SACRAMENTO COUNTY

2023

Quality Management Frequently Asked Questions (FAQ)

VERSION 1

QM Frequently Asked Questions (FAQ)

The purpose of this document is to answer some of the frequently asked questions that have been received during the QM Q&A Meeting, UR Committees, Documentation Trainings and from the QMInformation Inbox. QM continues to offer support within the UR Committees, Documentation Trainings and QMInformation Inbox.

For Further Information:

- QM related questions: QMInformation@saccounty.gov
  - Visit the QM Documentation Standards website: Documentation Standards (saccounty.gov)
- EHR related questions: BHS-EHRSupport@saccounty.gov
  - Visit the BHS EHR website: BHS Electronic Health Record (saccounty.gov)
- EHR Billing related questions: BHS-EHRBilling@saccounty.gov
  - Visit the EHR Billing Claiming website: Claiming (saccounty.gov)

Contents:

INQUIRY:

Question:

Are we still able to send Service Requests to Access in SmartCare?

Answer:

Service Requests are called “Inquiry” Screen in SmartCare and can be sent to Access Team.

ASSESSMENT:

Question:

How do you incorporate the MSE and CHQ in the CalAIM Assessment? I am under the impression that the MSE and CHQ are no longer part of the clinical bundle, but are to be incorporated into the CalAIM assessment?

Answer:

Within the CalAIM Assessment, Domain 1 includes the mental status exam. Domain 4 includes health information that was within the Health Questionnaire**.**

Question:

For an LPHA, when they review bundles they would enter a note stating their review of assessments to confirm medical necessity and that LPHA will continue to provide oversight. In Avatar it would be billed under assessment, what would this be billed for Smart Care since it is not face-to-face?

Answer:

Please note that the CalAIM Assessment must be completed by the LPHA/LPHA Waived staff. OQP are able to contribute to the assessment within their scope of practice. Masters and Doctoral Level Students will have access to the CalAIM Assessment and diagnosis screens. The assessment must be co-signed by an LPHA. If the LPHA was supporting in completing the Masters and Doctoral Level student’s assessment in regards to reviewing, providing input and oversight, then they may use the Assessment LPHA procedure code.

Question:

For assessments by a psychologist in the MH program: should we be using multiple codes for the documentation to capture the FTF assessment, hospital record review time, assessment report writing time, etc? How do we capture all these different components when they are not listed in the progress note template now?

Answer:

Psychologists can utilize “Assessment LPHA” when gathering assessment details and evaluation which could include the review of collateral reports. Review of Hospital Records can be utilized when conducting a review of hospital records, other mental health records, psychometric and/or projective tests, and other accumulated data for diagnostic and service planning purposes. Document accordingly based on the procedure code selected.

Question:

Is there a chance that a "Start Date" will be added into SmartCare for the intake/first face to face/billable service?

Answer:

All Programs will have an “Enrollment Date.” The intake would typically be the first face to face service post enrollment date and this would be reflected within the services billed.

Question:
Isn't Enrollment Date the old Admit Date rather than the Initial Face-to-face (old Start Date/Intake)? Cell B4 in Non-Bill, ECM and Local Codes says Enrollment Date is the initial; face-to-face intake appointment...

Answer:
Enrollment is when the Provider actually enrolls/adds the referred individual into their program, which may or may not be the first face to face intake session. The intake may take place on the day of enrollment or afterwards.
See the Cal MHSA Website: https://2023.calmhsa.org/how-to-add-the-client-to-your-program/

Question:
Is the CSI Standalone assessment required for new Wellness Center admissions?

Answer:
For CORE Wellness Center admission: The CSI Standalone Assessment is only required when a client is being referred for ongoing treatment. If the client is only attending Wellness Centers and not attending any treatment program; then this screen would not be required.

CARE PLAN:
Question:
What would be the guidance for ending plans like housing plans? They will eventually not be active anymore - should they be deleted from the care plan section with an accompany note to document no longer needing it?

Answer:
Please document in the service note that you are updating or end dating the plan that is documented within the Care Plan field. As an example, if you are ending a housing plan, then you would document the ending of the housing plan within the service note and you may remove that specific housing plan from the Care Plan field.

DIAGNOSIS/PROBLEM LIST:
Question:
How would entering multiple diagnoses look like? Edit the original dx or add a new form?

Answer:
See
“How to Enter a Diagnosis” at https://2023.calmhsa.org/how-to-add-a-diagnosis/
“How to Modify and/or Re-Order a Diagnosis” on the CalMHSA Website at https://2023.calmhsa.org/how-to-modify-and-or-re-order-a-diagnosis/

Question:
Should we include medical diagnoses on the Problem Lists, or are they meant to just include items that our program is treating?

