QRTIPS
Health Care Agency • Behavorial Health Services • CYS Quality, Review & Training

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Useful Encounter Document (ED) Reminders

- **What does "Face To Face" on the ED mean?**

  Answer: These boxes are to indicate whether or not the client was present at the time the service was rendered. Therapy, case management, or medication services can all be "face to face," so long as the client is present in the session or at the meeting that is being billed to Medi-Cal. Phone conversations, ancillary meetings, or family therapy sessions wherein the client is not physically present are not considered "face to face."

- **What exactly is "Trauma" referring to on the ED?**

  Answer: The Trauma boxes are there to indicate if the client has ever been exposed to any known traumatic events. While it is true that what may be considered "traumatic" is somewhat subjective, this item on the ED is NOT referring to whether or not the client currently (or has historically) carried a diagnosis of Acute Stress Disorder (ASD) or Post-Traumatic Stress Disorder (PTSD). However, if a client has been diagnosed with either of the above mentioned diagnoses, then the YES box for Trauma on the ED should always be marked.

- **What is the "Substance Abuse Diagnosis" box for on the ED?**

  Answer: The Substance Abuse box on the ED should be used exclusively when the client meets the criteria for a Substance Abuse Disorder that you have included in the client's 5-Axis Diagnosis. This does NOT pertain to situations in which a client experiments with one or more substances yet falls short of DSM-IV-TR criteria for substance abuse. Remember, if you include a Substance Abuse diagnosis on the ED, you must also check the "Substance Abuse Diagnosis" box. The IRIS system will not allow entry of billing information when Substance Abuse is checked "YES" but there is no Substance Abuse diagnosis concurrently listed on the ED. A *rule out* or *history of* substance abuse does not count and for these situations the "NO" or "UKNOWN" box would be checked.

- **What is "Non-Billable" travel time and where is it documented on the ED?**

  Answer: This refers to travel time from one site to another that is NOT billable to Medi-Cal for one reason or another. For example, time traveling from one Medi-Cal certified site to another (e.g., from one CYS clinic to another) will NOT be reimbursed by Medi-Cal and cannot be billed. However, you should still document "non-billable" travel time on the ED when applicable. Non-billable travel time is documented on the ED under a non-billable travel time CPT code. The travel minutes must be hand-written or typed in next to the non-billable travel CPT code and NOT at the top of the Encounter Document where billable travel time is typically indicated.

- **What diagnoses need to be listed on the ED?**

  All diagnoses listed on the MTP are required to be recorded on the ED. The "treated today" must be listed on the left column of the ED in the box for Dxs and the "non-treated today" must be listed on the right column of the ED. There is an exception to this; the R/Os and H/Os diagnoses do not need to be listed on the ED.

- **What is Different Day Documentation?**

  Per our contract with the State, Clinicians are required to bill MediCal services in a true and accurate way, and their signature on the ED and the progress note attests to this. Different Day Documentation on the ED and on the progress note is meant for the clinician to reflect truly and accurately when the documentation for a service is done. If the documentation of a service was done 15 days or later after a service was provided, then this documentation must be dated as such and also be coded as a non-compliant service. Clinicians are expected to report when the documentation was truly done.