RESOURCES FOR CHAPLAINS

CMS Chaplain Services Codes

How Do Chaplains Use The Codes?

This section contains code descriptions developed by a team of health care chaplains led by Transforming Chaplaincy and HealthCare Chaplaincy Network and building on descriptions already in use by the Veterans Health Administration. They are meant to guide implementation of these codes throughout US health care. Codes should be applied in all settings of care including virtual/telehealth visits or groups.

Chaplain Assessment

Use this code whenever a chaplain performs and documents a comprehensive spiritual assessment of a patient during a visit. For encounters that do not meet this code's criteria, use the individual counseling code Q9002 for a visit with an individual patient or Q9003 for an encounter with a group of patients, even if this is an initial encounter.

Q9001 Assessment by chaplain services

- Assessment includes spiritual, religious, existential (S/R/E) history, identifying S/R/E concerns and resources, the level and nature of spiritual distress, and the impact of S/R/E issues/resources on the patient's coping, their health status, and their receipt of health services. Recommendations for addressing S/R/E issues in patient care should be included.
- Use comprehensive and evidence-based spiritual assessment models/tools. Examples of these include the 7x7 model and the Spiritual AIM model.
- Documentation and chart review are included in this code and may not be coded separately.

<u>Required elements for documentation:</u>

- Relevant spiritual, religious, existential history and practices and their importance.
- Current S/R/E concerns/needs, resources, and practices and their impact on coping with illness and health status.
- The level and nature of spiritual distress.
- Recommendations for addressing S/R/E issues in patient care.
- Relevant family, social, community, and developmental factors impacting the patient's coping and health (e.g., family and social dynamics, community resources/needs, and developmental history), where applicable.
- Assessment of pertinent emotional state(s)/expressions or state of mind including suicidal/homicidal ideation where applicable.
- Care plan or treatment plan, including the frequency and nature/types of chaplaincy services/interventions needed for ongoing care/treatment as appropriate.
- If counseling is planned, the documentation should indicate that the patient consents to and is able to participate in and benefit from counseling.
- Anticipated treatment duration (interval), where applicable.

Chaplain Individual Counseling

Use this code for any visit with an individual that does not include a spiritual assessment. Use the code for an initial encounter without spiritual assessment or a follow up visit with an established patient, including a bereavement visit.

Q9002 Counseling, Individual, by chaplain services

- Counseling of others related to the patient can be included if the encounter would normally be included in documentation and the interactions are separate from the visit with the patient.
- Documentation and chart review are included in this code and may not be coded separately.
- Counseling of staff is **not included** with this code.

Required elements for documentation:

- Reason for encounter.
- Currently acute and relevant S/R/E concerns/needs and resources and their impact on coping with illness and health status (as presented in the encounter).
- The current level and nature of spiritual distress (as presented in the encounter).
- Appropriate high-risk factors (such as suicidal/homicidal ideation) where applicable.
- Chaplaincy interventions and their outcomes/impact should be explicitly stated.
    - Using published taxonomies or established/consensus-based terminology for describing chaplaincy interventions is highly recommended.
    - Listing interventions should be limited to a few most important/impactful interventions that were most helpful/useful to the care recipient.
- Recommendations for addressing S/R/E issues in patient care.
- Changes in treatment plan when appropriate, indicating the frequency and nature/types of chaplaincy services/interventions needed for ongoing care/treatment.
- Time spent.

Chaplain Group Counseling

Use this code for any established patient in a chaplain-led group discussion, including bereavement.

Q9003 Counseling, Group, by chaplain services

- Documentation and chart review are included in this code and may not be coded separately.
- Documentation must be present in each patient's health record.

Required elements for documentation:

- Reason for encounter and the goal(s) of group counseling.
- Currently acute and relevant S/R/E concerns/needs and resources and their impact on coping with illness and health status (as presented in the encounter).
- The current level and nature of spiritual distress (as presented in the encounter).
- Appropriate high-risk factors (such as suicidal/homicidal ideation) where applicable.
- Chaplaincy interventions and their outcomes/impact should be explicitly stated.
    - Using published taxonomies or established/consensus-based terminology for describing chaplaincy interventions is highly recommended.

    - Listing interventions should be limited to a few most important/impactful interventions that were most helpful/useful to the care recipient.
- Recommendations for addressing S/R/E issues in patient care.
- Changes in treatment plan when appropriate, indicating the frequency and nature/types of chaplaincy services/interventions needed for ongoing care/treatment.
- Time spent.

A Note on Wording

Note that the wording of the code descriptions themselves was set by CMS and **must be used as written** for proper coding. "**Q9001 Assessment by chaplain services**" is straightforward and will be readily understood by all chaplains. The use of the terms "counseling" in the other two chaplain services codes – "**Q9002 Counseling, Individual, by chaplain services"** and "**Q9003 Counseling, Group, by chaplain services**" may seems less obvious to chaplains but must be used as written. How did these terms come to be?

Some years ago, chaplains from the U.S. Department of Veterans Affairs (VA) mounted a successful effort that resulted in three codes for recording the work of health care chaplains, but only in the VA health care system. Those codes were:

- Q9001 Assessment by Department of VA Chaplain Services
- Q9002 Counseling, Individual, by Department of VA Chaplain Services
- Q9003 Counseling, Group, by Department of VA Chaplain Services

The naming convention adopted reflected the familiar HCPCS codes already in use by therapists and other clinicians at the VA who performed detailed assessments on patients as well as individual and group counseling sessions.

After two years of unsuccessful lobbying by HCCN and partners, in October 2022 CMS finally agreed to allow those Q codes to apply to all chaplains in health care, using the VA wording but without the reference to the VA. Keeping the wording of the codes as close to the original as possible made it much more likely that CMS would approve the HCCN version requested. This is why the new codes are the same as the original ones but with "Department of VA" removed. For the full CMS report on the proceedings that led to this adoption, see pp. 168-173 of the official CMS publication accessible here: https://www.cms.gov/files/document/2022-hcpcs-application-summary-biannual-1-2022-non-drug-and-non-biological-items-and-services.pdf

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