**Individual/Group Providers – OFFICE HOUR**

**Question/Answers as of July 7, 2023**

Send questions to [mcare@fresnocountyca.gov](mailto:mcare@fresnocountyca.gov)

Please access the document via the link. This is a living document and will be updated as necessary. Q&A document can be accessed at [DBH CalAIM Q&A](https://www.co.fresno.ca.us/departments/behavioral-health/providers/calaim) . Q&A will be updated weekly and will be included in communication to Individual/Group providers. Q&A are categorized by date received and new information, updated follow up or items that require additional follow up will be noted in **RED**.

***Friday, April 28, 2023 (4:00pm)***

**Q**: Will there be a chance for group providers to do a data dump instead of doing the 1500’s.

**A**: Yes, we should have more info for you in a few weeks.  We last heard (this morning) we should hear more on this in a few weeks (from our lead – CalMHSA team) as far as (1) what format and (2) what fields will be included.  In sum, the system (new EHR, called SmartCare) will support this functionality at the go-live (July 1, 2023).

**Q**: Do County recommend using SmartCare program?

**A**: Yes, we would like all to use SmartCare. However, we can only transition providers who currently use our EHR on 7/1/23. Next step is to see if others can utilize the EHR.

**Q**: Recommend for individual providers to use EHR?

**A**: Plan is to have all use EHR but will need to evaluate at a later date. How do we get all to use SmartCare. How do we onboard providers. Will need to implement for current users first. Will need to work with SmartCare and CalMHSA to set up users. Scheduled for FY 2024-2025.

**Q**: Will the rate go up or down?

**A**: Will find out next week when the rate sheet goes out. Not going down but cannot provide the rates until next week.

**Q**: Those who bill AVATAR can transition 7/1/23. Can those who bill via 1500 work towards using EHR? ETA for transition?

**A**: There are different levels of access. Those with access will convert to SmartCare. Right now, providers submit paper claims and Managed Care enters the claim. Continue to submit paper claims. Do not have a timeframe when we can onboard new providers.

**Q**: Will the rates released next week be final or will they just be draft like the org rates were initially?

**A**: Rates will be final.

**Q**: will all counties involved in smart care be using standardized forms for things like assessments?

**A**: Yes, all will use the same forms.

**Q**: Assessment form changed. Assessment form is 2 pages. Was told to use whatever was online.

**A**: Make sure you are familiar with the billing manual. CalAIM made changes to the assessment requirements. Make sure to hit the 8 domains required by CalAIM. Documentation manuals are on County website (<https://www.co.fresno.ca.us/departments/behavioral-health/home/for-providers/contract-providers>). Recommend downloading the assessment form. It is compliant with CalAIM. CPT codes are all inclusive of documentation and travel. Will not code doc time separately. Makes doc time quicker and easier.

**Q**: So looking at the assessment from your website, is that identical to what will be in SmartCare?

**A:** No, SmartCare is different.

**Q:** Cannot edit the assessment to use my heading.

**A:** County will look at the form to see if others can edit/personalize. Templates are unlocked and now available to providers.

***Friday, May 5, 2023 (8:15am & 4:00pm)***

**Q**: Why Org provider rates by the Hour and Ind/Group Rates by the Minutes?

**A**: All providers are billing by the minute = 1 CPT unit is 15 minutes; round up by whole CPT

**Q**: Will Rates improve the reimbursement time, is there is discussion that this will improve the reimbursement for payment?

**A**: DBH, is discussion, hope is that the mechanism will be available to enter claims and process in a timely manner. (*MSO, MCO, Provider Connect* – SmartCare). DBH, Contracts Division will map out claims/payment process. DBH is transitioning to a new EHR System and working with CalMHSA. DBH will provide a training regarding process for claims. DBH goal is to improve the current process.

**Q**: Will CPT Codes allow for Billing for Transportation?

**A**: There is a CPT Code for Transportation. Individual/Group Providers Agreement doesn’t provide for transportation as a deliverable service. Documentation and Travel Time billing is already built into new rates.

**Q**: Some clients are out of town, up to 60 minutes, has DBH identified how services will be reimbursed?

**A**: Travel/Documentation is already built into new rates. Existing Agreement does not allow for Transportation. Individual/Group Providers can access Managed Care Plans to assist with transportation.

