

Payment Reform FAQs: SMHS

General Services

1. At times, there are clinical interventions that happen when transporting a beneficiary (i.e., rapport building, etc.). How can this be documented?
 - a. Clinical discretion should be used. Staff will need to calculate what time was spent providing a service, and what time was spent in travel alone; this should then be broken down in the progress note *duration* fields.
2. After completing an interview with a beneficiary for an assessment, how do I document the time spent writing up my clinical formulation (when away from the beneficiary)? Also, what code is most appropriate?
 - a. The service code would be Assessment (331CA). For this scenario, direct service time is 0, documentation time is however long it took to write up the assessment, and transportation time is 0.
 - b. Note: Direct service is reimbursable; the other durations are important to capture as well.
 - c. QI is exploring other service codes that may be used to capture clinical formulation time without the beneficiary present. Staff should reference the Documentation Guide which will contain all current updates.
3. Is there a different definition of what an assessment is, considering now that it can only be billed 15 minutes?
 - a. Assessment service definitions have not changed; most assessments will last longer than 15 minutes. The Add-On "extended service" should be used to cover the additional assessment time. For example, if the assessment service is 90 minutes, the assessment service time is 15 minutes and the extended service time is 75 minutes. (15+ 75= 90).
4. Are assessments always billed for 15 mins and then we use extended service Add-On for all additional time?
 - a. Yes.
5. How should completion of assessment measures with the parent of a minor beneficiary (PSC35 for example) be captured?
 - a. Use 311CA if only the parent is part of the service.
6. Will there be any changes for residential setting where we bill by the day (to include daily progress notes, weekly summaries, and discharge summaries)?
 - a. This is not changing other than the CA being added to the end of the service code.
7. Will service codes now have time limits?
 - a. Certain services will have a max duration and if the service goes beyond the maximum time, the extended service Add-On may be used. A matrix outlines all this in the Clinical Documentation Guide.

8. Does the beneficiary have to be present during a case management service to “count” as direct service?
 - a. No, in order to be reimbursed for case management, the beneficiary does not need to be present.
9. Is communication with the medication provider still billable under case management without the beneficiary present?
 - a. Yes, this may be billed as case management and does not require the beneficiary present.
10. When receiving and reviewing records prior to a session, would this be an Add-On to the primary assessment service code? (i.e. Psychiatric Evaluation 90885 CPT code).
 - a. QI is exploring other service codes that may be used to capture this activity. Staff should reference the Documentation Guide which will contain all current updates.
11. How do we account for time setting up and breaking down activities (group and individual)?
 - a. This time is non-billable. Only direct service, documentation time, and travel time is captured in the progress note. Staff may capture set-up/break-down as a separate 330CA Non-Billable progress note.
12. For providers conducting an assessment with the parent of a minor child (when the beneficiary is NOT present), can this still be counted as direct service for the assessment?
 - a. It is best practice to include the child as part of the assessment process. Therefore, whenever possible, clinicians should plan to offer this service when the child can be present for at least part of the meeting, in order to bill for the direct service of an assessment. If an assessment is being conducted with the parent only, staff may use the 311CA Collateral service code.
13. Can clinicians bill Plan Development for completing the “Clinical Formulation” section of Domain 7 within the CalAIM Assessment, as this involves careful consideration of planned services and direction for the beneficiary’s care?
 - a. Completing any of the 7 domains should be billed under Assessment. QI is exploring other service codes that may be used to capture clinical formulation time without the beneficiary present. Staff should reference the Documentation Guide which will contain all current updates.
 - b. If plan development was the main service being provided during an assessment/treatment planning session, it is acceptable to bill 391CA Plan Development.
14. Could the “Telephone Assessment and Management Service” code be used to document a check-in with a caregiver over the phone without the beneficiary present? And if so, would it be reimbursable?

- a. This service type most closely aligns with 311CA Collateral. Standalone Collateral services are not reimbursable when the beneficiary is not present.
15. Is Family Psychotherapy (with beneficiary present) under 26 minutes still billable?
- a. The maximum service time for the primary code for this service is 50 minutes. In order to be able to claim for one unit, the rendering staff must bill at least 26 minutes (duration must be beyond the half-way point). The duration between 0-25 is not beyond the half-way point and would not be reimbursable at this time. For services that go beyond 50 minutes, the extended service add-on code should be used to capture the additional minutes.
16. If a clinician is seeking consultation from another licensed staff about a beneficiary, who bills for the service? What code is used for this?
- a. Only the person seeking the consultation may bill a 363CA Clinician Consultation service code.
17. Does a beneficiary need to be present to bill as direct service when billing for 391CA Treatment Planning for problem list development?
- a. When the beneficiary is present and work is done around the problem list development this may be captured under direct service time. When the beneficiary is not present, this time may be captured in documentation time.

Collateral

1. How does Payment Reform change the way we document Collateral services?
 - a. The latest guidance on Collateral Services for Specialty Mental Health can be found in CalAIM Memo 012 and/or in Exhibit A (below)
 - b. Currently, Collateral services can be documented two different ways:
Add-On Collateral: Collateral as an “Add-On” is collateral documented as part of a primary service. The beneficiary must be present during the collateral service.
Collateral Stand-Alone: Collateral activities conducted without the beneficiary present can be captured by using the 311CA service code which has been renamed Collateral Rehabilitation.
2. Is Collateral a reimbursable service?

Yes. Both Collateral as an Add-On and Collateral Rehabilitation as a stand-alone service are (now) reimbursable effective 7/01/2023.
3. What codes should be billed if services are provided **only** to a family member without the beneficiary present?
 - a. If it is a collateral service, use the 311CA Collateral Rehabilitation service code.

