

Frequently Asked Questions

12.31.2011

General Questions for the Outpatient Rule:

1. In the training, it was said that services done by clinical trainees will be reimbursed by the supervisor's rate. Is there a chart available? Does this change the master's level and practitioner cut backs for Community Mental Health Centers?

Answer: The services provided by clinical trainees are paid at the clinical supervisor's rate as of June 28, 2011. The rates posted in the chart are the current maximum allowed, fee-for-service, rate for the code. However, services may be reimbursed at an adjusted rate when provided by a master's level enrolled provider (80% of maximum allowed rate). A rates chart can be found on the [Outpatient Rule webpage](#) under the Resources section.

2. Are clinicians required to document literal start and stop times for each session or appointment? Is this for all settings and for all services performed by a mental health provider—including a nursing home or other inpatient setting? Does the start/stop time for all the work for the client or just face to face time?

Answer: Yes, a clinician must document the start and stop time for each face-to-face appointment/session with a client. Documentation requirements are the same for outpatient services provided under a physician plan of care for a nursing home resident. Documentation of services provided to a person who is an inpatient must follow the hospital's protocol but psychotherapy provided under a physician plan of care provided to an inpatient should follow the same documentation requirements for start / stop times.

3. How does a clinician document the 3 appointments for an extended diagnostic assessment?

Answer: The clinician would write a case note for each appointment documenting the start and stop time for each appointment. There also should be an explanation documenting how the client met the eligibility criteria for the extended diagnostic assessment.

4. If a psychotherapy group normally has 5 or 6 members but only 2 members are able to attend on a given day (due to weather, illness, etc.) can that session be billed?

Answer: Psychotherapy groups must be designed to have a minimum of 3 members to meet the threshold of a group intervention. In extreme cases (like illness or snow storms) a psychotherapy group can be held with only 2 members but that cannot be an on-going situation. When submitting a claim for the service (with 2 group members instead of 3 or more) apply the appropriate modifier for reduction of service.

5. Both the CAGE AID and the GAIN-SS are acceptable to use as drug and alcohol screenings in the process of completing an outpatient DA as per the latest DHS update bulletin - correct? Neither of these screenings is reimbursable through MHCP - correct? Are any screenings for drug and alcohol issues reimbursable through MHCP? How can an agency be added to the state's GAIN-SS license?

Answer: Yes, the CAGE-AID and the GAIN-SS are endorsed screening tools to be used in the diagnostic assessment process to comply with the current Outpatient Rule. There is not a separate billing code for conducting or interpreting a drug and alcohol screen because it is an expected portion of the diagnostic assessment criteria and is reimbursed as a part of the diagnostic assessment session. While the GAIN-SS is copyrighted by Chestnut Health Systems, the State of Minnesota Department of Human Services maintains a license for the following users:

- Enrolled and Approved Minnesota Health Care Program Providers
- MCO contracted providers with Minnesota Department of Human Services
- Approved treatment providers licensed under Minnesota Rule 31
- County social service and county juvenile corrections staff
- Approved assessors under Minnesota Rule 25
- Approved Minnesota gambling treatment providers
- Minnesota Department of Human Services State Operated Services
- Minnesota tribal entities

Contact DHS for questions about the license agreement or to be added to the license agreement.

6. Now that DHS has included “patient” in the parties that can be included in “explanation of findings”, does this mean that DHS will separately reimburse a psychologist or neuropsychologist for CPT code 90887 when they provide the test results to the patient?

Answer: An “explanation of findings” session requires the presence of other people and *may* include the client. Explaining the results of psychological testing to the client themselves is considered a part of the testing process and is compensated within the rate for the original service.

7. If a client switches insurance during the therapy process to fee-for-service MA and their original insurance company did not require a CASII/SDQ or any screening tools, what should the clinician do in order to make sure the client's DA meets criteria for the outpatient rule?

