

Division of Behavioral Health Community Support 101

BILLING/DOCUMENTATION

Q: Is time spent developing, implementing, updating, reviewing, and revising a treatment plan a billable activity?

A: While the Division is making every effort to make the processes in the rehabilitation programs consistent, the answer to this is currently different for CPR and CSTAR. The development and implementation of treatment plans are included in the assessment rates for each rehabilitation program. For Community Psychiatric Rehabilitation (CPR), all treatment planning activities are included in the CPR assessment rate. For Comprehensive Substance Treatment and Rehabilitation (CSTAR), treatment plan reviews are not considered to be included in the assessment/treatment plan rate and are billable to Individual Counseling by the individual counselor. For both programs the Community Support Specialist (CSS) should be working with other members of the consumer's treatment team to establish one treatment plan that reflects the person's goals and the various interventions and staff responsibilities associated with those interventions. However, time spent writing and updating the treatment plan is not billable to community support (CS). The Division will continue to explore options for consistency.

Q: When a consumer has a medical hospitalization, are we allowed to continue to bill throughout their stay in the hospital (assuming medical necessity), not just the day of admittance and the day of discharge?

A: Yes, CS may be billed while a person is in a medical hospital bed. However, CS may not be billed during an inpatient psychiatric hospitalization or Medically Monitored Inpatient Detox (MMID) stay.

Q: Can community support be billed when texting or emailing the consumer?

A: No, only verbal communication, whether face-to-face or on the telephone is billable as CS.

Q: Can community support be billed for doing video/internet games with a consumer?

A: No.

Q: It has been challenging for staff to use collaborative documentation when working one on one with younger active children either in the home or at school. Could you address this a little more to help new workers in the field?

A: Collaborative documentation may not work in every situation. If not completed collaboratively, progress note documentation is not billable as a community support service. If appropriate, and if the parent is present, documentation may be done collaboratively with the parent.

Q: When a counselor/therapist meets the criteria and demonstrates competency of a CSS, is there anything that would prevent them from providing CS in a crisis situation?

A: As a counselor, in crisis situations, the service provided and billed would be counseling.

Q: In the CS training it is noted that there is no CS billing when an individual is in a hospital; however, the CS training goes on to say that if the service is justified by individual need then a CSS can accompany a consumer while providing a needed service and get reimbursed for this time. Is time spent working with the hospital case manager on a discharge plan billable?

A: There are two types of hospitalization to address. If a consumer is hospitalized on the physical health side, CS may be provided and billed throughout the hospitalization as medically necessary. If a consumer is hospitalized in a psychiatric setting or MMID, CS may not be billed during the stay except for the day of admission and the day of discharge. However, it is expected that the service will be provided as needed for coordination of care and discharge planning.

Q: Can CS be billed while a consumer is receiving MMID services? What if the consumer does not have Medicaid?

A: No, CS cannot be billed while a consumer is in MMID regardless of Medicaid status.

Q: What happens when a CSTAR adolescent is admitted to a psychiatric hospital bed, and we need to encourage parent/guardian involvement, or they need assistance in navigating the hospital system or follow-up care?

A: CS cannot be billed while a CSTAR consumer is in a psychiatric hospital bed except for the day of admission and the day of discharge. This includes any collateral contacts with family, parents, or guardians. It is expected that the service will be provided as needed for coordination of care and discharge planning.

Q: When can a CSS bill for recreational activities?

A: CS can be billed for recreational activities with youths only. There must be an identified need, the interventions must occur in a community setting, there must be skill building with the youth and parent/family, and the intervention is provided on a time-limited basis. Need for such service should be identified in the youth's assessment with identified objectives and interventions on the treatment plan. It is expected that the parent/guardian will participate in these activities and in the transfer of the skill building.

Q: Please clarify when transporting a consumer is billable to CS.

A: If other transportation means are available, those alternatives should be utilized first. There must be a need for a CS service intervention to be provided during the time together. Simple transportation (picking up at point A and dropping off at point B with no CS intervention provided) is not billable. Anytime there is a need for the CSS to assist with transportation needs, the assessment and treatment plan should both clearly identify what those needs are and the medical necessity of providing the service.

Q: I have a consumer who I meet with to take to the nursing home to see his mother and sister. The training says you can't take consumers to meet with family members. He has trouble getting along with the nursing home staff and needs support. In this situation when the consumer would otherwise be unable to visit family alone without CSS intervention, would the service be billable?

