Fresno County Department of Behavioral Health

CalAIM Q & A

As of 12/8/2023

(Red font = New Info, Update or Correction)

Fresno County Department of Behavioral Health (DBH) is committed to providing the most up to date information during our transition to the California Advancing & Innovating Medi-Cal (CalAIM) initiative. We have put together a list of questions and answers that will provide information on the initiative. If you would like to submit a CalAIM question for Mental Health (MH), please send your inquiry to DBHCompliance@fresnocountyca.gov. For questions related to the Drug Medi-Cal Organized Delivery system (DMC-ODS), please submit questions to SAS@fresnocountyca.gov.

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CPT & Procedure Coding

CQ1: I am a contracted provider in private practice. My question is, if the PS is seen for 60 minutes and I do 10-minute note, would I be able to bill for the 10 minute note under the CPT codes? Also, if the person served is being seen in their home and I drive to their home and back to office, would I be able to bill the minutes to and from the patient's home? How about if a family therapy session were to take 1 hour and 20 minutes?

A: Effective with the new CalAIM payment reform guidelines, neither documentation time nor travel time may be claimed. So, in the first scenario, the provider may not claim the additional 10 minutes for documentation following a 60-minute session. In the second scenario, the same is true, and the provider may not claim for time to drive to the patient's home and back to the office. With regards to the final question about claiming a family therapy session that lasted 1 hour and 20 minutes, family therapy falls under the service therapy codes 90832-90837 – *Psychotherapy, XX minutes with Patient* with the use of an add-on code to capture extended direct service time. For specifics on the selection of the appropriate service code and add-on code for an extended family therapy session, please refer to the SMHS Billing Manual found at https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx. Rather than the CPT code, the provider will enter the SmartCare procedure code associated with that service.

CQ2: Can DBH provide a crosswalk of current codes to new codes?

A: DBH will work on this.

CQ3: For providers that are full EHR users, will everyone providing or documenting services need to know the SmartCare codes?

A: No, practitioners will select a description of the service provided from a dropdown menu, enter some additional information about the service (for example, total duration of Face-to-Face time) and SmartCare will map to the SmartCare code on the back end.

CQ4: For providers that are lite EHR users, how will SmartCare know which codes to use?

A: Providers that will be submitting a billing upload will need to include the SmartCare procedure code.

CQ5: What are the codes for individual and group counseling?

A: Individual codes are: H0004, T1006 (non-billable); Group code: H0005

CQ6: What code should be used for assessment? When an LPHA bills for an assessment its currently under Care Coordination, but the CPT code is not available to LPHAs?

A: The completion of an assessment would be billed using G0396, G0397 and G2011. The code used would depend on the time spent completing the assessment.

CQ7: Would interactive complexity (CPT code 90785) apply for a longer assessment if justified?

A: This code is an add on code to document conditions that increased the complexity of an encounter, such as the need for interpreter services or CPS involvement. This code is intended for documentation (data collection only) and does not provide any additional reimbursement.

CQ8: How is a reimbursement rate determined when codes are used by multiple practitioner types?

A: Each practitioner has a profile in SmartCare that includes their licensure or certification type. When services are entered into the system under a particular practitioner, their practitioner type determines the reimbursement rate. This means that each CPT or HCPC code has various reimbursement rates depending on who provides the service.

CQ9: Is CPT code H0033- Oral Medication Administration allowed to be claimed by a Mental Health Rehab Specialist (MHRS)?

A: No, MHRS/clinical staff can not claim for code H0033 - Oral Medication Administration. Medication Administration is a medication support service and cannot be provided by a non-licensed professional.

CQ10: Which CPT codes are we able to bill to?

A: Contracted providers who WILL NOT use SmartCare as the clinical electronic health record will have access to all CPT and HCPCS codes. Those codes that may be claimed to Medi-Cal are listed in the Specialty Mental Health Medi-Cal Billing Manual and the Drug Medi-Cal Organized Delivery System Billing Manual. These manuals that are effective July 1, 2023 and other tools are found on the state's MedCCC webpage: MedCCC - Library (ca.gov). However, ALL providers will enter SmartCare procedure codes for billing purposes. Fresno DBH has ensured that the SmartCare codes appropriately crosswalk to these CPT codes. The SmartCare EHR includes functionality to capture the appropriate code based on the service information entered. Contracted providers who WILL use SmartCare fully as a clinical electronic health record will benefit from functionality allowing the practitioner to quickly access only the CPT and HCPCS codes that are within their scope of practice.

If they determine they are missing access to a particular code, in error, they may follow the DBH process to request access.

CQ11: How do we code for group rehabilitation (Providing psychoeducation, practice opportunities, support, encouragement, experiential activities, and reflective prompts to promote improvements in functioning and reduction in barriers to progress; formerly code 85; able to be provided by MHRS, clinicians)?

A: To bill for group rehabilitation services, use the code for psychosocial rehab services H2017. This is a HCPCS code therefore may be used by non-licensed/registered providers, such as case-managers. We will need to ask MedCCC about the missing HQ modifier for groups.

CQ12: HQ (group modifier) is not listed as an allowable modifier for psychosocial rehabilitation services (H2017) which would make it a group services; however, the definition of psychosocial rehabilitation states that it is delivered “to a beneficiary or a group of beneficiaries” (p. 134). Does 90853 (group therapy) then capture all group services across providers?

A: No, 90853 is a therapy code to be used by only licensed/registered providers. Also, if a licensed/registered provider does a group rehab service they would also use the SmartCare procedural code for H2017. This HCPCS code is allowed to be used by all disciplines. To bill for group therapy services, use the SmartCare procedural code for CPT 90853. This group therapy code should be used by a licensed/registered provider as listed in Service Table 11 of the SMH Medi-Cal Billing Manual. The group modifier HQ must also be added.

CQ13: Is it the correct understanding that we would use this code (59) if there were two individual psychosocial rehabilitation services in the same day by the same provider in the same location as a way of distinguishing one from another?

A: No, the 59 modifier is generally about overriding a lockout. Instead, you are describing what is defined as a “Duplicate service”.

CQ14: Do we know if the location codes have been fixed by CalMHSA? Someone stated the codes were not all correct. An example given was group home code 14 and that the code was different than what is in the billing manual vs. the CalMHSA batch upload file.

A: Location codes crosswalk behind the scenes. Location codes in the batch file are SmartCare specific and they crosswalk to the actual billing manual code. The billing manual uses the place of service listing, which is slightly off from the location code IDs in SmartCare. Like the Procedure Codes, it gets crosswalked behind the scenes.

CQ15: I was wondering if you have any information on billing rates. $2.01 for Licensed and $1.71 for Unlicensed. My question is for the times that are 52 mins for a 90834 would I calculate the rate x 45 mins or the 52 mins? Or is there a whole other rate sheet I'm not aware of?

A: As an MHP group provider, when completing your claims via submission of CMS 1500 forms, first we refer you to the SmartCare Procedural Code list for identifying and claiming for services. This is especially important as there are three unique CPT codes for psychotherapy with patient with varying units (30 minutes; 45 minutes; 60 minutes) that are cross walked to the SmartCare Procedural Code 93 – psychotherapy with patient. When determining how a claim for 93 – psychotherapy with patient would be reimbursed, yes, there are certain thresholds and ranges to consider.

On the CMS 1500 form, the provider would utilize SmartCare Procedural Code 93, and the unit of claiming would be documented as 52 (minutes). You are correct that the charges would fall under the equivalent reimbursement for CPT 90834 – psychotherapy 45 minutes with patient as the claim did not cross the threshold to reimburse at the 60-minute rate. At the billing rates cited, the charges for this claim by a licensed clinician would be $90.45 and the charges for this claim by an unlicensed clinician would be $76.95. As SmartCare does crosswalk all claims in the background to the appropriate CPT codes for transmission to Medi-Cal, and only whole units are claimed, this calculation is based on 1 unit of CPT 90834 – psychotherapy 45 minutes with patient, not the direct service time documented of 52 minutes.

There are no other rate sheets for MHP Individual/Group providers other than those shared at the bi-weekly Individual/Group Provider Office Hours on Friday mornings. If you do not have the Outlook invitation to these Office Hours, please send an email to mcare@fresnocountyca.gov and request to be added to this Teams regular support meeting.

CQ16: Could I please get clarity on how billing for groups will function? My understanding is:

> ***Example 1*: One 30-minute group, which consists of 5 clients, would equal a total of 10 billable units. 30-minute (2) units x (5) Clients = 10 Units Billed**
>
> ***Example 2*: 53-minute group (4) units x (10) clients = 40 Units Billed**

Is this correct?

A: From the new billing manual posted over the last few days the formula is number of minutes for the group counseling session/15 min increments = total units to submit to DHCS using code H0005. DHCS will then divide the rate by 4.5. For these examples:

> ***Example 1:*** One 30-minute group, which consists of 5 persons served. Please note the number of clients does not matter under the new formula. Formula: 30 minutes/15 minutes = 2 units billed per person. DHCS would then divide our rate ($197.05) by 4.5. Current rate for AOD counselor is $197.05/hour so $43.78. It would be 2 units x $43.78 = $87.57
>
> ***Example 2:*** 53-minute group (4) units x (10) clients = 40 Units Billed. Please note again the number of persons served does not matter under the new formula. Formula: 53 mins/15 mins = 3.53 units. I think we have to round to the nearest whole unit so this would turn into 4 units per person. DHCS would then divide the rate by 4.5. Current rate for AOD counselor is $197.05/hour so $43.78. It would be 4 units x $43.78 = $175.12

For providers entering directly into SmartCare, there is no need to worry about the modifiers or add-on codes, as SmartCare will perform the correct claiming protocols in the background, so the direction regarding modifiers would not apply.

CQ17: I have a question about codes H2021 and T1017. What is the difference between the two codes and when would code H2021 be the preferred code to use over T1017? What makes community wrap services (H2021) different from T1017 when you are working with another agency for linkage and service coordination? Can you please provide some clarification?

A: For SUD, see excerpt from DMC-ODS Billing Manual v 1.4, pg. 133: "*Community-based wrap-around service: This service is designated by HCPCS code H2021 and refers to coordination of care between providers in the Drug Medi-Cal System and providers who are outside the Drug Medi-Cal System. H2021 can only be used to show that a delivery-system coordination of care has occurred."* For other kinds of coordination, other service codes must be used.

For SMHS, see excerpt from SMHS Billing Manual v 1.4, pg. 185*: "Community-based wrap-around service: This service is designated by HCPCS code H2021 and refers to coordination of care between providers in the Mental Health System and providers who are outside the Mental Health system. H2021 can only be used to show that a delivery-system coordination of care has occurred."* For other kinds of coordination, other service codes must be used.

CQ18: I am seeking direction with billing Collateral as an add on code. What is the Smart Care Procedure Code, Code Duration (Minutes), and minimum threshold?

A: There is no add-on code for Collateral. Please refer to **DQ38** for additional information regarding Collateral.

CQ19: Can we bill for a parent group? If so, would we use the group rehabilitation procedure? What would be the appropriate procedure to bill for such service?

A: The SMHS Billing Manual, draft v1.4 (pages 127-128), as well as BHIN 22-026, Behavioral Health Prevention Education Services, HCPCS H0025, Modifier HE, may be used by certified peer support specialists for skills building group services. This crosswalks to SmartCare Procedure Code 19, labeled as Behavioral Health Prevention Education Service. Fresno DBH will follow up soon with further guidance on parent group services provided by other disciplines or provider types.

CQ20: I have a quick question regarding H2011 mobile crisis code (26). For crisis intervention that are done by other qualified providers, should this be the code that we use? I believe the code 91 is solely for clinical staff and is not a code that other qualified providers can utilize.

A: SmartCare procedure code 26, identified as mobile crisis/crisis intervention, does have both characteristics for claiming the new mobile crisis intervention service and separately crisis intervention in an outpatient setting. Specifically, the direction received from MedCCC is as follows:

To clarify, H2011 is used two ways in SMHS claims:

1) H2011 in a Place of Service that is not 9 (Prison/Correctional Facility) or 15 (Mobile Unit) – As a Crisis Intervention Service. This is billed in **15-minute units**, per Service Table 2 in version 1.4 of the SMHS Billing Manual.
2) H2011 with Place of Service 15 (Mobile Unit) – As a Mobile Crisis Intervention Service. This is billed on a **per-encounter basis**.

As this is a HCPCS code (H2011) that is open to all providers, this would be the appropriate procedure code to claim crisis intervention by LPHAs and other qualified providers in an outpatient setting.

CQ21: I'm using the CPT Code crosswalk for the first time to review some errors in a batch upload and I'm hoping you can help me make sure I'm reading this right. The way I'm looking at the crosswalk and the dependent codes it looks like you can't bill for interactive complexity if the procedure code is for psychosocial rehabilitation. Does that sound right to you?

