August 2024

QRTips

Behavioral Health Services
Quality Management Services
Quality Assurance & Quality Improvement Division

Non-Billable Documentation Clairification

Recent chart reviews highlighted a healthy amount of progress notes being claimed as non-billable when, in fact, a billable service was provided. Here are some tips and reminders about non-billable services:

- Non-billable services **solely** focus on:
  - Academic educational services (e.g. helping with homework, tutoring)
  - Vocational services in which work or work training is the focus and the purpose
  - Recreational activities (e.g. going to a theme park)
  - Socialization that does not tie back to a mental health goal
  - Transportation
  - Clerical (e.g. faxing, leaving message, making copies)
  - Payee related
- Services that do not meet a CPT/CDM time threshold
  - Example: If referral and linkage was provided for only five minutes, this activity would be documented as non-billable, as the threshold to select a *70899-412 Targeted Case Management* code is eight minutes.
- Intra-agency consultations with another provider on a client's mental health team is billable. (e.g. clinician meeting with rehab specialist to get updates on goals and behaviors)
- Specialty Mental Health Services (SMHS) should still be claimed as billable, even if the progress note is completed past the documentation due date.
- Youth shelters are not lock out locations for SMHS, as clients placed there are not on a 5585 hold.
- Avoid using a non-billable code when it is unclear which code to select. When unsure, consult with:
  - Service Chief or Program Supervisor
  - Contract Monitor
  - QMS via AQISSupportTeams@ochca.com

TRAININGS & MEETINGS

AOA Online Trainings

AOABH Annual Provider Training

MHP AOA QI Coordinators' Meeting

NEXT Teams Meeting: 09/05/2024

10:30- 11:30am

CYS Online Trainings

CYPBH Integrated Annual Provider Training

MHP CYS QI Coordinators' Meeting

Teams Meeting: 08/08/2024

10:00-11:30am

More trainings on CYS ST website

HELPFUL LINKS

QMS AOA Support Team

QMS CYS Support Team

BHS Electronic Health Record

Medi-Cal Certification

Documentation Tips: Linking Service to Mental Health Need

Progress notes require a narrative describing the service, including how the service addressed a client's behavioral health need (e.g., problem, symptom, condition, diagnosis, risk factor).

Please review the examples below. "Needs Improvement" narratives are vague and do not link the service to the client's behavioral health need. "Clearly Documented" narratives include interventions that address a client's behavioral health need AND uses terminology that accurately describes the service and code selected for billing.

Service Type	Needs Improvement	Clearly Documented
Psychosocial Rehabilitation	Provider met with client to *check-in*. Client shared that he fought with his mom and doesn't know how to stop fighting with her.	Provider met with client to collaboratively address ongoing communication problems with his mother frequently leading to verbal "fights." Provider gathered information about two recent arguments then provided communication skill information. Coached client on active listening skills & a non-verbal skills (eye contact and physical distancing) and *explored alternative skills to possibly improve the relationship.*
Psychotherapy	Provider met with client to *talk about how she's feeling*. Client shared she feels sad that her friend passed away. Provider expressed condolences.	Provider noted signs of sadness or depression and *explored client's current experience and self-report of "feeling down" about a friend's passing.* Provider guided client in processing *feelings of sadness towards her friend's passing and discussed how grief is often separate from and can complicate already existing depression.*
Targeted Case Management	Provider *asked* client if she called Social Services about her food stamps. Client answered that she hasn't had free time to call. Provider *called Social Services with client.*	Provider followed up with *client about applying for food stamps*. Provider *referred client to Social Services* to inquire about additional benefits she might be eligible for and then assisted *the client with the phone call as she was unable to call independently due to her anxiety.*
Assessment	During intake, provider *asked client about mental health history*. Client listed hospitals that he's been to in the last year.	Using both open-ended and closed-ended questions, gathered *history of hospitalizations and experience of past traumas*. Assessed *for current S/I, H/I, and any other safety concerns*. Client denied current S/I or H/I. No current safety concerns were reported nor noted by provider during this visit.
Plan Development	Client missed his last appointment. Provider *called client to check-in*. Client reported he is anxious about going to lower level of care.	Client missed recent appointment with this provider and the lower level of care clinician for warm handoff. Provider contacted client to *follow up and monitor status.* Client reported feeling anxious about transitioning to lower level of care. Provider *reviewed client's progress in treatment and treatment options and* confirmed client's continued intent to link to new provider

*Please note: The "Clearly Documented" narratives are only EXAMPLES of what may have happened in the "Needs Improvement" session. Only the provider is aware of what actually occurred in session and should document accurately.

