multiple-Family Group Psychotherapy, 84 Min (90849-1) Psychiatric Evaluation of Hospital Record, 60 Min (90885-1) Environmental Intervention for Medical Management Purposes (90882-1) Interpretation of Psychiatric Results to Family, 50 Min (90887-1) Preparation of Report of Patient's Psychiatric Status (90889-1) Administration of Patient-Focused Health Risk Assessment Instrument (96160-1) 	<ul style="list-style-type: none"> Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Physician, Patient and/or Family not Present, 30 Min+ (99367-1) Medical Team Conference by non-MD, Patient/Family not present, 30 Min+ (99368-1) Office Outpatient Visit of New Patient, 15-29/30-44/45-59/60-74 Min (99202-1/99203-1/99204-1/99205-1) Office Outpatient Visit of an Established Patient, 10-19/20-29/30-39/40-54 Min (99212-1/99213-1/99214-1/99215-1) Home Visit of a New Patient, 15-29/30-59/60-74/75-89 Min (99341-1/99342-1/99344-1/99345-1) Home Visit of an Established Patient, 20-29/30-39/40-59/60-74 Min (99347-1/99348-1/99349-1/99350-1) Prolonged clinical staff service during an evaluation and management service in the office or outpatient setting, first hour (99415-1) Prolonged clinical staff service during an evaluation and management service in the office or outpatient setting, each additional 30 min (99416-1) Inter-Professional Telephone/Internet/Electronic Health Record Assessment Provided by a Consultative Physician, 5-30 Min (99451-1) Transitional Care Management Services: Communication (direct contact, telephone, electronic) within 14 calendar days (99495-1) and Transitional Care Mgmt Services: Communication (direct contact, telephone, electronic) within 7 calendar days (99496-1) 	<ul style="list-style-type: none"> Family Psychotherapy (w/o Pt Present), 50 Min (90846-1) Family Psychotherapy (w/ Pt Present), 50 Min (90847-1) Health Behavior Intervention, Family (without the Patient present) Face-to-Face, 30 Min (96170-1) Health Behavior Intervention, Family (without the Patient present) Face-to-Face, Additional 15 Min (96171-1)
Oral Medication Administration, Direct Observation, 15 min (70899-109) H0033	N/A	N/A	N/A
Medication Training and Support-Individual per 15 Min (70899-110) H0034	N/A	N/A	<ul style="list-style-type: none"> 3.2 Residential Withdrawal Management (90899-779) H0012 can only be claimed with H0033 if there is a National Drug Code (NDC) on the claim.

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Medication Training and Support-Group per 15 Min (70899-111) H0034			
Office Outpatient Visit of New Patient, 15-29/30-44/45-59/60-74 Min (99202-1/99203-1/99204-1/99205-1)	<ul style="list-style-type: none"> Psychological Testing Evaluation, First Hour (96130-1) SUD Structured Assessment, 5-14/15-30/30+ Min (70899-102/70899-100/70899-101) G2011/G0396/G0397 SUD Screening (70899-105) H0049 SUD Brief Intervention, 15 Min (70899-117) H0050 SUD Recovery Incentives, 15 Min (70899-118) H0050 	<ul style="list-style-type: none"> Office Outpatient Visit of New Patient, 30-44 Min (99203-1) can be used with Office Outpatient Visit of New Patient, 15-29 Min (99202-1) with the appropriate modifiers Office Outpatient Visit of New Patient, 45-59 Min (99204-1) can be used with Office Outpatient Visit of New Patient, 15-29/30-44 Min (99202-1/99203-1) with the appropriate modifiers Office Outpatient Visit of New Patient, 60-74 Min (99205-1) can be used with Office Outpatient Visit of New Patient, 15-29/30-44/45-59 Min (99202-1/99203-1/99204-1) with the appropriate modifiers May be used with Office Outpatient Visit of an Established Patient, 10-19/20-29/30-39/40-54 Min (99212-1/99213-1/99214-1/99215-1) with the appropriate modifiers 	<ul style="list-style-type: none"> Inter-Professional Telephone/Internet/Electronic Health Record Assessment Provided by a Consultative Physician, 5-30 Min (99451-1)
Office Outpatient Visit of an Established Patient, 10-19/20-29/30-39/40-54 Min (99212-1/99213-1/99214-1/99215-1)	<ul style="list-style-type: none"> SUD Structured Assessment, 5-14/15-30/30+ Min (70899-102/70899-100/70899-101) G2011/G0396/G0397 SUD Screening (70899-105) H0049 SUD Brief Intervention, 15 Min (70899-117) H0050 SUD Recovery Incentives, 15 Min (70899-118) H0050 Psychological Testing Evaluation, First Hour (96130-1) 	<ul style="list-style-type: none"> Office Outpatient Visit of an Established Patient, 20-29 Min (99213-1) can be used with Office Outpatient Visit of an Established Patient, 10-19 Min (99212-1) with the appropriate modifiers Office Outpatient Visit of an Established Patient, 30-39 Min (99214-1) can be used with Office Outpatient Visit of an Established Patient, 10-19/20-29 Min (99212-1/99213-1) with the appropriate modifiers Office Outpatient Visit of an Established Patient, 40-54 Min (99215-1) can be used with Office Outpatient Visit of an Established Patient, 10-19/20-29/30-39 Min (99212-1/99213-1/99214-1) with the appropriate modifiers 	<ul style="list-style-type: none"> Inter-Professional Telephone/Internet/Electronic Health Record Assessment Provided by a Consultative Physician, 5-30 Min (99451-1)
Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office of outpatient setting, direct patient contact with physician supervision, first hour (99415-1)	<ul style="list-style-type: none"> SUD Structured Assessment, 5-14/15-30/30+ Min (70899-102/70899-100/70899-101) G2011/G0396/G0397 Psychological Testing Evaluation, First Hour (96130-1) 	<ul style="list-style-type: none"> Prolonged Outpatient Evaluation and Management Service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (99417-1) 	<ul style="list-style-type: none"> Inter-Professional Telephone/Internet/Electronic Health Record Assessment Provided by a Consultative Physician, 5-30 Min (99451-1)
Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office or outpatient setting, direct patient	<ul style="list-style-type: none"> SUD Structured Assessment, 5-14/15-30/30+ Min (70899-102/70899-100/70899-101) G2011/G0396/G0397 Psychological Testing Evaluation, First Hour (96130-1) 	<ul style="list-style-type: none"> Prolonged Outpatient Evaluation and Management Service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (99417-1) 	<ul style="list-style-type: none"> Inter-Professional Telephone/Internet/Electronic Health Record Assessment Provided by a Consultative Physician, 5-30 Min (99451-1)

