Billing Session

CalMHSA

California Mental Health Services Authority

Agenda

- CalAIM Same Day Billing Rule
- Service Error Report (s)
- Configuring SmartCare for New Programs
- Q&A

Same Day Service

Short Doyle Rule – Duplicate Services

A duplicate claim in SDMC is defined as the second and all subsequent claims that match all of the following criteria:

1. Same Beneficiary (CIN)
2. Same Submitting County
3. Same Facility Location NPI
4. Same Rendering Provider NPI
5. Same Date of Service
6. Same Procedure Code
7. Same Units
8. Same Amount Billed

Subsequent claims will be denied for being a duplicate unless the claim has a duplicate service procedure modifier.

New CalAIM Rule – Same Day Service

Outpatient Services

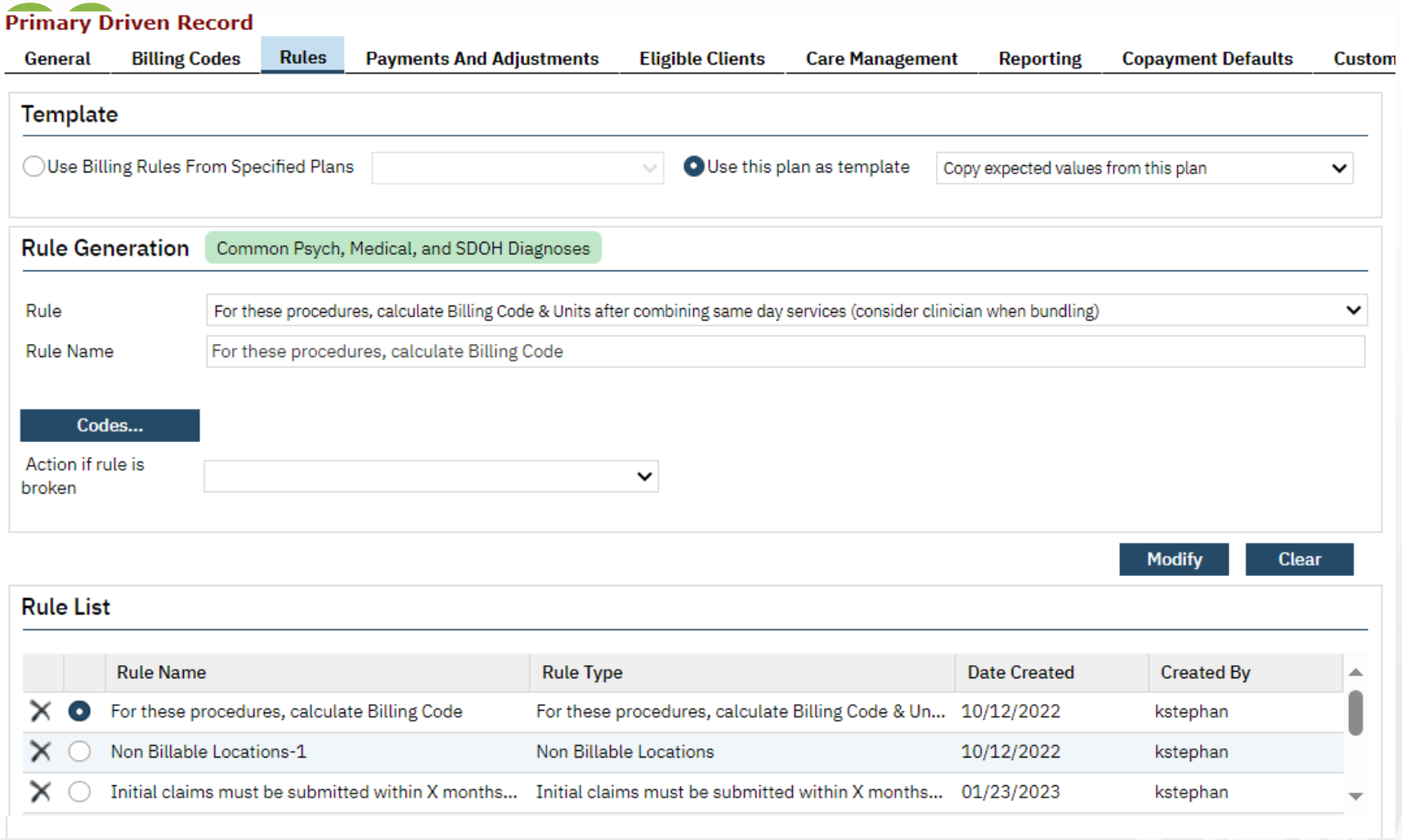
Outpatient services are listed in service tables 1-109. Except for Sign Language or Oral Interpretive Services (T1013) and Interactive Complexity (90785), a claim for an outpatient service is considered a duplicate if all the following data elements are the same as another service approved in history:

- The beneficiary's CIN
- Rendering provider NPI
- Procedure code(s)/modifier(s)
- Date of service

New CalAIM Rule – Same Day Service

If a provider renders two services to the same beneficiary on the same day in two or more separate encounters, all encounters must be claimed as one service to ensure the additional encounters are not denied as duplicate services. For example, if a provider renders psychotherapy for crisis to a beneficiary for 30 minutes in the morning and provides psychotherapy for crisis to the same beneficiary for 30 minutes in the afternoon, the claim would be submitted for 60 minutes of psychotherapy of crisis (90839).

New CalAIM Rule – Same Day Service



New CalAIM Rule – Same Day Service

Code	Procedure	Duration Range	Rate
99213	Medication Support	8-22	$50.00
99214	Medication Support	23 - 37	$75.00
99215	Medication Support	38 - 52	$100.00

- A Client Has Two, 20 Minute Visits
- What would Happen?

- A Client Has One 20 Minute Visit, and One 15 Minute Visit
- What Would Happen?

New CalAIM Rule – Problem

- This rule is a Medi-Cal only rule. So, while Medi-Cal wants us to combine the two 99213s together, if there is a payor that is primary to Medi-Cal, they may not have this same requirements.
- This means that the calculation to combine the two charges together ONLY gets applied when we are beginning the process to produce claims for Medi-Cal
- There are issues related to how the Charges appear on the system's Ledger.
  - We need to have each Service remain (each has a note that needs to be part of the medical record),
  - We need to have the separate Charges remain (we might need to bill these separate charges to a primary plan)

New CalAIM Rule – Same Day Service

- This means that the calculation to combine the two charges together ONLY gets applied when we are beginning the process to produce claims for Medi-Cal
- This requirement presents issues related to the sequence of events.
  - For the system to perform this calculation, it presumes both service records are entered into the system without fail for the system to make the connection between the two occurring on the Same Day
  - Contractor Invoicing occurs before the calculation of Medi-Cal Claims. So, the services entered by contractors will result in two initial charges (99213). How are they supposed to present/invoice those to the County?

Same Day Service – Problem?

