Additional Clinical Doc Resources

See following slides.

AFTER SIGNATURE: 1.) MAY INDICATE MH DEGREE, LICENSE, REGISTRATION, AND CERTIFICATION (IN GREEN ABOVE) AND 2.) MUST INDICATE MEDI-CAL CREDENTIAL (IN BOLD ON PG 2).

F.Y.I.

Sample Provider Signature Sheet

NAME	AGENCY POSITION TITLE	MEDI-CAL CREDENTIAL	SIGNATURE REQUIRES M/C CREDENTIAL
NORI TSU	PHYSICIAN	MD	Nori Tsu, MD
IRMA CALLOWAY, BS	MENTAL HEALTH SPEC.	MHRS	Irma Calloway, MHRS
HENRY BAR-SMITH	MH CLIN SPEC	PSYD-W (Waivered Psychologist)	H Bar-Smith, PsyD-Waivered
GENOVEVA MARTINEZ, PhD	MENTAL HEALTH SPEC.	MHRS (Has PhD but not licensed or waivered.)	Genoveva Martinez, MHRS
JANEY MILLER	PEER COUNSELOR or FAMILY PARTNER	ADJUNCT STAFF	J Miller, Adjunct Staff
DANIELLE BOGGEMAN, MS	STUDENT TRAINEE	TRAINEE	D Boggeman, Trainee
DREW MANUEL	NURSE	LVN	Drew Manuel, LVN
LOUIS ALMANZA	ADV PRACTICE NURSE	NP	Louis Almanza, NP
LUDEEMA WILLIAMS	MH CLINICIAN	MFT & LPCC	L Williams, MFT, LPCC
ANTHONY SANCHEZ, MS	ALCOHOL & DRUG COUN.	LADAC	A Sanchez, LADAC
LASHANA JONES, AA	SUD COUNSELOR	CATC-I (Registered Intern)	Lashana Jones, CATC-I

Medi-Cal Credentials: Every signature in chart must indicate one of these. *(In addition, may also indicate designations from pg #1 [in green].)*	**MD, DO, NP, CNS, PA, RPh, RN, LVN, Psych Tech, NP/CNS/PA Student** *or* **Intern**; **PhD-L** or **PsyD-L** (licensed); **PhD-W** or **PsyD-W** (waivered); **MFT, LCSW, LPCC, LPCC-F** (includes family counseling) **MFT-Intern, ASW, PPC-Intern, RPh-Intern; MHRS**; **MFT** *or* **MSW** *or* **PCC Waivered Trainee** (Student in MH: MA/MS/MSW/PhD/PsyD Program); **Adjunct Staff** (Peer or Family providers); and **SUD Board Registration or Credential** (for AOD)

ACBHCS Scope Of Pracice 2016 9-28-16.Doc

Procedure Codes continued

323-90791– Face to Face Psychiatric Diagnostic Evaluation
(Performed by Licensed/Registered/Waivered LPHA or Trainee with Licensed LPHA Co-signature. Dx has additional requirements.)
Not a Planned Service—May be Provided when Needed

Evaluate current mental, emotional, or behavioral health.
Includes but is not limited to:

MENTAL STATUS
CLINICAL HISTORY
RELEVANT CULTURAL ISSUES
DIAGNOSIS
USE OF TESTING PROCEDURES FOR ASSESSMENT PURPOSES (I.E. BECK)

- **565-90792 – Face to Face Psychiatric Diagnostic Evaluation above with Medical Component—only** performed by Medical Providers (MD, DO, APN—CNS or NP, & PA)
- **325-90889 Non Face to Face Psychiatric Diagnostic Eval with or without Medical Component**
- **324-90791 – Face to Face Behavioral Evaluation** (Completion of CFE, CANS, ANSA-T, ANSA, or approved equivalent)
- **326-90899 – Non Face to Face Behavioral Evaluation** (CFE, etc.)

Procedure Codes continued

Plan Development (581) (PD)

(Performed by LPHA—recommended, trainee—acceptable, or other—allowed but carefully assess training/experience.)

Not a Planned Service—May be Provided when Needed

- Plan Development is defined as a service activity that consists of development of client plans (with client collaboration), and/or monitoring and recording of a client's progress towards their mental health objectives.
  - Writing Client Plan in Collaboration with Client.
  - Plan Monitoring– when considering updating Client Plan given trigger event, change in functioning, etc.

Procedure Codes continued

Plan Development (581) Cont.

- Intra-agency/clinic PD only occurs when the Plan is being reconsidered and the *writer could not obtain the information from the written record.*
- For example, clinician did a home visit and becomes aware client went off their anti-psychotic (historically linked to decompensation and hospitalization). Next MD appointment is one month away. She returns to office to meet with the psychiatrist to develop a plan to address the issue immediately.
- This is *not done routinely* in-house such as a Case Manager meeting with the MD after she sees the client, or the clinician meeting with the Family Partner after the Partner sees the client/family.

Procedure Codes continued

Individual (381) or Group Rehab (391)

(Performed by all with appropriate training and experience.)

PLANNED SERVICE—MUST BE IN CLIENT PLAN (see exceptions in Clin Doc Manual)

- **Improving, Maintaining, OR Restoring skills of impairments that are a DIRECT result of the included Dx signs, symptoms, or behaviors:**
- Allowed Example from DHCS:
  - ***"The most common example would be a client with schizophrenia who has social skills deficits which are the direct result of the schizophrenic disorder. Training will focus on social skills development.***

-John Griffith, PhD, DHCS Consulting Psychologist, email correspondence of 5/20/15

Procedure Codes continued

Individual (381) or Group Rehab (391) Cont.

(Performed by all with appropriate training and experience.)

PLANNED SERVICE—MUST BE IN CLIENT PLAN (see exceptions in Clin Doc Manual)

- Disallowed Example from DHCS:
  - ***Client has Major Depression with symptoms of insomnia, depressed mood, anhedonia, indecisiveness, fatigue, feelings of worthlessness and psychomotor retardation.***
  - ***Clinician wishes to address an identified impairment (or skill deficit) of poor ADL's.***
  - ***"In this example , the 'deficit'—i.e., failure to perform ADLs—is not really a deficit at all. The client KNOWS how to bathe, brush teeth, comb hair, etc."***

    -John Griffith, PhD, DHCS Consulting Psychologist, email correspondence of 5/20/15
  - ***Rehab services could be provided to address the deficits of Major Depression in the areas of: interest in life (anhedonia), self-worth (feelings of worthlessness) and energy (fatigue).***

Procedure Codes continued

Collateral (311) ***for family engagement use Code 310***

(Performed by all with appropriate training and experience.)

CURRENT REQUIREMENT: PLANNED SERVICE—MAY ONLY BE PROVIDED AFTER THE COMPLETION OF THE CLIENT PLAN*

- Services provided to Significant Support person
  - Consultation, Training and Psychoeducation of significant support person in client's life where the
    - *Focus is always in achieving mental health Objectives in Client Plan—If Plan is not completed, there is no way to do so.

- Definition—Supporting Client Plan by:
  - Gathering information from, or
  - Explaining results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or
  - Advising them how to assist clients

Procedure Codes continued

Collateral (311) **for family engagement use Code 310 Cont.*

- Intra-agency/clinic Collateral does not occur. If necessary, it is most likely Plan Development.
- For example, clinician becomes aware client went off their anti-psychotic (historically linked to decompensation and hospitalization) and needs to meet with the psychiatrist to modify the plan to address the issue immediately

Procedure Codes continued

Collateral Caregiver (310)

PLANNED SERVICE—MUST BE IN CLIENT PLAN (see exceptions in Clin Doc Manual)

(Performed by all with appropriate training and experience.)

- For the purpose of supporting and tracking family engagement in clients'/consumers' treatment.
- A service activity provided to a caregiver, parent, guardian or person acting in the capacity of a family member for the purpose of meeting the needs of the mental health objectives.
- The client/consumer is generally not present for this service activity.
  - If the client/consumer is present, and the service provider facilitates communication between the client/consumer and his/her caregiver(s), a family therapy procedure code is likely more appropriate (if within scope of practice of the provider—not MHRS or Adjunct Staff).
    - If the client is present and the focus is on the significant other supporting the client's MH Objectives—Collateral Caregiver may be used.
    - If the focus is on the client's skill building with caregiver present—Ind. Rehab. May be used.

Procedure Codes continued

Collateral Family Group (317)

PLANNED SERVICE—MUST BE IN CLIENT PLAN (see exceptions in Clin Doc Manual)

(Performed by all with appropriate training and experience.)

- **317 Collateral Family Group** is defined as a service activity provided in a group setting composed of two or more sets of family members, caretakers or significant support persons in the life of a client in treatment.
- Services may be provided by LPHA and/or MHRS level staff. Adjunct Staff, peers, and family partners may provide this service with documented evidence of ongoing supervision, education, and experience.
- Collateral Family Group services may be used in providing psycho-education, resources and skills to family members/significant support persons to assist clients in gaining or re-gaining emotional equilibrium and community and family functioning.

Procedure Codes continued

Case Management/Brokerage (571)

PLANNED SERVICE—MUST BE IN CLIENT PLAN (see exceptions in Clin Doc Manual)

(Performed by all with appropriate training and experience.)

- Help clients to access medical, educational, social, vocational, rehabilitative, or other community services that are identified in the Client Plan and Assessment.
- Services activities may include, but are not limited to:
  - Communication with client & other individuals.
  - Coordination of care
  - Referrals
  - Monitoring service delivery to ensure client's access to services.
  - Monitoring client's progress toward making use of services.
- MH Plan must document need for case management due to severe impairment due to MH Dx that results in client being unable to make and maintain other community service referrals.
- See prior slides for documentation requirements.

Procedure Codes continued

Case Management/Brokerage (571)

- Intra-agency/clinic Case Management rarely occurs.
- This is *not done routinely* in-house such as a Case Manager meeting with the MD after she sees the client, or the clinician meeting with the Family Partner after the Partner sees the client/family.
- If appropriate it is most likely PD. I.e., clinician finds client's depression has worsened with suicidal ideation and asks to meet with the psychiatrist in order to explore adding a Medication Evaluation to the Client Plan (when the client had not been receiving Med Svcs).

Procedure Codes continued

Psychotherapy:

Individual: (441/442/443)

Family: (413, 449)

Multi-Family Group: (455)

Group : (456)

May use +491-90785 for Interactive Complexity for all Psychotherapy EXCEPT Family.

PLANNED SERVICE—MUST BE IN CLIENT PLAN (see exceptions in Clin Doc Manual)

(Performed by Licensed/Registered/Waivered LPHA—recommended & trainee—currently allowed.)

- A therapeutic intervention
- Focus primarily on symptom reduction
- Can be provided as individual, family, or group

Selecting the Code for Individual Psychotherapy

Individual Psychotherapy:

Time Based Code: (441/442/443)

Code selected based on the time of the time spent with the client.

See Choosing Time Based Codes on Next Slide.

Procedure Code: Therapy	CPT Code	Typical Time Period (minutes)	Actual/F-F Time (minutes)
441	90832	30” Psychotherapy	16-37”
442	90834	45” Psychotherapy	38-52”
443	90837	60” Psychotherapy	53”-beyond

Choosing the non E/M Codes based on Face to Face Time Spent in Session

- **Always choose code based on the exact number of f-2-f minutes.**
  - Documentation time & Travel Time will be included in Total Time and therefore reimbursed.

- **For non f-2-f [i.e. telephone, f-f = 0 min's] indicate the *client contact minutes* in the body of the note and select the time based code below. Also, indicate "phone" in the "location" field.**

- **FOR A TIME BASED CODE, AN AUDITOR CANNOT VERIFY IF THE CORRECT CODE IS CHOSEN IF F-F OR CONTACT TIME IS NOT INDICATED IN THE PN—AND THEREFORE WOULD DISALLOW.**

Procedure Codes continued

Multi-Family Group Psychotherapy (455)

PLANNED SERVICE—MUST BE IN CLIENT PLAN (see exceptions in Clin Doc Manual)

(Performed by LPHA—recommended & trainee—currently allowed.)

- **<u>455 Multi-Family Group Psychotherapy</u>** is defined as Psychotherapy delivered:
  - to more than one family unit each with at least one enrolled client.
  - Generally clients are in attendance.

- Services may be provided by LPHA (licensed and registered/waivered) and MH Students/Trainees.

Procedure Codes continued

Prorating Group Services

PLANNED SERVICE—MUST BE IN CLIENT PLAN (see exceptions in Clin Doc Manual)

Group Rehabilitation: 391, Collateral Family Group: 317 *(usually provided by Family Partners),*

Group Psychotherapy: 456,

& Multi-Family Group Psychotherapy : 455

- Prorated Requirement:
  - When claiming for services in a group setting, time claimed must be prorated for each child/youth represented within the Progress Note:
    - List all staff present with justification for their presence
    - List the number of clients present (or # clients represented)
      - Include the number of all clients regardless of they are being claimed to ACHBCS/Medi-Cal/etc.
    - List total time of group service, total documentation time, and total travel time (regardless if they were ACBHCS/Medi-Cal clients or not.) See specific examples for time breakdowns of different scenarios.
    - INSYST will calculate the billable time per client

Prorating Group Services, Example 1

1 Clinician Provides Group therapy to 6 clients:

- Suppose 1 clinician sees 6 clients (all Medi-cal eligible) in a group for 60 minutes. After the group it takes the clinician 10 minutes each to write 6 progress notes (1 for each client.)
  - You must indicate in the PN: 6 group participants
- The clinician would enter the following into a progress note.
- Face to Face time: 60 Documentation time: 60 Total time: 120 Group count 6
- INSYST will divide 120 (total staff time) by 6 (number of clients/charts) and pay you 20 minutes for each billing/progress note.
- Once you do 6 billings/progress notes (1 for each client in the group) you are paid 20x6 = 120 minutes.
  - Therefore, in the end, you get paid for the full amount of time that it took you to provide face to face service and complete the documentation.
- Notice how in each progress note the documentation time is 60 minutes—not the 10 minutes doc time for that client. This is because that number will get divided by the number of clients in the group. So in this case you will get paid 10 minutes.

