Quality Assurance Bulletin

November 25, 2009 No. 09-10 Revised

Program Support Bureau

Los Angeles County, Department of Mental Health

REVISION TO BULLETIN 09-10
Procedure Code Changes

These changes will NOT go into effect until after the IS shuts down and comes back on line.

Quality Assurance Bulletin 09-10 has been retracted and the section regarding "Changes in Case Consultation/Team Conference" has been removed due to corrected Medicare claiming issues. For this reason, the Case Consultation/Team Conference procedure codes will remain the same (99361/99362). No changes will be made to these codes. The complete Guide to Procedure Codes has been updated to reflect this retraction.

In addition, the implementation date of the Procedure Code changes detailed in Bulletin 09-10 has been updated. As noted above, **the changes will NOT go into effect until after the Integrated System (IS) shuts down and comes back on line.** Once the Integrated System (IS) comes back on-line for SD/MC II claiming, it is expected that all Department staff will utilize the new codes for all services entered that have a service date within this current fiscal year. If changes in contract computer systems cannot accommodate to this timeframe, it is hoped that transition to the newly established Procedure Codes can be accomplished within two months of when the IS comes back on-line for SD/MC II claiming.

The State is implementing modifications to the manner in which claims for clinical services are electronically coded and transmitted. Collectively, these changes are known as "Short-Doyle/Medi-Cal II" (SD/MC II). Under SD/MC II, claims must be submitted to outside payer sources before being sent to the State. For this reason, it is imperative that all Procedure Codes and Procedure Code usage be HIPAA compliant. The Guide to Procedure Codes has been updated to reflect the required changes in Procedure Codes under SD/MC II. This Bulletin outlines the changes in Procedure Codes which must be implemented **when the IS comes back on-line for SD/MC II claiming**.

The complete updated Guide to Procedure Codes can be found at
http://dmh.lacounty.gov/ToolsForAdministrators/agency_admin.html

Please see the attached "Changes in Procedure Codes – SD/MC II" for a visual diagram of the changes noted below and the attached "Table of Contents" from the Guide to Procedure Codes for a listing of pages changed as of 11/13/09. Also note the attached "Helpful Hits for Using the Guide" in which Bullet 7 has been updated to explain the shading in the revised coding tables.

Changes in Case Consultation/Team Conference
Changes Retracted

This is a 2-sided document.

Change in H2015 Usage

Procedure Code H2015 has been used for multiple purposes including therapy over the telephone, therapy with less than 20 minutes face-to-face time, record review, stand-alone plan development and triage when an episode is opened. The addition of new Procedure Codes will allow for distinct Procedure Codes for these services. **Beginning December 1, 2009 Procedure Code H2015 will only be used for individual and group rehab services** (see attached Changes in H2015 Usage).

The new Procedure Code for therapy over the telephone and therapy with less than 20 minutes face-to-face time is H0046. See pages 3 and 4 of the Guide to Procedure Codes for additional information (attached).

A unique Review of Records Procedure Code (90885) will be opened up for use by all programs under SD/MC II. The Review of Records Procedure Code should only be used for the following activities: assessment and/or diagnostic purposes, continuity of care when receiving a transferred or new client, or plan development when not in the context of another service. What has been know as "stand alone plan development not in the context of another service" should only be done in the context of having reviewed the client's Clinical Record and, thus, will now be incorporated into the definition of Review of Records. See page 10 of the Guide to Procedure Codes for additional information (attached).

