QA KNOWLEDGE ASSESSMENT SURVEY # 7 Answer Rationales

(All correct/best answer options are highlighted in yellow.)

Question 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

Question 1 Answer: B

Rationales for Question 1 Answer Options**:**

Option A:

Per the current Organizational Provider's Manual - Rev.9-14-23 (pg. 8), "*Only direct care is reimbursable: If the service code billed is a client care code, direct client care means time spent with the patient for the purpose of providing healthcare. If the service code billed is a medical consultation code, then direct client care means time spent with the consultant/members of the beneficiary's care team.*"

(Guide to Procedure Codes, pg. 5)

Direct Care (time goes into duration determination):

① Time with client
② Time with significant support persons if the purpose of their participation is to focus on the treatment of the client
③ Time with consultant
④ Time with client's care team

Option A, "Time spent with the client providing patient care" **is** considered direct care, therefore this option is incorrect.

Option B:

Per the current Organizational Provider's Manual - Rev.9-14-23 (pg. 8), "*Direct client care does not include travel time, administrative activities, chart review, **documentation**, utilization review and quality assurance activities or other activities a provider engages in either before or after a patient visit. (SMHS Billing Manual) For additional information, refer to the Guide to Procedure Codes.*" Therefore, Option B is correct, as documentation is **not** considered direct care.

(Guide to Procedure Codes, pg. 5)

Non Direct Care (time does NOT go into duration determination):

① Travel time
② Chart review time
③ Documentation time
④ Administrative time (general team meetings, utilization review, quality assurance activities)

Please note that if documentation is done collaboratively with the client during the session, where the practitioner actively engaged with the client in documenting their clinical session to enhance client engagement, rapport, and effective communication, then that Collaborative Documentation process is considered part of the Direct Care being provided to the client.

Option C:
Per page 5 of the current Guide to Procedure Codes 7-26-23 Final.pdf (govdelivery.com), "*direct care is not the same as "face-to-face" service. It is a group of activities defined by DHCS* (the California Department of Health Care Services) *that emphasizes time spent directly providing care to the client as well as additional activities working directly with significant support persons.*" Option B, "Time with significant support persons if the purpose of their participation is to focus on the treatment of the client" **is** considered direct care, therefore this answer option is incorrect.

Option D:
See Rationale for Option A above which supports why Option D ("Time with the client's care team") is not the correct answer option for Question 1.

Question 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

Question 2 Answer: C

Rationales for Question 2 Answer Options:

Option A:
In the scenario above, 45 minutes was the amount of time the practitioner spent meeting with the client at their home and assisting with researching housing resources. Even though that activity involving the client is considered direct care, there was another activity conducted during the service contact described above that is also considered direct care which took 25 minutes, "Help client fill out the housing application". Given that multiple activities (in this case, Targeted Case Management interventions) would be considered direct care, 45 minutes is not the total amount of direct care time for the activities listed above. Option A is therefore incorrect.

Option B:
95 minutes of the time listed in the scenario above includes 25 minutes of "*Travel to client's home*". Per the current Organizational Provider's Manual - Rev.9-14-23 (pg. 8), "*Direct client care does not include **travel time**, administrative activities, chart review,*

documentation, utilization review and quality assurance activities or other activities a provider engages in either before or after a patient visit." Option B is therefore incorrect.

Option C:
This answer option of 70 minutes excludes "*Travel to client's home*" and "*Write progress note (non-collaboratively) after client visit*" listed in the scenario above which are both not considered direct care. The 70 minutes of time includes the activities "Meet with client at their home and assisted with researching housing resources" and "Help client fill out the housing application". Both these activities involve providing a direct treatment service (Targeted Case Management interventions) with the client present to assist the client in reaching their mental health treatment goals, and therefore are considered direct care. Because those direct care activities total 70 minutes, Option C is the correct response.

Option D:
This answer option of 100 minutes includes "*Travel to client's home*" and "*Write progress note (non-collaboratively) after client visit*" listed in the scenario above, which are both not considered direct care. Option D is therefore incorrect.

Question 3.

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

A. True
B. False

Question 3 Answer: B

Rationales for Question 3 Answer Options:

Option A: As part of CalAIM Payment Reform changes (and per QA Bulletin 23-04: CalAIM Payment Reform) collateral services are no longer a distinct service component and can no longer be billed as a distinct service activity. However, it is now a method of service contact. Providers can claim for contacts with significant others and should identify the procedure code that best describes the service provided. The Guide to Procedure Codes 7-26-23 Final.pdf (govdelivery.com) indicates if a procedure code may be utilized when working with a significant other. Therefore, option A is not the correct answer option for question 3.

Option B: See the rationale for Option A above which supports why Option B is the correct answer for this question.

Question 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.

Question 4 Answer: B

Rationales for Question 4 Answer Options:

Option A: Per the Guide to Procedure Codes 7-26-23 Final.pdf (govdelivery.com) (pg. 3), a Base Code is the primary code used to describe an activity or service, and Add-on Codes are additional codes that may be added to a base code to supplement the primary service. Add-on Codes provide more information regarding what was involved with the service provided but cannot be billed independently.

Examples of Add-on Codes:

① Sign Language/Interpretation (T1013)
② Interactive Complexity (90785)
③ Caregiver Assessment (96161)
④ Interpretation/Explanation of Results (90887:CG)

Option A, "*Add-On Codes cannot be billed independently*" is a true statement, therefore it is not the correct response for this question (#4).

Option B: See answer rationale for Option A above which supports why Option B is a false statement and therefore the correct response to Question 4.

Option C: **Per the Guide to Procedure Codes (pg. 3),** a Prolong or Extend Duration Code is a type of Add-On code that may be utilized to extend the time/duration of base (procedure) codes that have a duration/unit limit. Therefore, Option 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*" is a true statement and not the correct answer choice for this question (#4).

Question 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

Rationales for Question 5 Answer Options:

Option A: Per the Guide to Procedure Codes 7-26-23 Final.pdf (govdelivery.com), the Interpretation/Explanation Result Add-On code (90887:CG) may be added to the base code when the treatment of the patient requires explanation to the family, employers or other involved persons for their support in the therapy process. This may include reporting of examinations, procedures, and other accumulated data. Option A is therefore the correct response.

Option B: Prior to CalAim Payment Reform changes, explaining evaluation results to a client's parent or other significant support person could be claimed as a distinct service, "Collateral", with its own separate code. After CalAim Payment Reform, collateral services are no longer a distinct service component and can no longer be billed as a distinct service activity, but rather as a method of contact when allowed for certain services. In the scenario for this question, the appropriate base code for the clinician's service to the client evaluating their mental status or brief evaluation using a screening tool would be used to claim for that service and the Interpretation/Explanation Result

Add-On code would be added to include the time spent explaining the evaluation results to the parents after meeting with the client. Option B, “False” is inaccurate because current claiming rules allow for use of the Interpretation/Explanation Result Add-On code in the scenario described in Question 5.