contact with physician supervision; each additional 30 minutes (99416-1)			
Home Visit of a New Patient, 15-29/30-59/60-74/75-89 Min (99341-1/99342-1/99344-1/99345-1)	<ul style="list-style-type: none"> Psychological Testing Evaluation, First Hour (96130-1) SUD Structured Assessment, 5-14/15-30/30+ Min (70899-102/70899-100/70899-101) G2011/G0396/G0397 SUD Screening (70899-105) H0049 SUD Brief Intervention, 15 Min (70899-117) H0050 SUD Recovery Incentives, 15 Min (70899-118) H0050 	<ul style="list-style-type: none"> Home Visit of a New Patient, 30-59 Min (99342-1) can be used with Home Visit of a New Patient, 15-29 Min (99341-1) with the appropriate modifiers Home Visit of a New Patient, 60-74 Min (99344-1) can be used with Home Visit of a New Patient, 15-29/30-59 Min (99341-1/99342-1) with the appropriate modifiers Home Visit of a New Patient, 75-89 Min (99345-1) can be used with Home Visit of a New Patient, 15-29/30-59/60-74 Min (99341-1/99342-1/99344-1) with the appropriate modifiers 	<ul style="list-style-type: none"> Inter-Professional Telephone/Internet/Electronic Health Record Assessment Provided by a Consultative Physician, 5-30 Min (99451-1)
Home Visit of an Established Patient, 20-29/30-39/40-59/60-74 Min (99347-1/99348-1/99349-1/99350-1)	<ul style="list-style-type: none"> Psychological Testing Evaluation, First Hour (96130-1) SUD Structured Assessment, 5-14/15-30/30+ Min (70899-102/70899-100/70899-101) G2011/G0396/G0397 SUD Screening (70899-105) H0049 SUD Brief Intervention, 15 Min (70899-117) H0050 SUD Recovery Incentives, 15 Min (70899-118) H0050 	<ul style="list-style-type: none"> Home Visit of an Established Patient, 30-39 Min (99348-1) can be used with Home Visit of an Established Patient, 20-29 Min (99347-1) with the appropriate modifiers Home Visit of an Established Patient, 40-59 Min (99349-1) can be used with Home Visit of an Established Patient, 20-29/30-39 Min (99347-1/99348-1) with the appropriate modifiers Home Visit of an Established Patient, 60-74 Min (99350-1) can be used with Home Visit of an Established Patient, 20-29/30-39/40-59 Min (99347-1/99348-1/99349-1) with the appropriate modifiers 	<ul style="list-style-type: none"> Inter-Professional Telephone/Internet/Electronic Health Record Assessment Provided by a Consultative Physician, 5-30 Min (99451-1)
Prolonged Outpatient Evaluation and Management Service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (99417-1)	N/A	N/A	N/A
Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Physician, Patient, and/or Family not Present, 30 Min+ (99367-1)	<ul style="list-style-type: none"> SUD Screening (70899-105) H0049 SUD Brief Intervention, 15 Min (70899-117) H0050 SUD Recovery Incentives, 15 Min (70899-118) H0050 	N/A	N/A
Transitional Care Management Services: Communication (direct contact, telephone, electronic) within 14 calendar days, 54 Min (99495-1)	<ul style="list-style-type: none"> Telephone Assessment and Management Service, 5-10/11-20/21-30 Min (98966-1/98967-1/98968-1) 	<ul style="list-style-type: none"> Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Physician, Patient and/or Family not Present, 30 Min+ (99367-1) and Medical Team Conference by Non-MD, Patient/Family not Present, 30 Min+ (99368-1) 	N/A