Plan Development vs. Targeted Case Management

Plan Development services are described as developing and/or approving client plans, reviewing or monitoring a client's progress, goals or updating the problem list. Plan development also includes case consultations and treatment team meetings for the purpose of monitoring progress or goals.

Targeted Case Management services assist a client in accessing needed medical, educational, social, vocational, rehabilitative, or other community services. These activities may include, but are not limited to, coordination and referral.

Plan Development Services	Targeted Case Management
Developing, reviewing, monitoring goals	Communication, coordination, referral
Addresses treatment planning, TCM/ICC goals	**Address access to services**
Example phrases found in plan development notes: • Collaborated with client to develop TCM Care Plan • Collaborated with client to update Legacy Care Plan • Reviewed and adjusted current treatment goals with client • Consulted with member of treatment team and updated Problem List	Example phrases found in case management notes: • Referred client to lower level of care (LLOC) to continue managing mental health • Assisted client with completing application forms because client is unable to do so independently due to anxiety • Contacted PCP with client's caregiver to discuss physical health concerns

Example of a plan development service vs. a targeted case management service:

	Plan Development Service	Targeted Case Management
Purpose of session:	To review client's treatment goals and progress	To review client's progress with recent referral to Peer Mentoring
Intervention/ Service:	Provider met with client at clinic to query client's thoughts about the treatment services she is receiving at this clinic. Provider encouraged client to share her thoughts with clinician and psychiatrist. Provider reviewed and updated client's TCM goals to reflect client's current needs.	Provider called client to ask if there are any updates regarding the recent referral made to Peer Mentoring. Due to client's anxiety, client is unable to drive herself to Peer Mentoring services for intake. Provider reviewed options with client such as OCTA reduced bus fare and contacting Peer Mentoring to ask if the program would be able to meet with client at her home or at this clinic for intake.

Reminder (County only): The BH Plan Development Progress Note is now in IRIS

Group Services

Group codes effective 7/1/24

Code	Service

70899-429 (H2017)	**Psychosocial Rehabilitation, per 15 minutes**
	• HQ modifier automatically applied in IRIS applied when Group Psychosocial Rehabilitation is selected.
	• Minimum 8 minutes; maximum 1440 minutes
	• Group service provided directly to clients
	• Group Psychosocial Rehabilitation examples:
	  • *Communication skills* such as teaching clients about different communication styles and practicing assertiveness
	  • *Activities of Daily Living skills* such as teaching clients the importance of hygiene.

90853-4	**Group Psychotherapy, 50 minutes**
	• Minimum 23 minutes; maximum 57 minutes
	• For service time of 58 minutes or more, enter total service time even if it exceeds the maximum allowed minutes for this service. IRIS will reconcile when the new CDM is established for T2021.
	  • Please note: This guidance may change in the future
	• Group service provided directly to clients
	• Group Psychotherapy examples:
	  • Group members share their experiences with depression and what motivates them to live
	  • *Processing groups* such as survivors of sexual assault or mothers with post-partum depression

90849-4	**Multiple-Family Group Psychotherapy, 84 minutes**
	• Minimum 43 minutes; maximum 91 minutes
	• For service time of 92 minutes or more, enter total service time even if it exceeds the maximum allowed minutes for this service. IRIS will reconcile when the new CDM is established for T2021
	  • Please note: This guidance may change in the future
	• Group service provided directly to clients and their family members
	• Group Multiple-Family Group Psychotherapy examples:
	  • Clients and family members share and *process* their experiences dealing with schizophrenia disorder and what has helped them

CDM code to be determined **(T2021)** *Not yet in IRIS	**Therapy Substitute, 15 minutes** • If service time for 90853-4 is 58 minutes or more, use T2021 instead of 90853-4 and enter total service time. Units will be calculated by IRIS. • If service time for 90849-4 is 92 minutes or more, use T2021 instead of 90849-4 and enter total service time. Units will be calculated by IRIS.