A: After reviewing the SMHS Billing Manual v 1.4, interactive complexity (90785) is not a supplemental service code that can be used with psychosocial rehab (H2017). 90785 is dependent on codes that can be found on pg. 135 of the SMHS Billing Manual v 1.4.

Also see 5.7.0 Claiming for Interpretation and Interactive Complexity (pg. 25)

- Only one unit of interactive complexity is allowed with any service.
- Interpretation (T1013) should not be claimed together.

Definition of Interactive Complexity (CalMHSA Procedure Code Definitions):

1. Managing maladaptive communication (related to, e.g., high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicates delivery of care.
2. Caregiver emotions/behavior that interfere with implementation of the treatment plan.
3. Evidence/disclosure of a sentinel event and mandated report to a third party (e.g., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.
4. Use of play equipment, physical devices, interpreter or translator to overcome significant language barriers.

CQ22: Can any billable staff use procedure code 298 Legal Report Writing Note for CPS or APS reports?

A: This code is non-billable and is not reserved to specific disciplines, programs or program types. It is available to all disciplines and programs.

Problem List

PQ1: How many days from intake does the problem list (PL) have to be completed? How often should it be updated? Will we be provided with a template and sample?

A: There is no regulatory guidance defining how many days from intake the Problem List should be completed. Problems should be added to the Problem List as they are identified through the assessment and other interactions with the person served. DHCS did not prescribe how often the Problem List should be updated, leaving it to the clinical judgment of providers. Problems should be added and resolved as clinically appropriate. To learn how to add problems to the PL click on the following link: https://2023.calmhsa.org/how-to-add-a-problem-to-the-problem-list/

PQ2: Are we able to document PL in progress notes instead of a separate form since we are discontinuing the use of treatment plans?

A: No, identified problems should be added to the problem list which is a separate document. The identified problem should also be documented in an assessment or progress note.

PQ3: This question has been archived.

PQ4: This question has been archived.

PQ5: This question has been archived.

PQ6: This question has been archived.

PQ7: This question has been archived.

PQ8: This question has been archived.

PQ9: This question has been archived.

PQ10: Is there a timeframe required to resolve the PL items?

A: No. You would update the PL as clinically appropriate.

PQ11: For persons served with existing treatment plans, will the problem list be the first service provided on 9/19/22?

A: Yes, at the next appropriate service on or after 9/19/22, you will enter the problem list with the person served and/or family member, or as clinically appropriate, and discontinue the treatment plan for any service that does not require one.

PQ12: Are the items on the PL meant to be general, i.e., PTSD can have different symptoms?

A: Yes, per the direction and examples from the CalMHSA documentation manual. According to BHIN 22-019, “the problem list is a list of symptoms, conditions, diagnoses, and/or risk factors”. Therefore, the symptoms identified within a diagnosis can be listed separately or as a diagnosis itself (e.g. using Z codes).

PQ13: Do we add any problems that a person served identifies even if it is not a mental health problem/diagnosis?

A: Yes, problems identified by the person served and/or support persons should be included on the problem list including physical health and social determinants of health. Per BHIN 22-019, “the problem list shall include problems or illnesses identified by the beneficiary and/or significant support person”. A problem on the PL is not a diagnosis made by the person adding the problem. By adding a problem to the PL a practitioner is not providing a diagnosis. Only the diagnosis will be on the claim and is therefore billable. Providers entering problems on the PL should add problems that are within their scope of practice if it is key to their intervention. If a problem is identified that is outside the scope of practice or one that they will not be specifically treating, the problem should be documented in a progress note and a referral made to the appropriate provider.

PQ14: Can a non-LPHA (case manager, rehab specialist, LVN) enter physical health problems identified by the person served/support person?

A: Providers should add problems to the problem list that are within their scope of practice. At this time, there is no mechanism in Avatar to add a problem to the problem list without also selecting an ICD 10 code. Since medical conditions are outside the scope of practice for an LPHA, a medical problem reported by a person served should be documented in a progress note. Providers entering problems on the PL should add problems that are within their scope of practice. If a problem is identified that is outside the scope of practice, the problem should be documented in a progress note and a referral made to the appropriate provider.

PQ15: This question has been archived.

PQ16: Currently, on the progress note form, staff could view the problems listed on the treatment plan and select the problem they addressed in Avatar. Will that functionality change to allow staff to view the current problems on the problem list within the progress note?

A: The progress note in Avatar does not have this functionality.

PQ17: Will Avatar Lite users need to complete the PL form in Avatar?

A: Users will need to create their own PL within their own EHR or paper chart. DBH has developed a paper PL that can be utilized by providers without an EHR.

PQ18: Can I complete the PL and targeted case management (TCM) care plan narrative in one service?

A: Yes.

PQ19: Do we list provider on the PL as Therapist or LMFT or LMHC, SLMHC, UMHC, CMHS, AMFT, ASW, etc.?

A: BHIN 22-019 states that the name and title of the provider that identified and entered the item on the Problem List must be present.

PQ20: Where can I find a copy of DBH's Policy or information about the PL?

A: There is not a DBH policy as of yet but a News You Can Use was sent by DBH QI in early September 2022 regarding the problem list. DHCS's BHIN 22-019 and CalMHSA clinical documentation guide also provide details on the problem list.

PQ21: Can we delete a problem on the PL that was created in error in the EHR?

A: No, you must mark it as resolved and complete a corresponding progress note to document the error.

PQ22: If a problem is being identified that was not previously mentioned in the assessment, would we need to update the assessment or complete a core assessment addendum?

A: Maybe. If the new problem is a significant piece of clinical information that adds to or changes the clinical picture or adds value to the diagnostic formulation, then it may be appropriate to update the assessment. Assessments are updated as clinically appropriate. The Assessment is not required to be updated simply because a new problem is added to the Problem List.

PQ23: Is there an updated list of specifically ICD-10 codes for medical conditions related to pregnancy? Should our LMHCs, CMHS, and Psychiatrists be including pregnancy related to whether those need to be included in the Problem List, and if so, can they list those ICD-10 codes in terms of their scope of practice (like we used to do under 5-axis assessment under medical condition section). Sorry, but there doesn't seem to be any real clarity about this, especially since Perinatal Wellness Center exists to support mental health conditions arising from the medical condition of being pregnant (Perinatal Mood and Anxiety Disorders, a.k.a., PMADs).

A: Providers should add problems to the problem list that are within their scope of practice. At this time, there is no mechanism in Avatar to add a problem to the problem list without also selecting an ICD 10 code. Since medical conditions are outside the scope of practice for an LPHA, a medical problem reported by a person served should be documented in a progress note.

PQ24: I need clarification, last week in a meeting we were told to let staff know to start transitioning individuals in their caseloads from treatment plans to problem list as soon as today (I know this will take time, but it was stated that if a person served had an expired TP or soon to expire TP, that as of today we would start doing the PL). However, in the most updated Q and A (dated 9/16/2022) DQ4 stated to continue with Treatment plans until DBH QI issues guidance on the PLs, but in another section of the same Q and A PQ7 it stated to work with supervisor to transition TPs to PLs.

A: Both statements are accurate. Guidance referred to in DQ4 regarding the problem list was sent on 9/8/2022. The response to PQ7 directed individuals to work with their supervisor regarding timeline to transition persons served on their caseload to problem lists as it is not likely that the caseloads would be transitioned to PL in one day. This is a process issue that should be decided at the program level.

PQ25: We understand that we can claim to any suspected diagnoses during the assessment process. After the assessment is completed, if we want to add a diagnosis code to the PL and

bill to it, do we need to do a reassessment or do we just add the code to the PL and start providing services to address that new diagnosis/problem and claim to it?

A: If after completing the assessment you find that a problem (suspected diagnosis) no longer applies you would mark the problem as resolved and this would be documented in a progress note. If a new problem is identified after the assessment is completed, the problem (updated diagnosis or problem) should be added to the problem list and should be documented in a progress note. If completing the assessment results in a change or update to a diagnosis you must also update the diagnosis page. BHIN 22-019 specifies that the time period for providers to complete an initial assessment and subsequent assessments for SMHS is up to clinical discretion; however, providers shall complete assessment within a reasonable time and in accordance with generally accepted standards of practice. It is up to the clinical discretion of the provider taking into consideration the generally accepted standards of practice whether the new problem identified warrants a reassessment of the person served.

PQ26: This question has been archived.

PQ27: Will there be more "problems" listed that we may choose from? The issue is that we are forced to choose a more general, non-specific problem which doesn't represent the real issue. <u>Example</u>: 'negative thinking' is the real issue, but I had to choose 'dysphoric mood'. Perhaps there's a better available choice that I haven't come across yet? In the case above, the REAL problem isn't conveyed.

A: Though there are a variety of ICD-10 codes to choose from, unfortunately there may not be a specific code for every symptom, impairment, or problem. In cases where the problem that is being addressed in treatment does not have a corresponding ICD-10 code, please select the most appropriate alternative ICD-10 code and describe the problem in your subsequent progress note.

PQ28: Are we allowed to collaborate with person-served to write a list for the problem list and then after the session input the problems into AVATAR? I noticed while doing the problem list with a person-served in session that I was spending time searching for terms/items that would fit the identified problems when I could have been using the time to support person-served in other ways instead. Also, if we input the problems after the session; is this time billable?

A: For direction on specific implementation of new practices such how to collaborate with a person served in creating a problem list in session, please consult with your immediate supervisor. If you are documenting items in the problem list immediately following your engagement with a person served as part of your documentation of the session, this time could be rolled into the service activity claim; however, if completing documentation on a later date, the time it takes to simply complete documentation may not be claimable. This is not new direction specific to CalAIM documentation standards and we again recommend you consult with your immediate supervisor for direction.

PQ29: Does a clinician need to add the Dx to a CMHS staff's PL?

A: All providers work off a single PL for each person served. A problem list would not necessarily "belong" to CMHS or a single clinician rather it is to be a shared list to be used and actively created by each provider within their own individual scope of practice. Since any provider type may add any problem reported by the person served, there is no need for clinician to add a problem for a CMHS staff. A problem list is not a diagnosis list.

PQ30: For persons-served applying for and/or participating in federal funded subsidized housing programs; do they need to have a current treatment plan, or will the PL replace the treatment plan? What about other affordable housing programs not receiving federal funds?

A: If the provider is engaging in targeted case management to address housing problems identified on the PL, including assistance in applying/participating in federally funded housing programs, a TCM treatment plan narrative in a progress note is required in addition to the housing problem being identified on the PL.

PQ31: If a person served receives services from us at RMH and All 4 Youth, do we create a separate PL for each program or do we work off of one PL for both programs?

A: As the two Fresno County MHP contracted programs are utilizing a shared EMR, the person served should have one problem list. The two MHP contracted providers should be consulting on a regular basis about ongoing care and identification of problems on the PL.

PQ32: On the treatment plan there was a box to check for asking and providing the PS with information on how to establish an Advance Directive. With the PL, this is no longer included on the form. Is this something we need to still be asking persons served about and providing them the informational pamphlet if they do not have one established already?

A: CalAIM does not change the requirement to provide information regarding the Advance Directive. Please continue to provide the informational pamphlet if the person served does not have an established Advance Directive. This action can be documented in a progress note.

PQ33: Does PS with both Medi-Cal and Medicare coverage require a treatment plan to be completed as before CalAIM or does a Problem List suffice because they have Medi-Cal?

A: If the person served has both Medi-Cal and Medicare coverage then both the treatment plan and the Problem List are required. CalAim does not change Medicare requirements. Medicare is always billed before Medi-Cal and therefore the treatment plan is required.

PQ34: Is it true that a Problem List must be completed before any services can be billed?

A: The problem list does not need to be completed prior to the delivery of a Medi-Cal reimbursable service. The problem list may be created at the same time as the initial service. In SmartCare, identified problems must be added to the diagnosis list in order to claim for the service provided. There is no mechanism in SmartCare for Problem List items to be automatically added to the diagnosis list. This is why both the Problem List and the diagnosis screen are needed at this time.

PQ35: Is it true that a Problem List alone allows medication services to be billed?

A: Outside of the specific times when a treatment plan is otherwise required (i.e., the person served has Medicare or SD/MC, etc.), medication support services may not be claimed based on the problem list. Billing/claiming is based on the diagnosis list, not the problem list. Identified problems must be added to the diagnosis screen list in order to claim for services. There is no mechanism in Avatar for PL items to be automatically added to the diagnosis list.

To bill for medication services there must be a diagnosis. In the instances that a treatment plan is required there must also be a treatment plan. Every person served needs a Problem List. Billing in Avatar is based on the diagnosis on the medical note. There is no mechanism in Avatar for the Problem List to be automatically added to the diagnosis list.

PQ36: Is it true that a Problem List does not expire as long as there are problems to be addressed?

