PAYMENT REFORM

LEARNING TOGETHER

OUR CURRENT SYSTEM

EXAMPLE OF CURRENT HCPC AND CPT CODES

90791 – Assessment	KTAH2017 – Intensive Home-Based Services
90834 – Individual Therapy	H0032 – Plan Development
90853 – Group Therapy	H2011 – Crisis Intervention
90847 – Family Therapy	T1017 – Targeted Case Management
90887 – Collateral	KTAT1017 – Intensive Care Coordination
H2017 – Rehabilitation	*Medication Service Codes

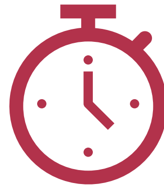
CPT = Current Procedural Terminology (Or HCPC Level I Codes)
HCPC= Healthcare Common Procedure Coding System

CURRENT SERVICES BY DISCIPLINES

	LPHA*	MHRS	MHW**
Assessment, Individual/Group/Family Therapy	Yes	No	No
All other Mental Health Services, incl. IHBS	Yes	Yes	Yes
TCM/ICC	Yes	Yes	Yes
TBS	Yes	Yes	Yes
Crisis	Yes	Yes	Yes
*Includes waivered/registered staff and Trainees with required education		**Requires co-signature	

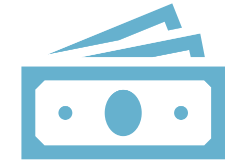
OUR CURRENT SYSTEM

We use a combination of CPT codes and HCPC codes



Claims are in per minute increments

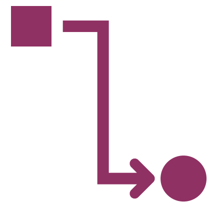
Total claims include documentation and travel time



True Up happens annually with cost reporting

OUR FUTURE SYSTEM

OUR FUTURE SYSTEM



CPT based system*

Claims will be for units of service (no partial units allowed, whole numbers only)

Total claims are only for Direct Patient Care

WHY

- Center for Medicare and Medicaid Services (CMS-Federal Government) expects all Medicaid programs to adopt CPT codes where appropriate to enable data analysis/comparison between states
  - Increase the ability to understand the services rendered
  - Add granularity to describe the services provided
  - Provides a more accurate reflection of the range of services and needs of beneficiaries served
- 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

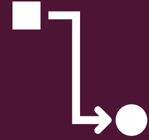
IMPORTANT TERMS

- **Direct Patient Care:** Time spent with the client. (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 patient visit).
- **Medical consultation codes:** Time spent with the consultant/members of the beneficiary's care team.
- **Intern:** A registered, pre-licensed mental health professional who is working in a clinical setting under supervision.
- **Waivered Professional:** A professional from another state whose license is recognized by California. Waivered professionals can bill under their own license and do not need to use an HL or a GC modifier.

IMPORTANT TERMS

- **Maximum Units that Can be Billed:** All codes will be billed in units. Most CPT codes that are listed in the billing manual have a time or time range associated with them.
  - A unit of service is attained when a mid-point is passed. 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.
- **Lockouts:** Lockouts are codes that cannot be billed together. Sometimes lockouts can be overridden with an appropriate modifier. Lockouts that can be overridden are indicated with either one or two asterisks in the lockout column in the billing manual.
- **Medi-Cal Billing Manuals:** Billing Manual SMHS Billing Manual DMC ODS

CPT CODES



CPT are more detailed definitions for codes that are standardized nationwide.

Codes Specify the billing increment or a range of time.