- For Billing to Medi-Cal – No
  - Assuming that Both Services are Entered Before the Claims Are Created
- For Contractor Invoicing - Kind Of
  - Currently, this requirement will result in Over-Payment to Contractors as Their Services will NOT be combined.
  - As we saw, the Net Amount of the Two Service will **Sometimes** exceed the value of a combined service
- CalMHSA is working on developing reconciliation processes/report to address these overpayments

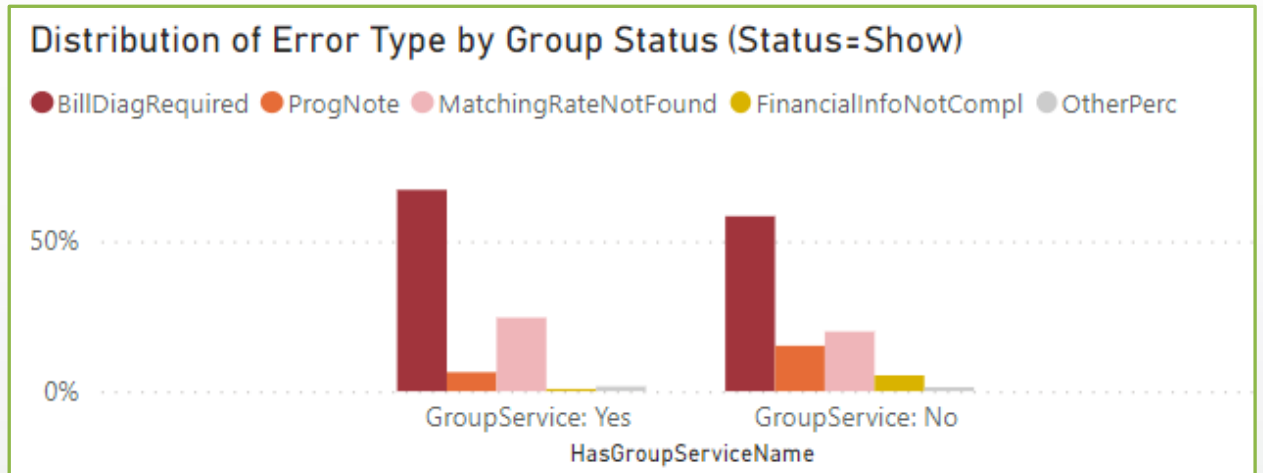
The Numbers

County	Count of ClaimLineItems	Count of ClaimLineItems with Multiple Charge References	Percentage
Colusa	15001	430	3%
Contra	44031	998	2%
Fresno	170076	3290	2%
Glenn	26795	152	1%
Humboldt	16760	122	1%
Imperial	391330	6996	2%
Kern	404089	2105	1%
Kings	18601	174	1%
Lake	22310	69	0%
Marin	17067	187	1%
Mono	2532	13	1%
Nevada	76592	1594	2%
Obispo	23021	561	2%
Placer	16877	192	1%
Sacramento	88178	1317	1%
SanBenito	10077	110	1%
SanJoaquin	42162	661	2%
SantaBarbara	72190	1268	2%
Siskiyou	24933	113	0%
Sonoma	17527	361	2%
Stanislaus	24028	712	3%
Tulare	27723	78	0%
Ventura	270706	7238	3%

Diagnosis Billing Errors

Diagnosis Errors – Problem?

- Yes – Billing Diagnosis Errors Account for 59.4% of Service Errors

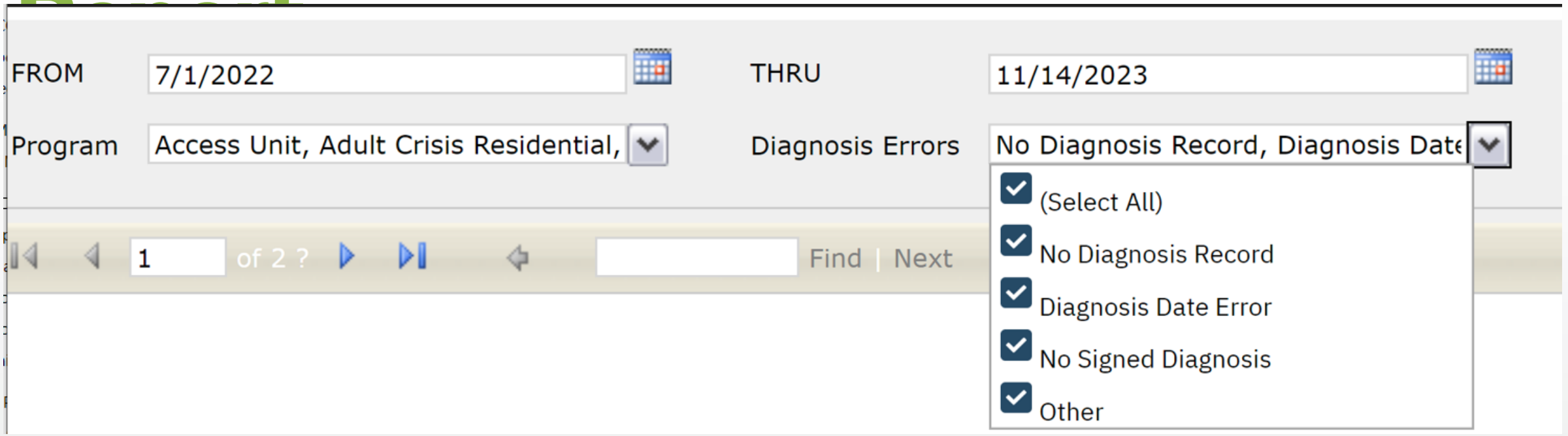


HasGroup Service	BillDiagReq uired	ProgNote NeedsSig	MatchingRate NotFound	FinancialInfo NotCompl	Other Perc	Total ErrorCount
0	58.3%	15.1%	19.9%	5.3%	1.4%	21505
1	67.1%	6.3%	24.5%	0.4%	1.6%	2936
Total	**59.4%**	**14.1%**	**20.4%**	**4.7%**	**1.4%**	**24441**

Diagnosis Errors – How Can I Address?

- There is a new report in all County PROD Systems called “CalMHSA Billing Diagnosis Errors Report”
- It has been assigned to user roles
  - County Affiliate SysAdmin
  - LPHA/Clinician
  - Clinician Supervisor
  - Reception and Front Desk
  - Medical Records/Quality Assurance
  - Billing Supervisor
  - Billing
  - Medical Supervisor

CalMHSA Billing Diagnosis Errors



- Yes – Billing Diagnosis Errors Account for 59.4% of Service Errors

CalMHSA Billing Diagnosis Errors Report

Report will categorize and group the errors into the following use cases:

Use Case 1 – There are no Diagnosis Documents with the same “Program” that correspond to the “Service Program”

Use Case #2 there IS a Diagnosis Document with the same “Program” that corresponds to the “Service Program”, but the “Effective Date” of the Diagnosis Document is before the “Date of Service”

Use Case #3 There IS a Diagnosis Document with the same “Program” that corresponds to the “Service Program”, and the “Effective Date” of the Diagnosis Document covers the “Date of Service”, but the “Status” of the document is not “Signed”

CalMHSA Billing Diagnosis Errors Report

Service Diagnosis Errors
From 07/01/2022 Through 11/14/2023

Program	Diagnosis Error	Service Id	Client Id	Client Name	DOS	Procedure	Clinician Id	Staff Name
Access Unit	Diagnosis Date Error	2550	1096	Asano,Jason	04/10/2023	Group Psychotherapy (Other Than of a Multiple-Family Group)	620	Rowe,Charla
		2560	1096	Asano,Jason	04/12/2023	Group Psychotherapy (Other Than of a Multiple-Family Group)	623	Vencill,Kacey

