THE COUNTY OF FRESNO
Department of
Behavioral Health

New Service Coding and Documentation

With Mary Johnson, Compliance Staff Analyst

Today We Will Talk About:

- Introduction to CPT Codes
- High level discussion of considerations surrounding this transition.

Why This Topic? California Advancing and Innovating Medi-Cal (CalAIM)

CalAIM is a DHCS initiative to streamline Medi-Cal through a set of BH policies

These policies will:

- Improve access to care
- Streamline administrative functions and requirements
- Modernize payments

DHCS Payment Reform Goals for July 1, 2023

Implementation of fee-for-service pay structure

-end of cost-based reimbursement

-simplifying county BH plan payments and reducing administrative burden

Intergovernmental Transfers (IGTs)

-enable counties to provide non-federal share of cost for services without certified public expenditures and cost-based reimbursement

Implementation of CPT coding

-improve reporting and support data-driven decision making

-align with other healthcare delivery systems and comply with CMS

Fresno County DBH Goals for July 1, 2023

Implementation of fee-for-service pay structure

-Contracts and the Business Office are hard at work to ensure the smoothest possible transition to FFS pay structure

-Office Hours Session – CalAIM Payment Reform Notice, Wednesday mornings 8:00 AM-9:00 AM

Intergovernmental Transfers (IGTs)

-mainly impacts DBH fiscal team members

Implementation of CPT coding

-be on the lookout for upcoming trainings, which will have more specificity, both from DBH and CalMHSA

-will cover clinical and billing/invoicing topics

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Why be Happy About Payment Reform/ CPT Codes:

- Standardization in coding across systems of care, even internationally
- Improved care coordination across all provider types
- For SmartCare users, automatic service coding and only codes associated with provider type will be shown/available for use, which will increase efficiency and compliance
- Increased granularity of CPT codes will allow better data-capturing, which can be used to optimize business practices in preparation for the move towards capitation
- Provides a more accurate reflection of the range of services and needs of our persons served

CPT Code Transition

In general, CPT codes will be used for clinical services provided by licensed professionals providing services in their scope of practice.

DHCS is planning to continue to use HCPCs for non-clinical services (e.g., rehabilitation) and services provided by non-licensed staff.

Claim by Units of Service Instead of by the Minute

All codes will be billed in units. Most CPT codes that are listed in the Medi-Cal billing manual have a time or time range associated with them.

When a code did not have a time or time range associated with it, DHCS assigned a time of 15 minutes to that code.

Codes are billed in whole units only. For example, a provider is unable to bill for 1.5 units of service.

Codes have a maximum number of units that the procedure may be billed in a 24-hour period.

Some codes cannot be billed together and others can only be billed together in extraordinary circumstances. In the billing manuals, codes that cannot be billed with the procedure listed in column Code are listed in the Lockout Codes column.

For some codes, a unit of service is attained when a mid-point is passed. For example, CPT code 90839 (psychotherapy for crisis, first 60 minutes) can be claimed when 31 minutes of direct service have been provided. Thirty-one minutes is more than mid-way between zero and 60 minutes.

Claim by Units of Service Instead of by the Minute, Examples

Some CPT codes are determined by the minute range and the unit will always be one (1)

- i.e. to claim 40 minutes of in office Medication Support Service, you would claim one unit of 99203, which covers 30-44 minutes of MSS

Some codes (mostly HCPCS) are claimed based on 15 minute increments

- i.e. Targeted Case Management for 45 minutes can be claimed with three units of T1017 (1 Unit=each 15 minutes)

Examples, continued

99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report E/M services provided to an established patient, parent, or guardian. 5-10 minutes of medical discussion.
99442	Telephone evaluation and management service by a physician or other qualified health care professional who may report E/M services provided to an established patient, parent, or guardian. 11-20 minutes of medical discussion.
99443	Telephone evaluation and management service by a physician or other qualified health care professional who may report E/M services provided to an established patient, parent, or guardian. 21-30 minutes of medical discussion.

- **Example 1: 19 minute Telephone evaluation and Management code service**
- **Example 2: 25 minute Telephone evaluation and Management code service**
- **Example 3: 5 min Telephone evaluation and Management code service, plus 6 minutes of documentation**

CPT Billing is Based on Time Spent on Direct Person Served Care

For a care codes (e.g. therapy or evaluation and management), direct care means face-to-face time spent with the person served for the purpose of providing healthcare.

For a consultation code, direct care means time spent with the consultant/members of the person served's care team.

Direct care does not include travel time, administrative activities, chart review, documentation, utilization review, quality assurance activities, or other activities a practitioner engages in before or after a person served's visit.

Important Note: the rates given providers were calculated to include these activities, though they now are not explicitly claimed.

Increased Rules on When Codes May be Used

Supplemental Codes:

Dependent procedures cannot be billed unless the provider first bills the primary procedure (to the same person served by the same provider on the same date and same claim).

