Mental Health Service Codes FAQ

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Additional Resources for Staff	
QM Website	Your one stop shop for QM resources.
HS_BHRS_ASK_QM@smcgov.org	Got questions? Send them to Ask QM.

Information about Service Codes

1. **Why are service codes changing?**
As part of the changes under CalAIM, the way that counties are being reimbursed for services provided to beneficiaries is changing. DHCS refers to this as Payment Reform. This requires providers to use updated service codes, called Current Procedural Terminology (CPT codes) and Health Care Common Procedure Coding System (HCPCS) to bill for services. CPT codes and HCPCS codes are a uniform language for coding medical services. ** BHRS still uses some internal codes for billing for services, but behind the scenes, our billing department crosswalks some of these codes to the applicable CPT or HCPCS code when submitting to the state for reimbursement.*

TIP: Don't worry so much about the new codes or trying to memorize them. Instead look at the description in the cheat sheet for the type of service you are providing to ensure you are selecting the correct service code. If you aren't sure, email HS_BHRS_ASK_QM@smcgov.org.

You can find more information from DHCS about why Service Codes are changing HERE.

2. **When do these new service codes go into effect?**
As of July 1, 2023, Payment Reform under the new CalAIM requirements goes into effect. Any services provided before July 1, 2023, should still use the old service codes that BHRS has used in the past to code services. Any services provided on or after July 1, 2023, should use the new CalAIM codes. To view the complete list of CalAIM codes, see the "Service Code Cheat Sheet."

For example, if you provided an assessment service on June 30th, and did not write your progress note until July 1st, you would still use the old service code of (5) Assessment since the service was provided prior to July 1, 2023, before payment reform went into effect. If you provided the service on or after July 1, 2023, then depending on your discipline, for example if you are a LMFT (not an MD/NP) then you would use the service code of 5CA for Assessment (non-MD/NP).

3. **Do I need to memorize these new service codes?**
You do not need to memorize these new service codes, but naturally you will become more familiar with them over time. In Avatar, you will be able to type in the name of the service that you provided and then the name of the service, along with the service code, will appear. For example, most new service codes will have "CA" (for CalAIM) at the end of service code and there are some additional new codes for CalAIM. Please make sure you use the new service codes for services provided on or after July 1, 2023, as noted in the question above.

   Please note that the old service codes will remain in Avatar for a period of time to allow for providers to enter in progress notes using the old codes for services provided before July 1, 2023.

4. **Why are some services limited by specific time-frame minutes?**
Under CalAIM, some of the new CPT and HCPCS codes used for billing have maximum time frames that can be billed for per day. If there is a maximum time frame associated with a certain service code, you will see a note in the description for that service code on this cheat sheet. This does NOT mean that you cannot bill for the additional time spent providing this service, it just means that due to the new claiming system, providers are required to document this additional time in a different category in the progress note.

5. **What are Add-On codes?**
For the service codes that have maximum time frames, as indicated in this cheat sheet for certain services, the remainder of the time you spent providing a service, over the maximum amount allowed to be entered into the normal service time category, needs to go in the Add-On section as one of the Prolonged Service Codes to be billed.

   An Add-On code refers to a service that cannot be billed for on its own. These services will only be billed for, or reimbursed, if they are included on the same progress note as another billable service that occurred on that same day. For example, the new Sign Language or Oral Interpretive code, is an Add-On services which will only be billed if the service occurred on the same day as another service and was documented in that same progress note.