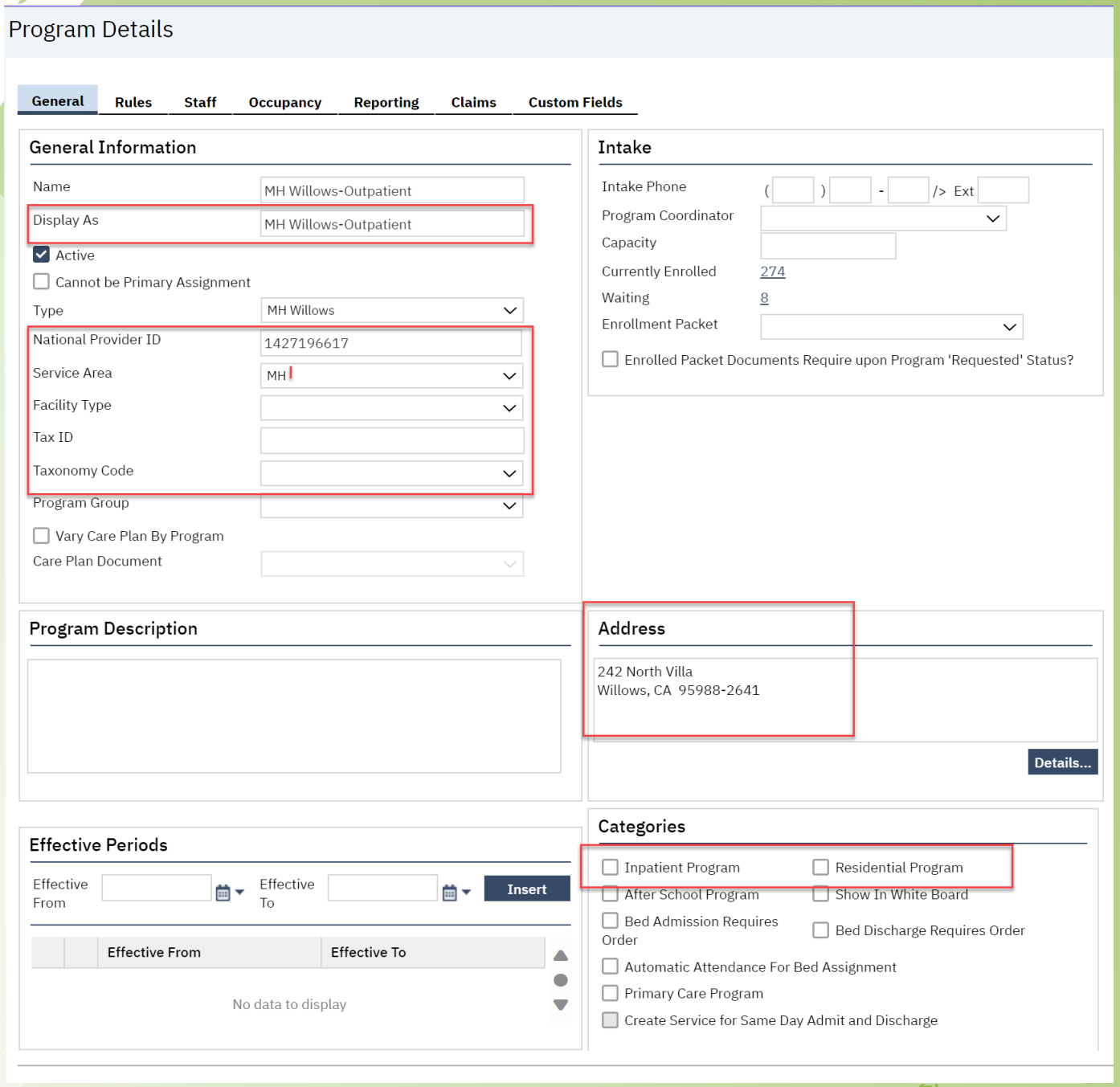
Configuring SmartCare for New Programs

Agenda

- Program Setup
- Items to Setup and Consider
  - Program Name (Naming Convention)
  - Procedure Codes
  - Locations
  - Clinical Data Access Grouping (CDAG)
  - Staff/Users
  - TEDS Setup – State Reporting
  - 274
  - Rates & Billing Codes
  - Claim Formats/Billing Claims Override
  - Financial Assignments
- Q&A

PROGRAM DETAILS

- Program Display Name
- NPI
- Service Area
- Facility Type
- Tax ID
- Taxonomy Code
- Address (9 digit zipcode)
- Categories



PROGRAM DETAILS-CUSTOM FIELDS

State Reporting program data

Program Details

General | Rules | Staff | Occupancy | Reporting | Claims | Custom Fields

California Reporting

Organization Unit Code
Provider Group Name
CalOMS Service Type
CalOMS Provider ID

CSI Mode of Service: Outpatient Services
MH Provider Number: 1101

OSHPD

OSHPD Facility Identification Number

Legacy Program Reference

Legacy Program ID: 1000

NACT/274 Reporting

If the Program is a Primary Program/Site and is reportable directly under a Provider Group select the checkbox for 'Medi-Cal reportable for NACT/274 as a Primary Site and Information Complete' and select the appropriate Provider Group from the drop down. If the Program is reportable under a Primary Program/Site select the checkbox for 'Program is reportable under an existing Primary Site' and select the appropriate Primary Site. 274 Sites are defined as those Programs that are reportable directly to a Provider Group and have the Provider Group selected in the Program Details.

Medi-Cal reportable for NACT/274 as a Primary Site and Information Complete ☐ Program is reportable under an existing Primary Site ☐

Provider Group | Primary Site

274 Facility Type | Institutional Facility Type

Licensed Bed Count | Available Bed Count | Staffed Bed Count

Provider Number | Hours of Operation | ADA Compliant for Physical Plant ○ Yes ○ No

TDD/TTY Equipment Available ○ Yes ○ No | Distance Between Site and Closest Public Transportation | Telehealth Station/Equipment Available at Site ○ Yes ○ No

Language Capacity - Arabic | Language Capacity - Armenian | Language Capacity - Cambodian

Language Capacity - Cantonese | Language Capacity - English | Language Capacity - Farsi

Language Capacity - Hmong | Language Capacity - Korean | Language Capacity - Mandarin

Language Capacity - Other Chinese | Language Capacity - Russian | Language Capacity - Spanish

Language Capacity - Tagalog | Language Capacity - Vietnamese | Language Capacity - American Sign Language (ASL)

Language Line Available ○ Yes ○ No | Other Language Services Available | Primary Site Contact Email Address

Primary Site Contact Facsimile Number | Site URL Address

IsMediCalCertified ○ Yes ○ No | MediCal Certification Date | MediCal Expiration Date