A: No, the CSS should be working with the consumer on preparing him for the interactions with the nursing home staff by modeling and practicing with him before he goes to the family visit and check with him to see how it went after the visit. If the service described above is provided, it cannot be billed.

Q: The training said no shopping outside of the community. Sometimes I may take someone about 30 minutes away to shop. For example, one consumer likes TJ Maxx in another city. What if there are no stores in their community or if there are less expensive stores a little further out? In this situation the consumer would not otherwise be able to go to the store of their choice without CSS intervention, would the service be billable?

A: No, it is not acceptable to travel outside of a consumer's home community to shop. Shopping with consumers in general is not a billable CS service. You must be able to justify the medical necessity of why the CSS is providing a service intervention in any setting. Natural supports should be utilized for this activity unless there is a medically necessary intervention for the CSS to provide. Recreational shopping is not a medical necessity.

Q: Can we bill CS for writing up a critical intervention plan and mailing to the consumer?

A: No, documentation time is only billable when done collaboratively with the consumer.

Q: A CSS is trying to find emergency housing for a consumer and makes five phone calls to various organizations, spending a total of 25 minutes, but not more than 6 minutes with any one resource. Can the CSS bill for any of this? Can the CSS bill 2 units (25 minutes) and write one note?

A: Yes, if a CSS does multiple, brief collateral activities in a day for a single consumer, they may add the total time together. For billing purposes, the total time spent in a day should be added at the end of the day to calculate the number of units to be billed. The documentation may be in a single progress note summarizing the activities or in separate progress notes. However, please note that either method of documentation must include the exact time of the interventions per DMH and Medicaid documentation requirements.

Q: A CSS returns a consumer to their residential facility and then meets for 20 minutes discussing this consumer with the residential facility manager without the consumer present. Can this be included in the consumer CSS note, identifying the 20 minutes (1 unit) collateral contact and summarizing the discussion? Or is this a separate Collateral Contact note (1 unit)?

A: This may be documented in a single progress note or in two separate progress notes. If it is documented in a single note, the exact time spent with the consumer and in the collateral contact with the residential facility manager must be clearly noted and distinguished.

Q: If a consumer moves into a Skilled Nursing Facility (SNF), and staff is assisting the consumer after they have officially moved into the SNF, before discharging, is this billable?

A: No, Medicaid will not pay for any services for a consumer residing in a skilled nursing facility.

Q: I know that we cannot bill for time spent reviewing charts. Can we bill checking CyberAccess and noting any alerts for a consumer as community support, or would this be considered time spent reviewing a chart?

A: No, this would not be considered a billable community support activity.

Q: If the CSS attends the consumer's appointment with the doctor, can the CSS bill community support?

A: It depends. As long as the CSS documents and justifies why they are participating in the session and what allowable CS intervention they are providing during the time, yes, it is billable. If the CSS attends consumer appointments with the doctor on an ongoing basis, this should be noted in the treatment plan. However, the CSS should be working to develop natural supports to meet this long term need.

Q: If a CSS sits in on an IDDT session, can the CSS bill that time?

A: No.

Q: If a CSS stays with the consumer while he/she receives a service or procedure from a nurse, can the CSS bill that time?

A: It depends. As long as the CSS is providing a separate intervention during the nurse's services, yes, it is billable. If the CSS attends consumer appointments with the nurse on an ongoing basis, this should be noted in the treatment plan. However, the CSS should be working to develop natural supports to meet this long term need.

Q: Is Community Support built into the per diem rate for Youth Intensive CPR, or may it be billed separately?

A: Community Support is built into the per diem rate for Youth Intensive CPR; it may not be billed separately.

Q: Can a CSS bill for reviewing the medication administration record at a residential facility to determine if a consumer has been medication compliant?

A: No.

Q: Can a CSS bill for time spent alone in a waiting room while a consumer receives medical services?

A: No.

Q: Our tele-psych doctors are now saying the CSS and nurse both need to be in the doctor appointment with the client and parent. Can the CSS bill along with the nurse and tele-psych doctor?

A: Medical necessity is not justified just because the doctor requires the staff to be present. If the doctor insists that the CSS be present as a matter of course at all tele-psychiatry appointments you can have them there, but you cannot bill their time. However, if the CSS provides a specific, medically necessary intervention during this time the service is billable to CS. It should also be noted that nurse time is not billable during the same clock time as the physician's medication services (E/M services) whether provided through tele-psychiatry or face-to-face.

