

## FAQ 3-9-15

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1. Can a Care Coordinator write a treatment plan for all services delivered by the agency? **Yes, but everyone participates.**
2. Can a Care Coordinator do the CAR scores? **Care Coordinator may gather information, but does not score.**
3. Can I get some clarification on something from the TA training? I thought it was stated that the case managers could and should complete the CAR assessment for health home consumers by consulting and gathering info from all team members? Is this the case, and is it written that way in the OHCA rules? Can/should we proceed with that model or wait until it is officially in writing, if it isn't already. **Care Coordinator may gather information, but does not score. Please refer to new table for details and billing codes.**
4. Can you help clarify on the T2001 and S0215 travel and transportation codes?  
**Please refer to new table for details and billing codes.**
  - a. Are those for PACT and SOC only or can those codes be used for adults as well?
5. We can see discussing HH and conducting outreach and engagement in the context of a case management encounter or even a therapy session. What seems unclear is how G9001 works in those circumstances. Do we carve out 15 min of a CM or therapy session that is for G9001 so that there is no overlap or can these events occur concurrently? **I liken the G9001 code to a pseudo-case management service. Using that logic, a therapy session is supposed to include any case management provided since the coding guidelines consider CM to be an integral part to the therapy session (i.e. CM is not separately billable for any CM provided during a therapy session). So, if during the course of the session, the therapist mentions health homes, I don't think they should be able to bill the outreach code. But if separate and distinct from the therapy service, the provider spends at least 8 minutes talking to the client about health homes, then they need to make a separate note in the chart and can bill the G9001.**

The same logic would apply during a case management session. For instance, if the CM is focusing on identifying resources for housing for 30 minutes, then works with the client to explain HH's and how they may be of benefit to the client for at least 8 minutes after the 30 minute CM session, then they could bill G9001 if the note reflects that the outreach/engagement session was distinct from the CM services provided.
6. Can Care Coordination be coded by multiple staff at the same time on the same client? For example, We have a nurse, LBHP and APRN who are all meeting to consult about a client. Can those three staff all code their Care Coordination? **Yes, they will not be audited like FFS, allows for care coordination.**