ACBHCS QA "Train the Trainer" Training:
Mental Health Service Authorization, and Records Auditing Compliance Standards.

DONNA FONE, MFT, LPCC:
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INTERIM QA ASSOCIATE ADMINISTRATOR

CLINICAL REVIEW SPECIALISTS:
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JEFF SAMMIS, PSYD

Agenda: **3/11, 5/13, 7/8, 9/9, & 11/7/16 9:00 am – 4:30 pm**

09:00 - 09:15:	Introductions: *slides 1 – 6*
09:15 – 09:30:	System of Care Audit—2015 Q4 Findings: *slides 7 - 17*
09:30 - 10:30:	CQRT Authorization Process, Medical & Service Necessity, and MH Assessment Requirements: *slides 18 - 48*
10:30 - 10:45:	**Break**
10:45 - 11:15:	Client Plan Requirements: *slides 49 - 61*
11:15 - 12:15:	Client Plan Examples**:** *slides 62 – 78*
12:15 - 12:30:	*Progress Notes: slides 79 - 83*
12:30 - 01:00:	**Lunch**
01:00 - 02:30:	Procedure Codes I: *slides 84 +*
02:30 - 02:45:	**Break**
02:45 - 03:30:	Procedure Codes II : through *slide 121*
03:30 - 04:00:	Lock-outs, Claims Disallowances, Minor Consent, Resources: *slides 122- 125*
04:00 - 04:30	Wrap-up, Post Test, Evaluation, and Training Slides *126 - 198*

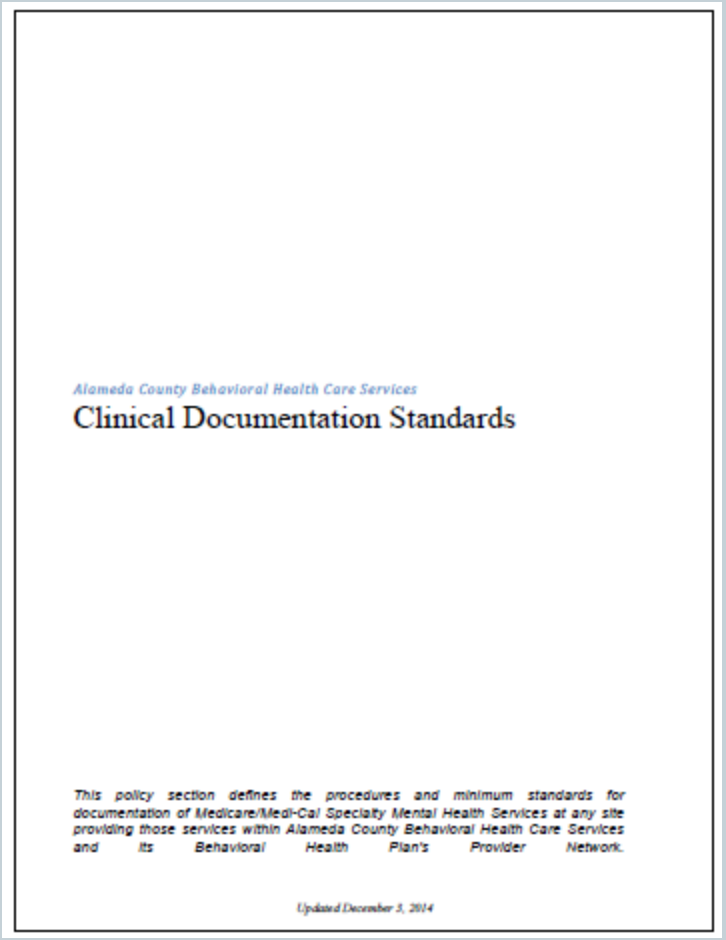
Training Objectives

- CQRT Chart Auditing & Authorization Process
  - Understand the purpose of the CQRT and its function in improving compliance with documentation standards.
  - Understand the distinction between the Clinical & Quality Review.
  - Understand the expectations of how to prepare and participate in Alameda County BHCS CQRT meetings. Understand the forms and paperwork necessary to participate in Alameda County BHCS CQRT meetings.
  - Understand the Clinical Review Cycles of charts and how they guide clinical practices.
  - Be able to facilitate and/or improve ongoing internal Clinical Quality Review Teams.

Training Objectives

- Clinical Documentation:
  - Discuss the core elements of Medical Necessity and the Clinical Loop *aka* Golden Thread
  - Strengthen the ability to assess and document client problem areas, symptoms, strengths, and impairments in an Assessment.
  - Improve the ability to develop client goals and mental health objectives in compliance with Medi-Cal/DHCS requirements.
  - Learn how to document Medi-Cal/DHCS Progress Notes.

ACBHCS Clinical Documentation Standards Manual

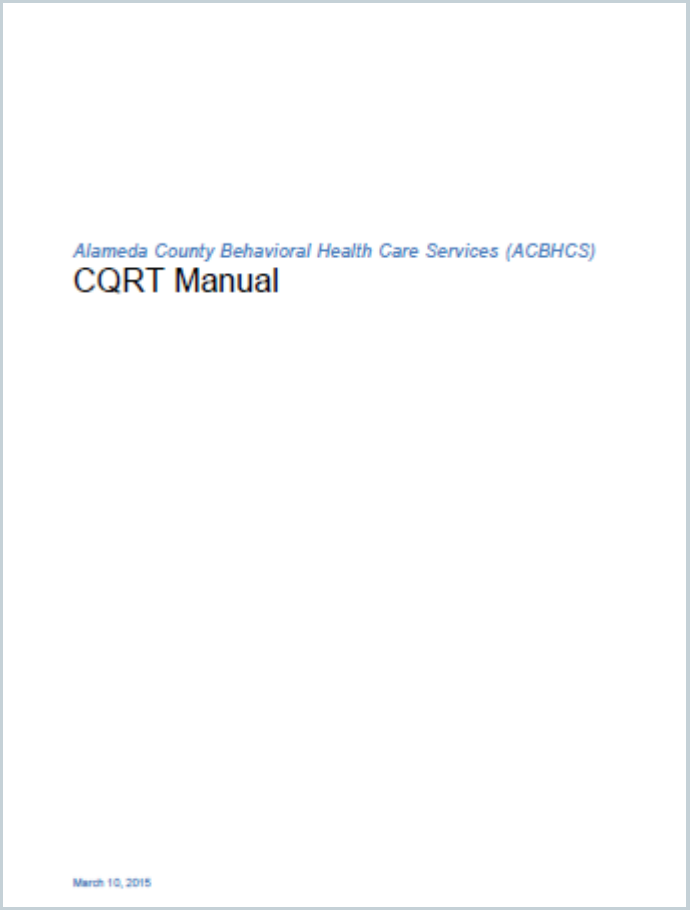


Alameda County Behavioral Health Care Services

Clinical Documentation Standards

This policy section defines the procedures and minimum standards for documentation of Medicare/Medi-Cal Specialty Mental Health Services at any site providing those services within Alameda County Behavioral Health Care Services and its Behavioral Health Plan's Provider Network.

