

WELCOME!

Alameda County Behavioral Health Care Services
Quality Assurance Office

Medi-Medi Documentation Training
June 2011



Content Disclaimer

- General Overview: Non-exhaustive list of rules & regulations.
- Primary authority: Provider contract with ACBHCS.
- References: See Resources slides for web links.
 - Medi-Cal: Title 9 and MHP contract with DMH.
 - Medicare References: Centers for Medicare & Medicaid Services (CMS); Palmetto materials (clearinghouse for California Medicare); California State regulations & licensing boards.
- General rules & regulations do not permit any person or agency to provide a service for which they are not authorized to provide by licensure or contract.
- Attendees must ensure the application of these rules within their organization's practices.



PowerPoint Contents/Agenda

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- Introduction
 - Medi-Medi: What Does This Mean For Us?
- Informing Materials: Beneficiary/Consumer Rights
 - (Break 15 min.)*
- Documenting Services: Medical & Service Necessity
- Services: Who Can Provide Them?
 - (Lunch is Provided - 1 hr.)*
- Service Definitions
- Services Billable to Medi-Cal only

PowerPoint Contents/Agenda

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- Do's & Don'ts
(Break 15 min.)
- Clinical Documentation Standards
- Progress Notes: Billing, Frequency, & Note Content
- Developing Client Plans
- Clinical Quality Review Team (CQRT)
- Staff Qualifications
- Resources



Services & Activities NOT Addressed in this PowerPoint

- Crisis Stabilization/Emergency Room
- Hospitalization/Intermediate Care
- Medi-Cal Administrative Activities (MAA)
- MHSA/FSP Service Codes
- Therapeutic Behavioral Services (TBS)

- Medi-Medi claiming (for data entry staff)
- Medicare provider applications
 - Please contact Provider Relations for these questions (800-878-1313)



Some Background...

You are either employed by Alameda County BHCS or a contracting agency to provide mental health services.

- BHCS administers *primarily* two Federal/State insurance plans for:
 - Beneficiaries of Medi-Cal (Medicaid)
 - Beneficiaries of both Medi-Cal and Medicare Part B (Medi-Medi)
- Insurance programs must inform their beneficiaries of their rights.
- Insurance programs have rules about:
 - What services they'll pay for & how to document those services.
 - How to prove that those services were appropriate for the beneficiary.
 - How to prove the services were actually provided.

This training addresses how to prove that services meet these rules.



Medi-Medi:

“What does this mean for us?!?”

The documentation rules in this training apply to all Medi-Cal & Medi-Cal/Medicare (Medi-Medi) client charts.

- The State DMH now requires all providers to apply to become Medicare providers & bill Medicare directly for eligible services.
 - BHCS Provider Relations has given trainings on the application process & how to enter Medi-Medi claims. (Questions? Contact Provider Relations)
- Medi-Cal is still the payor of last resort (DMH Info. Notice #10-11 – see Resource slides for web link).



Medi-Medi:

“What does this mean for us?!?” cont’d.

How BHCS manages the billing behind the scenes...

New procedure codes were created for services that are billable to both Medi-Cal & Medicare (see handout). These codes allow InSyst to send claims to either entity, per the client’s insurance.

- **All providers must now use the new procedure codes!**
Exceptions: Medi-Cal only Family Therapy w/o Client & AB3632 providers use same codes as before.
- Medi-Medi providers submit claims to Medicare **and** to InSyst. InSyst “holds” those claims until the provider notifies BHCS of Medicare’s response (paid or denied).
- If it’s a valid Medicare denial, InSyst then bills it to Medi-Cal.
 - **Therefore, Medi-Medi providers must document to both Medicare & Medi-Cal standards... fortunately, they are very similar!**



Medi-Cal & Medicare: Things in Common!

Medi-Cal & Medicare share the following basics:

- **Medical Necessity & Service Necessity definitions are the same;** and
- **The overall definition of services is the same:**
 - Services are: Interventions designed to provide
 - the maximum reduction of mental health disability, and
 - the restoration, improvement or maintenance of functioning
 - of the individual.

**Nothing has changed about how to determine
Medical & Service Necessity!**



Medi-Cal & Medicare: Things in Common!

cont'd.

- **The definitions of specific services are the same** (e.g., Assessment or Therapy).
 - Medicare is slightly more restrictive about how someone benefits from Psychotherapy. (addressed later)
- **BHCS will use the same Medi-Cal medical necessity list of “included” diagnoses for Medi-Medi clients.** (handout)
 - Medi-Medi Providers: The primary diagnosis code must be on each clinical document (e.g., Assess/Plan/PN).
- **Non-billable activities & lockout situations are the same.** Providers still may not bill clients for them.

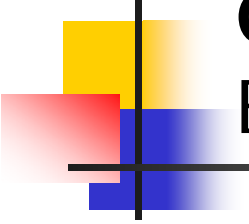


Medi-Cal & Medicare: Differences!

Medi-Medi providers need to know the differences:

- **Progress Notes for Assessment must include a “Plan.”**
- **Medicare does not cover certain services.** These are:
 - Rehab, Case Management/Brokerage, Evaluation, Crisis Intervention, and Day Treatment Intensive/Rehab, TBS
 - Also Collateral & Plan Development, which Medicare “bundles” into their reimbursement rate – see next slide.
- **Medicare does not cover certain staff.** These are:
 - Any unlicensed staff; Licensed MFT's

HOWEVER... those services, and any services provided by non-covered staff, will now claim directly to Medi-Cal and will bypass Medicare.



Medi-Medi Caveats for **Collateral & Plan Development:** Billing Medi-Cal vs. Medicare

For **Collateral & Plan Development:**

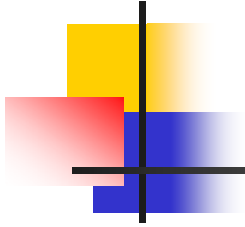
- If provided **with client present** during a **Medicare billable** service:
 - Include the time in Face-to-Face time, document it, and bill all to Medicare ("bundled").
- If provided **without client present**, bill to **Medi-Cal**.
 - Collaterals bill directly to Medi-Cal if location codes are Phone or Community.



Medi-Cal & Medicare: Differences!

cont'd.

- **Medicare only covers Face-to-Face time with client/family.**
 - Some new procedure codes contain F-to-F time ranges (e.g., Individual Therapy 45-50 min. or 75-80 min.).
 - Staff choose codes per type of service & session's F-to-F time. (If doesn't fit neatly in time range, always "down-code," never "up-code"!)
- **Medicare does not cover documentation/travel time** (doc. time considered "bundled" into reimbursement rate).
 - If Medicare reimburses, cannot bill Medi-Cal for doc./travel time.
 - Medi-Medi Providers: To allow for flexible billing, Progress Notes for potential Medicare billables must now indicate BOTH Face-to-Face time and Total time (includes doc./travel, if applicable).
 - If InSyst bills a service to Medi-Cal, it will claim for Total time.



Informing Materials



Notifying Clients of their Rights: Informing Materials Packet

All providers are *required* to use the “Informing Materials Packet,” distributed in Summer 2010. The packet replaces all previous BHCS forms (see QA website).

- Contains updated BHCS documents regarding client rights (e.g., Consent to Treat, Freedom of Choice, HIPAA-HITECH, etc.), per State/Federal requirements.
- Simplifies review with clients at admission & required offering to all clients for annual review.
- Single signature page requires only 1 signature by client & staff for all materials. Multiple spaces for ‘client initial/date’ to prove annual review offered to clients.
- Personalize packet & PASSWORD PROTECT before distributing to staff for use, per instruction sheet.

Informing Materials Packet

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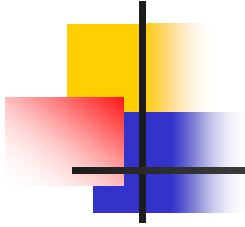
Not included in the Informing Materials Packet:

- BHCS items *required* to be posted or available in lobby for client review:
 - Available at gainformingmaterials@acbhcs.org
 - "Complaint poster"
 - Grievance/appeal forms & envelopes
 - "Member Handbook" pamphlets in 8 languages
 - Available at www.acbhcs.org/providers
 - "Guide to Medi-Cal MHS"
 - Current Provider List (updated quarterly)
- Provider's *required* written policy about confidentiality of records at their site



Do we need a break?!?

Yes!



Documenting Services: Medical & Service Necessity



4 Reasons to Document What You Do & Use Correct Service Codes

- Supports quality care
- Supports continuity/coordination of care
- Basis of billing (simply required for payment!)
- Protection against audits & malpractice



Medical Necessity Criteria

As always, ALL providers MUST document the following:

- Primary diagnosis must be “included” on Medi-Cal list (see MN handout).
 - That diagnosis must be supported by chart documentation. Charting from the Initial Assessment onward must provide a “chain of clinical evidence” (per DMH auditors).
 - An “excluded” diagnosis may be addressed in treatment, but may not be the sole focus of a service.
 - Specify symptoms & behaviors meeting DSM criteria of each diagnosis that is a focus of treatment.

Medi-Medi Providers: The primary diagnosis code must be on each clinical document.



Medical Necessity Criteria

- Impairment in life functioning exists & is a result of an included Medi-Cal diagnosis:
 - Describe the impairments to life functioning (aka client's mental health barriers to reaching their life goals)
 - Indicate how the impairment/barriers are related to included diagnosis
 - Don't assume that a valid diagnosis = impairments!
And don't assume that you can't address client strengths just because you also address mental health barriers!!!



Service Necessity Criteria

- To meet Service Necessity:
 - Services (therapy, rehab, etc.) must address the functional impairment resulting from the primary included diagnosis.
 - Services are expected to diminish or prevent impairment OR allow appropriate development.
 - The condition would not be responsive to physical health care treatment.

Also:

- The condition could not be treated by a lower level of care (e.g., staff/clinician, provider agency, frequency of service).
- If more than 1 staff provides the same service at the same time, must identify the unique contribution for each staff (suggest within pertinent Progress Note).



Medical & Service Necessity Criteria - EPSDT ONLY (under age 21)

If a youth does not meet the functional impairment criteria for medical necessity, the services provided must correct or ameliorate either:

- a documented mental illness or condition

Or

- the documented risk of developing a mental illness or condition, or of not progressing developmentally as expected.

(EPSDT clients must still have an “included” diagnosis.)



“What types of clinical documents do I need to create for each client?”

1. Initial Assessment
2. Client Plan
3. Annual Community Functioning Evaluation (ACFE) (n/a for some programs)
4. Progress Notes
5. Discharge Note/Summary



How do Those Documents Support Medical & Service Necessity?

