Payment Model Demonstration Project | Billing and Coding Guide

California Advanced Primary Care Initiative

California Quality Collaborative

About This Document

This document is designed as a comprehensive guide for participants of the California Advanced Primary Care Initiative's Payment Model Demonstration Project. The guide clarifies the billing and coding procedures essential for optimizing financial outcomes under the demonstration project payment models. This guide serves as a crucial resource for health care providers navigating the complexities of the demonstration project framework, ensuring they are well-equipped to meet both regulatory compliance and program-specific financial goals.

How to Use This Guide

- **Understanding Payment Structures:** Familiarize yourself with the different payment models within the demonstration project, including Direct Services Payment, Population Health Management Payment and Performance Incentive Payment. This section helps you understand where specific services and billing codes fit into the demonstration project payment framework.
- **Applying Billing Codes:** Use the detailed lists of CPT and ICD-10 codes provided for different services under Fee-For-Service Plus (FFS+) and Capitation to ensure accurate billing for the services rendered.
- **Maximizing Reimbursements:** Leverage the information on how to document non-directly billable services that support population health management and performance incentives to ensure your practice can claim and receive all entitled payments.
- **Ensuring Compliance:** Adhere to the documentation and coding guidelines detailed in this guide to meet demonstration project compliance requirements and qualify for incentive payments based on performance metrics and quality measures.

The initiative's payment model aims to boost compensation for primary care providers in California by promoting value-based care. It includes three elements designed to increase practice revenue, enhance care coordination, and improve provider satisfaction. Participating practices can earn up to 30% more in payments, though allocation may vary by plan.

The three elements are:

1. **Direct Services Payment** (Fee-for-Service Plus, Basic, or Intermediate Capitation)
2. **Population Health Management Payment** (Support for care coordination and data infrastructure)
3. **Performance Incentive Payment** (Rewards for quality improvement and equity-sensitive outcomes)

This model supports both patient relationships and practice sustainability.

Payment Model Demonstration Project | Payment Models

	Element 1 Direct Services Payment (Three Tracks)		**Element 2** Population Health Management Payment		**Element 3** Performance Incentive Payment
Track A	**Fee-For-Service Plus:** Plans continue to pay FFS for all direct patient care services.	+	A prospective, adjusted regular payment based on PMPM to support Advanced Primary Care attributes such as population health management functions • referral & follow up • patient outreach • coordination with other resources • transitions of care • team care • infrastructure, data & reporting, etc.	+	Rewards practice performance on common measure set • Payment for meaningful improvement (10% relative) if original score is between simple numerical targets loosely tied to the national 25th to 66th percentile benchmarks • Payment for attainment if scores above around the 66th percentile (higher) • Pay more for improvement or attainment on equity sensitive measures.
Track B	**Basic Capitation:** Pays a prospective, adjusted PMPM payment for E&M, all other services paid FFS				
Track C	**Intermediate Capitation:** Pays a prospective, adjusted PMPM payment for E&M and additional services, all other services paid FFS				

Element 1: Direct Services Payment

Three Potential Tracks for Element One - Direct Services Payment

A. FFS+ Model Direct Services: All direct services are reimbursed Fee For Service (FFS)
B. Basic Level Capitation Hybrid Model Direct Services: Evaluation and management services are capitated Per Member Per Month (PMPM), all other services remain FFS.
C. Intermediate Level Capitation Hybrid Model Direct Services: Evaluation and management services and additional services (transitional care management, advance care planning, non-oral drugs, certain small surgeries, some ultrasounds) are capitated PMPM, all other services FFS.

A. **Fee-For-Service Plus (FFS+):** Providers bill for each service provided using standard CPT codes for all direct patient care services.