Updated December 3, 2014



Alameda County Behavioral Health Care Services (ACBHCS)

CQRT Manual

March 10, 2015

Potential Audiences

(See Scope of Practice Handout)

- **LPHA**—Licensed
- LPHA—Registered or Waivered

- MH Graduate **Students *(aka Trainees)***

- **MHRS**

- **Adjunct** & Other Staff
  - Consumer Workers
  - Family Partners

Audit tools & outcomes of 2015 4th Quarter System of Care audit

Presenters: Donna L. Fone, MFT, LPCC
Tony Sanders, PhD
ACBHCS Quality Assurance Office

Mental Health SOC Audits

- 10-30 Children's Charts
- 10-30 Adult Charts
- 3-month audit period
- Performed quarterly
- Audit report packet made available to entire system after provider appeal period (client & provider information is de-identified)

ACBHCS CHART AUDITS

- Quality Review
  - ✓ Review of entire chart to assess for quality of care & documentation

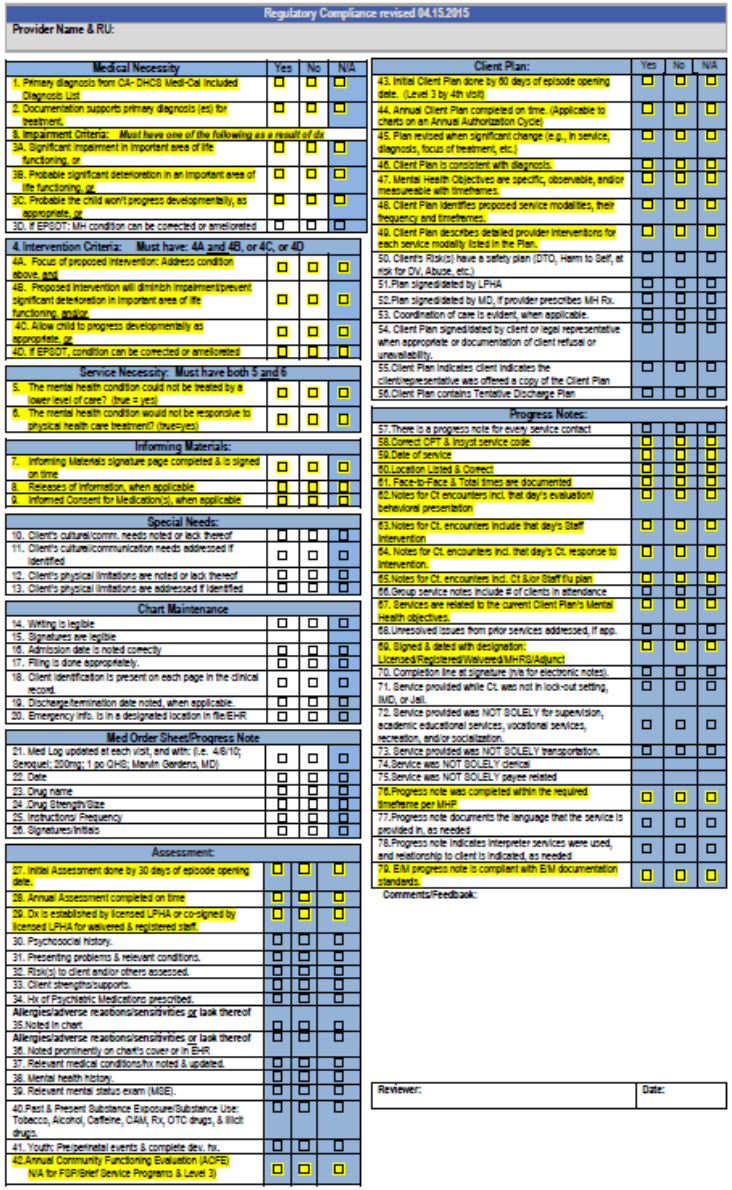
- Claims Review
  - ✓ Review of each individual progress note to see if it substantiates claim

The Quality Review

- 9 areas of the Quality Review include:
  - ✓ Informing Materials
  - ✓ Screening
  - ✓ Medical Necessity
  - ✓ Assessment
  - ✓ Client Plan
  - ✓ Special Needs
  - ✓ Medication Log, Med Consents, E/M
  - ✓ Progress Notes
  - ✓ Chart Maintenance

Regulatory Compliance Tool

- Quality Review Items are also listed on the Regulatory Compliance Tool



Regulatory Compliance revised 04.15.2015

Provider Name & RU:

Medical Necessity	Yes	No	N/A
1. Primary diagnosis from CA- DHCS Medi-Cal Included Diagnosis List	☐	☐	☐
2. Documentation supports primary diagnosis (es) for treatment.	☐	☐	☐
3. Impairment Criteria: *Must have one of the following as a result of dx*			
3A. Significant impairment in important area of life functioning, or	☐	☐	☐
3B. Probable significant deterioration in an important area of life functioning, or	☐	☐	☐
3C. Probable the child won't progress developmentally, as appropriate, or	☐	☐	☐
3D. If EPSDT: MH condition can be corrected or ameliorated	☐	☐	☐
4. Intervention Criteria: Must have: 4A and 4B, or 4C, or 4D			
4A. Focus of proposed intervention: Address condition above, and	☐	☐	☐
4B. Proposed intervention will diminish impairment/prevent significant deterioration in important area of life functioning, and/or	☐	☐	☐
4C. Allow child to progress developmentally as appropriate, or	☐	☐	☐
4D. If EPSDT, condition can be corrected or ameliorated	☐	☐	☐
Service Necessity: Must have both 5 and 6			
5. The mental health condition could not be treated by a lower level of care? (true = yes)	☐	☐	☐
6. The mental health condition would not be responsive to physical health care treatment? (true=yes)	☐	☐	☐
Informing Materials:			
7. Informing Materials signature page completed & is signed on time	☐	☐	☐
8. Releases of information, when applicable	☐	☐	☐
9. Informed Consent for Medication(s), when applicable	☐	☐	☐
Special Needs:			
10. Client's cultural/comm. needs noted or lack thereof	☐	☐	☐
11. Client's culture/communication needs addressed if identified	☐	☐	☐
12. Client's physical limitations are noted or lack thereof	☐	☐	☐
13. Client's physical limitations are addressed if identified	☐	☐	☐
Chart Maintenance			
14. Writing is legible	☐	☐	☐
15. Signatures are legible	☐	☐	☐
16. Admission date is noted correctly	☐	☐	☐
17. Filing is done appropriately.	☐	☐	☐
18. Client identification is present on each page in the clinical record.	☐	☐	☐
19. Discharge/termination date noted, when applicable	☐	☐	☐
20. Emergency info. is in a designated location in file/EHR	☐	☐	☐
Med Order Sheet/Progress Note			
21. Med Log updated at each visit, and with: (i.e. 4/8/10; Seroquel; 200mg; 1 po QHS; Marvin Gerdens, MD)	☐	☐	☐
22. Date	☐	☐	☐
23. Drug name	☐	☐	☐
24. Drug Strength/Size	☐	☐	☐
25. Instructions/ Frequency	☐	☐	☐
26. Signatures/Initials	☐	☐	☐
Assessment:			
27. Initial Assessment done by 30 days of episode opening date.	☐	☐	☐
28. Annual Assessment completed on time	☐	☐	☐
29. Dx is established by licensed LPHA or co-signed by licensed LPHA for waivered & registered staff.	☐	☐	☐
30. Psychosocial history.	☐	☐	☐
31. Presenting problems & relevant conditions.	☐	☐	☐
32. Risk(s) to client and/or others assessed.	☐	☐	☐
33. Client strengths/supports.	☐	☐	☐
34. Hx of Psychiatric Medications prescribed.	☐	☐	☐
Allergies/adverse reactions/sensitivities or lack thereof 35.Noted in chart	☐	☐	☐
Allergies/adverse reactions/sensitivities or lack thereof 36. Noted prominently on chart's cover or in EHR	☐	☐	☐
37. Relevant medical conditions/hx noted & updated.	☐	☐	☐
38. Mental health history.	☐	☐	☐
39. Relevant mental status exam (MSE).	☐	☐	☐
40.Past & Present Substance Exposure/Substance Use: Tobacco, Alcohol, Caffeine, CAM, Rx, OTC drugs, & Illicit drugs.	☐	☐	☐
41. Youth: Pre/perinatal events & complete dev. hx.	☐	☐	☐
42.Annual Community Functioning Evaluation (ACFE) N/A for FSP/Brief Service Programs & Level 3)	☐	☐	☐

