QA Knowledge Assessment Survey #7 – Payment Reform

1. Under CalAIM Payment Reform, only "Direct Care" time is reimbursable to Medi-Cal for Outpatient (Mode 15) Services. Which one of the following is **not** considered direct care?

   ☐ A. Time spent with the client providing patient care
   ☐ B. Time spent outside of session by practitioner (non-collaboratively) documenting the time spent with client providing patient care
   ☐ C. Time with significant support persons if the purpose of their participation is to focus on the treatment of the client
   ☐ D. Time with the client's care team

2. For the service contact below, how much of the time listed with the practitioner's activities is considered Direct Care?

- Travel to client's home (25 min)
- Meet with client at their home and assisted researching housing resources (45 min)
- Help client fill out the housing application (25 min)
- Write progress note (non-collaboratively) after client visit (5 min)

   ☐ A. 45 minutes
   ☐ B. 95 minutes
   ☐ C. 70 minutes
   ☐ D. 100 minutes

3. Under CalAIM Payment Reform, Collateral is a distinct service with its own code.

   ☐ A. True
   ☐ B. False

4. Which one of the following is **not** true regarding Add-On codes?
   ☐ A. Add-On Codes cannot be billed independently.
   ☐ B. Add-On Codes can be billed independently.
   ☐ C. A Prolong Code is a type of Add-On code that may be utilized to extend the time for procedure codes that have a duration/unit limit.

5. When a clinician meets briefly with a client's parents to explain evaluation results and discuss implications for client's treatment, right after they met with the client to conduct a mental status exam or brief evaluation using a screening tool, they may add the Interpretation/Explanation Result Add-On code (90887:CG).

- [ ] A. True
- [ ] B. False