Payment Reform Reminders (revised 7/10/24)

Reminders and updates from Payment Reform coding rules effective July 1, 2024:

1. **Assessment Codes:**

- **90791-4 Psychiatric Diagnostic Evaluation; 90792-4 Psychiatric Diagnostic Evaluation with medical services (both 60 min):**
  1) Can now be used up to **60 minutes** instead of a maximum of 15 minutes, which was a DHCS limit prior to 7/1/2024. However, a minimum of 31 minutes must be met to utilize these 2 codes (90791-4 and 90792-4).
  2) If session time is **68 minutes or more**, the provider can use the **Assessment Substitute** HCPC code T2024. An IRIS CDM number has not been assigned yet. An announcement will be made when this code is available. Please note that this code is a substitute code, and not an add-on code, meaning the provider will use this code **instead of** the CPT code 90791-4 or 90792-4. Please note this code will not be submitted to Medicare or Medi/Medi cases. More details to come regarding use of the Assessment substitute code. IRIS will be giving instructions regarding how to code the Assessment substitute code while it is being built into the IRIS system.
  3) Direct patient care for 90791-4 includes interviewing the client, caregiver or any person (including previous providers) who might be considered the client's historian.
  4) 90791-4 can be used for **non-face to face write up of Domain 7 only (Clinical formulation, diagnosis, determination of medical necessity and treatment recommendations) by licensed/waivered/registered clinicians.** [DHCS' rationale for paying for Domain 7 only and not Domain 1-6, is that they have already paid for the documentation of Domain 1-6, when the provider documented the information in their session's progress note. The increase rate of reimbursement covers for the session and documentation time. Domain 7, however, would not have been documented yet, because it requires synthesizing of all information into a clinical formulation of the diagnosis(es)/problems, clinical theory behind the problem, justification of medical necessity for continued treatment and treatment recommendations to resolve all problems identified. Therefore, Domain 1-6 write up of report can only be claimed when doing this activity collaboratively with the client during the session of gathering the information – Added 7/10/24]. Please have clinicians use 90791-4 for write up of Domain 7 instead of 70899-418 Mental Health Assessment by Non-Physician code as of 7/1/2024.
- **70899-417 Comprehensive Multidisciplinary Evaluation**
  1) Per DHCS billing manual, pg. 59 (May 2024 release), **CFT meetings will use this code** by all providers attending the meeting instead of ICC.
  2) Please note all providers, except Certified Peer Support Specialist (CPSS) can use this code.

- **Other assessment codes that were extended from 15 min to 60 min** (minimum 31 min. must be provided to bill these codes), **and will be able to utilize the Assessment substitute code for 68 minutes or more, when it** (T2024) **is built in IRIS:**
  1) 90885-4 Psychiatric Eval of Hospital Record, other psych reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purpose
  2) 96105-4 Assessment of Aphasia…
  3) 96110-4 Developmental Screening
  4) 96125-4 Standardized Cognitive Performance Testing
  5) 96127-4 Brief emotional/behavioral assessment….
  6) 96146-4 Psychological or Neuropsychological Test Administration

  *Please do not submit the Assessment substitute code to Medicare for Medicare or Medi/Medi cases

2. **Plan Development:**

- Includes treatment planning service activities that consist of the development of the client plans, approval of client plans and/or monitoring of a client's progress.
- Direct Patient Care - these services can be done with the client, caregivers or treatment team members which meets the requirement of direct patient care.
- Plan development consists of the consultation type codes and activities including the Medical Team Conference by Non-MD with or without Patient or Family; and Medical Team Conference by MD – Pt/fam not Present, at least for 30 minutes (99366-4, 99368-4 and 99367-4). These three (3) codes can be used by clinicians licensed/waivered/registered or MD as long as there is a team of three (3) different disciplines. These codes are not used for a CFT meeting.
- 70899-422 Mental Health Service Plan Developed by Non-Physician can be used for consultation between 2 providers regarding treatment or treatment plan development and is available to all disciplines except Psychiatrists and Certified Peer Support Specialists.

3. **Psychotherapy (Individual, Family and Group) – Use of Therapy substitute code for sessions past the maximum service time:**

- 90837-4 has a time limit of 53-67 minutes. Sessions 68 minutes or longer can be coded with the **Therapy substitute code (T2021)**. This code (T2021) has not been built in IRIS yet, and the CDM number (70899-TBD) has not been determined. More information and details to come regarding this code. IRIS will be giving instruction shortly of how to track those times after 7/1/2024.
- 90847-4 has a time range of 26-57 minutes. Sessions 58 minutes or longer can use the Therapy substitute code (same as Individual) instead of the CPT code, when it is built in IRIS.
- 90849-4 Multi-family group psychotherapy (minimum 43 min; maximum 91 min) and 90853 Group Psychotherapy (minimum 23 min; maximum 57 min) can use the Therapy substitute code for sessions longer than their maximum allowed time, by substituting the Therapy substitute code instead of the CPT code. The minimum amount of time to

utilize the Therapy substitute code instead of 90849-4 is 92 minutes; and instead of 90853-4 is 58 minutes.

