Introduction

When services are provided by more than one provider to a person in care, it is important to communicate and collaborate with other providers as well as with the person in care, to support their goals and align treatment. This document is intended to provide guidance to mental health program staff regarding collaboration and consultation with other direct service providers.

In the past, the person in care or a significant support person had to be a participant in the collaboration or consultation for the collaborative contact or consultation to be billed as a service. With the CalAIM initiative, direct service providers ***may*** bill / claim for services, even without the presence of the person in care / support persons when:

- **the collaboration / consultation produces actionable item(s) on behalf of the person in care and/or a change to the client's treatment *and***
- **the provider claiming has made a unique contribution to the collaboration *and***
- **both the actionable item(s) and the unique role of the provider in the collaboration is clearly documented in the individual's medical record**

General Guidance

Provider collaboration, case consultation and coordination of care can take many forms. It is common to have treatment teams with some combination of LPHAs, Mental Health Rehabilitation Specialists (MHRS) / SUD Counselors, Peer Support Specialists, medical providers and other qualified staff who work with the person in care. Every interaction amongst the treatment team will not be claimable, however many activities will be. Multiple staff may claim for the collaboration or consultation, as long as each provider has made a unique contribution and documents their role / unique contribution in the activity.

Collaboration and case consultation activities do not have a specific claim associated with them. Rather, the claim depends on the service provided (e.g., the intervention of each provider).

Examples of collaboration / consultation activities that **<u>are claimable</u>**:

- Mental health (MH) therapist and MH rehab counselor collaborate on a Problem List update for a shared client (**claim**: Plan Development)
  NOTE: Adult FQ therapists are not able to bill for this activity
- Case conference concerning the assessment of the person in care; LPHA can bill assessment, and Rehab counselor can bill rehab evaluation
  (**claim**: Assessment or Rehabilitation Evaluation depending on the scope of the provider)
- Multi-disciplinary team meeting that results in collaborative development or update to the Problem List, TCM Care Plan and/or ICC/IHBS Client Plan (**claim:** Plan Development for the time spent directly on discussion that leads to a treatment update; all providers who provide a unique contribution to actionable item on behalf of the person in care, and who have a unique role in the meeting may bill)

- Discussion between multiple providers concerning linkage or referrals; Example: rehab counselor consults with therapist regarding potential need for eating disorder (EDO) treatment which results in referral / linkage to EDO treatment (**claim:** Targeted Case Management (TCM), or if applicable, Intensive Care Coordination (ICC))
- Staff (MHRS, Case Manager, Therapist) attends a specialist appointment (psychiatry, primary care provider, etc.) with the person in care to support them in managing their mental health symptoms during the appointment; goal of attendance is to ensure best outcome of the appointment. Without the staff's support and interventions, the person in care would not have been able to have a productive meeting with the specialist (**claim:** TCM)
  NOTE: Adult FQ therapists are not able to bill for this activity
- Case Manager provides information to residential staff regarding their client's current presentation and needs in order to support stabilization of mental health symptoms and client's ability to return to less restrictive treatment environment (**claim:** TCM)
- Reviewing and amending / updating the Problem List with an LPHA if the activity is centered on exploring alternative interventions that may help the person in care reach their goals (**claim:** Plan Development)
- LPHA, whose role is to meet with the client to oversee the assessment and complete the Diagnosis & MSE, gathers information from primary staff (non-LPHA) for assessment. LPHA is gathering info and the non-LPHA is providing info. (**claim:** according to intervention / service provided)
- Current provider gathering treatment information from prior provider regarding effective treatment interventions and pertinent history (**claim:** Assessment or Rehab Evaluation depending on intervention & provider scope of practice)

Examples of activity that **<u>is not claimable</u>**:

- A quick check-in / update regarding a client that does not result in treatment change or actionable item
- Translation services
- Giving advice to a colleague
- Providing appointment information to clients
- Attending specialist appointment with client when *not clinically indicated* / the outcome would have been the same if the provider did not attend
- Calling and leaving client a voicemail; texting clients; emailing clients
- The time for providers in a case conference or meeting who do NOT directly contribute to the client's care
- Supervision of clinical staff / trainees, when the activity is centered on personal insight for the clinician that may be impacting the staff's work with clients
- FQ Therapist attends FQ Psychiatrist appointment