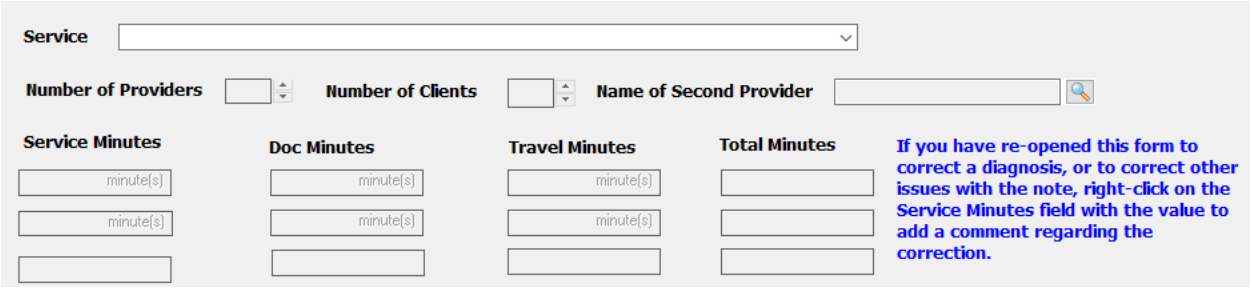
70899-420 (H0025)	**Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior) [Peer Support group session], 15 minutes.**
	• Minimum 8 minutes; maximum 1440 minutes
	• This code can only be used by Certified Peer Support Specialists under the direct supervision of an LPHA/LMHP.
	• Group service provided directly to clients or clients and their family members.
	• Behavioral Health Prevention Education Service [Peer Support Group Session] examples:
	  • Teaching clients relaxation and self-care techniques.
	  • Teaching clients about the importance of having a support system and identifying members of their support system.

*When selecting a service code, ensure that the service is within the provider's scope of practice.

Documentation Requirements for Group Services:

A. When a group service is rendered, a list of participants is required to be documented and maintained by the provider.
B. Every participant shall have a progress note in their clinical record that documents the service encounter and their attendance in the group, and includes:
    i. The type of service rendered
    ii. The date that the service was provided to the member
    iii. Duration of direct patient care for the service
    iv. Location/place of service
    v. A typed or legibly printed name, signature, of the service provider, and date of signature
C. The progress note for the group service encounter shall also include a brief description of the member's response to the service.

Billable Group Services tab in IRIS (County only):



One Provider:

A. Service: Select the code that best describes the group service provided
- The service must be within the scope of practice of the provider

B. Number of Providers: Enter/select "1"

C. Number of Clients: Enter total number of clients that attended the group

D. Service Minutes: Enter the duration of the group
- Must meet minimum required minutes to bill

E. Documentation Minutes: Enter the duration it took to type the progress note.

F. Travel Minutes: Divide total travel time by number of clients.
- Although travel time is non-billable, it should be reported on the "NEW Billable Services" tab if the service was billable.

Two Providers (co-facilitation):

A. Service: The co-facilitators will agree upon which code best describes the group service provided and both will select that code for documentation and billing
- The service must be within the scope of practice of both providers.
- Each provider will write an individual progress note for half of the members in the group.
  - For example: Eight clients attended a group with two co-facilitators. *Provider A* will write an individual progress note for four group members and *Provider B* will write an individual progress note for the other four group members.

B. Number of Providers: Enter/select "2."

C. Number of Clients: Enter total number of clients that attended the group.
- Both providers should document the same total number of clients because they co-facilitated the group together

D. Name of Second Provider: Each provider will enter the name of their co-facilitator.

E. Service Minutes: Enter the total duration of the group.
- Must meet minimum required minutes to bill.
- Both providers should document the same duration because the group was co-facilitated

F. Documentation Minutes: Enter the duration it took to type the progress note.

G. Travel Minutes: Divide total travel time by number of clients.
- If *Provider A* drove and *Provider B* did not drive, *Provider A* will divide total travel time by the number of clients they are documenting for.
- If *Provider A* and *Provider B* drove, each will divide their own total travel time by the number of clients they are documenting for.
- Although travel time is non-billable, it should be reported on the "NEW Billable Services" tab if the service was billable.

