

Frequently Asked Questions

Collected at Audit / Clinical Documentation Discussions

Beginning in 2008, the Department of Human Services (DHS) began to attend community forums and discuss the requirements for documenting services that were reimbursed directly by Division of Medical Assistance Programs (DMAP) through Medicaid. DHS was represented by staff from both the Addictions and Mental Health Division (AMH) and the Provider Audit Unit (PAU) from the Office of Payment Accuracy and Recovery (OPAR). These discussions were developed in response to a number of audits during which the providers expressed opportunities to interact with DHS staff and learn what the auditors used as criteria.

What follows is a list of questions that were asked of AMH and PAU in preparation for the discussions or during the discussions. AMH plans on reposting the list as answers are developed for subsequent questions. Providers are encouraged to submit questions that are not addressed in the document by emailing them to Jay Yedziniak, Oregon health Plan Coordinator at joseph.a.yedziniak@state.or.us. Once received they will be posted in the section titled "Questions to be Addressed". Questions that concern multiple sections are listed in multiple sections to increase the ease with which a provider can locate the question and answer.

The document is intended to be easy to use. Identify the area of interest on the Table of Contacts and click on that topic. You will be directed to a page that contains the questions answered for that topic. Click on the question and you will be directed to the question and answer in the document. At any point you can click "Back to Home" directed to the Table of Contents page.

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ASSESSMENTS

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BILLING

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For those services provided using a “clubhouse” model as defined in OAR, what are the specific administrative requirements allowing for such services to be provided and claimed under Medicaid (H0036)?

[If the code used to receive reimbursement for a service provides is based on 15 minute intervals, does the service have to be a t least 15 minutes in duration?](#)

Are there some meaningful services that can be provided in seven and a half minutes or less? Are there any encounter codes we can use in these situations?

When two distinct qualified health care professionals provide the same service to a member at different times during the day, can the units be rolled onto one claim line?

Can 90801 and 90889 be used for services provided by an LMP?

Can H0036 be used for “Strength Based Case Management?”

Can providers bill consultation for communications to other agencies/providers via fax or email?

What are the rules for billing for services to parents when the child is not present?

May child service providers begin billing for care coordination services prior to seeing the child face-to-face?

When the therapist provides family therapy and the patient is present for only a portion of the time, what code should be used; 90847--family therapy with patient present, 90846--family therapy without patient present or both? Both of these codes are per session codes.

If a QMHA answers the help-line, can this be encountered or billed fee-for-service? If so, under what code and what information is required to be gathered?

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Can a crisis services be provided telephonically?

When consumers request phone counseling in situations where they cannot make it to the office, can this be sufficiently documented to permit billing fee-for-service?

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MISCELLANEOUS

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Will peer-delivered “Warm Line” services be a billable mental health service?

If an agency or MHO identifies a pattern or problems in charting and develops an action plan to address them, can a component of the plan allow the agency or MHO to go back and correct the clinical records?

If the supervisor (QMHP) signs off on services provided by the QMHA, can the QMHA perform more than the permissible codes?

Are the credentials of the clinician necessary to have on each signed document?

CPMS Termination Code 70 = “recovery” allows providing many short-term services after the closing of the CPMS. Providers use the CIA program code (child inactive) to capture these. There is no treatment plan to substantiate the need for these services as required by Medicaid. Please provide clarification on how to reconcile the CPMS policy statements and Medicaid rules.

If a case manager and psychiatrist provide services at the same time to the same client, how are the services documented appropriately for payment for each provider?

How do you report treatment of below-the-line diagnoses if the treatment is justified as preventative treatment interventions?

What rule should apply to have a simple but sufficient file when a person moves from open card to managed care and back to open card?

Under what circumstances can a variance be requested? Can they be individual and/or regional, or organizational?

How can providers advocate for changes to rules that don't seem consistent with evidence based practices or that present unnecessary challenges to mental health services?

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Can V codes (for example V62.82 bereavement) be encountered once the treatment phase has been initiated?

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1. Can a QMHA perform/complete a mental health assessment if signed off by a QMHP or higher?
 - a. No, an assessment is not within the scope of practice for a QMHA. A QMHA can participate in the assessment process such as collecting history and other pertinent information. The formulation of a diagnosis is outside the scope of a QMHA and therefore requires face-to-face time with the QMHP.