Can I bill for Supervision?
IT DEPENDS!!
DON'T: claim for supervision focused on insight for the provider
DON'T: claim every time a client is discussed in supervision (be mindful of Fraud, Waste & Abuse)
DO: claim for clinical consultation that results in actionable item on behalf of person in care, or a change in treatment for the person in care

Mental Health Service Definitions

Targeted Case Management: (e.g. Brokerage/Linkage/Referral): Services that assist a person in care to **access** and **link** to needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and **referral**; **monitoring** service delivery to ensure access to service and the service delivery system; monitoring of individual progress.

Plan Development: Service activity which consists of development of plans, review of Problem List, and/or monitoring of a person in care's progress.

Assessment: Service activity which may include a clinical analysis of the history and current status of a person in care's mental, emotional, or behavioral disorder; relevant cultural issues and history; diagnosis.

Collateral: Service activity (consultation and/or training) to a **significant support person** in an individual's life with the intent of improving or maintaining the mental health status of the person in care. The goal of this service activity is to provide information to the **significant support person** so they may assist the person in care in increasing resiliency, recovery, or improving engagement with services, and/or to assist the support person in better understanding mental health symptoms and their impact on the person in care. Collateral may also include family counseling with the significant support person(s) to improve the functioning of the person in care. The person in care does not have to be present.

Progress Note Content

Template content:

Presentation: Not required. You may document pertinent presentation information.

Intervention (Narrative Description of Service): This section provides a short /general description of:

- Who was involved in the collaborative conversation & their role as a direct provider
- Staff unique contribution to the activity
- The information shared /discussed
- How the information from the collaboration will be used on behalf of the person in care and/or to change or update treatment

Response: Not required; if the person in care participated, you may document their response

Referrals to Community Services: Not required.
You may include brief referrals provided.

Follow up Care/ Discharge Summary:
Include next steps, information regarding collaboration with the person in care and others, and how the collaborative information / determinations will be implemented.

Provider Collaboration and Case Consultation Progress Note Examples

Billable Service Code: Rehab Evaluation M433

Intervention (Narrative Description of Service):
Case manager met LPHA to discuss need for updated assessment for person in care who was recently hospitalized. After discussion of current functioning and complaints, including increasing anxiety and suicidal ideation, along with increasing use of alcohol to calm anxiety, there was agreement that the assessment should be updated.

Follow up Care/ Discharge Summary:
LPHA will meet with the person in care to complete MSE and to determine if the diagnosis should be updated. Case manager will continue gathering updated psychosocial information with person in care.

Billable Service Code: Plan Development M432

Intervention (Narrative Description of Service):
Case manager met with psychiatrist and team supervisor to discuss Susan's current Problem List as Susan reported she will soon be homelessness. Discussion included Susan's current goal to find affordable housing after Adult Residential program. Inadequate housing will be added to Susan's Problem List.

Follow up Care/ Discharge Summary:
Case manager will provide activities to help Susan connect with community resources and access applications to housing programs for lower level of care.

Billable Service Code: Targeted Case Management M401

Intervention (Narrative Description of Service):
Non-FQ Therapist met with case manager and psychiatrist following intervention to address the person in care's inability to manage emotions due to their anxiety; the person in care reported their anxiety to be high and that they would like to attend a group that focuses on anxiety and depression. Discussion centered around identifying group treatment options and free Mindfulness classes. After collaboration, non-FQ therapist contacted Group Intervention Center and spoke with an intake counselor to obtain information about the appropriateness of their Anxiety Support Program to meet client's needs. Non-FQ Therapist then relayed this information to the case manager for follow-up with the person in care.

Follow up Care/ Discharge Summary:
Case manager to assist person in care to register with Group Intervention Center Anxiety Support Group.

Resources

- CalMHSA Documentation Guides: HERE
- Santa Cruz County CalAIM Information Page: HERE
- DHCS Behavioral Health Information Notice 22-019: Documentation Requirements: HERE