Answer: The clinician can do an addendum to the diagnostic assessment and complete the screening tools and CASII (or whatever else is missing in the original document) to make sure the diagnostic assessment meets the current rule.

8. In the bulletin it is stated that a brief 90801 receives up to 10 visits, and an extended can receive up to 3-4 more, but what is the amount of visits that standard receives? Or is this determined upon authorization?

Answer: A diagnostic assessment determines if and which mental health diagnosis a client has and what forms of mental health treatment is medically necessary. Most services require a standard or an extended for eligibility. Please see the MHCP provider manual for authorization thresholds for each service.

9. For billing Diagnostic Assessments, I know that for a Clinical Trainee it needs to be billed under the Clinical Supervisor's NPI. However, on what form does this need to be billed on? Can it be a UB or does it need to be a HCFA?

Answer: The department requires electronic billing. The DA is billed on the 837P form or through MN-ITS. The clinical supervisor's NPI must be on the line with the DA procedure code and must include the modifier HN to indicate the service was provided by a clinical trainee.

10. If a client starts out with either MA or PMAP and sometime during the standard or extended diagnostic assessment process they switch to the other type of insurance do we just bill the DA report to the insurance that the client has at that time. Will the agency run any risk during an audit if the face to face sessions occurred with the insurance that did not get billed for the report.

Answer: The billing date is the date the report is completed and signed. Bill the DA to the appropriate payer that is effective on that date.

11. How is travel time billed for appointments during an extended diagnostic assessment session?

Answer: Travel time must be billed with a service. Total travel time is billed with the same date as the extended diagnostic assessment session. Individual travel time per appointment should be documented in the client's file. The extended diagnostic assessment session date is the date that the report is written and signed by the licensed mental health professional.

12. What is the link to the new Outpatient Rule webpage that is documented in the Bulletin #11-53-03?

Answer: The Outpatient Mental Health Services [Webpage](#) has many helpful resources including training materials.

13. With the 6/28/11 effective date of these rules, is that the point at which we implement the new limitations such as getting a prior authorization for clients needing more than the threshold of 10? Or is it retroactively inclusive of the whole calendar year?

Answer: there is not prior authorization for clients needing more than 10 psychotherapy sessions—if a client received a brief diagnostic assessment (which determined eligibility for 10 psychotherapy sessions) and now requires more than 10 sessions, a clinician would conduct a standard or extended diagnostic assessment to determine eligibility for the rest of the year.

14. How do we figure out the services accessed by a client prior to starting services at our clinic? I thought I had read where this was available through MN-Its but do not see how to accomplish it. Will outpatient mental health be added to the Health Information Request tool that is available to other provider types? Is it possible to get instructions of where to access MN-ITS to check the tracking for visits for an eligible client?

Answer: Use information on DHS [MN-ITS User Guides](#) page. Go to Verifying Eligibility and click on first link. On page 2 of the guide go to the section called Understanding your Eligibility Response (271). On the response you are looking for *fee for service benefit limits*.

15. What are the acceptable or necessary supporting documents for prior authorization review? Do we still use the MN Universal Treatment Plan?

Answer: See the documentation expectations for specific services and the general documentation for health care services. Link to provider manual. MHCP fee for service does not use the MN Universal Treatment Plan.

16. For outpatient mental health services (psychotherapy or testing) is it accurate to use the DHS-4159 for "children" 18 and younger and the DHS-4695 for adults?

Answer: If you are asking if these forms can be used for outpatient services, the answer for the CTSS authorization form DHS-4159 is no—it can only be utilized for CTSS services. The form DHS-4695 can be used for prior authorization for outpatient service for adults and children or through the MN-ITS system (which is preferred).

17. Will MN-Its be ready to accept 278 transactions for mental health prior to March, 2012? If it's ready now, it would not accept my input as recent as yesterday (10/18/11). Will DHS roll out any sooner than March, 2012 with the mechanism for reviewing previous authorization requests and where a submitted request is within the authorization process, as stated in MN Statutes 256B.0625 - Subd. 25, item #3?

