Shasta County Health and Human Services Agency
Utilization Management/Quality Assurance

Payment Reform Tips and Guidance

CHOOSING THE RIGHT CODE:

- The goal in implementing the new billing codes is for you to do your best to choose the correct code.
    - Review the service code document for your credential, choose the code that you think best fits the service you provided, document the required elements –
        - Description of the service provided, including how the service addressed the beneficiary's behavioral health needs (e.g., symptom, condition, diagnosis, and/or risk factors)
        - Next steps including, but not limited to, planned action steps by the provider or by the beneficiary, collaboration with beneficiary, collaboration with other provider(s) and any update to the problem list as appropriate.
    - If you can't seem to find a code that fits the service, or there is more than one code that seems to fit, discuss it with your supervisor. If you still can't decide, you can call the UM/QA team for help.
    - Remember, we have all the same codes we had before except for Collateral. You can always default to the codes you previously used.
    - **IMPORTANT NOTE:** You no longer need to worry about "Upcoding" because our rates are now based on your discipline or credential, not on the code you bill. For instance, if you are a social worker, any service you provide, no matter what the code is, will bill at the same rate as any other service you provide. So…no upcoding.
- DHCS is focusing on providing feedback on quality of care and giving Corrective Action Plans when Counties have areas they need to improve.
    - They will only be recouping for fraud, waste, and abuse.
    - This is also how the UM/QA team will be reviewing charts and progress notes. Our focus will be on supporting staff with training and helpful feedback.
- **COLLATERAL:**
    - There is no longer a separate code for collateral services. Instead, you will bill for whatever service you are providing using a code that allow working with the caregiver/significant support person without the client being present. The 5 codes listed below can be provided to a significant support person.
        - **Rehab Services**: Meeting with a caregiver/significant support person for the purpose of coaching, skill development as a means to support the client with managing behavioral health needs. (all disciplines)

- **Phone Assessment and Management:** Calling the parent/significant support person to get current status of client, assess symptoms/behaviors, assess for current needs. (NP/CNS, lic/waivered psychologist, lic/reg clinicians)
- **Targeted Case Management:** Meeting with caregiver/significant support person for the purpose of connecting them with resources/community supports to address the client's needs. (all disciplines)
- **Plan development:** Meeting with a caregiver/significant support person to develop a care plan/client plan. (all disciplines, except MD/DO)
- **MH Assessment by Non-Physician (H0031**): Meeting with a caregiver/significant support person to gather information for an assessment or reassessment. (all disciplines, except MD/DO)

- Your service code document identifies which codes can be provided to significant support persons.

➢ **CRISIS SERVICES:**

- Crisis Psychotherapy, 90839 and 90840, includes: urgent assessment and history of a crisis state, a mental status exam, and a disposition. Clinicians should use this whenever doing a crisis evaluation or other crisis services.
- Crisis Intervention, H2011, should be used by all other disciplines for crisis services.

➢ **NOTE FOR CLINICIANS ON ASSESSMENT CODE:**

- Licensed and registered clinical staff should use H0031 MH Assessment by Non-Physician rather than 90791 Psychiatric Diagnostic Evaluation when doing assessments.

  Shasta County has made this decision due to the restrictions on the 90791 Psychiatric Diagnostic Evaluation code. Specifically, if you bill 90791 for an assessment, you are not allowed to bill for therapy or crisis therapy on the same day.
- You will be provided with further guidance when/if this issue is cleared up.

➢ **MULTI-SERVICE NOTES:**

- Avatar does not currently have an option for multi-service notes. However, with the change to rates by provider rather than by code, your need for multi-service notes should be greatly reduced.
- You should bill the code that covered the bulk of whatever service you provided.
  - Examples:
    - You provided rehab to a client and there were some elements of case management during the service, you would not need to write two notes.
    - Same for therapy with some case management elements.

- If you mostly provided case management and there was small amount of rehab involved, you would just bill case management.

- If you provided two very distinct services, each for a significant amount of time, for which you are able to track your time separately, then it would be appropriate to bill for two separate services.

➢ **DUPLICATE SERVICES:**

- Services are considered duplicate if the following are the same:
  - Client
  - Provider
  - Procedure Code
  - Date of Service
- If you provide the same type of service to the same client on the same day, if it is allowable to do so, Avatar will roll the service times together and bill them as one service. You as the provider, do not need to worry about it being a duplicate service.
  - For instance, you provide two assessment services to a client and write two separate notes. That's ok because Avatar will take care of it when the services are billed.
  - It is also allowable for you to combine the time and write one note. For instance, you do several assessment activities in one day for the same client. It is fine for you to combine the time and write one note.

➢ **TRACKING YOUR SERVICE TIME:**

- Services are no longer billed by the minute. Tracking the service time is still important, just not as "exactly to the minute" as it was in the past. Services are now billed in units that are measurements of time and can be 15 min, 30 min, 45 min, etc. depending on the code. The units for each code are listed on your service code document.
- Documentation and travel time are no longer included in the billed time.
- You should still track and enter your documentation and travel time, although they are no longer included in the billed time. As mentioned in the CalMHSA training, this information will be helpful for continued rate setting in the future.

➢ **DEFINITION OF "DIRECT CARE":**

- DHCS policy states that **only direct patient care** should be counted toward selection of service 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.

- Direct care is time spent directly providing care to the client as well as additional activities working directly with significant support persons and/or members of the beneficiary's treatment team.
- Review your service code document to determine which services can be provided to significant support persons and which can be performed with treatment team members.
- Time working on assessments – the time spent working on an assessment when the client or significant support person is not present, is part of direct client care. It is a clinical service that involves case formulation, diagnosis determination, and treatment planning.

NOTE ABOUT PROGRESS NOTES AND TREATMENT PLANNING:

- DHCS gave us feedback during the triennial that they expect to see ongoing care planning in the progress notes. They emphasized that although we are no longer required to created complicated treatment plans with required signatures, etc. we are still expected to document ongoing treatment planning. When reviewing our documentation, they will look for this in each progress note in the "Plan/Next Steps" section of the progress note.