- **Relevant CPT Codes:** These cover all procedural and office visit services **typically provided in an outpatient setting.**
  - **Example: CPT codes 99201-99215 for office visits.**

B. **Capitation Payment:** Providers receive a fixed PMPM amount covering specified services, with variations based on the level of capitation.

a. **Basic Capitation:**
- Covers mainly E&M services.
- **Relevant CPT Codes:** 99201-99215 (E&M codes for office visits).

Table: Capitated Services and CPT Codes – Basic Level Capitation Hybrid Model (B)

Services Covered Under Capitation	**Services to be Paid Fee for Service**
E&M 99201-99215	Immunizations 90281-90756, G0008-G0010
Other E&M 99300-99499	Annual Well Visits (AWV) 99381-99387, 99391-99397
	All other direct, billable services rendered by primary care practice

C. **Intermediate Capitation:**

- May include minor procedures and certain diagnostics.
- **Relevant CPT Codes:** Varies based on specific agreement and services included.

Table: Capitated Services and CPT Codes – Intermediate Level Capitation Hybrid Model (C)

Services Covered Under Capitation	**Services to be Paid Fee for Service**
E&M 99201-99215	None
Other E&M 99300-99499	Home Visits, Rest Home Visits, Skilled Nursing Facility (SNF)
Medicine Services 90757-99756 HCPCS – S & Q codes	Echocardiograms, Specimen Handling, Inhalation Treatment, Filling of Inflatable Pump, COVID Testing, Flu Vaccines, IV Tubing, IV Infusion, Pap Smear, IUDs, Abortion
Temporary HCPCS – G & C codes	COVID Testing
Drugs, Non-Oral, and Chemo – HCPCS – J codes	Ceftriaxone, Progesterone, Asthma-related, Nausea-related, IV Fluid, IUDs, Estradiol, Cortisone, Chemo
Category III – Codes ending in T	None
	All other direct, billable services rendered by primary care practice

Element 2: Population Health Management Payment

A prospective payment made monthly or quarterly, calculated PMPM to support population health management activities.

- **Covered Activities:**
  - Care coordination, patient outreach and education and data management.
- **Billing and Coding Tips:**
  - Document all activities meticulously.
  - **Relevant ICD-10 Codes:** Use specific codes that justify the interventions (e.g., Z71.89 for other specified counseling, Z00.00 for general adult medical examination).

Table: Population Health Management (PHM) ICD-10 Z Codes

Interventions	**ICD-10 Codes[1,2,3]**	**Interventions**	**ICD-10 Codes**
General Adult Medical Examination	Z00.00	Housing instability, housed, homelessness in past 12 months	Z59.812
Problems related to education and literacy	Z55	Housing instability, housed unspecified	Z59.819
Less than a high school diploma	Z55.5	Transportation insecurity	Z59.82
Problems related to health literacy	Z55.6	Financial insecurity	Z59.86
Problems related to employment and unemployment	Z56	Material hardship due to limited financial resources, not elsewhere classified	Z59.87
Occupational exposure to risk factors	Z57	Other problems related to housing and economic circumstances	Z59.89
Problems related to physical environment	Z58	Problems related to social environment	Z60
Inadequate drinking-water supply	Z58.6	Problems related to upbringing	Z62
Other problems related to physical environment	Z58.8, Z58.89	Upbringing away from parents	Z62.2
Basic services unavailable in physical environment	Z58.81	Child in custody of non-parental relative	Z62.23
Problems related to housing and economic circumstances	Z59	Child in custody of non-relative guardian	Z62.24
Homelessness (Updated)	Z59.0	Other specified problems related to upbringing	Z62.8
Homelessness unspecified	Z59.00	Personal history of abuse in childhood	Z62.81
Sheltered homelessness	Z59.01	Personal history of child financial abuse	Z62.814
Unsheltered homelessness	Z59.02	Personal history of intimate partner abuse in childhood	Z62.815
Inadequate housing	Z59.1	Parent-child conflict	Z62.82
Inadequate housing, unspecified	Z59.10	Parent-step child conflict	Z62.823
Inadequate housing environmental temperature	Z59.11	Non-parental relative or guardian-child conflict	Z62.83
Inadequate housing utilities	Z59.12	Non-parental relative-child conflict	Z62.831
Other inadequate housing	Z59.19	Non-relative guardian-child conflict	Z62.832
Lack of adequate food	Z59.4	Group home staff-child conflict	Z62.833
Food insecurity	Z59.41	Other specified problems related to upbringing	Z62.89
Other specified lack of adequate food	Z59.48	Runaway [from current living environment]	Z62.892