Q: Can CSSs bill CS for revising and updating the treatment plan for consumers who are in the CPR maintenance program?

A: Treatment planning (H0032) is the code that is used for treatment planning activities (development, reviewing and updating) for consumers in the CPRC maintenance level of care. This service must be provided by a QMHP and cannot be billed as community support.

Q: If counselor/therapist is trained and classified as a counselor and CSS and provides a crisis intervention service over the phone, can they bill CS?

A: Within CPRC, the service provided would be crisis intervention and resolution (please see the service definition for correct billing of this code) and must be billed by a QMHP. Within CSTAR, the service provided would be counseling, however services provided over the phone cannot be billed to individual counseling. Regardless of billing, the service should be documented.

Q: I have several questions regarding billing for court related activities with our consumers. Our child and youth staff often attend court proceedings related to the

children we serve. Sometimes they have been subpoenaed and sometimes they attend in order to gain information or provide support for their consumer. I would assume that any time spent sitting in the court room gathering information or time spent sitting with the consumer would not be billable. Is that correct? If a CSS testifies during the court proceeding, would that be billable as a collateral contact? If a CSS provides direct contact and interventions to the consumer prior to court or following court, is that billable (as long as it is tied to the treatment plan)?

A: Time spent sitting in the court room gathering information, when not directly interacting with the consumer or court officials, would not be billable to CS. Time spent providing a community support intervention when directly interacting with the consumer, before, during or after court, would be billable to CS. Time spent providing a community support intervention when directly interacting with the court officials on behalf of the consumer, including time spent testifying during the court proceeding, would be billable to CS as a collateral contact.

Q: How do we bill for CS services provided while in psychiatric hospitalization?

A: CS can be billed on the day of admission and the day of discharge for a consumer in CSTAR and CPR. For consumers receiving CPS services, "POS" Case Management can be billed for discharge planning activities while the consumer is in a psychiatric hospital. CPS providers may also bill Medicaid Administrative Case Management-Outreach for time spent reviewing inpatient admissions with inpatient staff and working with staff and consumers on discharge planning may be billed. This includes travel time to and from the facility, direct contact with facility staff and consumers, and phone contact. At this time CSTAR programs do not have non-Medicaid billing codes available for psychiatric hospital discharge planning activities.

Q: It seems to me that the redirection and prompts on use of social skills during family visits would be exactly the thing a CS should be doing. Would the Division consider revisiting this scenario?

A: The Division believes that active rehabilitation work with family to facilitate positive interactions and supports, to help a person remain in the community and to effectively deal with their illness in the context of their family as a support system is not the same as "accompanying a consumer to a family visit." Interventions must be medically necessary and identified in the assessment and treatment plan. Agencies must carefully document the medically necessary intervention provided to the consumer while with the consumer's family, because this can very easily slide into a gray area that could

result in recoupment. Examples of activities that are not allowable include, but are not limited to taking a consumer to a family reunion; dropping a consumer off to visit with a family member or staying throughout a social visit with family; and taking a consumer to a birthday party, picnic, or other family social event. In these instances the goal is social and unrelated to the person's mental illness and therefore, inappropriate for billing.

Q: Will DMH revisit billing during short educational videos that then include discussion about the information provided?

A: CSS may provide psychoeducation by using short videos that are clearly educational in nature such as those related to mental or physical health. Evidence Based Practices such as "Love and Logic" and "1, 2, 3 Magic" (for youth) would be appropriate examples. Documentation must include the description of the interaction between the consumer and CSS during the video and specific examples (i.e., role playing, completing worksheets, stopping the video and reviewing the material). The videos are a tool to teach the skill.

Q: Is development of the critical intervention plan billable if done collaboratively with the consumer?

A: Yes.

Q: Is there any time when it is appropriate to bill CS for looking in Cyber access for important information?

A: If there is a clinical need to review Cyber Access information with the consumer present and participating, it can be billed to CS. However, it is advised that consumers learn to use Direct Inform, the patient portal of Cyber Access. You may bill CS to teach the consumer how to set up their Direct Inform account and teach them to navigate the site. This should be a time limited intervention. If the consumer is not present and participating, review of Cyber Access is not billable to CS. Do not confuse this with guidelines to review Cyber Access during outreach to disease management (DM) consumers. CSSs providing outreach to DM consumers bill this service function to Outreach (prior to enrollment in CPR or CSTAR), never to CS.