Prorating Group Services, Example 2a

2 Clinicians Provide Group therapy to 6 clients:

- You have three options on how to bill/document this.
- **Option 1:** Both clinicians can do their own progress notes/billings for all clients.
  - Each Clinician would write a progress note (PN indicates interventions that the writer did) and bill:
  - Face to Face time: 60 Documentation time: 60 Total time: 120 Group count 6
- This is the easiest and suggested method for billing/documenting when more than one clinician is running a group.
- Each clinician would indicate their own interventions and need for a co-staff.

Prorating Group Services, Example 2b

2 Clinicians Provide Group therapy to 6 clients:

- **Option 2:** One clinician can write the progress notes for all clients (in this case the writer indicates all group interventions—not just their own) and add a co-staff billing time to account for the other clinician's time.
- The one clinician would write a progress note and bill for each client:
- Primary Staff: Face to Face time 60 Documentation time: 60 Total time (Primary Staff): 120
- For Co-staff group time indicate: 60 (The co-staff time field is not present in InSyst until the RU for the service is entered.)
- Group count 6
- Notice that the co-staff time did not get entered into Total time. The Co-staff time acts like a secondary total time field for the 2nd staff. Since the second staff didn't do any progress notes, they only billed for their face to face time.
- When there is a second facilitator always indicate the clinical reason why such as: "A second clinician needed to address and individual client's crisis outside of the group 1:1 while the other clinician continues with the group."

Prorating Group Services, Example 2c

2 Clinicians Provide Group therapy to 6 clients:

- **Option 3:** One clinician can write the progress notes for some of the clients and the co-staff writes the notes for the remainder of the clients. The other clinician would write a progress note for the remainder of the clients:
- Staff 1 (writes PN for three of the clients):
  - Primary Staff: Face to Face time 60, Documentation time: 30, Total time (Primary Staff): 90 (Only total time entered into InSyst).
  - For Co-staff group time indicate: Face to Face time 60 Documentation time: 30 Total time (Co-Staff): 90 (Only total time entered into InSyst).
  - Group count 6
- Staff 1 (writes PN for the other three clients):
  - Primary Staff: Face to Face time 60, Documentation time: 30, Total time (Primary Staff): 90 (Only total time entered into InSyst).
  - For Co-staff group time indicate: Face to Face time 60 Documentation time: 30 Total time (Co-Staff): 90 (Only total time entered into InSyst).
  - Group count 6

Add-On Codes (+)

Add-On (+) codes describe additional services provided within a service. They are added to select, primary codes and demonstrate an enhanced service.

- *Added time increments (crisis therapy)*
- *Added service (interactive complexity or psychotherapy)*
- *Add-on (+) codes are never used as stand alone codes*
- *Add-on codes are designated by a + sign*

Crisis Add-On Codes:

- Additional Time Spent: for Crisis Therapy—concept in general.
  - 377-90839 is used for the first 30-75”
    - Add all other time (documentation, travel, etc.) to the 377 code.
  - 378-90840 is used for each additional 16-45”
  - For paper charting (not Clinician’s Gateway): when you go beyond a 377 and use a 378--the 377 is indicated as 60” and the balance (16 – 45”) moves down to 378.
  - If an additional 378 is needed the earlier 378 indicates 30” and the balance (16 – 45”) moves down to the next 378.
  - The final 378 includes the actual remaining minutes of f-f time (if 16 minutes or greater).
    - If 15 minutes or less—do not add another 378: just add it to the 30” of the final 378 code

Crisis Codes continued

Crisis Therapy (*formerly*, Crisis Intervention)
377-90839 (First 60 Minutes of Face **to Face Services)**
+378-90840 (For each additional 16-30 Minutes of Face to Face Services)
(May be performed for such crisis activities by staff that their training and experience allows.)

- A service lasting no more than **8 hours (total for all providers)** 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.
- **Only use when the client is at imminent risk for danger to self/other and/or gravely disabled.** The purpose is to stabilize the client.
- Service activities include but are not limited to one or more of the following: Medication Support Services, Assessment, Collateral, and Therapy.
- **In Clinician's Gateway:**
- **Select 377 for 30 – 75 minutes F-F and add on documentation time for Total Time.**
- **If additional face-to-face beyond 75 minutes, 377 becomes 60 min's + doc time and remaining f-f- minutes are added to 378**

Add-On Code for Additional Service Provided: **Interactive Complexity +491-90785**

- Refers to one or more, of 4 specific <u>communication factors</u> *during* a visit that complicate delivery of the primary psychiatric procedure (individual psychotherapy/group psychotherapy/assessment):
  - The need to manage maladaptive communication.
  - Caregiver emotions or behaviors that interfere with implementation of the treatment plan.
  - Evidence or disclosure of a Sentinel Event and mandated reporting to a 3rd party with initiation of discussion of the event.
  - Use of play equipment to overcome barriers to diagnostic or therapeutic interaction.

Add-On Code for Additional Service Provided: **Interactive Complexity +491-90785 cont.**

- Documentation Requirements:
  - Indicate the specific type of communication complication (see four on previous slide).
  - Document the specifics of the communication difficulty.
- Can only be used with these codes:
  - **323-90791 & 565-90792 Psychiatric Diagnostic Evaluation.**
  - 441-90832, 442-90834, 443-90837 **Ind. Psychotherapy**
  - 456-90853 **Group Psychotherapy (for the specific client)**

***Cannot* be used with Crisis Therapy, Family Therapy, or with E/M Codes.**

Interactive Complexity (+) 491-90785 Add-on in InSyst & CG

- Select primary procedure code and indicate minutes (into InSyst or Clinician's Gateway) as previously described.

- Select Interactive Complexity Add-on Code (no associated minutes).
  - InSyst, Select code 491-90785 and enter one (1) minute
  - Clinician's Gateway, Select "Interactive Complexity: Present"

Medication Support Services

- May be provided by Medical Providers (MD, DO, NP)
- Medication Support Services may include, but are not limited to:
  - Evaluation of the need for medication;
  - Evaluation of clinical effectiveness and side effects;
  - Obtaining informed consent;
  - Medication Education
  - Instruction in the use, risks, and benefits of and alternatives for medication;
  - Assessment of the client
  - Collateral and Plan development related to the delivery of the service and/or
  - Prescribing, administering, dispensing and monitoring of psychiatric medications

Medication Support Services cont.

- Contact and Site Requirements
  - Medication Support Services may be either face-to-face or by telephone with the client or with significant support person(s)
  - May be provided anywhere in the community
  - 469-90862 for Medication Management has been eliminated.

Medication Support: RN/LVN/Psych Tech only **(Not an add-on)**

369 Meds Management by RN/LVN/Psych Tech's **Only**

This procedure code was developed for RN's and LVN's who provide medication management but who cannot bill Medicare. This code is for Medi-Cal billable only.

- This code should be used when doing medication injections and providing medication support
  - **Face-to-Face and Non Face-to-Face**
- The expectation is that time spent would be 15-30 minutes. If service is provided beyond 30 minutes, the documentation must support that level of service.
- RN, LVN, Psych Tech's may exclusively use this code for all services they provided.

Evaluation and Management (E/M) Codes: 99###

- Two Methodologies for charting:
  - *Coding by the Elements—see QA Training Website for resources.*
  - *Counseling and Coordination of Care:*
    - *Make up the great Majority of Client Medication Support Services in Community Mental Health.*
    - *See slides below and QA Training Website for additional resources.*

Evaluation and Management (E/M) Codes: 99###

- When "Counseling & Coordination of Care" exceeds 50% of face-to-face time, the E/M Code is selected on the basis of the face-to-face service time.

- If "Counseling & Coordination of Care" was less than 50% of the face-to-face time, the E/M Code must be selected based on the complexity of the visit.
  - Refer to E/M Clinical Documentation Training
  - E/M Training Materials:
  - http://www.acbhcs.org/providers/QA/training.htm
  - Scroll down to "*Training Handouts & Resources*"

E/M Codes: when >50% of f-f time is Counseling & Coordination of Care

- The majority of E/M services provided in Community Mental Health involve >50% of face-to-face time which is spent performing Counseling (aka in psychiatry as Supportive Psychotherapy) and Coordination of Care services.
  - Especially extended visits such as **645—99214** & **646-99215**
- Psychiatrists often label what the CPT defines as "Counseling" as supportive psychotherapy.
- The components of "Supportive Psychotherapy" are usually considered as overlapping with "Counseling" (as defined by CPT) and should not be claimed as E/M + Add-on Psychotherapy .
- Such interventions are claimed as "Counseling and Coordination of Care" as part of the E/M visit. Claim E/M only.

E/M Codes: when >50% of f-f time is Counseling & Coordination of Care

- **Documentation:**
  - Outclient--Indicate Face-to-Face time (Inclient—Indicate Unit Floor Time).
  - Indicate Counseling and Coordination of Care time.
    - Or at least statement: "Counseling and Coordination time was greater than 50% of face-to-face time."
    - Start and end times also recommended.
    - Example:
      - 646-99215; F-F time = 50": start 13:00 and end 13:50;
      - Counseling and Coordination of Care time = 40"
      - Doc time = 8"; Total time = 58"
  - List the content topics of Counseling and Coordination of Care discussed &
  - Provide a detailed description of discussion of each content topic documented.

E/M Codes: when >50% of f-f time is Counseling & Coordination of Care

- **Indicate Content Topics of Counseling**
  - Diagnostic results, Prior studies, Need for further testing
  - Impressions
  - Clinical course, Prognosis
  - Treatment options, Medication Issues, Risks and benefits of management options
  - Instructions for management and/or follow-up
  - Importance of compliance/adherance with chosen management options
  - Risk factor reduction
  - Client education and instructions

E/M Codes: when >50% of f-f time is Counseling & Coordination of Care

- Coordination of Care:
  - Services provided by the medical provider responsible for the direct care of a client when he or she **coordinates or controls access to care or initiates or supervises other healthcare services** needed by the client.
  - outclient **coordination of care must be provided while face-to-face with the client (or family)**.
- Provider must detail and thoroughly document what was discussed for each content topic covered!
  - E.g. for Compliance/Adherence discussion:
    - *"20 minutes of 25 minutes face-to-face time spent Counseling re: the importance of medication compliance with mood stabilizer for bipolar disorder. Explored impact of when client went off her medications—including recent 5150 and involuntary hospitalizations…"*

E/M Codes: when >50% of f-f time is Counseling & Coordination of Care

"Established Patient"—Office Codes	Face-to-Face Minutes
641 – 99211 Simple Visit	5 (3 – 7 minutes)
643 – 99212 Problem Focused Visit	10 (8 – 12 minutes)
644 – 99213 Expanded Problem Focused Visit	15 (13 – 20 minutes)
645 – 99214 Mod Complexity Visit	25 (21 – 32 minutes)
646 – 99215 High Complexity Visit	40 (33 + minutes)

OUTPATIENT/OFFICE PSYCHIATRIC PROGRESS NOTE
COUNSELING AND/OR COORDINATION OF CARE

Patient's Name: _____ **Date of Visit:** _____

Interval History: _____

_____

_____

_____

Interval Psychiatric Assessment/ Mental Status Examination:

_____

_____

_____

Current Diagnosis: _____

Diagnosis Update: _____

Current Medication(s)/Medication Change(s) – No side effects or adverse reactions noted or reported ☐

_____

_____

Lab Tests: Ordered ☐ Reviewed ☐ : _____

_____

Counseling Provided with Patient / Family / Caregiver (circle as appropriate and check off each counseling topic discussed and describe below:

☐ Diagnostic results/impressions and/or recommended studies ☐ Risks and benefits of treatment options

☐ Instruction for management/treatment and/or follow-up options ☐ Importance of compliance with chosen treatment

☐ Risk Factor Reduction ☐ Patient/Family/Caregiver Education ☐ Prognosis

_____

Detailed discussion of Counseling (aka in psychiatry as Supportive Psychotherapy) topics:

Coordination of care provided (with patient present) with (check off as appropriate and describe below):

Coordination with: ☐ Nursing ☐ Residential Staff ☐ Social Work ☐ Physician/s ☐ Family ☐ Caregiver

Additional Documentation (if needed):

Duration of face to face visit w/patient : _____ min. Start Time _____ Stop Time _____ CPT _____

Greater than 50% of face to face time spent providing counseling and/or coordination of care: ☐

Psychiatrist's Signature: _____ Date: _____

Medication Support: Medical Providers (MD, DO, NP, PA, CNS) **(Not an add-on)**

- 367—Medication Training and Support
- This procedure code was developed for non face-to-face Medication Services, and therefore is **Not** billable to Medicare,
  - Used ONLY for Non face-to-face services
  - MD, DO, NP, & PA's may exclusively use this code for all non-face-to-face services they provide.