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Transitional Care Management Services: Communication (direct contact, telephone, electronic) within 7 calendar days, 75 Min (99496-1)	<ul style="list-style-type: none"> Telephone Assessment and Management Service, 5-10/11-20/21-30 Min (98966-1/98967-1/98968-1) 	<ul style="list-style-type: none"> Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Physician, Patient and/or Family not Present, 30 Min+ (99367-1) and Medical Team Conference by Non-MD, Patient/Family not Present, 30 Min+ (99368-1) Transitional Care Management Services: Communication (direct contact, telephone, electronic) within 14 calendar days, 54 Min (99495-1) 	N/A
Inter-Professional Telephone/Internet/Electronic Health Record Assessment Provided by a Consultative Physician, 5-30 Min (99451-1)	N/A	N/A	<ul style="list-style-type: none"> Office Outpatient Visit of New Patient, 15-29/30-44/45-59/60-74 Min (99202-1/99203-1/99204-1/99205-1) Office Outpatient Visit of an Established Patient, 10-19/20-29/30-39/40-54 Min (99212-1/99213-1/99214-1/99215-1) Home Visit of a New Patient, 15-29/30-59/60-74/75-89 Min (99341-1/99342-1/99344-1/99345-1) Home Visit of an Established Patient, 20-29/30-39/40-59/60-74 Min (99347-1/99348-1/99349-1/99350-1) Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office of outpatient setting, direct patient contact with physician supervision, first hour (99415-1) Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; each additional 30 minutes (99416-1)
NATURAL HELPER/TRADITIONAL HEALTH SERVICES			
Service Code:	Codes Requiring Modifier 59, XE, XP, or XU to Use on the Same Day:	Codes Requiring Modifier 27, 59, XE, XP, or XU to Use on the Same Day:	Codes that CANNOT be Used on the Same Day:
Natural Helper Services (CDM – TBD) T1016	N/A	N/A	N/A
Traditional Healer Services (CDM – TBD) H0051	N/A	N/A	N/A

Modifier 27 = Multiple Outpatient Hospital Evaluation and Management (E/M) Encounters on the Same Date

Modifier 59 = Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from services performed on the same day and is used to identify procedures/services that are not normally reported together but are appropriate under the circumstances.

Modifier XE = Separate encounter, a service that is distinct because it occurred during a separate encounter (separate encounters on the same date of service).

Modifier XP = Separate practitioner, a service that is distinct because it was performed by a different practitioner.

Modifier XU = Unusual Non-Overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service.

Modifiers XE, XP, and XU give greater specificity than Modifier 59, therefore should be used instead whenever possible. Modifier 59 should only be used when no other more specific modifier is appropriate.

Instructions for Attaching the Appropriate Modifier:

It is the claims for service codes listed in the 2nd and 3rd columns that require the modifier – NOT for the service in the 1st column!! Be sure to look at each row that corresponds to all services provided for the applicable date of service (see example below).

EXAMPLE:

Provider A conducts an intake service using SUD Screening (70899-105) H0049 code and then later on the same day, Provider A conducts Family Psychotherapy (w/o Pt Present), 50 Min (90846-1). A modifier must be used to bill both services as separate client encounters. If, in this case, the same rendering provider performed both services as two distinct encounters, the XE modifier may be attached to the claim for the Family Psychotherapy (w/ Pt Present), 50 Min (90847-1). *You must look at both rows on table above for the SUD Screening (70899-105) H0049 AND Family Psychotherapy (w/o Pt Present), 50 Min (90846-1) to determine the need for a modifier in this scenario!!*

IMPORTANT: Documentation in progress notes for both services must make clear the medical necessity for each service to justify the use of the modifier and billing of each service.