[1] https://www.cms.gov/files/document/zcodes-infographic.pdf
[2] https://www.aapc.com/blog/87187-new-z-codes-capture-more-social-determinants-of-health/
[3] https://www.cms.gov/files/document/cms-2023-omh-z-code-resource.pdf

Other problems related to housing and economic circumstances	Z59.8	Other problems related to primary support group, including family circumstances	Z63
Housing instability, housed	Z59.81	Problems related to certain psychosocial circumstance	Z64
Housing instability, housed, with risk of homelessness	Z59.811	Problems related to other psychosocial circumstances	Z65

Element 3: Performance Incentive Payment

Rewards providers for meeting specific performance benchmarks related to quality measures and patient outcomes.

- **Key Components:**
  - **Quality Measures**
- **Benchmarking Performance:** Practice performance on these measures is compared to predefined benchmarks or thresholds. These benchmarks are usually set based on historical performance data, percentile rankings (e.g., 25th to 66th percentile), or absolute target goals.
- **Improvement and Attainment:** Payments are structured around:
  - **Improvement:** Practices can earn incentives for showing significant improvement in their performance scores compared to previous measurements. For example, moving from the 30th percentile to above the 50th percentile in a given measure.
  - **Attainment:** Practices achieving performance above a certain percentile (e.g., the 66th percentile) may receive additional payments to acknowledge their high level of care quality.
  - **Equity Sensitive Measures:** reducing disparities in healthcare outcomes. Performance incentives may include higher payments for improvement or attainment on measures that are considered equity-sensitive, helping to ensure that all population groups receive high-quality care.

Quality Measures for Billing and Coding Guide	

1. Health Outcomes & Prevention	**Asthma Medication Ratio (AMR)**
	• CPT Codes:
	  • Outpatient CPT codes for Medication Management: 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483
	  • Telephonic and Telehealth CPT Codes: 99441-99443, 98966-98968, 99444, 99212-99215, 99201-99205
	  • CPT Modifier Codes for Telehealth: 95, GT, 02
	• Asthma Diagnosis ICD-10 Codes: J45.21-J45.22, J45.31-J45.32, J45.41-J45.42, J45.51-J45.52, J45.901-J45.902, J45.990, J45.991, J45.998
	• Uncomplicated Asthma ICD-10 Codes: J45.30, J45.40, J45.50, J45.909
	• Exclusion ICD-10 Codes:
	  • Cystic Fibrosis: E84.0, E84.11, E84.19, E84.8, E84.9
	  • Emphysema and Other Emphysema Conditions: J43.0-J43.2, J43.8, J43.9, J98.2, J98.3
	  • COPD: J44.0, J44.1, J44.9
	  • Acute Respiratory Failure: J96.00-J96.02, J96.20-J96.22
	  • Chronic Respiratory Conditions Due to Fumes or Vapors: J68.4
	• Documentation Tips: Document medication adherence and patient education.