Typically used by physicians and licensed providers

Therapy Codes	
90832	Psychotherapy, 30 Minutes with Patient
90833	Psychotherapy, 30 Minutes with Patient when Performed with an Evaluation and Management Service
90834	Psychotherapy, 45 Minutes with Patient
90836	Psychotherapy, 45 Minutes with Patient when Performed with an Evaluation and Management Service
90837	Psychotherapy, 60 Minutes with Patient
90838	Psychotherapy, 60 Minutes with Patient when Performed with an Evaluation and Management Service

CPT CODE SELECTION

- There is no crosswalk from ‘old’ codes to ‘new codes’
- CPT code selection may depend on
  - Discipline*
  - Duration of service
  - Location
  - Method of delivery (face to face, phone, telehealth)
- Modifiers may depend on
  - licensure
  - Method of service delivery (face to face, phone, telehealth)

UNITS OF SERVICE

Units vs. Minute based claims

- Claims will be submitted for units of service, not number of minutes
- This Billing Manuals list the maximum number of units that a procedure may be billed in a 24-hour period .
- When a code did not have a time or time range associated with it, DHCS assigned a time of 15 minutes to that code.
- Example:
  - 60 minutes of Rehabilitation (H2017), will be claimed as 4 units of H2017
  - 31 minutes of Psychotherapy for crisis, first 60 minutes (90839) will be claimed as 1 unit of 90839

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes Note: The below outpatient services are locked out against inpatient and 24-hour services except for the date of admission.	Dependent on Codes	Medicare COB Required?	Maximum Units that Can be Billed	Allowable Modifiers
Psychotherapy, 30 Minutes with Patient	90832	• MD/DO • PA • PhD/PsyD (Licensed or Waivered) • SW (Licensed, Registered or Waivered) • MFT (Licensed, Registered or Waivered) • NP or CNS (Certified) and	All except 09	Cannot be billed with 90791 90792 90833-90834 90836-90840 90845 90847 90849 90853 90865 90867-90869* 90870 90880 96112-96113 96116* 96127* 96161* 99202-99205** 99212-99215**	None	Yes	1	59 93 95 GC HK HL HV XE XP XU
		• PCC (Licensed or Registered)		99217-99223** 99231-99236** 99241-99245** 99251-99255** 99304-99310** 99324-99328** 99334-99337** 99341-99345** 99347-99350** 99366-99368** 99441-99443** 99451** 99605-99606**				

DIRECT PATIENT CARE

- Claims will only include direct client care (Face to face, by telehealth or telephone when and if applicable)
- Transportation and Documentation time are not claimable
  - This change should be considered when determining cost of doing business

RATES

CHANGES IN RATE STRUCTURE

- Only Outpatient rates are being discussed at this time
- Outpatient rates are going to be CPT code practitioner based
  - These rates were developed based on analysis of the reports WE all submitted back in 2022 to CalMHSA.

OLD

- Rates were per minute and per service code
- Fiscal used your published rates or our state rates, which ever was less
- Documentation and travel time were claimed

NEW

- Rates will be based on practitioner type
- Unclear how your published rates may need to change or will affect new pay structure
- Cost of doing business needs to be reflected in new rates

FISCAL FORECASTING

- Placer has been conducting fiscal forecasting to identify critical concerns and has submitted preliminary findings to DHCS and is awaiting response.
  - Placer continues to negotiate with DHCS for overall rates that will be inclusive of service and oversight of the MHP.
- Contractor rates will be determined based on contractor cost of doing business
- HHS Fiscal teams are working on completing a contractor-based analysis for each of our providers
  - Analysis will be based on cost reports submitted November 2022
  - Contractors are encouraged to complete their own analysis and propose rates under this new model

WHAT NEXT

- Conducting a business cost analysis, looking at direct care by provider type will help you determine how the new rate structure may affect your business and help you propose rates
- Consider changes in business process to be more in line with payment reform
  - E.g. Collaborative doc.
- EHR Set up: Proper EHR setup will help staff make decisions and account for variables
  - Limit selectable codes per program and staff type
  - Drive billing code and modifier determinations by location, method of service delivery and duration
  - Consider joining SmartCare to have support in this area

MORE TRAINING & GUIDES WILL BE COMING FROM CALMHSA SOON

WE WILL ALL LEARN TOGETHER!

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County of Placer