Los Angeles County Department of Mental Health
Quality Assurance Unit

MAT Frequently Asked QA Related Questions

Prior to Opening Cases

1. **If a MAT Assessor has not yet opened an episode and gets invited to attend a Staff Engagement, how would they capture that time?**
   A: Without an open episode, any services provided would not be claimable to DMH. MAT providers should always review the situation to determine if it would be appropriate to open an episode and begin the assessment process.

Assessment Process

2. **If a MAT assessor has not met with the child or caregiver face to face yet but needs to participate in the Staff Engagement Meeting, can they use that meeting to gather assessment information from DCFS? (New as of 6/30/21)**
   A: As long as the legal representative for the child has already been informed of the assessment and has agreed to start the assessment process, the MAT assessor may begin gathering information from DCFS and claim for those assessment services. The first assessment contact does not need to be face to face with the child, but the legal representative should be informed about the nature and purpose of the assessment, and agree to those services (Refer to LACDMH Policy 312.02 Opening and Closing of Service Episodes).

3. **If I haven't talked to the legal representative yet about the assessment process, can the first assessment contact be for record review? (New as of 6/30/21)**
   A: While the first assessment contact does not need to be face to face with the child, the legal representative must be informed about the assessment process and agree to it. If no contact was made yet with the legal representative, the assessment process cannot begin.

4. **Can you provide some examples of how to better bill Medi-Cal in the 4 steps of the MAT/CFT process?**
   A: When claiming to Medi-Cal, MAT providers should be claiming for the Specialty Mental Health Service provided. During the MAT/CFT process, staff should consider what SMHS is being provided throughout all 4 steps. Since MAT providers mostly provide assessment services, it is likely that service provided throughout the MAT/CFT process is for the purpose of assessment. Once medical necessity has been established, other services provided throughout the MAT/CFT process are likely Intensive Care Coordination (ICC).

   1. ***Case Exploration/Case Review*** *– If you are gathering information from a person (either the child or a significant support) for the purpose of assessment, then claim 90791. If gathering information from record review, then claim 90885.*
   2. ***Engagement*** *– If you are gathering information from a person (either the child or a significant support) for the purpose of assessment, then claim 90791.*
   3. ***CFT Meeting*** *– If you are gathering information from a person (either the child or a significant support) for the purpose of assessment, then claim 90791. If the assessment has been completed, and you are working on planning and coordinating services as part of ICC, then claim T1017HK.*

4. ***Debrief Meeting*** *– If you are gathering information from a person (either the child or a significant support) for the purpose of assessment, then claim 90791. If the assessment has been completed, and you are working on planning and coordinating services as part of ICC, then claim T1017HK.*

5. **Is it required to do a CANS 0-5 on a 0-5 child? Can a CANS-IP be completed instead on a child 0-5? Is there additional training required to complete the 0-5 CANS?**
   A: No. Using the CANS 0-5 form specifically is not required, however the questions on this form may be more applicable to the 0-5 age group. There is no additional training for using the CANS 0-5. For more information, refer to Clinical Forms Bulletin 21-01.

6. **If DCFS provides a CANS with the MAT referral, does the assessor need to complete a new CANS?**
   A: Yes, providers will need to complete a new CANS, using the DCFS CANS as a baseline. For more information, please refer to the CANS and PSC-35 FAQs.

7. **Does the MAT assessor need to include the Initial CANS when linking to a provider for treatment?**
   A: Yes. If the MAT assessor completed the Initial CANS for a client who will be transferred to another provider for ongoing treatment, the Initial CANS can be shared with that provider. The receiving provider will be required to complete the Reassessment CANS upon the six month mark. For more information, please refer to the CANS and PSC-35 FAQs.

8. **If the client does not meet medical necessity and will not be referred for ongoing services, would MAT practitioners need to complete the CANS? (New as of 6/30/21)**
   A: No, a CANS is not required to be completed if the client does not meet medical necessity. However, the CANS can be a useful tool that can be done during the assessment process in determining medical necessity. If the CANS is completed after the determination of no medical necessity, it cannot be claimed to Medi-Cal, but it may be useful in determining any non-Specialty Mental Health Services such as MHSA PEI Stepped Care. For more information, refer to the CANS and PSC-35 FAQs.

9. **Is a Client Treatment Plan (CTP) required to for the MAT Assessment?**
   A: No. A CTP is only required prior to initiating treatment services with a client. Treatment services are services that address a client's mental health needs (e.g. therapy to address depression) and are not for the purpose of assessment, plan development, crisis intervention, or emergent linkage. A CTP is not needed for MAT since only assessment and linkage services are being provided to a client. MAT providers should clearly document the plan to provide linkage to ongoing mental health treatment within the progress note(s).

10. **How do providers claim when multiple assessors need to collaborate with each other when working with large sibling sets?**
    A: If the purpose of the assessors' collaboration is for assessment purposes (e.g. sharing assessment information to inform each child's assessment), then each assessor would claim assessment for that time spent (90791). If the purpose of the assessors' collaboration is to plan for linkage to treatment and other services after the determination of medical necessity, then Intensive Care Coordination (ICC - T1017HK) can be claimed.

