

# Service Encounter Reporting Instructions (SERI) Frequently Asked Questions Behavioral Health Organizations - May 2016

## MODALITIES, SERVICES and PROGRAMS:

### MENTAL HEALTH SERVICES

#### Crisis Services-

**Q. Does an agency/provider need to hold a crisis license in order to report the H2011 CPT code? Or can any agency/provider report this service?**

*A. Any agency that is providing crisis services must be licensed to do so.*

#### Peer Support-

**Q. Can peer support services from a peer parent be provided to siblings of enrolled children?**

*A. Peer parent can provide services to a parent but cannot provide services to a sibling or child.*

#### Family Treatment-

**Q. TMRSN recently heard that the Family Psychotherapy (with client) and Family Psychotherapy (without client) – CPTs 90846 and 90847 – must be conducted by a Licensed Marriage and Family Therapist (LMFT). Is this true? The SERI does not differentiate these types of licensures under allowable “Provider Types”. Are other provider types, i.e., MHPs, allowed to perform these services even if they are not a LMFT?**

*A. No. The person has to be an MHP or under the supervision of an MHP with documented education in family systems etc. etc. Please see WAC 388.877 (A) 0155*

### Evidence Based Practices (EBP)-

**Q. A couple of our SUD providers have asked if they can report EBPs for adult services based on the SERI effective 4/1/2016. We have told them not to do so until we receive confirmation from DBHR to include adult services in EBP reporting. My understanding of current and 4/1/2016 EBP reporting in the SERI is it is only associated with children's services, specifically page 105 of SERI v201511.0 and v201602.0 state "Activities to be reported using this process are related to services delivered to children." Can you please confirm if my understanding is correct? If so, can you also please advise if EBP reporting for adult services is anticipated in the future by DBHR, and if so, if there is a timeframe for when that will be?**

*A. Currently--No.*

*CMH EBPs as outlined in SERI are the only EBPs currently required to report.*

### **SUBSTANCE USE DISORDER SERVICES:**

#### Assessments-

**Q. Can an update to an ASAM Assessment be done via a phone call, using H0001 with a modifier of 52?**

*A. ASAM Assessments are to be done face to face -- not over the phone.*

*Please see WAC 388-877-0610(1) a*

#### Case Management-

**Q. With the v201602.0 SERI, under Case Management is a limitation where only CDP or CDPT Provider Types are only allowed to provide the service to Medicaid individuals. Is it true that this limitation is in place as a part of the State Plan for SUD services? If so, is it truly the expectation that Case Management SUD services provided by non-CDP/CDPT Provider Types are to be funded by non-Medicaid funds when delivered to Medicaid individuals?**

*A. Yes it is true that the limitation is in place because of the state plan. Medicaid funded case management must be provided by a CDP or CDPT. And yes, the expectation would be that because of the state plan language that any case management services provide by a non-CDP/CDPT would need to be funded by non-Medicaid funds even when delivered to Medicaid individuals.*

### OST Services-

**Q.** What is the expectation for time reporting for this code? Will it just be the time associated with “dosing”? (i.e., 5-10 minutes) Or, is there an expectation that the time for the services listed in the modality definition (Individual, group ,etc.) will be included in the reporting of H0020 (i.e., dosing 5 min, individual 60 min, and group 120 min in a single day = 185 min) ?

*A. Please see DBHR Guidance Document Opiate Substitution Service Encounter Reporting Instructions sent to BHO Administrators.*

### Recovery Support Services-

**Q.** If an SUD outpatient agency does not have SABG funding specific for Recovery Support services, can they still report Recovery Support services, and if so, what service codes would they use to report those services? We assume they cannot use H0047 for them since it is only for: (1) Recovery Support services with SABG funding on page 44, or (2) case management as described on page 122, of SERI v201602.0.