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2. Can a mental health agency submit claims for the services provided by an intern?
 - a. Oregon's Medicaid State Plan defines a Qualified Mental Health Provider and Qualified Mental Health Associate, as well as state that all services will be provided by QMHPs or QMHAs; therefore, criteria of QMHPs may not be waived for services provided as a fee-for-service transaction. MHOs have the responsibility and flexibility to assure the managed care services are provided by appropriate practitioners. Please consult your MHO for details. For clients not enrolled in managed care, the practitioner must meet the requirements laid out in the definitions of QMHP or QMHA. An intern status does not qualify or disqualify somebody as an appropriate practitioner.

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3. Can the intern perform a QMHP-level service but not bill or encounter?
 - a. The agency has the responsible to act in the best interest of the client. Additionally, the client should be given the opportunity to provide informed consent. If the agency is satisfied that the intern has reached a level of development and is supported with appropriate supervision, services provided by an intern may be appropriate. As stated in question 4, MHOs have some authority and encountering the service might be appropriate. Please contact your local MHO for details.

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4. What is the current role and responsibility of the Provider Audit Unit in auditing a mental health organization?
 - a. The Provider Audit Unit (PAU) currently engages in audits of fee for service providers, and not managed care/mental health organizations. PAU does provide consultation with the DHS units responsible for the oversight and monitoring of the managed care/mental health organizations.
 - b. PAU may perform an audit of a mental health provider who is both a fee for service provider and a panel member of a mental health organization. Although not required by regulation or contractual clause, PAU may, as necessary inform the mental health organization of the audit findings of a panel member under a fee for service audit.

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5. Will peer-delivered “Warm Line” services be a billable mental health service?
 - a. MHOs have the authority to reimburse for these types of services. Contact your MHO for more information. For clients not enrolled in managed care, services provided by peers not meeting the definition of a QMHA are not reimbursable.

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6. What is the rule outlining the need for a progress note to document a mental health and comprehensive mental health assessment was completed?
 - a. There is not a rule that requires a progress note be written to support the reimbursement for an assessment. What is required in 410-120-1360 is that the clinical record be annotated. Inclusion of the assessment in the clinical record would meet this requirement. AMH recommends a note be included in the chart that directs a reviewer to the assessment and to maintain complete documentation. This note does not need to meet the definition of a progress note and is only a recommendation.

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7. How is supervision provided by a QMHP to be documented—in each chart or other method(s)?
 - a. The supervision is of the practitioner, not the client, so it is not necessary for it to be documented in each client chart.
 - b. OAR 309-016-0077 requires that supervision be documented and each agency may employ specific methods/processes to demonstrate compliance.

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8. What does the LMP supervision of “all cases” mean, and how is this to be documented?
 - a. The supervision is of the practitioner, not the client, so it is not necessary for it to be documented in each client chart.
 - b. OAR 309-016-0075 requires that supervision be documented and each agency may employ specific methods/processes to demonstrate compliance.

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9. If an agency or MHO identifies a pattern or problems in charting and develops an action plan to address them, can a component of the plan allow the agency or MHO to go back and correct the clinical records?
 - a. No, clinical or medical records are legal documents and the altering of existing documentation outside of the requirements established in OAR 309-032-0565(2)(d) may be considered fraud and referred to the Medicaid Fraud and Control Unit of Oregon’s Department of Justice if discovered.

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10. For those services provided using a “clubhouse” model as defined in OAR, what are the specific administrative requirements allowing for such services to be provided and claimed under Medicaid (H0036)?
- a. H0036 does not limit the service to a particular model. The service delivered must be a “structured developmental or rehabilitative program designed to improve or remediate a person's basic functioning in daily living and community living. Programs shall include a mixture of individual, group, and activity therapy components and shall include therapeutic treatment oriented toward development of a person's emotional and physical capability in areas of daily living, community integration, and interpersonal functioning. The documentation requirements are not different from all other Medicaid rehabilitative mental health services.

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11. Can a QMHA perform a crisis assessment which is signed off by a QMHP and be billed for?
- a. There is no such code as a crisis assessment. An assessment done at the time of a crisis is no different than an assessment at any other time and requires some QMHP time to complete and determine the medical necessity of any interventions provided. If the client is receiving services at a time of crisis the QMHA can provide some services within the scope of their practice.

