Quality Assurance Bulletin

Quality Assurance Unit

County of Los Angeles – Department of Mental Health

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PAYMENT REFORM FOR SPECIALTY MENTAL HEALTH SERVICES EFFECTIVE JULY 1, 2023

This Bulletin provides updated guidance related to Specialty Mental Health Services (SMHS) and claiming requirements for all Medi-Cal Specialty Mental Health Services (SMHS) based on Department of Health Care Services (DHCS) Behavioral Health Information Notices (BHIN) 22-046 and 23-023, which go into effect July 1, 2023. While Payment Reform in general applies to all services, the specific changes outlined within this Bulletin apply to outpatient Mode 15 services. Any changes for other services such as Community Outreach Services (COS) or Inpatient Services, are specifically indicated in the Bulletin.

California Advancing and Innovating Medi-Cal (CalAIM) is a multi-year initiative by the State DHCS to improve the quality of life and health outcomes of Medi-Cal beneficiaries by implementing broad delivery system, program and payment reforms across the Medi-Cal program (QA Bulletin 21-07). As part of CalAIM, there have been many policies and procedures implemented to reduce administrative burden and complexity (e.g., QA Bulletin 22-04 regarding Documentation Redesign) and/or increase flexibility (e.g., QA Bulletin 22-05 regarding New First Point of Contact Requirements).

Effective July 1, 2023, DHCS is transforming the way in which counties are reimbursed for services. Payment reform transitions counties and providers from a cost-based reimbursement model (i.e., reimbursement based on allowable, actual costs incurred to provide eligible service and not necessarily on the units of service provided) to a fee-for-service reimbursement model (i.e., reimbursement by the eligible services provided). This eliminates the need for labor-intensive cost reconciliation and is a first step towards moving to more innovative value-based payment models. Under this payment methodology, reimbursement is now directly linked to services provided, and is no longer settled at cost.

In addition to the change in reimbursement method, payment reform transitions DHCS from using a limited code-set based on type of service provided (e.g., Medication Support Services, Targeted Case Management) to a more complex, specific, and granular code-set to improve reporting and support data-driven decision making. This move aligns the SMHS Medi-Cal delivery system with other healthcare delivery systems' coding methodologies and complies with all Centers for Medicare and Medicaid Services (CMS) and American Medical Association (AMA) requirements.

Pre-CalAIM	CalAIM
• Reimbursement on an interim basis for each service rendered until annual cost reports submitted which are subject to audit, reconciliation, and cost settlement. • Reimbursement is limited to cost, regardless of the amount of services provided. • Each provider has a different rate based on the cost of services provided. • Procedure Codes submitted to DHCS are limited at the Type of Service (e.g., MHS) level.	• Reimbursement on a final basis (no additional settlement) based on an established fee schedule. • Reimbursement is not limited to cost and is based on the amount of services provided. • All providers have the same rate for services. • Procedure Codes submitted to DHCS match CMS/AMA rules at a granular level to provide greater information about the services provided.

Key Changes Under Payment Reform

1. **Emphasis is on Direct Care**: *Refer to "Direct Care" under the Introduction section of the Guide to Procedure Codes*
   - Reimbursable time for outpatient Mode 15 services only includes direct care time. Direct care does not include travel time, administrative activities, chart review, documentation, utilization review and quality assurance activities or other activities a practitioner engages in either before or after a client visit.
   - When calculating the new rates under Payment Reform, DHCS took into consideration the amount of time spent on activities other than direct care.
   - For client care procedure codes (e.g., therapy or evaluation and management), direct care means time spent with the client, caregiver, or significant other for the purpose of providing services.
   - For consultation procedure codes (e.g., Targeted Case Management, treatment planning), direct care means time spent with the consultant/members of the client's care team.
   - As some field-intensive programs and services may incur greater travel time than the average amount of travel accounted for in the rate, LACDMH has added a new travel time non-billable to Medi-Cal procedure code for contracted providers use in specialized settings.