6. **What happened to the Collateral Service code? It is not included on the Service Code Cheat Sheet.**
Under CalAIM, the way that a Collateral is billed has changed. Instead of a collateral service being its own distinct service code, the way it was previously, collateral instead is viewed as a component of many different services. A provider working with the client's support person would select the service code that most accurately represents the service they are providing and indicate on the progress note that this service was provided to the collateral contact. Here are a few examples:

Sample Scenario	Service Code
Meeting with the client's caregiver/significant support person to gather assessment information.	Assessment
Meeting with the client's caregiver/significant support person to develop a plan for treatment.	Plan Development
Meeting with the client's caregiver/significant support person for the purpose of coaching, skill development as way to support the client with managing behavioral health needs.	Rehabilitation

Meeting with the client's caregiver/significant support person for the purpose of connecting them with resources/community supports to address the client's needs.	Case Management

7. **For Group Progress Notes, why do I no longer need to add the number of participants in a group?**
Under CalAIM, DHCS adjusted the rates they bill for groups to eliminate the calculation that our billing department does on the back end to divide the total group time between the number of participants in the group. Instead, put the number of minutes that each participant/client attended. For example, if the group was 60 mins and each participant was there for the total duration of the group, then input 60 mins. If a participant/client showed up late (15mins late), then you would input 45mins for that specific participant/client. You still need to write progress notes for each participant/client. If there was a co-practitioner for the group, that co-practitioner would have to write their own progress note for each participant/client.

CalAIM Progress Note Webinar New FAQ's

8. **Regarding Same Day Note, is it necessary to write 1 progress note or can I write 2 different progress notes for the same service, same client on the same day?**
If you provide more than one occurrence of the same service (using the same service code) for a particular client on the same day, these services **<u>MUST</u> be combined into ONE note**. If you provide multiple different services (using different service codes) on the same day for a particular client, please continue to write separate notes for each service.

9. **Regarding Same Day Note, what if the place of service is different when providing the same type of service?**
If the services were the same type of service but place of service was different, you **MUST** document these services in one note and select the location of the time provided that was the longest. Then, within the progress note field please make note that there were two different locations where the services were rendered. Please summarize within one progress note.

10. **Regarding Same Day Note, can one progress note be done if a group and individual service is rendered on the same day?**
If a group was provided to a client and then you provided individual therapy, that would not be the same service type and you would therefore need to write two progress notes.

11. **Regarding Same Day Note, what if they are different service codes though?**
If you provided two distinct services that use different services codes (e.g., rehab and case management) these two services would need to be documented in two separate notes. They should NOT be combined into one progress note. Same day services (note) would only apply if it's the same service multiple times in one day.

12. **Regarding a collateral service such as providing psycho education for client's mental health and/or providing support training for the caretaker will it be considered case management or rehabilitation service?**
    A provider working with the client's support person would select the service code that most accurately represents the service they are providing and indicate on the progress note that this service was provided to the collateral contact. Please refer to question #6 for more examples.

13. **With collaterals being take away, would parenting tips in support of the client's treatment be coded under rehabilitation?**
    You can still provide a collateral service; you are now coding it differently by using a different service code. See answer above.

14. **For minor clients, how are we coding for when we provide psychoeducation, coaching or recommendations to parents/caregivers?**
    A provider working with the client's support person would select the service code that most accurately represents the service they are providing and indicate on the progress note that this service was provided to the collateral contact. Please refer to our service question #6 above and see our examples.

15. **Caregiver addition – in progress notes: What if the client is an adult and the parent did participate in session? Can I click yes for "Did caregiver participate in session?"**
    Yes, as long the client approves the parent participation and the appropriate release have been signed.

16. **Caregiver addition – in progress notes: Can we add "caregiver present" even if the client is not a dependent adult/minor?**
    Yes

17. **Caregiver addition – in progress notes: Can you clarify caregiver? Would that be a board and care operator? Is this only for conserved clients?**
    Yes, this can be anyone that is providing caregiving support to the client. While this is traditionally thought of as just the parent or guardian, this could also include Board and Care operator, home health aide if you determine that that individual is providing significant care giving support to the client. Use clinical judgement in making this determination.

18. **Is the time spent reviewing a chart prior to providing a billable service considered part of the service?**
    We know this question was brought up during the webinar and we are following up with DHCS to ensure we give you all the right guidance. Please stay tuned.