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12. What information provided in an assessment must be restated in a treatment plan?
 - a. No information needs to be restated. The requirement is that the information is contained in the clinical record. The treatment plan is the planned interventions aimed at treating the medical conditions identified in the assessment. The more clear this thread is throughout the record, the more easy the process is discovered by chart reviewers.

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13. Are there some meaningful services that can be provided in seven and a half minutes or less? Are there any encounter codes we can use in these situations?
 - a. There may be clinically significant interactions that occur in less than seven and one-half minutes. Services provided on a per occurrence basis do not have time limitations. Services with a 15-minute limitation require at least seven and one-half minutes of intervention provided by the same practitioner during the day in order to be reimbursed.

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14. When mental health services are provided to a client on an “ad-hoc” basis, and the resulting treatment is not specifically referenced on the treatment plan:
- a. How can a progress note be written to meet the requirement to reference a treatment goal?
 - i. AMH does not prescribe a format for this information to be contained in the clinical record. Only that the clinical record contain an explanation of how the service relates to the treatment plan.
 - b. Does the treatment plan get updated on each intervention and date of service to include the “ad-hoc” new service?
 - i. No. Once the “ad hoc” service is planned to continue, the treatment plan should be updated.
 - c. If the client does not want to revise his/her treatment plan, yet the intervention is medically necessary, how is the provider to document the service provided for treatment plan purposes?
 - i. Continue documenting as in part a. and in addition, document the steps taken to update the treatment plan.

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15. When documenting the length of a service, is the provider to document the start time and number of minutes, or is documenting the code (as a specifically timed code) sufficient?
- a. All services are to be documented in the actual time/number of minutes it took for the therapeutic intervention. The code the service is going to be billed as is not sufficient to meet the requirement of time spent delivering the intervention. The provider may choose to include start and end time of the intervention (10-10:13 am), the actual number of minutes (13 mins) or another methodology sufficient in documenting the actual time spent delivering the intervention.

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16. How are crisis services to be documented?
- i. Crisis services do not require documentation different than other Medicaid reimbursable services.
 - b. If the client does not have a valid assessment?
 - i. The record must document the medical necessity (including diagnosis) of the services to be provided.
 - c. The client has a valid assessment but the treatment for the crisis is not a listed need?
 - i. See #14
 - d. The treatment plan does not have the service provided in the crisis as a listed service?
 - i. See #14

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17. What services are allowed telephonically?
- a. <http://www.oregon.gov/DHS/mentalhealth/publications/main.shtml#codebooks>. Any codes with a subset T such as "T1023_T" are eligible to be reimbursed when provided telephonically and meeting all requirements.

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18. If the supervisor (QMHP) signs off on services provided by the QMHA, can the QMHA perform more than the permissible codes?
- a. No, the QMHA may only provide those interventions that are within the scope of their training.

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19. Are the credentials of the clinician necessary to have on each signed document?
 - a. The assessment, treatment plan, and progress notes do not require the practitioner's credentials to be included in the documentation. However, in determining whether a practitioner acted within the scope of their practice, it will be important to have a list of all practitioners and their credentials if the clinical record does not contain the information.

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20. CPMS Termination Code 70 = "recovery" allows providing many short-term services after the closing of the CPMS. Providers use the CIA program code (child inactive) to capture these. There is no treatment plan to substantiate the need for these services as required by Medicaid. Please provide clarification on how to reconcile the CPMS policy statements and Medicaid rules.
 - a. The policy and rules are not in conflict. If a provider is required to meet both requirements, then both are to be met. CPMS allows the reporting of services to continue and if Medicaid is used to reimburse a provider for the services, a current treatment plan must be included in the clinical record prescribing those services.

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21. What is the acceptable practice for documenting medical necessity?
- a. The most common method of documenting medical necessity for Medicaid reimbursable services is an assessment that concludes with an above the line diagnosis and upon which is formed a treatment plan with planned services which pair to the diagnosis on the Prioritized List to alleviate the symptoms of the illness.

