YOLO COUNTY
Health & Human Services Agency

# Quality Management
# Payment Reform Office Hours FAQ

| UPDATE: 9/16/24 | |
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| Q1. | **Can you provide clarification on when to use 90791 Psychiatric Diagnostic Evaluation vs H0031 Mental Health Assessment by a Non-Physician?** |
| A1. | **Clinicians should use 90791 Psychiatric Diagnostic Evaluation, 60 minutes, when doing an assessment.** Previously, 90791 was limited to 15 minutes but the Department of Health Care Services (DHCS) changed it to allow us to bill for the amount of time medically necessary to complete the service.<br><br>You may provide more than one assessment service per day for the same client. However, you may only bill the code one time per day for the same client. If you do more than one assessment service on the same day for the same client, you must combine the service descriptions and the times for all the assessment services into one note.<br><br>For example, as part of the comprehensive assessment process, you interview the client and parent in the morning and in the afternoon, you speak with the client's teacher. You would create one note in which you document both services in the narrative and include the total time for both services in the service duration field.<br><br>H0031 can be used by some providers that are allowed to perform **limited assessment activities**. For information about what assessment services may be provided by your discipline, refer to the Scope of Practice tab in the current code sorter tool.<br><br>H0031 can also be used by clinicians when doing assessment services to inform treatment recommendations or when assessing for any changes in needs without doing a full assessment or reassessment.<br><br>9896XMH Telephone Assessment and Management – This code may also be appropriate for assessment services when the service provided is between 5-30 minutes and meets the billing guidelines. (See the code sorter Code Descriptions tab for service and billing guidelines.)<br><br>**NOTE**: Regarding billing for assessment activities when the client, family or other informant is not present, the following guidelines are from DHCS:<br><br>"Time spent working on the assessment when the client or caregiver/significant support person are not present is billable when the time is spent consolidating and synthesizing clinical information to make recommendations for treatment or to make a clinical diagnosis." |
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| Q2. | **What's the difference between CPT codes and HCPCS codes?** |

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| A2. | CPT stands for Current Procedural Terminology. CPT codes begin with a number (e.g., 90791). HCPCS stands for Healthcare Common Procedure Coding System. HCPCS (often shortened verbally to "hicpics") begin with a letter, (e.g., T1017).<br><br>CPT codes have a greater level of specificity for billing purposes and should be used whenever there is an appropriate CPT code, rather than defaulting to a HCPCS code.<br><br>For example, if you're a clinician and you provide 48 minutes of in-person crisis services, you should use 90839MH rather than H2011MH.<br><br>**Additionally, CPT codes are usually billable to Medicare and since we are required to bill Medicare prior to billing Medi-Cal, we are required to use CPT codes whenever there is an appropriate CPT code.** |
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| Q3. | **What code can clinicians use when reviewing treatment history, court reports and visitation notes?** |
| A3. | When done <u>as part of an assessment</u>, **reviewing documents such as treatment history, court reports, and visitation notes** can be incorporated into "90791MH Psychiatric Diagnostic Evaluation" or "90885MH Psychiatric Evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes."<br><br>If you review these documents for the purpose of making updated treatment recommendations or to update a clinical diagnosis when not doing the comprehensive assessment or updating the assessment, then you could use 90885MH or H0031. The code you choose will depend on the amount of time you spent on the activity. 90885MH has a minimum billing time of 31 minutes while H0031MH has a minimum billing time of 8 minutes.<br><br>Reviewing information such as visitation notes solely to gather information regarding progress in treatment, it is not a billable service.<br><br>NOTE: You cannot bill for reviewing the chart in preparation for seeing a client. This is a change from pre-payment reform. With the implementation of payment reform, activities such as chart review in preparation to see a client or to monitor a client's progress are included in the service and time spent on those activities should not be included in the service duration.<br><br>**NOTE:** Regarding billing for assessment activities when the client, family or other informant is not present, the following guidelines are from DHCS:<br><br>"Time spent working on the assessment when the client or caregiver/significant support person are not present is billable when the time is spent consolidating and synthesizing clinical information to make recommendations for treatment or to make a clinical diagnosis." |
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| Q4. | **Is there an additional code for extended time for the therapy code, 9083XMH?** |
| A4. | No. Beginning 7/1/24, 9083XMH Psychotherapy has been changed to allow billing for as much time as is medically necessary for the service. The time is no longer capped at 60 minutes. |
| **UPDATE: 10/4/24** | |
| Q5. | **What code should we use now that there is no longer a code for collateral?** |
| A5. | You can still provide collateral services, you just use the code that best describes the service you provided, such as Rehabilitation, Plan Development, Targeted Case Management, Psychotherapy, etc.<br><br>For example, if you work with a parent teaching them how to manage a child's behaviors, you might bill rehabilitation or psychotherapy, depending on the content of the work and your discipline. |
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| Q6. | **What service code should we use when we provide Parent-Child Interaction Therapy (PCIT)?** |
| A6. | PCIT is an evidenced-based treatment modality and, as with collateral, the service code would depend on the service you provide. Review the service you provided and choose the code that best describes that service.<br><br>You'll find extensive service code descriptions in the "Approved Yolo County SMHS Codes" (aka the "code sorter"), on the Code Descriptions tab. |
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| Q7. | **Should prescribers use 90792 Psychiatric Diagnostic Evaluation with Medical Services for their initial assessment?** |
| A7. | Yes. 90792 is the appropriate code. |
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| Q8. | **Can prescribers use H0031 "Mental Health Assessment by a Nonphysician" for services such as seeing a patient when there is not an appointment or checking in with a parent regarding medications?** |
| A8. | Doctors cannot use H0031. Prescribers that are not MD/DOs, (e.g., NP, PA, CNS) are allowed to use H0031, however it may not be appropriate for them to do so, or only under limited circumstances.<br><br>All prescribers are eligible to bill their services to Medicare. However, Medicare does not pay for HCSPS codes such as H0031, therefore, prescribers should always use a CPT code when appropriate and only use HCPCS codes when there is no appropriate CPT code.<br><br>(See Q/A2 above for details on HCPCS vs CPT codes.) |