A: A problem list does not have an expiration date. The Problem List should be reviewed regularly and is updated as clinically appropriate by the addition and resolution of problems.

PQ37: Are there specific Z-codes we can anticipate utilizing more frequently when providing behavioral health services and if so, where can we find a list for these Z-codes?

A: Yes, we do anticipate that there will be more frequently used Z-codes. You can find a list to these Z-codes on the DBH CalAIM webpage. Please note, this list is meant to be a tool/guide for anticipated commonly used Z-codes and not meant to limit which Z-codes may be used.

PQ38: Can both clinicians and CMHS staff use the R and T codes?

A: This is a great question that we are still seeking clarification on. Though there are a variety of ICD-10 codes that fall under "R" and "T", not all are appropriate to support medical necessity for a SMHS or DMC-ODS intervention activity for Medi-Cal reimbursement as not all "R" or "T" codes are specific to behavioral health needs or impairments. At this time we strongly encourage LPHA/LMHP providers to use the following options when a diagnosis has yet to be established: ICD-10 codes Z55-65; ICD-10 code Z03.89; or in cases where services are provided due to a suspected disorder that has yet to be diagnosed, options are available for an LPHA or LMHP to use any clinically appropriate ICD-10 code such as codes for "other specified" and "unspecified" or "factors influencing health status and contact with health services." CalAIM information notices identified the use of Z codes only for non-LPHA staff; R and T codes were not included. For further guidance, please refer to the CalMHSA clinical documentation guide.

PQ39: I believe I heard during a Q&A or read in a Q&A that medication services cannot be billed unless there is an assessment completed as well as a Problem List (and POC if the PS has Medicare). Is it correct that a completed assessment is required to bill for medication services whereas for other services, they may be billed before the assessment is completed?

A: A prescriber must have completed an assessment, diagnosis and prescribed medication before medication services can be billed. This is not specifically a CalAIM or Medi-Cal billing rule, but rather a general order of practice. Currently, this is done via the Core Assessment and/or the Psychiatric Evaluation in Avatar for those providers using Avatar as an EHR. There are extenuating parameters if the person served is a Medicare beneficiary. In most situations as long as the proposed intervention, in this case medication support, is consistent with addressing one or more problems as identified on the established problem list, then the service would be eligible for Medi-Cal reimbursement.

PQ40: If a clinician reaches a different diagnosis than the prescriber (i.e., Schizophrenia vs. Schizoaffective D/O), should both be listed in the Problem List?

A: Yes. The problem list has a column to list who identified the problem. Best practice would be to consult among the treatment team regarding the person's diagnosis, but in the meantime, there is a record of who identified what problem/diagnosis.

PQ41: I have some questions regarding the problem list and targeted case management plan. We currently have a section on our EHR that will allow us to add problem list on to person served's EHR, however I want to make sure that it meets the formatting standard that Fresno County wants before continuing with it. Do you have a format standard in place that I can look over to ensure that our problem list section meets your guideline? In addition, is there a timeframe that the targeted case management needs to be completed by and do you happen to have a template or example for me, so I can support my team with it?

A: The DBH Problem List template was sent to all MHP providers in September. The template can be found on the DBH CalAIM Web-Based Trainings Page here. Though we have no similar template for the targeted case plan narrative, the CalMHSA Documentation Guides at California Mental Health Services Authority | Documentation Guides (calmhsa.org) has all the information needed to complete

the TCM care plan. The TCM care plan may be completed the same day the targeted case management is delivered.

PQ42: Can we enter all issues on PL regardless of Share of Cost (SOC)?

A: Yes.

PQ43: Are we required to provide a copy of the PL along with the Discharge Summary for continuity of care?

A: There is nothing in writing stating it is required, but it is best clinical practice. Additionally, for continuity of care, best practice is the warm hand off which is collaborative and comprehensive and ensures linkage.

PQ44: Just to confirm, there is no signature requirement for the PL?

A: No signature is required.

PQ45: If there is an active problem on the Problem List, should it be included in the diagnosis updates for every episode with active services?

A: The Problem List is separate and distinct from a program's diagnoses list in a medical record, as not all "problems" equal a diagnosis. The Problem List is used to inform the diagnostic impressions for a person served. The responsibility to maintain a single, current Problem List belongs to each provider delivering care. It is important that the services rendered are consistent with the problems as identified on the Problem List. Two persons served with the same diagnosis may experience different impairments and have different needs as identified, but a problem itself may not be a mental health condition that would be included in a diagnoses list. Please note that for Avatar and SmartCare users, billing is based off the diagnosis list, not the problem list.

PQ46: One of my staff recently used the code, R 45.89 (Guilty Feelings) on the Problem List for one of her persons served. She attempted to use it yesterday with one of her other persons served; however, it was not available. Do you know what may have occurred?

A: The problems from the problem list would not show in the progress note, only the diagnosis since a diagnosis is needed to claim the service. If the staff wants to use that code for claiming the service on the progress note, then they would need to update the diagnosis form with that code first. The problem list is not a diagnosis so anyone can enter the problem. This appears to have been a technical issue in the system.

PQ47: For the problem list, can a case manager transferring (transcribing) a diagnosis already on file from an assessment by a therapist or doctor put the name and date that the doctor or therapist gave that diagnosis? This is more for existing persons served who do not yet have a problem list. Since they are not themselves giving a diagnosis, would this be okay? Or will this need to be done solely by doctor or therapist when dealing with non-Z codes?

A: The entries in the PL need to be manually completed by the user including the provider who identified the problem. The entries in the PL are not specifically diagnoses. Anyone can enter the problems whether they are the one who identified it, or the persons served identifies. This direction has changed since the onset of the use of PL. DBH has received guidance clarifying that a problem can be entered outside of your scope of practice.

PQ48: Is it possible to get a list of R-codes that are appropriate for Licensed Mental Health practitioners to use? From my understanding R-codes are medical codes used by physicians, and seem to capture a single symptom. So far we've been discouraging use of these codes

due to them not capturing medical necessity for services beyond a short-term skill building type of thing. However, we have had some situations where other DSM & SDOH codes don't seem to capture the issue and there have been requests to use R-codes in those situations.

A: There is no specific list of R-codes appropriate for LPHAs to use. The recommendation is for an individual LPHA to use their clinical judgement when selecting a diagnosis when the LPHA believes an R-code is more appropriate than a SDOH or other specific DSM diagnostic code.

PQ49: We have a person served who was receiving services with TP Diversion but transferred to RMH. The RMH clinician completed a new assessment for the person serviced and did not agree with the dx of Schizoaffective they had from Diversion and decided to give a dx of Schizophrenia, which was justified in the clinical summary of the assessment. The question we had was whether the RMH clinician leaves the Schizoaffective dx and adds Schizophrenia to the problem list or does the clinician have to change Schizoaffective to "resolved" to remove it? Is it okay to have both dx active on the problem list?

A: If after the new assessment the new treating LPHA determines the diagnosis of Schizoaffective is no longer appropriate for the Problem List, the treating LPHA would mark the problem on the PL as "resolved".

PQ50: With new direction on documentation procedures connected to CalAIM to create a progress note for explanation of updating problem list and initial assessment screening, I'm concerned about the future process of reviewing historical information (i.e., reasons problems were added to problem lists and initial presentation when referred for clinically appropriate services). For example, if in 6 mo. to a year staff wants to review progress by checking the initial reason for a problem being added; will we need to go through the progress notes to identify that specific note? Or will there be a form that we can click on to review this information (like what we currently have in AVATAR for the POC and assessment, etc.)?

A: To obtain documentation that pertains to the decision to add a problem to the Problem List, the provider can reference the **Problem List Viewer** or **Problem List Widget** within Avatar to obtain the date that the problem was added and then search for documentation on or around this date.

PQ51: Can the Case Manager (non-LPHA) write in the diagnosis previously determined by the LPHA that originally determined the mental health condition of person served in order to build the PL?

A: When the diagnosing LPHA is no longer available, you can do one of the following:

1. The LPHA currently directing care can enter the diagnosis into the PL, or
2. The Case Manager may do it as long as they identify the person who made the diagnosis, the provider type and the date the problem was added to the PL (along with the appropriate diagnosis). We also recommend one of the following:
    a. The Case Manager note this in the progress note; therefore the PS also knows it's on the PL, or
    b. The Case Manager write an administrative note-to chart that simply says this case manager added the dx determined by [name of LPHA] on [date LPHA gave Dx] to the problem list and will notify the treating clinician.

All SUD Levels of Care

AQ1: During yesterday's training we were notified that we must have a consent form signed by the person served allowing telehealth or telephonic services be provided during the course of treatment. Has the County developed an approved form of this consent, or will the present Consent to Treatment form be modified to include the consent? I don't want to create our own SUD Consent for Treatment form and have it not meet the DBH standards. Will a statement in the intake note suffice for now without a signed form?

A: New SUD Telehealth Consent form has been created and is now available on the Provider page.

AQ2: In the DSM-V, we weren't able to find questions related to Tobacco Use Disorder (TUD) as indicated in the question on the new health questionnaire. It just lists impairments to come up with a diagnosis. Are you aware of a list of questions we should be asking?

A: Behavioral Health Information Notice 22-024 includes links to resources with several tools that can be used to meet this requirement. The Fresno County SUD Assessment was created to identify all substance use disorders, including tobacco use. All questions found in the "Substance Use History" section of the Fresno County SUD Assessment can be used to identify TUD.

AQ3: Can you clarify what "stand alone" care coordination means?

A: A standalone service refers to a service that can be provided without receiving concurrent services with other levels of care. CalOMS is not required when providing a standalone care coordination service. Additional intake paperwork is not needed in order to bill for this service, although DBH recommends that an appropriate release of information and consent to treatment is completed.

AQ4: Does "Clinician Consultation" include conversations between residential programs and Beacon when seeking residential authorizations and there is a disagreement about the appropriate level of care?

A: Clinician Consultation does not include conversations between residential programs and Beacon when seeking residential authorizations. The authorization process includes a review of the DSM and ASAM Criteria to ensure that the person served meets the requirements for residential service as covered under DMC-ODS. Clinician Consultation is designed to assist clinicians with seeking expert advice on treatment needs for specific DMC-ODS persons who may have complex cases.

AQ5: For "Clinician Consultation" does the consulted clinician need to be credentialed to provide services? (Managed Care)

A: Clinician consultation, which was formerly known as physician consultation, allows for any DMC-ODS LPHA to consult with addiction medicine physicians, addiction psychiatrists, licensed clinicians, or clinical pharmacists on complex cases. Providers can receive clinician consultation at no charge through the Clinician Consultation Center by calling 844-326-2626.

AQ6: Can we have more clarification on the group sign-in sheet requirements? What is mandated on a group participant list?

A: According to BHIN 22-019, when a group service is rendered, a list of participants is required to be documented and maintained by the plan or provider. Although not specified in the BHIN, best practice would indicate that the list of group participants also contain the date of service, time of service, whether the group was in-person or telehealth, and the name/title of provider(s) rendering the service. This would enable DHCS, the County or other entity adjudicating claims to verify information included in claims submitted.

AQ7: Do the relaxed reassessment timelines apply to both residential and outpatient?

A: The reassessment timelines apply to every level of care except NTP/OTP. Residential providers will still follow established reauthorization timelines.

AQ8: Can we use the ASAM-C for the initial assessment, or does it have to be the Fresno County SUD Assessment Tool?

A: The Fresno County SUD Assessment Tool must be used.

AQ9: Did the reassessment timelines for residential services change?

A: Residential providers will continue to follow the established reauthorization process and timelines.

AQ10: I would like to hear more on how to arrive at medical necessity with an SUD unspecified diagnosis.

A: If the person served only meets criteria for an SUD unspecified diagnosis, medical necessity cannot be established beyond the assessment period. If the person served meets criteria for an additional SUD diagnosis, the SUD unspecified diagnosis can be a secondary or tertiary diagnosis beyond the assessment period. An unspecified SUD diagnosis is allowed throughout the assessment period as you gather information to make the final determination if medical necessity is met for an actual SUD diagnosis. For example, you could initially assign an Unspecified Alcohol-Related Disorder to a PS whom you have identified as having a pattern of alcohol use, but yet to complete the assessment process to see how their alcohol use has impacted their life.

AQ11: This question has been archived.

AQ12: Can a person being served in residential treatment stay in treatment if its longer than 120 days and meets medical necessity for that placement of care if the timeline of treatment has been removed?

A: Yes, as long as they meet medical necessity and ASAM criteria. The average length of stay goal is 30 days for our system of care, but that doesn't mean that it is a hard cap on the length of stay.

AQ13: This question has been archived.

AQ14: Will you be providing a new template for the daily residential note at some point, or will it remain the same and we just document daily?

A: DBH is revising the residential progress note to reflect the new requirement. The revised note will be made available to all providers once it has been finalized.