Client Plan:	Yes	No	N/A
43. Initial Client Plan done by 60 days of episode opening date. (Level 3 by 4th visit)	☐	☐	☐
44. Annual Client Plan completed on time. (Applicable to clients on an Annual Authorization Cycle)	☐	☐	☐
45. Plan revised when significant change (e.g., in service, diagnosis, focus of treatment, etc.)	☐	☐	☐
46. Client Plan is consistent with diagnosis.	☐	☐	☐
47. Mental Health Objectives are specific, observable, and/or measureable with timeframes.	☐	☐	☐
48. Client Plan identifies proposed service modalities, their frequency and timeframes.	☐	☐	☐
49. Client Plan describes detailed provider interventions for each service modality listed in the Plan.	☐	☐	☐
50. Client's Risk(s) have a safety plan (DTO, Harm to Self, at risk for DV, Abuse, etc.)	☐	☐	☐
51.Plan signed/dated by LPHA	☐	☐	☐
52.Plan signed/dated by MD, if provider prescribes MH Rx.	☐	☐	☐
53. Coordination of care is evident, when applicable.	☐	☐	☐
54. Client Plan signed/dated by client or legal representative when appropriate or documentation of client refusal or unavailability.	☐	☐	☐
55.Client Plan indicates client indicates the client/representative was offered a copy of the Client Plan	☐	☐	☐
56.Client Plan contains Tentative Discharge Plan	☐	☐	☐
Progress Notes:			
57.There is a progress note for every service contact	☐	☐	☐
58.Correct CPT & Insyst service code	☐	☐	☐
59.Date of service	☐	☐	☐
60.Location Listed & Correct	☐	☐	☐
61. Face-to-Face & Total times are documented	☐	☐	☐
62.Notes for Ct encounters incl. that day's evaluation/ behavioral presentation	☐	☐	☐
63.Notes for Ct. encounters include that day's Staff Intervention	☐	☐	☐
64. Notes for Ct. encounters incl. that day's Ct. response to Intervention.	☐	☐	☐
65.Notes for Ct. encounters incl. Ct &/or Staff f/u plan	☐	☐	☐
66.Group service notes include # of clients in attendance	☐	☐	☐
67. Services are related to the current Client Plan's Mental Health objectives.	☐	☐	☐
68.Unresolved issues from prior services addressed, if app.	☐	☐	☐
69. Signed & dated with designation: Licensed/Registered/Waivered/MHRS/Adjunct	☐	☐	☐
70. Completion line at signature (n/a for electronic notes).	☐	☐	☐
71. Service provided while Ct. was not in lock-out setting, IMD, or Jail.	☐	☐	☐
72. Service provided was NOT SOLELY for supervision, academic educational services, vocational services, recreation, and/or socialization.	☐	☐	☐
73. Service provided was NOT SOLELY transportation.	☐	☐	☐
74.Service was NOT SOLELY clerical			
75.Service was NOT SOLELY payee related			
76.Progress note was completed within the required timeframe per MHP	☐	☐	☐
77.Progress note documents the language that the service is provided in, as needed	☐	☐	☐
78.Progress note indicates interpreter services were used, and relationship to client is indicated, as needed	☐	☐	☐
79. E/M progress note is compliant with E/M documentation standards.	☐	☐	☐

Comments/Feedback:

Reviewer:	Date:

Preliminary Outcomes from MH SOC Audit – 4TH quarter 2015

Claims Compliance by Age

Table #1: Claims Compliance by Age				
Population	**Number of Claims**	**Allowed Claims**	**Disallowed Claims**	**Percent Compliant**
All	494	429	65	87%
Children <18 yrs.	265	237	28	89%
Adults ≥ 18 yrs.	229	192	37	84%

Preliminary Outcomes from MH SOC Audit – 4TH quarter 2015

Claims Compliance Results by Chart

Table #3: Claims Compliance Results by Chart		
Number of Charts	**Charts % Compliance**	**Percentage of Total**
13	95 – 100%	52%
3	85 – 94%	12%
1	75 – 84%	4%
5	65 – 74%	20%
3	<65%	12%

Preliminary Outcomes from MH SOC Audit – 4TH quarter 2015

Claims Compliance Results by Provider

Table #4: Claims Compliance Results by Provider		
Number of Providers	**Average Chart Compliance**	**Percentage of Total**
10	95 – 100%	50%
4	85 – 94%	20%
2	75 – 84%	10%
2	65 – 74%	10%
2	<65%	10%

PRELIMINARY OUTCOMES FROM MH SOC AUDIT – 4TH QUARTER 2015

Reasons for Claims Disallowance

Reason for Recoupment	Frequency
Service modality (med services, case mgt, etc.) is not indicated in Client Plan.	14
No Client Plan in effect at time of service delivery (missing staff signatures, etc.).	14
Non-billable activity (supervision & vocational related).	12
Progress Note missing.	6
PN does not include Provider's intervention.	6
Service claimed while in a lock-out setting (psych inpatient, juvenile hall, etc.).	5
Non-billable activity: clerical/admin/voicemail/no show/scheduling appt.	4
Service claimed (PN) does not relate back to current MH Objective in Client Plan.	3
Service provided is outside scope of practice of person performing the service.	2
Duplication of services	2
PN does not meet medical necessity-not a MH service	2
Incorrect Service Code.	2
No Client signature on Client Plan for date of service claimed, or reason why not.	1
Non-billable activity: payee related.	1
Non-billable activity: transportation related.	1
Non-billable activity: completion of Mild-Moderate-Severe Screening Tool	1

Disallowed MH Service Modality by Frequency

Table #6: Disallowed MH Service Modality by Frequency		
Disallowed MH Services by Modality	**Number of Claims**	**Percentage of 65 Total Disallowed Claims**
Case Management - Brokerage	19	29%
Plan Development	13	20%
Individual Rehab	8	12%
Med Mgt by RN	6	9%
E/M Med Services	5	8%
Collateral	5	8%
Psychotherapy	3	5%
Behavioral Eval	2	3%
Med Training/Support	2	3%
Psych Diag Eval	1	1.5%
Group Rehab	1	1.5%

Top 10 Quality Review items that need addressing throughout SOC

- Ten important quality non-compliance items were:
  - **MH Assessments and Client Plans were not completed initially, OR rewritten (annually), within required timeframes.**
  - Mild-Moderate-Severe Screening Tool and/or CFE/CANS/ANSA were not completed.
  - Safety Plans (or objectives) were not completed for DTS/DTO.
  - Cultural/Linguistic/Physical needs were not assessed and/or addressed.
  - Informed Consents for Medications were not done, or were missing elements.
  - Progress Notes did not include: the required components (P/BIRP), were late, or illegible.
  - Required signed Releases of Information were not present.
  - The ACBHCS required "Informing Materials Signature Page" was not fully completed.
  - Assessments were missing key elements such as Developmental History (for youth), allergies, medical history (physical health), all 7 substance use areas, etc.
  - No documentation that the client was offered a copy of the Client Plan.