- Initial Assessment establishes MN for services.
 - Provide a statement to support the client's ability to benefit from services (*e.g., "how benefited in the past," "now has supportive team," "though impaired in xyz, has strengths in abc," etc.*).
- Initial Client Plan builds on the Assessment.
 - Establishes client's goals & MH barriers to achieve them
 - Identifies MH objectives, per barriers
 - Identifies MHS & staff interventions to address barriers
 - Licensed signature attests that MN/SN are met
- Ongoing Client Plans are progress reports & support ongoing MN/SN.



How do Those Documents Support Medical & Service Necessity?

- Progress Notes - EVERY ENTERED SERVICE MUST MEET MN/SN in the corresponding progress note. You attest that this requirement is met by entering the service for reimbursement.
 - *Therefore, if the client's response to interventions does not support ongoing ability to benefit from services, a rationale for services should be provided (e.g., new crisis, decomp, etc.) or reconsider the intervention.*



Documenting Medical Necessity – Early Special Considerations

While the Initial Assessment is being created:

- If Mental Health Services (other than Assessment) are provided, the medical necessity rationale for each service must be in the Progress Note.

While the Initial Client Plan is being developed:

- Mental Health Services may be provided as long as the medical necessity for services is clearly identified in the Initial Assessment.
- If a clinical need arises that is not identified in the Assessment, the medical necessity rationale for each service addressing the new issue must be in the Progress Note.

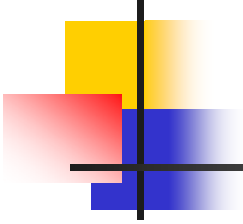


Documenting Medical Necessity – Medi-Medi Requirement

Medicare requires that every Progress Note indicate the “Plan/Next Steps” for services. This has been an ongoing BHCS requirement for PN’s, except in PN’s for Assessment activities.

Medi-Medi providers must now include that notation in Assessment PN’s:

- Example: “Gathered mental health/family history for Assessment. Plan: Continue assessment, will provide _____ if medically necessary.”
- Example: “Gathered MH/family history. Plan: Continue assessment, refer for case management & rehab.”



Services: Who can provide them?



Staff Qualifications

The following staff qualifications are described at the end of this PowerPoint:

- *Licensed Practitioners of the Healing Arts (LPHA)*
 - *Including Medical Staff: MD/DO, PA, RN, NP, CNS*
- *Waivered and Registered LPHA*
- *Graduate Student /Trainee*
- *Mental Health Rehabilitation Specialist (MHRS)*
- *Adjunct Mental Health Staff & Other Staff Not Meeting Above Category Qualifications*

Also see "Documentation Standards Policy" at QA website.



Staff Qualifications: Medi-Cal

Medi-Cal Eligible Staff: Services may be provided by anyone that the hiring provider determines is qualified, per BHCS criteria.

Providers must:

- Keep personnel materials to justify determination.
- Understand the practice requirements for each staff's governing board or committee.
- Ensure, on an ongoing basis, that all staff credentials are up-to-date and meet criteria.
- Report changes in staff licensure & status to BHCS Provider Relations (e.g., intern to licensed status, suspensions & restrictions on license, etc.).



Staff Qualifications: Medi-Medi

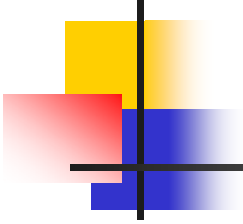
Medi-Medi Eligible Staff: Licensed/certified & Medicare-approved.

- LCSW
- Clinical Psychologist
- Physician (MD/DO)

With supervising staff MD:

- Physician Assistant (PA)
- Nurse Practitioner (NP)
- Clinical Nurse Specialist (CNS)

Providers must follow the same rules on previous slide.



Service Definitions



Specialty Medi-Cal & Medi-Medi Services

Medi-Cal

Mental Health Services

Assessment
Collateral (incl. Family Therapy)
Plan Development
Rehabilitation (Ind./Group)
Psychotherapy (Ind./Group)
Evaluation

Other Specialty MH Services

Case Management/Brokerage
Medication Support/Mngmt.

Psych/Neuropsych Testing
Day Treatment
Crisis Intervention

Medi-Medi

Psychiatric Services

Assessment (Initial Psych Eval)

Psychotherapy (Ind./Group/Family)

Medication Support/Mngmt. **OR**
Evaluation/Management (E/M)
Psych/Neuropsych Testing



What's Billable to What?

Billable to Both Medi-Cal & Medicare

- ❖ Assessment
- ❖ Psychotherapy
- ❖ Psychological/Neuropsych Testing
- ❖ Medication Management

Bill only to Medi-Cal

- ❖ Rehab
- ❖ Collateral
- ❖ Plan Development
- ❖ Evaluation (ACFE)
- ❖ Case Management/Brokerage
- ❖ Day Treatment Intensive/Rehab ("bundled" services)
- ❖ Crisis Intervention
- ❖ EPSDT Services

Bill only to Medicare

- ❖ E/M Services (only medical staff)



Assessment Services

Assessment (code 433): Purpose is to...

- determine medical necessity and
- facilitate treatment planning
- by gathering information & documenting a client's mental health & medical history, current status, and factors impacting their mental health (any co-occurring conditions?),
- while beginning to develop a staff-client partnership.
(Assessment requirements in later slide.)
- No "cap" on Assessment services in order to determine MN.
- Assessment services can be provided later to clarify diagnoses or if a client's clinical presentation needs to be re-evaluated.

(Medicare also offers an "Interactive" option (code 434) for this service for clients who haven't developed or have lost expressive/receptive language skills. There is no comparable service in Medi-Cal.)



Medi-Medi Only Assessment Options

Assessment (code 433):

- Initial MD Note also meets basic documentation requirements.

Versus

Evaluation/Management for New Patients (codes 545-549, per time; *549 limit 1 every 3 years).

- Can be used for any outpatient visit for a new client.
- Provider: Only medical staff can use these codes.

Versus

E/M for Returning or Ongoing Patients (codes 641-646, per time)

- Provider: Only medical staff can use these codes.



Assessment: Who can Provide it?

Medi-Cal: Any MH staff may collect and provide assessment information & enter it into the Assessment document for review (e.g. family hx., psychosocial hx., etc.).

- Licensed, waived, registered, or graduate student staff synthesize the information if provided by others, complete, & sign the document. (Graduate students must have a co-signature from a licensed LPHA)
- Only registered, waived, licensed LPHA staff, or graduate student trainees may conduct the Assessment and sign the document.
- Signature attests that these requirements are met.

Medi-Medi: Only CP, LCSW, or MD (or medical staff if within scope/certification) may do any of the above.



What if Client gets Medicare Post-Assessment/Client Plan?

If an Assessment/Client Plan is done by non-Medicare qualified staff, theoretically, all services provided under those documents are not billable to Medicare.

- Potential Solutions:

- All Assessments/Client Plans are performed and signed by Medicare qualified staff. OR
- Only if client is likely to get Medicare soon, ensure that staff providing these services are Medicare qualified.
- If client gets Medicare and those services were not done by Medicare qualified staff, recommend new Assessment/Client Plan be done by qualified staff (may update the prior Assessment/Client Plan).



Initial Assessment: Timeliness & Frequency

- Initial Assessment is due within 30 days of episode opening (EO) date.
 - “Loose” count of 30 days is okay, for example: EO date 3/14/09, so Assessment done by 4/14/09.
“Strict” count of 30 days just requires counting days (e.g. EO 3/14/09, so deadline is 4/12/09).
 - Exception for FSP & Identified Brief Service Programs: Complete within 60 days of EO date – always “strict” count of 60 days.
 - Deadline is per EO date, not per 1st client face-to-face!

Alameda County does not require an annual assessment – instead, the Client Plan requires inclusion of key assessment items related to client risk and/or items that may require updates.



Initial Assessment: DSM Diagnosis

- All 5-axes must be documented (age 0-5 crosswalk to DSM).
- Axis I or II: First-listed diagnosis must be the Primary focus of treatment (“Medi-Cal included” diagnosis only).
 - Insyst accepts Deferred Diagnosis to open episode; must update to “included” diagnosis at 30 days, if will provide treatment.
 - Insyst accepts No Diagnosis to close episode, if no MN found.
- Axis III: May be documented by non-medical staff. Indicate source (e.g., Per client, referral document or staff observation; See progress note on x/xx/xx of PCP collateral; etc.).
- UPDATE THE DIAGNOSIS IN INSYST whenever it changes!!!
Deferred/Provisional = 6 month limit unless explained.

Initial Assessment: Required Contents



CBO's must ensure that their templates contain at least this information. Will be notified when BHCS template is updated.

- Identifying Information
- Client Strengths & Supports
- Risk Situations
 - Address risks in Client Plan
- Presenting Problems
- Self-Identified Culture & Gender Needs
- Language/Communication Needs
- Co-Occurring Conditions, such as Substance Use – History/Last use
 - Include nicotine, caffeine, Rx, over-the-counter
- Medical/Health, Medication, Mental Health and Social Histories
 - Allergies (any kind) or lack thereof. Note prominently on outside of chart.

- Relevant Mental Status Exam
- Medical Necessity Items
 - 5-Axis DSM Diagnosis (see next slide)
 - Identify functional impairment
 - Identify basic service needs, including mental health

For Child/Adolescent

- Developmental History, including pre/perinatal history (document attempts to obtain info.).

Best Practice (not required at this time):

Clinical analysis/formulation clearly indicating MN with description of mental health barriers to achieving client's goals. (May be in Client Plan instead. Good place to note "Stages of change.")



Psychotherapy Service Types: Individual, Group & Family

Psychotherapy (see handout for codes, per Face-to-Face time): Focus is primarily on *symptom reduction* as a means to improve functioning, via exploration of intra- & interpersonal processes.

- Purpose is to alleviate emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth & development via:
 - Development of insight or affective understanding,
 - Behavior modification,
 - Supportive interactions, and/or
 - Cognitive discussion of reality.

Medicare also offers an “Interactive” option for this service for clients who haven’t developed or have lost expressive/receptive language skills. There is no comparable service in Medi-Cal.



Medi-Medi Only Psychotherapy with E/M

Individual Psychotherapy with E/M (codes 463-466, per time.

If doesn't fit neatly in time range, always "down-code"!):

- Same definition as Individual Psychotherapy, plus
- Minimal medical diagnostic evaluation (e.g., evaluation of co-morbid medical conditions, drug interactions, physical exam, interpretation of labs, etc.)
 - Example: Patient not on meds but requires ongoing evaluation for meds, and meets MN for psychotherapy.
- Provided by: Only MD (or medical staff if within scope & certification).
- Claiming Exception: E/M services are not separately payable when done by the same provider & on the same day as Individual Psychotherapy.



