To:	**BHS Contracted Mental Health Service Providers**
From:	**Behavioral Health Services**
Date:	**May 19, 2023 Revised May 20, 2023**
Title	**Payment Reform CPT Crosswalk for Specialty Mental Health Services**

Background
California Advancing and Innovating Medi-Cal, or CalAIM, is a transformational plan to modernize the State's Medicaid program. It will improve the quality of life and health outcomes of Medi-Cal beneficiaries, including those with the most complex health and social needs. CalAIM includes a series of far-reaching initiatives that together represent broad reforms of Medi-Cal programs and systems. The Department of Health Care Services (DHCS) is implementing CalAIM in partnership with Medi-Cal providers, Managed Care Plans (MCPs), counties, community-based organizations and other stakeholders. These changes will span a multi-year period, with the first reforms already underway effective January 1, 2022, and subsequent reforms to be phased in through 2027.

The next step in the implementation timeline is the launch of behavioral health payment reform and a transition to Common Procedural Terminology (CPT) codes. This will see counties transitioned from a cost-based reimbursement model to a model similar to Fee For Service. DHCS is launching new billing codes effective July 1, 2023, and the County of San Diego (County) is developing a plan to transition providers to this model. This transition will be in a phased approach and align with the roll out and build of Cerner Millennium.

Crosswalk of CPT Codes
A Crosswalk of Healthcare Common Procedure Coding System (HCPCS) and CPT codes that most closely aligns with services currently provided by our contracted providers within our Mental Health Plan has been created. The codes are taken from the Medi-Cal billing manuals from DHCS. We have worked diligently with our Billing Unit, Optum, and our Cerner and Millennium build teams to implement many back-end processes to facilitate a smooth transition to the use of CPT codes. We will continue to engage both internally and with our providers to identify services that are not covered by the currently identified codes and are potentially billable to Specialty Mental Health Service (SMHS).

Please be aware that the crosswalk will continue to be updated on an ongoing basis with any relevant changes communicated by DHCS. These changes, in addition to any claimable codes added in the future, will be communicated through both the monthly Up To the Minute (UTTM) and QIP meeting.

In the interim, programs should begin thinking about clinical workflows and business practices, primarily around productivity and provider types used for direct client services. Processes such as Collaborative Documentation could also be explored to support key changes resulting from changes to billing/claiming for SMHS as we move forward with CPT coding and Payment Reform.

What does this mean for providers?
We will be moving away from categorizing services by their service code number and begin categorizing services based on their service definitions and titles. Providers will select the service based on the service definition which best supports the service they provided to the client. These service definitions will then link on the back-end to the appropriate CPT or HCPCS code as shown in the two examples below:

- Licensed/Registered/Waivered LCSW completes BHA → selects "MH Assessment, Non-Physician" in EHR → link to CPT/HCPCS via Billing Set Up for Mental Health Assessment based on credential and time claimed

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- MHRS completes individual rehabilitation svc → selects "Rehabilitation Svc" → selects "Individual" for Provided To → link to HCPCS via Billing Set Up for Individual Rehab Service

Currently providers will still see the "old" service codes" (i.e. SC10, SC50…) in CCBH, however as we transition to Cerner Millennium, these service code numbers will no longer be associated with the Service Definitions/Service Titles – therefore we encourage providers to begin thinking and referring to the services they provide by the service definition rather than by service code.

Important Changes
There are a few significant changes providers should be aware of and take into consideration. The most notable are listed below.

- **Collateral** (SC33) – This is no longer available as a stand-alone service and would instead be claimed under the service which is the focus of the contact with the significant support person.
  - For example, case manager meets with a family member to discuss the coping skills the client is working on and the tools for the family to support. This would be documented as a Rehabilitation service with Provided to: Family.
- **Rehabilitation Services** – Rehabilitation codes will no longer be separated out as four distinct separate services or service codes. Instead, Rehabilitation codes will have two service definitions. The service indicator for "provided to" and narrative will identify who the service was provided to and the focus of the service.
  - Rehabilitation Svc – utilized for individual, family rehabilitation services.
  - Rehabilitation Grp – utilized for group rehabilitation services.
- **Medication Services/E&M Service codes** – Providers will select appropriate medication code for either an established or new patient and no longer select service code based on "problem severity" as the CPT code will be linked on the back-end based on time increment claimed.
  - Est. Patient Med Svc
  - New Patient Med Service
- **SC20 Medication Services Comprehensive** – This service will no longer available. Medical staff should select the appropriate CPT Service Definition which best supports the service provided, within their scope of practice. Most appropriate options include:
  - Medication Training and Support
  - Injection SQ/IM
  - Targeted Case Management
- **Group Psychotherapy codes** – There will separate and distinct service codes/definitions for group psychotherapy based on the individuals present in the group:
  - Group Psychotherapy
  - Multi-family Group Psychotherapy
- **Intensive Home-Based Services (IHBS)** – IHBS service code SC83 will no longer be a stand-alone service code/definition. Providers will select the service definition which best supports the service type provided –

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they may include but are not limited to assessment, plan development, therapy, rehabilitation, or case management services. IHBS services will be identified by a new **Contact Type** for IHBS.

- **Telephone and Telehealth Services** – If a service is provided via telehealth (audio only or audio/video) Place of Service selected must either be "Telehealth Home" or "Telehealth Outside Home," unless the service is mobile crisis. Place of Service is determined by the client's location at the time of the service.
    - Place of Service will be "Telehealth Home" or "Telehealth Outside Home" as billing will now be tied to place of service which will link on the back end.
    - Services provided via Telephone are now considered "Telehealth" services and should be claimed using the Telephone indicator for Contact Type and Place of Service as "Telehealth Home" or "Telehealth Outside Home."
- **Mobile Crisis Services –** Community Based Mobile Crisis Intervention Services are a new Medi-Cal benefit which is currently under implementation. Only those specific programs which provide mobile crisis services will utilize this service code/definition and unique Place of Service: Mobile Crisis
    - Additional add-on codes will be available to capture Transportation Mileage and Transportation Staff Time which can be claimed separately from the Mobile Crisis all-inclusive rate. Further details will follow once this Medi-Cal benefit has been implemented in full.

Additional Key Changes

- Billing is based on time spent on Direct Client Care. Only the time it takes to provide direct services are claimed towards the units of service.
    - Direct client 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. For the client care codes (e.g., therapy or evaluation and management), direct client care means time spent with the client for the purpose of providing healthcare/mental health services.
    - For specific services which allow consultation with family or members of the care team, etc., direct client care means time spent with the consultant/members of the client's care team.
    - While time spent in documentation and travel will no longer be claimable, it should continue to be entered in encounters as it will be incorporated into rates, and best inform future rate discussions.
- MH Providers will now claim by Units of Service instead of by the minute. Providers will still enter their service time on the front end which will crosswalk to units on the back-end via the billing set up. Providers will need to be aware of minimum and maximum time which can be claimed for services, which will be indicated on the CPT Crosswalk.
- The need for additional reports to support providers in monitoring service time within the new billing structure is also being explored and discussed at this time.

Training

- County BHS Staff training is available via CalMHSA:

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- CPT Codes 101 Introductions to CPT Codes
- CPT Codes 102 Optimization of CPT Codes for the Majority of Behavorial Health Services

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