Site DEA Number | Owner Name | Ownership Code

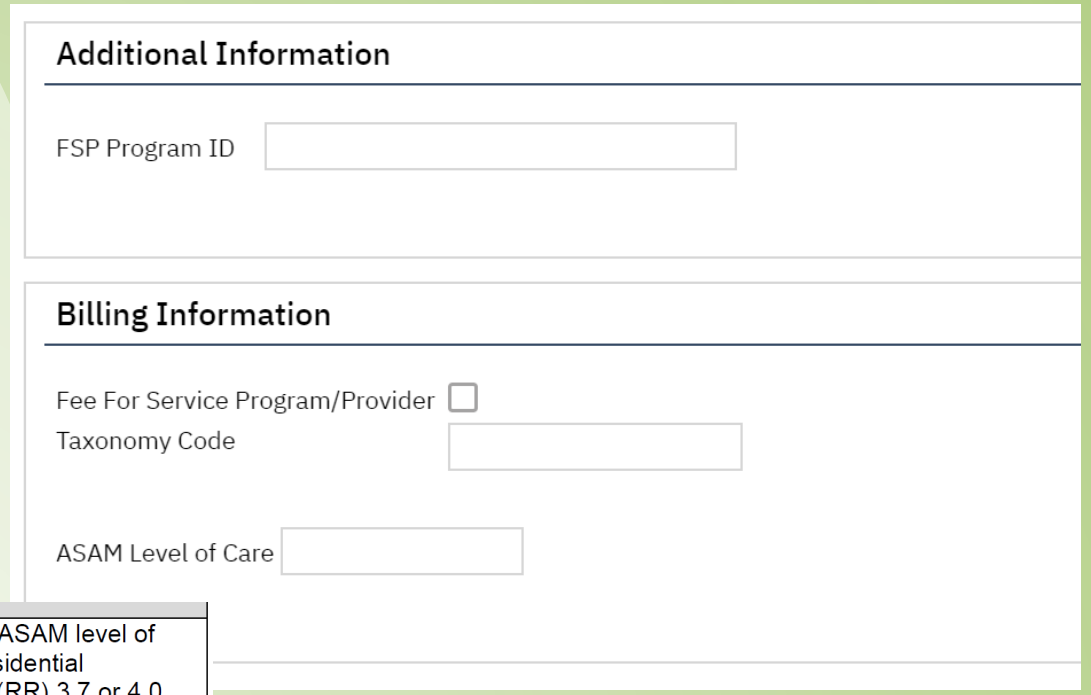
Ownership Percentage | Site County Location | Age Group Served

Licensed Capacity For OTP | Provider Type

PROGRAM DETAILS-CUSTOM FIELDS

Additional State Reporting program data & Billing Information

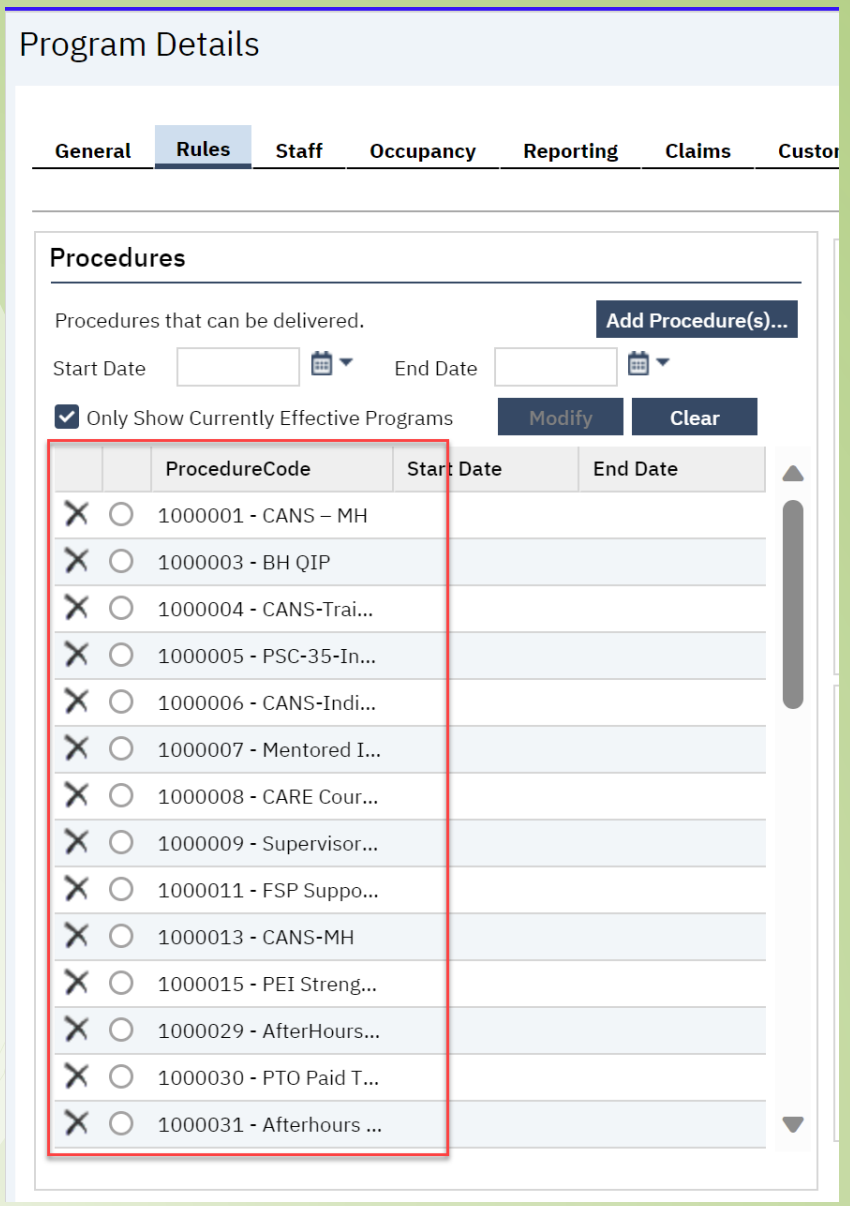
- FSP Program ID (State Reporting)
- FFS Program Identifier (When checked the “FFS” Claim note is added to the 837P Claim)
- Taxonomy Code
- ASAM Level of Care (This is for the DMC 837I per DHCS companion guide)



174		**REF03**	**Description**	RH37P RH37 RH37Y RH40P RH40 RH40Y WM37P WM37 WM37Y WM40P WM40 WM40Y		Describes the ASAM level of service for Residential Rehabilitation (RR) 3.7 or 4.0 and Withdrawal Management (WM) 3.7 or 4.0 and indicates Perinatal (P) or Youth (Y).