Procedure Code Review Questions

What codes now have distinct non f-f codes as well as f-f codes?

- Assessment and CFE/CANS/ANSA-T Behav Eval Codes

What differentiates the two MH Assessment Codes 323-90791 & 565-90792

- 323 is for non-medical providers and 565 is for medical providers (MD, FNP, etc.)

What is the difference between Collateral Codes 311 and 310

- 310 is with a caregiver significant support person and 311 is with any other significant support person

What would happen if a PN is audited which had total time indicated but not f-f time for Psychotherapy and why?

- Disallowed as Psychotherapy is a time-based code so it would not be known which code should have been selected.

Procedure Code Review Questions Cont.

How would I document in the PN a 90 minute group with 6 participants (4 M/C) and two facilitators of which one did a 10 minute note for each client?

- Group Psychotherapy with 6 clients, F-F time 90 minutes, Documentation Time 60 minutes, Total time 150 minutes, Co-staff = 1, Co-staff – 90 mins
- Additional co-staff needed to address any needed 1:1 clients in crisis outside of the group setting while the group continued with the other facilitator

Which is the most prevalent type of E/M service provided and how must it be documented?

- Counseling & Coordination of Care was more than 50% of the f-f time, indicate topics of CCC, AND indicate discussion of each topic area.

Interactive Complexity may be added to which 3 procedure codes?

- Assessment, & Group and Individual Psychotherapy

What codes do RN (who are not a NP) use?

- 369

What codes does a medical provider use for all services which are not f-f ?

- 367 Med Training& Support for all other non f-f svcs.

Claims

MH Services Lockouts (see updated handout)

- "Lockouts" are services that cannot be reimbursed or claimed due to the potential duplication of claim ("double billing") or ineligible billing site.

- Mental Health Services Not Reimbursable:
  - On days when State Hospital Services, Crisis Residential Treatment Services, Inclient Psychiatric Services or Psychiatric Health Facility Services are reimbursed by Medi-Cal,
  - except for the day of admission to the facility, and
  - except for 30 days prior to planned discharge for discharge placement services—See *Lock-outs Handout* for details. Document anticipated d/c date in record.

- On days when the client resided in a setting where the client was ineligible for Medi-Cal, e.g.,
  - Institute for Mental Disease (IMD),
  - Jail or Prison
  - Juvenile hall, Unless…
    - There is evidence of post-adjudication for placement, (i.e., the court has ordered suitable placement in a group home or other setting other than a correctional setting, jail and other similar settings) . See *Lock-outs Handout* for details.

Claims cont.

Non-Reimbursable Services/Activities

- No service provided: Missed appointment
- Solely transportation of an individual to or from a service
- Service provided which include payee related *(Indicate payee portion of visit in a separate—non-billable service note.)*
- Services provided was which include clerical
  - Includes leaving or listening to voice mail, or email, or texting, etc.
- Socialization Group
  - which consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors of the clients involved
- Translation and/or interpretive services (including sign language)
- Activities or interventions whose purpose includes providing vocational training, academic education or recreational activity are not reimbursable.
- Calling in a CPS/APS report.
- Completing CPS/APS reports. Report writing is not a Mental Health intervention. (No claiming for writing SSI disability report.)
- No claiming after client's death.

Of note re: Releases and Minor Consent to Tx:

- DHCS (per Jan. 2014 triennial audit) has indicated that all Release of Information Consent Documents are only effective for 12 months (unless fewer than 12 months is specified in the Consent).
- *Recommend renewing ALL at Annual Episode Opening Date.*
- All Client Records must be retained as long as required by law (seven years for 18yo and older, and until age 25 for those less than 18rs), AND until ACBHCS has finalized that fiscal year's cost settlement with DHCS (whichever is longer). *Currently the last ACBHCS/DHCS finalized cost settlement is through 6/30/2008—this will be updated in Clinical Documentation manual when needed.*
- You may wish to research requirements for the HIPAA Management Practices for the Release of Information (ROI Log).

Minor Consent, ages 12 – 17 yrs.

- Minor Consent Law:
  - www.youthlaw.org
    - Search in their website for "Minor Consent".
- Minors aged 12 – 17 yrs of age may consent to their own treatment under Family Code 6924 or Health & Safety Code 124260.
- ***If minor is consenting under Health & Safety Code 124260 – the provider must seek authorization from their QA technical contact to provide the service and thereby ensure that Medi-Cal is not claimed.***
- ***If minor is consenting under Family Code 6924– the provider may document as such and serve the client without any additional authorization.***
  - ***However, if the possibility of the caretaker being informed by Medi-Cal that services are being provided is a risk for the client—call QA and explain this so client may be authorized under 124260 instead without risk of the caretaker being alerted to treatment.***

DSM-IV & ICD-10 Cont.

DSM-IV & ICD-10 Training Resources:

- **YouTube Videos (search for DSM-5):**
  - **Recommended**:
    - Introduction: Using DSM-5 in the Transition to ICD-10: https://www.psychiatry.org/psychiatrists/practice/dsm/icd-10
    - Comprehensive: Changes from DSM-IV to DSM-5: https://youtu.be/7XIFqSm_eEA
  - Additional:
    - DSM-5 Update for Mental Health Counselors: https://youtu.be/48gDxzlmzEM
    - Clinical Assessment DSM-5 Part 1 (Family Therapy): https://youtu.be/BjnPfFS4-yo

- **American Psychiatric Association DSM-5 Texts: https://www.appi.org/products/dsm-manual-of-mental-disorders**
  - **Recommended for each clinic**: DSM-5 Texts: Desk Reference, Study Guide & Clinical Cases,
  - **Readily access recommended to assessment clinicians**: DSM-5 Pocket Guide (paper or mobile guide):

DSM-IV & ICD-10 Cont.

DSM-IV & ICD-10 Training Resources Cont.:

- **American Psychiatric Association DSM-5 Educational Resources and Diagnostic & Coding Clinic https://www.psychiatry.org/psychiatrists/practice/dsm**
  - **Highlights of Changes from DSM-IV-TR to DSM-5**

    http://www.dsm5.org/Documents/changes%20from%20dsm-iv-tr%20to%20dsm-5.pdf

- **Fact Sheets (Overall Changes and Disorder Specific):**
  - **https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/dsm-5-fact-sheets**

DSM-IV & ICD-10 Cont.

DSM-IV & ICD-10 Training Resources Cont.:

- **Specific Fact Sheets (Overall Changes and Disorder Specific):**
- **Attention-Deficit/Hyperactivity Disorder**
- **Autism Spectrum Disorder**
- **Bereavement Exclusion**
- **Conduct Disorder**
- **Disruptive Mood Dysregulation Disorder**
- **Eating Disorders**
- **Gender Dysphoria**
- **Intellectual Disability**
- **Internet Gaming Disorder (Section III)**
- **Mild Neurocognitive Disorder**
- **Mixed Features Specifier**
- **Obsessive Compulsive Disorder**
- **Paraphilic Disorders**
- **Personality Disorders**
- **Posttraumatic Stress Disorder**
- **Schizophrenia**
- **Sleep-Wake Disorders**
- **Social Anxiety Disorder**
- **Social (Pragmatic) Communication Disorder**
- **Somatic Symptom Disorder**
- **Specific Learning Disorder**
- **Substance Use Disorder**

DSM-IV & ICD-10 Cont.

DSM-IV & ICD-10 Training Resources Cont.:

- **American Psychiatric Association DSM-5 Educational Resources and Diagnostic & Coding Clinic https://www.psychiatry.org/psychiatrists/practice/dsm Online**

- **Assessment Measures:** https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/assessment-measures

- **Webinars:**
  - **Transitioning to DSM-5 and ICD-10-CM (free)** http://education.psychiatry.org/Users/ProductDetails.aspx?Activityid=381&ProductID=381
  - **DSM-5: Substance Related and Addictive Disorders (free)** http://education.psychiatry.org/Users/ProductDetails.aspx?Activityid=375&ProductID=375

DSM-IV & ICD-10 Cont.

DSM-IV & ICD-10 Training Resources Cont.:

- **American Psychological Association Recommendations by topic (includes written and digital):** http://www.apa.org/search.aspx?query=dsm-5
- **National Association of Social Workers: CA Chapter, DSM-5 Resources:** http://www.naswca.org/?177
- **American Counseling Association DSM-5 Resources (free podcasts):** https://www.counseling.org/search-results?q=dsm-5
- **American Mental Health Counselors Association DSM-5 Resources:** http://www.amhca.org/search/all.asp?bst=dsm-5
- **Additional Resources for a fee:**
  - **APA: DSM 5: What You Need to Know** http://education.psychiatry.org/Users/ProductDetails.aspx?Activityid=1310&ProductID=131

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DSM-IV & ICD-10 Cont.

DSM-IV & ICD-10 Training Resources Cont.:

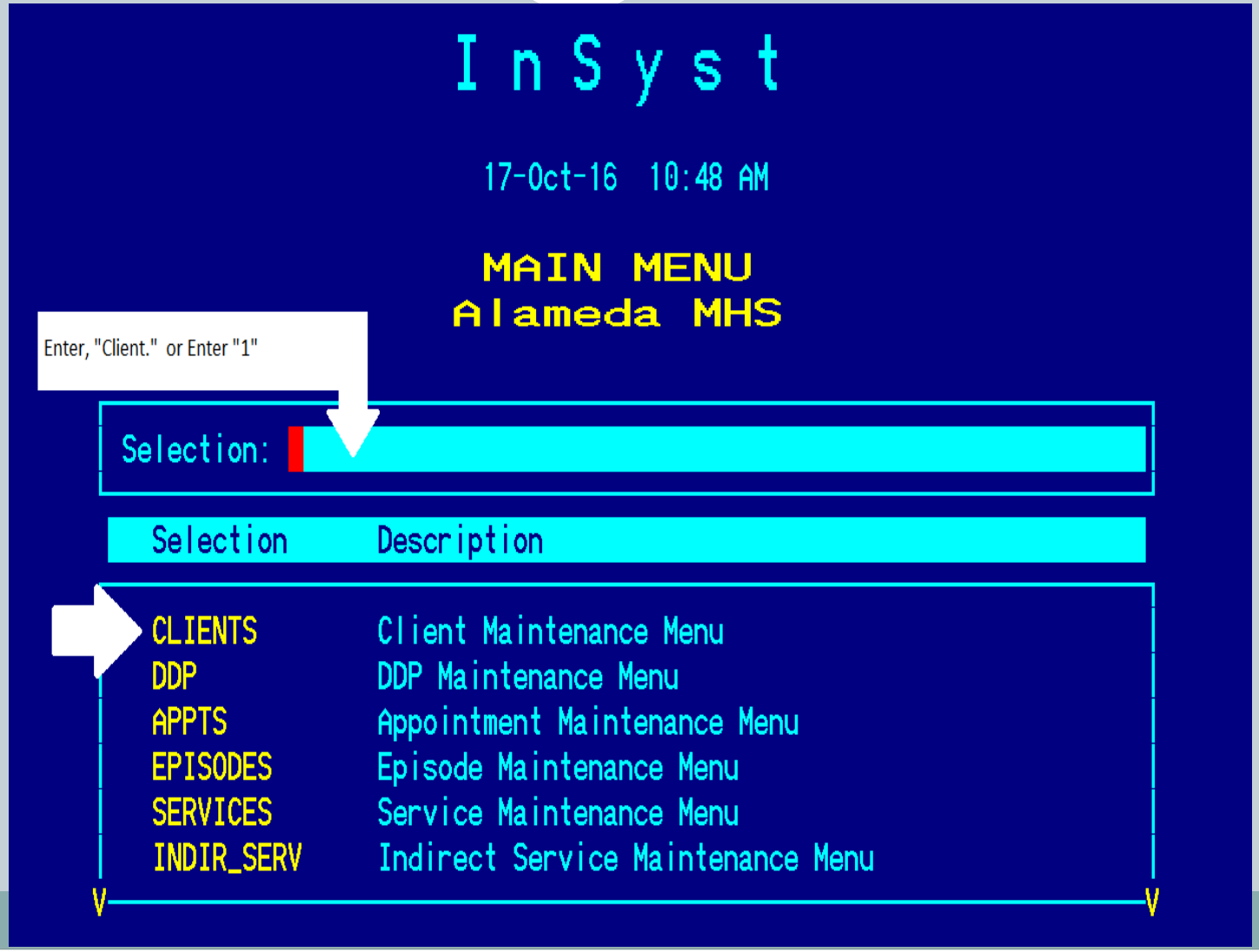
- **22 Hours of Online CEU Videos**
  - Understanding the DSM-5: Critical Issues and Diagnostic Revisions (6-hour version)
  - Understanding the DSM-5: Critical Issues and Diagnostic Revisions (4-hour version)
  - Understanding the DSM-5: Autism Spectrum Disorder & the Neurodevelopmental Disorders
  - Understanding Feeding and Eating Disorder in the DSM-5
  - Internet Addiction and the DSM-5
  - Understanding the DSM-5: Substance-Related and Other Addictive Disorders
  - The DSM-5 and the ICD-10-CM: Comparisons and Crosswalk