<https://www.calvivahealth.org/wp-content/uploads/2022/08/How-to-Get-a-Ride-for-Health-Care-Services-Brochure_SPA.pdf>

<https://www.calvivahealth.org/wp-content/uploads/2022/08/How-to-Get-a-Ride-for-Health-Care-Services-Brochure_HMG.pdf>

**Q**: Are we only allowed to bill for an Hour?

**A**: CPT codes are based on a Unit (15 minutes), ensure that you are billing appropriate codes, <https://www.co.fresno.ca.us/departments/behavioral-health/providers/calaim> Manual identifies maximum number of codes you can bill for services (Add On Codes). Ind/Group providers encouraged to attend trainings to get a better understanding on Codes. Billing is specific to CPT

**Q**: Will grant funds be available to providers to assist with this transition?

**A**: No. DBH encourages ind/gp providers to utilize alternative ways to be more effective and efficient.

**Q**: Any changes to Telehealth and location?

**A**: No changes to Telehealth and Location, there will be a new CPT Codes as it relates to Telehealth

**Q**: When will the Draft contract be ready for review?

**A**: DBH, Managed Care will try to send out Amendment I to Agmt No. 20-236 to all ind/gp providers, week of May 8th for review and signature.

**Q**: Trainings – are invites going out to all individual/group providers?

**A:** Trainings will be recorded and links will be available to all individual/group providers, link <https://www.co.fresno.ca.us/departments/behavioral-health/providers/calaim> will take you to those trainings.

**Q:** Were or how will this Q&A be communicated?

**A:** Suggest on CalAIM page, Compliance follow up with E.V.

**Q:** Where or can we send notification to add providers to mailing list?

**A:** Suggest providing name to Provider Relation Specialist to add them to the distribution list, PRS, *Dee Howell, Arlene Liles and Melinda Garcia*.

**Q:** Are there any samples to utilize for documentation?

**A:** Documentation Reform, manuals available can be referenced for documentation. Documentation related to CPT Coding, CalMHSA to provide additional information and require the same elements. Keep an eye out for tools and guides to assist with documentation.

***Friday, May 5, 2023 (8:15am & 4:00pm)***

**Q**: Will providers bill per minute?

**A**: No, providers will bill per unit based on CPT.

**Q**: County to Provider, how do you rate the transition to CPT codes?

**A**: Not sure yet, will be easy as they are familiar, as they currently utilize CPT Codes. County to provide a Crosswalk.

**Q**: Are Ind/Group Providers to use a CPT/HCPCS or SmartCare Procedural Codes?

**A**: Unsure. Once it determined, MC team will reach out to Individual/Group Providers of the flow process and Codes to be utilized within the CMS 1500 Forms

***Friday, May 12, 2023 (8:15am & 4:00pm)***

**Q**: Do you know if the contract will include an increase in the number of associates? Currently we are allowed 3 each (*Navjot K. Grewal, LCSW*)

**A**: MC Team members will look further into the matter, although AB690 allows for six associates, as for now the Agreement and Amendment I only allow for three associates. We cannot change the Amendment I to Agreement No. 20-236 going to the Board of Supervisors, June 20, 2023, and will consider for future Amendments. Note: any change to existing Agreement language will reflect current regulations and Board of Behavioral Health Sciences.

**Q**: Will the new contract include the ability to hire Nurse Practitioners under the new AB 890 change? (*Navjot K. Grewal, LCSW*)

**A**: Managed Care Team Members will follow up with *Navjot Grewal, Omid* for further clarification, regarding Nurse Practitioner and reach out to DBH Medical Team for interpretation of AB 890 which spells out supervision for Nurse Practitioners. We cannot change the Amendment slated for 6/20 board date and can consider for the future.

**Q**: Does transportation mean you have to have a person served in the car?

**A**: Transportation is a covered service. It is not the same as travel. Travel is when the provider travels to the person served. Transportation is transporting the person served. The Managed Care Plan (CalViva and BlueCross) are responsible for transportation. MCP’s contact info: <https://mss.anthem.com/california-medicaid/benefits/medi-cal-plan-benefits/transportation.html>

**Q**: Do you know if the contract will include an increase in the number of associates? Currently we are allowed 3 each (BBS does not have a limit) (*Navjot K. Grewal, LCSW*).