11. **What are examples of how MAT providers can claim for record review?**
    A: Record review for MAT providers are likely for the purpose of assessment. An example of this is when a MAT assessor reviews Court documents in order to inform the assessment. The time spent reviewing the records and adding that information to the assessment can be claimed as record review using 90885 as the procedure code.

12. **If staff determine that the client does not meet medical necessity, but they still need to gather information for the SOF, can they bill DCFS for the gathering of information? (New as of 6/30/21)**
    A: Once it is determined that a client does not meet medical necessity, Medi-Cal cannot be claimed. Information gathered for the SOF should be claimed to the DCFS MAT Non-Medi-Cal funding.

Child and Family Team (CFT) and Summary of Findings (SOF)

13. **Once the assessment is finalized and medical necessity is established, we start beginning to link the clients for services. How would we bill for our participating in the CFT meeting at this point? (New as of 6/30/21)**
    A: MAT providers should always consider what Specialty Mental Health Service is being provided. Since the assessment process has been completed, MAT providers are likely providing ICC during the CFT meeting. T1017HK should be used as the procedure code to claim for this service.

14. **Can you provide clarification on when to bill Plan development? What should providers claim when they are participating in the MAT/CFT process?**
    A: In general, Mental Health Services - Plan Development (procedure code H0032) would be claimed when providers are beginning to develop a client's treatment plan focusing on planning for the specific interventions that will be provided during treatment. However, in most MAT cases, since MAT providers are working within a CFT to coordinate an array of services, and clients are involved with more than one child serving agency (e.g. DCFS and DMH), ICC (T1017HK) will likely be used instead of plan development for these activities.

15. **How do providers claim for making edits to the SOF during the CFT meeting?**
    A: When claiming to Medi-Cal, MAT providers should be claiming for the Specialty Mental Health Service provided. Making edits to a document would not claimable to Medi-Cal. If a Specialty Mental Health Services was provided, then MAT providers would claim for that specific service.

16. **How do providers claim for extended conversations regarding "Placement Stabilization" within MAT/CFTs?**
    A: MAT providers should always consider what Specialty Mental Health Service is being provided. Placement Stabilization conversations involve gathering clinical information about the child and family that would likely inform the mental health assessment. If the MAT assessor is in the assessment phase and gathering information to inform the child's assessment, any relevant information gathered during Placement Stabilization can be claimed as 90791. If the assessment has already been completed, any information gathered that may assist with planning and coordinating services can be considered part of ICC, so T1017HK can be claimed.

After the Assessment/SOF

17. **Can assessors begin the linkage process as soon as they know a child meets medical necessity, even though the assessment and MAT/CFT are not completed?**
A: Once it is determined that a child meets medical necessity, the assessment should be finalized and completed as soon as possible so that it is ready to provide to the receiving provider. In most cases, a client would have to meet medical necessity in order for providers to be able to claim to Medi-Cal after the assessment. Providers may claim for emergent services prior to the completion of the assessment. Emergent services are defined as services needed to address an urgent condition which is "a situation experienced by a client that, without timely intervention, is highly likely to result in an immediate emergency condition" (Refer to QA Bulletin 17-09). Claiming for emergent TCM services prior to the completion of an assessment should be done in rare situations as these types of services are subject to heightened risk of audit disallowances.

18. **Do treatment providers need to have a finalized assessment and final SOF report prior to accepting a case?**
A: Outpatient providers who will be providing ongoing treatment to the child should be provided with a finalized and completed assessment. This helps to ensure that the clients already meet medical necessity, and providers can begin with planning for and providing treatment services.

19. ***What codes can be used to the MAT DCFS Non-Medi-Cal Funding Plan? Is ICC only available under MAT Medi-Cal Funding?*** **(New as of 6/30/21)**
A: Refer to QA Bulletin 18-07 regarding which procedure codes are available under each funding plan. ICC is available under both funding plans.

20. **Do we need to submit the Katie A. Subclass form and the new ICC form or just the ICC form? (New as of 6/30/21)**
A: The Katie A. Subclass form was discontinued and replaced with the ICC Eligibility Form. The ICC Eligibility Form should be used to indicate Katie A. Subclass determination.

21. **If linking a client to ongoing services exceeds 60 days, can MAT practitioners continue to claim ICC? Will a treatment plan need to be developed for this? (New as of 6/30/21)**
A: MAT providers can continue to provide and claim for care coordination for the client even if it exceeds 60 days. A formal Client Treatment Plan would not be needed as MAT providers are not providing treatment services, but MAT practitioners should be documenting the ongoing plan for the client's care and clearly state why linkage has been taking a long time.

22. **If client does not meet medical necessity, but the family can benefit from resources, are practitioners allowed to provide those and write non-billable notes? (New as of 6/30/21)**
A: Once it is determined that a client does not meet medical necessity, any subsequent activities can no longer be claimed to Medi-Cal. Staff may continue to provide assistance to the family. These types of services may be claimed to a DCFS MAT Non Medi-Cal or other non Medi-Cal funding source, if funding is available, or as never billable (00000).