Answer: Yes DHS will be ready before March 2012. See [5010 web page](#). DHS is communicating and updating this web page with the most recent 5010 changes.

18. If an interpreter is used during a diagnostic assessment and a 90802 (Interactive diagnostic assessment) is billed, is interpreting still billed separately or is that a part of the 90802?

Answer: The interpreter services are not a part of the 90802 rate and should be billed according to MHCP manual policy for billing interpreters. should be billed accordingly.

19. Is there a separate code for interactive psychotherapy? If there is an interpreter during individual psychotherapy is a 90806 billed?

Answer: There are several codes for interactive psychotherapy which are documented in the psychotherapy section of the [MHCP Mental Health services manual](#). Interactive psychotherapy is to be utilized under the following circumstances as documented in the MHCP manual:

Interactive Psychotherapy

Interactive psychotherapy is typically provided to children, and procedures are distinct diagnostic and medical psychotherapeutic procedures using physical aids and nonverbal communication to overcome barriers to therapeutic interaction between the physician and recipient who:

- Has lost or has not yet developed either the expressive language communication skills to explain his/her symptoms and response to treatment; or
- Does not possess the receptive communication skills to understand the mental health professional if he/she were to use ordinary adult language for communication.

Interactive psychotherapy services count toward the same coverage and authorization limits as individual and group psychotherapy sessions.

Do not provide individual or group psychotherapy concurrently with interactive individual or interactive group psychotherapy.

In order to determine whether interactive psychotherapy or individual psychotherapy is utilized should be determined by pairing the service that is being provided with the service definition in the MHCP provider manual.

20. When billing for an individual, group, or family psychotherapy session prior to the completion of the diagnostic assessment, are there appropriate or acceptable diagnoses to be used?

Answer: The diagnosis code should be the same as what is determined in the diagnostic assessment. Generally, a clinician would hold the claim for the psychotherapy session until the diagnosis is determined.

21. Can the Adult Update (which can be used in years 2 and 3 to maintain eligibility for services) be utilized to determine eligibility for Adult Mental Health Targeted Case Management?

Answer: No, in order to determine eligibility for MH-TCM, an extended or standard diagnostic assessment needs to be conducted. A recipient must meet criteria for SPMI or SED (Children) to meet criteria for Mental Health Targeted Case Management.

Clinical Supervision:

1. Is there a DHS expectation in terms of how often and for what duration clinical supervisors are supposed to meet with clinical trainees and/or mental health practitioners?

Answer: There is no set time required; each supervisee needs a different level of clinical supervision—frequency and duration, based on their clinical development. The clinical supervisor determines what is necessary, based on their clinical judgment and comfort level, and describes the frequency, duration, and method (individual and/or group) of supervision in the supervision plan per supervisee. DHS' expectation is that the clinical supervisor complies with the supervision plan.

2. Where can one find the Clinical Supervision Assurance form?

Answer: The form can be found on the [Outpatient Rule](#) website and through this [link](#).

3. In order to be a clinical supervisor for services within this rule (diagnostic assessments, psychotherapy, partial hospitalization, DBT, Adult Day treatment, etc.) does the clinician have to meet ALL of the criteria listed in rule?

Answer: Yes. In order to submit claims to MHCP for a clinical trainee or a practitioner providing services covered in this rule, the clinical supervisor needs to meet all of the criteria.

4. Is the supervision plan a requirement for all of the mental health practitioners listed in this rule or just for the clinical trainees?

Answer: The supervision plan requirement applies to all mental health practitioners providing services under this rule.

5. What is the duration of time that supervision records (the supervisee record) need to be kept?

Answer: This is an agency human resource and legal decision; follow requirements for medical records retention as documented in the MHCP provider manual.

6. On slide 19 of DHS's presentation on The Planning for and Provision of Clinical Supervision, the last bullet point is "authorized scope of practice (has 3 sub-items)". Can you direct me to a resource that tells me what those 3 sub-items are?