CQRT (Clinical Quality Review Team) Chart Auditing & Authorization Process

- The primary purpose of the CQRT is to review medical necessity, service necessity, review the quality of the chart documentation, and authorization of services for the next treatment cycle.
- CQRT committees meet a minimum of one time per month.
- For ACBHCS run CQRT meetings: only licensed, waivered, or registered LPHA's (Licensed Practitioner of the Healing Arts) are permitted to participate in chart review and authorization of services.
  - *It is **strongly advisable** that an agency's staff person who is charged with Quality Assurance oversight, and for running the agency's internal CQRT meeting also be a person who meets the above criterion.*

CQRT (Clinical Quality Review Team) Chart Auditing & Authorization Process cont.

- Charts are reviewed based on the date of the case episode opening. The review cycle begins on the first of the month in which the episode was opened.
  - Outpatient services are reviewed at 60 days and annually.

Month Episode is **Opened**	**Cycle**	Bring to the Chart to the CQRT **during** the month	With a new TX plan to cover services beginning	And not signed **before** this date
January (e.g. 1/15)	Jan 1-Dec 31	December	1/1	12/1
February (e.g.2/2)	Feb 1-Jan 31	January	2/1	1/1
March (e.g. 3/30)	Mar 1-Feb 28	February	3/1	2/1

CQRT (Clinical Quality Review Team) Chart Auditing & Authorization Process cont.

- Charts must contain all of the elements required by Medi-Cal Documentation Guidelines. The best tools to keep you in compliance are the Documentation Manual and page 2 of the CQRT forms (also known as the Regulatory Compliance Tool)
- The **Clinical Review** (see yellow highlights on Regulatory Compliance Tool) ensures that ongoing Medical & Service Necessity has been documented.
  - Is there an completed Assessment with Medi-Cal Necessity & a Treatment Plan?
  - Is there evidence that progress is being made toward the goals/objectives and is the client is benefitting from treatment?

  Are the required dated signatures on the Assessment, Treatment Plans, Progress Notes, Community Function Evaluations/CANS, and Informing Material page?

CQRT (Clinical Quality Review Team) Chart Auditing & Authorization Process cont.

The Quality Review is a **comprehensive review of the chart** (15% of all charts brought to CQRT):

- The chart is reviewed using the complete Regulatory Compliance Tool.
- There must be a continuity *("Golden Thread")* between the **Assessment** & Included Medi-Cal Diagnosis, the **Treatment Plan** Mental Health Goals & Objectives, and the interventions documented in the **Progress Notes.**

CQRT (Clinical Quality Review Team) Chart Auditing & Authorization Process cont.

- It is recommended that QA lead staff review charts with prior to their scheduled CQRT to give feedback and ensure timely authorizations.
- In the **BHCS CQRT**, charts with deficiencies must be corrected and returned the following month when:
  - Medical Necessity has not been established
  - Assessment or Client Plan Missing
  - Signatures Missing on Treatment Plan
    - Authorization is pending completion of above.

CHILDREN'S MENTAL HEALTH SERVICES Clinical/Quality Review

v.04.15.2015

Complete the following:

1. Date:
2. Client Name:
3. Client Insyst #:
4. Provider Program Name:
5. Reporting Unit:
6. Clinician:
7. Episode Opening Date:
8. Authorization Cycle:

Request for (check all that apply):

9. Mental Health Services:

☐ Individual Psychotherapy	Frequency		and As Needed ☐	Duration		
☐ Individual Rehabilitation	Frequency		and As Needed ☐	Duration		
☐ Medication Services	Frequency		and As Needed ☐	Duration		
☐ Case Management/Brokerage	Frequency		and As Needed ☐	Duration		
☐ Family Psychotherapy	Frequency		and As Needed ☐	Duration		

Group Services

☐ Family Collateral Group	Frequency		and As Needed ☐	Duration		
☐ Multi-Family Therapy	Frequency		and As Needed ☐	Duration		
☐ Psychotherapy Group	Frequency		and As Needed ☐	Duration		
☐ Rehabilitation Group	Frequency		and As Needed ☐	Duration		

10. Day Treatment Services (check all that apply):

Intensive: ☐ 90 Days (3 months) Rehabilitative: ☐ 180 Days (6 months)

11. Discharge Readiness Criteria & Tentative Date:

12. Medical Necessity- (Medi-Cal Included Diagnosis; Support for Primary Diagnosis, Impairments to Functioning):

13. Focus of Treatment (Address Barriers to Lower Level of Care, Psychological issues, Risk (s) to Client or Others, Co-Occurring Issues etc.):

14. List Proposed Interventions (i.e. CBT, M.I., If a Risk has been identified include how these will be assessed and contained.):

15. Agency Clinician: _____ Recommended Approval: ☐ Yes ☐ No

Signature/Credentials

16. Agency Supervisor: _____ Recommended Approval: ☐ Yes ☐ No

Signature/Credentials

17. CQRT Reviewer: _____ Recommended Approval: ☐ Yes ☐ No (30 Day Return)

Signature/Credentials

18. ☐ Full Authorization - Start Date: End Date:

19. 30 Day Returns:

☐ 30 Day Authorization - Chart to be returned to CQRT:

☐ No Authorization - Chart to be returned to CQRT:

20. CQRT Chair Comments:

21. Chart to be returned to CQRT - Date:

22. CQRT Chair Signature/Credentials: _____ Date: _____

CHILD MENTAL HEALTH SERVICES CQRT FORM

Regulatory Compliance revised 04.15.2015

Provider Name & RU:

Medical Necessity	Yes	No	N/A
1. Primary diagnosis from CA- DHCS Medi-Cal Included Diagnosis List	☐	☐	☐
2. Documentation supports primary diagnosis (es) for treatment.	☐	☐	☐
3. Impairment Criteria: ***Must have one of the following as a result of dx***			
3A. Significant impairment in important area of life functioning, or	☐	☐	☐
3B. Probable significant deterioration in an important area of life functioning, or	☐	☐	☐
3C. Probable the child won't progress developmentally, as appropriate, or	☐	☐	☐
3D. If EPSDT: MH condition can be corrected or ameliorated	☐	☐	☐
4. Intervention Criteria: Must have: 4A and 4B, or 4C, or 4D			
4A. Focus of proposed intervention: Address condition above, and	☐	☐	☐
4B. Proposed intervention will diminish impairment/prevent significant deterioration in important area of life functioning, and/or	☐	☐	☐
4C. Allow child to progress developmentally as appropriate, or	☐	☐	☐
4D. If EPSDT, condition can be corrected or ameliorated	☐	☐	☐
Service Necessity: Must have both 5 and 6			
5. The mental health condition could not be treated by a lower level of care? (true = yes)	☐	☐	☐
6. The mental health condition would not be responsive to physical health care treatment? (true=yes)	☐	☐	☐
Informing Materials:			
7. Informing Materials signature page completed & is signed on time	☐	☐	☐
8. Releases of information, when applicable	☐	☐	☐
9. Informed Consent for Medication(s), when applicable	☐	☐	☐
Special Needs:			
10. Client's cultural/comm. needs noted or lack thereof	☐	☐	☐
11. Client's cultural/communication needs addressed if identified	☐	☐	☐
12. Client's physical limitations are noted or lack thereof	☐	☐	☐
13. Client's physical limitations are addressed if identified	☐	☐	☐
Chart Maintenance			
14. Writing is legible	☐	☐	☐
15. Signatures are legible			
16. Admission date is noted correctly	☐	☐	☐
17. Filing is done appropriately.	☐	☐	☐
18. Client identification is present on each page in the clinical record.	☐	☐	☐
19. Discharge/termination date noted, when applicable.	☐	☐	☐
20. Emergency Info. is in a designated location in file/EHR	☐	☐	☐
Med Order Sheet/Progress Note			

42.Annual Community Functioning Evaluation (ACFE) N/A for FSP/Brief Service Programs & Level 3)			

Client Plan:	Yes	No	N/A
43. Initial Client Plan done by 60 days of episode opening date. (Level 3 by 4th visit)	☐	☐	☐
44. Annual Client Plan completed on time. (Applicable to charts on an Annual Authorization Cycle)	☐	☐	☐
45. Plan revised when significant change (e.g., in service, diagnosis, focus of treatment, etc.)	☐	☐	☐
46. Client Plan is consistent with diagnosis.	☐	☐	☐
47. Mental Health Objectives are specific, observable, and/or measureable with timeframes.	☐	☐	☐
48. Client Plan identifies proposed service modalities, their frequency and timeframes.	☐	☐	☐
49. Client Plan describes detailed provider interventions for each service modality listed in the Plan.	☐	☐	☐
50. Client's Risk(s) have a safety plan (DTO, Harm to Self, at risk for DV, Abuse, etc.)	☐	☐	☐
51.Plan signed/dated by LPHA	☐	☐	☐
52.Plan signed/dated by MD, if provider prescribes MH Rx.	☐	☐	☐
53. Coordination of care is evident, when applicable.	☐	☐	☐
54. Client Plan signed/dated by client or legal representative when appropriate or documentation of client refusal or unavailability.	☐	☐	☐
55.Client Plan indicates client indicates the client/representative was offered a copy of the Client Plan	☐	☐	☐
56.Client Plan contains Tentative Discharge Plan	☐	☐	☐

Progress Notes:			
57.There is a progress note for every service contact	☐	☐	☐
58.Correct CPT & Insyst service code	☐	☐	☐
59.Date of service	☐	☐	☐
60.Location Listed & Correct	☐	☐	☐
61. Face-to-Face & Total times are documented	☐	☐	☐
62.Notes for Ct encounters incl. that day's evaluation/ behavioral presentation	☐	☐	☐
63.Notes for Ct. encounters include that day's Staff Intervention	☐	☐	☐
64. Notes for Ct. encounters incl. that day's Ct. response to intervention.	☐	☐	☐
65.Notes for Ct. encounters incl. Ct &/or Staff f/u plan	☐	☐	☐
66.Group service notes include # of clients in attendance	☐	☐	☐
67. Services are related to the current Client Plan's Mental Health objectives.	☐	☐	☐
68.Unresolved issues from prior services addressed, if app.	☐	☐	☐
69. Signed & dated with designation: Licensed/Registered/Waivered/MHRS/Adjunct	☐	☐	☐
70. Completion time at signature (n/a for electronic notes).	☐	☐	☐
71. Service provided while Ct. was not in lock-out setting, IMD, or Jail.	☐	☐	☐

20. Emergency info. is in a designated location in file/EHR	☐	☐	☐

Med Order Sheet/Progress Note			
21. Med Log updated at each visit, and with: (i.e. 4/8/10; Seroquel; 200mg; 1 po QHS; Marvin Gardens, MD)	☐	☐	☐
22. Date	☐	☐	☐
23. Drug name	☐	☐	☐
24. Drug Strength/Size	☐	☐	☐
25. Instructions/ Frequency	☐	☐	☐
26. Signatures/Initials	☐	☐	☐

Assessment:			
27. Initial Assessment done by 30 days of episode opening date.	☐	☐	☐
28. Annual Assessment completed on time	☐	☐	☐
29. Dx is established by licensed LPHA or co-signed by licensed LPHA for waivered & registered staff.	☐	☐	☐
30. Psychosocial history.	☐	☐	☐
31. Presenting problems & relevant conditions.	☐	☐	☐
32. Risk(s) to client and/or others assessed.	☐	☐	☐
33. Client strengths/supports.	☐	☐	☐
34. Hx of Psychiatric Medications prescribed.	☐	☐	☐
Allergies/adverse reactions/sensitivities or lack thereof 35.Noted in chart	☐	☐	☐
Allergies/adverse reactions/sensitivities or lack thereof 36. Noted prominently on chart's cover or in EHR	☐	☐	☐
37. Relevant medical conditions/hx noted & updated.	☐	☐	☐
38. Mental health history.	☐	☐	☐
39. Relevant mental status exam (MSE).	☐	☐	☐
40.Past & Present Substance Exposure/Substance Use: Tobacco, Alcohol, Caffeine, CAM, Rx, OTC drugs, & illicit drugs.	☐	☐	☐
41. Youth: Pre/perinatal events & complete dev. hx.	☐	☐	☐

71. Service provided while Ct. was not in lock-out setting, IMD, or Jail.			
72. Service provided was NOT SOLELY for supervision, academic educational services, vocational services, recreation, and/or socialization.	☐	☐	☐
73. Service provided was NOT SOLELY transportation.	☐	☐	☐
74.Service was NOT SOLELY clerical			
75.Service was NOT SOLELY payee related			
76.Progress note was completed within the required timeframe per MHP	☐	☐	☐
77.Progress note documents the language that the service is provided in, as needed	☐	☐	☐
78.Progress note indicates interpreter services were used, and relationship to client is indicated, as needed	☐	☐	☐
79. E/M progress note is compliant with E/M documentation standards.	☐	☐	☐

Comments/Feedback:

Reviewer:	Date:

The Golden Thread

- Definition:
  - The “Golden Thread” is the sequence of documentation that supports the demonstration of ongoing medical necessity and ensures all provided services are reimbursable.
  - The sequence of documentation on which medical necessity requirements converge is:
    - The Assessment
    - The Client Plan
    - The Progress Note

Medical Necessity for Outpatient Specialty Mental Health Services

- Medical Necessity criteria for outpatient Specialty Mental Health Services are set forth in the California Code of Regulations, Title 9, Title 22; Code of Federal Regulations, Title 42, MHSD Information Notices and DHCS/MHP Contract.
- In order for outpatient Specialty Mental Health Services to be reimbursable through the Medi-Cal Program, all three of the required medical necessity elements must be applicable and be documented in the beneficiary's record.