Q: If the consumer is in a SNF, can POS case management be billed?

A: Yes. Consumers enrolled in CPS services may receive POS case management when

in an SNF. Agencies should evaluate the appropriateness of continuing to provide services when a consumer is in this level of care.

Q: Is texting an ok/billable means of communication for the deaf/hard of hearing population?

A: No. This is not a Medicaid reimbursable form of communication.

Q: If kids are in juvenile detention, can we bill CS to community service like when they are in the hospital?

A: No, not at this point in time, but we may allow this in the future.

Q: Can we bill medication administration/extended day treatment (nurse service) and CS at the same time?

A: It depends. As long as the CSS documents and justifies why they are participating in the session and what allowable CS intervention they are providing during that time, yes, it is billable. If the CSS attends consumer appointments with the nurse on an ongoing basis, this should be identified as a need in the assessment and noted in the treatment plan. However, the CSS should be working to develop natural supports to meet this long term need.

Q: Are there any exceptions to the rule about billing on consumers while they are in jail? There are a lot of collateral contacts and communication that still needs to take place while a client is incarcerated.

A: Currently no services are billable while a consumer is incarcerated. The Division is working on development of a special service category for billing limited services while a consumer is incarcerated. More information will be provided at a later date.

Q: When you are working on treatment planning is it acceptable to bill if this is being done through collaborative documentation?

A: No. Treatment planning is not billable to CS.

Q: For those of us in the ADA world that are transitioning to the new service definitions can you explain the difference between CSS services and counseling services? We have been use to fairly clear boundaries between the two services but now it appears that CSS can cover a great deal of what we are used to being counseling.

A: The Division is developing a guidance document and it will be issued as soon as it is finalized.

Q: Can a CSS bill for discussing the Wellness Plan Review with their clients?

A: Yes, if using the Wellness Plan worksheets that is a billable intervention to CS.

Q: We understand from the Q&A document that educational movies can't be billed to community support – what about work out videos if the CSS does the video with the child for exercise/health purposes?

A: Promotion of health/wellness/fitness is an important part of community support. The introduction of exercise videos for the promotion of wellness should include a physician consult, discussion about level of ability, scheduling of activity, etc. When medically necessary, a one-time demonstration could be appropriate but the documentation must clearly support the necessity of the CSS involvement. For sustainability, a parent/guardian should be included.

Q: Are treatment planning reviews billable to community support?

A: No. However within CSTAR, reviews completed by the Individual Counselor may be billed to Individual Counseling.

Q: If you have a staffing to review the ITP, how do you bill this activity? What if the consumer is present and part of the discussion? It seems to fit under function #4 and we don't want to lose billing for that group process.

A: This activity is not billable. It is expected that the CS is a part of this function, but it is not billable to CS.

Q: Transportation – when is it ok?

A: When it is in conjunction with accessing a medically necessary service and no other

transportation means are available, it is billable to CS. All other means of transportation should be exhausted, including natural supports, NEMT, public transportation, OATS, etc.

Q: Transportation with children – if you are transporting them to school when they are getting switched over to new transportation with the school, is this ok?

A: In CSTAR Women and Children programs only- You may bill CS to assist a child with getting to school until the school has made arrangements for the child's transportation. This should be very time limited and the CSS should be working with the mother to ensure the child's school needs are being arranged.

Q: For children who are collateral dependents – can we bill their enrollment into the system? Mom goes through the assessment, then the child goes through the assessment – how do we bill?

A: First of all, “enrollment” of services in CIMOR or an internal system is not a billable service. Currently there is no billing code specific for billing screening and assessment for collateral dependent services. Up to six units of H0004 UK may be billed for assessment.

Q: Can the Individual Counselor (IC) bill CS – like when billing for info to Probation and Parole (P&P)?

A: If the IC is functioning as the IC and there is an assigned CSS, the IC should not bill CS. The exception would be the rare occasion, such as in rural offices, when the IC is also functioning as the CSS.

Q: If a CSS leaves employment with the agency, can the counselor bill CS while the agency is trying to get the position filled?

A: Yes, if the IC qualifies as a CSS and the service meets the CS service definition, s/he may bill CS in the interim.

Q: Is there a daily limit for CS?

A: Yes, the limit is 24 units/day in CSTAR and 32 units/day in CPR. The DBH will be proposing to Medicaid that the unit limits are made the same for both programs.