Answer: During Fall 2011, the training slides were revised due to feedback from the training. You may visit the [Outpatient Rule website](#) to view the updated training materials on Clinical Supervision. The information is also found in MN Rule 9505.0371, Subp.4 (C), item 6, a-c. They are: a) description of the supervisee's service responsibilities, b) description of the client population, and c) treatment methods and modalities.

7. Where can someone get a copy of the MN Rule (9505.0371) about the provision of clinical supervision for mental health practitioners?

Answer: Links to the official Rule can be found on the [Outpatient Rule website](#) at the top of the page.

8. What is the definition of a Mental Health Practitioner? What is the definition of a Clinical Trainee? What are the State requirements for these two positions?

Answer: This information is located within the MN Rule 9505.0371 with the [Mental Health Practitioner defined in Subpart 5 \(B\)](#). The definition of a clinical trainee is defined in [9505.0371 Subpart 5 \(C\)](#).

9. A CTSS supervisor is required to sign off on all progress notes; under Rule 47 is there a similar expectation or would a chart review note every 30 days be sufficient?

Answer: Signing and reviewing case note frequency is determined by each supervisor and described in the supervision plan. Whatever is determined through the supervisor's clinical judgment should be applied to the case notes and chart review.

10. Where does one document clinical supervision?

Answer: Documentation expectations should be described within the supervision plan and then maintained. Documentation of clinical supervision needs to go in multiple places. Client records would include information that is client specific, to carry out treatment recommendations. A supervisee/supervision record tracks progress of a supervisee and includes information about their work and development as a mental health practitioner or clinical trainee.

11. How often do I need to document clinical supervision?

Answer: The supervision plan needs to be updated annually per supervisee, at a minimum. There needs to be documentation of every supervision session recorded to demonstrate that the plan is being followed. Whatever is documented in the plan needs to be documented in the supervisee or the client record.

12. If the clinical supervision plan includes specific number of hours for individual and group supervision does that need to be documented.

Answer: Yes. Supervision meetings need to be documented to demonstrate that the plan was maintained and followed.

Diagnostic Assessments:

1. Is an extended Diagnostic Assessment required for any child under the age of 5 or just recommended (i.e. could a standard be done).

Answer: An extended Diagnostic Assessment is strongly recommended for a child under the age of 5 but is not required.

2. How should the new range of diagnostic assessments be billed when a client has both Medicaid and Medicare?

Answer: Always bill Medicare first, please note that Medicare does recognize the 3 tier modifiers but do recognize the standard 90801 and 90802. Follow Medicare standards for billing a diagnostic assessment.

3. How do you bill an extended if you have multiple assessors who are all mental health professionals (i.e. appointments done by different people on the team)?

Answer: All appointments to complete an extended diagnostic assessment must be done by the same mental health professional.

4. Is there a timeframe in which all 3 appointments for an extended needs to be completed?

Answer: No there is nothing written in Rule that the 3 appointments need to be done within a particular timeframe.

5. If a client comes in and a brief diagnostic assessment but the client does not return for therapy, is that a billable service? Could it be billed as a therapy session?

Answer: In order to submit a claim for a Brief Diagnostic Assessment, all the requirements for the brief need to be met (MHCP reimburses for the session—the product that is completed not the face-to-face interview time). If therapy was not provided during that session, therapy cannot be billed. The claim and the service need to match.

6. How does the billing for a psychotherapy session before a diagnostic assessment is complete work?

Answer: It is generally assumed that the psychotherapy session is done in-between the diagnostic interview but before the report (and therefore claim) has been generated for the diagnostic assessment. It is not meant to be used as the first meeting with a client. A clinician would hold the claim for the psychotherapy session until the diagnosis is determined.

7. Are PMAPs required to offer the same diagnostic assessment tiers?

Answer: Yes, Prepaid Medical Assistance Plans are required to honor all the benefits available to clients in Minnesota Health Care Programs.