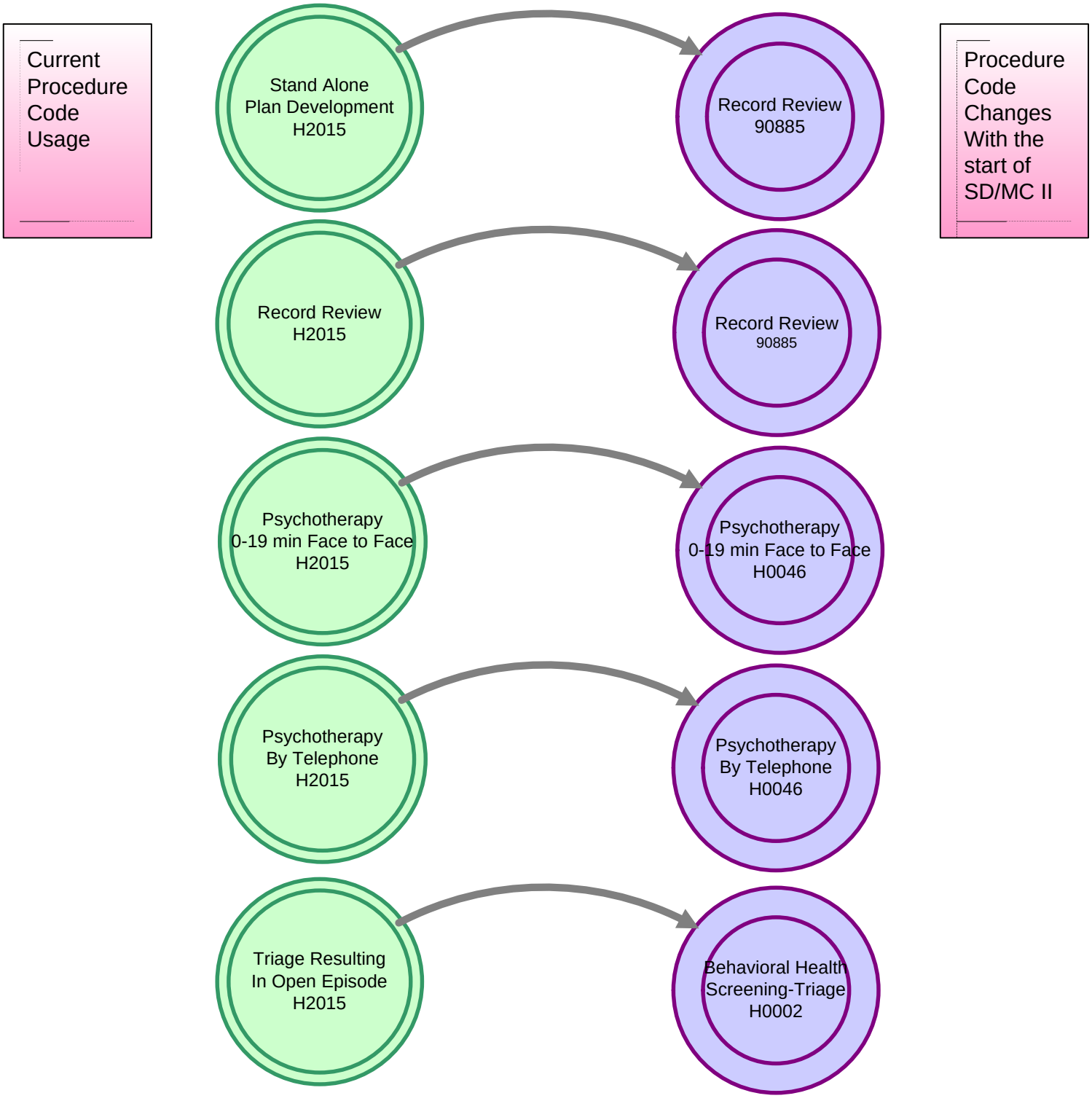
Directly-Operated programs were recently instructed to use Procedure Code H2015 for Triage when an episode is opened within the same calendar month of the triage contact. **A new Behavioral Health Screening-Triage procedure code (H0002) is now available for triage situations which result in an open episode within the same calendar month of the triage contact.** See Page 10 of the Guide to Procedure Codes for additional information (attached).