Agencies will be notified when any policy changes are made.

Q: Children (collateral dependent) – do we still have the restriction of 20 units for child CSS?

A: Yes. The limitation is 20 units per child.

Q: The Division previously stated that if the service could be provided in a group, it should be. Is it true that this is no longer the Division's message?

A: Yes. CS is a one-on-one service that should be provided as needed to meet each individual consumer's needs. CS should be provided primarily in the community or home.

Q: Can a CSS add new information to a treatment plan if during the course of a CS service session; the CSS and consumer discover that there is another goal the consumer should be working on?

A: The CSS and consumer should be continually discussing treatment goals. If during the course of a CS service, it is determined that an additional goal needs to be added to the treatment plan, the treatment discussion is billable but time spent updating/writing the treatment plan is not billable to CS.

Q: Can two CSSs go out together for safety reasons?

A: Yes, but only one CSS may bill. If there are safety concerns, the CSS should consider meeting the consumer in a public place.

CARE COORDINATION/COLLATERALS

Q: Is time spent in email communication with collateral contacts billable?

A: No, only verbal communication with collateral contacts is billable as community support.

Q: It is my understanding that the community support specialist is able to bill when communicating with the consumer or collateral contacts by phone. Is this correct?

A: Yes, community support may be billed for direct contact by phone with consumers and collateral contacts. The purpose of the call, the CSS intervention, and the amount of time must be clear. The amount of time needed to meet the definition of a unit of service must also be present.

Q: We write letters of engagement to consumers whom we are unable to reach by phone. Is this billable as community support?

A: No, community support may not be billed for time spent writing letters.

Q: We use a client status report to provide monthly updates to Probation and Parole based on the DMH-DOC Treatment Guidelines. Is this billable as community support?

A: No, completing a client status report is not billable as community support. However, if this function is completed collaboratively with the consumer, then it could be billed.

Q: Is it true that only one worker can work with a consumer for both mental health (CPR) and substance abuse issues (CSTAR)?

A: If an agency provides both CPR and CSTAR programs, it is expected the agency would assign one CSS to provide CS services. If the consumer is receiving CPR and CSTAR services from two different agencies, the CSSs should coordinate care in order to not duplicate services.

Q: Is it true that clinical staffings are not a billable service?

A: The Division defines staffing as routinely scheduled meetings to discuss multiple consumers' current statuses and/or recovery goals; distribution of assessments and treatment plans/reviews for the purpose of obtaining signatures; discharge planning; coordination of schedules; and, crisis coverage planning. Routine clinical staff meetings as defined above are not billable as a community support service.

However, it would be permissible for the CSS to bill for meetings if the consumer is present and participating, and the purpose of the meeting is a service intervention provided with members of the treatment team. The CSS should be the only staff billing for this time. This would not be billable to CS if the purpose of the meeting is to interview for or develop the assessment, treatment plan, or treatment plan review.

Q: Is it permissible to bill CS for helping a consumer transition from one level of service to another, such as helping a consumer transition from an outpatient treatment level to a residential setting?

A: Yes, as long as there is justification that without the CSS intervention the transition may not be successful.

Q: Can CS be billed for conducting clinical reviews (clinical utilization review requests for ADA providers only)?

A: It depends, if the consumer is present in a face-to-face session while data is entered and staff shares or collaborates with the consumer regarding what is being documented, it is billable. If the consumer is not present, it is not billable.

Q: Can an individual counselor also serve as a consumer's CSS? This is of particular importance in remote/rural areas.

A: For ADA, as agencies have transitioned to CSTAR in rural areas, we have emphasized the importance of having a designated CSS staff on the treatment team. This particular question is currently under review by the Division. As a reminder, only qualified individuals may provide CS services that meet the definition of a key service function.

Q: Is communication between CSS and nurse reimbursable?

A: Yes.

Q: Regarding billable collateral contacts, the CS training states that we cannot bill for contact with CSS supervisors, other CSSs, and staff who provide group services. If all of our counselors/therapists facilitate groups, then does this exclude them?

A: CS may be billed for collateral contact with staff providing individual counseling to the identified consumer, regardless of whether or not that counselor(s) also facilitates groups.

Q: When it states on the slides "verbal contact not face-to-face with consumer but on behalf of the consumer" is this referring to locating resources or scheduling appointments or referrals that a consumer cannot contact himself/herself? Will the consumer need to be present when contacting other agencies?