19. **Why do they expect the assessments times to be just 15 minutes?**
    Under CalAIM, some of the new CPT and HCPCS codes used for billing have maximum time frames that can be billed for per day. If there is a maximum time frame associated with a certain service code, you will see a note in the description for that service code on this cheat sheet. This does NOT mean that you cannot bill for the additional time spent providing this service, it just means that due to the new claiming system, providers are required to document this additional time in the add-on section of the progress note.

20. **Is it what type of appt was offered or what type of appt they accept? They may decline an in-person appt offered so we schedule a phone.**
    It's what type of appointment was offered. For example, an office appointment was offered but was declined and phone appointment was offered in lieu of the office was accepted in the follow up category of the progress note you would mark phone and office. It is all appointments that we offered.

21. **When writing a note, what if you are unsure if the follow up appointment will be in person or over the phone? What should we choose in Avatar?**
    If the client can't confirm what type of appointment will be next, you can leave the section blank as it is not a mandatory field.

22. **For services with time limits like group therapy, does this mean that BHRS only gets paid for those 15mins?**
    No. The time spent providing the service, even for those with time limits, is also billed and we will get paid for it. Capturing the time spent in addition to those time-caps is especially important, so please ensure you add the additional time (add-on codes) spent providing direct-client care.

23. ****What if you do not enter progress notes into Avatar? Will there be a new PDF progress note form available?**
    Yes, our PDF progress note has been updated to reflect the changes to the progress note under CalAIM. You can find the PDF progress note here Behavioral Health Staff: County SOC Contractors - San Mateo County Health (smchealth.org)

24. **What's the difference between telehealth and telehealth home? Is it the location of provider or patient?**
    "Telehealth Home" should be used only when the client is located at their home while receiving services via telehealth. For telehealth services provided when client is located elsewhere (any location that is not client's home and is not a lockout location), continue to use the regular "Telehealth" location code. Please see our guide Remote Services Location Code FAQ BHRS Quality Management - San Mateo County Health (smchealth.org)

25. **What are some examples of "other billable time"?**
    After June 30, 2023, "other billable time" will be grayed out and no longer captured. You should include your documentation time (one field) separately and any travel time (another field) used to provide a service to a client. These are the only time fields.

26. **The MH Service Code FAQ and Service Code Cheat Sheet is missing Individual Therapy from 1-15 minutes. What is that CPT code?**
    There is no code for individual therapy for less than 15 mins. If you provided individual therapy that was less than 15mins, please reconsider what services you did provide and code accordingly.

27. **What would classify a dependent adult? someone conserved, someone with a developmental disorder?**
    Dependent adult means someone 18 yrs. or older; is wholly or partially dependent upon one or more other persons for care or support, either emotional or physical; has not established financial independence; has not been determined to be eligible as a person; would be in danger if care or support is withdrawn.

28. **Any estimate on when there will be an updated documentation manual?**
    Currently, we do not have an estimated date. We hope to have one by the end of year/2023.

29. **Why have maximum billing times been established? Should we work to only provide services in the allotted time/will long billing times be flagged?**
    Under CalAIM, some of the new CPT and HCPCS codes used for billing have maximum time frames that can be billed per day. If there is a maximum time frame associated with a certain service code, you will see a note in the description for that service code on this cheat sheet. This does NOT mean that you cannot bill for the additional time spent providing this service, it just means that due to the new claiming system, providers are required to document this additional time in the add-on section of the progress note. Please see our Service code cheat sheet.

30. **Are we allowed to type the June notes into Avatar NX?**
    Yes, you can.

31. **Do the new service codes only work on Avatar NX or can I document the new service codes using the old Avatar?**
    If you are still using the old Avatar, please use the new CalAIM service codes for services provided on or after 7/1/2023. It is crucial that regardless of what Avatar you are using, that you implement the new guidance on the service codes. For example, if you are providing an assessment or crises intervention after July 1st, then you should be using 5CA (Assessment) and 2CA (Crises Intervention). Please use the Cheat Sheet as a reference to help you determine the new service code.