Answer:
Yes, it is recommended that diagnosis should be entered on the Client Clinical Problems (problem list) because it is part of their "problems" that would be addressed in services. If medical diagnosis are reported to staff and staff plan to provide support in regards to that (i.e., linking to PCP, coordinating care with medical providers, etc.), then yes the medical diagnosis would be included in the Problem List.

Question:
When entering an ICD10, it gives a long list of options to pick from. How will we know which is the correct option? I tried using the SNOMED as a guide to select the correct one; however the SNOMED seems to only be attached to one ICD10 in SmartCare, where the County Crosswalk shows the same SNOMED are used for multiple diagnosis. Example F43.9 (SNOMED 47505003 - Unspecified trauma and stressor related disorder); when that SNOMED is entered into SmartCare only the description of PTSD comes up.

Answer:
Please utilize the DSM5/ICD 10 with SNOMED cross walk handout provided with documentation training to ensure that you select the most relevant information in SmartCare.

DISCHARGE:
Question:
For discharge reasons, there used to be an option of "client declined services" - that option does not exist anymore. What discharge reason do we use for when a client opts to terminate services prior to completion of treatment goals?

Answer: Please refer to the handout: *SmartCare Discharge Options (Effective 7/1/2023):* Please see the link: dischargeoptions.pdf (saccounty.gov). You can also obtain copies of handouts by attending a QM Documentation training or emailing QMInformation@saccounty.gov. One option to consider may be, "Discharged from service/Noncompliant with treatment."

Question:
Do we need a discharge summary when discharging a client from TBS, or a do we only need a simple discharge progress note, plus completing the discharge screen in SmartCare? No "discharge summary" scanning anymore?

Answer:
Yes, you would continue to complete the discharge documentation via a Service Note to capture details that used to be in the D/C Summary. There are some additional screens that should be considered when discharging a person from services.
This is outlined in the Mental Health Provider Checklist:
- Client Information (Client) to add any external referrals and make any updates
- CSI Standalone Collection (Legal Class/Status at discharge)
- CSI Standalone Assessment (if applicable to add the Closure Reason)
- Review Client Clinical Problem Details (Client) for Accuracy
- Diagnosis Document (Client)
- Special Populations LP (Client), if applicable.
- Client Programs (Client) to change status to Discharged.
- Treatment Team (Client) to end date as a treatment team member.

Question:
Can you describe the difference between the administrative discharge and the never engaged in services options for discharge?

Answer:
D/C Reason #1: Administrative Discharge: Provider makes the decision to terminate services due to lack of participation post enrollment. (Formerly: Reason Not Available).
**Please note that this would be used post enrollment.*
D/C Reason #9: Never engaged in services: Client was referred and opened to provider as a result of an inquiry/services requested but client never engaged in (showed up/enrolled in) services of any kind. (Formerly: Reason Not Available).
**Please note that this would be used prior to enrollment.*

EHR RELATED DOCUMENTATION:
Question:
A brief review of the referral process would be appreciated to clarify the small details.

Answer:
See "How to Make a Referral" at https://2023.calmhsa.org/how-to-make-a-referral/. For further training on this process please register for the "Provider Administrative Staff SmartCare Training" with the EHR Support Team held every other Tuesday at 9 am.

Question:
Are episodes still being tracked? We enter this info into our own EHR. Will Sac County be tracking?

Answer:
SmartCare does not have episodes. SmartCare does have Programs that clients are referred and enrolled to. On the Mental Health side, the Clinical Data Access Group (CDAGs) are open so information is shared; while on the Substance Use Prevention and Treatment side, the CDAGs are closed and information is contained only within each Program.

Question:
Since the codes are not showing in SmartCare, could the column for "Dependent on Codes" column include have the Procedure Name please?

Answer:
That request can be shared with QM leadership and BHS-EHR leadership for consideration for future versions.

Question:
Is there way to generate NOABD? Or do we manually create?

Answer:
The NOABD's are not electronically available in SmartCare yet. Please continue to complete NOABDs and scan them in the record. Here is the P&P: https://dhs.saccounty.gov/BHS/Documents/BHS-Policies-and-Procedures/PP-BHS-QM-02-01-Notice-of-Adverse-Benefit-Determination.pdf

Providers must keep track of the number and type issued and report this to Rolanda Adams; Email: AdamsRo@saccounty.gov, by September 1st of each year for the prior fiscal year. Previously, for Avatar users this information was gathered by BHS and non-Avatar users had to keep track. With the change to Smartcare, all providers need to have a mechanism to track the type and number issued.