What is not Psychotherapy?

Psychotherapy is **not**:

- Marriage/couple counseling
- Training or monitoring of ADL's (Therapy is not Rehab!)
- Socialization services (e.g., teach grooming skills)
- Recreation (e.g., bingo)
- Comfort care (e.g., general conversation)
- Excursions or entertainment
- Client education/skill-building (e.g., shopping skills)
- To treat Tobacco Use Disorder
- Telephone calls (Medi-Cal: Psychotherapy by telephone *with justification*; Medicare: Never)



Psychotherapy: Who can Provide it?

Medi-Cal and Medicare restrict providers of Therapy to:

- Licensed LPHA's*
- Medical staff, if within their scope of practice & certified.
- Medi-Cal also allows for license-track staff* to provide Therapy (board-registered interns, masters/doctoral level trainees doing internship).

*Medicare does not reimburse for any services provided by licensed MFT's or unlicensed staff.



Individual Therapy: Medi-Medi Special Documentation Issues

- Client's capacity: Must be clearly documented that the client has the capacity to understand & respond meaningfully, in order to benefit from Psychotherapy (medical/service necessity).
 - Cognitively impaired clients must be able to process information, express thoughts, & retain/apply concepts from one session to next.
 - Provide this info in the Assessment, Client Plan & Progress Notes.
- "Lengthy" Therapy sessions:
 - 75-80 minutes: Document reason for exceptional length of session in the Progress Note.
 - 90+ minutes: **At this time, BHCS does not have this Medi-Medi procedure code** which requires that the rationale for 90+ min. be submitted with the claim.
 - ❖ It is possible to claim this service to Medi-Cal, however, if the client's MH condition requires this service, it is likely that Crisis Intervention is a more accurate reflection of service necessity.



Group Therapy

Group Therapy (code 456):

- Same general definition as Psychotherapy (insight oriented/process)
- Provided in group setting with clinician as facilitator
- Personal & group dynamics are explored to allow emotional catharsis, instruction & support
- Co-Staffed Progress Notes are okay (more later).

Medicare also offers an “Interactive” option for this service for clients who haven’t developed or have lost expressive/receptive language skills. There is no comparable service in Medi-Cal.



Group Services: Put it in the Client Plan!

- There must be an Objective in the Client Plan that relates to the identified functional impairment addressed by the group services.
 - And Group service must be listed as an Intervention for that Goal/Objective.

(Group services are at risk for disallowance if not identified & justified in the Plan!)



Do we need... Lunch?!?

Yes!



Family Therapy

- Medi-Cal: No reimbursement for Family Therapy. However... BHCS created a Collateral Family Therapy procedure code (318):
 - Per current rules, the client doesn't need to be present in order to claim Collateral Family Therapy.
 - If not Medi-Medi & have been using this code, continue to use it.
- Medi-Medi: Reimburses for Family Therapy, with or without the client present (procedure codes 449 or 413).
 - If client is Medi-Medi, must use one of these codes to ensure proper billing.



Family Therapy cont'd.

Family Therapy/Collateral Family Therapy: Same general definition as Individual Therapy.

Service Rules: Family Psychotherapy is considered reasonable & necessary when provided to:

- Assist family to address the MH issues/behaviors of the client.
- Improve the client's treatment compliance (progress toward MH objectives).

Reminder: The primary purpose of any service is to address the client's mental health condition.



Family Therapy

cont'd.

Definition of “family” for Family Therapy:

- Traditional family members
- Live-in companions
- Significant others involved in the care of the client (includes foster parents).

Does not include paid staff at a facility/institution
(Collateral is used when working with people who are paid to address a client's MH condition).



Psychotherapy: Documentation Issues for Serious Mental Illness (SMI) 1/2

For clients with long-term/serious MH conditions:

Managing symptoms & avoiding more deterioration are acceptable objectives & outcomes as a result of providing Psychotherapy.

- Document the reasonable expectation that a client's MH condition would deteriorate if service ended.

Medi-Medi Providers - Use the Client Plan to note:

- Estimated # of sessions required to reach treatment goal.
- Why Psychotherapy is the appropriate modality instead of, or in addition, to a different psychiatric services.
- Make the statement that stabilization/maintenance of functioning is expected through the use of this service.



Psychotherapy: Documentation Issues for SMI

2/2

- Frequency of Services, after a client is stabilized:
 - Individual Psychotherapy more than 1x/week: If the client still requires more than 6 months of psychotherapy after they are stabilized, significant documentation of medical necessity would be required.

Medi-Medi Providers: Significant documentation of medical necessity would be required if providing more than 26 sessions of Psychotherapy with E/M per year.
(codes 463-466)



Psych/Neuropsych Testing

Psychological & Neuropsychological Testing (see code sheet): Psycho-diagnostic assessment of emotionality, intellectual abilities, personality & psychopathology. Includes developmental testing.

Billable to Medi-Cal & Medi-Medi in order to:

- Help determine diagnosis & treatment planning. Therefore the clinical record must already indicate presence or symptoms of mental illness.
- Service includes: Administration, scoring, interpretation, time necessary to integrate other sources of clinical data, and explanation of results to others.
- Claim this service per minute (though Medicare bills this service in hourly increments, Insyst can not).



Psych/Neuropsych Testing cont'd.

- Neuropsych Tests are objective/quantitative in nature & include:
 - Individually administered ability tests
 - Comprehensive sample of ability domains
- Providers: Clinical Psychologist or MD
 - A PA, NP or CNS may provide testing, if supervised by CP or MD, within their scopes of practice AND within tasks/procedures.
 - LCSW's with certification to administer certain tests may do so
 - retain proof of certification on site.



Psych/Neuropsych Reports

- Psych/Neuropsych Test Reports must include:
 - Date (or date range) performed
 - Total time
 - Reason for referral
 - Current evaluation
 - Scoring & interpretation
 - Recommendations for interventions, if necessary
 - Identity of person(s) performing service
 - Signature including licensure



Psych/Neuropsych Progress Notes

- For each time period per day spent working on Psych/Neuropsych Testing,
 - There must be a Progress Note indicating:
 - Face-to-Face time with client/patient, if any
 - Total time
 - Brief description of testing activity for that day



Medi-Cal & Medi-Medi: Medication Support/Management

Medication Support/Management (code 469): Prescribe, administer, dispense and monitor medications that are necessary to alleviate symptoms of mental illness. Includes evaluation of need for medication, side effects & effectiveness; obtaining informed consent; medication education and plan development *related to the delivery of the service and/or assessment of the client.*

- **Medi-Medi Providers: See next slides for more service options.**

Provided by: MD/DO and...

Programs with an MD on staff may allow the following to provide this service, per qualifications & service agreement:

- Physician (MD)
- Physician Assistant (PA)
- Nurse Practitioner (NP)



Medi-Medi Only: Medication Support/Mngmt.

Med Support (also code 469): Same definition as in previous slide, however...

- Should be used when counseling and coordination of care is **less** than 50% of face-to-face time.
- When counseling and/or coordination of care dominates (**more** than 50%) of the physician encounter with patient and/or family, then **time** may be considered the **key or controlling factor** to qualify for a particular level of E/M Services.
- The extent of counseling and/or coordination of care must be sufficiently documented in the medical record to justify the code choice.



Medi-Medi Only: Evaluation & Management (E/M)

Evaluation & Management - E/M (see code sheet):

- Patient office-based visits and consultations provided by MD's
 - Or by other medical staff when supervised by MD & within their *Standardized* or *Delegation of Services Agreements*.
- Only counseling (not psychotherapy!) may be provided (clarified in next slides).



Medi-Medi Only E/M Counseling Defined

Counseling is a discussion with a patient and/or family concerning one or more of the following areas:

- Diagnostic results, impressions etc.
- Prognosis
- Risks and benefits of treatment options
- Instructions for treatment and/or follow up
- Importance of compliance
- Risk factor reduction
- Patient and family education



Medi-Medi Only

E/M Counseling is Not Psychotherapy

Psychotherapy is any combination of the below services, provided to facilitate therapeutic change:

- The development of insight or affective understanding
- The use of behavior modification techniques
- The use of supportive interactions
- Cognitive discussion of reality



Medi-Medi Only

Components of E/M Services

E/M Progress Notes: Key components to address

- History
- Examination
- Medical Decision Making
- Counseling
- Coordination of care (if applicable)
- Nature of presenting problem
- Face-to-Face Time and Total Time



Medi-Medi Only

E/M Location codes

E/M Codes have specific locations attached to them (see code sheet).

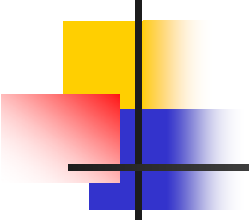
Example: 641-646 is an office visit

- BHCS does not have the capacity to create InSyst billing codes for every CPT E/M code, but does have the most commonly used codes. If other locations are regularly used by your staff, please contact Provider Relations with the required specific CPT codes to add.

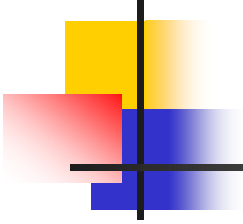
All providers should review the CPT Manual (published by the AMA) to become familiar with CPT code structure & definitions.

Medi-Medi Only

E/M Codes & Time Reporting



Code	CCC Time	Total F-F Time	<i>Approx.</i>
643	5.5-7.5 minutes	10-14 minutes	\$45
644	8-12.5 minutes	15-24 minutes	\$75
645	13-20 minutes	25-39 minutes	\$113
646	21-minutes	40-....	\$152
469 (Med Support)			\$65
564 (M0064)			\$17



The following slides describe services
only billable to Medi-Cal



Medi-Cal Only

Collateral Services

Collateral is a service activity with a client's significant support person(s) in order to improve or maintain the mental health status of the client.

- Who is a Significant Support Person? Any person identified by client or staff who has, or could have, a significant role in improving the client's mental health condition.
- Client doesn't need to be present for Collateral services.

Also Collateral: Consultation with someone outside a program's treatment team to discuss a client's treatment (gathering information for treatment planning purposes).

Medi-Medi providers: If with client, service bundled.



Medi-Cal Only

Plan Development

Plan Development services are any activities related to development & approval of Client Plans, and/or monitoring a client's progress toward Client Plan goals & objectives. (Medicare considers this as "bundled" with any service.)

Also PD: Team discussions re. client's treatment are billable only when:

- Driven by the client's mental health needs, or
- Driven by staff need to review client's MH progress
- Co-Staffed Progress Notes are okay (more later).