H. *If there are two facilitators, the group should have at least four or more clients. Each provider will document group services for at least two of those clients in order to bill for group services.*

Documentation Reminder for Powerforms
(County Only)

If you are starting, adding to, or modifying a PowerForm, a corresponding progress note should also be completed the same day to capture the service.
For example:

- 7/8/24: Starting the BH Assessment PowerForm with client
  - Complete corresponding assessment progress note on 7/8/24 to capture the assessment service with client
- 7/22/24: Meeting with the client again to continue the BH Assessment PowerForm
  - Complete corresponding assessment progress note on 7/22/24 to capture the ongoing assessment service with client
- 7/26/24: Completing the comprehensive assessment with provider's clinical formulation of client presentation and determination of medical necessity for domain 7 of the BH Assessment
  - Complete corresponding assessment progress note on 7/26/24 to capture the service

MANAGED CARE SUPPORT TEAM

MCST OVERSIGHT

- EXPIRED LICENSES, WAIVERS, CERTIFICATIONS AND REGISTRATIONS
- NOTICE OF ADVERSE BENEFIT DETERMINATION (NOABDS)
- APPEAL/EXPEDITED APPEAL/STATE FAIR HEARINGS
- CHANGE OF PROVIDER/2ND OPINIONS (MHP/DMC-ODS)
- CAL-OPTIMA CREDENTIALING (AOA COUNTY CLINICS)
- CLINICAL/COUNSELOR/MEDICAL/QUALIFIED PROVIDER SUPERVISION
- GRIEVANCES & INVESTIGATIONS
- COUNTY CREDENTIALING
- ACCESS LOGS
- MHP & DMC-ODS PROVIDER DIRECTORY
- PAVE ENROLLMENT (MHP PROVIDERS ONLY)

REMINDERS, ANNOUNCEMENTS & UPDATES

ACCESS TIMEFRAMES

MHP

10 BUSINESS DAYS - ROUTINE
Outpatient Services

~~24~~ 48 HOURS – URGENT
CALENDAR DAY
Inpatient Hospital Discharge
Correctional Health Jail Discharge

4 HOURS - EMERGENT
CALENDAR DAY
Crisis Assessment/Evaluation

TIMELY ACCESS & ISSUING NOABDS (MHP ONLY)

- Federal Access Standards defines **Urgent** appointments to be offered within **48 hours** **NOT** 24 hours.
- **Emergent – 4 hours** is a County standard that does not require a Timely Access NOABDs to be issued to the beneficiary. This is not a Federal Access standard.
- If timely access is NOT met for "Routine" and "Urgent" access appointments, then the provider must issue a Timely Access NOABD to **new** clients initially requesting access to services for the first time. Existing clients currently receiving services within the MHP do **NOT** require a Timely Access NOABD for a follow-up appointment upon a hospital or jail discharge.
- The County and County-Contracted programs will continue to offer an appointment for hospital and jail discharges within 24 hours to provide a higher standard for quality of care. Programs do NOT need to issue timely access NOABDs to **new** clients unless it exceeds offering an appointment within 48 hours.

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

MEDI-CAL CLAIMING DURING THE BBS 90-DAY RULE PRIOR TO BBS REGISTRATION NUMBER

(OPTIONAL COUNTY CONTRACTED PROGRAMS ONLY)

- The State Department of Health Care Services (DHCS) will honor the 90-day Board of Behavioral Sciences (BBS) rule and allow practitioners to provide services as if they are registered while they wait for their registration number after the completion of their Live Scan. DHCS has confirmed that Associates are considered "registered" during this 90-day period and can claim Medi-Cal for assessments and therapy services.
- The provider must submit the Clinical Supervision Report Form (CSRF) to MCST and follow the 90 day BBS rule guidelines below prior to delivering any Medi-Cal covered services:

CLINICAL SUPERVISION

COUNTY-CONTRACTED PROGRAM REQUIREMENT

- ✓ Post degree hours may only be counted as of the date recorded at the bottom of the Request for Live Scan Service form.
- ✓ CSRF Form, BBS Responsibility Form, Written Agreement (if applicable) and a completed **Live Scan Fingerprint Form** from the employer must be submitted to MCST.
- ✓ IRIS will **NOT** enter the provider into the system to bill for services if they do not have an Associate #.
- ✓ Once BBS issues an Associate #, the provider must submit updated clinical supervision forms to IRIS and MCST, along with the PAN.
- ✓ Without a PAN, IRIS will **NOT** activate the provider to begin billing for Medi-Cal covered services.
- ✓ County Employees do **NOT** qualify for the BBS "90-day rule" clause in the law. Human Resources requires an Associate # in order to hire a Behavioral Health Clinician I.

https://www.bbs.ca.gov/pdf/90day_rule.pdf

90-DAY RULE FOR GRADUATES

- County-Contracted programs **MUST** hold the claims until the registration number comes through (if it is issued retroactively). The Live Scan date on the Live Scan form is the date the BBS will use as the registration date for the Associates. This means, as soon as the provider receives their registration number from BBS the program administrator must immediately:
  1. Submit an updated CSRF with the newly assigned registration #.
  2. County Credential the provider and include a copy of the **Request for Live Scan Service form** for the credentialing approval letter to incorporate the date the Live Scan form was completed to deliver Medi-Cal covered services.
  3. Submit an updated PAN along with supporting documents to IRIS to add the provider into the system to begin entering and billing for services, retroactively.

DISCLAIMER:

The program will take the risk of any billed services being disallowed, if the provider separates from their employer prior to receiving their BBS registration # or if the BBS registration # is not granted.

REMINDERS, ANNOUNCEMENTS & UPDATES (CONTINUED)

PROVIDER DIRECTORY(MHP ONLY)

- All MHP programs are **NO** longer required to enter NACT data on the Provider Directory Spreadsheet. The newly revised Provider Directory spreadsheet will have the NACT fields removed, the newly eligible providers included, etc.

MCST TRAININGS ARE AVAILABLE UPON REQUEST

- **NEW** MHP and DMC-ODS programs are required to schedule a full training to comply with the MCST oversight and DHCS requirements. It is recommended to have the Directors, Managers, Supervisors and Clinical Staff participate in the training to ensure those requirements are met and implemented. Please contact MCST to schedule the training at least a month prior to delivering Medi-Cal covered services.
- If you and your staff would like a refresher on a specific topic or a full training about MCST's oversight please e-mail the Health Services Administrator, Annette Tran at anntran@ochca.com and the Service Chief II, Catherine Shreenan at cshreenan@ochca.com.

MONTHLY MCST TRAININGS – NOW AVAILABLE

MCST is offering open training sessions effective **1/1/24** for new and existing providers. The 2-hour training will be on NOABDs, Grievances, Appeals, 2nd Opinion/Change of Provider and Access Logs.

Please e-mail AQISGrievance@ochca.com with Subject Line: MCST Training for MHP or DMC-ODS and a MCST representative will send you an e-mail invitation to attend the training via Microsoft Teams.

2nd Tuesdays of the Month @ 1 p.m. MCST Training (MHP)
4th Tuesdays of the Month @ 1 p.m. MCST Training (DMC-ODS)

MANAGED CARE SUPPORT TEAM

GRIEVANCES, APPEALS, STATE FAIR HEARINGS, NOABDS, 2ND OPINION AND CHANGE OF PROVIDER
Leads: Esmi Carroll, LCSW Jennifer Fernandez, LCSW

CLINICAL SUPERVISION
Lead: Esmi Carroll, LCSW

ACCESS LOGS
Lead: Jennifer Fernandez, LCSW

PAVE ENROLLMENT FOR MHP
Leads: Araceli Cueva, Staff Specialist Elizabeth "Liz" Fraga, Staff Specialist

CREDENTIALING AND PROVIDER DIRECTORY
Credentialing Lead: Elaine Estrada, LCSW
Cal Optima Credentialing Lead: Sam Fraga, Staff Specialist
Provider Directory Leads: Elaine Estrada, LCSW Sam Fraga, Staff Specialist