   Note: There are no changes in what is considered reimbursable under COS.

2. **Reimbursement is by Provider Type (in most case Discipline):** *Refer to CBO Bulletin NGA 23-005 for Legal Entity Outpatient rates.*
   - Each provider type has an identified rate per hour and the rate is utilized no matter the service provided.
   - Previously rates had been set based on the Type of Service provided (e.g., Mental Health Services, Crisis Intervention).
   - For purposes of reimbursement, students of clinical disciplines (e.g., Masters in Social Work (MSW) student) are included under Mental Health Rehabilitation Specialists.

3. **Procedure Codes are Selected Based on CMS and AMA Rules Using CPT and HCPCS Procedure Codes:** *Refer to the Guide to Procedure Codes for a complete list of allowable CPT and HCPCS procedure codes.*
   - DHCS requires the use of Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) procedure codes on outpatient claims and expects all providers to follow CMS and AMA rules when selecting a procedure code unless otherwise noted in the DHCS Billing Manual.
   - The most specific procedure code must be selected to best describe the service provided. HCPCS procedure codes (codes beginning with a letter) are less specific and may be used when an appropriate CPT procedure code is not available.
   - Students of clinical disciplines (e.g., Masters in Social Work (MSW) student) are only allowed to use HCPCS procedure codes. While the procedure codes they are allowed to use are different, there are no change in the services they are allowed to provide under direct clinical supervision with co-signature.

4. **Add-On, Modifiers and Prolong Codes Must be Used**: *Refer to the Add-On Codes section and the Extended Duration Code column of the Guide to Procedure Codes.*
   - Add-on procedure codes must be utilized to further describe a service (e.g., additional time and/or complexity) and should be utilized whenever appropriate in order to maximize reimbursement (e.g., T1013 as an add-on when an interpreter is utilized to deliver the service). Each add-on code has its own unit of service and reimbursement rate.
   - Modifiers (two characters added to a procedure code) are used to further define a CPT or HCPCS procedure code (e.g., HQ for a group service), indicate the method of delivery (e.g., 93 for telephone services), identify residents or registered/waivered staff (e.g., HL for registered Associate Social

Workers) or indicate the funding source (e.g., HV for Family First Prevention Services Act Aftercare services (FFPSA)).

5. **Modifiers and Procedure Codes are Utilized to Identify if Services Must Go to Medicare:** *Refer to "Other Items" under the Introduction section of the Guide to Procedure Codes*
   - Medi-Cal is the payer of last resort. Providers must submit claims to Medicare for Medi-Cal eligible services performed by Medicare-certified providers in a Medicare certified facility before submitting a claim to Medi-Cal. Refer to CBO Bulletin NGA 10-007 & 13-012.
   - Taxonomy Codes are no longer utilized to distinguish the claims that must go to Medicare.
   - Registered/waivered practitioners of clinical disciplines (e.g., Associate Social Worker or MD resident) must utilize a modifier on all claims to distinguish claims from licensed staff who are required to claim to Medicare (when the client has Medicare). Residents under the direction of a teaching physician must also utilize a modifier on all claims to distinguish claims from physicians who are required to claim to Medicare.
   - Some procedure codes are not required to be submitted to Medicare and may be claimed directly to Medi-Cal. Refer to the Guide to Procedure Codes for a list of procedure codes that are not required to be submitted to Medicare.

6. **Claims for Outpatient Services Must Include the Units of Service**. *Refer to the "Structure of the Guide" section of the Guide to Procedure Codes.*
   - While the exact number of minutes spent on a service is no longer required on the claim, practitioners should have a good idea of the amount of time spent on direct care in order to indicate the number of units for the claim or select the correct procedure code.
   - Some CPT procedure codes are determined by the minute range and the unit will always be one (1).
   - The unit for some procedure codes (mostly HCPCS) are determined based on 15-minute increments.
   - All procedure codes have a maximum number of units that may be claimed. For some procedure codes, a prolong procedure code may be added if the maximum unit has been met.