**A**: No change to the number of associates. The contract limit is still 3.

**Q**: Will the new contract include the ability to hire Nurse Practitioners under the new AB 890 change? (*Navjot K. Grewal, LCSW*)

**A**: DBH will need to review but it is not part of this amendment.

**Q**: How do we determine the duration? Is it based on severity or diagnostic. We usually complete the assessment and provide the treatment.

**A**: Time is still the main factor. The duration of the session does not need to be exactly 30 minutes. It needs to be at least half of the time. Where there is a range, must be within the range. Severity or diagnostic does not matter, it’s purely based on time. You can use CPT codes plus add-on codes to extend time.

**Q**: With new contract, will we still have yearly audits and what will be involved with audits?

**A**: CalAIM does not change the fact that we still need to monitor contracts. DBH is moving to bi-annual audits. The minimum requirement for monitoring is every 3 years. DBH decided on a 2-year cycle. CalAIM did changed the auditing tool. A copy of the tool was sent out about 2 months ago. Some services are no longer recoupable. We are mainly looking at fraud, waste, and abuse. We can resend the tool.

**Q**: For those that do not have AVATAR, will they have an opportunity to join SmartCare. Is there a licensing fee? Can providers have AVATAR-lite like access?

**A**: DBH would love for everybody to join SmartCare. For now, we can only convert providers who are already using our EHR. We cannot add others who are not using the EHR at this time. Will review and discuss after we launch on 7/1/23. More information will be sent out as it developed. We are still working with CalMHSA and SmartCare to see if providers can have AVATAR-lite like access. For now, please continue the current process of submitting 1500. We will explore if AVATAR-lite is possible in the future. MSO and Provider Connect will allow providers to enter claims directly instead of the 1500 form.

**Q:** If I have a minor that needs service, can I refer her for transportation?

**A**: That’s a question for the MCP.

**Q**: Is it possible to get a "cheat sheet" of the most frequently used CPT codes for various services and scenarios for certain disciplines e.g., LCSW, AMFT, Case Managers.  We got the frequently used Z-codes from these trainings, and it was very helpful for our providers

**A:** Please check the [Billing Manual](https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx). A cheat sheet is helpful, but we do not want to limit you to these codes only. CalAIM allows you to use a code to a higher level of specificity.

**Q:** Can you explain the codes when there is a limit to the max duration?

**A:** The max unit is based on a 24-hour clock. If the duration is longer than allowable time on the code, than use add-on codes until you get to the total duration of the service. Example: Therapy has a max unit of 1, with 1 representing 60 minutes. You completed a 70-minute session. You will use a code for 60 minutes and add-on code to capture the remaining 10 minutes.

**Q**: I see a lot of minors; the sessions are usually longer than normal. What codes do I use?

**A**: Select primary code to cover the first block of time and then use add-on code to capture the remaining minutes. Justify the session with documentation and use codes to capture the time.

Example: 90837 - psychotherapy, 60 minutes with patient; G2212 - prolonged service each additional 15 minutes

**Q:** Is coding is different from SmartCare? If I use the 1500 forms, will I stop using the Fresno’s codes and start using the CPT codes?

**A:** Yes, on 7/1/23, DBH will start using SmartCare, you will need to switch to CPT codes. SmartCare uses descriptors. Fresno will have crosswalk codes available. The services you provide must algin with CPT codes. The Medi-Cal Billing Manual effective 7/1/23 outlines all the codes/services that are covered

**Q:** Is there a training for those not in SmartCare on how to code?

**A:** There are trainings for how to code. DBH will have further trainings available. DBH recommend individual and group review the Billing Manual and look up the codes you already use. The purpose of CalAIM is to streamline service. We want to mirror what happens on the physical health side. 1500 is a universal code. You will complete the 1500 like any other health care provider. You will no longer use Fresno’s code. It will be similar to how you bill insurance. We also don’t want to tell providers what codes to use because there are multiple codes, add-on codes, you can use.

***Friday, May 19, 2023 (8:15am & 4:00pm)***

**Q:** What is the process of how we are going to process our claims, do we have a procedure right away?

**A:** The Department is working with Streamline and CalMHSA as to how Individual/Group Providers will process claims through the Departments Managed Care Division. This will involve two separate phases. The initial Phase 1) Individual/Group Providers to continue CMS 1500 Forms process for payment, and 2) Allows the Individual/Group Provider the option to submission of CMS 1500 Forms for claims or Direct Data (Claims) Entry by the Individual/Group Provider. Direct Data (Claims) Entry will require an approval by the County and a transition and training process. County will provide technical support. Details for both processes continue to be worked out between DBH, CalMHSA and Streamline.