4. Which staff members can use the Collateral Add-On Code?
 - a. Psychiatrists and Licensed/licensed eligible staff can use the Collateral Add-On code for certain services (except for certified peer specialists). Further, staff who bill Plan Development may use this Add-On code.
 - b. This Add-On is restricted to certain service codes. See the Add-On Code Matrix in the Clinical Documentation Guide for a comprehensive grid showing which Add-On Codes can be used with a particular service code.
5. Why are providers able to use the Collateral Add-On code with 336CA Triage but not with the 331CA Assessment?
 - a. This is a billing rule based on how these map to CPT codes on the 'back end'.
6. Are Collateral groups (such as Circle of Security) billable?
 - a. Yes, staff who use the 358CA Collateral Group Rehabilitation code are able to claim for this service.

Add-On Codes

1. Where can we find the max service time before we have to do an Extended Add-On?
 - a. The Matrix at the end of the Clinical Documentation Guide in the Appendix section.
2. Can you have more than one Add-On?
 - a. Yes, more than one Add-On may be selected depending on the practitioner type/service type.
3. If there is Interactive Complexity and interpretation during the same session, which Add-On should I choose?
 - a. Interpretation should be selected. Interpretation time should be equal to the direct service duration.
4. When providing Interpretation, when would it be appropriate to bill for the service, and who would bill for the service?
 - a. If a staff (i.e., BHA, SWIII, etc.) provides solely interpretation services for a Case Coordinator/Psychiatrist then the Case Coordinator **or** the Psychiatrist would bill for that service with the interpretation Add-On but *not both*. If the interpreting staff is meeting with the beneficiary/family after the session to provide 'cultural linkage' and ensure understanding of what was interpreted previously, this may be billed as 301CA Case Management separately, but this must be clearly documented in the progress note.
 - b. For MCBH staff or partner providers who are providing the direct interpretation for a person in care during a primary service, interpretation

activities can now be captured on the Scheduling Calendar in AVATAR; See CalAIM Memo 010 for further guidance (Located on QI Website).

5. If a staff member is bilingual and provided services in both Spanish (i.e., to monolingual parents) and English (child/youth), would the interpretation Add-On be appropriate?
 - a. No. This Add-On is only used when a third party is providing the interpretation. Staff would document in the progress note that the service was provided in Spanish to parents and English to beneficiary.
6. Are Add-On codes available for case management?
 - a. The only Add-On code that can be used with case management is the Interpretation Add-On.
7. Are Add-On codes available for lock out codes?
 - a. No, Add-On codes are not available for lock-out codes.
8. Is the 341CA Individual Therapy service code now limited to 60 minutes?
 - a. No, that is not the case. The 341CA Individual Therapy primary code can be used for service duration up to 60 minutes. If the duration is beyond 60 minutes, then the clinician should use the extended service add-on code for that duration beyond the 60 minutes (i.e. the direct service is 74 minutes then the primary service code duration will be 60 minutes and the extended add-on duration will be 14 minutes). Additional information can be found in the Add-On Matrix in the Clinical Documentation Guide.
9. If a SWIII writes a hold or is involved with a crisis situation, how do they bill if it's over 74 minutes, since they can't use the add-on code?
 - a. Non-licensed/license eligible staff will just enter their total duration as under the primary service section of the progress note and the add-on does not apply.

Other

1. If beneficiary is unhoused, how would this be documented under Location?
 - a. If the beneficiary is unhoused, document as Telehealth/Telephone Client Not at Home. If beneficiary is residing at a temporary shelter or residential program, document as Telehealth/Telephone Client at Home.
2. For a Telephone/Telehealth service to a parent (without the beneficiary present), what location should be selected?
 - a. Use the "Client Not at Home" selection.
3. What if my Agency/Program does not document in Avatar, how will these changes impact submitting our claims?
 - a. Continue "business as usual" until further guidance is provided from MCBH Billing Department.

4. How will sustainability be tracked? In the current reports, only direct service time is tracked, thus drive time, note writing, and assessment writing time is not being accounted for.
 - a. At this time, the 310 report is still pending updates and QI is working on developing a Service Activity Report which will capture how staff are spending their time.
5. If a provider is submitting late notes for dates of service prior to 7/1/23, which telehealth code should be used?
 - a. The regular service code should be used (without the CA), and telehealth should be selected for the location field.
6. Can MHRS staff use the 331CA Assessment as well?
 - a. Updates are pending release to the Mental Health Service Code section of the Clinical Documentation Guide to clarify the use of the 331CA code. There *are* some services that other qualified providers can bill using the 331CA Assessment code. These include making contributions to the assessment such as: gathering the beneficiary's mental health and medical history, substance exposure and use, and identifying strengths, risks, and barriers to achieving goals (BHIN 22-019).
 - b. Note: staff should reference the Documentation Guide for updates related to this.
7. When staff document using lockout codes, should the time spent face-to-face with the beneficiary be captured under direct service time, or documentation time?
 - a. Direct service time.
8. How should Case Management Services be billed for HART?
 - a. Services should be billed as they have been done before, the only difference is that all service codes will have the CA suffix.

Exhibit A

Revised 10/26/2023

Collateral as an Add-On	Collateral as Stand-Alone
<ul style="list-style-type: none"> • Collateral is not the primary service but instead an Add-On to another primary service • The person in care is part of the service delivery • Collateral as an Add-On is reimbursable • Staff would select Collateral as an Add-On to the primary service 	<ul style="list-style-type: none"> • Collateral is provided as the primary service (i.e. meeting with the significant support person only) • The person in care may not be part of the service • Collateral as a “stand-alone,” service <u>is reimbursable</u> • Staff would continue to use the 311CA Collateral service code, now called: Collateral Rehabilitation