Therefore, this is not billable if provided to meet:

- Agency's needs (peer review, incident debriefing)
- Staff clinical supervision requirements
- Staff development needs

Medi-Medi providers: If with client, service bundled.



Medi-Cal Only

Rehabilitation Services

Rehabilitation services help improve, maintain or restore clients' support resources & functional skills (e.g., social, daily living, hygiene).

- May include counseling, psycho-social education, informational support, medication education, etc.
 - "Counseling" is psychosocial education. *It is not Therapy.*
 - Medication education supports compliance. *It is not prescribing, dispensing or distributing medications.*
- Objective in the Client Plan that relates to the identified functional impairment addressed by the group services.
 - And Group service must be listed as an Intervention for that Goal/Objective.

Types: Individual / Group



Medi-Cal Only

Case Management/Brokerage

Case Management services help clients to access medical, educational, social, vocational, rehabilitative or other community services that are identified as needed in the Client Plan or Assessment.

- Service activities may include, but are not limited to:
 - Communication with client & significant support persons (collateral)
 - Coordination of care
 - Referrals
 - Monitoring service delivery to ensure client's access to services
 - Monitoring client's progress toward making use of services (plan dev.)

When a CM service includes Plan Development or Collateral, may document as part of that service, or split into separate services/PN's.



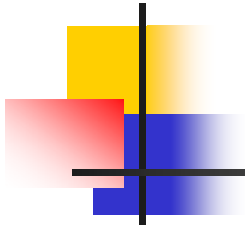
Medi-Cal Only

Crisis Intervention

Crisis Intervention is a service lasting no more than 8 hours in a 24-hour period: Immediate response to client's acute psychiatric symptoms in order to alleviate problems which, *if untreated, would present an imminent threat* to the client, others or property.

- The purpose is only to stabilize the client.
- Crisis Intervention activities may include: Assessment, Collateral, Rehab and possibly Therapy. However, those activities are all documented as Crisis Intervention.

Note: Crisis Intervention service is not Crisis Stabilization, which is a type of program.



To Do & Not To Do!



DO COORDINATE CARE!!!

Document what others are providing to increase clinical efficiency, increase clinical effectiveness and decrease claiming risks.

Collateral calls to coordinate treatment with another provider is “best practice” and a reimbursable service!



Don't Duplicate Services

If different providers are doing the same service, for example:

- Social Services CM and Mental Health CM.
- School-based therapist and outside agency therapist.
- They may not duplicate the focus of the services;
- In each provider's Client Plan:
 - Clearly document the rationale for why the same service is being provided; and
 - Delineate staff responsibilities.
 - Best Practice: Create MH Objective for coordination of care. (*Required for TBS client.*)



Non-Billables: Activities Not Covered by Medi-Cal & Medicare

Lockouts:

- Client incarcerated.

Exceptions:

- a) *Adjudicated* youth in Juvenile Hall (awaiting placement only – get proof of placement order!).
- b) On day of admission.

- Client inpatient psychiatric (hospital, IMD, psych SNF).

Exceptions:

- a) On day of admission.
- b) Case Management only for discharge planning.

Doing FOR client:

- Personal care activities (e.g., child care, cleaning, meal prep, shopping).



Non-Billables, cont'd.

Non-mental health activities:

- Solely work, educational, recreational & social activities
- Solely clerical activity documented (fax, voicemail, email)
- Solely payee, transportation or interpreter services
(FYI: Providers may not give illegal reason for payee requests! e.g., to buy illicit drugs)
- Prep time for services (e.g., set up room, copy handouts, research activities, etc.)
- Staff processing/debriefing time in preparation for or after a service (e.g., co-staffers decide roles/activities for the day, process group dynamics afterwards, etc.)
- Utilization Review/CQRT activities

Less than InSyst minimum of 5 minutes



Medi-Cal Only

Some Billable, Some Not...

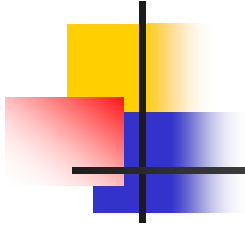
Reports/Forms: Some are billable to Medi-Cal, some are not.

- Non-billable: Reports/forms completed for purposes *other than* to determine medical necessity or for treatment (e.g., CPS/APS report, Court-ordered report, SSI application).
- Billable only to Medi-Cal: Reports/forms that are:
 - Noted as utilized *for treatment purposes* (e.g., Social Services/Court-ordered "Treatment Updates"); or
 - Noted as a *mental health intervention* (e.g., CPS report made with client; help reduce client's anxiety re. SSI app as they complete their portion; para-transit app done as a CM).



Do we need... Lunch?!?

Yes!



General Standards for All Clinical Documents

General Documentation Standards



- MUST BE LEGIBLE (illegible signatures may not pass audit; suggest typed name/licensure under sig. line or “signature page”)
- Use only ink (black is still the standard, but not required)
- Every page must have some form of client ID
- Only County-designated acronyms (see QA website)
- Don't leave blank areas on forms (indicate “n/a” or “none”)
- No post-it's or loose papers (can staple)
- No names of other clients in charts. Consider confidentiality when using family names.
- Don't “rubber stamp” your writing! Tailor it to changing needs of individuals.

General Documentation Standards, cont'd.

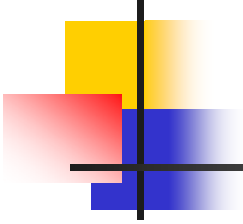


- All staff entries require a "complete signature".
 - Include date.
Exception: When progress note date of service is same as date written.
 - Include licensure, degree or job title. *If licensed, must use licensure with signature.*
 - End entries with a drawn line to indicate nothing was added post-signature. (n/a for electronically signed entries)

General Documentation Standards, cont'd.



- Errors: No 'white-out'. No scribbling over errors, especially over dates!
Do draw one neat line through error, initial & date.
 - For electronic documents, add addendum.
 - Only original authors make edits. Reviewers or supervisors DO NOT edit original authors but may add addendum.
- Addendums/notations: Include dated initials or signature when adding information.



Creating Clinical Documents

(some not billable to Medicare –
but still required! 😊)



Client Plan

Strength-based treatment planning, including creating Client Plans in partnership with clients, is considered best practice by BHCS. However... the provision of mental health services must still be based on the ongoing assessment of a client's functional impairments that result from the primary diagnosis for treatment.



Client Plans: Timeliness & Frequency

- Initial Client Plan: As of 11/1/10, must be completed within 60 days of episode opening date (EO).
 - Example: EO is 5/9/10; Initial CP done by 7/14/10. (Initial Client Plan may be completed *before* deadline.)
- Use the MHS 485 report's 60-day prompt to avoid late Initial Client Plans!
- 60 days = per the EO date, not per 1st face-to-face with client.

Use the MHS 485 InSyst report to avoid late Client Plans!

Client Plans:

Timeliness & Frequency, cont.

- Annual Client Plans: Completed during the month prior to the episode opening month.
Example: EO Month April = Annual Client Plans are always completed in March.
- 6-Month Update: Complete in 6th month from EO month.
Example: EO Month April = 6-Month Updates are always completed in September.
 - FSP exception: 6-Month Update not required.

The MHS 485 Report gives 6-month prompts for these documents... use it!

Initial/Annual Client Plans: Required Contents



CBO's must ensure that their templates contain at least this information. Will be notified when BHCS template is updated.

- Describe client's life goals, strengths & supports.
- Identify objectives to address functioning issues & mental health barriers that interfere with client reaching life goals.
 - Objectives are measurable or observable.
 - Provide current baseline as "best practice."
 - Estimated timeframes to reach objectives (revise when objectives are reached.)
 - Remember for Medi-Medi Psychotherapy, put # of sessions!
- Identify service interventions & frequency to help reach MH objectives (e.g. Group Rehab 1x/week, Medication Support 1x/month). Utilize client strengths/supports whenever possible.
- May identify client/signif. supports' tasks to help reach objectives.



Initial/Annual Client Plans: Required Contents, cont.

- Key Assessment Items (updated with each review):
 - Diagnosis
 - Risk situations
 - Client strengths & resources
 - Special needs (communication, physical, cultural, etc.)
- "Best practice" - Coordination of Care: When applicable, include MH Objective for coordination of client's care with other identified providers.
 - *For minors with TBS, Client Plan must indicate coordination of services with TBS provider.*
- Tentative Discharge Plan.
- A way to prove that client was offered a copy of the Plan.
- Signatures (see next slides).



Client Plans: Required Signatures

All Client Plans must be signed by:

- The staff providing & documenting the services.
 - If not licensed, waived, or registered, must be co-signed by a licensed LPHA staff.
- Create/sign within the month it's due! (though InSyst doesn't accept entry until following month)
- If provider agency's MD prescribes psychotropic medication, MD must sign.
- The client - on the Plan (more in next slide).
- The client's legal representative, when appropriate, as determined by the provider.

Client Plan is not a legal document (unlike a consent), so does not REQUIRE client's legal rep. unless client is unable to represent self. Follow your program's rule about this.



Client Plan: Client's Signature

Clients' dated signature **on** the Client Plan indicates their participation in treatment planning. Client signature is **required**, minors included if understand concept of ownership.

DMH sanctioned test to know if minor has concept of ownership: If minor knows that their "x" on a ball means it's theirs.

- If unable to obtain client signature, note why near the signature line (with dated initials). Examples:
 - "Client unavailable to sign due to current incarceration."
- If client disagrees with Plan or refuses to sign, note that.
- Note follow-up efforts (with dated initials) to obtain the signature, either on Plan or reference dated progress note that describe efforts.
- If client lacks capacity to represent self, legal representative must sign.

ANY change in planned services after client's signature invalidates the signature, so requires client & staff re-signature!



Annual Community Functioning Evaluation (ACFE)

- The ACFE is completed when the Client Plan is done and annually thereafter.
- All providers are required to complete this quantified assessment of functioning.

Exception: FSP & Brief Service programs

- Use the Evaluation code for this activity (code 321).

Discharge Note (usually non-billable)

VS.

Discharge Summary (may be billable)

Discharge Note: A Progress Note that includes brief documentation of the following:

- Reason for discharge/transfer.
- Date of discharge/transfer.
- Referrals made, if applicable.
- Follow-up care plan.

This is usually considered an administrative activity and non-billable.

However, if done as part of a final billable service with the client present (e.g., discussed in last session), it is billable.

Note: No services are billable after a client dies, even if episode still open!