If you have questions regarding the information in this QA Bulletin, please contact your Service Area QA liaison or your MHSA Age Lead QA liaison.

c: Executive Management Team
District Chiefs
Program Heads
ACHSA
Department QA staff
Compliance Program Office
Nancy Butram, Revenue Management
Donna Warren-Kruer, Network Org. Provider

Changes in Procedure Codes – SD/MC II

Wednesday November 25, 2009



Changes in H2015 Usage

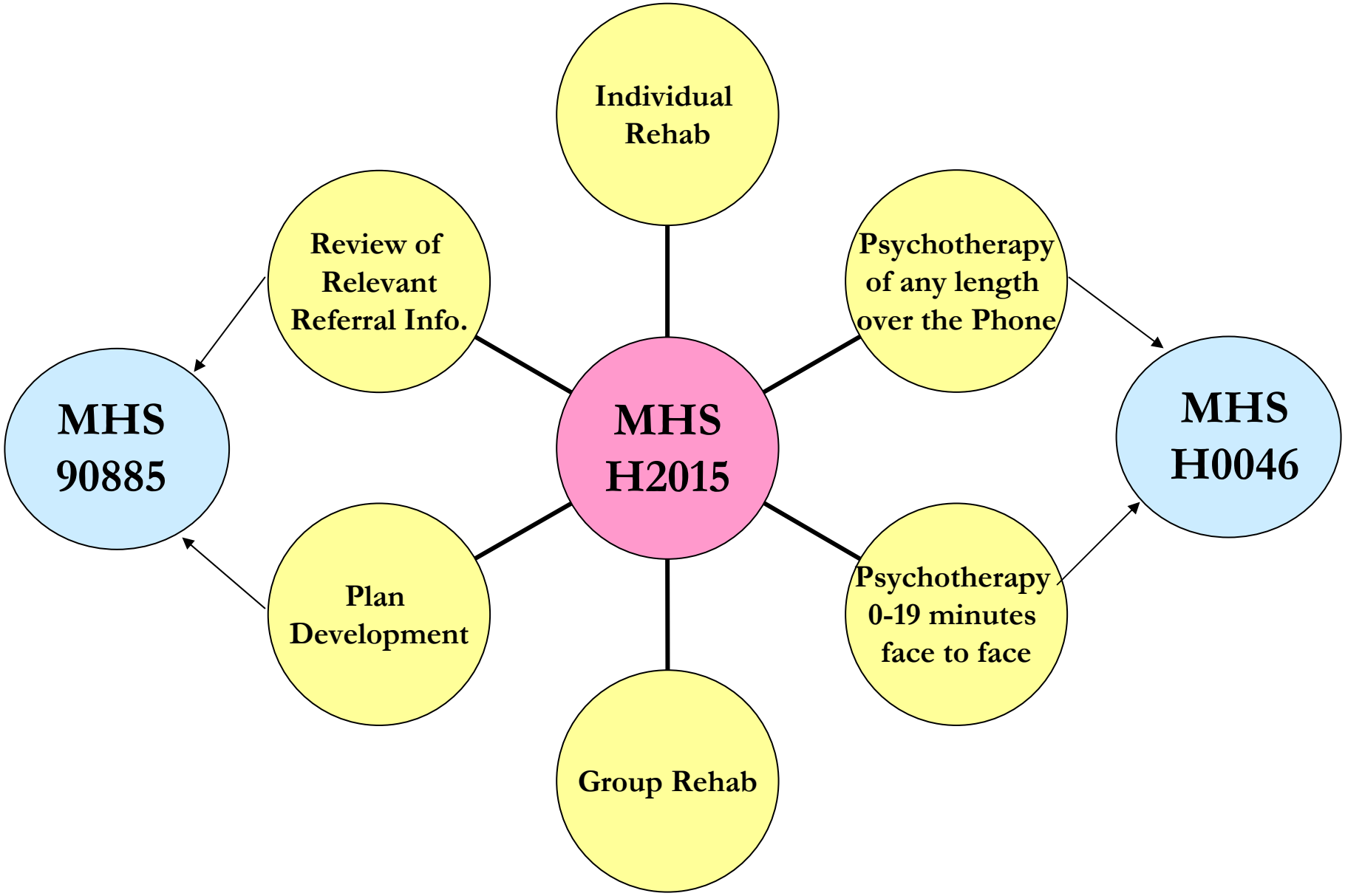


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TABLE OF CONTENTS (CONTINUED)

HELPFUL HINTS FOR USING THE GUIDE

DMH directly-operated and contract staff should address **questions and issues** to their supervisors/managers, who may, as needed, contact their Services Area Procedure Codes Liaisons for clarifications. Network Providers should contact Provider Relations.