We will provide a finalized procedure as soon as possible. We do not have a I final decision now. More than 20 California counties area part of SmartCare implementation. We will provide the training materials accordingly. Please be prepared that June will be a heavy month of training. DBH commits to having support mechanism for after Go Live on July1st. CalMHSA will also have support structure for questions and training. We are on this journey together. The department is committed to receive, process and pay claims in timely matter.

***Statement from leadership*:** Lets focus on the front end of the system right now so we can assure accurate payment is made. Come June, the department and all our providers will be focusing on receiving training so that we can utilize the system. It is recognized that group providers have a different process than the individual providers. We want you to rest assure, all providers will get paid timely. No matter what, the focus point right now is the partnership between the department and the provider. As we walk through this journey every single day between now and July 1, and even after that.

* This week the Department sent out the pre-approved County Council approval for review and signature, the item is going to the Board of Supervisors for final approval on June 20th, 2023, it is nonnegotiable. If you did not received the Amendment, you may request it via email managed care inbox. May 26th is the deadline to receive signatures, without a signature the county will not have a mechanism to pay for services after July 1st.

**Q:** Did the group talk about the letter sent out yesterday?

**A:** No, here it is verbally, and the letter was just signed yesterday and it's going out this morning, you should be receiving it later today via email.

**Q:** As we transition to Smart Care is this replacing Avatar for claims submission?

**A:** Yes, ***Netsmart, Avatar***, electronic health record (EHR), will transition to ***Streamline, SmartCare*** EHR, effective July 1, 2023.

**Q**: Why are we transitioning

**A**: The new EHR system will be more beneficial making workflow easier and ensure Department meets CalAIM requirements and compliance standards.

**Q**: Are inpatient rates changing.

**A**: Yes, rates will change and vary. As we are communicating directly with the providers, and they are being contracted individually.

**Q**: Is there an update on individual/Group Providers transitioning to EHR.

**A**: Yes, all individual/Group Providers are encouraged to use the County’s EHR. Once MSO/Provider Connect is built into SmartCare, Managed Care will assist Individual/Group Providers in the transitioning, support and training requirements. Individual/Group Providers will be notified in advance to properly prepare for transition into the County’s EHR.

**Q**: Can you elaborate on the quality improvement plan requirements for individual and group providers?

**A**: “*Department’s Quality Improvement Team will work with Executive/Leadership Team to identify outcomes measures specific to Individual/Group Providers and will work with providers expected outcome measures*”.

**Q**: When individual contracted providers transition to EHR, will we need to keep a physical record also pertaining to patients such as Consent Form, MHA notes etc., or will all of that will be in EHR only?

**A**: With full SmartCare EHR Access, the goal is that EHR will be where the record lives and will be accessible to other providers including the patient portal. The goal is to become electronic so an individual can access their clinical documents rather than paper charts avoiding repetitious data entry. If a form is unavailable, it can be scanned into EHR system.

**Q**: Will more trainings be offered.

**A**: Yes, more training will be offered. We can also continue to build into what we are already doing and get the benefit from learning from each other.

**Q**: will you need specific access to access EHR?

**A**: yes, specific access will be needed. Request to be approved by Department IT.

**Q**: Regarding transportation. When a client is commuting is there a cap on distance?

**A**: It is covered under Managed Care Plans (CalViva and Anthem Blue Cross) you can direct questions to them.

**Q**: Will it take longer to received payments for providers entering paper claims?

**A**: It will help streamline our process and should cut the time down.

**Q**: We have been doing CPT Codes for other counties and insurances, will we not be done by minutes anymore or will we be doing the 15 minute, 30 minutes.

**A**: By units, each unit is equivalent to 15 minutes.

**Q**: For trainings would we all be going through the CalMHSA LMHS website?

**A**: Yes, the training would have to be accessed through CalMHSA Moodle application.

***Friday, May 26, 2023 (8:15am & 4:00pm)***

**Q**: When will CPT and HCPCS codes go into effect?

**A**:They will take effect as of July 1st.

**Q**: Where can we find CPT and HCPCS codes?

A:In the billing manual.