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| Q9. | **If a youth is eligible for Intensive Care Coordination (ICC), under what circumstances should we use ICC vs Targeted Case Management (TCM)?** |
| A9. | If a youth is eligible for ICC, all case management services should be billed as ICC not TCM.<br><br>ICC is just TCM with a modifier (HK) that indicates it's being provided in a specialized mental health program for high-risk populations. It does not pay at a higher rate, it just provides data showing the correct type of service is being provided for beneficiaries who qualify for it. |
| **Update 10/18/24** | |
| Q10. | **Can Targeted Case Management be provided and claimed when the client is not present for the service?** |
| A10. | There are direct care requirements under CalAIM reforms, and "direct care" can include time spent meeting directly with client or caregivers, significant support persons, and other professionals.<br><br>So as long as the service is medically necessary, the answer is "Yes."<br><br>Example:<br><br>The housing specialist meets with the clinician and PSC without the client present to gather information about the client's housing needs. The housing specialist then begins working to assist the client to find appropriate housing.<br><br>1. The housing issue should be on the problem list. If not, it should be added.<br><br>2. All staff claiming for the service need to include their contribution and meet all other progress note requirements. |
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| Q11. | **If I accidentally choose the wrong date or wrong code for a service, who can fix it?** |
| A11. | It depends on the status of the note. Supervisors and Managers can change the date of a progress note as long as it is within the same month of the service or by the 15th of the following month OR if the status displays as "Open" in the "Edit Service Information" form. If you need to make a correction after the status no longer displays as "Open," you will need to send the request to Quality Management.<br><br>Which staff can fix other types of progress note errors depends on what the error is. Information on who is able to fix which errors can be found on the Progress Notes Error Resolution Guide on the MyAvatar Resources page.<br><br>For information on other Avatar corrections, check the Point of Contact for Avatar Corrections Microsoft Word - Point of Contact for Avatar Corrections Final 01.24.23 (yolocounty.gov) |

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| | More Avatar help is on the MyAvatar Resources page MyAvatar Resources \| Yolo County |