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22. What are the signature requirements for mental health assessments, comprehensive mental health assessments, treatment plans, treatment plan updates, and progress notes?
- a. The mental health assessment requires the signature of the QMHP completing the assessment.
 - b. The comprehensive mental health assessment requires the signature of an LMP and the practitioner completing the assessment if different than the LMP.
 - c. The treatment plan requires the signature of a physician or other licensed practitioner and the person completing the treatment if different. Oregon currently recognizes psychologists licensed by the State Board of Psychologist Examiners, nurse practitioners registered by the State Board of Nursing, or clinical social workers licensed by the State Board of Clinical Social Workers as practitioners meeting the definition of other licensed practitioners (ORS 430.010(4)(a)).
 - d. Treatment plan updates for clients in treatment more than one continuous year require the signature of an LMP. For updated completed within the first continuous year of treatment, the requirements are for signature by physician or other licensed practitioner.
 - e. Progress notes require the signature of the practitioner providing the intervention.

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23. If a case manager and psychiatrist provide services at the same time to the same client, how are the services documented appropriately for payment for each provider?
- a. Many times, two practitioners of the same agency can not be reimbursed for concurrent services. If the provider believes that the services are independently reimbursable, documentation must reflect the unique service/intervention provided and the time it took to deliver the unique service.

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24. Can 90801 (psychiatric diagnostic interview) and 90889 (Preparation of report of patient's psychiatric status, history, treatment or progress for other physicians, agencies or insurance carriers) be used for services provided by an LMP?
- a. An LMP can appropriately provide services that may be billed as a 90801. 90889 is not a code that is currently paired on the HSC prioritized list, included in the Oregon Health Plan, or reimbursed through non-OHP Medicaid mental health rehabilitative services.

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25. Can H0036 (community psychiatric supportive treatment) be used for "Strength Based Case Management?"
- a. "Strength Based Case Management" is not a term defined by AMH. If the service is provided as a structured program designed to improve a person's basic functioning in daily and community living then it may meet the definition of a service reported as H0036.

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26. Is a client's signature on a treatment plan required?
- a. No. The level of client involvement desired by the client should be noted in the clinical record. Often times, this involvement is documented by a signature on the treatment plan.
 - b. How do you document parental participation?
 - i. The most common method is by signature on the treatment plan.

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27. Is a progress note required when an assessment or treatment plan is the service provided?
- a. Yes. A progress note must exist in the clinical record to support all Medicaid reimbursed services (OAR 410-120-1360(1)(b)).

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28. How do you report treatment of below-the-line diagnoses if the treatment is justified as preventative treatment interventions?
- a. Clients served through managed care receive Prevention, Education and Outreach (PE&O) services and you should speak with your MHO to find out more. Provided there is not an above the line diagnosis that can justify the treatment, it is not a covered benefit for clients who are not enrolled in managed care.

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29. If a QMHA answers the help-line, can this be encountered or billed fee-for-service? If so, under what code and what information is required to be gathered?
- a. AMH reimburses for services based on the service provided to the client rather than the delivery mechanism, such as the telephone. There are reimbursable codes that a QMHA can deliver telephonically to clients not enrolled in managed care. If the client has not yet been assessed and a treatment plan developed, there are no codes that the QMHA can use to be reimbursed for their time when serving a client not enrolled in managed care.

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30. When consumers request phone counseling in situations where they cannot make it to the office, can this be sufficiently documented to permit billing fee-for-service?
- a. AMH has distributed a memo detailing services that can be reimbursed when provided telephonically. An updated list of these codes is available on our website. On the Rates tables, codes reimbursed when provided telephonically are indicated with a subscript "T" (e.g. T1023_T). When providing telephonic services a provider must meet all documentation requirements and document the reason why the service was provided telephonically. Meeting all other requirements and stating that the service was provided telephonically because the client would not otherwise receive the service.

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31. What are the rules for billing for services to parents when the child is not present?
- a. No different rules apply. Some family therapy codes state "patient not present". Additionally, the service is to be billed under the Medicaid eligible client who receives the benefit of the intervention.

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32. When is it appropriate to use the crisis code? Does the crisis service need to be included in the treatment plan? Can the crisis code be used when the member is not open for treatment and there is not a treatment plan?
- a. Crisis Intervention codes H2011 and S9484 are available through managed care only and rules regarding their use and documentation are defined by the MHO. Please contact them with questions.