**Q:** Will all services be paid at the same rate?

**A**:Yes, services are paid by license type and location.

**Q**: Is case management CPT coding the same as Psychotherapy?

**A**:Look in billing manual for HCPCS codes on page 133, code # T 1017 = 1 unit for each 15 min. if you provide at least 8 min. of service you can bill for 1 unit of case management.

**Q**: What happens if the signature page is not returned by the deadline?

**A**:The individual group or provider will not be a part of the contract meaning we will not have a way to pay you as of July 1st. We will follow up to ensure transition of all persons served to another provider within the network.

**Q**: Will we be notified if our signature was received or not?

**A**:Yes, a confirmation email will be sent once received, also an alert was sent if not received.

***Friday, June 2, 2023 (8:15am & 4:00pm)***

**Q**: A master service agreement question—-the agreement sent out with track changes a few weeks ago is different than the original agreement executed in 2020. Will the agreement & amendment #1 both execute with an effective date of July 2023?

**A**: Yes, both the amendment and agreement will be considered one document and only one signature page will be added, in addition any time we add or remove a provider it must go to the Board of Supervisors for approval, we will not need a new signature from everyone. Managed care division will be prepared to go to the Board of Supervisors monthly. For any significant changes we will go to the Board of Supervisors, and we will require signatures from individual and group providers.

**Q**: Are you aware if all other counties will be updating their fee schedules as well? We are an inpatient provider, so we bill other counties besides Fresno.

A: The agreements between the county and the state are changing however it does not mean that the contracts between the county will change, as each county will make their own agreements with the State.

**Q**: Regarding CalAIM, I have a new client going to Mexico for two months. Do I keep them open or close them out?

A: It is up to you; two months is not too long. There is not a requirement to provide a certain number of services per month to keep them open, so it is an option to you as a provider whether you would like to keep the case open or close it out.

**Q**: In the assessment form for service providers, will travel time be the same?

A: The travel time and documentation time are still being collected. While they are not paid activities, the state is still collecting the info to inform future rate setting down the line.

**Q**: The assessment form was not usable.

A:We are addressing the need to make sure the form is downloadable and accessible.

**Q**: Are we required to use the county templates, or can we use our own?

A: No, we are not required as it was provided as a guide. The requirements are in the CalMHSA manual. You can modify the template just make sure that you capture what is required within the seven domains.

**Q:** How does collaborative documentation play into the person served.

A: Collaborative documentation at the end of a session should be utilized as part of the therapeutic intervention and included in time spent with the person served.

**Q**: If you have a provider not used to practice and it takes them longer to complete, are their restrictions on the time used.

A: It takes the time that it takes, the collaborative documentation needs to be part of the therapeutic intervention and needs to take place in front of the client and completed together. The CPT codes are very descriptive and if used correctly, will handle the billing side.

**Q**: Is there an online training for collaborative documentation.

A: live training is provided in house only.

**Q**: Is there a new client record audit checklist for individual/group providers that addresses the CalAIM requirements?

A: Yes, we have sent it out a couple of times and we will attach it again.

**Q**: I get clients already assessed by the county within a week, therefore billing twice for the same thing if I do another assessment. Can I agree with the County’s assessment to cut time, or do I need to bill the entire time for the same assessment?

A: Yes, you can agree. If you get a complete assessment from the County, you can agree with the assessment, review, and make a note agreeing with diagnosis or of anything noticed differently, therefore cutting time down and not repeating services. Making sure that we provide a good example of quality of serviced. There is not a need to do a new assessment. (We will get back to providers on which CPT codes to use in this instance)

**Q**: Are the contracts/agreements we signed for CalAIM or for the Fresno County Behavioral Health?

A: Contracts are Fresno County only.

***Friday, June 9, 2023 (8:15am & 4:00pm)***

**Q**: I switched over from a Sole Proprietor to Incorporated, do I need to report or inform County?

**A**: Yes, if there is a change in Employee Identification Number (EIN), change in service location or deliverable services, you are to notify Managed Care team members. You may also be required to additional information on documentation such as PAVE and/or credentialing application. Please contact County Managed Care, Contracts Division or Business Office.

**Q**: What if our org is a limited user, can we get moved over to whatever will be consistent with Avatar Lite for our Group Provider?

**A**: Yes, that is correct. County will need to test and approve prior to releasing it to the individual/group providers.