Question:
We cannot find the ICC Screener in SmartCare. Is it in there, if so, where? If not, what is the procedure for completing this?

Answer:
There is not an ICC/IHBS Screening Screen in SmartCare. In Documentation Training, we are recommending that providers document the outcome of the ICC/IHBS Screening within the Service Note. In addition, Providers would complete a paper copy of the ICC/IHBS screening tool that will be scanned into their electronic health record. UR Committee worked on creating a draft ICC/IHBS Screening that may be utilized during the time that there is not an official screen in SmartCare.

Question:
If clients fall into more than one special population, which one do we select or can we select more than one?

Answer:
You should be able to select more than one. If you are having difficulties with the functionality of the form, please contact the BHS-EHR Team for assistance.

Question:
Where should we scan mandated reports and sensitive documents to? Also, what about hospital records?

Answer:
Please do not scan in mandated reporting documents into the EHR. This needs to be maintained in an administrative confidential record outside of the EHR. QM and the UR Committee are working on updates to the Scanned Document Form and will be scanned using uniform naming conventions.

PROCEDURE CODES:
Question:
Are all MHSA codes now available for all programs or are they still program specific?
Answer:
The use of Support Service Codes/MHSA codes has not changed. If your program (contract) was allowed to use these codes prior to 7/1/23, then you can continue to use MHSA codes. Please verify the use codes assigned to your Program with your Contract Monitor.

Question:
I've reviewed the Procedure Code Manual and am struggling to see any significant differences between the non-diagnosing mental health evaluation codes H0031 and H2000. Is there a way that the county is thinking about these two codes differently?
Answer:
For both Assessment Contribution non-LPHA (H0031) & Comprehensive Multidisciplinary Evaluation (H2000) please see the Procedure Code Description. While these are both assessment type codes, the Comprehensive

Multidisciplinary Evaluation procedure code would be utilized when multiple disciplines are working together to complete or provide input within an evaluation/assessment.

Question:
If we can no longer bill collateral, what are our option codes similar to collateral?

Answer:
Yes, 95010 Collateral is no longer a specific Service Code/Procedure Code. See Procedure Code Manual V.2, Documentation Guideline tab, under line 13: Collateral Type Codes.

Question:
When the updated version of the Procedure Manual comes out, will there be a specific list of what changes please?

Answer:
Updated Procedure Manual's will include a "Version Summary" tab that will include a list of all updates. All Procedure Manual's will be updated and shared with BHS.

Question:
Any updates about student interns and billing for assessments and therapy?

Answer:
Master Level Student's are able to enter the information into the CalAIM Assessment like they were able to do in Avatar along with the co-signature and oversight, input and consultation from the LPHA. This update includes not having to be limited to putting the assessment information in the service note only. The Master Level Student may gather all areas of the assessment, again with that oversight, input, consultation and co-signatures from the LPHA. This update to the documentation of assessment information was revised within version 2 of the SMHS Procedure Code Manual. See the tab "Version Summary", column E, line 5 for specific details. Master Level Students also need the LPHA co-signatures on the Diagnosis Screen. As of version 4 of the SMHS Procedure Code Manual, the following procedure codes are available for the Master level Student Classification: Assessment LPHA, Individual Therapy, Group Therapy, Family Therapy-Client Present. These claims will not go out to DHCS until we receive formal guidance from the state.

Question:
MHUCC: Can non-certified peers use Sac_Crisis Support and Sac Family support?

Answer:
No this would not apply to MHUCC. For other MHP Programs, check if your program design allows for these codes. Yes non-certified peers can use codes that are identified as "Non-certified Peer/Outreach Codes" that have the "SAC_" prefix before the name. Please refer to the section for "Non-Certified Peers" on the Version 2 of the SMHS Procedure Code Manual within the tab labeled, "Non-Bill, ECM and Local Codes."

Question:
What is the distinction between TCM/ICC and Team Case Conference with Client/Family Absent procedure codes, they seem very similar.

Answer:

Please refer to the SMHS Procedure Manual, specifically the column labeled “Procedure Code Description.” There are a couple of procedure codes that do speak to a “Multi” or “inter” disciplinary team being part of those consultations. This would mean staff of more than one discipline for that service to be used.

- The “Comprehensive Multidisciplinary Evaluation” procedure, does speak to a “multidisciplinary” team needing to participate in that consultation.
- Team Case Conference with Client/Family Present, does speak to an “Interdisciplinary” team meeting participating in that planning.
- Team Case Conference with Client/Family Absent, does speak to an “Interdisciplinary” team meeting participating in that planning.

