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Physician Visit Limit Stakeholder Meeting

Tuesday, November 27, 2012
1700 K Street, 1st Floor
Sacramento, CA 95814



Agenda

- ▶ Welcome and Introductions
- ▶ Status of the State Plan Amendment
- ▶ Physician Visit Medical Policy
- ▶ Implementation of a Tracking Mechanism
- ▶ Questions and answers
- ▶ Adjourn



State Plan Amendment 11-013

- ▶ **Recap:** SPA 11-013 was initially submitted to the Centers for Medicare and Medicaid Services (CMS) on July 28, 2011.
- ▶ The SPA will amend the State Plan to implement Welfare and Institutions (W &I) Code Section 14131.07.
- ▶ Section 14131.07 limits physician office visits to seven (7) per fiscal year (July 1 – June 30).



State Plan Amendment 11-013

- ▶ Visits limited are for services provided by a physician, or a medical professional under the supervision of a physician, that are covered benefits under the Medi-Cal program.
- ▶ SPA taken off the clock on May 14, 2012.
- ▶ DHCS continues to work closely with CMS on SPA language.



Physician Visit Policy

- ▶ Physician services provided at the following:
 - Hospital outpatient departments;
 - Physician offices;
 - Community clinics;
 - Federally-qualified health centers (FQHCs);
 - Rural health clinics (RHCs); or Indian Health Services (IHS)



Exemptions

The following beneficiaries are exempt from the seven visit limit:

- ▶ Beneficiaries that are pregnant – through 60 days postpartum;
- ▶ Beneficiaries under age 21;
- ▶ Beneficiaries receiving Specialty Mental Health Services;
- ▶ Beneficiaries in a long-term care facilities (NF-A, NF-B, and NF-DD); Beneficiaries enrolled in Program for All-Inclusive Care for the Elderly (PACE); Senior Care Action Network (SCAN) and AIDS Healthcare Foundation;
- ▶ Beneficiaries enrolled in Medi-Cal Managed Care;
- ▶ Beneficiaries enrolled in Medicare and Medi-Cal.



Exceptions

Visits for the following types of physician services are exempt from the physician visit limit. Providers must document exceptions in the beneficiary's medical record.

1. The physician service may prevent an emergency room visit;
2. The physician service may prevent an inpatient hospital admission;
3. The physician service is required to provide ongoing necessary medical and/or surgical therapy or treatment;
4. The physician visit is required for a diagnostic workup;
5. The physician visit is required for an in-home supportive services assessment and/or form completion.



Physician Documentation

- ▶ Physicians must document that the beneficiary met one or more of the “exception” criteria;
 - Written documentation that the service met one of the “exception” criteria; and
 - Maintain documentation in the beneficiary's medical file.



Physician Visit Billing Codes

- ▶ The following codes are applicable for physician office or clinic visits.
 - Current Procedure Terminology (CPT)
 - 99201–99215, 99241–99245, 99385–99387, and 99395–99397

- ▶ The following codes are applicable for physician office or clinic visits provided in an FQHC, RHC or IHS.
 - 01, 04, 15, 16, 23, or 24



Claims System

- ▶ The Fiscal Intermediary (FI) will implement system modifications to limit physician and office visits to seven (7) for claims billed with the CPT codes listed above.

- ▶ Physician services claims for the following will be excluded from the visit limit and will be processed by the FI through the standard claims process.
 - Pregnancy;
 - Children under age 21;
 - Long-term care beneficiaries in a SNF or ICF;
 - AIDS Healthcare Foundation, Senior Care Action Network, Program for All Inclusive Care for the Elderly, and Managed Care Plans; and
 - Medicare and Medi-Cal eligibles.



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Claims System

- ▶ Electronic and paper claims billed using a CPT Code, must include modifier “KX” to denote the beneficiary met the “exception” criteria.
- ▶ Claims without the “KX” modifier will count towards the visit limit.
- ▶ Claims for physician services without a modifier exceeding seven visits will be subject to denial.
- ▶ Supporting documentation is not required to process claims.



Claims System

FQHC, RHC, AND IHS CLAIMS

- ▶ Electronic and paper claims billed using a two digit, per-visit code instead of a CPT Code must include exception verbiage in the attachment/remark field on the claim to justify physician services.
- ▶ Only the existence of an attachment/remark statement is required on the claim. Documentation in the beneficiary's medical record is required.



Tracking Mechanism

- ▶ Implementation of a tracking mechanism
 - Will allow providers to determine the number of physician visits a beneficiary has received in the fiscal year.
 - Potentially Web based.



Provider Education

- ▶ Updates in the Medi-Cal Provider Manual;
- ▶ Post a Medi-Cal Provider Bulletin on the DHCS web site; and
- ▶ Access to physician visit email mailbox at physicianvisitlimit@dhcs.ca.gov and List-Serve.



Implementation

- ▶ Will begin after implementation of a tracking mechanism for providers.



Questions and Answers



Email Address

Physicianvisitlimit@dhcs.ca.gov