- Readers will quickly note that, except for those services funded entirely by CGF, there are no codes that identify payer information, such as PATH. Payer information will be maintained by providers in the administrative part of the new IS and when claims are being prepared, will match the service code on the clinical side of the IS with the payer information on the administrative side of the IS. Therefore, if claims are to go to the correct payer source, it is imperative that the Administrative side of the system be maintained.
- The codes have been categorized into types of services similar to those we now in use in order to facilitate the transition to Level I (CPT) and Level II (HCPCS) codes.
- To facilitate transition to these new codes, the Activity Codes and the FFS Codes that have been in use are listed in association with the new Procedure Codes.
- Medicare does not reimburse for travel and documentation time, so in order to appropriately claim to both Medicare and Medi-Cal total service time for the Rendering Provider must be broken out into face-to-face and other time for most services. Both of these times need to be entered into the IS and documented in the clinical record.
- While the basic structure of the tables is the same, many vary in their content because the requirements of different sets of codes are so different.
- The "Scope of Practice" column that used to define who could report the code is now headed "Rendering Provider". This is HIPAA language that the DMH is embracing, but the information in the column provides the same information regarding usage of the code. The categories of staff the DMH will continue to recognize are these: physician (MD or DO); licensed or waivered clinical psychologist (PhD or PsyD); licensed or registered Social Worker; licensed or registered MFT; registered nurse (RN); nurse practitioner (NP); clinical nurse specialist (CNS); psychiatric technician (PT); licensed vocational nurse (LVN); and mental health rehabilitation specialist (MHRS). See Page vi, Reporting and Documentation Notes, for documentation comments.
- The table heading on each page indicates whether the codes on that page may be used by Network and/or SD/MC Providers. Individual, Group, and Organizational Network Providers may only use lined or shaded Services and shaded codes and only the disciplines as noted under the Network header. SD/MC Organizational Providers may use shaded codes on pages 1-2, 7-9, and 27 & 28 AND any unshaded codes. The Table of Contents also indicates whether the codes on a page are applicable to Network, SD/MC, or both.
- Only one Activity Code per Service Function was left as "active" in the legacy MIS when the IS was implemented. All other codes were marked "inactive". Numbers in **BOLD** in the "Service Function" and "Former Activity Code" columns are the legacy MIS default codes, that is, the only active codes now recognized by the legacy MIS. Activity Codes in **(BOLD parenthesis)** are codes that were not formerly associated with the service, but now serve as the MIS default code for the service. These are the ONLY codes that a can be used in the legacy MIS for the service.

INDIVIDUAL PSYCHOTHERAPY (NON-FAMILY) – SD/MC & NETWORK PROVIDERS

Individual Psychotherapy services that a provider wishes to deliver in conjunction with Day Treatment Intensive or Day Rehabilitation must have authorization from the Department's Central Authorization Unit prior to delivery.

	Short-Doyle/Medi-Cal (SD/MC)			Network Medi-Cal		
Service	**Duration of Face-to-Face**	**Code**	**Rendering Provider**	**Duration of Face-to-Face**	**Code**	**Rendering Provider**
Insight oriented, behavior modifying, and/or supportive psychotherapy delivered to one client.	0-19 minutes	H0046 (former code H2015)	MD/DO or RN: Licensed PhD/PsyD: Licensed or registered and waivered LCSW & MFT: Licensed or registered or waivered NP or CNS: Certified and student professionals in these disciplines with co-signature	**Ind, Gp, & Org** 0-19 minutes	Not Reimbursed	MD/DO or RN: Licensed PhD/PsyD: Licensed LCSW & MFT: Licensed NP or CNS: Certified
	20-44 minutes	90804		**Ind, Gp, & Org** 20-39 minutes	90804	
	45-74 minutes	90806		**Indiv & Group** 40-74 minutes **Org** 40-50 minutes	90806	
	75+ minutes	90808		**Indiv & Group** 75+ minutes **Org**: NA	**Indiv & Group** 90808 **Org**: Not Reim	
Interactive psychotherapy using play equipment, physical devices, or other mechanisms of non-verbal communication delivered to one client.	0-19 minutes	H0046 (former code H2015)		**Ind, Gp, & Org** 0-19 minutes	Not Reimbursed	
	20-44 minutes	90810		**Ind, Gp, & Org** 20-39 minutes	90810	
	45-74 minutes	90812		**Indiv & Group** 40-74 minutes **Org** 40-50 minutes	90812	
	75+ minutes	90814		**Indiv & Group** 75+ minutes **Org**: NA	**Indiv & Group** 90814 **Org**: Not Reim	