A: It is appropriate and allowable to locate resources and schedule appointments or referrals that a consumer cannot contact himself/herself. It is not required that the consumer be present; of course, it is always best to have the consumer present as you model your process for finding the resource, talking with the resource, etc. It is very important that the assessment and treatment plan identify why the consumer is not able to make these contacts on his/her own. Not having a phone is not a good reason, but it would be a good example of why you as a CSS would be receiving the response to an inquiry that you and the consumer made together, such as contacting a housing representative to call your number back.

Q: Can the CSS bill community support for consulting with PSR staff, either when the consumer is attending a PSR activity or when they are not?

A: No, consultation with PSR staff is not billable as community support.

Q: If a doctor and CSS consult regarding a consumer, can the doctor bill Physician Consultation and the CSS bill community support?

A: Yes, the CSS bills CS for the collateral contact and the physician bills Consultation Services as outlined in the Medicaid CPR manual (CPR only).

Q: If the doctor and CSS review an annual CPR assessment in a case staffing meeting, can the doctor bill, and/or can the CSS bill?

A: No, neither staff can bill in this situation. The time of both staff is included in the bundled CPR assessment rate.

Q: Would interagency referrals and follow up with doctors, therapists, etc. be counted as a collateral agency contact?

A: Yes, consultation with professional agency staff who are also delivering services to the consumer is billable as community support. This would include making referrals to those other staff, as well as case consultation/coordination, as necessary.

Q: I am making the assumption that "care coordination" with other staff within our own organization would include the CSS with IDDT provider, CSS with therapist providing counseling under Enhanced PSR, and CSS with PSR Supervisor. Would this also include CSS to CSS, such as CSS who handled a crisis call to the assigned CSS? What about a CSS who is going on vacation and reviews a consumer with the CSS who will be covering that consumer during their vacation?

A: Case coordination/consultation by the CSS with IDDT staff and therapists may be billed as community support. Case coordination/consultation with PSR staff (including the PSR supervisor/director) and with other CSSs is not billable.

Q: Can case coordination by a CSS with a psychiatric nurse that works with the consumer's psychiatrist be billed?

A: Yes.

Q: Can nurses and IDDT staff bill collaterals?

A: No, only the community support service includes collateral contacts as a billable activity.

Q: We have Med Aide trained CSSs that, as part of the service, talk to nurses, pharmacies, and fill the consumer's med box, all without the consumer present. Would all these be considered billable as CS?

A: Communication with nurses and pharmacies on behalf of the consumer is considered a collateral contact and is billable to CS. However, filling a medication box without the consumer present would not be a billable activity.

Q: If there are two siblings and they each have a separate CSS, can the two CSSs collaborate and bill for that?

A: No.

Q: If there are two agency locations and separate CSSs, but they need to collaborate regarding a consumer, can they bill for that?

A: No. The CSS may bill to communicate with the counselor to appropriately coordinate care.

Q: Can we bill CS for collateral contacts when a child/youth is in a psychiatric hospitalization?

A: CS may be billed to the “Youth Community Services” category in CIMOR while a child/youth is in a psychiatric hospital bed. DO NOT BILL THE SERVICE TO THE YOUTH CPR CATEGORY.

Q: ADA--CPS, CPS--ADA can one agency with more than one location/service have a CSS work with another CSS in same agency to refer for services?

A: It is expected that agencies will begin moving to a single CSS model. CSS to CSS care coordination is not billable.

Q: What if the CSS was coordinating with another agency to transfer the consumer or seek additional services for consumer?

A: Yes, this would be billable as collateral contact, as long as the coordination is not with another CSS.

Q: Can the CSS bill if working with a nurse either in the agency or outside the agency?

A: Yes, this collateral contact may be billed to CS.

Q: If we call an agency on behalf of the client and the client is not present, can we bill CS?

A: Yes, this collateral contact may be billed to CS. All efforts should be made to include the consumer and documentation should explain the consumer’s non-participation.

TRAVEL

Q: How will the travel time work for CSS if meeting with multiple consumers at the end destination? For example, travel to a community setting to meet with three individuals...does the travel time only get billed to the first consumer seen versus split between all three?

A: Community Support is an individual service, so you should only meet with one consumer at a time. Travel to the location would be billed to the first consumer to whom you provided services. Additionally, travel back to the office would be billed to the last consumer to whom services were provided.