Updating or Inserting New Emergency Contact Information in INS

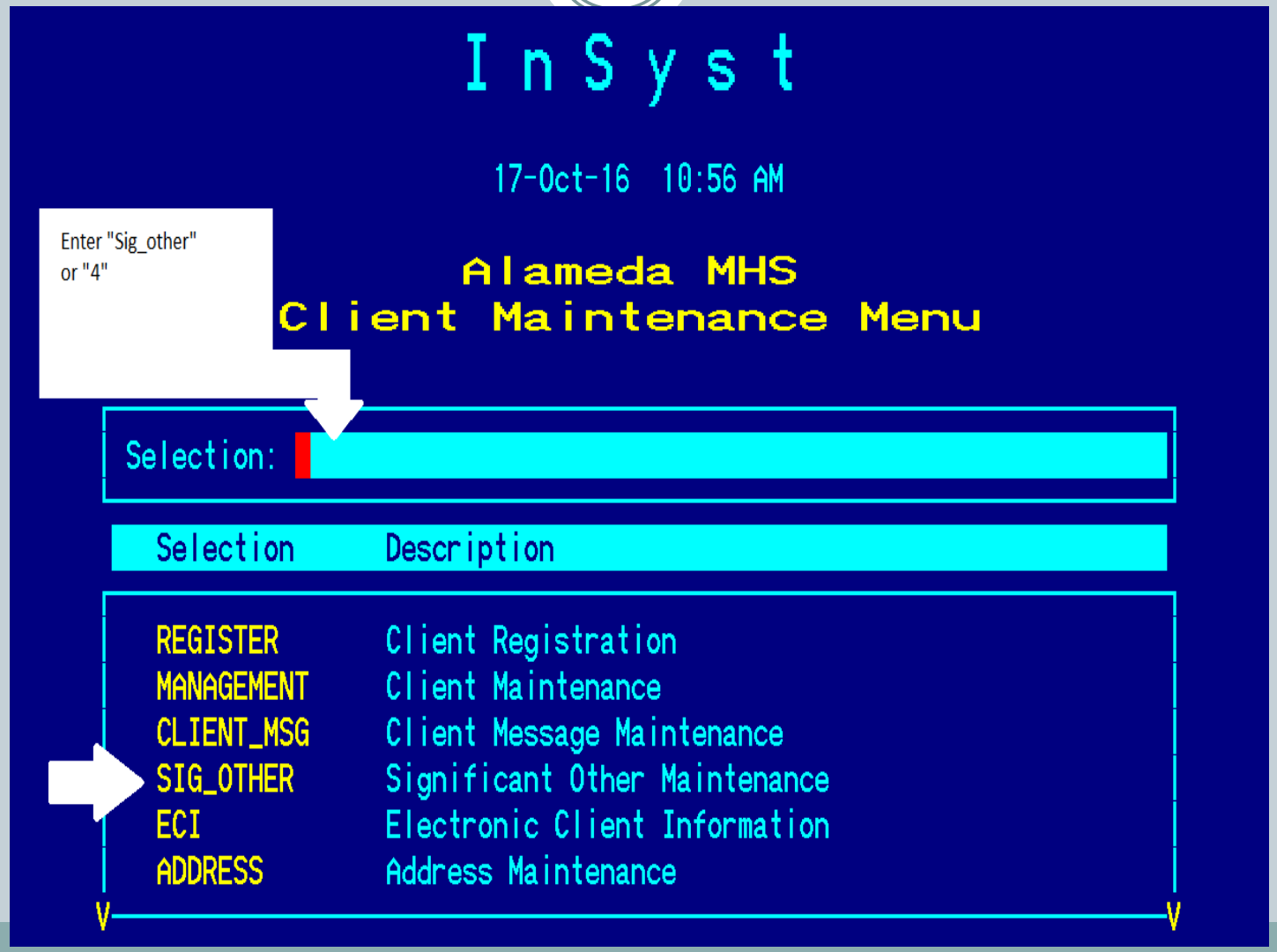
A CLIENT'S EMERGENCY CONTACT INFORMATION MUST BE ENTERED, AND KEPT UPDATED IN INSYST.

AS WELL, IT IS RECOMMENDED EACH PROVIDER HAVE A DESIGNATED LOCATION IN THEIR MEDICAL RECORD FOR EMERGENCY CONTACTS.

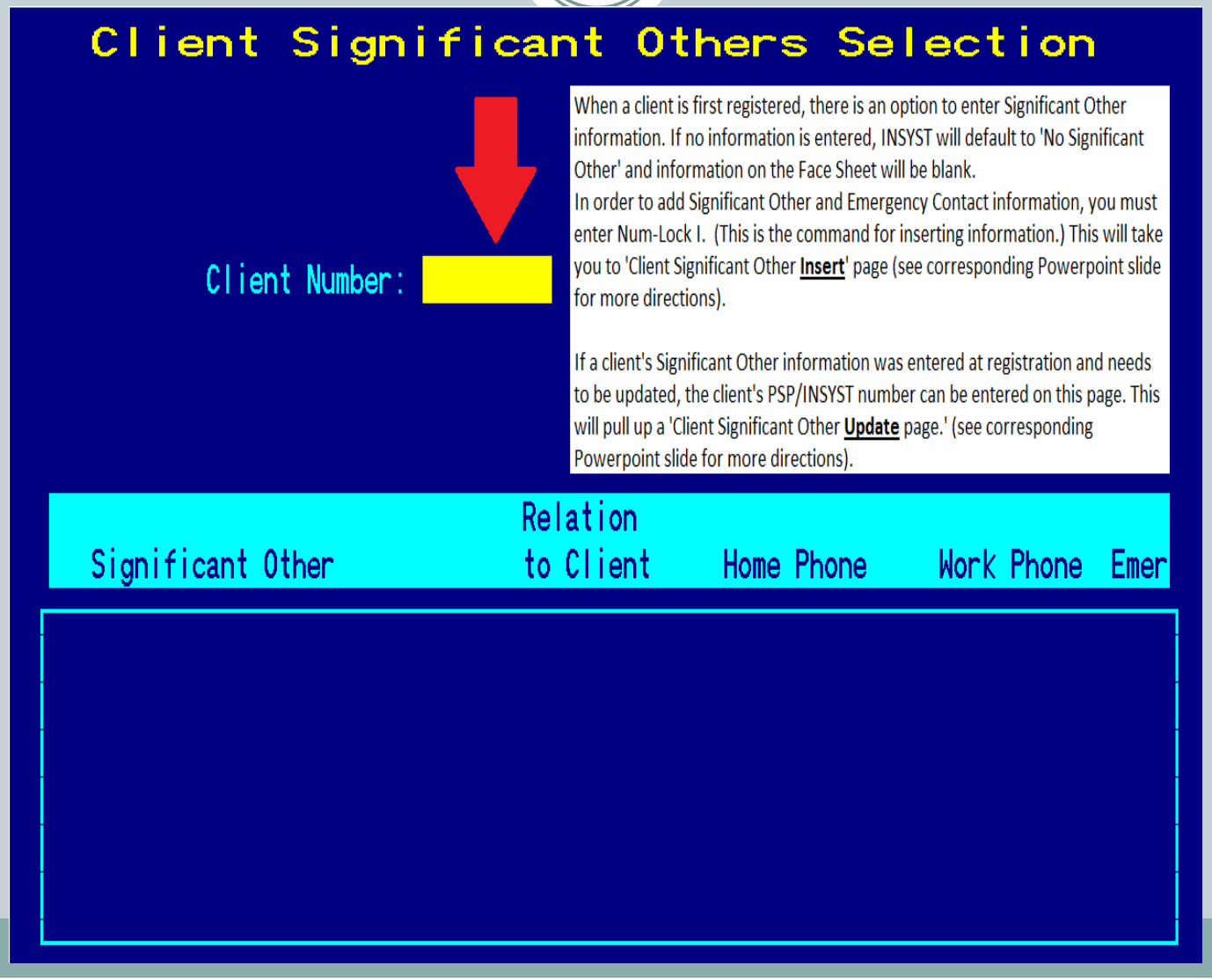
How to Update Emergency Contact Information



How to Update Emergency Contact Information



How to Update Emergency Contact Information



Inserting Significant Other Info if None was Entered at Episode Opening.


```
                    Client Significant Others Insert

          Client Number:  75134621  BABY        TEST

 Name Last: SIMPSON          First: MARGE        Effective Date:  10/21/2016
 Relationship to Client: MOTHER                  Expiration Date:   /  /

      Street
   Number:    742                    City: SPRINGFIELD
   Direction:                        State: CA  Zip Code: 94619+ 555
   Name:      EVERYGREEN TERRACE     Country: USA
   Type:
   Apartment:                        Home Phone: (510) 867-5309 Ext.: 0
                                     Work Phone: (    )    -     Ext.: 0

   Comment:

 X Emergency Contact      X Client's Guardian      X Family Member
   Don't Display on Rpts  X Primary Caregiver

   Continue: Y              Confidential Information          USER: SAMMISJ
Successful insert.  Insert total = 1.
```

Make sure to check 'Emergency Contact' and any other field that is appropriate.

Updating Significant Other Information that has already been entered.

Client Significant Others Selection

Client Number: PSP INSYST #

	Significant Other		Relation to Client	Home Phone		Work Phone	Emer
U	First Name	Last Name	Mother, Father..., etc.	(510)	Phone Number	( ) -	X
	First Name	Last Name		(510)		( ) -	

Type U to update information and make changes.

This page must show an X next to Emergency Contact, for it to show up on the Face sheet. If it does not, update the information.

How to Update Emergency Contact Information

Client Significant Others Update

Client Number: PSP #

Name Last: Last Name First: First Name Effective Date: Date you enter Info
Relationship to Client: MOTHER Expiration Date: / /

Street
Number: 0 City:
Direction: State: Zip Code: 00000+ 0
Name: Country:
Type:
Apartment: Home Phone: (510) Phone # Ext.: 0
Work Phone: ( ) - Ext.: 0

Make sure this has an X in this field.

Comment: client's foster mother

X Emergency Contact X Client's Guardian Family Member
Don't Display on Rpts Primary Caregiver

End Result Is a Face Sheet with Emergency Contact Info

Client Information Face Sheet

Report MHS 140
Run Date: 21-OCT-2016 Page: 1

****

CONSUMER INFORMATION

Name: BABY TEST
Address:
, 00000
Phone: ( )
Staff:
Aliases: None
RP Owes: $0.00
Insurance: None

Number: 75134621
SSN: ___-___-____
Other ID #: 0
Marital: Nvr Marr
Disability: None
Medicaid: Not Eligible

Birthdate: 1-JAN-1950 Age: 66
Sex: F
Language: Thai
Education: None
Ethnicity: O So Asian Hispanic Origin:

SIGNIFICANT OTHERS

Name	Relation	Home Phone	Work Phone	Address	Emergency
SIMPSON MARGE	MOTHER	(510) 867-5309	( ) -	742 EVERYGREEN TERRACE, SPRINGFIELD, CA 94619-0555	X

****

CLINICAL HISTORY

RU	Opening	Closing	Primary Diag	Clinician	Physician	Total Units	Last Service	Legal Status	Legal Consent	Stability Rating & Date
-----CLOSED EPISODES----------										
WEST MHS	2-JUL-07	28-JUL-14	295.70	WHITE, R	Staff, G	0		W60000	NA	

****

Total Episode Count = 1

Additional Handouts

- Suicide/Homicide Risk Assessment
- Medi-Cal Benefits Help Desk

HIPAA Resources

- 42 USC 1395 US Department of Health and Human Services – www.hhs.gov
- Office of Civil Rights (enforces HIPAA Privacy & Security Rules) – www.hhs.gov/ocr/privacy/index.html
- CA Office of Health Information Integrity (CAL OHII) – www.Calohii.ca.gov
- CA Hospital Association- www.calhospital.org (publications include the CHA California Health Information Privacy Manual-2013)
- American Psychological Association http://apapracticecentral.org/business/hipaa/index.aspx
- NASW: http://www.socialworkers.org/hipaa/
- AAMFT: http://aamft.org/iMIS15/AAMFT/Content/Advocacy/HIPAA%20Resources.aspx
- American Psychiatric Association: http://psychiatry.org/psychiatrists/practice/practice-management/hipaa
- American Counseling Association: https://www.counseling.org/; http://www.counseling.org/docs/private-practice-pointers/meeting_hippa_requirements.pdf?sfvrsn=2

Helping the Client Identify Impairments—Role Play

- *"You said you've been feeling very sad, anxious and irritable. How does this play out at home, at work, with friends?"*

- *"What do you think is making it difficult for you to…*
  - *do your work?"*
  - *take care of things at home?"*
  - *get along with others?"*
  - *do the things/activities that you once enjoyed?"*

Identifying Impairments
Role Play Continued

How do your (depressive/anxious) symptoms impact your:

(Social/family relationships)

decreased contact with friends ?"
loss of intimate relationships?"
family relationships?"

(Performance at work or school)

avoidance of certain jobs?"
being late to work due to depression?"
decreased contact with co-workers?"
failing grades due to depressive mood / poor concentration?"

(Participation in hobbies, leisure activities)

avoidance of certain leisure activities?"

Medical Necessity Criteria

- It is very important to remember that the medical necessity criteria are INTERLOCKING.

