QRTIPS

Health Care Agency, Behavioral Health Service, CYBH Quality Review and Training

September 2014
Revised 6/1/2015

Case Management Changes/Clarification: 14 day documentation rule

BHS' understanding of documentation and billing rules continues to be refined though audits, discussions with DHCS and consultation with multiple sources. The following changes to documentation and billing rules are to be reviewed with all BHS staff, who provide and document clinical services billable to Medi-Cal. These changes will be effective **Tuesday, September 2, 2014.**

I. Case Management (CPT Code 90899-1)

BHS has traditionally allowed a variety of services to be billed under case management as long as they referred to coordination of care, monitor service delivery and access to community services. Moving forward the **medical necessity criteria** for billing case management is defined as the following:

- The case management resulted in a change to the treatment plan, **or**
- The case management resulted in a change to the course/delivery of treatment, **and**
- The documentation clearly indicates how the client is likely to benefit from the case management service.
- The documentation clearly indicates the specific need or purpose for case management service.
- The documentation is clearly related to addressing the mental health condition.

For additional information, please review the following specific case management examples:

1. Case Consultations and Treatment Team Meetings (Intra-Agency Team)

   Case consultations and treatment team meetings are billable as long as the above criteria are documented, and these services can be clearly distinguished from supervision. It is important to remember that billable case consultations and treatment team meetings should occur when there is a clinical need and not just as routine events. In addition to this, when billing case management for participation in a treatment team meeting, the **unique contribution** of each member of the team must be documented. Giving or simply receiving information from another member of the team may not meet the medical necessity criteria for billing case management, which could result in the service being at risk of recoupment.

For example, if the individual and group therapist meet to discuss what services have been provided to the client to date, this would be a non-billable activity. However, if two clinicians meet to discuss what services have been provided, and it is decided that group therapy needs to be added to the plan, this consultation would be billable.

2. Review of Records

   Traditionally, clinicians have been allowed to bill case management if they, shortly after acquiring the case, conduct a chart review to better understand the client's history. Reviewing the clinician's own chart under any circumstances is now considered a *non-billable* activity. Clinicians should not be billing case management for reviewing the chart upon transfer or as part of the 60 day, six month or annual review.

3. Child, Elder, Dependent Adult Abuse Reporting

   Programs have traditionally billed case management for calling and reporting suspected abuse to either CPS or APS. We have traditionally allowed the call to be billable, but the time spent completing the actual report form to be non-billable. Moving forward, the filing of abuse reports**, both verbal and written**, shall be coded as **non-billable**.

II. Revised 14 Day Different Day Documentation Rule

There is a change in the 14 day different day documentation limit. The Date of Service is now considered Day 1. For example, if a service was provided on 9/1/14, you have up to 9/14/14 to write your progress note. Any note on 9/15/14 or later is considered non-compliant and would require the non-compliant chart CPT code.

For County EHR clinics, the support staff will be running a daily report and informing therapists if documentation still needs to be completed.