8. If a patient has residual cognitive impairment (i.e. from a traumatic brain injury) and is only able to respond to questions with a “yes” or “no”, should questions about such things as “perceptions of his/her illness” or “recipient’s description of symptoms be presented in such a fashion so as to allow the patient to respond with a “yes” or “no”?

Answer: Clinical judgment needs to be utilized to determine how questions should be asked and when collateral contacts can provide insight and information needed for the diagnostic assessment.

9. If a client indicated that they have no history of drug or alcohol use, is a clinician still required to use the screening instruments to determine if the client has the potential for such abuse?

Answer: Yes, a chemical health screen is necessary for everyone (unless they have recently been through a chemical health evaluation that provides more thorough information than the screen can provide).

10. Is there an Adult Diagnostic Assessment form that is endorsed by DHS?

Answer: No. There is only a suggested child’s diagnostic assessment template.

11. Are there definitions of “cultural influences” available with examples?

Answer: Yes. A [Cultural Influences Defined](#) handout was created as the training evolved over Fall 2011. There is a link to it on the Outpatient Website.

12. If the client does not have any family history of medical or mental health that is relevant to the assessment, but does have chemical dependency history, can the provider just document the chemical dependency information?

Answer: If nothing is mentioned within the diagnostic assessment report, it could be assumed that it wasn't assessed. A simple statement such as "the client reported no medical or mental health history of note" would suffice.

13. Is it required that there be a formal Diagnostic Assessment interview each year to maintain eligibility for services or can a clinician just write up a report based on the information garnered during the year and bill for that service?

Answer: In order to submit a claim for a Diagnostic Assessment there needs to be a face to face diagnostic assessment interview. Simply remembering all the information garnered during the year would not be sufficient. A clinician cannot bill for a service when the service has not been provided.

14. What are the recommendations for a couple's intake for the diagnostic assessment? is it advised to do a separate DA for both individuals or is one sufficient if only one of them is being diagnosed?

Answer: Couples psychotherapy is not a covered service for Minnesota Health Care Programs. Family psychotherapy is a covered service. Generally family therapy is based on the medical necessity of that service (as evaluated in a diagnostic assessment) and then claims are submitted under the name of that client.

15. If someone comes in for only 1 diagnostic assessment interview appointment, what can be billed?

Answer: A claim is submitted based on the product that is created. If the clinician was able to garner sufficient data for the brief and a brief diagnostic assessment report was produced, a claim for a brief would be submitted.

16. Do I need to request an authorization if a client has already had 2 diagnostic assessments this year and I need to do another one?

Answer: Authorizations for diagnostic assessments 3 and 4 during the calendar year will be granted for the following reasons: 1) the client is looking for a second opinion, 2) the clinician finds the previous diagnostic assessment to not be applicable or current (either the clinician does not agree with the previous diagnosis or the client's mental health condition has changed markedly) or 3) the client refuses to give consent for a release of information to the previous provider to obtain the other diagnostic assessment.

17. Can you do an update off of another provider's diagnostic assessment?

Answer: Yes. The decision to do an update or a new diagnostic assessment annually for adults is based on the clinician's clinical judgment.

18. Can I update a diagnostic assessment that is 5 years old?

Answer: No. A diagnostic assessment for an adult may be updated on years 2 and 3 of service but need a new diagnostic assessment on year 4. For example, a client receives a standard diagnostic assessment in 2011; in 2012 and 2013 the clinician may choose to do an adult update if their clinical judgment determines that is the best diagnostic option for the client. In 2014 the client needs to have a new standard or extended diagnostic assessment to determine eligibility for on-going mental health services.

19. How do I do an authorization?

Answer: Follow the authorization process described in the [MHCP Provider Manual](#).

20. In order to provide just medication management services, is a standard or extended diagnostic assessment required?

Answer: No, a brief diagnostic assessment may be utilized to determine eligibility for a medication management service.