Covered Diagnosis ⟺ Qualifying Impairment(s) ⟺ Interventions

The interventions/services which are billed to Medi-Cal must address the qualifying impairment(s) which result from the covered diagnosis.

Interventions or services which address the impairment resulting from <u>non-covered diagnoses</u> are not reimbursable..

The Golden Thread

- Medical Necessity:
  - Completion of a Mental Health Assessment which documents:
    - Symptoms/behaviors/impairments to determine a diagnosis
    - Strengths/needs/barriers
  - Carry Assessment information forward into the Client Plan which documents:
    - Objectives linked to symptoms/behaviors/impairments
    - Interventions to achieve the identified objectives
  - Carry forward into the Progress Note which documents:
    - Goal-based interventions provided to the client
    - Intervention is linked to a specific MH Objective

MH Assessment
Step 1 of the Golden Thread

- What is the purpose?
  - Learn about client's story
  - Gather a lot of information about the client in a brief period of time in order to formulate a diagnosis, develop a conceptualization, and collaboratively create a treatment plan (acknowledged by client's signature).
  - Determine if the client meets medical necessity:
    - (Does he/she have an "included" diagnosis and an impairment in life functioning due to his/her mental health symptoms?)

MH Assessment
Step 1 of the Golden Thread *continued*

- Presenting Problems (symptoms/behaviors):
  - Document the intensity, frequency, duration and onset of current symptoms/behaviors

- Impairments in Life Functioning:
  - Document the connection between impairments and their relationship to MH symptoms/behaviors of the diagnosis
    - e.g., difficulty keeping a job due to his depressed mood, lack of energy, and difficulties concentrating, which are significantly interfering with his work performance.
  - Best practice to document both the client's activity level both **prior to** and **at the onset** of symptoms.

MH Assessment
Step 1 of the Golden Thread *continued*

- What to document in the PN vs within the MH Assessment Form:
  - If all information for the Initial Assessment is gathered in <u>one assessment contact</u>
    - Reference Initial Assessment completed in the Progress Note
      - "Completed Initial Assessment (see Initial Assessment dated xx/xx/xx in clinical record)"
      - Sign/date the Assessment as of the date of the assessment contact
  - If information for the Initial Assessment is gathered in <u>multiple assessment contacts,</u>
    - Reference sections of the Initial Assessment completed in each Progress Note
    - Sign/date the Assessment as of the date of the last assessment contact

DSM-IV & ICD-10 Dx effective 10/1/15

Phase I (Non-Clinician's Gateway users):

For clients' with newly created Assessments (Initial, Annual, Updated) beginning 10/1/15:

1. Once the DSM-IV Dx is established for treatment purposes—document the DSM-IV Dx in the MH Assessment and enter the code into InSyst.
2. Refer to the DSM-IV to ICD-10 crosswalks (attached) to determine the appropriate ICD-10 Dx for the DSM-IV Dx. Document that specific ICD-10 Dx in your MH Assessment (along with the DSM-IV Dx). It is crucial that you utilize the specific ICD-10 Dx (indicated in the cross-walk for that DSM-IV Dx) so that it will match what is automatically generated in InSyst for claiming purposes. *Note, the Crosswalks were revised on 9/26/15.*
3. Please note, InSyst will automatically cross-walk to the DSM-IV Dx that is entered, and will submit that code to Medi-Cal for claiming purposes. (Again, that code must match exactly what you have entered into the MH Assessment.)

Update all existing clients' Assessments:

1. Look up the clients' cross-walked ICD-10 Dx (from their DSM-IV Dx) in InSyst (*Episode Update Screen* or *Episode Opening Screen*), or from the cross-walks provided (see website link and attachments).
2. Create a MH Assessment Addendum:
   a. Title the page *Addendum to "MH Assessment dated: __/__/____"* (date of last MH Assessment).
   b. Indicate the DSM-IV Dx's along with the cross-walked ICD-10 Dx's. (For all diagnoses, not just the primary Dx.)
   c. Print the LPHA's name, M/C credential and the date (signed) at the bottom of the page.
   d. LPHA signs the MH Assessment Addendum and it is added to the Client's Medical Record. Note, if the LPHA is waivered or registered—a licensed LPHA must co-sign.
3. It is expected that the updating of all open clients' MH Assessment records will be completed within the next two to four weeks.

DSM-IV & ICD-10 Dx effective 10/1/15

Phase I (Clinician's Gateway users):

Effective 10/1/15, ICD-10 Diagnostic Codes will be displayed on all Clinician's Gateway progress note and assessment templates where the Episode Diagnosis Information currently displays.

-- For InSyst: the DSM-IV codes that exist in InSyst will be cross-walked to the corresponding ICD-10 codes.

-- Until further instruction, you must continue to use DSM-IV Diagnostic Codes until you are trained in ICD-10.

-- The DSM-IV and ICD-10 Diagnostic Codes will display together on Clinician Gateway data entry screens and printed notes.

-- InSyst and Clinician's Gateway ICD-10 and DSM-IV must match. If you change the Dx in Clinician's Gateway, InSyst must be updated. Include a note in your assessment indicating that this is a new Dx and that you will submit a Dx update into InSyst for claiming and future services.

Please note, Clinician Gateway users are not being asked to create MH Assessment Addendums for existing open clients.

Phase II (not yet in effect):

In Phase II, the clinician will have the opportunity to refine the ICD-10 Dx. That is, they will not be restricted to utilization of only one specific ICD-10 Dx for each DSM-IV Dx.

If you have any questions, or need any assistance in the implementation of this requirement, please email your Quality Assurance Technical Assistance contact. See list below. (If you would like to ask your questions in person, you may also attend the monthly QA Brown Bag Luncheons held on the first Friday of the Month from noon – 1pm at 2000 Embarcadero, Fifth floor, Oakland CA.)

Service Modalities

SERVICE MODALITIES REQUESTED *(WHEN RELEVANT, ALL INCLUDE: COLLATERAL, INTERACTIVE COMPLEXITY, PSYCHIATRIC DIAGNOSTIC EVALUATION, CRISIS INTERVENTION, & PLAN DEVELOPMENT)*

☐ **GROUP** (THERAPY; REHABILITATION; COLLERATERAL FAMILY; AND/OR MULTI-FAMILY THERAPY)

☐ CASE MANAGEMENT/BROKERGE	☐ INDIVIDUAL REHABILITATION	☐ TBS
☐ THERAPY (INDIVIDUAL; FAMILY)	☐ PSYCH TESTING	KATIE A. SERVICES:
		☐ ICC
☐ MEDICATION SERVICES	☐ OTHER: _____	☐ IHBS

Client Plan
Step 2 of the Golden Thread *continued*

Example - Symptoms / behaviors / impairments related to the primary diagnosis (from the Assessment)

- *"For the past month, client has been experiencing depressed mood with a loss of energy, loss of interest or pleasure in almost all activities, and social withdrawal"*

- *"Depressive symptoms are significantly interfering with client's academic/work performance, and impacting his social and family relationships"*

Client Plan
Step 2 of the Golden Thread *continued*

Example – MH OBJECTIVE targeting symptoms

- **Client Goal:**
  - *"I want to be able to go out do things with my family & friends, again"*
- **Mental Health Objective:**
  - *"To decrease depressive symptom of anhedonia as evidenced by an increase in the # of social interactions from 0x to 3x per week in the next 12months"*
  - *"To decrease depressive symptom of poor self-esteem as evidenced by an increase in positive self-statements (by self-report) from 0x to 2x per week in the next 12 months."*
  - *"To decrease depressive symptoms through the utilization of recovery tools as outlined in the client's 'WRAP Plan' within the next 12 months."*
- **Service Modalities**
  - *"Individual Rehabilitation (weekly and as needed), & Psychiatric Medication Services (monthly and as needed) both over the next 12 months"*

Client Plan
Step 2 of the Golden Thread *continued*

- **Detailed Clinical Interventions:**
  - **Individual Rehab:**
    - *"Assist the client in re-engaging in pleasant social activities through the use of an activities chart in order to address the impairment of having lost all interest in previous enjoyable social activities as a direct result of her symptom of anhedonia of her Major Depression."*
    - *"Teach and reinforce active problem-solving skills in order to increase client's self-efficacy in order to address the impairment of poor self-esteem which is a direct result of her Major Depression."*
    - *"Help the client to identify early warning signs of relapse, review skills learned, and develop a plan for managing challenges (WRAP tools) in order to help prevent the relapse of depressive symptoms."*
  - **Med Services:**
    - *Med Mgt. strategies to engage client in collaboration to find, and optimize the dosage for, effective anti-depressive medications.*

Client Plan
Step 2 of the Golden Thread *continued*

Verb	Measure	Target Person	Client's Behavior	Baseline Measure	Goal Measure	Time Frame
To Increase	# of min's	Client	Engages in pleasurable activities (social, physical, pleasant)	From 0x/day	To 30'/day	Within 12 mos.
To Increase	# of times	Client	Uses active problem-solving Skills	From 0x/week	To 5x/week	Within 12 mos.
To Increase	# of times	Client	Uses relaxation skills	From 0/week	To 5x/week	Within 12 mos.

Client Plan
Step 2 of the Golden Thread *continued*

Exercise: Turn to the person sitting next to you and together create a scenario including the following: Included Dx; Signs, Sx and Bx of Dx; Impairments; and then write a SMART MH objectives such as:

- Insomnia (Sx of depression)
  - *"Improved ability to fall asleep within 30 minutes of… going to bed from 0 times per week to 5 times per week within the next 6-12 months."*
  - *"Improved ability to stay asleep at least 6 hours once having fallen asleep from 0 times per week to 5 times per week within the next 6-12 months."*
- Decreased Appetite (Sx of depression)
  - *"Improved appetite as evidence by eating two or three meals per day from 1 times per week to 5 times per week within the next 6-12 months."*
- Anergy (Sx of depression)
  - *"Improved energy as evidenced by leaving the home for outside activities 3 or more times per week, from 1 time every two weeks, within the next 6-12 months."*
- Poor self-care/ADL's (Impairment of depression)
  - *"Improved ability to care for self by showering or bathing 3 – 4 times per week, from 1 time per week, within the next 6-12 months."*

Client Plan
Step 2 of the Golden Thread *continued*

Exercise: Break into groups and write SMART objectives for the following (See Tx Planning Guides such as the Wiley series.):

1) Inability to maintain housing/placement (address underlying MH Sx's)

2) Inability to (or maintain) study/work (behavior, attendance, achievement, functioning) (address underlying MH Sx's)

3) Intrusive thoughts

Exercise: Break into groups and write SMART objectives for the following:

4) Thoughts (or actions) of… self/other harm

5) Hallucinations (visual/auditory)

6) Phobia/Anxiety as evidence by… (or self-report of…)

Client Plan
Step 2 of the Golden Thread *continued*

Exercise: Break into groups and write SMART objectives for the following:

7) Concentration as evidence by… (or self-report of…)

8) Inattention as evidence by… (or self-report of…)

9) Oppositional Behavior (provide example such as re compliance with authority)

Client Plan
Step 2 of the Golden Thread *continued*

Exercise: Break into groups and write SMART objectives for the following:

10) Anger Control as evidence by …. (or self report of…)

11) Conduct/Anti-social Behaviors (shoplifting, lying, vandalism, cruelty to animals, etc.)

12) Behavioral Regression as evidenced by…. (or caretaker report of……)

Client Plan
Step 2 of the Golden Thread *continued*

Exercise: Break into groups and write SMART objectives for the following:

13) Legal Problems (Address underlying MH symptomology)

14) Family/Relationship Problems (Address underlying MH symptomology)

15) Substance use habits as evidence by… (Address underlying MH symptomology)

CANS-Child & Adolescent Needs & Strengths Assessment

User Manuals and Rating Sheets can be found under **"Resources"** http://www.acbhcs.org/providers/CANS/resources.htm

Alameda County CANS Forms
Comprehensive Multisystem Assessment - Early Childhood (Birth to 5) Manual
Comprehensive Multisystem Assessment - Early Childhood (Birth to 5) Score Sheet
Comprehensive Multisystem Assessment - Children and Youth (6-17) Manual
Comprehensive Multisystem Assessment - Children and Youth (6-17) Score Sheet
Adult Needs and Strengths Assessment for Transition Age Youth Manual
Adult Needs and Strengths Assessment for Transition Age Youth Score Sheet

Pre-Certification Training Workshop Materials can be found under "**Training and Certification**"
http://www.acbhcs.org/providers/CANS/training.htm

Pre-Certification Training Workshop Materials
Tip Sheet: Certification 101
Tip Sheet: Learning Management System (LMS) Registration
Tip Sheet: Training the Trainers
ANSA-T Pre-certification Vignette "Patricia"
CANS 0-5 Pre-certification Vignette "Morgan"
CANS 6-17 Pre-certification Vignette "Kim"

CANS Support: Alex Jackson: ajackson@acbhcs.org

MH Plan Example #2: Impairment: Inability to obtain/maintain employment: chronic periods of un- or under-employment

Billable example:

- **Dx & Impairments: Schizophrenia—Paranoid delusions, paranoid auditory hallucinations with negative symptoms of flat affect, poor planning and follow-through which results in: social withdrawal, lack of motivation (such as ability to attend desired vocational services) and neglect of personal hygiene.**
- **Impairments: Client MH Impairments described above prevent client from successfully accessing and participating in employment activities (required for Case Mgt.).**
- **Goal: Client states: "I want a job so that I can support myself".**
- **Long Term MH Goal: Decrease positive and negative signs of schizophrenia so that they do not interfere with the client's ability to obtain and maintain meaningful employment. It is expected successful engagement in vocational services will decrease client's psychotic impairments (specified in MH Objective).**

MH Plan Example #2: Impairment: Inability to obtain/maintain employment: chronic periods of un- or under-employment continued

Billable example cont.:

Mental Health Objective(s):

- **#1) Client will attend to daily hygiene (as evidenced by taking a shower and wearing clean clothes) 6 of 7 days/week (now 0) by 6-12 months.**
- **#2) Client will identify the role of 6 of his symptoms of schizophrenia that result in employment difficulties from 0 now by 9-12 months.**
- **#3) Client will learn and implement 4 - 6 assertiveness and other communication skills (now 0) by 12 months.**
- **#4) Client will identify and challenge 5 -10 (currently 0) delusional beliefs and generate 5 – 10 (currently 0) reality-based alternatives regarding barriers to employment by 12 months.**

Billable example cont.:

Case Management Objective(s):

- **Client will connect with provider for a Vocational assessment and if appropriate will participate in Vocational services to address his employment goals as evidenced by participation in vocational services activities (8 of every 10 scheduled activities, currently 0) over the next 12 months. Such successful vocational engagement will result in decreases in delusions/paranoia and social isolation; and increases in self-esteem, improved daily hygiene and improved communication/assertiveness skills (MH Objectives #1, 3, & 4).**

MH Plan Example #2: Impairment: Inability to obtain/maintain employment: chronic periods of un- or under-employment continued

Billable example cont.:

- **Service Modality:**
  - **Individual and group rehab 1x/week, and as needed, for 1 year;**
  - **Case Management 1x/month, and as needed, for 9 – 12 months;**
  - **Individual Psychotherapy 1x/week, and as needed, for 1 year;**
  - **Medication Management 1x/month, and as needed, for 1 year.**

- **Detailed Interventions:**
  - **Psychotherapy – CBT to help identify paranoid thinking and to generate reality based alternatives.**
  - **Individual & Group Rehab – build client's awareness to track and manage psychotic symptoms, teach coping skills such as relaxation techniques, and build client's self-care skills.**
  - **Case Management – Link client to, and monitor/support maintenance of desired vocational services *in order to increase participation in positive daily/coping activities and decrease psychotic symptomology*.**
  - **Medication management strategies to engage client in collaboration to find anti-psychotic medications that he is able to tolerate without significant side-effects that have led him to discontinue medication regimen in the past.**

MH Plan Example #2: Impairment: Inability to obtain/maintain employment: chronic periods of un- or under-employment continued

Non-billable example.:

- **Mental Health Objective:** Client will obtain stable employment within 6 months.
- **Service Modality:** Case management 1x/week and as needed for 1 year
- **Detailed Interventions:** Case management - Case manager will work with client to job search and assist client in filling out necessary applications. ***[Case Mgt is not acting as a job coach—but is linking to and monitoring client's participation in such services.]***

MH Plan Example #4: Case Management Services

Billable example:

- **Included M/C Dx:** Schizophrenia, Disorganized Type – auditory hallucinations, disorganized speech, disorganized behavior, flat affect. Client has multiple untreated medical issues, a substance use disorder, history of drug related arrests, housing difficulties, vocational problems, difficulty maintaining ADL's, poor medication compliance, problems with social interactions, and a long history of psychiatric hospitalizations.
- **Impairments** include disorganized speech and behaviors preventing him from being able to access and follow thru with services and treatment related to the above listed life areas and areas of functioning. *(Required for case mgt. objective.)*
- **Goal:** I want to have stable housing, get a job, and stop using drugs.
- **Long Term MH Goal** – decrease positive and negative symptoms of schizophrenia and increase independent living skills so that they do not interfere with the client's ability to obtain stable housing and employment, participate in SUD treatment, obtain medical treatment, attend to ADL's, and keep from being hospitalized. Successful participation in housing services, employment, medical and SUD treatment is expected to decrease client's MH impairments.

MH Plan Example #4: Case Management Services cont.

Billable example cont.:

MH Objectives:

- #1) Client's paranoid a/h will decrease from 5 times daily to 3 – 5 times weekly, or less in the next 6 – 12 months.
- #2) Client inattention to ADL's will increase as evidenced by taking shower's 1 or less times per month to 2 – 3 times per week in the next 6 – 12 months.

MH Plan Example #4: Case Management Services cont.

Billable example cont.:

Case Management Objectives:

- Client will attend all scheduled medical appointments (current 1 out of 5) and follow through with any recommended medical treatment in the next 12 months. Client's successful access and participation in medical services as is expected to to increase ADL's.
- Client will attend all scheduled psychiatric medication management appointments (approximately 1x per month, current 0x) in the next 12 months. Client's successful access and participation in psychiatric medication management as is expected to decrease a/h and psychiatric hospitalizations and to increase ADL's.
- Client will attend and participate in all appointments at the Vocational Rehab program as scheduled by their staff in the next 12 months (current 0). Client's successful access and participation in vocational services as is expected to decrease a/h and psychiatric hospitalizations.

MH Plan Example #4: Case Management Services cont.

Billable example cont.:

- **Service Modality:** Case Management 1x/month and as needed for the next 12 months.
- **Detailed Interventions:** Case Management – Link and help client to utilize medical services for untreated medical issues. Monitor/support client's attendance at medical appointments. Link and monitor/support client's progress in an SUD treatment program. Link and help client utilize medication management services and monitor medication compliance. Link and support/monitor client's progress in vocational rehab program. Client's participation in vocational services, SUD Tx, medical and psychiatric care is expected to is expected to decrease a/h and psychiatric hospitalizations and to increase ADL's.

MH Plan Example #4: Case Management Services cont.

Non-billable example:

- **Mental Health Objective:** Client will obtain stable employment within the next 6 months.
- **Service Modality:** Case management 1x/month and as needed for the next 12 months.
- **Detailed Interventions:** Case management- Case manager will conduct a job search and assist client in filling out necessary applications. ***[Case Mgt. is not acting as a job coach—but is linking and monitoring client's participation in vocational support programs.]***

B.I.R.P. Progress Note Checklist

B Behavior Counselor observation, client statements	Check if addressed
1. Subjective data about the client—what are the clients observations, thoughts, direct quotes?	
2. Objective data about the client—what does the counselor observe during the session (affect, mood, appearance)?	
I Intervention Counselor's methods used to address goals and objectives, observations, client statements	
1. What goals and objectives were addressed this session?	
2. Was homework reviewed?	
R Response Client's response to the intervention, progress made toward Tx Plan goals and objectives	
1. What is the client's current response to the clinician's intervention in the session?	
2. Client's progress attending to goals and objectives outside of the session?	
P Plan Document what is going to happen next	
1. What in the Tx Plan needs revision?	
2. What is the clinician going to do next?	
3. What is the next session date?	

General Checklist	Check if addressed
1. Does the note connect to the client's individualized treatment plan?	
2. Are client strengths/limitations in achieving goals noted and considered?	
3. Is the note dated, signed and legible?	
4. Is the client name and/or identifier included on each page?	
5. Has referral and collateral information been documented?	
6. Does the note reflect changes in client status (eg. GAF, measures of functioning)?	
7. Are all abbreviations standardized and consistent?	
8. Did counselor/supervisor sign note?	
9. Would someone not familiar with this case be able to read this note and understand exactly what has occurred in treatment?	
10. Are any non-routine calls, missed sessions, or professional consultations regarding this case documented?	

Progress Notes
Step 3 of the Golden Thread *continued*

- How do I modify the B/PIRP PN format when not providing services directly to the client (collateral, case management, etc)?
- ***Case mgt. example***:
  - "B/P" = Documents what is presently going on with the client *today* (brief narrative) that necessitated this service. *(i.e. client's symptoms of severe paranoia today prevent him/her from accessing and utilizing needed housing support services—client has taken no action, in spite of desire to do so, to obtain housing services intake.)*
  - "I" = Identifies what you did (i.e., what intervention was provided toward the mental health objectives): provided or received info, etc. *(i.e. assisted client in identifying next step in reaching out for an intake to housing support services.)*
  - "R" = Identifies contact's response toward the interventions and progress toward the purpose above "B" *(i.e. client agreed to call housing intake phone-line number provided today.)*
  - P = Provides plan for continued services as a result of this service: i.e. collaterals, coordination of care, etc. Can include any follow up by the provider or client. *(i.e. client will call for housing intake within the next 7 days and will f/u with this writer at next week's meeting to determine their success.)*
- ***Always indicate which (#) MH Objective (even if there is also a C/M objective) is being addressed by the Case Mgt Intervention!***

Progress Notes
Step 3 of the Golden Thread *continued*

- How do I modify the B/PIRP PN format when not providing services directly to the client (collateral, case management, etc)?
- ***Collateral example***:
  - "B" = Documents what is presently going on with the client (brief narrative) that necessitated this collateral service. (i.e., in session client reports mother is "punishing him" unreasonably for staying out past curfew and asks that I reach out to her to discuss this further)
  - "I" = Identifies what you did (i.e., what intervention was provided toward the mental health objectives): provided or received info, etc. *(i.e. I called the mother and strategized on reasonable discipline techniques when needed for curfew violation and emphasized positive reinforcement techniques when client meets curfew requirements)*
  - "R" = Identifies contact's response toward the interventions and progress toward the purpose above "B" *(i.e. Mother agreed to discussed and planned strategies.)*
  - P = Provides plan for continued services as a result of this service: i.e. collaterals, coordination of care, etc. Can include any follow up by the provider or client. *(i.e. Will follow-up at next client's visit regarding this and mother agrees to follow-up with me as desired.)*

Progress Notes
Step 3 of the Golden Thread *continued*

- Ask yourself:
  - *"What did I do?"*
  - *"What was the purpose of what I did?"*
  - *"Why was the service provided?"*
  - *"What benefit was provided to the client?"*
  - *"Does the service/intervention match to a mental health objective on the Client Plan?"*
- Progress Notes are used to document a reimbursable service.
- If "YES" to the following, then you have a strong reimbursable Progress Note:
  - Is it clear that I took some action that will help my client?
  - Will the action work toward improving or maintaining my client's mental health?
  - Did the service I provided relate directly back to the identified MH needs /MH included diagnosis / MH objectives of my client?

Progress Notes
Step 3 of the Golden Thread *continued*

Progress Note Staff Interventions

- All interventions must always link back to identified mental health need(s) of the client
  - Decreasing symptoms or behaviors must always link back to the identified mental health need
  - Increasing adaptive behaviors / skill development must always link back to the identified mental health need (Strength based approach.)

Progress Notes
Step 3 of the Golden Thread *continued*

Progress Note Staff Interventions Examples

- Engagement with Client at beginning of treatment
  - *"Engaged client to establish rapport, explain treatment rationale, clarify treatment process, and understand and address barriers to treatment to improve participation."*

- Psycho-education with Client:
  - *"Introduced Problem Solving Treatment to the client, established link between client's symptoms and depression, established the link between problems and depression, and facilitated a problem-solving orientation."*

Progress Notes
Step 3 of the Golden Thread *continued*

Key things to ask yourself

- *"What did you do? Why did you see the client? Is it reflected in the Progress Note?"*
- *"Does the Progress Note clearly relate back to a mental health objective on the Client Plan?"*
- *"Did you sign, write your credential that allows you to bill Medi-Cal, and date the Progress Note?"*
  - *See Scope of Practice document for allowed Medi-Cal credential designations.*
- *"Can the Progress Note be read by someone else (legible)?"*
- *""Did you complete and turn in your Progress Note to be filed (or file it yourself) prior to turning in the claim?"*

Objective & Progress Note Exercise

- **(See Progress Note Exercise Handout.)**
- Objectives:
  - Participants will be able to understand how to link Medical Necessity, Client Plan MH Objective, and Interventions in a Progress Note.
  - Participants will be able to write a Progress Note which meets documentation standards.
- Smaller groups will review a vignette (see attached training exercise)
  - Each group will collectively compose 2 MH objectives
  - Each group will collectively write a Progress Note based upon the BIRP model

Progress Note Exercise:

Objectives:

1. Participants will be able to understand how to link the Medi-Cal Included Diagnosis, the Client Plan Goals & Objectives, and Interventions in Progress Notes.

2. Participants will be able to successfully write Client Plan Objectives which are observable and/or measureable with baselines and timeframes.

3. Participants will be able to successfully write a progress note which meets Medi-Cal documentation standards linking the Included Diagnosis, Client Plan Objectives, and Interventions.

- 30 minutes
  - Break out in to smaller groups
  - Each group will collectively identify 2 mental health objectives based upon the client's goal stated in the vignette.
  - Each group will write a progress note for a psychotherapy session based upon client's presentation in the current session using the BIRP model. (Participants will think of an intervention, client response, and plan that is pertinent to the content of the vignette).
  - Review and revise notes with group

Vignette 1

You have been seeing John for 4 months and have developed a solid working rapport. He attends sessions as scheduled. He is a 22 year old, single, African-American, identified gay male, who lives with roommates in Berkeley, employed as a waiter, and is a Landscape Architecture major attending UC Berkeley. He began therapy to address feeling sad, lonely, and depressed for the past year, but maybe longer. His primary diagnosis is Dysthymic disorder. He has reported a decrease in his marijuana use during the past 6 months and is improving in his academics. His main goal is to be able to be in a steady relationship, complete school in the next 9 months, and then secure a position.