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33. Can a crisis services be provided telephonically?
- a. Crisis Intervention codes H2011 and S9484 are available through managed care only and rules regarding their use and documentation are defined by the MHO. Please contact them with questions.

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34. What rule should apply to have a simple but sufficient file when a person moves from open card to managed care and back to open card?
- a. In most cases, the documentation requirements are identical. When differences are noted, one way of ensuring complete compliance is to document to the strictest standard.

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35. May child service providers begin billing for care coordination services prior to seeing the child face-to-face?
- a. All Medicaid reimbursed services provided to Medicaid eligible clients must be supported by an assessment and a treatment plan.

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36. Can a provider use assessments from other providers and not duplicate assessments and begin the delivery of treatment services based on the assessment completed at another facility or agency?
- a. Yes. The current provider must have a copy of the document in the client's record and take full responsibility for the content of the assessment used as the basis for treatment.

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37. Can providers bill consultation for communications to other agencies/providers via fax or email?
- a. Currently, only telephone services and those provided meeting the definition of telehealth are reimbursable. The Health Services Commission has recently added codes designed specifically to bill for services provided through these and other electronic means. DMAP and AMH continue to collaborate on how to incorporate the use of these codes into the Oregon Health Plan.

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38. Is it a requirement that the QMHA notes are co-signed by a QMHP?
- a. No. Progress notes must only be signed by the practitioner providing the service.

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39. Under what circumstances can a variance be requested? Can they be individual and/or regional, or organizational?
- a. Variances may be requested for any circumstance that the provider believes places an undue burden on the organization. AMH has the authority to grant variances when the request is not in conflict with federal guidelines. They may be organizationally or regionally based as long as all affected providers sign the request. AMH is willing to work with providers in developing the request to make the process more efficient.

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40. Can the assessment be billed more than one time if it takes multiple sessions to complete?
- a. No. Assessments billed as 90801 (psychiatric diagnostic interview), 90802 (Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication) and H0031 (mental health assessment by non-physician) are per occurrence codes which means that the code is reimbursable at the completion of the intervention.

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41. How can providers advocate for changes to rules that don't seem consistent with evidence based practices or that present unnecessary challenges to mental health services?
- a. AMH has formed an integrated services and support rule committee to revise the administrative rules under which services are provided. This committee will have a draft available in the fall of 2008 for provider comment. On an ongoing basis, comments about the rules related to Medicaid mental health services should be directed to the Medicaid Policy Unit. [Question 17](#) explains where the services allowable for telephonic delivery are listed.

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42. When a client is not able to make an appointment for medically appropriate medication adjustments, can this be accomplished over the phone and what code would be used?
- a. AMH has made available several medication related service codes when provided telephonically. If the service delivered meets the definition of H0034 Medication Training and Support or H2010 Comprehensive Medication Services these codes will be reimbursed when provided telephonically and all other requirements are met.

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43. When the therapist provides family therapy and the patient is present for only a portion of the time, what code should be used; 90847--family therapy with patient present, 90846--family therapy without patient present or both? Both of these codes are per session codes.
- a. The appropriate billing depends upon the circumstance and documentation. Per session codes are to reimburse for a treatment encounter. If only one treatment encounter occurred during the time spent both with and without the client, then billing both might be considered inappropriate. There is no edit in the system that would deny reimbursing for both on the same day, and it is the provider's responsibility to assure the documentation supports the claims submitted.

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44. Can documentation on the treatment plan include terms such as PRN, as needed, or ad hoc?
- a. The treatment plan is required to prescribe the frequency, scope and duration of services expected to be provided to improve the client's medical condition. Terms such as PRN, as needed and ad hoc do not specify the frequency, scope and duration of services as required.

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45. When two distinct qualified health care professionals provide the same service to a member at different times during the day, can the units be rolled onto one claim line?

Provided that the two health care professionals work for the same billing agency and each of the two interventions are independently billable, the services must be rolled onto one claim line and the number of units adjusted to report both interventions.

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46. If the code used to receive reimbursement for a service provides is based on 15 minute intervals, does the service have to be at least 15 minutes in duration?

- a. No. AMH has released a memorandum on rounding that provides instruction on the appropriate rounding of minutes into units. For a code reimbursed as a 15 minute unit, the service must be 7 and one-half minutes or greater and less than 22 and one-half minutes to receive reimbursement for one unit of service delivery.

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