AQ15: It would be helpful to clarify the program modalities impacted by BHIN 22-024 Tobacco Assessment, and BHIN 22-025 Naloxone. It is my understanding these requirements are not applicable to NTPs.

A: The BHIN 22-024 applies to all licensed residential facilities or SUD facilities certified by DHCS in accordance with AOD certification standards. BHIN 22-025 applies to all licensed residential SUD facilities. Although form DHCS 5103 can be used to satisfy this requirement, it is not required to be completed by SUD programs who are not required to comply with AOD certification standards.

AQ16: Do delays in 30-day timeframes for treatment plans require a new treatment plan?

A: The marker will be the day the assessment was completed not the beginning of the stay. If a reassessment is needed during the term of the treatment plan, do a reassessment. Providers will need to use good clinical judgement.

AQ17 What do we need to be doing right now to be up to date on all changes?

A: Complete the documentation trainings available on CalMHSA's website. SUD providers should attend DBH SUD provider meetings for support. SUD providers are encouraged to submit questions regarding CalAIM to the SAS inbox. https://www.calmhsa.org/calaim-2/

AQ18: The new Health Questionnaire includes the question about tobacco use and we were provided with samples of questions that could be asked. Our question is, "if a person served identifies that they may have a TUD, however the LPHA is not able to identify that TUD due to lack of questions on the assessment, are we to do anything other than provide them with the link to address the issue?" I heard mention of putting it on the treatment plan or problem list, however I wouldn't know where to put it on the treatment plan or how to address it as we don't provide treatment for TUD.

A: The new Health Questionnaire addresses tobacco use with a question attesting that tobacco use has been assessed with DSM-5 or similar evidence-based tools. To make the appropriate diagnosis of TUD, tobacco use should be assessed like any other substance during the assessment process.

AQ19: Are substance use counselors required to obtain signatures or some kind of okay from a LPHA on the items on their problem list?

A: The problem list does not require signatures or co-signatures rather it only records the person who identified/added/removed each problem. SUD counselors would only be able to utilize Z55-Z65 codes on the problem list. An LPHA would need to add any items outside of Z55-Z65 codes while working within their own scope of practice on the problem list.

AQ20: How can a SUD Counselor/Case Manager bill for completing a problem list? Since they are performed simultaneously with a treatment plan, should we just add the additional time to the formulation of a treatment plan or include it in the documentation time? Or at all?

A: Newly identified problem(s) should be added to the Problem List whenever they are identified. This could be during the assessment, an individual counseling session, during care coordination, etc. Overall, it depends on the service you are providing; you would bill under that service's respective code.

AQ21: Since we are still supposed to complete a SUD treatment plan, many of the problems identified in the assessment have to do with identifying physical health as well as mental health issues. I understand we are not supposed to reflect those on the problem list as they are outside of our scope, however, there are many other issues that we identify such as getting a physical examination that we cannot align with a Z code. Is there any indication as to what problems we should and what problems we should not carry over to the problem list? If we identify problems on a treatment plan that don't align with a Z code what should be our course of action?

A: Providers entering problems on the Problem List should add problems that are within their scope of practice utilizing the proper code. If a problem is identified that is outside the scope of practice, the problem should be documented in a progress note and a referral made to the appropriate provider. The need for a physical examination would be documented on the treatment plan only. At this time, the direction is to place any identified risks/needs (physical/mental health) that do not align with a

particular Z code on the Treatment Plan only. DBH is currently looking at all Z codes to see which might be the most frequent/relevant for providers to utilize on the Problem List. More information regarding this topic will be shared in the future.

AQ22: When will the progress notes be updated on the SUD website?

A: The updated progress note forms are available now and can be found on the SUD Providers webpage: Substance Use Disorder Providers | County of Fresno

AQ23: Why do the Moodle trainings recommend that providers include the amount of time spent documenting services?

A: SmartCare has a designated space to capture documentation time and travel time. Although this is not required information, the County strongly encourages providers to use these fields. This information will be useful for DHCS and County analysis to inform decision-making for SUD rates over time.

AQ24: When will the billing upload template be available?

A: CalMHSA has developed a template that is currently being tested. As soon as testing is complete the template will be shared out to providers.

AQ25: Will AOD counselors still be able to do ASAM assessments?

A: Yes, AOD counselors can complete ASAM assessments and bill under G0396, G0397 and G2011.

AQ26: Is billing for assessments limited to 30 minutes?

A: Managed Care will research the allowable billing codes for assessments and provide further guidance. Assessment codes G0396, G0397 and G2011 can be billed once during a 24-hour period. Assessments are not limited to 30 minutes, however, reimbursement to providers will be limited to the amounts allowed by the appropriate CPT code according to the DMC ODS billing manual. Assessments can be conducted over the course of several encounters and providers can begin treatment prior to the assessment being completed. The current timeframes for completion of an assessment are 30 days for adults and 60 days for youth and persons experiencing homelessness.

AQ27: Is the assumption that documentation is happening within the intervention rather than after the intervention?

A: There are no assumptions about when documentation is occurring. Providers should explore ways to improve efficiencies which could include collaborative or concurrent documentation for some services while face-to-face with the PS.

AQ28: Are there any new services coming out?

A: There are no new modalities of service, however, there are new billing codes that providers can start billing for as of 7/1/23 that will more accurately describe the service that is being provided.

AQ29: Is SmartCare a true EHR that bills as notes are entered?

A: Yes, SmartCare is a true EHR that will bill as notes are entered for providers that opt in to using the full EHR.

AQ30: What is the link to the current billing manual?

A: The most-current billing manual for DMC-ODS can be found at: MedCCC - Library (ca.gov)

AQ31: Is there a timeline for when SmartCare will be rolled out to providers that opt in?

A: This will be determined by the implementation plan submitted by each provider as part of the Transition Optimization Opportunities.

AQ32: Are notes still required for each intervention?

A: Yes, notes are still required and should provide an accurate picture of the person's condition, treatment provided, and response to care at the time the service was provided.

AQ33: Are June services to be billed in Avatar?

A: Yes, bill all services provided through June 30, 2023 in Avatar and begin using SmartCare for services from July 1 forward.

AQ34: Is the County moving current Avatar enrolled PS into SmartCare or will providers be required to do this?

A: All PS enrolled in services prior to 6/26 will be moved over to SmartCare by the County. Providers will need to track new enrollments after that date and enter those into SmartCare after July 1.

AQ35: Can providers get training on entering new PS into SmartCare?

A: A billing training will be provided soon.

AQ36: Does SmartCare check eligibility for providers?

A: SmartCare has a built-in feature to check Medi-Cal eligibility the provides immediate results. Providers will be required to continue to verify eligibility each month.

AQ37: Generally, we complete the intake (consents and orientation) in the beginning of the appointment. Could we bill for this under care coordination CPT code? What are the times allowed for care coordination?

A: This activity does not seem to fit under care coordination since no care is being coordinated.

AQ38: Can I bill for health questionnaire and CalOMS separately under a CPT code? Maybe care coordination?

A: This activity does not seem to fit under care coordination since no care is being coordinated.

AQ39: Can I break up the ASAM in two days?

A: Yes, the ASAM can be broken up into as many sessions as clinically appropriate as long as assessment timeframes are met.

AQ40: Would you be open to creating a committee group to assist with adjusting the forms like the ASAM? Made up potentially of LPHAs. My team is open to providing some feedback on what could be eliminated from the ASAM that doesn't capture DSM criteria.

A: At this time, we will not be creating a committee in an attempt to revise the Fresno specific ASAM assessment. DHCS provided an ASAM assessment developed by UCLA that is recommended for use by all counties. CalMHSA has incorporated an ASAM assessment into the new semi-statewide EHR (SmartCare) that participating counties (including Fresno) will be using. The state is moving towards consistency in regard to the ASAM assessment whether a county is or is not using the semi-statewide EHR. We will look to align our forms to match the CalMHSA developed clinical forms currently found in the new EHR.

AQ41: Is the IDD a requirement from the state or Fresno County?

A: The IDD form is a Fresno specific form which captures all the mandated LPHA assessment activities outlined in DHCS BHIN 23-001.

AQ42: Can you please send a one-page reference of outpatient CPT codes? I can't make sense of the different codes that are just for SUDS. I can't find the care coordination codes.

A: Please refer to the PowerPoint presentation which covers a set of CPT codes which may cover key activities for SUD programs. All DBH contracted providers also have access to the CalMHSA Moodle trainings which cover DMC ODS CPT codes and services as a resource. SUD programs are still responsible for determining which allowable CPT codes they may be able to use for all activities conducted at their programs. Also see the DMC-ODS Billing Manual: MedCCC - Library (ca.gov)

AQ43: What is the Z code we could use to see clients for services if we take 30 days to finish assessment? If the TX plan and IDD are due within 7/10 days of admission, could we push back technically the admission?

A: Please refer to DHCS BHIN 22-013 for a description of all Z codes which can be used prior to completing the assessment and finalizing a diagnosis in outpatient settings. The Z codes can also be used any time including after the assessment is finalized.

AQ44: Is the county going to adjust the mandated form to allow for a shorter time to compete assessment?

A: DBH will continue to look for opportunities to make assessment and documentation practices more efficient. There is no timeline for when any changes will be made to documentation or assessments by DBH.

AQ45: Just to be clear, the non-billable service code for screening was the first one shown, correct?

A: The most current DMC-ODS billing manual has been updated to show that H0001 can now be used to claim for screening. Additionally, we received confirmation from DHCS that screening can indeed be billed using H0001.

AQ46: So, we're not going to bill for screenings or treatment plans?

A: Screenings are now billable. Please see the question above (AQ45) for further details. Additionally, DHCS recently released guidance that treatment planning is no longer required, with the exception of Narcotic Treatment Programs.

AQ47: Under disciplines - AOD, is any distinction made between a certified or registered counselor or any other title for SUD counselors?

A: Under "AOD" there is no distinction made between a registered counselor or a certified counselor.

AQ48: Assessments take longer than 30 minutes and the person is there and needs to be done that day, can we bill longer?

A: At this time, DBH understands that the CPT code for assessments that take longer than 30 minutes are only reimbursed under the G0397 code for 30+ minutes. DBH will continue to research this item and provide further guidance as it becomes available.

AQ49: When you talk about flexibility regarding Assessments, what exactly does that mean?

A: DBH was referring to allowed rules and guidelines around completing an assessment. Assessments can be completed within 30 days or 60 days if the person served is under 21 or homeless. A person can start services prior to the completion of the assessment. Assessments can also be completed via telehealth or telephone.

AQ50: Can assessments be completed by phone?

A: Yes, assessments can be completed by phone or telehealth.

AQ51: Can we bill for more than 1 service per day? Example: an individual session and a group service on the same day.

A: Yes, SUD treatment providers can bill for more than 1 service per day. Please refer to the DMC ODS Billing Manual for lockouts or exceptions.

AQ52: Providers cannot do intake, ASAM, and assessment in 30 minutes.

A: DBH understands the challenges around the new CPT codes and reimbursement structures. We will continue to research this item and provide further information as it becomes available.

AQ53: Are IDDs only allowed to be billed for 15 mins max per day?

A: DBH will continue to look into how to reimburse providers for the completion of the IDD. At this time, DBH is unsure whether we can use the 90791 CPT code is reimbursable for this process. However, DBH will provide further clarification as it becomes available.

AQ54: Are discharge planning activities non billable, but required to complete?

A: DBH has received clarification that discharge planning activities are billable activities. Providers can use the CPT code T1007 (CalMHSA procedure code 15) to bill for these activities.

AQ55: Can we get the actual reference for your understanding from the state that H0001 (Alcohol and/or Drug Assessment) is not a legitimate CPT for assessment and why it isn't?

A: DBH provided the DMC ODS Billing Manual published by DHCS which specifies that the H0001 code is to be used for screenings and not for assessments.

AQ56: Are these time constraints with the assessment codes being imposed on mental health as well or only SUD?

A: Mental Health and SUD services and billing requirements are found in separate Medi-Cal Billing Manuals from DHCS. Please refer to the appropriate billing manual for the time/duration allowances for assessment codes. [MedCCC - Library (ca.gov)]

AQ57: Can we bill unbillable services as an individual session?

A: Providers should only use appropriate and allowable codes for services provided. If a service is not reimbursable, providers should not use an incorrect reimbursable CPT code.

AQ58: Can we break assessment up into 4 portions?

A: Assessments can be broken up into as many sessions as necessary as long as they meet the established timeframes for completion and are at the benefit of the person served and not merely for the convenience or financial interest of the provider. DMC-ODS has the responsibility to ensure that the system of care avoids wasteful practices under our compliance program.

AQ59: Wondering about times – Times and End times – how to work that on an assessment if it's worked over different days? It sounds like the actual Assessment form has one spot to enter the start and end time for the assessment session. Either more space needs to be added to be able to capture the potential multiple durations, or we decide if and what exact info must be on the form, hence update the form.