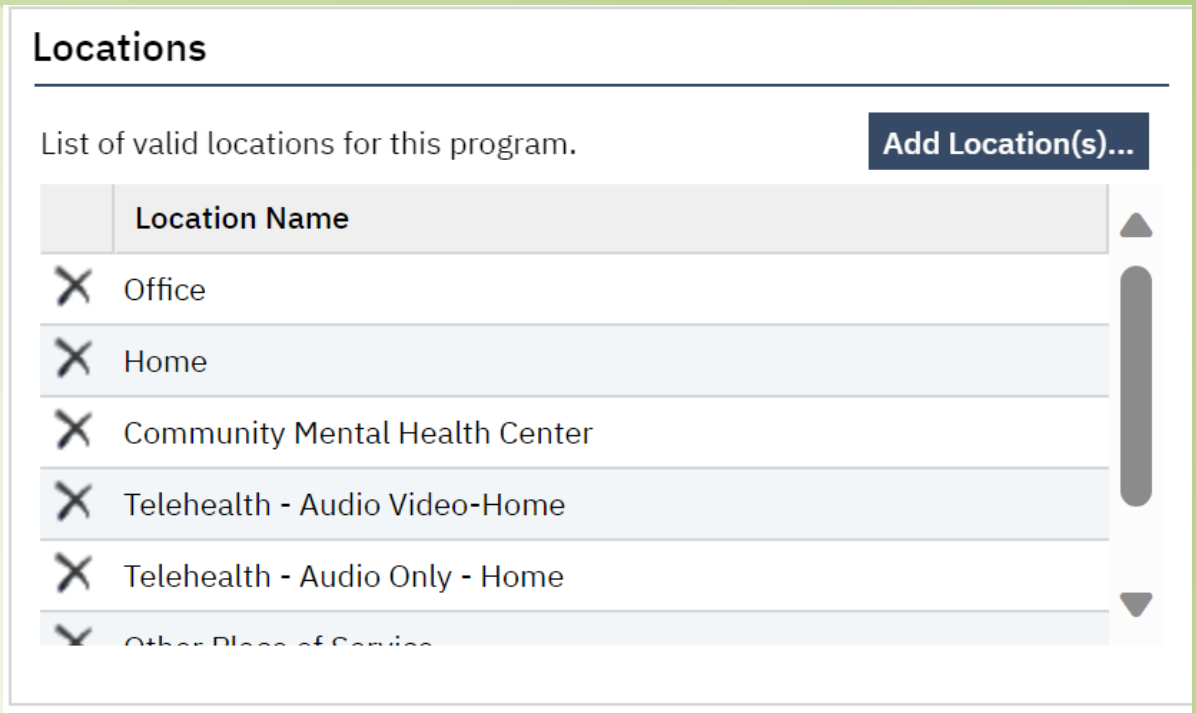
Procedure Codes

Add the procedure codes the program is certified for under the corresponding Service Area



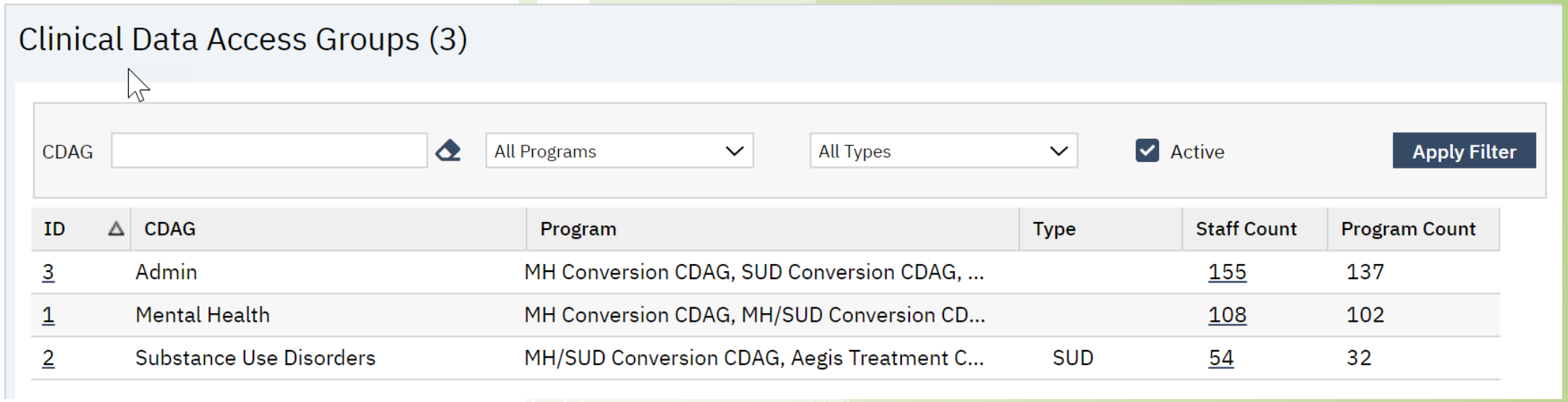
Locations

Add the locations applicable to the program only. Do not add all locations.



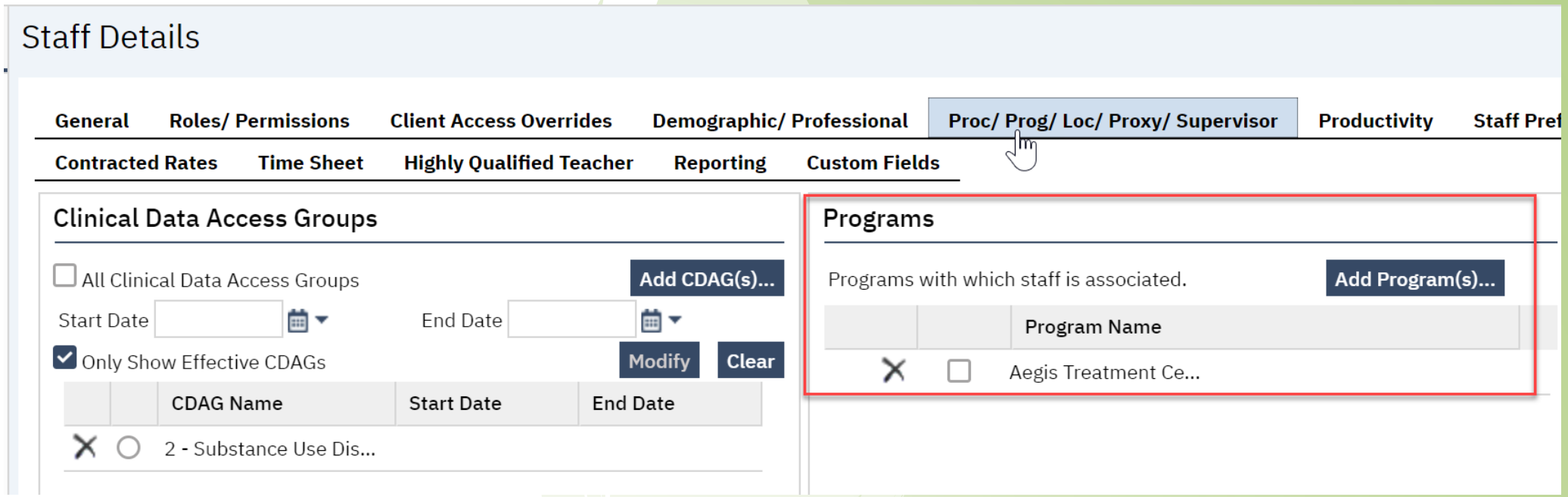
Clinical Data Access Grouping (CDAG)

This is a very important step after adding a new program. Once you save your new program, you will not be able to access the program until you add it to the appropriate CDAG group.