COMPLIANCE INVESTIGATIONS
Lead: Catherine Shreenan, LMFT

CONTACT INFORMATION
400 W. Civic Center Drive., 4th floor
Santa Ana, CA 92701
(714) 834-5601 FAX: (714) 480 -0775

E-MAIL ADDRESSES
AQISGrievance@ochca.com (NOABDs/Grievance Only)
AQISManagedCare@ochca.com

MCST ADMINISTRATORS
Annette Tran, LCSW
Health Services Administrator

Catherine Shreenan, LMFT
Service Chief II

Service Chiefs and Supervisors:

Please remember to submit monthly program and provider updates/changes for the Provider Directory and send to: AQISManagedCare@ochca.com and BHSIRISLiaisonTeam@ochca.com.

Review QRTips in staff meetings and include in your meeting minutes.

***Disclaimer**: The Quality Management Services (QMS) Quality Assurance (QA) and Quality Improvement (QI) Division develops and distributes the monthly QRTips newsletter to all MHP providers as a tool to assist with various QA/QI regulatory requirements. It is NOT an all-encompassing document. Programs and providers are responsible for ensuring their understanding and adherence with all local, state, and federal regulatory requirements.*

QMS MAILBOXES

Please email questions to the group mailboxes to ensure emails arrive to the correct team rather than an individual team member who may be out on vacation, unexpectedly away from work, or otherwise unavailable.

Group Mailbox	QMS Team	Oversees
AQISCalAIM@ochca.com	CalAIM Services Team	ECM and Community Supports referrals and questions
AQISCDSS@ochca.com	Inpatient and Designation Support Services	General questions regarding Certification and Designation
AQISDesignation@ochca.com	Inpatient and Designation Support Services	Inpatient Involuntary Hold Designation LPS Facility Designation Outpatient Involuntary Hold Designation
AQISGrievance@ochca.com	Managed Care Support Team	Grievances & Investigations Appeals/Expedited Appeals State Fair Hearings NOABDs
BHSInpatient@ochca.com	Inpatient and Designation Support Services	Inpatient TARs Hospital communications ASO/Carelon communication
AQISManagedCare@ochca.com	Managed Care Support Team	Access Log Errors/Corrections Change of Provider/2nd Opinion Supervision Forms for Clinicians/Counselor/Medical Professionals/MHP Qualified Providers County Credentialing Cal-Optima Credentialing (AOA County Clinics) Provider Directory Expired Licenses, Waivers, Registrations & Certifications PAVE (MHP Only)
AQISMCCert@ochca.com	Inpatient and Designation Support Services	MHP Medi-Cal Certification PAVE County SUD clinics only
AQISSUDSupport@ochca.com	SUD Support	CalOMS questions (clinical-based) DMC-ODS Clinical Chart Reviews DATAR submissions DHCS audits of DMC-ODS providers DMC-ODS ATD MPF updates SUD Documentation questions and trainings SUD Newsletter questions
AQISSupportTeams@ochca.com Please identify AOA or CYS in subject line	AOA & CYS Support Teams	AOA & CYS Documentation Support CANS/PSC-35 Medication Monitoring MHP Chart Reviews QRTips Provider Support Program (AOAST only)

BHSHIM@ochca.com	BHS Health Information Management (HIM)	County-operated MHP and DMC-ODS programs use related: Centralized retention of abuse reports & related documents Centralized processing of client record requests, Clinical Document Review and Redaction Release of Information, ATDs, Restrictions, and Revocations IRIS Scan Types, Scan Cover Sheets, Scan Types Crosswalks Record Quality Assurance and Correction Activity
BHSIRISFrontOfficeSupport@ochca.com	BHS Front Office Coordination	IRIS Billing, Office Support
BHSIRISLiaisonTeam@ochca.com	BHS IRIS Liaison Team	EHR support, design, maintenance Add, delete, modify Program organizations Add, delete and maintain all County and Contract rendering provider profiles in IRISRegister eligible clinicians and doctors with CMS and assist in maintaining their PTAN status
BHSNACT@ochca.com	BHS IRIS Liaison Team	Manage the MHP and DMC-ODS 274 data and requirements Support of the MHP County and Contract User Interface for 274 submissions