*A. Added a note SABG or SF only. And added Modifier HG to identify funded by state addictions agency.*

### Rehab Case Management-

*A. Concurrent or auxiliary services may be provided when the staff providing the service is not assigned to the residential facility.*

**Q2.** Under mental health reportable services, there is no “case management” other than rehab case management that I can find, yet an agency can and needs to be licensed to provide case management services. If they are licensed to provide case management, how do they report those services? How do they bill for those services, etc? Is it considered a “community support service” per the data dictionary? Are there allowable codes in the SERI? And can case management that is not rehab case management be paid for with Medicaid? As you can see, I am confused. The fact there is only a SUD case management service, but yet a MH case management certification????

*A. Report H2015 – Comprehensive community support services per 15 minutes. (Individual treatment services)*

**Q1.** It was mentioned at an MIS meeting that the decision had been made that Rehab Case Management code could NOT be used for an enrolled individual during incarceration. Our

programs (WiSe and 3 Rivers Wraparound) serve many youth that have Juvenile Justice involvement and our staff continues to facilitate services in order to maintain continuity of care and planning for stability and success post discharge. These services may include direct service with the individual and family, collaboration with the Juvenile Justice staff and other team members. If this is the case, we request documentation of the changes and effective dates so that we may make the necessary changes.

**Q2. Can you and/or the SERI work group clarify whether or not Rehabilitation Case Management is allowable in the following locations – Jail/Prison, Juvenile Detention Facility, CLIP Facility, Evaluation & Treatment Facility, Medical or Psychiatric Inpatient Facility - for the purposes of discharge planning and coordination of care?**

**I have received feedback that there have been mixed instructions on how/when to use this code.**

*A to Q1&2. Under mental health - there is no such thing as case management, we have rehabilitation case management which is a specific service described in our state plan and is a Medicaid service. CFR states providers may not use Medicaid funded services for a person in jail, prison, Juvenile detention facility.*

**Q. The SERI (pp. 137-138) has two codes for withdrawal management services (acute and subacute), each defined as to be reported in minutes, which is challenging for a facility-based service (“residential addiction program inpatient” in the HCPCS Definition), but we can instruct our provider to report the actual minutes for the admission and discharge dates and 1440 minutes (24 hours) for each day in between.**

However, a bigger problem is that there are only person-specific provider types (for example: RN/LPN ; ARNP/PA; CDP; CDPT), unlike with other codes on the MH side which have more generic options for “provider type”: that is, Mental health services in a residential setting codes allow “08 / NA”; Stabilization services code allows “12-Other (Clinical Staff)”.

**We urge you to add “08 N/A” or “12-Other (Clinical Staff)” to the Provider Types allowed so that we can report more sensible encounter data, which is essentially for a *per diem* service.**

For now, we are planning to tell our single detox provider to report the encounter for each day with the provider type of the “highest credentialed” provider who provided services that day.

*A. Provider Type “12 other clinical staff” will be added.*

#### **MODIFIERS:**

**Q. The HZ modifier Definition is “Funded by criminal justice agency”**

A. The **CJTA agency** is just one that has funds allocated for CJTA-historically funds have been allocated to the counties- the counties contract with the outpatient providers for services using CJTA funds.

**Q1. We need to know what agencies that encompasses (or what funding), so that we know when it is supposed to be reported.**

**Q2. Please clarify if our providers should report the HZ modifier if the individual is involved with criminal justice program or only if a criminal justice program is funding part of the treatment?**

A to Q1&2. Using the HZ modifier is to identify the Client eligibility determination used for individuals who are eligible under CJTA regardless of funding.

**Q. TG-Complex High Level of care. What is the definition? Is this what is used to differentiate between OP and IOP?**

A. On Page 122 Services with the TG modifier are to be associated with Intensive Outpatient Treatment.

**Q. UA - Brief Intervention-How is this defined? If we are referring to 'Brief Intervention' It seems like it would only fit under H0050, but it shows in the SERI as a modifier under 96153, 96154, H0001, H0004, etc.**

A. UA modifier page numbers will be updated in appendix. Page 128 will also be updated.

**Q. Spokane County RSN/BHO would like to know if we should be reporting the U8 modifier for Stabilization Services (S9484) when performed with our WISE clients. The U8 modifier is not indicated in the SERI for S9484 currently or effective 4/1/2016, but we are thinking it may be an appropriate service code for WISE reporting.**

A. CMH team is in support of including Stabilization Services in the WISE service model, identifying it with a U8 modifier, and allowing if the agency is DBHR certified and approved to provide WISE services. The U8 Modifier will be added to Stabilization Services.