Today he presents with sad affect and discussed feeling disappointed with himself because he drank a lot the other night, overslept, and missed one of his classes. He also stated that he feels uncertain that he will ever meet guys that are "easy going and have a good head on their shoulders."

Vignette 2

You have just met with Donovan for the 3 initial assessment sessions. He is a 42 year old Mexican-American, Bilingual, and is employed as an electrician in his cousin's company. He is originally from Oaxaca, Mexico, has been in the US off and on since he was 14 years old, is an undocumented person, living in San Leandro with his wife and their 3 children. He reported occasional use of alcohol and denied all drug use or experimentation. He denied a history of mental health issues/treatment. He was directed by his PCP to seek out counseling for intense panic attacks. He is not clear what counseling is about, but is willing to give it a try. He reported that he does not want to take medications and would rather find another way to stop what is happening. He reported his sleep is "rocky", has intermittent nightmares that he cannot remember, and wakes up in a pool of sweat. You were able to identify with him that his main concerns are to stop the sudden panic attacks.

Vignette 3

Yolanda is a 15 year old, African American female. She has been in counseling with you for approximately 2 months. She was brought in for counseling by her parents who were concerned about her abrupt change in mood after a break-up with her boyfriend. For the past 3 months, she has been feeling predominantly sad, anxious, her sleep has been disrupted, and she reports having difficulty concentrating. She denies any self-harm behaviors or thoughts, has no history of mental health issues/treatment, and denies all substance use. In general, she is bright, has a long-history enjoying school, and has several close friends. She described her relationship to her family as very good. Her main goals are to stop feeling sad and be able to feel good about herself. Her primary diagnosis is Adjustment Disorder with mixed Anxiety and Depressed Mood. Today she is reporting she has not spent time with her friends in a long time, feeling lonely, her affect is sad and she discussed feeling anxious about the upcoming summer break. She discussed feelings of rejection and unworthiness since her boyfriend broke up with her. She reported she is mostly listening to music and studying on her own after school and in the past week has become suddenly angry with her younger sister when she came into her room.

Progress Note

Client Name: _____ MRN: _____

Service Date: _____ Service Code: _____ Service Location: _____

Included Diagnosis: _____

Objective #: _____

B (Today's Behavioral Observation/Assessment):

_____
_____
_____
_____

I: (Clinician's Intervention)

_____
_____
_____
_____

R: (Client's Response)

_____
_____
_____
_____

P: (Today's Plan: Follow up, Homework, Focus of Next Session, etc.)

_____
_____
_____
_____

Clinician Name: _____

Clinician Signature: _____ Date: _____

Client Plan
Step 2 of the Golden Thread

- What is the purpose?
  - Ensures a client's care is goal directed and purposeful
  - Allows anyone involved in a client's care to see, at a glance, what a client's services are aimed at and directed toward
  - Creates a "road map" for the client, family, and mental health / medical staff
  - Lists markers of progress; "Is the client getting better?" "Is the client stabilizing?" "Is the client progressing developmentally as appropriate?"

Objective Formulation Exercise:

Axis I Diagnosis: _____

Client's Stated Goal:

_____

_____

_____

Objective 1 (Observable & Measureable, With Baseline & Timeframes):

_____

_____

_____

Objective 2 (Observable & Measureable, With Baseline & Timeframes):

_____

_____

_____

Psychiatric Diagnostic Evaluation Procedure Codes: 323—90791, 565—90792 Cont.

- Reporting Psychiatric Diagnostic Procedures (crucial if Medicare claiming):
  - For Medicare Claiming: Each Psychiatric Diagnostic Codes may be reported only once per day (unless seeing the client and significant other separately).
  - 323-90791 Psych Diag Eval may be provided by a non-medical provider on the same day as 565-90792 Psych Diag Eval with Medical Component is provided by a medical provider (Psychiatrist/ANP/PA).
  - For Medicare Claiming (OK for claiming to Medi-Cal): Cannot be reported with an E/M code on same day *by same individual provider* (Psychiatric assessment may include prescribing).
  - For Medicare Claiming (OK for claiming to Medi-Cal): Cannot be reported with psychotherapy service code on same day *by any provider*. (Have psychiatric provider use E/M if needed.)
  - For Medicare Claiming (OK regardless for claiming to Medi-Cal): May be reported more than once for a client when *separate diagnostic evaluations* are conducted with the *client* and *other collaterals* (such as family members, guardians, and significant others).
    1. Diagnostic evaluation for child with child.
    2. Diagnostic evaluation for child with caretaker.
  - Use the same codes, for later reassessment, as indicated.

Plan Development (581) cont.
What is Plan Monitoring?

- A service meets the requirement for plan monitoring if it contains the following elements, which must be clearly documented in the client chart:
- *Document the event that triggered the clinical indication for monitoring* e.g. change in behavior, symptoms, impairments, etc., *or the circumstance*, such as a child has a marked change in behavior at school and has become increasingly aggressive; or an adult client serviced by a clinical interdisciplinary team has recently been released from the hospital.
- *Document the progress of the client as it relates to the event or circumstance* e.g. client's behavior, symptoms, impairments are worse, better, no change – again, relating it back to the mental health objectives.
- *Document the outcome of the monitoring*; that is, what will happen as a result of the service e.g. change to client plan, change in medications, no change, etc.
- *If the service is part of an interdisciplinary team meeting, document all participants present* (therapist, case manager, psychiatrist, etc.) and the role each played. *The corresponding progress note should clearly document how this activity is related to the client plan.*

Procedure Codes continued

Plan Development (581) cont.

- Monitoring a client's progress must be related to the client's mental health objectives *except* when the triggering event or circumstance represents a new clinical issue not yet included in the client plan. In this case, the client plan should be changed to include a related mental health objective, or, there should be documentation as to why no change to the plan was made.
- Monitoring the progress of a client is always a part of a regular service such as individual rehabilitation or psychotherapy i.e. a client's progress note should always include a section on behavior or presentation for that day. If the client presents a significant clinical change, this may indicate a clinical need for a plan development service.
- Supervision is never a plan development service. *No contact may be claimed when a staff person is meeting with their supervisor, regardless of the content of the meeting*.

Plan Development (581) cont.
What is Plan Monitoring?

- A service meets the requirement for plan monitoring if it contains the following elements, which must be clearly documented in the client chart:
- *Document the event that triggered the clinical indication for monitoring* e.g. change in behavior, symptoms, impairments, etc., *or the circumstance*, such as a child has a marked change in behavior at school and has become increasingly aggressive; or an adult client serviced by a clinical interdisciplinary team has recently been released from the hospital.
- *Document the progress of the client as it relates to the event or circumstance* e.g. client's behavior, symptoms, impairments are worse, better, no change – again, relating it back to the mental health objectives.
- *Document the outcome of the monitoring*; that is, what will happen as a result of the service e.g. change to client plan, change in medications, no change, etc.
- *If the service is part of an interdisciplinary team meeting, document all participants present* (therapist, case manager, psychiatrist, etc.) and the role each played. *The corresponding progress note should clearly document how this activity is related to the client plan.*

Plan Development (581) cont.

- Monitoring a client's progress must be related to the client's mental health objectives *except* when the triggering event or circumstance represents a new clinical issue not yet included in the client plan. In this case, the client plan should be changed to include a related mental health objective, or, there should be documentation as to why no change to the plan was made.
- Monitoring the progress of a client is always a part of a regular service such as individual rehabilitation or psychotherapy i.e. a client's progress note should always include a section on behavior or presentation for that day. If the client presents a significant clinical change, this may indicate a clinical need for a plan development service.
- Supervision is never a plan development service. *No contact may be claimed when a staff person is meeting with their supervisor, regardless of the content of the meeting*.

PSYCHOTHERAPY FACE TO FACE TIME = 36” (:36)
DOC/TRAVEL TIME = 30” (:30)
TOTAL TIME = 66” (1:06)

Service Entry, Individual

IFER

Interventions

Service #: New Title: Clinician's Progress Note

Service date: 03/05/2015

Client: Number 75087772 Last Name TEST First Name CINDY TWO

Client opened: 3/8/2007

Util. review date::

1 Procedures: 441 90832 Psychotherapy30 min

Client Plan due date:: 10/31/2014 C/P has expired!

KTA ELIGIBLE(Jul 1 2013)

Last assessment: 10/26/2012

Service Location: Select Location

Med. Compliant: N/A Side Effects: N/A

Emergency? Pregnant?

Staff Time

Primary Clinician: 14219 - SANDERS-PFEIFER, R. ANTHONY Provider: 9999CG - CLINICIAN GATEWAY TEST MHS AD 2 Primary Total Time: 01:06

Add Additional Clinicians

EM Plus Psychotherapy or Additional Crisis: None 2nd FF Time: 2nd Tot Time:

Interactive Complexity: Not Present

Instructions

Respond to problems/goals/objectives of treatment plan and signs and symptoms related to diagnosis. Include treatment interventions and address changes in the client's functioning. If there is little progress, include an explanation of the limited progress.

3 Primary FF Time 00:36 Hours:Minutes

Services were provided in English

by Interpreter or clinician

Episode Diagnosis Information

Axis I	Axis II	Axis III	Axis IV	Axis V
296.44	799.9	99	J	000

Claiming Face-to-Face Time and Total Time: InSyst Direct Entry

Psychotherapy: 45" f-f time, 10" doc. time, and 20" travel time. Total time = 75"

- Choose code based on f-f time (if on the phone—base on contact time):
  - 442-90834 (Ind Psych 38-52 min.)
- Enter Total Time:
  - 75"

Warning: *To choose code based on total time result in disallowance.*

Claiming Face-to-Face Time and Total Time: Clinician's Gateway

<u>Psychotherapy: 36" f-f time, 10" doc. time, and 20" travel time. Total time = 66". (1:06)</u>

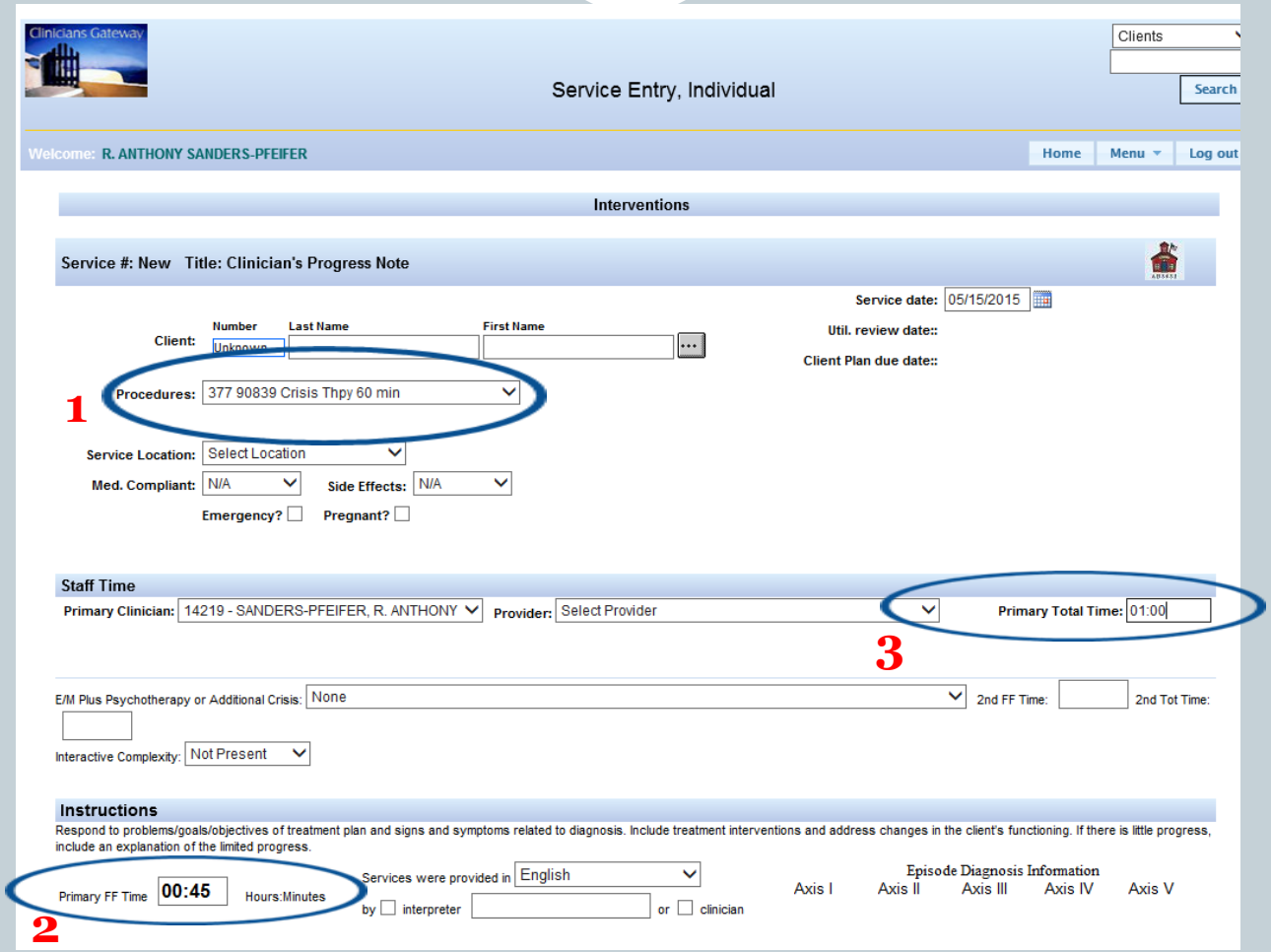
- Choose code based on f-f time (or contact time for telephone) and enter that amount of time for that code:
- 441-90832 (Ind Psych 16-37 min.) enter:
  - 36" in "Primary F-F Time"
  - Total time. Enter:
    - 66" (1:06) in: "Primary Total Time"