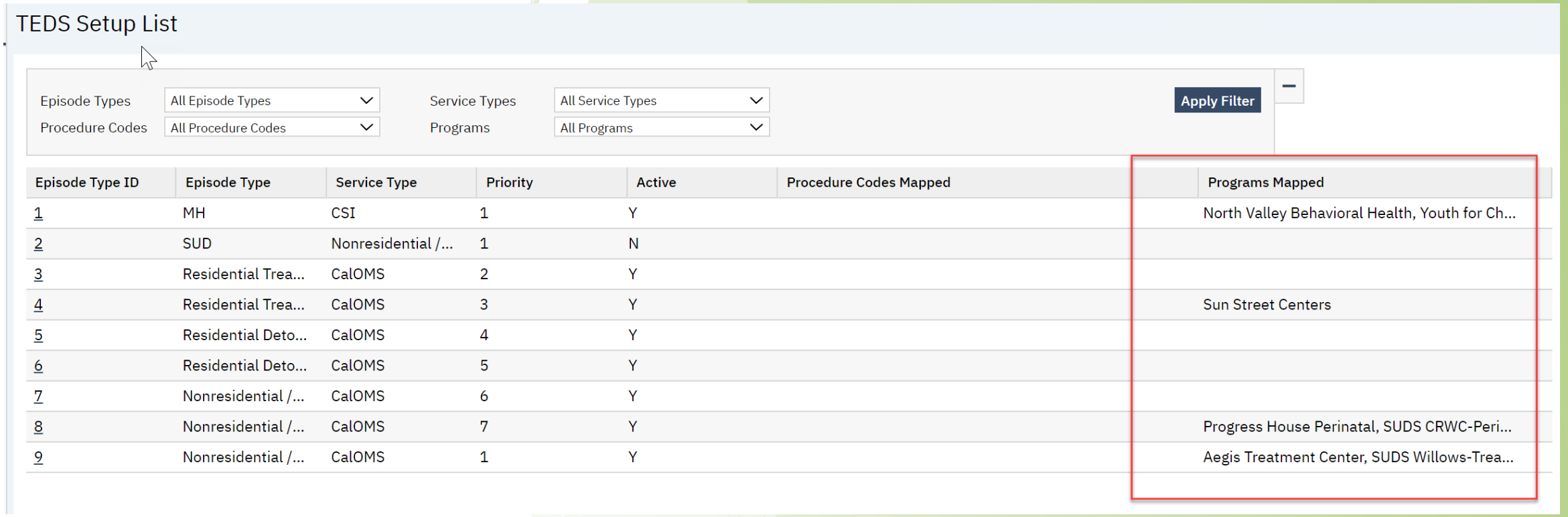
Staff/Users

After adding your new program, you will need to grant access to all of the Staff/Users. The users will not be able to see the new program in the dropdown until they have been granted access.



TEDS Setup

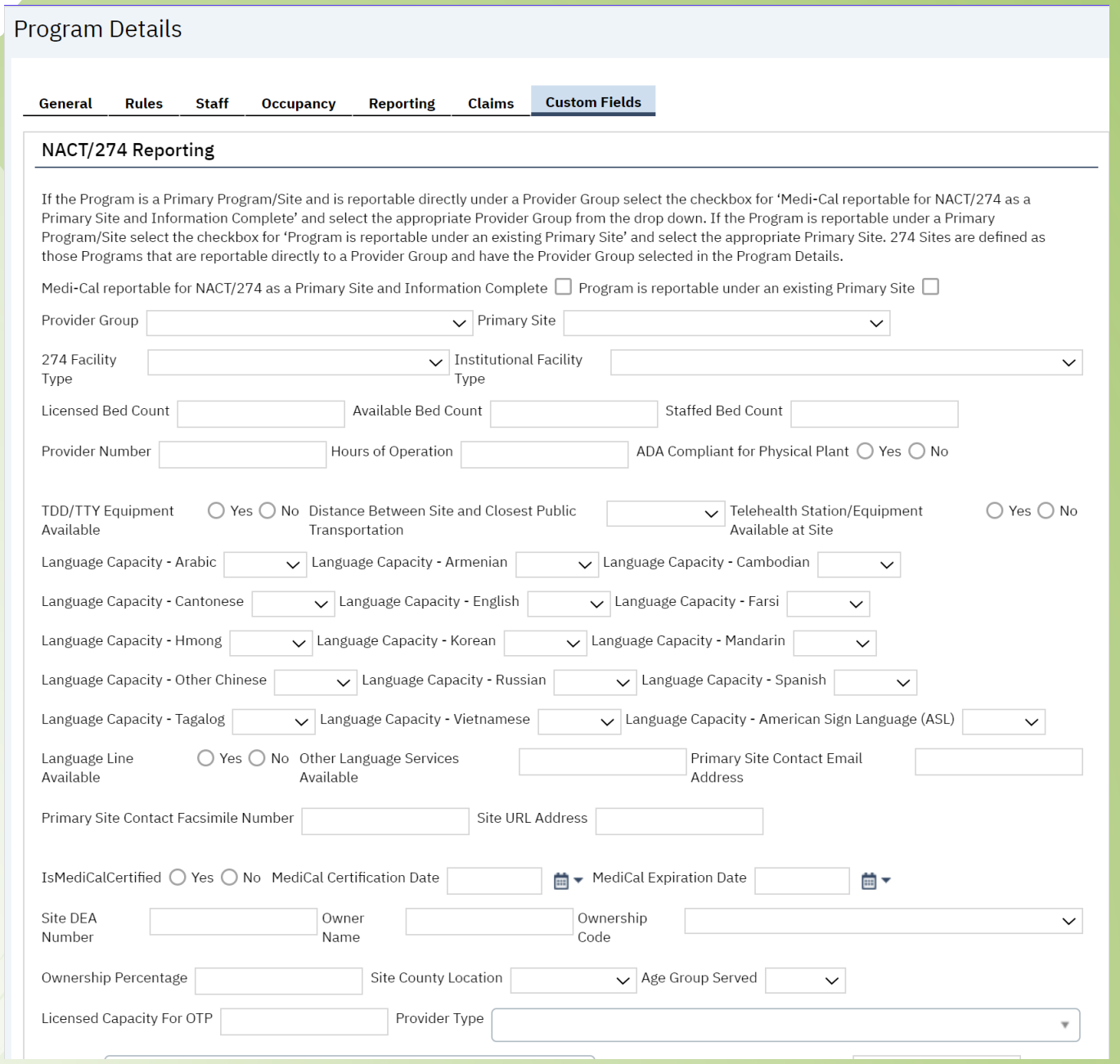
If the new program reports CalOMS or CSI, the program will need to be added to the appropriate Episode Type



Episode Type ID	Episode Type	Service Type	Priority	Active	Procedure Codes Mapped	Programs Mapped
1	MH	CSI	1	Y		North Valley Behavioral Health, Youth for Ch...
2	SUD	Nonresidential /...	1	N		
3	Residential Trea...	CalOMS	2	Y		
4	Residential Trea...	CalOMS	3	Y		Sun Street Centers
5	Residential Deto...	CalOMS	4	Y		
6	Residential Deto...	CalOMS	5	Y		
7	Nonresidential /...	CalOMS	6	Y		
8	Nonresidential /...	CalOMS	7	Y		Progress House Perinatal, SUDS CRWC-Peri...
9	Nonresidential /...	CalOMS	1	Y		Aegis Treatment Center, SUDS Willows-Trea...

