QRTIPS
Health Care Agency • Behavorial Health Services • CYS Quality, Review & Training

March 2009

Billable Services Progress Notes

Dear Happy to Help,
I am never sure if I can bill for the time it takes to fill out referral forms and other information regarding a client. Can you help me understand how to differentiate what is billable to Medi-Cal from what isn't?
Sincerely,
Super Conscientious

Dear Super Conscientious,
You raise an excellent question! We are certainly determined to bill whenever warranted! The issue at hand is whether or not the document concerned requires your professional/clinical angle. Forms such as those requested for a client applying for SSI, TBS applications and parts of Wraparound applications clearly require a clinical perspective in their completion. So billing for your time on such forms is warranted. It is also important to keep a copy of said forms in the chart so that they can be located by auditors. On the other hand, it has been determined that the written form of the CAR report form is considered "*administrative*" and thus non-billable. This "administrative" perspective may further apply to some forms such as mentor applications, some WRAP forms, and within clinic referral forms, i.e. to request a psychiatrist for a case on forms not requiring clinical information.
Sincerely,
Happy to Help

Dear Happy to Help,
My MRT has been requesting that I rewrite notes because he says the intervention is only vaguely related to the CSP goals even when I am stating what happened in the session! Can you help me avoid future re-writes?
Sincerely,
Outta Time

Dear Outta Time,
I realize it is annoying to have to rewrite a note….needless to say we are seriously not allowing billable services to go unbilled to avoid the rewrite AND we want all of our billable notes to survive the review of the auditors. I would encourage you to explore ways of keeping on the track of working closely to the CSP goals such that the interventions always directly address one or more CSP goals. It is a given that the work you do is goal-oriented, thus, every note (with very unique exceptions ie., if a crisis arises during a session, then this issue must be addressed even if it is not part of the CSP) needs to reflect the connection between what you do in session and the goals developed for the client. What "actually happens in the session" has to be documented in terms of the addressing of the CSP goal(s). I suggest referring to your CSP when you write your notes in order to make sure that your documentation reflects a tight connection between the intervention and the goal. Finding a chart is sometimes challenging as is not all have their assessments in the shared folder, so you may have to be creative in order to

have the cues you need at your fingertips. I also suggest talking to your colleagues to get efficient ideas on how to tighten up in this area.

Thanks for your understanding,
Happy to Help