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# Behavioral Health Quality Management CalAIM Documentation and Payment Reform

## Questions and Answers (Q&A)

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| **Q:** | **How do we get a copy of the standardized assessment for children 0-5y?** |
| **A:** | This form has been uploaded to the Behavioral Health Quality Management website: Behavioral Health Quality Management \| Yolo County under the following path: Documents → Documentation & Forms → Clinical Documentation → Mental Health |
| **Q:** | **Our program runs groups. Do we still calculate group time using the group formula?** |
| **A:** | No. The group formula is no longer needed, so you don't need to document it in the progress note narrative or calculate each client's time separately. Service time for the group will equal the direct time spent in the group service (for example, the group was 60 minutes long, so the service time will be 60 minutes). Calculations per each client are taken care of on the backend of the claiming process by DHCS. |
| **Q:** | **Can we add to our documentation time the time it takes to go through the code sorter tool to find the correct code? It has seemed to be cumbersome.** |
| **A:** | No. The time spent utilizing the code sorter should not be included in documentation time. We understand the code sorter can be cumbersome as we begin to familiarize ourselves with it. Yolo County is currently in the process of developing a list of commonly utilized codes by classification to help assist with this process. |
| **Q:** | **I would like to confirm that the minimum number of minutes when using G2212MH for a prolonged office visit is 1 minute (with the timeframe for that code listed as 1-15).** |

*Revised: 11/01/2023*

Every effort is made to update this information in a timely fashion, however, as regulations frequently are revised, it is strongly recommended to consult the DHCS BHIN page for the current year, the DHCS CalAIM FAQ website, review current P&Ps, and/or contact HHSA BH-QM at HHSAQualityManagement@yolocounty.org with questions to assure accuracy.

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| **A:** | This code can only be utilized in 15-minute increments, so the 15-minute duration must be met to use this code. It can be used up to 14 times in a 24-hour period, and only with E&M codes. Please note that due to potential issues with Medicare claims, Yolo County is recommending only using this code (G2212) if the person providing the service is a physician or other qualified health care professional (e.g., PA, NP, or CNS). |
| **Q:** | **If we use the language line, is the duration for this add-on code just the duration of the service itself (e.g., if I bill H0031MH for 90 minutes with an interpreter from the language line, do I input T1013MH for 90 minutes?)** |
| **A:** | The duration for this add-on code should be for the length of time the interpreter is utilized. This time cannot exceed the amount of time the original service was billed for. In the example above, a maximum of 90 minutes of T1013MH can be billed. |
| **Q:** | **Can we utilize both the add on codes for Interactive Complexity (90785) and the add on code for Sign language or Oral Interpretative Services (T1013) during the same service?** |
| **A:** | No. Interactive Complexity may not be used with the add on code for Sign language or Oral Interpretative Services (T1013MH) or for Crisis Intervention codes (90839MH and 90840MH). If you're providing a service where the communication is straightforward and only capturing interpretation, use T1013MH. |
| **Q:** | **My understanding is that we no longer need to document a start and end time in a progress note- is that correct?** |
| **A:** | The required elements of a progress note are to document the type of service rendered (e.g., individual therapy), a narrative describing the service, including how the service addressed the client's behavioral health needs, the date the service was provided, the duration of the service, the location of the beneficiary at the time of receiving the service, and next steps (such as planned action steps by the provider or client, etc.). Start and end time are not required elements of a progress note. |
| **Q:** | **Are there any recommended "best practices" for how to document progress notes that capture multiple same service contacts with the same client, by the same practitioner, on the same day?** |
| **A:** | If documenting multiple same service contacts with the same client by the same practitioner for the same day (e.g., several targeted case management services), it is recommended to document either the start and end time of each contact for that day, or the duration of each contact on that day, in the narrative of the note. As a reminder, |

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| | each contact should capture the specifics of each contact including location of the contact. |
| **Q:** | **What is the code to use for a Clinic Crisis Clinician if the Crisis is under 15 minutes?** |
| | The first unit of crisis services is billed in a 15-minute increment, which means if the service duration meets the midpoint (8 minutes), then it can be claimed to the billable Crisis Intervention code H2011MH (for crisis intervention between 8-15 minutes in length). If the service duration is less than 8 minutes, use the unbillable crisis intervention code (YASSESMH). Unbillable codes are located on the first tab of the Approved Yolo County SMHS Codes ("Code Sorter") tool.<br><br>As a reminder, always claim to the service provided and not to the credential or title of a service practitioner. For example, a crisis clinician should not claim everything as a crisis service just because that is their title. Crisis services should only be claimed when an immediate emergency response is required that is intended to help a client cope with a crisis (potential danger to self or others, and/or a severe reaction/behavior that is above the client's normal baseline). |
| **Q:** | **If TCM is done while a client is on a hold in the ER (not in a psychiatric setting yet) is this still a lockout?** |
| **A:** | The ER is not a lockout for SMHS. |
| **Q:** | **What is the code to use for collateral?** |
| **A:** | There is no single code to use for claiming collateral. Rather, collateral services are billed as a component of another service. When providing services with caregivers, significant support persons, and/or other professionals (on behalf of the client who may not be present), use the code that captures the covered service being provided at the time (e.g., assessment, psychosocial rehabilitation, etc.). Another way to look at it is to consider what you are hoping to gain when meeting with the significant support person or other professional (ex, are you hoping to get more information to add to your clinical formulation of the client [assessment] or hoping to help the parent understand and assist with implementing skill building exercises [rehabilitation]). Considering questions like this can help you clarify which code to use. Regardless of the code selected, be sure to clearly note in the progress note that the service provided was to a collateral contact if the client is not present. |
| **Q:** | **Are we required to use the Z-Code for "Encounter for observation" at the start of all admissions prior to diagnosis?** |