Discharge Note

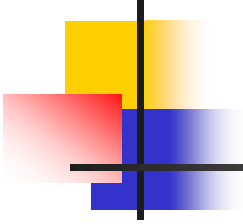
vs.

Discharge Summary, con't.

Discharge Summary: A substantive document that meets the requirements of a Discharge Note *plus a summary of the following:*

- Treatment provided.
- Overall efficacy of interventions (including medications, their side effects/sensitivities and dosage schedules).
- Progress made toward the mental health objectives.
- Clinical decisions/interventions:
 - Treatment planning recommendations for future services relevant to the final Client Plan; and
 - Referral(s) for aftercare services/community support services.

BHCS considers this billable as Plan Development when documented to be **clinically necessary for continuity of care.**



Progress Notes

Billing

Frequency

Note Content



Progress Notes: Documenting Interventions

Staff interventions are your billable activities! But your agency only gets paid for those activities when they are documented appropriately in the Progress Notes.

Progress Notes are the record of all services, whether entered for reimbursement or not. A service must be documented before it can be entered into Insyst.

Does EVERY SERVICE billed have to meet medical necessity & service necessity?

YES !!



Medi-Cal & Medi-Medi

Billing for Services

Services for both Medi-Cal & Medi-Medi are billed on a per-minute basis for the exact number of minutes used by persons providing a reimbursable service.

The only exception is:

- Medi-Cal: Day Treatment Intensive/Rehab
(per full-day or half-day)
- Billing is related to the service provided, not staff qualifications (e.g., MD doing Rehab bills for Rehab, not Med Support).



Medi-Cal Only

Documentation Time & Travel Time

Documentation time & travel time to provide a service (both ways) is billable to Medi-Cal when part of a reimbursable service.
(Exception: Day Treatment)

Non-billable examples:

- If travel to meet client, but client not there, documentation & travel time are not billable.
- If the activity itself is not billable, then documentation & travel time are not billable.
- Travel time to/from home or between provider sites (site w/ provider number, including affiliated satellite & school sites).

Entering documentation/travel time:

Total Time: Add up service time + documentation time + travel time.



Multiple Staff - Co-Staffed Services: Documentation of Service Necessity

When multiple staff provide the same service to the same client(s), it's called a Co-Staffed Service (e.g., group, team Plan Dev.):

Co-staffing requires the PN to indicate why multiple staff are necessary (service necessity).

- For regularly occurring co-staff services (often groups), providers may include a service necessity statement in the PN's template.
- Here are two template examples for a group service:
 - “2 staff facilitate group to maintain optimal client:staff ratio for containment, interventions, provide feedback & track progress.”
 - “2 staff required to provide containment & facilitate group process.”
- All staff get “credit” for the full service time, as long as there is service necessity for all staff involved.



Multiple Staff - Co-Staffed Services: Progress Notes

For co-staffed services, there are 2 Progress Note options:

1. Co-Staffed Progress Notes: 1 staff (primary) writes all or some PNs & indicate:
 - Primary staff's total time (service time + documentation time)
 - Co-staff's name/ID# & their total time (only service time)
2. Individual Progress Notes: Each staff writes own PN:
 - Each staff's PN indicates the presence of co-staff(s)

Please Note: InSyst only allows 2 staff per Co-Staffed Note.

- If more than 2 co-staff provide the service, "leftover" staff have the same two PN options as above.



Progress Notes: Timeliness & Frequency

Services must be documented during the shift or within one (1) working day.

- Outpatient Mental Health Programs:
 - Every service contact, usually per minute
- Day Treatment Rehabilitation:
 - Weekly summary
- Day Treatment Intensive:
 - Daily Notes & Weekly Summary (Weekly requires LPHA sig.)

Tip

Write enough to account for service delivery time. Use common sense:
Brief service=brief note. Long service=longer note.



Late Progress Notes

- Progress Notes written after 1 working day must be labeled “late entry”.
 - Date of service delivery is noted at the beginning (e.g., Late entry for 3/3/09).
 - Signature date is the date the note is written.
- If No Note = Service may not be entered!
- If written after 3 working days into the next month:
 - Data entry supervisor must authorize entry of the service.
 - Agency may not be reimbursed until year-end.
 - Agency's data reports may not be accurate.



Multiple Clients - Group Services: Billing & Progress Note

Must write a Progress Note for each
Medi-Cal and Medi-Medi client!

Progress Notes must indicate the following, which is
also necessary for InSyst to calculate billing:

- Total service minutes (group time + time to write all client notes – regardless of insurance)
- Total # of all clients (regardless of insurance)



Group Note Time: Example #1

60 minute group

6 clients: Each note takes 8 min. ($6 \times 8 = 48$ min.)

1 staff (writes all Progress Notes on all clients, including OHC)

- Staff time:

- $60 \text{ min.} + 48 \text{ min.} = \underline{108 \text{ min. total}}$



Group Note Time: Example #2

60 minute group

6 clients: each note takes 8 min. ($6 \times 8 = 48$ min.)

2 staff (1 staff writes all Progress Notes on all clients, including OHC)

- Primary Staff (note writer) time:
 - 60 min. + 48 min. = 108 min. total
- Co-Staff time:
 - 60 min. total



Group Note Time: Example #3

60 minute group

6 clients: each note takes 8 min. ($6 \times 8 = 48$ min.)

2 staff (split notes 50/50; each staff writes 3 co-staffed notes)

- Primary Staff time for 3 clients:
 - 60 min. + 24 min. = 84 min. total
- Co-Staff time for those 3 clients:
 - 60 min. total

Use same procedure for 2nd staff to write their 3 co-staffed notes, just shift who is Primary Staff.



Medi-Cal & Medi-Medi Progress Note Basics

All Progress Notes for all clients must include:

- Date of service delivery, including year
- Procedure code (helpful to include type of service)
- Location of service (per InSyst codes)
- Face-to-Face time and Total time (includes doc./travel time)
- DSM diagnosis code
- Refer to relevant Client Plan Objective(s)
- Description of staff activity (see next slide for client encounter)
- Staff signature & licensure, professional degree, or job title (if licensed, must include it, e.g., LCSW, MD; co-signature, if applicable)
- Recommend include typed name/licensure (legibility)

Medi-Medi reminder: Next step/plan on Assessment PN's



Medi-Cal & Medi-Medi

Progress Notes: Client Encounters

Medi-Cal: Face-to-Face/Phone. Medi-Medi: Face-to-Face only.

Progress Notes for client sessions must support medical necessity for the service by documenting the following:

- Reason for contact/service
- Assess client's clinical presentation (relevant hx, if applicable)
- Staff interventions (actions to reach Objectives)
- Client's responses to interventions; Progress
- Follow-up plan (e.g., next date of service, referral, prescribe medication, patient/family education, f/u instructions)
- If app., physical exam findings, test results, diagnosis changes.

Standard Progress Note format like BIRP is helpful! (handout)

Medi-Medi reminder: Therapy 75-80 min. requires reason for exceptional length in the Progress Note.



Sample Progress Note: Individual Therapy

- 6/18/10
- 64 min. F-to-F; 69 min. Total time
- Location code xx
- (445) Individual Therapy (Note: had to “down-code” per minutes)
- Objective #1: “Reduce depression/anxiety”
- Client was less disheveled today, had flat affect but maintained eye contact. Voiced concerns about her social skills but says she’s less depressed/anxious overall & wants to take a dance class but client appears ambivalent about this. Just had dream that triggered abuse memories – we explored this with support & empathy but she became flooded with anxiety. Engaged her cognitively to manage this – she thinks it’s connected to her anxiety about the possible dance class & using her body to express herself.
- Plan: F/u next week re. dreams & how coped with anxiety.
- Freudian Slippers, PhD.



Sample Progress Note:

Individual Rehab (Medi-Cal only)

- 6/12/10
- 50 min. F-to-F; 95 min. Total time (Note: includes travel)
- Location code xx (for client's home)
- (381) Individual Rehabilitation
- Objective #2: "Improve self-care impacted by depression."
- Worked with client on hygiene skills impacted by his depression & social isolation as he did not shower this week & did not leave home. Co-created a chart to keep track of ADL's & his feelings to help him see connection. He was willing to do this activity & was talkative, maintained eye contact. Responded well to praise & active support, seemed more hopeful at end of session.
- Plan: Monitor progress with chart in next sessions.
- Jane Doe, Case Manager

Progress Notes:

Crisis Intervention

Medi-Cal Only

In addition to Individual Services progress note contents, Crisis Intervention notes must address:

- Relevant clinical details to support MN (events leading to crisis, how client is imminently at risk of DTS/O/GD due to mental health issues OR how client's condition is highly likely to become an immediate psychiatric emergency)
- Assessment of risk & measures taken to reduce risk
- Involvement of client in their own aftercare safety plan
- Collateral & community contacts to participate in follow-up



Sample Progress Note: Crisis Intervention

- 3/3/10
- 210 face to face/270 total time
- Location code xx (for field)
- (371) Crisis Intervention
- Objective #1: "I won't be aggressive toward BART police" and #2: "I will follow B&C rules so I can stay there with my girlfriend for the next 6 months."
- Got call from BART Officer Shields at Ashby Station that RB had raised his arms aggressively at BART passenger & refused to leave when asked by Officer. He'd been panhandling & increasingly threatening as people ignored him. Shields knows RB, so called me to help calm RB and return him to his B&C. I went to BART & found RB still arguing with Officer, refusing to leave. It took a while to de-escalate RB by reminding him of Goals above, especially #2, & the risk of eviction if he didn't maintain control. I helped him call his girlfriend to make dinner plan as motivation to reduce aggressive & argumentative behavior. As he calmed, he let me to walk him to the parking lot but then got agitated & tearful which required more monitoring to avoid his re-escalation to aggression. Helped him do guided imagery re. dinner w/ gf; was then calm enough to transport to B&C – on the way, helped him restate Plan goals & dinner plan. Officer said won't press charges "this time"; RB confirmed tomorrow's appointment & agreed to call the program if begins to get agitated again.
- Jane Doe, Case Manager



Progress Notes: Group Services – Therapy or Rehab

Group Progress Note Content:

- Group's mental health goal (e.g., Social Skills Group)
- Relate service to client's MH Objective(s)
- Report on client's group interaction & involvement
- Describe staff interventions & client's responses
- Follow-up plan



Group Progress Notes: Special Situations

- Client leaves group early.
 - Staff indicates total group service time, since staff was available for client the entire time.
- Some notes take longer/shorter than others.
 - Keep track of time per note & add for total time



Sample Progress Note: Group Therapy

- Date/Location/#Clients/Service (Group Therapy 456)
- Primary Staff: 60 F-t-F; 116 TT *(60 min. + 56 min. @ 8 x 7 min. each)*
- Co-staff: J. Tzudiker, MFT #007, 60 min. To maintain optimal client/staff ratio for clinical interventions.
- Objective #3: "Improve ability to tolerate/increase social contact."
- Group Focus: Practice social interaction via role play
- Client participated in social situation role-plays with peers though initially anxious, distractible & unable to sit calmly. Said she enjoyed the activity & that it helped reduce some anxiety. She participated in group exploration of feelings during activity; able to identify increased anxiety when talking with males. Co-staff & peers normalized that (given her history) & provided support. Will attend next week's group.
- B.B. Wolfe, MFT

Describes behaviors/interventions related to process.