**Q**: Do we need to meet the mid-point to claim the G2212 code?

**A**: If you are using code G2212, you have used 60 minutes and maxed out the code, G2212 code will add on 15 min. you can claim multiple G2212 after you maxed out the first code. A good way to tell whether you need to hit a halfway point for a specific code is by looking at the billing manual. If a code has a flat time associated with it, you must hit the midway point to claim that code, i.e., with G2212 it says, "each additional 15 minutes." Because it just has the flat 15 minutes, you must hit the midway point. The codes that you don't need to hit the midway point are the codes that have a time range, i.e., with 99347 Home Visit of an Established Patient, 10-20 minutes, if you are within that range, you can claim that code.

**Q**: Regarding CPT and Smart Care Codes when will the date be finalized what codes we will be using?

**A**: We are hoping to have it before June 20th.

**Q**: Can you clarify duplication of services under CalAIM? For example, can clients attend an individual therapy session AND a group therapy session with the same provider on the same day?

A: You can refer to the billing manual on page 24 it discusses duplicate services. If all data elements are the same all 4 points. if two services were provided in the same day you can combine them into one you would add modifiers so it would not be considered duplicate services are the same service, by the same provider, to the same person served, on the same day. To avoid denial for duplicate services, you roll the minutes together. For example, two 30-minute sessions would be submitted as 1 claim for 60 minutes. Individual therapy and group therapy wouldn't be considered a duplication, as they would be claimed with different CPT codes. When using 90853 (group psychotherapy other than a multiple-family group), the modifier HQ (group setting) is required. There is a separate procedure code for group therapy from individual therapy, collateral may no longer be a stand-alone service, this code will always be used as an add on. what we were trying to explain is that if you're using in, if you're providing individual psychotherapy, you're probably going to use 90837. And then if you're providing a group therapy, that would be this CPT code which is 90853 with the modifier HQ, because you're noting it's in a group setting and because you're using two different CPT codes and you're adding this modifier, it would not be considered a duplication of service.

**Q**: About the rationale not to raise rates for unlicensed providers given that CalAIM no longer pays for documentation time?

A: Finance response: The new contracted unlicensed provider rate is $1.71/min ($102.60/hr). This rate is for ALL services, of which the majority of service types are currently paid at a lower rate. Assuming all service types were paid at $1.71/min instead of the current rate, that equates to a 11% increase in overall rate.

**Q**: Question about collateral services. I thought I heard that collateral is no longer a covered service. However, I see that CPT code 90887 is for "Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family

or Other Responsible Persons, 15 minutes". Isn't this the same as collateral services?

**A:** To simplify this code 90887, which is interpretation of or explanation of results of psychiatric or other medical procedures to family or other responsible persons, who 15 minutes, that is a long way of saying collateral. We do have a CPT code to acknowledge collateral activities. However, beginning July 1st, you may not claim collateral as a standalone service. It must use of CPT code. 90887 is dependent on Ace. so, the person was saying we can't bill collateral anymore and the answer is no, that's incorrect. We do have this code, but it must be it is dependent on a different service of the same claim. You may not build collateral as a standalone and please capture from the morning meeting. There is this wonderful slide from the Cal Mesa training that kind of explains that when you're doing a collateral activity with a family member, please consider the type of intervention you are providing because you may not be providing what we think of as collateral. You might be doing an assessment and gathering assessment material information from a family member, or you might be doing planned development with a family member, and in those cases, you would Bill for the assessment or the planned development, not just assume that because you were speaking with a significant support person, it must be called collateral.

**Q**: CMS 1500 forms, can there be a place I can go to make sure they are correctly filled out, is there a faster way to get that information as it is taking 2-3 weeks to get notice of error.

**A**: We are looking at a change in our processes, but we won't know that until we figure out exactly if we're going to utilize the MCO and or if there's going to be any changes to our entry for claims from Smartline streamline smart care.

**Q**. Metal health assessment form was still locked.

A: The website is updated, and you will no longer need the password.

**Q**: We had a rejection since the patient had Medicare as well as medical. Do we bill Medicare first then once we receive a rejection, would we rebill Medical?

**A**: Yes, we would like you to bill Medicare first get a denial then bill us. Medical is the last to be billed as a secondar insurance Finance response: MC is correct. DBH must have a denial letter from Medicare before we can bill Medi-Cal.