A: The current assessment form posted on our DBH SUD webpage has a field to add additional dates and times. DBH will review the assessment form and determine if any changes are required. DBH will communicate any changes as they are made.

AQ60: When will forms be available to look at?

A: DBH will provide forms as they are updated or completed. There are no established timeframes for updates to forms.

AQ61: Are ASAM Assessments only reimbursed up to 30 minutes?

A: We've recently learned that providers will be reimbursed for up to 60 minutes of staff time when completing ASAM Assessments. DHCS has capped that procedure code at 60 minutes so any time spent beyond that will not be reimbursed at this time. Providers should continue to enter the actual time spent providing the service when submitting billing for accuracy and tracking purposes. DBH will continue to advocate for the full staff time spent completing ASAM assessments to be reimbursed in full and will provide additional information as it becomes available.

SUD Residential Treatment Programs

RQ1: Who decides what gets recouped and who gets that money? Why does the DMC Contract have to be for less money than any other contract when it requires more work and staff than any other contract?

A: Recoupments are based on requirements in the Intergovernmental Agreement, Provider Manual, Behavioral Health Information Notices, Contractual obligations, etc. Any recouped funds are returned to DHCS or SABG depending on the funding source.

RQ2: Why do we need to do a daily group note in residential treatment? If persons served are in residential treatment and they are not participating in every group every day, then they will be discharged from treatment for non-compliance.

A: Daily progress notes are now required by DHCS as identified in BHIN 22-019. A daily progress note should be completed for each person served.

RQ3: Why is there a 30 day limit on treatment and why do we have to get a reauthorization every 30 days?

A: There is no limit on treatment. Treatment is based on medical necessity. The State would like to see a trend toward a 30-day average, but treatment is still based on medical necessity. We are unable to change the prior authorization guidelines, so authorizations will continue at least every 30 days.

RQ4: Has the date to complete the initial assessment changed from 3 days? What is the purpose of utilizing the initial assessment for the purpose of a reassessment, when the

current reassessment form is much more useful in documenting progress? The initial assessment's questions are pretty much just relevant to intake purposes.

A: The assessment is needed to request authorization for the residential stay, so the timeframe of 3 days has not changed. In regard to reassessment, the Fresno County ASAM based reassessment captures all domains and will continue to be accepted until such time as DHCS issues additional guidance. The reassessment will be renamed "Updated Assessment" and uploaded to the County website.

RQ5: Is the assigned counselor required to write the note or can a facilitator write the note? What is the purpose of the daily note? Would the note just consist of the group they attended, topic, and if they did or did not participate?

A: For clinical or treatment services, the credentialed staff member who provided the service should write the note. Further discussion and direction regarding the implementation of the daily note in SUD residential is scheduled for October 3, 2022 at the CalAIM Provider Collaborative meeting from 2 PM-4PM.

RQ6: Is the timeframe for assessments changing in residential from 3 days to 6 days? Will the timeframe for assessments change for persons served 21 and younger in residential?

A: The assessment is needed to request authorization for the stay so the timeframe of 3 days has not changed. It is the same for adult and adolescent. BHIN 21-075 indicates that residential is an exception to the changes in assessment timeframes.

RQ7: Who will document daily progress notes? Primary SUD Counselor, LPHA, or any registered/certified or licensed staff?

A: For clinical or treatment services, the credentialed staff member who provided the service should write the note. Further discussion and direction regarding the implementation of the daily note in SUD residential is scheduled for October 3, 2022 at the CalAIM Provider Collaborative meeting from 2 PM-4PM.

RQ8: Will group notes be acceptable as daily progress notes?

A: Yes, as long as it is a clinical group (between 2-12) and facilitated/documented by a credentialed staff member. Separate notes for each service provided during the day will be accepted in place of a daily progress note.

RQ9: Will providers be receiving notices in writing when each new CalAIM requirement is required to be implemented?

A: Providers have already received notices and training on CalAIM requirements and the department will continue to support changes. CalAIM implementation is a work in progress that we will navigate together. It is less about hard and fast start dates and more about demonstrating that we are moving towards the new CalAIM requirements.

RQ10: Will budget adjustments be allowed or an additional rate setting period once we figure out how the changes will impact our staffing patterns?

A: Providers can request a rate review during this fiscal year. The county will consider adjustments up to the maximum county reimbursement rate. In order to submit a rate review, an OER must be submitted up to date.

RQ11: There is only one code (H0019) for residential which does not include room/board. Is that correct?

A: Nothing has changed for billing the day rates for residential. Treatment will be billed under H0019 and room/board will have separate billing codes.

General Questions

GQ1: This question has been archived.

GQ2: This question has been archived.

GQ3: How are other counties implementing these changes?

A: Each county has a BHQIP implementation plan and is implementing the changes according to their county plan.

GQ4: If multiple MHP providers are working with a family, does each agency have to have their own care coordinator or is it like the ICC coordinator where there is one person per family designated?

A: Every person served (PS) receiving SMHS must have an identified Care Coordinator. The identified care coordinator may be part of the existing mental health team (i.e., the treating therapist or a program case manager) but there must be a care coordinator that the person served can reach out to for linkage, etc. From the CalMHSA documentation clinical documentation manual p. 20 “Care coordination also meets federal requirements to ensure that each person in care has an ongoing source of care appropriate to their needs. Additionally, a person or entity must be formally designated as primarily responsible for coordinating the services accessed by the person in care. The person in care must be provided information on how to contact their designated person or entity.”

GQ5: How can we get more information from the state for our most frequently asked questions?

A: The Department of Health Care Services (DHCS) has posted version 1 of the CalAIM Behavioral Health Frequently Asked Questions (FAQ) document: https://www.dhcs.ca.gov/Documents/8-8-22-V1-CalAIM-Behavioral-Health-Initiative-FAQ.pdf. This FAQ document will be updated regularly. The DHCS FAQ document linked above can be found at the following webpage: https://www.dhcs.ca.gov/Pages/BH-CalAIM-Webpage.aspx. A new DBH webpage devoted to addressing CalAIM Behavioral Health information can be found here.

GQ6: Are we mandated to have suicide prevention training as a provider?

A: There is no requirement in CalAIM regulations for suicide prevention training. The CalMHSA documentation guide references the use of standardized screening tools. Domain 6 of the Assessment includes: “May include specific risk screening/assessment tools (e.g., Columbia Suicide Severity Rating Scale) and the results of such tools used.” CalMHSA LPHA Documentation Guide, pg.14. However, there are suicide prevention training requirements per the Board of Behavioral Sciences (BBS).

GQ7: Can anyone assist with a copy of DBH's policy about new hire CalAIM training that we can look at?

A: DBH does not have a policy regarding new hire CalAIM training. However, a Compliance Bulletin was sent out notifying the system of care that all providers of SMHS and DMC-ODS services must complete the CalMHSA trainings. This CalMHSA video training series is intended to prepare all existing and new providers.

GQ8: If a PS is being seen by an individual or group provider under contract with FCMHP, is that provider presumed to be providing care coordination? If not, how does PS receive this service?

A: Yes, if a person is being served by an individual or group provider, the individual or group providers is responsible for providing care coordination as needed by the person served.

GQ9: Are all staff required to take the CalMHSA trainings or only those who provide direct services to persons served?

A: All providers in the Fresno County system of care, which includes anyone who provides, documents and bills for mental health and/or substance use disorder services are required to complete the video trainings. And we encourage those who monitor or supervise these clinical services to complete the video trainings, though it is not required.

GQ10: Are Office Assistants required to take the CalAIM Trainings as well?

A: CalAIM training is required for direct care providers providing direct client care. OA training is a program level decision. It would depend on what role OAs are taking in particular programs.

MH Billable Services

BQ1: Will prescriber services also be billable without a completed assessment?

A: Prescribers must complete an assessment of the person in order to develop at a minimum a working diagnosis that would support the prescribing of a medication.

BQ2: My team works with persons served who are in an acute care psychiatric hospital, PHF, CSU or jail. We previously used 956 or 300 codes for billing lock outs. I see in the Clinical Documentation Manual that the emphasis is on care coordination. Can we bill for the care coordination that we provide while the person served is in one of these facilities?

A: There are no changes to the lockouts with CalAIM. Per Compliance Bulletin: Proper Use of Service Codes 956 and the 300-series, 300 codes are used for SMHS that occur in lock out settings.

BQ3: Can we bill for anything on a problem list besides ICD-10 diagnostic codes including F codes and Z codes?

A: Yes, a provider working within their scope of practice may address any problem on the problem list. Please submit claims using the ICD 10, which include F and Z codes.

BQ4: We have a person served that is awaiting conservatorship and is in an IMD. We have been in contact with the conservator. Is this a billable or non-billable (NB) service?

A: CalAIM does not change billable services in relation to services provided in an IMD. Services provided in an IMD are still a lockout. The only exception to the SMHS lock out is for Case Management – Placement.

BQ5: Can the Community Mental Health Specialist (CMHS) and Mental Health Rehabilitation Specialist (MHRS) bill 159 for themselves with or without the LPHA co- signature being required?

A: CalAIM does not change scope of practice or signature requirements. Individuals may sign documents within their scope of practice. 159 is used for completion of the treatment plans. Treatment plan information may be gathered by CMHS but must be signed by LPHA. Targeted Case Management plans are written as a narrative in the body of the note and can be signed by a CMHS.

BQ6: Is the discharge summary and plan able to be claimed as 159 without the PS/supportive person/parent present to review the plan? i.e. PS has an unplanned discharge, no contact to resume Tx.

A: No, if there is an unplanned discharge and no contact with the person served, completing the discharge summary is a non-billable administrative action. Additionally, discharge planning is not a standalone service, but an activity that takes place within the context of several service types: Care Coordination, Case Management, Individual Therapy, Treatment Planning and can be included (billed) as part of that service.

BQ7: Perinatal Clinicians are making phone calls the day prior for intake assessment to provide psychoeducation and other services. We understand that with CalAIM, we can bill that as a 205T case management service. Are we allowed to bill for services provided prior to the assessment or treatment plan?

A: With CalAIM, services can be delivered prior to the completion of the assessment and for many outpatient services. An assessment and treatment plan will no longer be required to begin SMHS. In order to bill for SMHS an ICD-10 code or Z code is placed on the problem list. For Targeted Case management, a case note is written and the narrative Targeted Case Management plan is written in the note.

BQ8: For medication services follow up appointments, can the psychiatrist bill medication services for the follow up appointment if the person served is not present (i.e., meeting with caregiver only)?

A: Yes, meeting without the person served present would still be a medication support service. Per the DHCS SMHS Billing Manual published in July 2022, medication support is defined as:

Medication Support Services include one or more of the following: prescribing, administering, dispensing and monitoring drug interactions and contraindications of psychiatric medications or biologicals that are necessary to alleviate the suffering and symptoms of mental illness. This service may also include assessing the appropriateness of reducing medication usage when clinically indicated. Medication Support Services are individually tailored to address the beneficiary's need and are provided by a consistent provider who has an established relationship with the beneficiary.

Services may include: providing detailed information about how medications work; different types of medications available and why they are used; anticipated outcomes of taking a medication; the importance of continuing to take a medication even if the symptoms improve or disappear (as determined to be clinically appropriate); how the use of the medication may improve the effectiveness

of other services a beneficiary is receiving (e.g., group or individual therapy); possible side effects of medications and how to manage them; information about medication interactions or possible complications related to using medications with alcohol or other medications or substances; and the impact of choosing not to take medications.

The service includes one or more of the following service components

- Evaluation of the need for medication
- Evaluation of clinical effectiveness and side effects
- The obtaining of informed consent
- Medication education including instruction in the use, risks, and benefits of and alternatives for medication
- Collateral
- Plan Development

BQ9: Can non-LPHA level staff bill for limited assessment services if they meet the degree and experience requirements?

A: With CalAIM, providers other than an LPHA can gather some of the documentation for an assessment, but there is currently no mechanism in Avatar for a non-LPHA to build or bill for an assessment. The Department will work toward solutions for this issue and advise providers when non-LPHAs can conduct assessment activities.

BQ10: How do staff bill for a case consultation meeting? Can all staff bill for the entire meeting?

A: If staff are billing for case management, each staff member would have their own unique provider NPI and would submit separate claims. This would not be considered a duplicate service and may be billed. Please note, this information applies to specialty mental health services only.