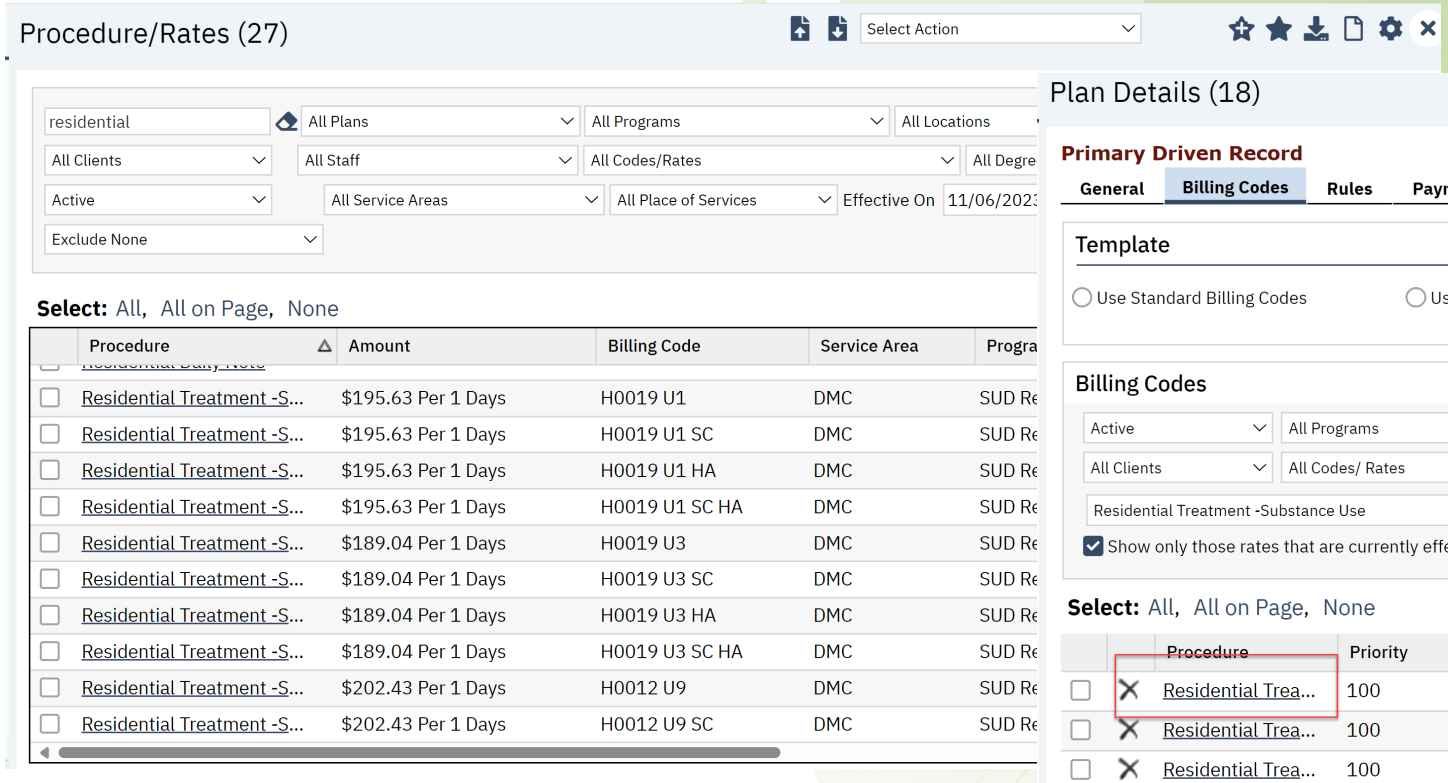
274

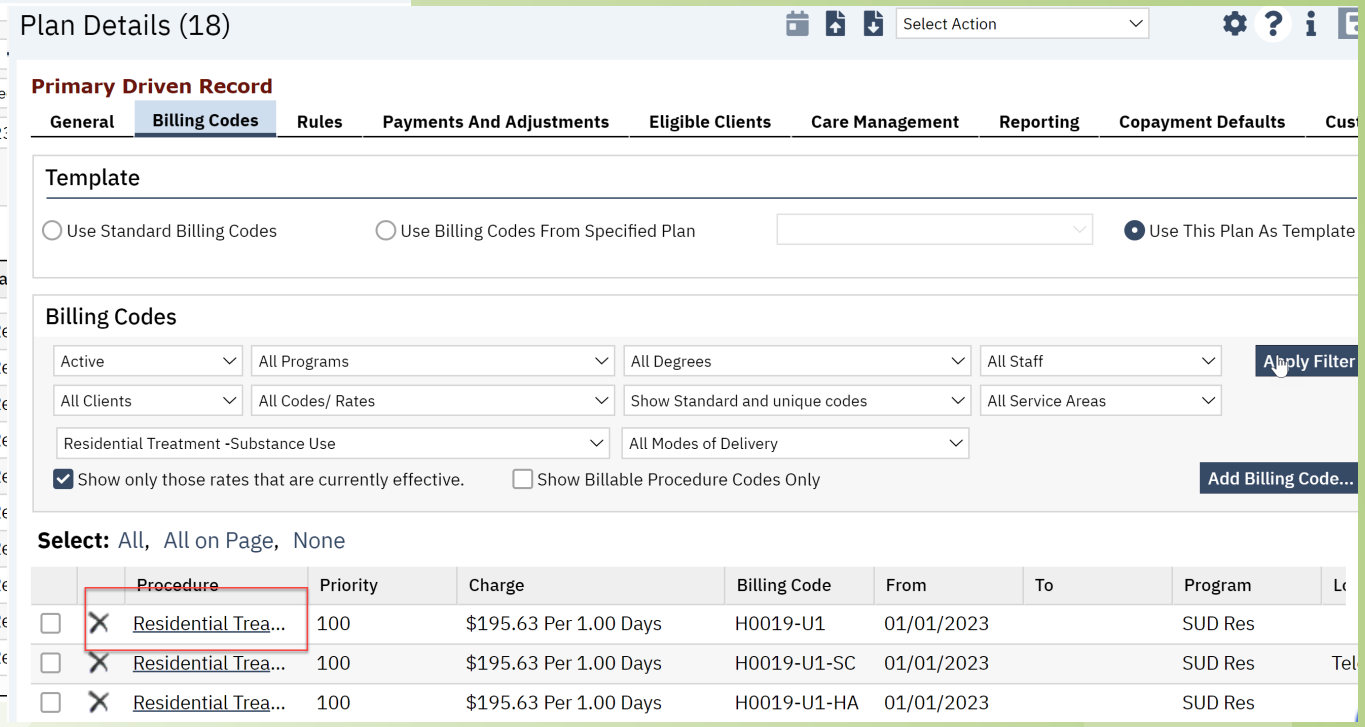
If the program is reporting on the monthly 274, this section on the Custom Fields will need to be filled out