Sample Progress Note: Group Rehab

- Date/Location/#Clients/Service (Group Rehab 391: Social Skills)
- 60 F-t-F; 123 TT *(60 min. + 63 min. @ 7 x 9 min. each)*
- 7 members--1 staff
- Objective #2: "Improve ability to tolerate/increase social contact."
- Client participated in social situation role-plays with peers though she was initially anxious, distractible & unable to sit calmly. She said she enjoyed the activity & that it actually helped to reduce some of her anxiety at even the thought of socializing more. Was able to identify increased anxiety when talking with the opposite sex which other members validated. I offered stress-reduction techniques to use in these situations & client said she'd think about trying to use them, but did not commit to practice.
- Plan: Client will attend group next week.
- Hans C. Anderson, Rehab Counselor

Describes behaviors and interventions that focus on skill building.



Case Example for Group: Client Plan's MN Statement

School-based MH program example: 12 year old male diagnosed with Generalized Anxiety Disorder which impacts school & social functioning.

- Medical Necessity is documented in the Client Plan:
 - Client has peer difficulties due to poor ability to contain anxiety when engaging with them in school, neighborhood & at church: He reports feeling increasing irritability & tension, says his “mind goes blank” which then increases his anxiety, and he often inappropriately leaves social situations like church & classroom. His response to anxiety has caused his grades to decline; this & his church behavior has created significant family tension.



Case Example for Group: MH Objective & Service Intervention

- Objective: Within 6 months, client will successfully engage with peers in 3/6 situations per day, as measured by self, school & home reports; current baseline = 1/6 per day.
- Service Intervention: Social Skills Group Rehab 2x/week to improve peer interactions & remain engaged with peers despite anxiety.



Case Example for Group: Progress Note Content

Progress Note:

- Social Skills Rehab Group
- Facilitated role play of today's recess interactions. Client fidgeted/grimaced when peers recalled his irritable/angry outbursts in team game. Staff helped client & peers notice physical signs of rising anxiety; asked everyone to rank anxiety from 1-10 to improve self-awareness/think clearly in the moment. Client able to rank 2/6 times; peers said they were impressed by his efforts.
- For next group on 9/17/11, help client practice biofeedback skills: Pair client with peer JT who likes using ranking to reduce anxiety in peer interactions.



Progress Notes: Collateral Service

If the collateral is with another professional, specify the contact person's name & relationship to client.

- Relate service/intervention to Client Plan Objectives
- Describe staff actions
- Describe collateral person's responses, if applicable
- Provide any relevant clinical decisions
- Identify follow-up plan

Medi-Medi reminder: If provided with client present:

- Include the time in F-to-F time.



Sample Progress Note: Collateral

- 6/21/10
- 0 min. F-t-F; 12 min. TT
- Location code xx (for phone)
- (311) Collateral
- Objective #2: "Stay in current residence for next 6 months."
- TL's mother called to say she'll move to Nevada next month. As his major support, she's worried about his ability to "keep it together" when she leaves. Suggested she meet with TL & his care team to see how we can each support him in this transition. She'll call the CM to set up the meeting & I agreed to be present.
- Freudian Slippers, PhD.



Progress Notes: Plan Development

Document in Progress Notes how the service either:

- Meets the client's mental health needs,
- OR
- Meets the need for treatment planning (if worked on a Client Plan, provide the Plan's start date).

Medi-Medi reminder: If provided with client present:

- Include the time in F-to-F time.



Sample Progress Note: Plan Development

- 7/1/10
- 0 min. F-to-F; 60 min. TT
- Location code xx
- (581) Plan Development
- Objective #N/A: Client Plan revised
- Created Annual Client Plan (see Plan dated 7/1/10).
- Jack N. Jill, BA, Peer MHS



Progress Notes: Plan Development Team Consultations

Team consultation progress notes :

- Only the minutes spent discussing a particular client are billable.
- Provide consultant's name
- Summarize discussion
- Describe the unique contribution of each staff involved.
- May write co-staffed note.

Co-Staffed Note Exception: If staff provided different *Specialty* MHS, they must write their own notes because reimbursement is different (e.g., MD provides Med Support expertise in consult with CM).



Progress Notes: Case Management (Medi-Cal Only)

Describe:

- Staff activities
- Relate to Objectives
- Note client's response, if applicable
- Next step, if applicable

Note: "Checking in" with client can meet Medical Necessity as "monitoring progress toward treatment goals," only when the outcome/progress toward MH Objective(s) is documented!



Sample Progress Note: Case Management

- 6/21/10
- 30 F-to-F; 60 TT
- Location code xx (for field)
- (571) Case Management
- Objective #3: "Reduce angry outbursts from 2 to 1x/week."
- Met TL to review support group referral from therapist. I shared info about the 2 groups & why I thought the anger management one would work best given his MH Objective. He said liked the idea but chose social skills one instead. He called about the group right then, but they need referral. I contacted therapist to fax it & we discussed importance of supporting TL's group choice, though we do think the anger group is more appropriate. I called the group counselor to make sure everything was set for TL to start next week; left message for TL.
- Jane Doe, Case Manager



Chart Documentation: Process Notes vs. Progress Notes

- Avoid *Process* Notes (aka Psychotherapy Notes) which are “HIPAA protected” notes that are purely observational, narrative content written by staff to help analyze contents/process of client contact session.
 - If Process Notes are written they should be filed separately from the clinical record (or shredded) in order to maintain their protected status per HIPAA.

The only treatment notes that should be in a clinical record are Progress Notes required to document services.

Recent DMH State-wide Audit Findings: Reasons for Disallowances



- Insufficient documentation of MN (e.g., no substantiation of diagnosis or impairments related to diagnosis, progress note doesn't address mental health condition)
- Client Plans not completed within required timeframes
- No documented evidence of client participation in treatment planning (no client signature/explanation on Plan)
- Service provided while client in lockout situation
- Progress Note missing, not signed by service provider,
- Progress Note describes solely academic, vocational, recreational, socializing, clerical, transportation or payee-related activities
- Time entered was greater than time on Progress Note (overbill).



Red Flags!

Auditors notice:

- Notes & Client Plans that all seem the same
- Paperwork that is difficult to read
- Client Plans that are not explicit
- Client Plans that don't comment on progress or lack thereof
- Too many check-off boxes without comments



Reviewing Medical Necessity: “Was that billable?”

When you wonder.... *“Was that billable just now?
What was the mental health value of what I just
did with this client?”*

- Ask yourself why the client requires your help to accomplish life tasks....

If the reason is related to mental health problems that you've identified in the Client Plan and/or in that Progress Note, your service is probably billable.



Do we need a break?!?

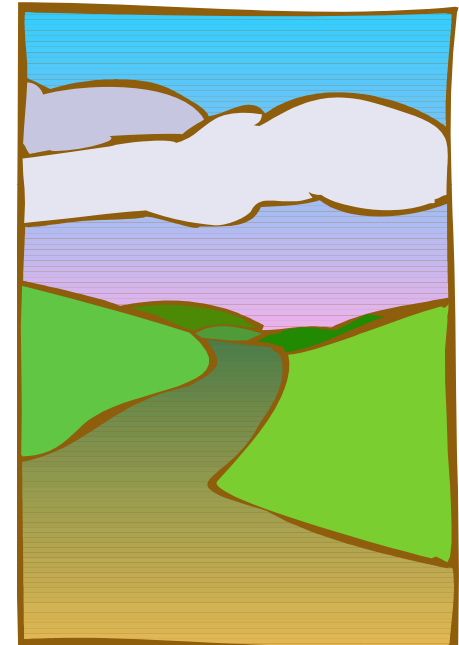
Yes!

Client Plan: Relationship Between Goals, Objectives & Interventions

Many staff are confused about the differences between goals, objectives & interventions. Here is a way to think about these important Client Plan elements.

Defining Goals:

- Client goals express their own hopes and dreams.
- Staff help identify the mental health barriers preventing attainment of those goals; barriers that can be addressed via the services provided.



Client Plan:

Client's goals are...

- BIG (life goals that stay true over time)
- Inspiring to the client
- Written in client's own words (help state them in positive language!)
- Linked to discharge & transition criteria

Partner with clients to understand underlying benefits of an "inappropriate" goal (e.g. to be a drug dealer – benefits may be money, power, prestige).

Identify together client's strengths, supports & resources that can help them achieve their goals.

Client Plan: Defining Objectives

“What Do Objectives Do?”

- Objectives divide big life goals into manageable units of completion.
- They take into account the client's culture & strengths.
- They provide time frames for assessing progress & celebrating achievements.



Client Plan:

Objectives & Medical Necessity

- Objectives describe positive changes in key behaviors, functions or status that the client agrees to accomplish, in partnership with you, in order to reach their goals.
- Objectives address a client's functional impairments & goal barriers DUE TO an "included" diagnosis.
- Think of Goldilocks: Objectives = "Just the right size!" Should be smaller than client's goals, but big enough to allow your Services/Progress Notes to relate to them over time.
- Revise objectives if they seem too difficult to achieve within a timeframe that feels hopeful to the client.
- And when objectives are met, revise them!
 - Keeps staff interventions relevant to the current Client Plan
 - Gives client & staff a well-deserved sense of progress & achievement!

Client Plan:

How to Write an Objective

Example

- | | |
|---|---|
| ■ Subject ----- | ■ Client |
| ■ Verb/Action Word ----- | ■ Will demonstrate |
| ■ What ----- | ■ Improved ability to ... x/y times, currently z/y times. |
| ■ When will it be done/timeframe? ----- | ■ Within x months |
| ■ How will it be measured? ----- | ■ As measured by ... |
| ■ Why is it important? ----- | ■ Link back to client's goals! |



Client Plan: Defining Interventions

Objectives & Interventions are different!