Notes:

- All of these services are classified as Individual Mental Health Services and are reported under Service Function 42.
- These services are recorded in the clinical record and reported into the IS in hours:minutes.
- Not all staff listed who can report the service may claim to all payer sources. The Department will keep its employees informed, and, as appropriate, its agencies, regarding rules and regulations for service delivery and reimbursement.
- When doing telephone therapy, face to face time is always zero and the code used is H0046.

Documentation Notes:

- Clinical interventions must be included in the progress note and must be consistent with the client's goals/desired results identified in the Service Plan.
- The service focuses primarily on symptom reductions as a means of improving functional impairments.

INDIVIDUAL PSYCHOTHERAPY (NON-FAMILY) WITH EVALUATION AND MANAGEMENT SD/MC & NETWORK PHYSICIANS AND NURSE PRACTITIONERS

Individual Psychotherapy services that a provider wishes to deliver in conjunction with Day Treatment Intensive or Day Rehabilitation must have authorization from the Department's Central Authorization Unit prior to delivery.

This service should be used by Physicians and Nurse Practitioners when providing medication prescription services in association with more than minimal therapy.

	Short-Doyle/Medi-Cal (SD/MC)			Network Medi-Cal		
Service	**Duration of Face-to-Face**	**Code**	**Rendering Provider**	**Duration of Face-to-Face**	**Code**	**Rendering Provider**
Insight oriented, behavior modifying, and/or supportive psychotherapy delivered to one client **WITH** evaluation and management.	0-19 minutes	H0046 (former code H2015)	MD/DO: Licensed NP: Certified and student professionals in these disciplines with co-signature	**Ind, Gp, & Org** 0-19 minutes	Not Reimbursed	MD/DO: Licensed
	20-44 minutes	90805		**Ind, Gp, & Org** 20-39 minutes	90805	
	45-74 minutes	90807		**Indiv & Group** 40-74 minutes **Org** 40-50 minutes	90807	
	75+ minutes	90809		**Indiv & Group** 75+ minutes **Org**: NA	**Indiv & Group** 90809 **Org**: Not Reim	
Interactive psychotherapy using play equipment, physical devices, or other mechanisms of non-verbal communication delivered to one client **WITH** evaluation and management.	0-19 minutes	H0046 (former code H2015)		**Ind, Gp, & Org** 0-19 minutes	Not Reimbursed	
	20-44 minutes	90811		**Ind, Gp, & Org** 20-39 minutes	90811	
	45-74 minutes	90813		**Indiv & Group** 40-74 minutes **Org** 40-50 minutes	90813	
	75+ minutes	90815		**Indiv & Group** 75+ minutes **Org**: NA	**Indiv & Group** 90814 **Org**: Not Reim	

Notes:

- All of these services are classified as Individual Mental Health Services and are reported under Service Function 42.
- These services are recorded in the clinical record and reported into the IS in hours:minutes.

SERVICES TO SPECIAL POPULATIONS – SD/MC ONLY

Service	Code	Rendering Provider
Multi-Systemic Therapy (inactive)	H2033	Any staff operating within his/her scope of practice
Community-based Wrap Around (inactive)	H2021	
MAT - Case Conference Attendance MAT Team Meeting time that cannot be claimed to Medi-Cal	G9007	

Notes:
- All of these services are classified as Individual Mental Health Services and are reported under Service Function 42.
- These services are recorded in the clinical record and reported into the IS in hours:minutes.