Rates & Billing Codes

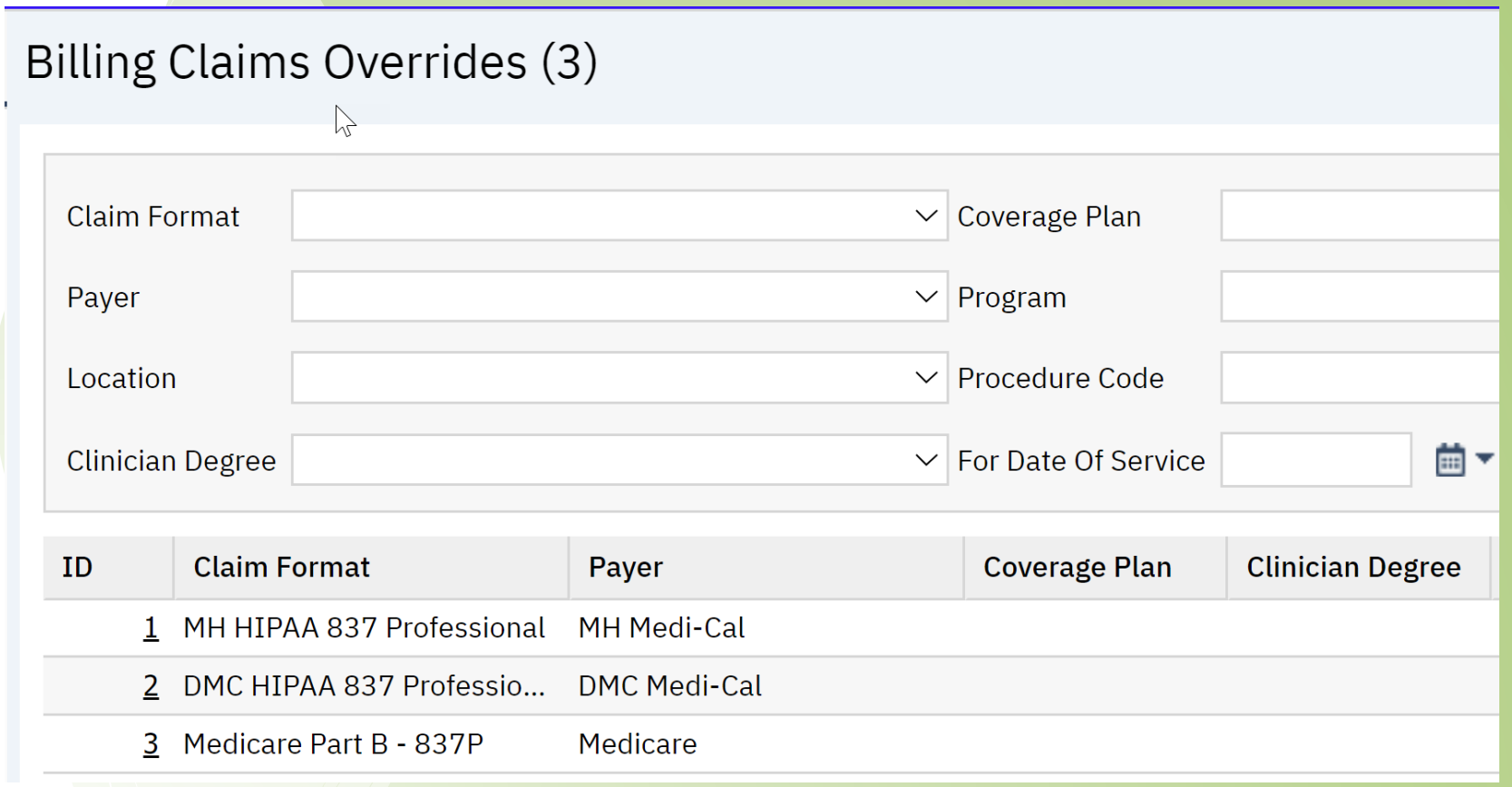
When adding a new program, the rates under the Procedure/Rates screen and billing codes setup against the plan will need to be evaluated to determine what will need to be setup for that new program. Generally, a new Mental Health program would not need any additional setup, however, a new Substance Abuse program will require additional setup due to the level of care modifiers. For example: If the new program is a Substance Abuse Residential program, rates will also need the new program added to the appropriate rate for the LOC.





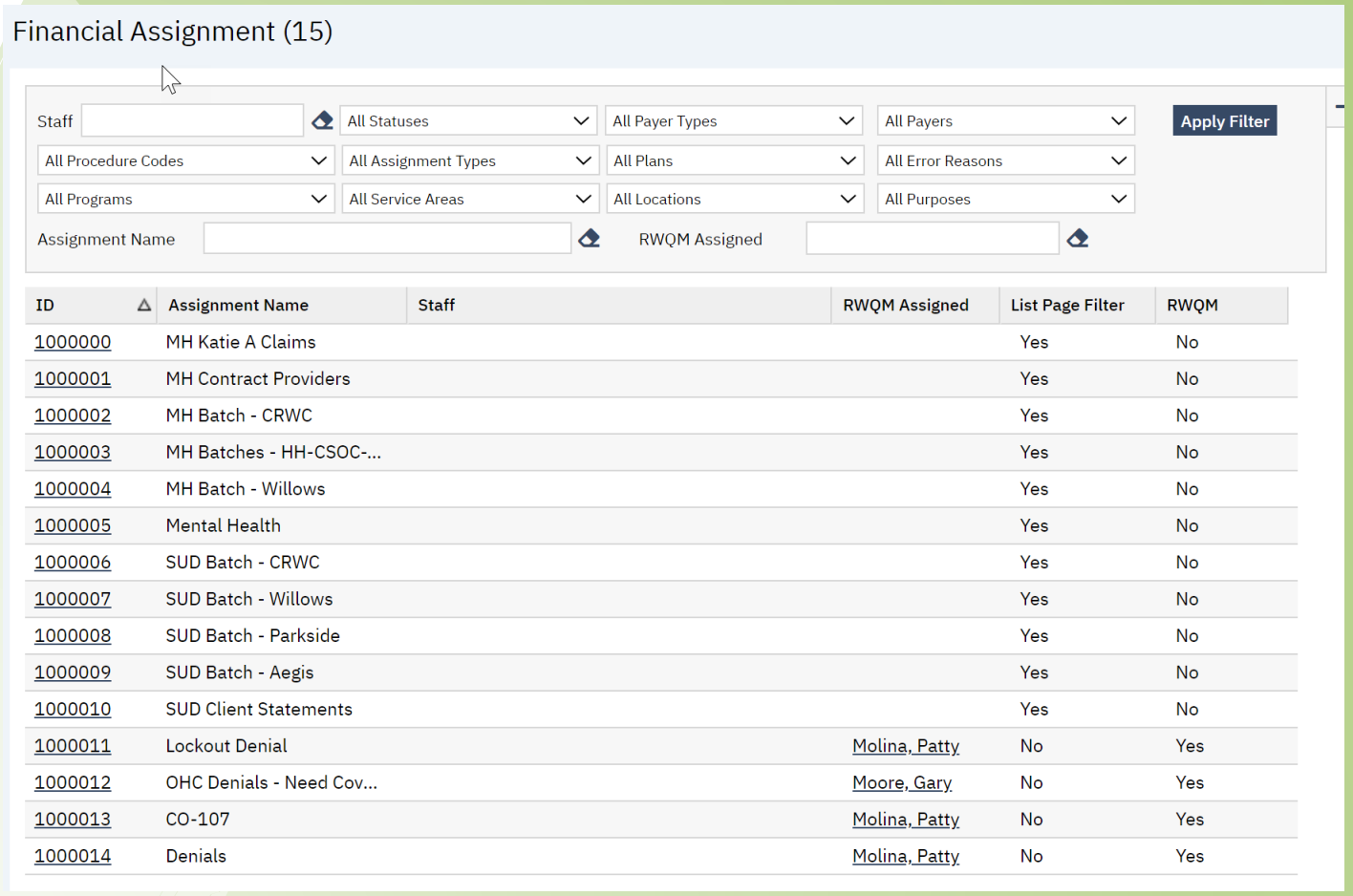
Claim Format/Billing Claims Override

When a new program is added, evaluate if the type of program will need a billing claims override.



Financial Assignments

Financial Assignments are an excellent tool to use to manage your charges and claims. If you have a new program, need to be added to the appropriate Financial Assignment.



ID	Assignment Name	Staff	RWQM Assigned	List Page Filter	RWQM
1000000	MH Katie A Claims			Yes	No
1000001	MH Contract Providers			Yes	No
1000002	MH Batch - CRWC			Yes	No
1000003	MH Batches - HH-CSOC-...			Yes	No
1000004	MH Batch - Willows			Yes	No
1000005	Mental Health			Yes	No
1000006	SUD Batch - CRWC			Yes	No
1000007	SUD Batch - Willows			Yes	No
1000008	SUD Batch - Parkside			Yes	No
1000009	SUD Batch - Aegis			Yes	No
1000010	SUD Client Statements			Yes	No
1000011	Lockout Denial		Molina, Patty	No	Yes
1000012	OHC Denials - Need Cov...		Moore, Gary	No	Yes
1000013	CO-107		Molina, Patty	No	Yes
1000014	Denials		Molina, Patty	No	Yes

Questions?

Thank You