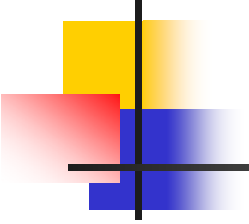
- Objectives are the WHAT –
 - What are the next significant milestones toward reaching client's Goal?
- Interventions are the HOW –
 - How will mental health services help reach Objectives?
 - How will client's strengths be utilized to get there?
 - How will be the staff's service focus help achieve Objectives, and ultimately client's Goal?

(Note: Current BHCS Client Plan template does not provide designated areas for staff interventions; please add them under relevant Objectives.)



Client Plan: Interventions Simplified

- What: Which mental health services will be provided?
- When: Frequency of those services?
- Who: Which staff will work with client?
Who else on team will help?



Client Plan Objectives: Case Example

- Sue is a warm & creative person who used to knit and paint & work as a secretary. She comes to the mental health clinic for medications to help relieve depression & social anxiety. She can get overwhelmed by sadness & self-critical thoughts at times & used to drink alcohol to “numb-out”. Sue is proud to have 30 days of sobriety and, feeling much better, she wants to get back into the workforce. She occasionally experiences cravings, but finds that she gets back on her feet more quickly now.



Client Plan: Example of Goal/Barrier Statements.

- Sue's Goal: I want a full-time job.
- Mental Health Barriers to Sue's goal:
 - Sue gets depressed and self-critical. She sometimes has cravings to use alcohol to relieve her symptoms, which are hard to manage, especially in a work setting. She is anxious around people. She misses appointments and often isolates herself due to depressed moods & social fears.



Client Plan:

Sample Mental Health Objective & Intervention

Objective: Within the next 6 months, Sue will increase her coping skills for depression & anxiety to help reach her goal of getting a job. She reports no current coping skills other than using alcohol.

- Subject: Sue
- Action: Will increase
- What: Coping skills for MH symptoms
- When: In the next 6 months
- Measure: Self-report & staff observation
- Why: To better manage depression & anxiety to reach job goal

Intervention: DTR staff will help Sue develop & practice 3 positive coping skills during Coping Skills Group provided 2x/week.

- Who: DTR staff
- What/When: Help develop & practice 3 coping skills 2x/week in Group



Connecting Mental Health Barriers & Objectives to Staff Interventions

- The next slides list common mental health barriers to task/goal accomplishment on the left. (laminated sample)
- Each barrier is matched with simple examples of mental health interventions on the right.
- The interventions are billable when the progress note clearly links the intervention to signs & symptoms of an included diagnosis, or refers to the Client Plan where the link is clear (usually an Objective).
- Make sure interventions are culturally appropriate!
- Combine basic interventions with client strengths to build on what's worked well in the past!



Connecting MH Barrier/Objective to Staff Interventions

Barriers:

- Angry outbursts
- Anxiety, excessive worry, fear of others' responses, mania, racing thoughts, feeling on edge, difficulty concentrating

Per cultural context, staff helps client to:

- Identify triggers
- Name emotions that underlie anger
- Identify healthy responses
- Offer/practice stress reduction techniques
- Co-create list of alternative activities to use when anxious



Connecting MH Barrier/Objective to Interventions, cont'd.

Barriers:

- Depression: Loss of interest in anything, little pleasure from enjoyable activities, sleep problems, low energy, hopelessness, low self-esteem, difficulty concentrating
- Grief & Loss: Thoughts dominated by loss of people/situation or grief from coping with a mental illness

Per cultural context:

- Identify positive self-talk statements
- Develop plan for social activity/exercise
- Create list of current negative self-talk for increased awareness
- Express unresolved emotions
- Create feelings journal
- Create meaningful goodbye rituals



Connecting MH Barrier/Objective to Interventions, cont'd.

Barriers:

- No hope or vision of a better future
- Lack of Motivation: poor follow through on tasks, poor hygiene, poor household maintenance
- Poor self-advocate or negotiation skills, unable to refuse requests

Per cultural context:

- Create list of good events
- List positive effects if improved follow through 5%
- Identify cognitive barriers
- Identify what's positive about not having motivation
- Practice/role play assertive expressions & responses



Connecting MH Barrier/Objective to Interventions, cont'd.

Barriers:

- Easily overwhelmed
- Poor social skills
- Difficulty trusting people
- Impulsivity
- Little or no insight into consequences of personal behaviors & choices

Per cultural context:

- Identify underlying beliefs/fears; Identify expectations
- Practice conversation skills
- Develop useful expectations of others
- Identify motivations for quick decisions
- Review pos/neg. experiences to find meaning within the outcomes



Group Discussion: Common Supervisory Challenges for Treatment Planning

Suggested topics... but please raise your own!

- Different Hats: Clinical Supervisor vs. Administrative Supervisor
- Truly Partnering with Clients: Staff Concerns?
- Incorporating Client Strengths: Encouraging Staff Creativity
- Planning for Discharge at Admission: Promoting Hope
- Staff Writing Abilities: Teaming Up for Support



Clinical Quality Review Team (CQRT)

Chart Review Process:
Ensuring Quality Care



CQRT Purpose

The purpose of chart review by a Clinical Quality Review Team is to:

- Review medical & service necessity,
- Review quality of care (e.g., coordination & consultation, follow up on past issues, etc.),
- Review quality of documentation of services,
- Give feedback, and
- Authorize ongoing services.

Per 2006 BHCS letter/policy, providers must:

- have an internal CQRT process to review charts that are due for a new/updated Client Plan.
- Exceptions: Day Treatment programs & newly contracted providers must attend a CQRT sponsored by BHCS (new providers x1 year only).



CQRT Process:

Does not eliminate audit risk but assists the provider in reducing risk of audit disallowances.

- Use the MHS 696 Report to ensure match between entered service and progress note elements.
- CQRT is not a substitute for a provider's internal Quality Assurance (QA) process.
- The DMH has the ultimate authority regarding Medi-Cal audits.



The Clinical Quality Review Teams will:

- Review the chart to ensure that adequate treatment and discharge planning are documented.
- Perform either a Clinical Review or a Quality Review to approve the continuation of services.



Clinical Review

The Clinical Review establishes ongoing Medical & Service Necessity:

- Is there a current Client Plan, “included” diagnosis and corresponding Progress Notes? (current = written in the month prior to next authorization period)
- Are there indications of progress being made toward the goals? If not, is there an explanation?
- Is there an appropriate discharge plan?
- Are required dated signatures & informing materials present?



Quality Review

Fifteen percent (15%) of charts reviewed each month are randomly chosen for Quality Review.



Quality Review

The Quality Review is more comprehensive:

- It includes the Clinical Review components
- Use the “Regulatory Compliance” checklist on reverse of online CQRT Review Request Form to review charts (current BHCS audit tool).
- Check for continuity between the Treatment Plan and the treatment documented in the progress notes.



Schedule for Chart Review

- Charts are reviewed based on the episode opening date of the case. The *review cycle* begins on the 1st of the month in which the episode was opened, no matter which day of the month it was opened.
- Outpatient and Rehabilitative Day Treatment charts are reviewed every six months. **The review cycle always stays the same.**
- Day Treatment Intensive charts are reviewed every three months.
- MHS Report 485 notifies providers that the UC Authorization is expiring and due for a reauthorization.



Timeline Examples for Outpatient and Rehabilitative Day Treatment

Month Opened	Authorization cycles: They never change!	Start date for Tx Plan created for CQRT:	New Plan may not be signed before:	Do CQRT in:
January	Jan 1 - June 30 July 1 - Dec 31	July 1 January 1	June 1 December 1	June December
February	Feb 1- July 31 Aug 1 - January 31	August 1 February 1	July 1 January 1	July January
March	March 1 - Aug 31 Sept 1 - Feb 28	September 1 March 1	August 1 February 1	August February



BHCS CQRT Reviewers are:

- Provider agency supervisors, or their designees, authorized to represent their agency in meeting AND provide their agency staff with feedback regarding QA requirements, issues/concerns or compliments given by the CQRT.
- LPHA and licensed, waived, or registered interns who have attended CQRT training or orientation.

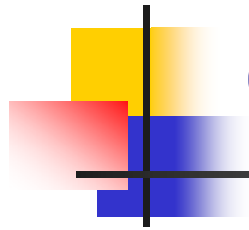


Chart Content for CQRT

Charts must contain all of the elements required by Medi-Cal Documentation Guidelines (see CQRT Manual, will be updated soon & available online).



Deficient charts: “30-Day Return”

If a chart is missing any of the items listed below, it is given one (1) month's authorization. Deficiencies must be corrected prior to return to the next month's CQRT:

- A completed CQRT Form
- Insufficient documentation of Medical Necessity
 - Impairment Criteria (all items)
 - Intervention Criteria (all items)
- Treatment Plan (all items)
- Progress Notes: if missing more than 30 consecutive days of notes
- In Quality Review, any item from page 2



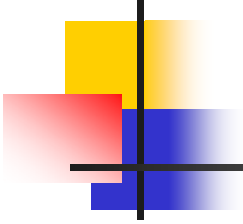
BHCS CQRT Meeting Schedules

- BHCS CQRT meetings are organized by the type of provider or primary treatment mode
- Meeting assignment is determined by the BHCS
- Schedules & CQRT documents are on the BHCS website, under Quality Assurance:
www.acbhcs.org/providers



Final CQRT Advice

- Read the CQRT Manual - it covers all aspects of the CQRT process. (updated soon!)
- Train your staff in the CQRT process.
- Develop a written agency QA Policy & Procedure Manual.
- Supervisors reviewing charts and returning to staff for correction prior to reviews will reduce deficiencies and the need for time consuming "30 day returns".



Staff Qualifications



Overall Staff Qualifications: LPHA

Licensed Practitioner of the Healing Arts (LPHA):

- Valid California clinical licensure in one of the following professional categories:
 - Licensed Clinical Social Worker (LCSW)
 - Licensed Marriage Family Therapist (MFT) (Note: No Medicare)
 - Licensed Clinical Psychologist (Lic. PhD)
 - Physician (MD & DO)
 - Other medical staff: PA, NP, CNS, RN (Note: RN No Medicare)

Approved Activities – *within scope of practice (SOP)*:

- Can provide all service categories, authorize services, co-sign
- Can conduct assessments, MSE's & diagnose. (RN's diagnosis may require co-signature per education/training.)



Clinical Social Worker (LCSW)

- Licensed in California
- May provide services within LCSW's training & expertise.
 - May NOT provide any Medicare service with E/M component.
 - May NOT provide Medicare services at hospital or SNF.
 - May NOT provide Medication Management.
- Medicare non-billable, but required: Attempt to consult with PCP/attending MD before providing services (unless that MD requested the service). Get client release & document all efforts. (Billable to Medi-Cal as Collateral.)