Q: In our organization, we have a CSS who has become CRADC certified and does both CSS work and IDDT services. She can bill for travel to and from working with her assigned consumers. My question is if she sees her assigned consumer, billing for travel to their home, and then does some in-home IDDT services after that with consumers who are not assigned to her as a CSS, can she bill for her return travel to the office (the same amount of time it took her to get to her consumer)? OR does the fact that she also did IDDT service prohibit her from being allowed to bill the return travel time?

A: Travel time may be billed when it is associated with Community Support services provided in community settings. It may not be billed when it is associated only with IDDT services. If a CSS travels to consumer A to deliver Community Support services, then travels to consumer B to deliver IDDT services, then travels back to the office, the time it takes to travel from consumer A to consumer B and then from consumer B back to the office is not billable, because it is not associated with delivering Community Support services. However, if the CSS spends a portion of the time with consumer B delivering Community Support services and a portion of the time delivering IDDT services, then all the travel time in this scenario would be billable.

Q: We are having difficulty trying to decide how the travel time would be billed when you go from consumer A to consumer B to consumer C. We do not come back to the office between visits. So does the travel time from Consumer A to Consumer B get billed to Consumer B? Even if Consumer B is close to the office and Consumer A lives 20 minutes away. It isn't practical to come back to the office after each visit.

A: If the CSS sees multiple consumers consecutively in one community visit, the billing time for consumer A starts when the CSS leaves the office to travel to meet with consumer A and ends when they are no longer face to face with consumer A. If they go directly to consumer B from consumer A, their billing time for consumer B starts when they leave consumer A. Staff are not expected to return to the office after each contact when seeing multiple consumers in the community during a single day. However, staff must ensure that the travel time being billed is connected to the direct contact with the consumer. If the CSS does not go directly to consumer B from consumer A, they must exclude from their billing time the travel that is not directly associated with getting to consumer B. Please see the separate attachment for further guidelines on billing travel scenarios.

Q: Can an agency bill Community Support for travel to and from a children's residential facility for monitoring a youth's progress, for transporting the parent to/from the facility (i.e. to facilitate the parents participation in facility meetings) and transporting the youth back and forth (admission, home visit, discharge)? This can add a significant amount of billable time.

A: Yes, this is billable time, if it is associated with monitoring and assessing the youth in the residential facility. However, please note that it is not required for staff to have face to face contact with youth in residential placements when those placements are a significant distance from the agency. But there may be times when it is appropriate for the CSS to actually travel the significant distance to the residential treatment center (e.g. when the child is having a very difficult time with the transition, or the residential treatment center is new to the staff member and meeting the treatment staff would be beneficial to the overall treatment of the child). Case coordination may occur by phone and/or through coordination with other administrative agents. It may not be a practical use of time or resources for a CSS to travel long distances for this type of case monitoring. CSSs should not be providing transportation only. If parents or the youth have simple transportation needs, those should be addressed using natural supports. CSSs should also attempt to find other resources to facilitate parent's participation in facility meetings, so he/she is not routinely relying on the CSS.

Q: Travel time may only be billed when associated with a specific completed service intervention in the consumer's home or community. Is the travel time billable when we bring a consumer to the office to complete the Annual Evaluation and the subsequent treatment plan reviews?

A: Yes, it is. However, attempts to access natural supports or other transportation means should be utilized first.

Q: Can a nurse bill travel time if they go to a consumer's apartment to give a shot for someone who is quite paranoid and otherwise wouldn't get their I.M. meds?

A: No, the revised billing instructions apply to CSSs and Community Support interventions, not Medication Administration.

QUALIFICATIONS

Q: Can a person with a lot of relevant experience be a CSS without a college degree?

A: Yes, an individual with at least four years of qualifying experience can provide community support services. The experience must be with one of the Department of Mental Health populations (substance abuse, mental health or developmental disability) and be some combination of the following:

1. Providing one-on-one or group services with a rehabilitation/habilitation and recovery/resiliency focus;

2. Teaching and modeling for individuals how to cope and manage psychiatric, developmental or substance abuse issues while encouraging the use of natural resources;
 3. Supporting efforts to find and maintain employment for individuals and/or to function appropriately in families, school and communities;
 4. Assisting individuals to achieve the goals and objectives on their individualized treatment or person centered plans.
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TRAINING

Q: All new CSS staff hired after January 1 must complete the training in Relias. Do they have 30 days to complete this?