BHS does not have additional general rules regarding billing for consultation as long as the note contains that clinical justification for the consultation. Sometimes clinicians may have specific expertise or knowledge that may justify a need for consultation. Yes a case holder can consult with more than one clinician at the same time if clinically necessary with that justification documented. In both scenarios that would be documented as part of that intervention to support the beneficiary.

The thing to be mindful of is to not bill for administrative internal meetings where there is not specific direct benefit to the beneficiary.

Question:
What code do you use for a CFT?

Answer:
TCM/ICC can be utilized for CFT. Please remember to complete the Special Populations LP (Client) Screen prior to use of that code capturing the CFT. In addition, scan the relevant CFT Meeting Minutes and CFT Sign in Sheet in the scanned document sections in order to cross reference that according to the “TCM/ICC” billings.

Question:
When can the procedural codes be sent out for agencies with their own EHR system?

Answer:
The SMHS Procedure Manual and DMC-ODS Procedure Manual was sent out to MH and SUPT leadership on 6-28-23. There was an updated version, version 2 SMHS Procedure Manual and DMC-ODS Procedure Manual dated 7-18-23 sent out the MHP and SUPT leadership. The updated versions will continue to be sent out to leadership at all provider sites.

CRISIS:
Question:
In the procedure code, “Psychotherapy for Crisis”, there's a question about "emergency indicator (yes/no)." what constitutes emergency? Maybe crisis situation?

Answer:
There is logic set up in the EHR system based on the aid code. Based on aid code, certain services will only be covered if there is an emergency or pregnancy related status. This would not apply for OP providers and would only be used for EDs. Therefore, OP Providers may select “No” should that indicator pop on their service note.

NON-BILLABLES/LOCKOUTS:

Question:
Are there still lock out periods? If so, how do we enter a service during this lock out period?

Answer:
Currently, CalMHSA is working on reviewing possible Lock Out Service Codes/Procedure Codes and those are not available at this time. There is a procedure code, “Client Non-Billable Srvc Must Document” that will allow you to document the non-billable activity within the narrative of the Service Note. TCM/ICC can be utilized for discharge planning from an inpatient psychiatric facility.

Question:
Will engagement attempts and lockout codes now go under non-billable srvc must document?

Answer:
Yes, unless you are able to use the SAC_Engagement code (formerly ENG01) for engagement prior to first face-to-face/intake. The procedure code during a lock out scenario is “Non-Billable Srvs Must Document”.

Question:
Post Hospital Jail assessment referrals, For non-billable services and engagement attempts for these clients, should we be using Status ' Scheduled' and Procedure 'Client Non Billable Srvc Must Document ' in the Progress Note in SmartCare. It seems Face to Face time needs to be entered in order to complete even non billable notes?

Answer:
Yes, this is correct. You would still enter the service time in the “Face to Face" field, however, it is understood that it is actually “face-to-face" by what you select for “Mode of Delivery.” Also, the time entered in the “Face to Face” field will not bill out since that is a Non-Billable code.

Question:
For the Service Note "Status", if select “no show”, which may just indicate no face to face, then we can't complete the note. How would you like us to manage this?

Answer:
Due to the functionality of the service note in SmartCare when you select, “No Show” as the status, the Note tab (where you would document your narrative) does not populate. If you are simply tracking “No Shows”, then you would not need to do anything further. However, if in addition to tracking the “No Show” you also want to add a narrative, then you would document add that narrative in the “Comments” field that is right below the “Interpreter Service” field.

Question:
While in jail only code is still non-billable correct?

Answer:
Yes, Medi-Cal is on lock out when your client is incarcerated. Please continue to document any services provided using the “Client Non-Billable Srvc Must Document” service note.

Question:
We spend a lot of time with court partnerships in MDT and court hearings. Hoping even though client is in jail (Medi_-Cal) locked out, that we could find SAC code to capture our time and document our efforts outside Non-Billable.

Answer:
We can only use MHSA services for people who are incarcerated when we are working on discharge planning/facilitating discharge. SAC_Engagement may be used to initially engage someone into the program in order to support with that transition of discharging and supporting them with getting connected to services. For MDT meetings while the client is on lock out can be documented via "Client Non-Billable Srvc Must Document" in which coordination can be documented within the service Note narrative section.

PROGRESS NOTES:
Question:
Can you go over Co-Facilitator Group and how to document? Are 2 staff allowed to sign and co-sign 1 group note per client present? Or do they need their individual/separate note?
Answer:
At this time the Group Note is not functioning properly in SmartCare. The BHS-EHR team has recommended that for now, groups are billed for by completing a "Service Note" for each individual in the group instead of the "Group Note" and selecting the appropriate group procedure code. For now, this would be similar to how this was billed for in Avatar. When the group note functionality becomes active, then 2 staff will be able to create one note which would be reviewed and co-signed by each staff/group facilitator. That would not be required but will be a new option should staff choose to co-bill groups.