Please see **DHCS Specialty Mental Health Services Medi-Cal Billing Manual, May 2022 Version 1.1**. On page 27, under **5.5.0 Duplicate Services: Outpatient Services,** the manual reads:

Outpatient services are listed in service tables 1-10. Except for Sign Language or Oral Interpretive Services (T1013) and Interactive Complexity (90785), a claim for an outpatient service is considered a duplicate if all the following data elements are the same as another service approved in history:

- *The beneficiary's CIN*
- ***Rendering provider NPI***
- *Procedure code(s)/modifier(s)*
- *Date of service*

In addition, on page 28, under 5.6.0 Co-Practitioners, the manual reads:

If multiple practitioners render services to the same beneficiary at the same time, each provider must submit a separate claim for the distinct service each practitioner rendered. Please see MHSUDS Information Notice 18-002 and BHIN 20-060R for more information about submitting claims to SD/MC for services rendered by multiple practitioners rendered to the same beneficiary at the same time.

BQ11: Can case managers and Peer Support Specialists (PSS) receive list of acceptable codes within their scope? They do not have a DSM or familiarity with Z codes.

A: Case Mangers and Certified PSSs may use Z codes with particular emphasis on Z codes 55-65 known as the Social Determinants of Health (SDOH). There is a list of SDOH codes on page 21 of the Certified Peer Support Specialist manual CalMHSA-MHP-CPSS-Documentation-Guide-06222022-1.pdf and page 36 of the MHRS and Other Qualified Staff manual which would include Case Managers CalMHSA-MHP-MHRS-Documentation-Guide-06222022-1.pdf.

BQ12: Will there be an expiration of an unspecified or NOS diagnosis? A point in time where diagnosis will no longer be reimbursed if not specified.

A: With the elimination of the list of included diagnoses, unspecified or other specified diagnoses are claimable diagnoses. DHCS has not set limits determining the length of time an unspecified or other specified diagnosis can be claimed. However, best practice is to be as precise as possible in your diagnostic opinion upon completion of the assessment.

BQ13: Traditionally we had to submit our claims for the specific diagnosis we were treating during that service. With CalAIM, we understand that there is no included diagnosis list, so can we submit all claims to the primary diagnosis that is on the problem list even if the service did not address that specific diagnosis? If that is not the case, how do we submit claims to get paid?

A: At this time, DBH will not change the way claims must be submitted or paid. Your service intervention should address an item on the problem list. All diagnoses (primary, secondary, etc.) should be on the PL, along with any applicable z-code (social determinants of health (SDOH)). The claimed diagnosis should correspond to the problem addressed in the progress note. More direction is forthcoming as Fresno County implements further system changes.

BQ14: Is it true that we can be paid for any claim submitted under any DSM5 code, including V codes (for example Parent-Child Relational Problem – V61.20) both during the assessment and any time after (for the duration the person served is enrolled in our program and meets medical necessity)?

A: Yes, enter DSM5 codes addressed during the intervention. You may use this code during the assessment and any time after and it should be listed on the Problem List. CalAIM moves us closer to whole-person care and providers should anticipate entering all problems identified and within their scope of practice as identified when assessing/interviewing the person served.

BQ15: Here's an example: A child has a clear trauma history, we do the assessment and they do not demonstrate medical necessity and do not have an F code DSM5 diagnosis. They do have some other V code diagnoses, such as V60.0 Homelessness, Child Neglect, Confirmed 995.52. Can we claim to the homelessness and neglect codes during the assessment process and any time after for ongoing treatment?

A: Yes, services to a person served under the age of 21 with a clear trauma history meets eligibility requirements for services and do not need to meet criteria for an F code in order to receive services. Services can be claimed during and after the assessment for ongoing treatment using a V (DSM5)/Z (ICD 10) code. In this instance, the history of trauma (for person served under the age of 21) makes them eligible for Specialty Mental Health Services.

According to BHIN 21-073, persons served under the age of 21 shall meet either of the following criteria:

(1) The person served has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following:

a. scoring in the high-risk range under a trauma screening tool approved by the DHCS
b. involvement in the child welfare system
c. juvenile justice involvement, or
d. experiencing homelessness.

OR

(2) The person served meets both of the following requirements in a) and b), below:

a. The person-served has at least one of the following:

i. significant impairment

ii. A reasonable probability of significant deterioration in an important area of life functioning

iii. A reasonable probability of not progressing developmentally as appropriate

iv. A need for specialty mental health services, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan (CalViva Health or Anthem Blue Cross) is required to provide

b. The person's condition as described in subparagraph (2) above is due to one of the following:

i. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.

ii. A suspected mental health disorder that has not yet been diagnosed.

iii. Significant trauma placing the person served at risk of a future mental health condition, based on the assessment of a licensed mental health professional

BQ16: How would I bill for creating the problem list? Would this still be 159?

A: It depends on the service you are providing; you would bill under that service's respective code. If only problem list creation and related interventions are discussed, then 159 could be used.

BQ17: Is there a list of "R" diagnostic codes available to reference?

A: There is no longer a list of included diagnoses. Please use the DSM 5 and corresponding ICD 10 codes.

BQ18: Will the programs still be required to take private insurance persons served since those services are not paid for by the private insurance or will there be another funding stream for those services?

A: The implementation of the new CalAIM documentation standards does not alter any of the programming components of individual MHP contracts. CalAIM documentation standards do not change previously established funding streams.

BQ19: Can staff bill travel time from traveling from a school site to another school site? My Team has not billed for travel time since they have been assigned school sites and provide services on-site. However, now that staff do not have office space, my team is now providing services in school sites not assigned to them and to cases from the Outpatient program.

A: No, staff cannot bill travel time when driving from school site to another school site.

BQ20: I was confused about the guidance on use of R codes and if they are billable, specifically, R45.89 Emotional dysregulation. Is this a billable code?

A: Under CalAIM guidance in BHIN 21-073, claims must include a CMS approved ICD-10 diagnosis code. R45.89 is a billable/specific ICD-10-CM code that can be used to indicate a diagnosis for reimbursement purposes. Only LPHA/LMHP may utilize this diagnosis within their scope of practice.

BQ21: Since all providers can bill without splitting time as long as there is justification for multiple providers providing services, are we still required to use lockout 300 codes? Let's say for instance, person served is at CRT and I consulted/collaborated with a case manager there to help person served with linkage to a phone and coordinating psychiatric appointment. Can I bill a 205 or do I still need to bill a 305?

A: CalAIM has made no changes to Lock-out rules. Billing a service separately when it is already part of the facility's bundled rate, or day rate is still not allowed.

BQ22: I was wondering if the payment reform initiative was going to impact how individual/group providers are paid?

A: Yes, the CalAIM payment reform will have an impact on how all MHP providers are reimbursed, including our MHP providers in our individual/group provider network; however, as a County we are still formulating those adjustments and innovations and will be sharing the reforms once firmly developed later this year.

BQ23: Are we allowed to provide Therapy services while a person served (PS) is temporarily out of state? If so, would that be billed as Therapy or Case Management? And would I use service code 956 or another code? Would there be an issue with health insurance if I were to bill for the services when the PS is out of state?

A: Since pandemic flexibilities are no longer in effect for telehealth, and even so, the state did not give specific direction on these situations, we are going to ask the state for guidance. There are several regulatory authorities at play here. BBS and CAMFT may have given guidance to allow for it only if the licensee or registrant meets the requirements to lawfully provide services in that state and telehealth services are allowed by that state, but we also need to be sure Medi-Cal will cover it or have billing procedures in place to ensure we do not claim inappropriately. Also, there would need to be steps in place to monitor eligibility. For example, making sure the person-served's Medi-Cal is active while they are not in CA.

We do, however, know it is important that the provider help the PS consider a plan should they need crisis services or plan to stay longer, especially if a disruption in care places them at risk. Until we hear guidance from the state, and develop some protocol around this situation, please direct staff to not provide ongoing therapy, unless there is significant need for it. If they do provide telehealth therapy, they should not bill Medi-Cal for it at this time. (Please use a 956 Service code). However, if the practitioner provides the services before the PS leaves the state, it is billable. I would readmit the PS when they return if that is what they want.

BQ24: Are we able to claim Medi-Cal while minor PS (under the age of 18 years) is temporarily residing in another county and is there any restriction on billing for services while youth is out of Fresno County?

A: Yes, you can claim to Medi-Cal. There is no restriction on billing if the PS is there temporarily. If their resident status changes to the other county, you can no longer bill. However, the PS can request

Continuity of Care or to see an out of network provider. If the PS decides to stay longer or ends up needing other health services while in the other county, that county might assist in setting them up as a resident of the other county and per Continuity of Care regs could remain under the care of our practitioner for up to 12 months in order to complete a course of treatment or to arrange for a safe transfer to a provider from the other county.

BQ25: We are not part of the electronic billing system. Will we be able to continue using paper claims?

A: There is no change to the use of the CMH 1500 claim forms effective July 1, 2023 and MHP Individual and Group providers will continue to submit paper-based claims until further notice.

BQ26: We were told there are no longer lock out situations (except for when the person served is in the jail location code 09), and that we can now claim for any services: for example, when a youth is on a 5150 at the hospital or the crisis stabilization center at Exodus or the Stars PHF, we can still provide and claim for services like therapy, rehab etc. since lockouts no longer exist. Is this true?

A: Lock outs still exist as we know them because they are written in Ca Regs. Please reference the SMHS Medi-Cal Billing Manual: MedCCC - Library (ca.gov). Pgs.59-60 discuss how to read the chart column called "Lockout Codes". H0031 Assessment is not a lock out procedure, meaning it's not a service that is bundled or locks out any other service. That's why it says "no" in that column. And it notes that this OP service is locked out against inpatient and 24-hour services except for the date of admission, in the header.

Inpatient, day and 24-hour services ARE Lock outs (with some allowances such as on the day of admission, etc. (See pg. 177 of the manual)

BQ27: Can we bill for completing intake paperwork such as privacy practices and consent to treatment?

A: If the intake paperwork (consent to treat, ROIs, NPP, etc.) is completed during the same session as a billable service (assessment, case management, etc.) then the entire face-to-face time is billable under the service provided. Simply completing intake paperwork is not a standalone, billable service.

BQ28: On review of the SMHS Medi-Cal Billing Manual under the service descriptions for SD/MC Allowable Disciplines it does not list LVNs as one of the disciplines allowed to provide injections - Subcutaneous or Intramuscular (pg 91 of the manual). I am wondering if I am reading this correctly. I have seen documentation from LVNs giving IM/intramuscular injections for a number of years now and wonder if this will be changing for SMHS Medi-Cal persons served?

A: DHCS has confirmed LVNs and LPTs are recognized provider types in SMHS. They can continue to administer medication and can claim for it using HCPCS code H0033 (SmartCare Procedure Code 75 – Oral Medication Administration). They can claim for providing medication training and support using code H0034. Version 1.5 of the SMHS billing manual will clarify that for DHCS claiming purposes, H0033 includes all modes of medication administration.

BQ29: What would we do if there were more than two individual psychosocial rehabilitation services in the same day by the same provider in the same location and the modifier had already been used by the second service? Example: Person served needs support 11:10am-11:22am, 1:31-1:50pm, and 3:43-4:44pm from Clinician using individual psychosocial rehabilitation. How would this be billed?

A: Per section 5.5.0 Duplicate Services of the SMH Medi-Cal Billing Manual, if a provider renders two services to the same person served on the same day in two or more separate encounters, all encounters must be claimed as one service to ensure the additional encounters are not denied as duplicate services.

BQ30: Is Fresno County using "roll up" minutes? If so, would this alleviate the challenges presented with the distinct procedural modifier presented above as units of service could be billed as a total across the day?

A: Yes. As described below by the consultant which matches CalMHSA guidance.

Below is guidance received from the Cardenas Group (https://www.cardenasgroup.org/):

Regarding roll up minutes: "Though there is variability between counties, unless they hear from Fresno specifically that the services must be entered separately, I would recommend they roll any services that are same practitioner, same client, same procedure code, same day into one claim when entering claims into the Fresno billing system. They could even write just one note for the total duration as long as it happened in the same day. The reason for it is that there is not a specific modifier that would permit billing the 2nd service at this time (maybe modifier 59 would work but it's questionable at this point)."

BQ31: Regarding code 90839 psychotherapy for crisis 30-74 minutes. How are rates calculated and paid to vendor for this? Will they get paid the same rate whether the service was 32 minutes or 71 minutes? Or is the paid rate prorated by the hour?

A: Yes, any duration within that range is considered 1 unit of that service. Please see the SMHS Billing Manual version 1.4. Service table 2 (page 87) codes for Psychotherapy for Crisis 90839. First 30-74 minutes with dependent code 90840 for each additional 30 minutes. There is also a section regarding aggregate limits within a 24-hour period on p. 30.

BQ32: Regarding flat rate for interactive complexity and interpretation by clinical staff: Will vendors be receiving any portion of that flat rate or is County keeping it all? If vendors do get a portion, do we know what % of the flat rate they will receive?

A: Vendors will receive the full flat rate for interactive complexity and oral or sign language interpretation.