4. **Crisis Psychotherapy – Psychotherapy for Crisis, First Hour** [Added 7-10-24]
   - Changed from First 30-74 minutes to First Hour
   - Minimum minutes required for billing = 30 minutes

5. **Medication Codes Time Range has change:** [Added 7-10-24]

   Office or Other Outpatient Consultation for a New or Established Patient

   - **99242-4 – 20-30 minutes**
   - **99243-4 – 30-40 minutes**
   - **99244-4 – 40-55 minutes**
   - **99245-4 - 55-75 minutes**
     - These codes can be used as the MD's consultation code with another doctor, used for 2nd opinion of conservatorship evaluation,
     - Add-on time can extend service time through CPT code 99417-4.
     - 99242-4 to 99245-4 codes have not been added into IRIS yet. More info. to come

   Home Visit of a New Patient code:

   - 99341-4: 15-25 minutes is now **15-29 minutes**
   - 99342-4: 26-35 minutes is now **30-59 minutes**
   - 99344-4: 51-65 minutes is now **60-74 minutes**
   - 99345-4: 66-80 minutes is now **75 minutes met or exceeded**

   Home visit of an Established Patient code 99437-4 – 99350-4:

   - 99347-4: 10-20 minutes is now **20-29 minutes**
   - 99348-4: 21-35 minutes is now **30-39 minutes**
   - 99349-4: 36-50 minutes is now **40-59 minutes**
   - 99350-4: 51-70 minutes is now **60 minutes met or exceeded**

6. **Supplemental code time change:** [Added 7-10-24]

   - 90887-4 – Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient, has now been expanded from 15 minutes to **50 minutes.** [This code has a minimum of 26 minutes for billing; and a maximum of 50 minutes, per rendering provider and procedure code per beneficiary, per day. As a supplemental code, please refer to the Supplemental Codes' Service Table for "dependent on codes" column.
   - 70899-428 – Prolonged Office or Other Outpatient code (formerly G2212) **has been deleted as of 7/1/24**

- **<u>Instead</u>** of 70899-428 (G2212) code, there are three (3) Prolonged codes expected to be built into IRIS. We do not have an expected available date, at this time; but will inform you as soon as we know. These new prolonged CPT codes are:
    - **99415-4 – Prolonged Clinical Staff Service, First Hour (add-on code only)**
        - Minimum additional time needed to use this add-on code is 30 minutes, in addition to the 74 minutes of 99205-4; or 54 minutes of 99215-4.
        - Maximum amount of additional time used with this code is 60 minutes added to 99205-4 (74 + 60 = 134); or 99215-4 (54 + 60 = 114**).**
        - Code dependent on 99205-4 or 99215-4
    - **99416-4 – Prolonged Clinical Staff Service, Each additional 30 min (add-on code only)**
        - Minimum of at least 149 minutes with 99205-4 & 99415-4 codes of service: e.g., – **at least 15 min. of 99416-4** + 74 min. of 99205-4 + 60 min. 99415-4 has been provided; or
        - Minimum of at least 129 minutes with 99215-4 & 99415-4 codes of service: e.g., - **at least 15 min.** of 99416-4 + 54 min of 99215-4 + 60 min. of 99415-4 has been provided
        - Maximum amount of units with 99416-4 is 44 units (22 additional hours)
        - Code dependent on 99205-4, 99215-4 and 99415-4
    - **99417-4 – Prolonged Outpatient Evaluation and Management Service, Each 15 minutes of total time add-on code only for:**
        - 99245-4 Office or Other Consultation for a New or Established Patient
            - Use 99417-4 if total service minutes of 99245-4 meet or exceed 84 minutes
        - 99345-4 Home Visit of a New Patient
            - Use 9941704 if total services minutes of 99345-4 meets or exceeds 104 minutes
        - 99350-4 Home Visit of an Established Patient
            - Use 99417-4 if total service minutes meet or exceed 89 minutes
        - Use to extend additional 15 minutes increments to longest service time of each of these three code sets listed above
        - Maximum units of 99417-4 that can be claimed is 91 units, or an additional 1365 minutes to the base codes