***Friday, June 16, 2023 (8:15am & 4:00pm)***

**Q**: Just to clarify, we are starting July 1st, but with June billing or will we wait till July ends to start using CPT codes for July?

**A**: We will continue to use Avatar Procedural codes until July 1st. We cannot use the new codes before July 1st. Effective July 1, 2023, we will use the CPT codes or smart care codes, we will continue with the 1500 forms. Through June 30th, 2023, continue to use Avatar codes. So, all your services that you're providing through the month of June are avatar service codes, so nothing changes until July 1st. When you submit you 15000 forms, please do not mix June & July services on your claims. On July 1st you will use the new process as to be determined. As of June, continue to use Avatar procedural codes. Please do not mix June & July services on one claim form.

**Q**: For a private provider like myself, I am contemplating contracting out with some other system, should I join SmartCare or look for an alternative while I wait?

**A**: We would like everyone to use SmartCare, that is the goal that we have shared with everyone in terms of a time frame would look like. My initial guess is we're looking at fiscal year 2023-24, so that would be starting between this July and this time next year. We will be talking about and trying to look at ways to expand and on-board vendors. There is a module in the new SmartCare EHR that we go live with July 1st called MCO that will be ready sometime the next fiscal year geared for contractors. In my opinion you do not need to invest in another platform as patience is they key now.

**Q**: Do we have the crosswalk ready for providers yet?

**A**: We were getting ready to provide the information then there were more codes added by SmartCare and CalMHSA, so it will be pushed out to you as soon as we have it updated with the additional procedural codes.

**Q**: Do all the registered providers need to take MHSA and CPT trainings?

**A**: Yes, all registered providers need to take the calling MHSA and CPT trainings

**Q**: I have been trying to get a CPT fee schedule or rate sheet. Has the County made on yet**?**

**A**: The rates are no longer based on service being provided, the rates are based on the type of practitioner or license.

**Q**: How will the county interpret the minutes when I send CPT code 99213 or 99214**?**

**A**: Based on the CPT codes given, 99213 is for 20-29 min and 99214 is for 30-39 minutes and that's for an established patient.

**99212** - Office or Other Outpatient Visit of an Established Patient, 10-19 Min

**99213** - Office or Other Outpatient Visit of an Established Patient, 20-29 Min

**99214** - Office or Other Outpatient Visit of an Established Patient, 30-39 Min

**99215** - Office or Other Outpatient Visit of an Established Patient, 40-54 Min

**Q**: where are the new CPT codes found**?**

**A**: The link is embedded in our agenda in our resources section. Cal Aim training goes over an extensive list of CPT codes. <https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx>

Please see calculations from the Business Office based on the list of Fresno County rates provided to us from DHCS:

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Provider Type | Procedure Code | Modifier | Type of Service | Service Description | Whole CPT Unit Mins | Per Min Rate | Amount Paid | Effective Start Date | Effective End Date |
| Licensed Physician | 99212 |  | Medication Support Codes | Office or Other Outpatient Visit of an Established Patient, 10-19 Minutes | 15 | 4.88 | $     73.20 | 07/01/2023 | 06/30/2024 |
| Licensed Physician | 99213 |  | Medication Support Codes | Office or Other Outpatient Visit of an Established Patient, 20-29 Minutes | 25 | 4.88 | $ 122.00 | 07/01/2023 | 06/30/2024 |
| Licensed Physician | 99214 |  | Medication Support Codes | Office or Other Outpatient Visit of an Established Patient, 30-39 Minutes | 35 | 4.88 | $ 170.80 | 07/01/2023 | 06/30/2024 |
| Licensed Physician | 99215 |  | Medication Support Codes | Office or Other Outpatient Visit of an Established Patient, 40-54 Minutes | 47 | 4.88 | $ 229.36 | 07/01/2023 | 06/30/2024 |

***Friday, June 23, 2023 (8:15am & 4:00pm)***

**Q**: Are Organizational providers going to use CPT codes or Smart Codes or both for claim submission

**A**: Validation of the flat file format is being finalized.

**Q**: Are provider IDs from Avatar coming over to Smart Care?

**A**: Yes, they are in the system already.

**Q**: A youth client came to me with medical and now needs a psychiatrist, what can I do to get them services?

**A:** You can refer them to the County for psychiatry services

Access Line - 800-654-3937

Youth Wellness Center - 2719 N Air Fresno Drive, Fresno CA 93727. Phone is 559-600-8918.