A: Our expectation is that all new staff will receive the training within 30 days. This training relates to competency #2 “understand and perform respective job assignments” that should be completed within the first 30 days.

Q: How long do we have for existing CSSs and CSS supervisors to complete the training in Relias?

A: The Division has not specified when individuals should be trained on the new CSS requirement; however, given that these requirements went into effect on January 1, 2014, it would be in the agency’s best interest to ensure that all staff delivering CS services, as well as those supervising CSSs receive the training as soon as possible.

Q: Is this training required for residential intensive community support staff in our facilities, HCH staff and PSR staff?

A: No, the training is required for all staff delivering CS services, as well as those supervising CSSs. Please refer to 9 CSR 7.110 (2) (A-F): all staff must be trained and qualified to perform their assigned services and duties.

Q: Please clarify about the documentation of completion/competency for CS 101 training. Must documentation of the training be maintained in personnel records?

A: No, documentation of all training must be maintained by the agency and available for review. The Relias Learning System is one way to maintain training records.

Q: Does the written plan we develop that indicates how competencies will be measured

need to be submitted to the Department?

A: No.

Q: Do the training test scores need to be submitted to the Department?

A: No, verification of competency must be maintained by the agency.

Attachment A – Travel Scenarios for Billing

Policy:

Travel time by a CSS from their office location to a consumer or collateral contact in the community, then back to the office location, in the course of delivering an allowable Community Support service, is billable. If a CSS does drive directly from their home residence to see a consumer without first going to the office, or returns to his/her home residence at the end of the day without returning to the office, the travel time billed may not exceed the lesser of the actual time vs. the time it would have taken him/her had he/she been starting from or returning to the office location. Agencies must monitor these situations closely to insure that DMH and Medicaid are only billed for time clearly associated with the delivery of community support services.

The travel time must be associated with an allowable Community Support intervention: if a consumer or collateral contact is not actually seen, the travel time is not billable.

When seeing multiple consumers consecutively in the community without a break in between, the billing time for the first consumer ends when the CSS leaves that consumer and starts for the next consumer as he/she begins driving to see the second consumer.

When seeing multiple consumers consecutively in the community with a break in between for non-consumer related activities, the billing time ends when the CSS starts their non-consumer related activities and begins again when they cease those activities and begin traveling to see the next consumer. However, please note that when there is such a break between consumer related activities, the amount of travel time billed to go from the break to the next consumer may not exceed the time it would have taken to drive to the next consumer had there been no break.

Here are some common scenarios you may encounter with directions on how to bill each:

Scenario #1

CSS drives from his/her office to consumer A in the community (15 min.), provides Community Support services to the consumer (60 min.), and then drives back to the office (15 min).

Total billable time to Consumer A = 90 minutes (6 units)

Scenario #2

CSS drives from his/her office to consumer A in the community (15 min.), provides Community Support services to the consumer (60 min.), then drives to consumer B (5 min.), sees consumer B (30 min), then drives to consumer C (20 min.), sees consumer C (60 min.), then drives back to office (20 min.).

Total billable time to consumer A = 75 minutes (5 units)
Total billable time to consumer B = 35 minutes (2 units)
Total billable time to consumer C = 100 minutes (7 units)

Scenario #3

CSS drives from their office to consumer A in the community (15 min.), provides Community Support services to the consumer (60 min.), then drives to consumer B (5 min.), but consumer B is not home, then drives to consumer C (20 min.), sees consumer C (60 min.), then drives back to office (20 min.).

Total billable time to consumer A = 75 minutes (5 units)
Total billable time to consumer B = 0 minutes (0 units)
Total billable time to consumer C = 100 minutes (7 units)

Scenario #4

CSS drives from their office to consumer A in the community (15 min.), provides Community Support services to the consumer (60 min.), then drives to consumer B home (5 min.), sees consumer B (30 min), then takes a 60 minute break for non-consumer related activities (i.e., has lunch with a friend, does personal business, etc.), then drives to consumer C home (15 min.), sees consumer C (60 min.), then drives back to office (20 min.).

Total billable time to consumer A = 75 minutes (5 units)
Total billable time to consumer B = 35 minutes (2 units)
Total billable time to consumer C = 95 minutes (6 units)

*note: the 15 minute travel time billed to get to consumer C may not exceed the time it would have taken had the CSS driven directly to consumer C from consumer B.