- i.e. if a provider renders a 30 minute psychotherapy service (90833), but wants to add a supplemental code for that service (i.e. interactive complexity, 90785), the psychotherapy must be entered first as the primary service.

Roll-up Services:

If provider renders 2 sessions of the same service to the same person served on the same day, all encounters must be claimed as 1 service (to avoid denial for duplicate services).

- i.e. if provider renders psychotherapy for crisis to a person served for 30 minutes in the morning and provided the same service to the same person served for 30 minutes in the afternoon, the claim submitted would be for 60 minutes of psychotherapy of crisis (90839).

Increased Complex Use of Modifiers

New modifiers for telehealth services

- 93 Telephone (Audio only)
- 95 Telehealth (Video and voice)

New modifiers for Interns/Residents

- HL – (Intern: Registered, pre-licensed mental health professional who is working in a clinical setting under supervision)
- GC – (Resident: issued a post graduate training license (and) enrolled in an Accreditation Council for Graduate Medical Education (ACGME)- accredited post graduate training program in California.)

New modifiers for waivers of code lock outs

- Waivers for code lock outs are modifiers that can override 2 codes that aren't allowed on the same day.
- XE, XP, XU

NOTE: The HE Modifier is no longer used for Outpatient Services

Leverage EHRs/Billing Systems

Limit Selectable Procedures

Program	What services does the program offer?
Person	What services are in a staff type's scope of competence?

Drive Billing Code & Modifier Determination

Location	Where was the service provided?
Method of Service	How was the service delivered?
Duration	How much time was spent on direct person served care?

SmartCare

- SmartCare is designed with CalAIM changes in mind, including AI service coding functions
- Semi-statewide: better interoperability and ease of operations across different counties
- Providers will be paid based on approved claims, which will likely result in more timely payment for SmartCare EHR users, with less additional documentation required
- Improved denial remark codes
- Real time Medi-Cal eligibility information for providers on SmartCare
- After July 1 Go-Live, no additional out-of-pocket to join us, the cost is built into rates
- Transition optimization funds

Important Note:

We will continue supporting our network of care, moving forward in partnership.

Times are a' Changing!

What WILL NOT change:	What WILL change:
• Fresno County DBH commitment to the Quad Aim: delivering quality care, maximizing resources while focusing on efficiency, providing an excellent care experience, and promoting workforce well-being • Managed Care chart reviews and technical assistance • Monitoring for any Medi-Cal fraud, waste, or abuse • Funding sources used to reimburse providers • Monthly payments	• CPT and HCPCS codes and modifiers • Shift to FFS from cost-based reimbursement • Additional denial rules for lockouts, duplicates, duration and places of services • Situations with hybrid funding, such as FSP, may require more than one payment stream • Providers will be paid based on approved claims (which will likely result in more timely payment for Smartcare EHR users, with less additional documentation required)

Reimbursement by Provider Type (Discipline) at a Fixed Rate

County reimbursement set by DHCS

- Finalized rates received from DHCS, county by county rates published

Provider rates set by DBH

- Provider rates and contracts have been sent out
- Vendor reimbursement rates were set based on the types of services provided in the contract as well as other factors, i.e. locality (rural vs. urban)
- DBH has a Payment Reform Workgroup and several more specialized workgroups focus on rate setting, the fee-for-service shift, etc.

With Implementation of Payment Reform, Providers Should Consider:

- Business practices, primarily the best use of medical/clinical staff time
- Type of provider used for direct services; thinking strategically about who will draw down Medi-Cal funding
- Thinking strategically about direct care services (CPT codes used for billing)
- Flexibility with setting salaries for provider types and/or programs based on the needs of the provider/agency (e.g. field based services, experience)

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Important Note: With the many changes, notably fee-for-service and the CPT transition, providers should begin developing policies in regard to these new billing models.

Upcoming and Available Trainings

- Introduction to CPT/HCPCS Procedural Codes
  - May 11, 2023 from 1:00p.m.-3:00p.m. with Sandra Nelson, Compliance URS
- CPT 101 and CPT 102
  - On-demand webinar by CalMHSA https://www.calmhsa.org/calaim-payment-reform-webinars/
- CPT Coding for Direct Service Providers
  - provided by CalMHSA via Moodle LMS; please complete asap upon release, so that questions and information gaps can be addressed prior to July 1
- To Be Announced (be on the lookout for training on billing as we finalize procedures)

Resources

- Medi-Cal Billing Manuals for SMHS and DMC-ODS
  - https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx
- CalMHSA Coding Manuals
  - https://www.calmhsa.org/calaim-references-and-manuals-effective-july-1-2023/
- AMA CPT Resources
  - https://www.ama-assn.org/practice-management/cpt

Questions?

Email Compliance at DBHCompliance@fresnocountyca.gov