	Breast Cancer Screening (BCS)
	• Mammography CPT Codes: 77055-77057, 77061-77063, 77065-77067
	• Mammography HCPCS Codes: G0202, G0204, G0206
	• Exclusion CPT Codes:
	  • Unilateral Mastectomy with a Bilateral Modifier: 19180, 19200, 19220, 19240, 19303-19307. Bilateral Modifier: 50, LT, RT
	  • Unilateral Mastectomy with Left/Right-Side Modifier: 19180, 19200, 19220, 19240, 19303-19307. Right/Left Side Modifier: LT, RT
	• Exclusion ICD-10 Codes:
	  • Bilateral Mastectomy: 0HTV0ZZ
	  • History of Bilateral Mastectomy: Z90.13
	  • Left Unilateral Mastectomy: 0HTU0ZZ
	  • Right Unilateral Mastectomy: 0HTT0ZZ
	  • Absence of Left Breast: Z90.12
	  • Absence of Right Breast: Z90.11
	• Documentation Tips: Proper documentation of mastectomy either bilateral or unilateral to assist in noting denominator exclusions.

	Childhood Immunization Status (CIS) Combo 10
	• CPT Codes: 90460, 90461, 90471-90474 for vaccine administration.
	• Vaccine Specific CPT Codes:
	  • DTap-IPV-Hib-HepB: 90697
	  • DTap: 90698, 90700, 90721, 90723
	  • HiB: 90644-90648, 90698, 90721, 90748
	  • Hepatitis A: 90633
	  • Hepatitis B: 90723, 90740, 90744, 90747, 90748
	  • Inactivated Polio Vaccine (IPV): 90698, 90713, 90723
	  • Influenza: 90655, 90657, 90661, 90662, 90673, 90685-90688
	  • Measles, Mumps and Rubella (MMR): 90707, 90710
	  • Pneumococcal Conjugate Vaccine (PCV): 90670
	  • Rotavirus Vaccine (2 dose): 90681
	  • Rotavirus Vaccine (3 dose): 90680
	  • Varicella Zoster: 90710, 90716
	• Documentation Tips: Keep records of each vaccine administered, patient name and DOB, including date and type given (not date ordered), test results, history of illness, or contraindication for a specific vaccine. Upload immunizations onto the California Immunizations Registry (CAIR).
	  • Specific for MMR, HepB, VZV, and HepA: Evidence of the antigen or combination vaccine (include specific dates) and documented history of the illness.
	  • Specific for DTaP, HiB, IPV, PCV, Rotavirus, and Influenza: Evidence of the antigen or combination vaccine (include specific dates) OR Notation indicating contraindication for a specific vaccine.

	Colorectal Cancer Screening (CRC)
	• CPT Codes:
	  • FOBT: 82270, 82274
	  • Flexible Sigmoidoscopy: 45330-45335, 45337-45342, 45345-45347, 45349, 45350
	  • Colonoscopy: 44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398
	  • CT Colonography: 74261-74263
	  • Stool DNA (sDNA) with FIT test: 81528
	• HCPCS Codes:
	  • FOBT: G0328
	  • Flexible Sigmoidoscopy: G0104
	  • Colonoscopy: G0105, G0121
	  • Colorectal Cancer (PET scan): G0213-G0215, G0231
	  • Stool DNA (sDNA) with FIT test: G0464
	• Documentation Tips: Record the date and type of screening performed(Fecal Occult Blood Test, Flexible sigmoidoscopy, Colonoscopy, CT colonography or Stool DNA (Cologuard) with FIT test report) and the findings of the procedure.

	Controlling High Blood Pressure (CBP)
	• CPT Codes: Regular visits (e.g., 99213, 99214), plus 93784 for ambulatory blood pressure monitoring.
	  • All Outpatient CPT codes: 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483
	  • All Telephonic and Telehealth CPT codes: 99441-99443, 98966-98968, 99444, 99212-99215, 99201-99205
	  • CPT Modifier codes for Telehealth: 95, GT, 02
	• CPT II Codes: 3074F-3075F, 3077F-3080F
	• Documentation Tips: Document each patient's blood pressure readings over time and management plans. Document BP readings taken and reported by member using any digital device.