**Q. Further definition for use of IVDU modifier (U5?) in SERI of the length of time "past" refers to in use of this modifier (30 days, 60, 90, etc.).**

A. The past 30 days should be used when completing a new assessment; if the individual is continuing in services providers can continue to identify them as an IUID. (Residential to outpatient, outpatient to residential, etc.)

**Q. Our providers are struggling with the HD definition(s) in the SERI for PPW. The SERI v201602.1 does not include a definition for the HD modifier on page 154. The only definitions for HD are located**

in the following service modalities/service codes:

Page 130 for H0018 (Intensive Inpatient Residential Services) - HD is used only for pregnant women or those with child(ren) 6 years of age or under.

Page 132 for H0019 (Long-Term Care Residential Services) - HD is used only for pregnant women or those with child(ren) 6 years of age or under.

Page 150 for H0043 (PPW Housing Support Services) - HD is used for: Pregnant, postpartum, or parenting (children age 17 and under) at the time they enter housing support services. Pregnant includes any state of gestation. Postpartum includes up to one (1) year, regardless of the outcome of the pregnancy or placement of children.

We understand from previous SERI workgroup meetings that the differences in the HD definition among the SUD service modality/service codes listed above is deliberate for the HD modifier based on the program, and although our SUD providers don't agree with it, they understand it.

What is confusing to our providers is there is no comprehensive definition on page 154 for the HD modifier in general, and there is no specific program HD definition by service modality or service code for all of the other modalities/programs as referenced on page 154 (only for pages 130, 132, and 150). Because of this, they don't know what the definition for HD is with all the service modalities/service codes that don't have it specified.

We would like to request a comprehensive definition for the HD modifier be added to page 154 of the SERI and that it state that the definition may vary by service modality or service code. We would also ask that a specific HD definition be added to each of the service modalities (or their associated service codes) that are referenced by the HD modifier on page 154 of the SERI. The HD definition is currently missing for the service modalities and their service codes on pages 121, 123, 126, 127, 128, 134, 136, 138, 141, 143, 145, 147, 149; and is currently only defined for pages 130, 132, and 150.

A. *The HD Modifier is as identified and defined by the CPT manual.*

#### **DEFINITIONS:**

**Q. Our Med staff wrote a comprehensive discharge summary when care is transferred to Primary Care. This is above and beyond required documentation but really critical for the best transition of care. Can this report writing be coded as Individual Community Support? Under Individual Treatment in the SERI it says:**

##### ***Inclusions***

**Report writing (e.g., extraordinary report writing, as defined by court reports, reports to DSHS).**

A. *Reporting writing includes activities "above and beyond" the routine plan of care and services provided/expected. Report writing that goes "above and beyond" does not include well written and detailed d/c summary. Report writing means additional reporting as may be required in addition to the usual routine plan of care and services provided/expected.*

**Q. Is court testimony on behalf/about SUD authorized clients in any court viewed as encounter-able? Specific to Drug Court clients, providers are being asked to handle the case staffing portion of this work and the client is not present, but superior court judge, defense, prosecutors, treatment provider are. They are usually approximately 3 hours, covering all clients in discussing their treatment plans, how they are doing in treatment, any emerging issues including relapse, and challenges/barriers to client success. Is this encounterable?**

*A. No. Time spent on staffing is not included.*

**CPT/HCPCS CODES:**

**Q. Why was code T1009 removed?**

*A. This was removed as it is not an encounterable service under the BHO system. However, it is still to be made available, just not submitted.*

