SECTION IX – PROCEDURE CODES, DIAGNOSIS CODES AND RATES

PROCEDURE CODES

Network Providers and their designated billing agents must ensure that the correct procedure and diagnosis codes are appropriately submitted on electronic claims. When choosing the appropriate procedure code, Network Providers must select the appropriate set of codes (primary code, allowable modifier, prolong code, replacement code, add-on code) that are identified according to the service, place of service, and duration of the service as provided in the *Guide to Procedure Codes* for Specialty Mental Health Services: https://dmh.lacounty.gov/qa/qama/

One of the objectives of the Health Insurance Portability and Accountability Act (HIPAA) is to enable health care providers throughout the country to be able to converse with each other about the services they are providing using a single coding system. Health care claiming has also been improved and simplified as a result of HIPAA. On July 1, 2023, the State Department of Health Care Services (DHCS) implemented Payment Reform under California Advancing and Innovating Medi-Cal (Cal-AIM) which fully aligns the State with other healthcare delivery systems and complies with CMS requirements for all State Medicaid programs to adopt Current Procedural Terminology (CPT) codes where appropriate. In addition, it will improve reporting and support data-decision making by disaggregating data on Specialty Mental Health Services (SMHS).

The two nationally recognized coding systems approved for use are the Current Procedural Terminology (CPT) codes and the Health Care Procedure Coding System (HCPCS). The CPT codes are five-digit numeric codes, such as 90791. The HCPCS are a letter followed by four digits, such as H0032.

CPT code definitions come from the CPT Codes Manual. HCPCS codes are almost exclusively simply code titles absent definition. Therefore, the definitions for HCPCS codes were established either exclusively or in combination from one of these sources - 1) California Code of Regulations (CCR), Title 9, Chapter 11, Medi-Cal Specialty Mental Health Services; 2) California Department of Health Care Services (DHCS) Letters and Information Notices; or 3) DHCS State Plan Amendments.

Network providers must ensure that procedure codes documented in the client record and submitted to the County's claims processing information system on electronic claims accurately reflect the specialty mental health services provided to the client.

CLARIFICATION OF FAMILY THERAPY, GROUP AND PLAN DEVELOPMENT PRODEDURE CODES

FAMILY THERAPY

Family therapy is defined as a specialty mental health service provided to an individual or multiple individuals **within a family**. The service must include the client's significant others, whether or not related by marriage or blood, such as a partner or spouse, parents, siblings, children, grandparents, etc. The client must be present when family therapy is provided.

A client's significant other(s) may be involved in the client's treatment with or without the client present, if the network provider determines that this would be of therapeutic value to the client. If the client is not present, the service is to be claimed as collateral.

It is not appropriate to open a case for the client's significant other(s) for the sole purpose of providing family therapy to the client. Each clinical case that is opened must meet medical necessity criteria and meet all Medi-Cal requirements for the delivery of specialty mental health services.

In no case will family therapy be reimbursed if the family is present only to observe the intervention of the therapist. Family observation of individual therapy is not considered an acceptable therapeutic intervention.

When family therapy is provided, only one claim is to be submitted regardless of the number of clients in the session. The name of any one client is to be selected and claimed once for the entire family session. That is, provider cannot bill for three separate family therapy sessions if there are three family members in the session. There are no exceptions to this rule.

Claiming for multiple units of family therapy is allowed only when the parents/caregivers/significant others are seen with a particular client at a different time from another client. There must be clinical justification clearly documented in the clinical record when multiple family therapy sessions are claimed.

GROUP THERAPY

Group therapy is therapy delivered to more than one family unit, each with at least one enrolled client. Multi-family group therapy is to be claimed as group therapy and not family therapy. This includes insight oriented, behavior modifying, supportive services delivered at the same time to more than one non-family client.

Only one claim is to be submitted regardless of the number of clients and family units in the session. Documentation for each group service claim must include how many clients were present/presented, who the facilitators were, and how long the group therapy lasted. That is, provider cannot bill for three separate group therapy sessions if there are three non-family clients in the session. There are no exceptions to this rule.

PLAN DEVELOPMENT

DHCS no longer requires a prospectively completed, stand-alone client plan for SMHS. Care planning is an ongoing interactive component of service delivery rather than a one-time event. The provider should adhere to all relevant care planning requirements in state or federal law. The provider shall document the required elements of the care plan within the client mental health record. Plan development may be done as part of an interdisciplinary inter/intra-agency conference and/or consultation with other mental health providers to develop and/or monitor the client's mental health treatment. Plan development may also be done as part of a contract with the client to develop and/or monitor the client's mental health treatment.

Team conference/case consultation claims must be clearly documented in the clinical record and include a summary of the client treatment planning process. The names of all attendees are to be included in the progress note.

TELEHEALTH SERVICES

Los Angeles County Department of Mental Health as the LMHP has been notified by the Department of Health Care Services (DHCS) to assist Medi-Cal providers in providing medically necessary health care services in a timely fashion for patients impacted by conditions that require

physical distancing. As a result, the approval of services via telehealth is sufficient and contract changes are not required. The introduction of telehealth to maximize the number of services that can be provided by telephone and telehealth and minimize community spread deceases. Telehealth services shall be provided and reimbursed from March 16, 2020, until further notice from the LMHP.

Network Providers shall make every effort to ensure that services furnished to Medi-Cal beneficiaries' standard of care is the same whether the patient is seen in-person, by telephone, or through telehealth.

Place of Service (POS) must be documented as the location where you would have provided the service in-person. Patients can receive telehealth services in their homes and providers may deliver services via telehealth from anywhere in the community, other than a clinic or other provider site. The POS should be where the provider would have normally provided the service, such as their office, however, if the provider is normally providing services in the community, then the progress note should indicate the POS as where they saw the client and provided treatment (e.g., Board & Care).

Network Providers rendering services in an inpatient setting must include POS as hospital or psychiatric health facility.

Authorized Video Telehealth Applications

Providers can use non-public facing remote communication products. Specifically, Apple, Facebook Messenger Video Chat, Google Hangouts Video, or Skype. However, Facebook Live, Twitch, TikTok and similar communication application must not be used by Network Providers.

PROCEDURE CODE RATES

The network provider rates associated with some of the procedure codes are included in Attachment I – *CalAIM IGP/FFS II Fee Discipline List*.

DIAGNOSIS CODES

Assessments must contain the required seven (7) uniform domains. To meet medical necessity criteria for Medi-Cal reimbursement the client must have one of the diagnoses specified in the CCR, Title 9, Chapter 11, Section 1830.205(b)(1)(A-R). The assessment should reflect the updated Cal Aims regulation created by the DHCS. Medical Necessity that applies to the service (whether or not the service is medically necessary). A mental health diagnosis is not a pre-requisite to access Specialty Mental Health Services (SMHS). There is a requirement that all Medi-Cal Claims include a CMS valid ICD 10 diagnosis code.

ICD-10 is the current HIPAA standard code set for dates of service and dates of discharge.