   Note: For inpatient, day services and COS, there is no change in the units submitted on claims.

7. **Short Doyle Medi-Cal (SD/MC) Inpatient Professional Services are Claimed Separately.**
   - Professional services are no longer included in the bundled rate for SD/MC inpatient services and, thus, must be claimed separately as Mode 15 outpatient services. They will be reimbursed at the outpatient rates.
   - Professional services are identified by any Mental Health Service or Medication Support Service procedure code allowable to be used in an Inpatient Hospital (place of service 21) or Inpatient Psychiatric Facility (place of service 51).
   - Professional services must be sent on an 837P using the NPI/taxonomy of the practitioner providing the service. All practitioners who provide professional services must be set up in the Network Adequacy: Provider and Practitioner Administration (NAPPA) application to ensure claims are accepted.

8. **Services to Significant Others is a Method of Service Delivery.** *Refer to "Service Contact" in the Introduction section of the Guide to Procedure Codes.*
   - Based on the newly approved State Plan Amendment (SPA) which governs allowable SMHS, collateral services are no longer a distinct service component and can no longer be billed as a distinct service activity. However, it is now a method of service contact if the purpose of the significant support person's participation is to focus on the treatment of the client.
   - Providers can claim for contacts with significant others and should identify the procedure code that best describes the service provided. The Guide to Procedure Codes indicates if a procedure code may be utilized when working with a significant other.

9. **A Single Note May be Written for a Contact.** *Refer to "Direct Care" in the Introduction section of the Guide to Procedure Codes.*
    - Practitioners are no longer required to write separate notes for two or more significant and distinct services (e.g., therapy and Targeted Case Management) delivered within a single contact.
    - If multiple interventions/services are provided in the same contact, only a single note is required to be written, describing all interventions, and a single claim submitted using the procedure code that describes the primary service provided.

10. **A Single Claim Must be Submitted For Legitimate Services that May Look Like Duplicates**
    - A claim will be considered to be a duplicate when the following data elements are the same:
      ✓Client ID ✓Practitioner ✓Procedure Code ✓Date of Service
    - To ensure multiple encounters of the same service to the same client on the same day by the same practitioner are not denied as duplicate services, a single note and claim shall be submitted combining the content and duration of the contacts. For example, if a practitioner provides psychotherapy for crisis to a client for 30 minutes in the morning and provides psychotherapy for crisis to the same client for 30 minutes in the afternoon, the claim would be submitted for 60 minutes for psychotherapy for crisis and a single note should be written describing the two contacts.
    - If it is not possible to write a single progress note due to the first note having already been finalized at the point of the second contact, providers may write a second note so long as the added total duration of the two contacts is on one claim.
    - There is no allowable duplicate over-ride modifier for the same service to the same client on the same day by the same practitioner which is why a single claim must be submitted with combined duration.

The Guide to Procedure Codes and the Organizational Provider's Manual have been updated to reflect the changes outlined in this Bulletin. Guidance in the Guide to Procedure Codes is based off the DHCS Billing Manual as well as AMA CPT/HCPCS rules. Due to DHCS being the payer source, DHCS rules are utilized if there is conflicting information between the DHCS Billing Manual and AMA rules. Providers will be notified as DHCS provides additional guidance related to procedure code usage under Payment Reform.

A short training video covering the new claiming requirements will be available on the QA Unit's website under "Training." For Directly Operated, additional guidance will be provided via an IBHIS Notification regarding how these changes will be implemented within IBHIS. Directly-Operated practitioners using IBHIS will not be required to select the appropriate procedure code/modifiers as this function will be centralized to a dedicated team along with logic established within IBHIS.

If contracted providers have any questions related to this Bulletin, please contact the QA Unit at QualityAssurance@dmh.lacounty.gov. If directly-operated have any questions related to this Bulletin, please contact the QA Policy & Technical Development team at IBHISErrorCorrection@dmh.lacounty.gov.

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