**Documentation-**

**Q. Residential is reimbursed on a daily rate, not by service encounter. Progress notes need to reflect a medical need. If a residential patient has more than one encounter in a day, and one of them documents medical necessity, would all of the other encounters also need to document medical necessity? In other words, a sample patient has attended 3 different groups in one day. The first group documents everything necessary to meet medical need. What if the third clinician neglects to document medical need? Would the residential program not be reimbursed for the entire day?**

*A. Any encounter that requires documentation must be written in a manner that reflects medical need. Contact your BHO for guidance.*

**Provider Types-**

**Q1. We would like to get examples of who would be provider type 12 -Other (Clinical Staff)**

*A. Please refer to the SERI for instruction and contact your BHO for further guidance.*

**Q2. (Related) Can you assist with the section below that is highlighted? We are trying to determine what it means. Provider Type: 12-Other (Clinical Staff)**

*A. Please refer to the SERI for instruction and contact your BHO for further guidance.*

**Q3. (Related) What does "Less than MA degree mean"? If a person has an AA or less and is agency affiliated but wants to do something like MH case management can they do that? For example H0036...does below Masters mean anything below Masters, including a HS diploma?**

A. *Please refer to the SERI for instruction and contact your BHO for further guidance.*

**Q4. (Related) Provider Type 05 - Below Masters- Would Bachelor Level staff use this? What if they have a waiver, then do they pick 09 – Bachelor Level with Exception Waiver?**

A. *Please refer to the SERI for instruction and contact your BHO for further guidance.*

**Q5. What about someone with an Associate Degree?**

A. *Please refer to the SERI for instruction and contact your BHO for further guidance.*

**Q6. How does this relate to 12 – Other Clinical Staff?**

A. *Please refer to the SERI for instruction and contact your BHO for further guidance.*

## **SUD Residential**

**Q1. Providing a bridge service while someone is in SUD residential-**

*With the transition of SUD Services into the BHO managed care environment, whether or not a BHO could have an open SUD outpatient benefit/authorization while a client is in Residential Treatment would be entirely up to the BHO and how they contract with their provider network. We recognize that closing and having to re-open an outpatient episode could prove to pose a barrier to smooth and timely transition between residential and outpatient treatment. On the mental health side, as you noted, this is frequently tracked as Rehab Case Management. Other RSNs also this service through the Individual Services as described in the mental health SPA. While the Rehab Case Management services are not available under the SUD SPA, there are several options for providing outpatient services to an individual receiving residential treatment:*

1. *The service could be tracked as a Case Management Encounter, under the SUD SPA, if the individual meets the requirements enumerated in the SPA:*
  - a. *Section D of Case Management Description states: “Description of Services: Case management will be used to either involve eligible clients in chemical dependency treatment to support them as they move through stages of chemical dependency treatment within or between separate treatment agencies.”*
  - b. *Since this is Targeted Case Management, the service recipient could not be receiving any other type of case management service. As per the State Plan: “Payment for case management services under the plan will not duplicate payments made to public agencies or private entities under other program authorities [for] this same purpose.”*
  - c. *The service should be ordered on the Individual’s OP treatment plan.*
  - d. *The service could only be provided by a CDP or CDPT employed by the OP SUD Behavioral Health Agency.*



2. *The service could be tracked as an individual outpatient service provided out of facility. This service could be Medicaid for Medicaid enrollees or also funded with SABG or state funds.*
  - a. *The service would need to be ordered on the OP treatment plan.*
  - b. *The service could only be provided by a CDP or CDPT.*
  
3. *The service could be provided as a Recovery Support Service funded the SABG or State only funds.*
  - a. *The Recovery Support Service would need to be identified on the Individual's Service Plan.*
  - b. *The Recovery Support Service could be provided by a range of providers, beyond CDPs or CDPTs.*

*Whether the service is provided as Medicaid encounter would also be influenced by whether or not the residential facility is classified as an IMD.*

*We will issue a guidance document to the SERI explaining that these services mentioned above can be provided when an individual is receiving residential chemical dependency treatment.*

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