BQ33: STRTP's are concerned that their groups will always run at a financial loss considering how DHCS calculates claims. Most STRTP's only have 2 to 6 youth in groups max and they can't combine homes to run groups to make them financially beneficial. We want to know if DHCS is aware of this and what might be done in the future regarding group rates for STRTPs?

A: DHCS calculated the group rate based on their calculations of the average group size. Per the SMHS Billing Manual version 1.4, DHCS will adjust the rate for groups by 4.5. Counties do not have control over the DHCS calculations, but we shall see what changes after the first year of Payment Reform.

BQ34: For codes 99212-99215, are the hourly paid rates to vendors prorated based off the code they use?

A: The 99212 - 99215 series for Medication Support Services is for the provider types, MD/DO, PA, NP or (CNS certified) for the service of Office or other outpatient visit of established person served. This series of codes falls under SmartCare procedure code 73. Providers need to enter SC code 73 and number of minutes, and SmartCare will calculate the corresponding CPT code according to the

minutes claimed and the corresponding CPT code. The CPT code ranges for this series starts on page 100 of the SMHS Billing Manual version 1.4.

BQ35: I reviewed the Medi-Cal Manual for ICC/IHBS, and it states: "used solely for the purpose of coordinating placement of the child or youth on discharge from those facilities. In this circumstance, ICC may be provided for the purpose of discharge planning, during the 30 calendar days immediately prior to the day of discharge". Just to make sure the treating provider cannot provide ICC as part of the discharge plan from a lock out setting to support with the transition.

A: From the Medi-Cal Manual for ICC/IHBS/TFC, page 30, the statement reads, “When ICC is provided in a hospital, psychiatric health facility, community treatment facility, or psychiatric nursing facility, it will be used solely for the purpose of coordinating placement of the child or youth on discharge from those facilities. In this circumstance, ICC may be provided for the purpose of discharge planning, during the 30 calendar days immediately prior to the day of discharge, for a maximum of three, nonconsecutive periods of 30 calendar days, or less, per continuous stay in the facility.” You are correct that if the treating provider is arranging for new placement of the child or youth (if the child/youth is not returning to the same place of residence they resided in prior to hospitalization/PHF/CTF/PNF stay), in this circumstance ICC may be claimed within 30 days of discharge. Any other SMHS, including ICC for other purposes, are considered locked out. This also applies to children/youth admitted to a juvenile detention facility until any related charges are adjudicated.

BQ36: Regarding clinical records review for the purposes of psychiatric assessment (Review of hospital records) which indicates that an LPHA can claim: If a clinician was reviewing records, not as a part of a Clinician’s own Assessment LPHA process, but as part of preparing a referral to medication services, would that be billable as long as they review that information with the doctor?

A: According to the DHCS Specialty Mental Health Services Medi-Cal Billing Manual V 1.4, page 61, in describing the Maximum Units that Can be Billed, it reads in part, “DHCS policy states that only direct patient care should be counted toward selection of time. Direct patient care does not include travel time, administrative activities, chart review, documentation, utilization review and quality assurance activities or other activities a provider engages in either before or after a patient visit.” So, the time the clinician spends reviewing records is not billable.

BQ37: One of our PS is at CRT, however from our understanding is that PS can leave the facility as long as they return by a certain time. Staff brought in a person served yesterday for their psychiatrist appointment. However now it brings up a couple questions- should we not allow our PS to see the doctor while they are at CRT? Or can they continue to see the doctor and if so, is it billable service?

A: Here is a bit of a deeper dive into the regulations and billing manual for your reference:

Per 9 CCR Section 1810.208, “Crisis Residential Treatment Service” means therapeutic or rehabilitative services provided in a non–institutional residential setting which provides a structured program for beneficiaries as an alternative to hospitalization for beneficiaries experiencing an acute psychiatric episode or crisis who do not present medical complications requiring nursing care. The service supports beneficiaries in their efforts to restore, maintain, and apply interpersonal and independent living skills, and to access community support systems. The service is available 24 hours a day, seven days a week. Service activities may include assessment, plan development, therapy, rehabilitation, collateral, and crisis intervention.

- Crisis residential treatment service does not include medication support services or targeted case management as part of the bundled service as defined above.
- Crisis residential treatment service definition can be found on page 15, Item 4.1.7 of the current SMHS Billing Manual.
- From page 177 of the current SMHS Billing Manual, Service Table 12-Existing 24-Hour and Day Services, In accordance with Title 9, CCR, § 1840.364, Crisis Residential Treatment Services are not reimbursable on days when the following services are reimbursed, except for day of admission to Crisis Residential Treatment Services: a) Mental Health Services, b) Day Treatment Intensive, c) Day Rehabilitation, d) Psychiatric Inpatient Hospital Services, e) Psychiatric Health Facility Services, f) Psychiatric Nursing Facility Services, g) Adult Residential Treatment Services, h) Crisis Intervention, and i) Crisis Stabilization.
    - Again, the lockout when Crisis Residential Treatment Service bundle is claimed does not include service claims for medication support services and targeted case management, as these are recognized as separate modes of service.
- Crisis residential treatment services are separate and distinct from psychiatric inpatient. Like inpatient settings, the lockouts above apply; however, the distinctions lie in the fact that the former is an unlocked, solely voluntary treatment setting while the latter is a locked facility. And even with inpatient hospital services, the medication support service – professional inpatient service may be claimed on the same day as an inpatient stay.

So, in a nutshell, if a person served is placed at the local CRT, they may not receive mental health services (assessment, plan development, therapy, rehabilitation, crisis intervention) on the same day that crisis residential treatment is claimed but may receive medication support services and targeted case management. The medication support services and targeted case management service claims should be documented as usual, whether provided in their clinic, via telehealth, or out in the community.

MH Documentation

DQ1: For Progress Notes, do we still include the following information: the location of the session, travel distance, and the method of Telehealth?

A: Yes, CalAIM does not change these requirements.

DQ2: Does the county have a template for the care plan required in TCM notes?

A: No, DBH does not have a template. Per the CalMHSA documentation guide for clinical services (pgs. 17-18), targeted case management services within SMHS require the development (and periodic revision) of a specific care plan that is based on the information collected through the assessment. The TCM care plan:

- Specifies the goals, treatment, service activities, and assistance to address the negotiated objectives of the plan and the medical, social, educational and other services needed by the person in care.
- Includes activities such as ensuring the active participation of the person in care, and working with the person (or the person's authorized health care decision maker) and others to develop those goals.

- Identifies a course of action to respond to the assessed needs of the person in care; and
- Includes development of a transition plan when the person in care has achieved the goals of the care plan. These required elements shall be provided in a narrative format in the person's progress notes.

DQ3: Do we have to continue to complete the Treatment Plan 5 page assessment?

A: The treatment plan has been replaced by a Problem List and the DBH Quality Improvement (QI) team is establishing training and education for the Problem List. Until the County provides guidance and training, please continue to utilize the treatment plan. Please note that due to federal regulations a treatment plan will continue to be required for, Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), Therapeutic Foster Care (TFC), Therapeutic Behavioral Services (TBS), and Peer Support Services (PSS). Targeted Case Management can be provided once the Targeted Case Management Plan is written in narrative format in the note.

The current assessment covers the 7 domains required by CalAIM:

- **Domain 1**: Presenting Problem(s) • Current Mental Status • History of Presenting Problem(s) • Beneficiary-Identified Impairment(s)
- **Domain 2**: Trauma
- **Domain 3**: Behavioral Health History • Comorbidity
- **Domain 4**: Medical History • Current Medications • Comorbidity with Behavioral Health
- **Domain 5**: Social and Life Circumstances • Culture/Religion/Spirituality
- **Domain 6**: Strengths, Risk Behaviors, and Safety Factors Domain
- **Domain 7**: Clinical Summary and Recommendations • Diagnostic Impression • Medical Necessity Determination/Level of Care/Access Criteria

Please see detailed information on pages 10-16 of the Medical Documentation Guide CalMHSA-MHP-Medical-Documentation-Guide-06232022.pdf and 11-15 of the LPHA Documentation Guide CalMHSA-MHP-LPHA-Documentation-Guide-06232022.pdf if you choose to revise the assessment.

DQ4: We have persons served that have expired treatment plans. We have been working on updating their treatment plans, however given the CalAIM guidelines, do we need to complete the process? And are services billable or NB since the treatment plan is technically expired?

A: Yes, please continue to update and use treatment plans until DBH QI issues guidance on the Problem List. According to the Annual Review Protocol for FY 21-22, an expired treatment plan is not listed as a reason for recoupment, so services are billable. When documenting the service provided the appropriate service code should be used for the service. The code does not change because of an expired plan. Please update the expired plan as soon as possible. **Note that for some services (ICC, IHBS, TBS, TFC, etc.) treatment plans are still required due to federal regulations.**

DQ5: Can we have a version of the paperwork or chart note the state is approving? Is there a new form for progress notes or are the progress note requirements less than they used to be? Do we have new guidelines for how to do this or is it just from the trainings that were given?

A: There is no new progress note form. Pages 25-27 of the LPHA Documentation Guide outline progress note requirements and examples are provided in **Appendix V** https://www.calmhsa.org/wp-content/uploads/CalMHSA-MHP-LPHA-Documentation-Guide-06232022.pdf

DQ6: Because this will not take effect until 8/1/2022, will we need to go back to all new existing patients with new type of paperwork?

A: The County, CalMHSA, and DHCS support a rollout plan within a reasonable timeframe. If the plans are to implement changes on 8/1/2022, please start your new documentation on 8/1/2022. It is not necessary to go back and make any changes prior to that date.

DQ7: How do the ATD form, Discharge Plan and Summary and progress note fit in with streamlining the documentation?

A: DBH's ATD form is used to enroll a person into a service program and serves to track their course of treatment and while they are enrolled in a program. ATD accounts for who is currently in treatment with your program and who is not. It demonstrates the start and end of treatment. Discharge Plan and Summary are required parts of clinical practice and indicate the plan for transition out of a program and summary for the next provider as the case is closed These instruments are used in clinical care as part of treatment to assist with transitions, identifying and documenting levels of care, and help ensure that persons served are in the appropriate level of care, and tracking those transitions. CalAIM does affect the use of these required documents.

The required content of progress notes has been simplified:

1) A narrative describing the service, including how the service addressed the person's behavioral health need (e.g., symptom, condition, diagnosis and/or risk factors), and
2) Next steps including, but not limited to, planned action steps by the provider or by the person in care, collaboration with the person in care, collaboration with other provider(s) and any update to the problem list as appropriate. Please watch the CalMHSA training video and the review the CalMHSA documentation guides.

DQ8: When and how is the Consent for Treatment completed?

A: This is an internal process issue not governed by CalAIM and should be completed in accordance with the program's procedures.

DQ9: Are barriers still required to be included in progress notes, such as Travel time more than 60 minutes, interpreters, telehealth barriers?

A: CalAIM does not make any changes to documentation of barriers. Per the CalMHSA documentation manuals, clinical documentation should reflect the content of the service provided including describing the intervention used, a narrative describing the service, including how the service addressed the person's behavioral health need (e.g., symptom, condition, diagnosis and/or risk factors, and the plan for next steps (p. 25-26 of the LPHA Documentation Guide). CalMHSA-MHP-LPHA-Documentation-Guide-06232022.pdf.

DQ10: Do all EPSDT covered minors still require a treatment plan? Do we need to create a treatment plan to authorize TBS for our minors?

A: Treatment plans are required by federal regulations for TBS, IHBS, ICC, TFC, & STRTPs. Additionally, a treatment plan in the form of a narrative in a progress note is required for TCM (formerly known as CM) and Peer Support Services. These are the services that still require a treatment plan under CalAIM. As mentioned above, TBS does require a treatment plan. Per BHIN 22-019, the two authorities to reference are:

1. DMH IN 08-38

2. Department of Mental Health Therapeutic Behavioral Services Coordination of Care Best Practices Manual

DQ11: If our EHR allows it, can we have two providers with one note?

A: This question is under review with the Department's IT and Business Office teams. A response will be provided in subsequent edition of this Q & A document.

DQ12: Can a treatment plan be documented within a progress note?

A: Targeted Case management treatment plans are required to be documented in narrative format in a progress note. Please note the required components:

- Specifies the goals, treatment, service activities and assistance to address the negotiated objectives of the plan and the medical, social, educational and other services needed by the person in care.
- Included activities such as ensuring the active participation of the person in care and working with the person (or person's authorized health care decision maker) and others to develop those goals.
- Identifies a course of action to respond to the assessed needs of the person in care; and
- Includes development of a transition plan when the person in care has achieved the goals of the care plan.

DQ13: Are all FCMHP providers still required to complete the CANS and PSC-35?