	Depression Screening and Follow Up for Adolescents and Adults (DSF-E)
	• CPT Codes:
	  • Behavioral Health Encounter: 90791, 90792, 90832, 90833, 90834, 90836, 90837-90839, 90845-90847, 90849, 90853, 90865, 90867-90870, 90875, 90876, 90880, 90887
	  • Depression Case Management Encounter: 99366
	  • Follow-Up Visit: 98960-98962, 99078, 99201-99205, 99211 – 99215, 99217-99220, 99241 – 99245, 99341 – 99345, 99347 -99350, 99381 – 99387, 99391 – 99397, 99401 – 99404, 99411, 99412

	• Telephonic and Telehealth CPT codes: 99441-99443, 98966-98968, 99444, 99212-99215, 99201-99205 • CPT Modifier codes for Telehealth: 95, GT, 02 • HCPCS Codes: • Depression Case Management Encounter: T1015, T1016, T1017, T2022, T2023, G0463 • Documentation Tips: Standard age-appropriate tool used for screening clinical depression and follow up care on or 30 days after the date of the first positive screen.
	Glycemic Status Assessment for Patients with Diabetes >9% (GSD) • HbA1c Testing CPT Codes: 83036, 83037 • CPT II Codes: 3046F, 3051F, 3052F • Documentation Tips: Record HbA1c levels, dates of tests, and adjustments to treatment plans.
	Glycemic Status Assessment for Patients with Diabetes <8% (GSD) • HbA1c Testing CPT Codes: 83036, 83037 • CPT II Codes: 3044F, 3051F • Documentation Tips: Record HbA1c levels, dates of tests, and adjustments to treatment plans. A distinct numeric result is required for numerator compliance; "unknown" is not considered a result/finding.
	Immunizations for Adolescents Combo 2 (IMA) • Meningococcal CPT Codes: 90619, 90733, 90734 • Anaphylaxis reaction SNOMED CT: 428301000124106 • Tdap CPT Code: 90715 • Anaphylaxis reaction SNOMED CT: 428291000124105 • Encephalitis reaction SNOMED CT: 192710009 (Tetanus), 192711008 (Diphtheria), 192712001 (Pertussis) • HPV CPT Code: 90649, 90650, 90651 • Anaphylaxis reaction SNOMED CT: 428241000124101 • Documentation Tips: Must include any of the following: Indicate the name of the specific antigen and the date of the immunization, a certificate of immunization that includes specific dates and types of immunizations administered, anaphylactic reaction to the vaccine or its components any time on or before the member's 13th birthday, encephalopathy with a vaccine adverse effect anytime on or before the member's 13th birthday (Tdap).

2. Patient Experience	**Patient Experience** • Billing Codes: Not directly billable; related to service quality and patient satisfaction surveys. • Documentation Tips: Ensure all patient interactions are documented for quality reviews.
3. High Value Care	**Total Cost of Care** • Billing Codes: Includes all CPT codes used within the reporting period. • Documentation Tips: Maintain comprehensive records of all services provided, including diagnostics, treatments, and outcomes.

Additional Information:
• **Data Submission**: Practices are required to submit these data points regularly through Cozeva, ensuring that all measures are tracked and reported accurately. • **Billing Implications**: Accurate documentation and coding for these measures are crucial for securing appropriate reimbursement and qualifying for performance-based payments.
Billing and Coding Tips:
• **Use Specific Codes**: Always use the most specific codes available to ensure accurate reporting and reimbursement. • **Regular Updates:** Stay updated with changes in CPT and ICD-10 codes as they can affect billing. • **Auditing and Monitoring:** Regularly audit billing practices to ensure compliance with Payment Model Demonstration Project requirements and prevent billing errors. • **Training**: Conduct regular training sessions for all coding and billing staff on the latest guidelines and changes specific to Payment Model Demonstration Project. • **Technology Utilization**: Leverage technology like Electronic Health Records (EHR) and billing software that can be updated to reflect the latest coding standards and can facilitate accurate data reporting.