



“Requested” Client Status Billing

This guide serves to provide clarification on what services may be provided and billed while a client is in “*Requested*” status in SmartCare (i.e., prior to formal SMHS enrollment), and, when enrollment is required under No Wrong Door. “Pre-enrollment” services are intended for screening, assessment of appropriateness, and care coordination only - not for ongoing treatment.

1. When to Use “Requested” Status for Clients

Place a client in “Requested” status when:

- A referral has been received, and eligibility is being determined, requiring client direct contact
- Limited care coordination is needed to determine appropriate level of care
- Facilitating a warm handoff of a referral to another provider
- Supporting access while client is pending formal intake assessment date
- Documenting any communication and engagement (billable/non-billable)

Requested status is not intended for ongoing treatment services and not all clients in “requested” status will receive SMHS prior to their enrollment.

2. Minimum Requirements for Entering/Billing for Services in “Requested”

Before submitting any billable claim(s), ensure:

- Demographics are entered in SmartCare (limited/current info is OK)
- Insurance information is entered
 - UMDAP
 - Medi-Cal or Any Other Insurance Information (as applicable)
- Financial screening completed (if applicable)
- Required CSI data completed (per SmartCare workflow)
- Service is documented with the appropriate CPT code
- Program has indicated a diagnosis for the client- SDOH Z Codes also allowable when applicable. Z03.89
- Medical necessity has been addressed when applicable within any billable services



Programs should utilize the [SmartCare Walk-In Workflow](#) when applicable.

*Non-Billable service notes may be entered without the above indicated requirements for entering informational or brief contact documentation.

For TADT Access Time reporting, screening or billed contact in “requested” status does not replace the first offered and first attended appointment. NOABD requirements still apply for timely access notices when applicable.

3. What Services are Appropriate in Requested Status?

A. Screening / Pre-Assessment (*May Be Billable*)

Purpose: To determine eligibility and medical necessity for your Program.

Examples:

- Structured screening tool administration
- Clinical interview to assess appropriateness for level of care/program requirements
- Review of presenting concerns

Billable if:

- A clinical service is provided
- Documentation supports the screening activity
- CPT code reflects the appropriate assessment/screening

Not billable if:

- Only providing general program information
- Scheduling appointments only
- **Screening tools should be approved by their COR; does not indicate completion of referral form or unstructured questioning about SMHS Sxs.

B. Targeted Case Management (TCM) / ICC (*May Be Billable*)

Purpose: Care coordination to support access or determine appropriate provider.

Examples:

- Linking client/family to supportive or needed community resources
- Coordinating with referral source



- Obtaining pertinent collateral information for access to services
- Insurance/benefits coordination
- Warm handoff to another agency

Billable if:

- Activity meets TCM/ICC definition
- Coordination is active and clinically appropriate (not a passive referral)
- Documentation supports service purpose

Not billable if:

- Providing general resource lists only
- Internal administrative tasks
- Information-only contact

C. Warm Handoff (*May Be Billable as TCM/ICC*)

Billable when:

- Active coordination with receiving provider is taking place
- Direct support being provided to client to ensure connection
- Follow-up to confirm linkage

Not billable when:

- Providing a phone number without coordination
- Passive referral

D. Peer Support Services / Community Health Worker (CHW) Services (*May Be Billable*)

Billable if:

- The service falls within the scope of Peer Support Specialist or CHW services
- The activity supports access to care, engagement, wellness, recovery, or service coordination
- Documentation clearly describes the intervention provided and purpose of the contact
- The service is directed toward the client's identified needs and supports medical necessity when applicable

Not billable if:



- Contact is solely administrative, informational or scheduling in nature
- No intervention, support, education, or coordination is provided to indicate billable service

4. When Enrollment Is Required (No Wrong Door)

A client must be enrolled immediately (not remain in “Requested” status) if any of the following occur:

- Crisis intervention
- Safety planning
- Ongoing psychotherapy
- Medication services
- Clinical treatment beyond screening and limited case management

If these services are provided:

1. Initiate enrollment
2. Assign admission date
3. Complete all required documentation and Assessment
4. Submit all claims accordingly

Requested status should **not** be used to delay enrollment when treatment has begun.

5. Quick Reference Table:

Service Type	Requested Status Billable?	Enrollment Required?
Screening call	Yes	No
Structured screening tool	Yes	No
Care coordination	Yes	No
Warm handoff	Yes	No
Peer/CHW Linkage	Yes	No
Crisis Intervention	No	Yes
Safety planning	No	Yes



Service Type	Requested Status Billable?	Enrollment Required?
Ongoing therapy	No	Yes

6. Monitoring and Ongoing Review

Please consult the following link via CalMHSA for guidance on how to follow up on clients in “requested” status: [How to Manage Referrals to Your Program - 2023 CalMHSA](#)

Please note that the requested status is not meant to house the client indefinitely. Timely access timelines are still required to be met with an NOABD issued if timely access to treatment cannot be achieved. The program should work to enroll the client, connect the client to another provider/ more appropriate referral via warm handoff or within clinically appropriate timeframes to prevent delays in treatment.