Medical Necessity Criteria (1 of 3)

- Must meet the following three:
  1. **An included diagnosis**

     (See Medical Necessity for Specialty Mental Health Services handout.); effective 10/1/15 it is required that the medical record reflect both the ICD-10 and DSM Diagnosis.

     - Having a diagnosis that is not "included" does not exclude a client from having his/her services reimbursed AS LONG AS
       - They also have an "included" diagnosis as the primary (FOCUS OF TX) diagnosis, and services/interventions are directed toward the impairment resulting from an "included" diagnosis.

MH Assessment
Step 1 of the Golden Thread *continued*

- **The Primary Diagnosis** is the Medi-Cal Included diagnosis that is the **PRIMARY FOCUS OF TREATMENT**.
  - The Primary diagnosis in the clinical record must match the primary diagnosis in INSYST to ensure an accurate clinical snapshot
  - All diagnoses must indicate both the DSM and ICD-10 Dx's
  - If the Diagnosis is revised you must update INSYST

STATE DEPARTMENT OF MENTAL HEALTH MEDI-CAL MANAGED CARE
Medical Necessity for Specialty Mental Health Services
that are the Responsibility of the Mental Health Plan

Must have all, A, B, and C:

A. Diagnoses

Must have one of the following DSM IV diagnoses, which will be the focus of the intervention being provided:

Included Diagnoses:

- Pervasive Developmental Disorders, except Autistic Disorder which is excluded.
- Attention Deficit and Disruptive Behavior Disorders
- Feeding & Eating Disorders of Infancy or Early Childhood
- Elimination Disorders
- Other Disorders of Infancy, Childhood, or Adolescence
- Schizophrenia & Other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Paraphilias
- Gender Identity Disorders
- Eating Disorders
- Impulse-Control Disorders Not Elsewhere Classified
- Adjustment Disorders
- Personality Disorders, excluding Antisocial Personality Disorder
- Medication-Induced Movement Disorders

Excluded Diagnoses:

- Mental Retardation
- Learning Disorders
- Motor Skills Disorder
- Communication Disorders
- Autistic Disorder (Other Pervasive Developmental Disorders are included.)
- Tic Disorders
- Delirium, Dementia and Amnestic and other Cognitive Disorders
- Mental Disorders due to a General Medical Condition
- Substance-Related Disorders
- Sexual Dysfunctions
- Sleep Disorders
- Antisocial Personality Disorder
- Other conditions, including V-codes, that may be a focus of Clinical Attention. (Except medication induced movement disorders which are included.)

A beneficiary may receive services for an included diagnosis when an excluded diagnosis is also present.

B. Impairment Criteria

Must have one of the following as a result of the mental disorder(s) identified in the diagnostic ("A") criteria:
Must have one, 1, 2, or 3:

1. A significant impairment in an important area of life functioning, or
2. A probability of significant deterioration in an important area of life functioning, or
3. Children also qualify if there is a probability the child will not progress developmentally as individually appropriate. Children covered under EPSDT qualify if they have a mental disorder which can be corrected or ameliorated (current DHS EPSDT regulations also apply).

C. Intervention Related Criteria

Must have all, 1, 2, and 3 below:

1. The focus of proposed intervention is to address the condition identified in impairment criteria "B" above, and
2. It is expected the beneficiary will benefit from the proposed intervention by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning, and/or for children it is probable the child will progress developmentally as individually appropriate (or if covered by EPSDT can be corrected or ameliorated), and
3. The condition would not be responsive to physical healthcare based treatment.

EPSDT beneficiaries with an included diagnosis and a substance related disorder may receive specialty mental health services directed at the substance use component. The intervention must be consistent with, and necessary to the attainment of, the specialty MH treatment goals.

MEDI-CAL INCLUDED DIAGNOSIS

295.10	Schizophrenia, Disorganized Type	302.3	Transvestic Fetishism
295.20	Schizophrenia, Catatonic Type	302.4	Exhibitionism
295.30	Schizophrenia, Paranoid Type	302.6	Gender Identity Disorder NOS
295.40	Schizophreniform Disorder	302.81	Fetishism
295.60	Schizophrenia, Residual Type	302.82	Voyeurism
295.70	Schizoaffective Disorder	302.83	Sexual Masochism
295.90	Schizophrenia Undifferentiated Type	302.84	Sexual Sadism
296.00	Bipolar I Disorder Single Manic Episode	302.85	Gender Identity Disorder in Adolescents or Adults
296.01 - .06	Bipolar I Disorder	302.89	Frotteurism
296.20 - .26	Major Depressive Disorder Single Episode	302.9	Paraphilia/Sexual Disorder NOS
296.30 - .36	Major Depressive Disorders, Recurrent	307.1	Anorexia Nervosa
296.40	Bipolar I Disorder Most Recent Episode Hypomanic	307.3	Stereotypic Movement Disorder
296.40 - .46	Bipolar I Disorder Most Recent Episode Manic	307.50	Eating Disorder NOS
296.50 - .56	Bipolar I Disorder Most Recent Episode Depressed	307.51	Bulimia Nervosa
296.60 - .66	Bipolar I Disorder Most Recent Episode Mixed	307.52	Pica
296.7	Bipolar I Disorder, Most recent episode Unspecified	307.53	Rumination Disorder
296.80	Bipolar Disorder NOS	307.59	Feeding Disorder of Infancy or Early Childhood
296.89	Bipolar II Disorder	307.6	Enuresis (Not Due to a General Medical Condition)
296.90	Mood Disorder NOS	307.7	Encopresis Without Constipation Incontinence
297.1	Delusional Disorder	307.80	Pain Disorder Associated With Psychological Factors
297.3	Shared Psychotic Disorder	307.89	Pain Disorder Associated with Psych & Medical Condition
298.8	Brief Psychotic Disorder	308.3	Acute Stress Disorder
298.9	Psychotic Disorder NOS	309.0	Adjustment Disorder With Depressed Mood
299.10	Childhood Disintegrative Disorder	309.21	Separation Anxiety Disorder
299.80	Asperger's Disorder/Rett's Disorder	309.24	Adjustment Disorder With Anxiety
299.80	Pervasive Developmental Disorder NOS	309.28	Adjustment Disorder With Mixed Mood
300.00	Anxiety Disorder NOS	309.3	Adjustment Disorder With Disturbance of Conduct
300.01	Panic Disorder Without Agoraphobia	309.4	Adjustment Disorder With Mixed Emotions & Conduct
300.02	Generalized Anxiety Disorder	309.81	Posttraumatic Stress Disorder
300.11	Conversion Disorder	309.9	Adjustment Disorder Unspecified
300.12 - .15	Dissociative Amnesia	311	Depressive Disorder NOS
300.16	Factitious Disorder w/Predominantly Psychological	312.30	Impulse-Control Disorder NOS
300.19	Factitious Disorder NOS	312.31	Pathological Gambling
300.21	Panic Disorder With Agoraphobia	312.32	Kleptomania
300.22	Agoraphobia Without History of Panic Disorder	312.33	Pyromania
300.23	Social Phobia	312.34	Intermittent Explosive Disorder
300.29	Specific Phobia	312.39	Trichotillomania
300.3	Obsessive-Compulsive Disorder	312.8	Conduct Disorder
300.4	Dysthymic Disorder	312.9	Disruptive Behavior Disorder NOS
300.6	Depersonalization Disorder	313.23	Selective Mutism
300.7	Body Dysmorphic Disorder/Hypochondriasis	313.81	Oppositional Defiant Disorder
300.81	Somatization Disorder/Somatoform Disorder	313.82	Identity Problem
301.0	Paranoid Personality Disorder	313.89	Reactive Attachment Disorder
301.13	Cyclothymic Disorder	313.9	Disorder of Infancy, Childhood, or Adolescence NOS
301.20	Schizoid Personality Disorder	314.00	Attention-Deficit/Hyperactivity Disorder, Inattentive
301.22	Schizotypal Personality Disorder	314.01	Attention-Deficit/Hyperactivity Disorder Combined
301.4	Obsessive-Compulsive Personality Disorder	314.9	Attention-Deficit/Hyperactivity Disorder NOS
301.50	Histrionic Personality Disorder	332.1	Neuroleptic-Induced Parkinsonism
301.6	Dependent Personality Disorder	333.1	Medication-Induced Postural Tremor
301.81	Narcissistic Personality Disorder	333.7	Neuroleptic-Induced Acute Dystonia
301.82	Avoidant Personality Disorder	333.82	Neuroleptic-Induced Tardive Dyskinesia
301.83	Borderline Personality Disorder	333.90	Medication-Induced Movement Disorder NOS
301.9	Personality Disorder NOS	333.92	Neuroleptic Malignant Syndrome
302.2	Pedophilia	333.99	Neuroleptic-Induced Acute Akathisia
		787.6	Encopresis, With Constipation/Incontinence