TBS:
Question:
For the Client Plan with TBS, do we still need to scan in the original care plans from the primary clinician? Or due to us being able to view all care plans this will no longer be necessary?

Answer:
Please note there are no longer separate Client Plans in the County EHR. In SmartCare, you will be able to view the Care Plan within the Service Note from the primary mental health provider (PMHP) if the PMHP is using SmartCare as their E.H.R. For PMHP whom use their own E.H.R, you will have to request a copy of the Care Plan.

Question:
For TBS do they still need to document an intake and discharge diagnosis, where and how would you like this documented?

Answer:
Yes, TBS needs to complete an intake diagnosis and it is still best practice to complete a discharge diagnosis. Diagnosis Document (Client) is the screen that captures that information. Please note that there is no longer a Diagnosis "Type" such as "Admission" or "Discharge" but rather the diagnosis would just be updated when appropriate.

Question:
Do we still need to complete the TBS client plan with the former document/Template, get signatures from Cg, Clt, Primary and LPHA, and then scan it into smart care? Or do we only complete the plan and add it to the Care Plan section of the progress note? Or do we do both? If It is only the second option, how do we print it and get signatures?

Answer:
TBS providers & BHS leadership have agreed to have TBS Client Plan moved into the Care Plan w/in the Service Note. There will not need to be a need for signatures for the Care Plan in the service note.

STAFF REGISTRATION:
Question:
Are Peer Staff and Peer Specialist different classifications? We had a staff who was originally classified as Peer Staff (in QM's language) who was showing up as OQP in SmartCare, until we received another email to say she was now classified as Peer Specialist.
Peer staff and Peer specialists have different access to codes?

Answer:
Certified Peers are now identified as Peers and would only use the codes listed under that tab. Uncertified Peers are now Other Qualified Providers (OQP) and would use the codes listed under OQP and/or the "SAC_" Non Certified Peer/Outreach Program Codes.

SUPT:
Question (SUPT specific):

What procedure do we use for case management? Is it ok to use Individual counseling?

Answer:
The ADS Counselor can use the TCM/ICC for Care Coordination, which used to be called Case Management. For LPHA's there are several Care Coordination services you have access to, so please take a look at procedure manual in the LPHA tab. For Individual counseling both ADS Counselor and LPHA have access to this procedure.

Question (SUPT specific):
What are the differences between TCM/ICC, Care Coordination outside System of Care, and Team Case Coordination with Client/Family Present/Absent?

Answer:
Team Case Coordination with Client/Family Present/Absent? This code is for LPHA's to be used by non-physicians when participating in an interdisciplinary team meeting when meeting without the client and/or family member or caregiver present. The goal of the meeting should be to identify the focus of treatment and discuss potential interventions to address needs and encourage strengths.

Question (SUPT specific):
As a Case Manager and when consulting with a patient's Primary AOD Counselor about a patient and their treatment regarding case management, can I bill for care coordination without the patient being involved in the conversation?

Answer:

Yes, ADS counselors can bill with or without the patient involved. For LPHA's refer to the list of Care Coordination services available that delineate if the client is present or not.

Question (SUPT specific):
Could we go through an example of writing a progress note from start to finish to show the required information?
A couple of specific questions along with that: how do we want people to document that a session is held in another language?
And is it a problem if we have two services starting at the same time (for example, if a clinician holds a session with two siblings who are both clients) and both start at 9:00 AM?

Answer:
In terms of the functionality of writing a progress note within SmartCare we will defer to the EHR to demo. In order to document the language within SmartCare within the Service note there is an Interpreter Service section where you can mark yes or no for Interpreter service scheduled, select the language, and interpreter agency scheduled, and a section for any additional comments. The system provides a warning when services appear duplicative due to the time entered. Staff can bypass this if the entry is correct. Ensure that the procedure description matches the procedure code selected.

Question:
For SUPT Programs, the LPHA credential has a "Report Generation for Care Coordination" code 90889, but the mental health side does not. Can this code be used on the mental health side? If not available on MH side, could the Review of Hospital Records-90885 code on MH side be used to help do report generation for Care Coordination? Trying to find out if we can now bill in MH side for writing a treatment summary for CPS, probation, family, transitioning treatment provider, documenting referrals for FSP or other provider services.

Answer:
The "Report Generation for Care Coordination" procedure is not available on the MH side. Please note that providers should not be billing for administrative only services such as writing letters or filing out referral/inquiries.