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| **A:** | While it is true that, to claim for the service, an ICD-10 code must be part of the claim, there is not one specific code that is required at the start of admissions prior to determining a "formal" diagnosis. Z03.89 (Encounter for observation for other suspected diseases and conditions ruled out) may be used by those with the LPHA credential if appropriate, but that level of credential may also use any clinically appropriate code prior to diagnosis, including "other specified" and "unspecified" disorders, or "Factors influencing health status and contact with health services." Those without a LPHA credential may use Z-Codes from the Z55-Z65 range during the assessment period, prior to a "formal" diagnosis being determined. If utilizing a Z code at the start of services, please remember to go back into Avatar to update the diagnosis once a more formal diagnosis has been established. |
| **Q:** | **Can Avatar users create their own progress note templates?** |
| **A:** | No, individual Avatar users do not have access to create their own progress note templates. Those templates are created by the Enterprise Applications (EA) team. If you believe a template would be helpful, please email HHSAQualityManagement@yolocounty.org and submit your request. The BH-QM team can follow-up with you and the EA team if it's determined the template suggested would be beneficial to all Avatar users. |
| **Q:** | **(Internal HHSA Staff only) Clarification is needed on the Post Staff Activity Log (PSAL)** |
| **A:** | We understand that payment reform has impacted PSALs and changes may be needed to this process. This is being reviewed by Yolo County management and we hope updated information can be provided soon. |
| **Q:** | **Is it true that the "direct care" requirement of CalAIM Payment Reform means that we can only claim for a service when the client is present?** |
| **A:** | No, this isn't entirely true. "Direct care" does include time spent directly with the client, but it also includes time spent with caregivers, significant support persons, and other professionals. In documentation, be clear to write if the client is/is not present and what other persons participated in the service. |
| **Q:** | **The "Interactive Complexity" add on code can be used when the service is more complex because of "maladaptive communication." What does that mean?** |
| **A:** | Examples of "maladaptive communication" include high reactivity, repeated questions, or disagreement among participants in the service that complicates delivery of care. Other examples include caregiver emotions/behaviors that interfere with the service, or use of play equipment or physical devices. |

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| **Q:** | **The training referred to monitoring for Fraud, Waste, and Abuse. What's the difference between those?** |
| **A:** | Fraud is knowingly and willfully executing a "scheme" to defraud any healthcare benefit to obtain money. It is always intentional.<br><br>Waste is overutilization of services or other practices that result in unnecessary costs to Medi-Cal (for example, data entry errors that over-inflate the time claimed for the service).<br><br>Abuse refers to practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to Medi-Cal (for example, claiming for an activity that isn't billable as a specialty mental health service, such as claiming a "transportation only" service as Targeted Case Management). |
| **Q:** | **Do I have to go through the Avatar Assessment form to complete the Avatar Safety Plan form with a client?** |
| **A:** | No – for Avatar users, the Safety Plan is a stand-alone form that can either be launched from the Assessment form (if you're completing one in Avatar) or can be accessed independently. |
| **Q:** | **When conducting assessments, the clinician often spends time outside of those meetings analyzing and synthesizing the information gathered to create the case formulation, determine the diagnosis, and make treatment recommendations. Are those activities, in which the clinician is working on the case formulation, diagnosis determination, and treatment recommendations without the client or significant support person present, billable service activities?** |
| **A:** | If time spent consolidating and synthesizing clinical information is part of the assessment to make recommendations for treatment or to make a medical diagnosis, then yes, the activity would count as service time and is claimable to the appropriate assessment code This is true for both DMC and SMHS services.<br><br>However, if you are referring to the time spent *preparing to do an assessment (e.g., time spent preparing to see a beneficiary, such as chart review and other intake activities)*, then no, these activities are already built into the outpatient rates and should not be counted as time used for code selection. You should only consider direct care time when choosing the most appropriate code to bill. |