**Q**: July 1t is coming fast, I am unsure of the process, will we be able to take the training on July 7th to have more clarification.

**A**: Yes, we will be training everyone to use the Smart care procedural codes. We will provide all information needed to claim for July services.

**Q**: For those of us completing the CMS-1500 form, it would be helpful to see how to calculate one claim. For example, what would be the claimable amount for a 52-minute individual psychotherapy session, a 71-minute psychotherapy session, etc.? The table we just viewed for licensed physicians, the table we just viewed for licensed physicians, it appears that the claim was paid per minute and not per unit.

**A**: This information will be provided to you on July 7th, to make sure the information is complete and accurate.

**Q:** Can we please have clarification on what Provider IDs from Avatar means? Is this regarding usernames or the actual Provider ID number in Avatar?

**A**: The 9xxxxx numbers were pulled to SmartCare. That number likely won't be displayed on the service screen since we are now able to lookup by name. Your program/organization/practice is tied to your name, and you would be able to select which one you are working under (if you are working for more than one agency/org).

***Friday, July 7, 2023 (8:15am)***

**Q**: If client is at home, what code would we use?

**A:** In Med-Cal Billing Manual, if service is telehealth: 10 is Telehealth Provided in Patient’s Home; 02 is Telehealth Provided Other than in Patient’s Home. *Place of service codes are located on pgs. 45-46 of the Specialty Mental Health Billing Manual Version 1.4*

**Q:** Request for more information on collateral and group services

**A:** DBH is working on developing guidance for internal and contacted providers.

**Q**: Can we include the units in 24.G. on CMS-1500 instead of minutes?

**A:** No, always use minutes.

**Q**: If a patient has CalViva Medi-Cal, or Anthem Blue Cross-Medi-Cal, do we bill the State of California Fresno County Medi-Cal?

**A:** You would either claim to CalViva or Anthem Blue Cross if the condition is mild to moderate and you are contracted with those Managed Care Plans. If the condition is severe, you would claim to Fresno County Specialty Mental Health Services.

**Q**: Would a ten-minute phone call be claimable?

**A:** If it is a claimable procedure and it meets the threshold for that procedure, then it will be claimable

**Q**: For Family Psychotherapy, do we not use the prolonged code of G2212? For example, if we provided 58 minutes of family psychotherapy, wouldn't it be 1 unit of 90847 and 1 unit of G2212?

**A:** yes, you would use the SmartCare code and enter the total number of minutes. SmartCare will automatically calculate. You must meet 51 % of the primary code for SmartCare to add the prolonged code of G2212.

**Q**: If I provide a service of 55 min to a minor child for therapy, then meet with parent after for another 43 min. how would I calculate billing on the claim form?

**A:** Collateral engagements can be claimed depending based on the actual procedure that you are engaged with. Psychosocial rehabilitation can also be used when providing information to caregiver**.**

**Q**:For physicians and prescribers, regarding CPT codes - we have a choice of choosing, time or medical decision making, if we code based on medical decision making. How do we bill when it is not based on time when, we must use only minutes.

**A**: Currently, the State has decided to use the codes only based on time. There are three add-on codes that can be used: interpreter, interpretation of labs, and medical complexity. Chapter 10 Service Tables in the DHCS Specialty Mental Health Service Medi-Cal Billing Manual states:

*Time: Each code is associated with a length of time or time range as part of the service description. DHCS policy will only consider the time it takes to provide direct services associated with that code as part of time. (p.59)*

Unlike Medicare or other payers, E/M services under Specialty Mental Health Medi-Cal will be based on time, not medical decision-making criteria (MDM). Therefore, at utilization review/audit, DBH will not require documentation of MDM**.**

**Q**: If we are not sure about the final calculations on the CMS-1500, can we leave it blank?

**A:** SmartCare Smart Care will automatically calculate the charge. You may leave the charges section of the CMS 1500 form blank if you prefer.

**Q:** How will audits be handled?

**A:** If you are scheduled for a compliance medical records review in the upcoming months, those audits will be claims submitted during the 2022-2023 Fiscal Year, before payment reform and the implementation of SmartCare. Thus, these audits will focus on past claims. We will be issuing audit guidelines in the future that pertain to the new standards.