A: Yes, CalAIM does not make changes to this requirement. FCMHP providers are still required to complete:

- The CANS for all Medi-Cal persons served from ages 6 through 20, at assessment, every 6 months, and at discharge. To complete this functional assessment tool, providers are required to be certified every year.
- The PSC-35 for all Med-Cal persons served from ages 3 through 18, at assessment, every 6 months, and at discharge

DQ14: Can a case manager/MHRS complete a Discharge Summary and Plan without an LPHA co signature?

A: CalAIM does not change the requirements for completion of the Discharge Summary and Plan. If the Discharge Summary and Plan are currently co-signed by a LPHA, please continue that practice.

DQ15: For the two-year valid period for assessments, does that start from the date of the assessment or the date the assessment is completed/finalized in Avatar?

A: Due to CalAIM documentation changes effective July 1, 2022 (BHIN 22-019) there is no longer a required timeframe for a reassessment. A reassessment should be completed when clinically appropriate based on the clinical judgement of the treating provider.

DQ16: Will a Medicare only person served still require a Treatment Plan?

A: CalAIM does not make changes to requirements regarding treatment plan for persons with Medicare only.

DQ17: Are we still allowed to have paper charting?

A: Yes, paper charting is acceptable.

DQ18: Our program is paper base; can we create a word document based on the 7 domains for our clinical staff to use for the assessment or can the county provide a word document for my clinical team to use?

A: There is now a paper version of the CalAIM assessment available from CalMHSA. Click **here** to access the form. Providers may choose to update their own assessment based on the criteria noted in BHIN 22-2019 and the CalMHSA documentation guides. A word document is acceptable. See the answer to **DQ3** above for links to detailed information.

DQ19: Is the start date of PL on 9/19/22 also the start date of clinical assessments no longer being updated every 2 years?

A: Effective 7/1/22, the time period for providers to complete an initial assessment and subsequent assessments for SMHS is up to clinical discretion; however, providers shall complete assessments within a reasonable time and in accordance with generally accepted standards of practice (BHIN 22-019 pg. 3; CalMHSA LPHA Documentation Guide pg. 38). There is no longer a requirement for an update every two years; rather, an updated assessment should be based on clinical judgement.

DQ20: Can we get a guideline of when we should be prompted to update the assessment or addendum?

A: See response above. There is no guideline or prompt to conduct a reassessment. An updated assessment should be based on clinical judgement (e.g., change in person served diagnosis, condition, impairments, major life changes, etc.)

DQ21: Can we get an example of a progress note that has sufficient description of the problem or symptoms since we're no longer using Tx plan goals in the narrative?

A: Appendix V of the CalMHSA LPHA Documentation Guide has examples of various types of notes, including a progress note. CalMHSA-MHP-LPHA-Documentation-Guide-06232022.pdf

DQ22: Will a TCM treatment plan need to be part of every case management progress note?

A: No. Once a TCM plan has been developed in narrative in a progress note, the plan does not have to be included in every case management progress note.

DQ23: For Full-Service Partnership (FSP) programs, are treatment plans no longer required?

A: Correct; however, all other requirements are still in place, including the Individual Service and Support Plan.

DQ24: For mental health outpatient services, will we be completing both the Treatment Plan and PL because we are providing case management services?

A: You will complete the PL and a plan for case management services shall be completed in a narrative in the progress note. A treatment plan is no longer completed.

DQ25: How often will the treatment plans be required to be updated for persons served with Medicare/Medi Medi or other qualifying services?

A: CalAIM does not make changes to requirements regarding treatment plan for persons with Medicare.

DQ26: Do I need an updated treatment plan for medication? I started problem lists and got flagged on the medication side that the treatment plan was expired. Can you clarify if the updated treatment plan is needed so I can fix this?

A: If the medical record of the person served contains a current problem list, no treatment plan/POC/care plan is needed to support medication support services. Please ensure that the medical record continues to contain an accurate medication consent.

DQ27: What is required for our prescribers to provide services? The same for our nonprescribers? I've seen that they must complete their psychiatric evaluation also.

A: Prescribers still have to complete their own psychiatric evaluation to determine if medication is needed.

DQ28: Does CalAIM change anything for nursing staff who support the psychiatrists?

A: There are no noted changes for nursing. There are however guidelines and practice expectations in the CalAIM Medical manual. Calaim-Documentation-Guide-2023-Medical-Staff-v2.pdf (calmhsa.org)

DQ29: Do we need to develop a new progress note for each case management service provided?

A: Yes. Each Targeted Case Management (formerly Case Management) service requires its own progress note. The initial TCM note would contain the TCM Plan and does not need to be repeated on each subsequent TCM note.

DQ30: Is a Treatment Plan required if the PS has Other Health Coverage (OHC) only, or in addition to Medi-Cal? If a Treatment Plan is required, then either a Core Assessment or Psychiatric Evaluation is required beforehand, correct?

A: The California Advancing and Innovating Medi-Cal (CalAIM) documentation standards are specific to Medi-Cal. The requirements for any other health coverage have not changed. If a treatment plan is required, an assessment must be completed prior to development of the treatment plan as treatment plans are based on information gathered in the assessment.

DQ31: Should the PS diagnoses be the same in all of the episodes with current services?

A: That depends. Within a treatment team, it is expected that the mental health team consult with one another regarding the identification of symptoms, impairments and diagnoses. If the person served is receiving SMHS from multiple MHP providers utilizing separate medical record systems, care coordination should be clearly documented especially if there are conflicting diagnostic determinations.

DQ32: I have a 2-part question on the group therapy progress note related to CalAIM. Based on the information from the CalAIM documentation guide, would this mean that if I run a group with clinician Jane Doe and we decide I write the note for this week, would the progress note have to detail what each clinician did? My second part of the question is from what is stated in the CalAIM documentation guide regarding the specific amount of time of involvement of each practitioner in the group activity. For example, if I joined the group late, and I facilitated the group for 32 minutes and Jane facilitated for the full 55 minutes, how do I reflect that on the progress note?

A: We are allowed to create one group note per CalAIM; however, the way our billing structure is set up we are not able to separate and claim the billing for each group practitioner. The solution is to

have each practitioner create separate group notes for each PS in the group and document their own specific interventions and outcomes. If a provider was not there for the entire group, then that would be reflected on the service time of that specific provider's note.

DQ33: With the new process of CMHS gathering and billing assessment activities, is the process of asking and obtaining verbal responses from the parent/guardian for the purpose of completing the PSC-35 a billable activity under assessment?

A: The PSC-35 is a State-mandated functional assessment tool that must be completed for every youth. If the information gathered by the CMHS in the process of completing the PSC-35 collaboratively with the parent is subsequently used to inform the written assessment (meaning the information gathered is integrated into the content of the MH assessment document), then it would be an activity billable under assessment. If the information gathered to complete the State-mandated PSC-35 is not integrated into the assessment, and only completed for the sake of meeting the State mandate, then the time taken to complete the outcome measurement tool should not be claimed. Also important to note – the PSC-35 is a simple survey tool that is supposed to be completed by the parent and should not take too long to complete even in a collaborative setting.

DQ34: Per the BHIN 22-065, we understand that contracted providers of the MHP are not required to use the screening tools if an individual seeking services contacts them directly. Our question is whether clinical programs operated by the county, rather than contracted with the county, are considered a "provider" of services and therefore exempt from completing the screening tools? Or, because these programs are operated by the county, are the individuals seeking services at a county operated program considered to be contacting the MHP and thus required to use the screening tools?

A: The Screening Tools are not required for use with persons served who contact mental health providers directly to seek mental health services. This definition of provider is inclusive of county-operated clinics. Mental health providers who are contacted directly by persons served seeking mental health services are able to begin the assessment process and provide services during the assessment period without using the Screening Tools, consistent with the No Wrong Door for Mental Health Services Policy described in All Plan Letter (APL) 22-005 and BHIN 22-011.

While the Screening Tools are not intended for use at the provider/clinic level, you are permitted (not required) to practice alternative uses of the tools in county-operated clinics if you wish. You are correct that the county is not permitted to require contracted providers to use the screening tool, but they are also permitted to opt-in to alternative usage as well.

DQ35: Would the Needs and Services plan fall under case plan and management?

A: No. The Needs and Services Plan required by California Department of Social Services/Community Care Licensing is not a clinical document and does not contain the elements equivalent to a care plan. The STRTP staff member is not able to claim case management for working on the Needs and Services Plan.

DQ36: Are signatures of persons served still required?

A: The only person who is required to sign a treatment plan of any kind is the provider completing the plan. In the past, DHCS and Fresno County DBH did require Plans of Care (aka treatment plans) be signed by PS as the way to evidence that the PS was actively involved in developing the plan. CalAIM has changed the requirement for Care Plans, including whether a PS signature is necessary. Please see the attached DHCS Behavioral Health Information Notice, BHIN 22-019 (ca.gov) which includes a chart of regulations on the topic of Plans of Care, based on types of service delivery or modality of care, e.g. NTP, STRTP, PHF, etc. This BHIN explains new requirements, as well as parts

of regulation that are superseded by CalAIM changes. It is however still important to document how the PS or their caregiver participated in creating any care plan.

DQ37: Now that we no longer need treatment plans for all persons served, we are wondering what the responsibility is for adding TBS to the treatment plan (or more specifically creating a treatment plan just to make a TBS referral). Will it still be on the referring party to create a treatment plan to send with the referral, or will it now be the TBS provider's responsibility to create their own treatment plan with TBS services once the referral is approved? On the referring party's side, we're wondering if just documenting in a CM note the plan to link them with TBS would be sufficient.

A: Like many of our existing processes and County policies, the TBS coordination process is currently under review regarding the required documentation necessary to grant prior authorization. This includes having a collaborative discussion with our County's TBS provider that has also begun. We are looking into whether a copy of a care plan narrative in a progress note/medical record along with current problem list will suffice and will be making recommendation as appropriate to the County's authorization policy and procedure guide surrounding all SMHS authorizations, including TBS, IHBS, and SARs. We will provide any change in TBS coordination direction when it becomes available.

DQ38: We wanted to confirm that for the collateral note, for services provided in conjunction with a covered service – can there still be a separate collateral note and a separate therapy note for services provided on the same day? Or do the actual notes have to be combined into one document?

A: "Collateral" as a service activity is still recognized and defined as a service activity to a significant support person or persons (SSP) in a beneficiary's life for the purpose of providing support to the beneficiary… and would include one or more of the following: consultation and/or training of the SSP to assist with increasing resiliency, recovery or improving utilization of services; consultation and training of the SSP to assist in better understanding of mental illness and impact; family counseling with the SSP to improve functioning of the person served.

Effective July 1, 2023, collateral services cannot be claimed as a stand-alone service; Claiming for collateral contacts will be dependent on the provision of a covered service. A collateral claim must be submitted together with the claim for the covered service, or it will be denied.

Counties can claim for collateral-type services and are advised to identify codes that best describe the activity performed by non-clinical staff when billing those services. HCPCS codes that may be used for collateral-type contacts are available in every category except therapy.

In Service Table 9 – Supplemental Service Codes the procedure code 90887 (Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes) may be used as a claimed service alongside and is dependent on the delivery of another covered service.

- When claiming 90887 alongside the dependent covered service, two claims and progress notes would be necessary.
- Only LPHAs may utilize CPT code 90887.

Other engagements with collateral contacts (a.k.a. significant support persons) and the direction above, "…Counties can claim for collateral type services and are advised to identify codes that best

describe the activity performed…" whether it be by clinical or non-clinical staff when - bill those services:

Please now refer to the CalMHSA guidance and table labeled "Collateral Services"

- The engagement with collateral supports may occur as part of a covered service itself. In this case, and in these cases the rendering provider would no longer utilize a separate, distinct service called, "collateral."
- Collateral engagement can be a component of many services, and when documenting the rendering provider would select the service code that most closely fits the service provided.

Example: If the CMHS provided psychosocial rehabilitation activities with a child/youth (i.e., role playing, skills-building), and speak to the caregiver before or after the time spent with the child/youth to provide the caregiver with consultation and training on the skills learned today – even if the child/youth is not present for this conversation – the separate engagement duration times with the young person served and the caregiver before/after would be combined and one progress note would be written.

Example when this would NOT apply: This ability to add/combine a collateral contact with a covered service would not apply if the procedure code specifies, "…with patient". I.e., 90832 Psychotherapy, 30 minutes, with patient. In these instances, two (2) service claims (and two progress notes) – one for 90832 psychotherapy, 30 minutes, with patient; and a second for 90887 interpretation or explanation of results of psychiatric or other medical procedures to family or other responsible persons, 15 minutes – would apply

DQ39: How do I stay up to date with any changes or updates to documentation requirements?

A: You can get the most updated information by going to the CalMHSA website to find all of their Documentation Guides. CalMHSA recently revised their Documentation Guides which can be found **here**. All edits and clarifications that were made can be reviewed in the "Documentation Guide Change Log" located at the end of each guide.