Warning: *To choose code based on total time result in disallowance.*

Crisis Code 377-90839 (Used Alone)

- **InSyst**
  - Crisis service lasting 45” f-f, + 15” doc/travel = 60” total
    - Based on f-f time choose code 377-90839 (30-75”)
    - Enter 60” (45” f-f + 15” doc/travel)
- **Clinician’s Gateway**
  - Crisis service lasting 45” f-f, 15” doc/travel
    - Use code 377-90839 for the 45” f-f time.
      - Enter 45” into “Primary f-f Time”
      - Enter Total Time of 60” (1:00) (45” f-f + 15” doc/travel) into “Primary Total Time”
      - *See screen shot*
- ***For < 30 minutes cannot use Crisis Code (if appropriate use and chart to a different code, e.g. individual psychotherapy, ind rehabilitation, etc.)***

CRISIS THERAPY FACE TO FACE TIME = 45” (:45)
DOC/TRAVEL TIME = 15” (:15)
TOTAL TIME = 60” (1:00)

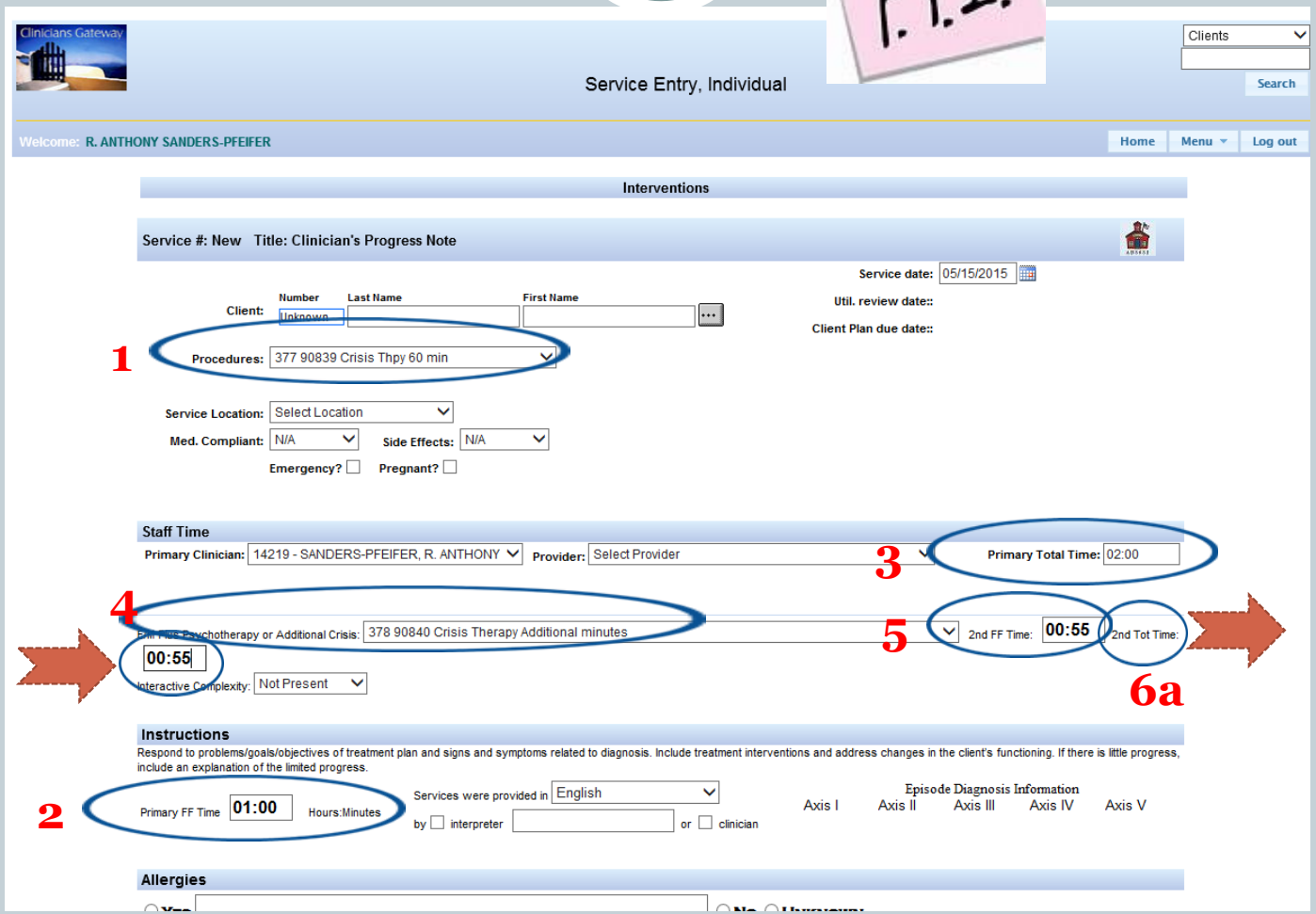


Crisis Code 377-90839 + 378-90840

- **InSyst**
  - Crisis service: 115” F-F Time + 60” Travel/Doc Time = 175” Total Time
    - Select Code 377-90839 for the 1st 60” F-F Time and enter 120” (60” F-F + 60” Travel/Doc
    - Select Code 378-90840 for next 30” and enter: 30” time
    - Select Code 378-90840 and enter 25” for the remaining F-F time
      - If F-F time <16” do not add another 378: add it to the 378 code above
  - In paper chart, indicate:
    - “377-90839, +378-90840, +378-90840. F-F = 115”, Doc/Travel Time = 60” Total Time = 175”

- **Clinician’s Gateway:**
  - Crisis service: 115” (1:55) F-F Time + 60” (1:00) Travel/Doc Time = 175” (2:55) Total Time
    - Select code 377-90839 and enter 60” (1:00) in “Primary FF Time” & 120” (2:00) into “Primary Total Time”. (The first 60” FF Time + Travel/Doc Time.)
    - Select code 378-90840 and enter= 55 “in “Secondary FF Time” & 55” into “Secondary Total Time”.
    - *See Screen Shot*

CRISIS THERAPY FACE TO FACE TIME = 115” (1:55)
DOC/TRAVEL TIME = 60” (1:00) TOTAL TIME = 175” (2:55)



Crisis Therapy: 154”f-f + 8”doc time

Paper Chart—InSyst entry

- 377-90839 is used for the first 60”
- 378-90840 is used for each additional 30”, AND the balance if it is less than 16” is added to the last 378-90840.
- 154” F2F Time and 8” Documentation Time.
  - Select 377-90839: enter 68” (60” F-F + 8” Doc Time”
  - Select +378-90804 (30”)
  - Select +378-90804 (30”)
  - Select +378-90804 (34”) (30” + 4” remaining F-F time when less than 16”)
- Because the F2F Time is the deciding factor whether or not to use another 378-90840 (not the documentation time or the travel time) any F2F time less than 16” is included in the final 378-90840—do not add an additional 378 code.

Clinicians Gateway entry

- Here is direction for entering into CG, using your first example of 154” (2:34) F2F Time & 8” (0:08)Documentation Time.
- In the **“Procedure”** field, select 377-90839.
- In the **“Primary FF Time”** field (lower left) enter (1:00).
- Enter (1:08) in the **“Primary Clinician Time”** field. (60” FF time + 8” Doc/Travel time)
- In the **“E/M Plus Psychotherapy or Additional Crisis”** field select 378-90840.
- In the **“2nd FF Time”** field enter 1:34 (remainder of FF time)
- In the **“2nd Tot Time”** field enter 1:34

Add-On Code for Additional Service Provided: **Interactive Complexity**

- Typical clients:
  - Have others legally responsible for their care, such as minors or adults with guardians
  - Request others to be involved in their care during the visit
  - Require the involvement of other third parties, such as child welfare agencies, parole or probation officers, or schools

Add-On Code for Additional Service Provided: **Interactive Complexity (491-90785) cont.**

4 specific <u>communication factors</u> *during* a visit that complicate delivery of the primary psychiatric procedure:

1. The need to manage maladaptive communication (related to e.g., high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicates delivery of care.

- Vignette (reported with 442-90834, Psychotherapy 45 min)
  - *Psychotherapy for client with maladaptive communication. Client was responding to internal stimuli throughout our session which made it difficult to focus the conversation on techniques to decrease anxiety.*

Add-On Code for Additional Service Provided: **Interactive Complexity (491-90785) cont.**

4 specific <u>communication factors</u> *during* a visit that complicate delivery of the primary psychiatric procedure:

2. Caregiver emotions or behaviors that interfere with implementation of the treatment plan

- Vignette (reported with 441-90832, psychotherapy 30 min)
  - *Psychotherapy for young elementary school-aged child. During the parent portion of the visit, mother has difficulty refocusing from verbalizing her own job stress to grasp the recommended behavioral interventions for her child.*

Add-On Code for Additional Service Provided: **Interactive Complexity (491-90785) cont.**

4 specific <u>communication factors</u> *during* a visit that complicate delivery of the primary psychiatric procedure:

3. Evidence or disclosure of a Sentinel Event and mandated reporting to a 3rd party (e.g., abuse or neglect with report to state agency) *with* initiation of discussion of the sentinel event and/or report with client and other visit participants

- Vignette (reported with 565-90792, psychiatric diagnostic evaluation with medical services)
  - *In the process of an evaluation, adolescent reports several episodes of sexual molestation by her older brother. The allegations are discussed with parents and report is made to state agency.*
    - *Time completing a report outside of the session is not billable.*

Add-On Code for Additional Service Provided: **Interactive Complexity (491-90785) cont.**

4 specific <u>communication factors</u> *during* a visit that complicate delivery of the primary psychiatric procedure:

4. Use of play equipment, physical devices, ~~interpreter or translator~~** to overcome barriers to diagnostic or therapeutic interaction with a client ~~who is not fluent in the same language or~~ who has not developed or lost expressive or receptive language skills to use or understand typical language.

- Vignette (reported with 456-90853, group psychotherapy)
  - *Group psychotherapy for a young child who requires play equipment to participate in the group therapeutic interaction*

****Per CMS, 491 should not be used to bill *solely* for translation or interpretation services as that may be a violation of federal statute.**

Interactive Complexity 491-90785 Add-on (+) in Clinician's Gateway (CG) EHR

Service Entry, Individual

R. ANTHONY SANDERS-PFEIFER

Home

Interventions

Service #: New Title: Clinician's Progress Note

1

Client: Number 75087772 Last Name TEST First Name CINDY TWO

Service date: 03/05/2015

Client opened: 3/8/2007

Util. review date::

Client Plan due date:: 10/31/2014 C/P has expired!

Last assessment: 10/26/2012

Procedures: 441 90832 Psychotherapy30 min

KTA ELIGIBLE (Jul 1 2013)

Service Location: Select Location

Med. Compliant: N/A Side Effects: N/A

Emergency? Pregnant?

Staff Time

Primary Clinician: 14219 - SANDERS-PFEIFER, R. ANTHONY Provider: 9999CG - CLINICIAN GATEWAY TEST MHS AD

3

Primary Total Time: 01:06

Add Additional Clinicians

EM Plus Psychotherapy or Additional Crisis: None 2nd FF Time: 2nd Tot Time:

4

Interactive Complexity: 90785 Present

Instructions

Respond to problems/goals/objectives of treatment plan and signs and symptoms related to diagnosis. Include treatment interventions and address changes in the client's functioning. If there is little progress, include an explanation of the limited progress.

2

Primary FF Time 00:36 Hours:Minutes

Services were provided in English

by Interpreter or clinician

Episode Diagnosis Information

Axis I	Axis II	Axis III	Axis IV	Axis V
296.44	799.9	99	J	000

Minor Consent, ages 12 – 17 yrs

- Cal. Family Code § 6924.
- "A minor who is 12 years of age or older may consent to mental health treatment or counseling on an outclient basis or to residential shelter services, if both of the following requirements are satisfied:
- The minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outclient services or residential shelter services. AND
  - The minor
    - (A) would present a danger of serious physical or mental harm to self or to others without the mental health treatment or counseling or residential shelter services, or
    - (B) is the alleged victim of incest or child abuse."

Minor Consent, ages 12 – 17 yrs

- Health & Safety Code § 124260
  - "[A] minor who is 12 years of age or older may consent to [outclient] mental health treatment or counseling services if, in the opinion of the attending professional person, the minor is mature enough to participate intelligently in the mental health treatment or counseling services."
- *If minor is consenting under this regulation—provider must contact QA to seek authorization to provide the service and to ensure that Medi-Cal is not claimed.*