Medical Necessity Criteria (2 of 3)

2. A qualifying impairment *(meets <u>one</u> of the following)*

a) A *significant impairment* in an important area of life functioning

b) A reasonable *probability of significant deterioration* in an important area of life functioning (without treatment)

c) For EPSDT (children < 21 yrs): a reasonable *probability that a child will not progress developmentally as individually appropriate;*

- If the client has had recent (within the last 3 months) h/i, s/I, or other high risk conditions, it must be noted in the MH Assessment, and an objective – or preferably Safety Plan – created for treatment purposes.

Medical Necessity Criteria (3 of 3)

3. And a qualifying Intervention (meets ***all three*** of the following)

1. The focus of the intervention is to address the condition of the impairment resulting from the included diagnosis
2. The expectation is that the proposed intervention will meet one of the following:
   a) Significantly diminish the impairment, or
   b) Prevent significant deterioration, or
   c) Allow the child to progress developmentally as individually appropriate,
3. And the conditions would **not be responsive** to physical healthcare treatment.

Medical Necessity & Key Documents

- The **Initial Assessment** (due* within 30 days of EOD) & the ongoing **Annual Assessment** (done within the month preceding the EOD anniversary month) documentation establishes Medical Necessity.
- The **Client Plans** due* within 60 days (include EOD as day 1) and annually thereafter which are based on the Initial Assessment and ongoing assessments.
- **Progress Notes** must contain evidence that the services claimed for reimbursement meet Medical Necessity by linking to a specific current MH Objective.

**For outpatient specialty MH services, see Clinical Doc Manual for exceptions: FSP, & time limited programs.*

Moderate to Severe Criteria

- All clients must now be screened for *Mild to Moderate* vs. *Moderate to Severe* criteria.
  - Screening is done upon referral and before Annual Assessment, at either point:
    - If the client does not meet *Moderate to Severe* criteria they must be referred out to a Beacon Provider.
- See ACBHCS/Providers/Forms/Access/Screening for MH Services
  - http://www.acbhcs.org/providers/Forms/Forms.htm#Access

Adult Behavioral Health Screening Form for Assessment and Treatment as Medically Necessary

MEMBER INFO

Beneficiary Name: _____ Date of Birth: ___/___/___ ☐ M ☐ F

Medi-Cal # (CIN): _____ Current Eligibility: ☐ Yes ☐ No Language/cultural needs: _____

Address: _____ City: _____ Zip: _____ Phone: (___) _____

Caregiver/Guardian: _____ Phone: (___) _____

Behavioral Health Diagnosis 1) _____ 2) _____ 3) _____

Is provisional diagnosis/diagnosis an included diagnosis for MHP services ☐ Yes ☐ No ☐ Unsure

Documents Included: ☐ **Required Release of Info completed** ☐ MD notes ☐ H&P ☐ Assessment ☐ Other: _____

Primary Care Provider _____ Phone: (___) _____

List A (check all that currently apply)	List B (Check all that currently apply)	List C
☐ Persistent mental health symptoms & impairments after psychiatric consult and 2 or more medication trials in past 6 months ☐ Co-morbid mental health and serious health conditions (specify below) ☐ Behavior problems (aggressive/assaultive/self-destructive/extreme isolation) (specify below) ☐ 3+ ED visits or 911 calls in past year ☐ Significant current life stressors [e.g. homelessness, domestic violence, recent loss] (specify below) ☐ Hx of trauma/PTSD that is impacting current functioning** ☐ Non-minor dependent ☐ May not progress developmentally as individually appropriate without mental health intervention (ages 18 to 21 only)	☐ 2+ in-patient psychiatric hospitalizations within past 18 months ☐ Functionally significant paranoia, delusions, hallucinations** ☐ Current & on-going suicidal/significant self-injurious/homicidal preoccupation or behavior in past year (specify below) ☐ Transitional Age Youth with acute psychotic episode ☐ Eating disorder with related medical complications ☐ Personality disorder with significant functional impairment** ☐ Significant functional impairment (not listed above) due to a mental health condition**	☐ Drug or alcohol addiction and failed SBI (screening & brief intervention at primary care)

	Referral Algorithm	
1	Remains in **PCP care** with Beacon consult or therapy only	☐ 1-2 in List A and none in List B
2	Refer to **Beacon Health Strategies** (eFax (866) 422-3413)	☐ 3 in list A (2 if ages 18-21) and none in list B OR ☐ Diagnosis excluded from county MHP
3	Refer to **County Mental Health Plan** for assessment (Fax – 510-346-1083)	☐ 4 or more in list A (3 or more if ages 18-21) OR ☐ 1 or more in list B
4	Refer to County Alcohol & Drug Program (1-800-491-9099)	☐ 1 from list C

Referring Provider Name: _____ Phone: (___) _____

Referring/Treating Provider Type ☐ PCP ☐ MFT/LCSW ☐ ARNP ☐ Psychiatrist ☐ Other _____

Requested service ☐ Outpatient therapy ☐ Medication management ☐ Assessment for Specialty Mental Health Services

Pertinent Current/Past Information (**Please specify current functional impairments in a core area of life due to the condition(s) checked) :