Clinical Psychologist (CP)

- Licensed in California at independent practice level to provide services directly to individuals.
- May provide services that are within CP's scope of practice.
 - May NOT provide any Medicare service with E/M component.
 - May NOT provide Medication Management.
- Medicare non-billable, but required: Attempt to consult with PCP/attending MD before providing services (unless that MD requested the service). Get client release & document all efforts. (Billable to Medi-Cal as Collateral.)



All Medical Staff

- Medical staff are required to know their respective licensing boards' requirements pertaining to:
 - Delegation of Services Agreement
 - Standardized Procedures



Physician

- Physician = MD/Psychiatrist/DO
- Licensed in California.
- May provide these broad services, per their training & expertise:
 - Psychiatric Services
 - Medicare Evaluation & Management (E/M)



Physician Assistant (PA)

1/2

- Licensed in California.
- Must practice under supervising MD. (*Limit 4 supervisees at any one time.*)
- To furnish/prescribe controlled substances, must have Federal DEA Registration number.
- Regulations for supervision & practice are per CA Dept. of Consumer Affairs' PA Committee, see website: pac.ca.gov
 - MD is responsible for following each patient's progress & for supervising PA's services (see PAC website). [MD is not required to co-sign Progress Notes.]
 - MD must be available in person or by reachable at all times when PA provides services; does not have to be on-site.



Physician Assistant (PA)

2/2

- May provide services that meet all the following:
 - Service is approved for supervising MD's scope,
 - MD has determined service is within PA's scope,
and
 - Service (tasks/procedures) is specifically defined in a *Delegation of Services Agreement* created collaboratively per PAC guidelines. For sample see website: capanet.org/pdfs/delegation.pdf
 - The *Agreement* must be kept on site & readily accessible



Nurse Practitioner (NP)

1/2

- Licensed in California, and
- Nationally certified in specialty area of psychiatry or mental health.
- Regulations for supervision & practice are per CA Board of Registered Nursing (website: rn.ca.gov).
 - Must provide services in documented collaboration with MD via written *Standardized Procedures* specifying tasks/procedures, experience & supervision requirements, etc. For samples see website: rn.ca.gov/pdfs/regulations/npr-b-20.pdf
 - Collaborating MD need not be present/evaluate each patient served by NP.
 - May provide services that are within NP's scope of practice, as identified in *Standardized Procedures*.



Medicare: Overlapping Medical Functions Nurse Practitioner (NP)

2/2

- If service is a Medicare “overlapping medical function” (e.g., E/M services), may only provide if:
 - Under MD supervision. (*No supervisee limit*).
 - Standardized Procedures exist for that service.
 - May furnish medications only if:
 - Under supervision of MD (*Limit 4 supervisees at any one time*), and
 - Has a Furnishing Number from CA BRN.
 - If furnishing controlled substances (Drug Schedule 2-5):
 - Meets above criteria for furnishing and
 - Has DEA registration number



Clinical Nurse Specialist (CNS)

1/2

- Licensed and certified in California.
- Master's degree in a defined clinical area of nursing.
- Nationally certified in specialty area of psychiatry or mental health by American Nurses Credentialing Ctr.
- Regulations for supervision & practice are per CA Board of Registered Nursing (see website: rn.ca.gov)
 - Must provide services in documented collaboration with MD via written *Standardized Procedures* specifying tasks/procedures, experience & supervision requirements, etc. For NP samples (no CNS sample) see website: rn.ca.gov/pdfs/regulations/npr-b-20.pdf



Clinical Nurse Specialist (CNS)

2/2

- Collaborating MD need not be present/evaluate each patient served by CNS.
- May provide services that are within CNS's scope of practice, as identified in *Standardized Procedures*.

- Medicare: If service is an "overlapping medical function," may only provide if:
 - Under MD supervision (*No supervisee limit*).
 - Standardized Procedures exist for that service.
 - May NOT furnish medications, even under supervision.



Medi-Cal Only

Waivered/Registered LPHA

1/3

Waivered Psychologist:

- Each psychologist candidate must obtain a waiver—even if he/she is registered with his/her licensing board.
- In order to be eligible for such a waiver, the *psychologist candidate* must have successfully completed 48 semester/trimester or 72 quarter units of graduate coursework, not including thesis, internship or dissertation. An official copy of a transcript reflecting completion of this coursework requirement must be submitted with the waiver application.

Psychologist candidates are granted waivers by DMH via application submitted to BHCS Director 's office.



Medi-Cal Only

Waivered/Registered LPHA

2/3

Registered MFT Interns & Associate SW's:

- Registered with the licensing board of jurisdiction for the purpose of acquiring the experience required for licensure.
- Remain registered with licensing board until licensure (must remain registered even though he/she is no longer accumulating qualifying hours).
- Receives clinical supervision.

Hiring providers oversee MFT Interns & ASW's.

No waivered/registered staff may hold themselves out as independent practitioners.



Medi-Cal Only

Waivered/Registered LPHA

3/3

BHCS Approved Activities – (*within Scope of Practice **AND** under LPHA supervision in their Scope of Practice*) :

- Authorize services & claim for all MHS, Crisis Intervention, Case Management, Day Treatment, Psych Testing.
- Conduct comprehensive assessments and provide diagnosis without co-signature.
- Create & sign Client Plans without co-signature.
- May co-sign the work of other staff within their scope of practice other than graduate students doing psychotherapy.



Medi-Cal Only

Graduate Student Intern/Trainee 1/2

Graduate student trainee:

- In field placement of accredited MSW, MA, MS, or clinical/educational psychology doctorate degree program to prepare for licensure; no minimum experience requirement.
- Some graduate students may qualify as MHRS, if employed by provider & if their experience permits.
- Students enrolled in degree programs other than those listed above may qualify as Adjunct Staff.



Medi-Cal Only

Graduate Student /Trainee

2/2

BHCS Approved Activities – (*within Scope of Practice **AND** under LPHA supervision*):

- Conduct comprehensive assessments and provide diagnosis, but requires licensed LPHA co-signature.
- Create Client Plans, but requires co-signature by licensed LPHA.
- Write Progress Notes, but requires co-signature by licensed LPHA.
- Psychotherapy, but requires oversight & co-signature of licensed LPHA.
- Claim for any service within scope of graduate program's discipline.



Medi-Cal Only

Mental Health Rehab Specialist (MHRS) ^{1/2}

MHRS staff must meet one of the following:

- Bachelor's degree + 4 yrs experience in MH setting as physical restoration, or social or vocational adjustment specialist.
- Up to 2 years graduate professional education = experience requirement/year-for-year basis.
- Up to 2 years post-AA degree clinical experience = educational requirement, in addition to requirement of 4 years' experience in MH setting.

Family Partners & Peer Counselors usually qualify as MHRS, but may qualify instead for other designations; providers must make that determination per the staff's education & experience.



Medi-Cal Only

Mental Health Rehab Specialist (MHRS) 2/2

BHCS Approved Activities – (within Scope of Practice):

- Gather assessment information & enter it into the Assessment document for review by licensed, waived, or registered LPHA staff.
- Create Client Plans (co-sign by licensed LPHA) and Progress Notes.
- Claim for all MHS (except Psychotherapy), Crisis Intervention, Case Management, Day Treatment.



Medi-Cal Only

Adjunct or Other Staff

1/2

Adjunct MH Staff & Other Staff Not Meeting Above Category Qualifications

- Level 1 providers have the prerogative & program flexibility to integrate/define other staff who can provide direct or supportive Medi-Cal services, per their BHCS contract (e.g., Bachelor's level staff, licensed in other state, etc.).
- No requirement to pay staff for Medi-Cal service provision (e.g., unpaid grad students/trainees/interns, volunteers or advocates), as long as unpaid persons meet Medi-Cal claiming & Scope of Practice rules.



Medi-Cal Only

Adjunct or Other Staff 2/2

BHCS Approved Activities – (*within Scope of Practice* **AND** *with evidence of ongoing supervision*):

- Claim for services (*except Psychotherapy*) & follow same clinical documentation rules per MHRS.
- *BHCS strongly advises that all such staff's documentation be co-signed by a licensed LPHA.*



Resources: Staff Qualifications

For staff qualifications & scopes of practice per California regulating organizations:

- Board of Registered Nursing (Nurse Practitioner, Clinical Nurse Specialist): www.rn.ca.gov
- CA Board of Behavioral Sciences (LCSW): www.bbs.ca.gov
- CA Board of Psychology (Clinical Psychologist): www.psychboard.ca.gov
- CA Medical Board: www.medbd.ca.gov
- CA Department of Consumer Affairs, Physician Assistant Committee: www.pac.ca.gov



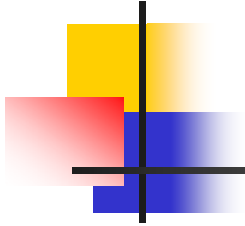
General Resources

- General QA Information: www.acbhcs.org/providers then QA tab at left for PowerPoint Trainings, Document templates, Informing Materials, CQRT Manual/schedule of meetings, List of Abbreviations, etc.
- EPSDT Documentation Manual: www.CIMH.org/downloads/epsdt (helpful for all providers even though written from children's services perspective).
- DMH Information Notice No.: 10-11 "Dual Eligible (Medicare/Medical) Claiming in Short Doyle Phase II":
<http://www.dmh.ca.gov/DMHDocs/docs/notices10/10-11.pdf>
- BHCS Provider Relations (claims questions; add service codes):
800-878-1313

Resources:

Medicare & CPT Materials

- “Medicare Part B – Mental Health Services Billing Guide,” by CMS & NHIC, Corp., July 2010 -- with caveat that Palmetto is now California’s Local Coverage Determination (LCD) entity, not NHIC: www.cms-billing.com/forms/NHIC_Medicare_B_Mental_Health_billing_guide_2008.pdf
- Center for Medicare/Medicaid Services (CMS) Manual Updates for 2010: www.cms.gov/manuals/Downloads/bp102c15.pdf
- “Local Coverage Determination (LCD) for Psychotherapy Services,” CMS, webpage updated 4/13/10; explains Medicare Psychotherapy services: www.cms.gov/mcd/viewlcd.asp?lcd_id=28294&lcd_version=17&show=all
- CPT (Current Procedural Terminology) Codebook for service code descriptions, published & updated annually by the American Medical Assoc.



QA Contact Info

For questions, *limit 1 contact person per provider* to maintain consistency of information at your agency!

Kyree Klimist, MFT, Associate QA Administrator

kklimist@acbhcs.org

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Tiffany Lynch, QA Secretary tlynch@acbhcs.org