Service	Code, (Modifier*)	Rendering Provider
Therapeutic Behavior Services	H2019 (HE*)	Any staff operating within his/her scope of practice

*Contract agencies submitting electronic claims to the Department must use the letter modifiers in the claims transmission.

Notes:
- This service is classified as Therapeutic Behavior Services and is reported under Service Function 58.
- These services are recorded in the clinical record and reported into the IS in hours:minutes.

OTHER SERVICES – SD/MC & NETWORK PROVIDERS

Service	Short-Doyle/Medi-Cal (SD/MC)		Network Medi-Cal	
	Code	Rendering Provider	Code	Rendering Provider
Behavioral Health Screening – Triage Service to determine eligibility for admission to a treatment program	H0002	Any staff operating within his/her scope of practice.	**Not Reimbursed**	MD/DO or RN: Licensed PhD/PsyD: Licensed LCSW & MFT: Licensed NP or CNS: Certified
Review of Records Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for: • Assessment and/or diagnostic purposes • Continuity of care when receiving a transferred or new client • Plan Development (development of client plans and services and/or monitoring a client's progress) when not in the context of another service	90885		**Not Reimbursed**	
Targeted Case Management (TCM) Services needed to access medical, educational, social, prevocational, vocational, rehabilitative, or other community services. These services, whether face-to-face, by phone, or through correspondence, provide for the continuity of care within the mental health system and related social service systems. Services include linkage and consultation, placement, and plan development in the context of targeted case management services.	T1017 (HE, HS*)		**T1017** (HE, HS*)	
No contact – Report Writing Preparation of reports of client's psychiatric status, history, treatment, or progress for other physicians, agencies, insurance carriers, or for discharge summary	90889		**Not Reimbursed**	

*Contract agencies submitting electronic claims to the Department must use the letter modifiers in the claims transmission.

Notes:

- Indiv=Individual Provider; Org=Organizational Provider
- All of these services, except TCM, are classified as Individual Mental Health Services and are reported under Service Function 42.
- TCM services are classified as Targeted Case Management Services and are reported under Service Function 04.
- These services are recorded in the clinical record and reported into the IS in hours:minutes.
- **TCM Medi-Cal Lockout:** Except for the day of admission or for placement services provided during the 30 calendar days immediately prior to the day of discharge for a maximum of three nonconsecutive periods of 30 days, TCM may not be reimbursed by Medi-Cal on the same day as any of the following services are claimed – psychiatric inpatient hospital services, Psychiatric Health Facility services, or Psychiatric Nursing Facility services. (These facilities include Institutions for Mental Disease - IMDs.)

TEAM CONFERENCE/CASE CONSULTATION – SD/MC & NETWORK PROVIDERS

	Short-Doyle/Medi-Cal (SD/MC)		Network Medi-Cal	
Service	**Code**	**Rendering Provider**	**Code**	**Rendering Provider**
Team Conference/Case Consultation Interdisciplinary inter/intra-agency conferences and consultations to coordinate activities of client care. Client may or may not be present.	1-59 minutes 99361	Any staff operating within his/her scope of practice.	1-59 minutes 99361	MD/DO or RN: Licensed PhD/PsyD: Licensed LCSW & MFT: Licensed NP or CNS: Certified
	60+ minutes 99362		60+ minutes 99362	

*Contract agencies submitting electronic claims to the Department must use the letter modifiers in the claims transmission.

Notes:

- Indiv=Individual Provider; Org=Organizational Provider
- These services are classified as Individual Mental Health Services and are reported under Service Function 42.
- These services are recorded in the clinical record and reported into the IS in hours:minutes.
- **The time of the conference determines the code, but that time should NOT be equated with claimable time.**
- **Face-to-face time must always be zero** because this is not a service directed toward the client and would distort the amount of appropriate reimbursable time; these codes are only used when the service is **directed towards** agency staff.
- For Team Conference: Other time should only include the actual time a staff person participated in the conference (listening and learning are not included) and any other time a staff person actually spent related to the conference, such as travel or documentation. Participation includes time when information was shared that can be used in planning for client care or services to the client.
- For Case Consultations (between two staff): All time spent during the consultation may be claimed as other time since each person must be actively participating for the entire duration.