Current symptoms and functional impairments: _____

_____

Brief Patient history: _____

_____

Name and Title*(Print:)_____ Signature: _____ Date:____

*Licensed LPHA, MD, DO, NP, CNS, PA

For Receiving Clinician Use ONLY

Assigned Case Manager/MD/Therapist Name: _____ Phone: (___) _____

Date communicated assessment outcome with referral source: _____

FINAL Alameda County Behavioral Health Care Services March 2015

Child 0 - 5 Behavioral Health Screening Form for Assessment and Treatment as Medically Necessary

MEMBER INFO

Patient Name: _____ Date of Birth: ___/___/___ ☐ M ☐F

Medi-Cal # (CIN): _____ Current Eligibility: _____ Language/cultural requirements: _____

Address: _____ City: _____ Zip: _____ Phone: (____) _____

Caregiver/Guardian: _____ Phone: (____) _____

Behavioral Health Diagnosis 1) _____ 2) _____ 3) _____

Is provisional diagnosis/diagnosis an included diagnosis for MHP services ☐ Yes ☐ No ☐ Unsure

Documents Included: ☐ **Required consent completed** ☐ MD notes ☐ H&P ☐ Assessment ☐ Other: _____

Primary Care Provider _____ Phone: (____) _____

List A (check all that apply)	List B (Check all that apply)
☐ Impulsivity/hyperactivity ☐ Withdrawn/isolative ☐ Mild-moderate depression/anxiety ☐ Excessive crying; difficult to soothe ☐ Significant family stressors * ☐ CPS report in the last 6 months ☐ Limited receptive and expressive communication skills ☐ Sleep Concerns: difficulty falling asleep, night waking, nightmares ☐ Peer relationship issues - little enjoyment or interest in peers; self-isolating; frequent conflict with peers ☐ Feeding/elimination difficulties ☐ Learning Difficulties ☐ Sexualized Behaviors ☐ Serious medical issues/other disabilities ☐ May not progress developmentally as individually appropriate without mental health intervention	☐ Significant Parent/Child attachment concerns ☐ Child age 0-3 with at least 2 items from List A ☐ Aggression and/or frequent tantrums ☐ Neglect/Abuse ☐ Self-Harm: frequent head banging/risky behavior ☐ Trauma ☐ Currently in out-of-home foster care placement ☐ At risk of losing home, child care or preschool placement due to mental health issue ☐ Separation from/loss of primary caregiver

*** Significant family stressors:** Caretaker(s) with serious physical, mental health, substance use disorders or developmental disabilities, domestic violence, unstable housing or homelessness.

	Referral Algorithm	
1	Remains in **PCP care** with Beacon consult or therapy only	☐1 in List A and none in List B
2	Refer to **Beacon Health Strategies**(eFax (866) 422-3413)	☐2 in list A and none in List B OR ☐Diagnosis excluded from county MHP
3	Refer to **County Mental Health Plan** for assessment	☐ 3 or more in List A OR ☐1 or more in List B

Referring Provider Name: _____ Phone: (____) _____

Referring/Treating Provider Type ☐ PCP ☐ MFT/LCSW ☐ ARNP ☐ Psychiatrist ☐ Other _____

Requested service ☐ Outpatient therapy ☐ Medication management ☐ Assessment for Specialty Mental Health Services

Pertinent Current/Past Information:

Current symptoms and impairments: _____

_____

Brief Patient history: _____

_____

Name and Title(Print:)_____ Signature: _____ Date:___

For Receiving Clinician Use ONLY

Assigned Case Manager/MD/Therapist Name: _____ Phone: (____) _____

Date communicated assessment outcome with referral source: _____

ALAMEDA COUNTY September 2014

Child 6 – 17 Behavioral Health Screening Form for Assessment and Treatment as Medically Necessary

MEMBER INFO

Patient Name: _____ Date of Birth: ___/___/___ ☐ M ☐F

Medi-Cal # (CIN): _____ Current Eligibility: _____ Language/cultural requirements: _____

Address: _____ City: _____ Zip: _____ Phone: (____) _____

Caregiver/Guardian: _____ Phone: (____) _____

Behavioral Health Diagnosis 1) _____ 2) _____ 3) _____

Is provisional diagnosis/diagnosis an included diagnosis for MHP services ☐ Yes ☐ No ☐ Unsure

Documents Included: ☐ **Required consent completed** ☐ MD notes ☐ H&P ☐ Assessment ☐ Other: _____

Primary Care Provider _____ Phone: (____) _____

List A (check all that apply)	List B (Check all that apply)	List C
☐ Impulsivity/hyperactivity ☐ Trauma/recent loss ☐ Withdrawn/Isolative ☐ Mild-moderate depression/anxiety ☐ Behavior problems (aggressive/self-destructive/assaultive/bullying/oppositional) ☐ Significant family stressors * ☐ CPS report in the last 6 months ☐ Excessive truancy or failing school ☐ Difficulty developing and sustaining peer relationships ☐ Eating disorder without medical complications ☐ Court dependent or ward of court ☐ May not progress developmentally as individually appropriate without mental health intervention	☐ 1 or more psychiatric hospitalization(s) in past year ☐ Suicidal/homicidal preoccupations or behaviors in past year ☐ Self-injurious behaviors ☐ Paranoia, delusions, hallucinations ☐ Currently in out-of-home foster care placement ☐ Juvenile probation supervision with current placement order ☐ Functionally significant depression/anxiety ☐ Eating disorder with medical complications ☐ At risk of losing home or school placement due to mental health issues	☐ Substance abuse

*** Significant family stressors:** Caretaker(s) with serious physical, mental health, substance use disorders or developmental disabilities, domestic violence, unstable housing or homelessness.

	Referral Algorithm	
1	Remains in **PCP care** with Beacon consult or therapy only	☐1 in List A and none in List B
2	Refer to **Beacon Health Strategies**(eFax (866) 422-3413)	☐2 in list A and none in List B OR ☐Diagnosis excluded from county MHP
3	Refer to **County Mental Health Plan** for assessment	☐ 3 or more in List A OR ☐1 or more in List B
4	Refer to **County program** or community resources	☐1 in list C

Referring Provider Name: _____ Phone: (____) _____

Referring/Treating Provider Type ☐ PCP ☐ MFT/LCSW ☐ ARNP ☐ Psychiatrist ☐ Other _____

Requested service ☐ Outpatient therapy ☐ Medication management ☐ Assessment for Specialty Mental Health Services

Pertinent Current/Past Information:

Current symptoms and impairments: _____

_____

Brief Patient history: _____

_____

Name and Title(Print:)_____ Signature: _____ Date:___

For Receiving Clinician Use ONLY

Assigned Case Manager/MD/Therapist Name: _____ Phone: (____) _____

Date communicated assessment outcome with referral source: _____

ALAMEDA COUNTY

September 2014

ALAMEDA COUNTY
Behavioral Health Care Services

Bi-Directional Medi-Cal Mental Health Level of Care Transition Form

INSTRUCTIONS: Complete this form when transitioning a Medi-Cal client in active services between levels of mental health care. Please provide details on the type of transition requested and also provide the clinical information on page 2. Clinical information can be completed on the form **OR** with last two progress notes and medication log (if applicable). When transitioning to the Managed Care Plan (mild to moderate impairment) level of care, please fax the completed form to Beacon at **866-422-3413 OR** to Specialty Mental Health (moderate to severe) level of care, please fax the completed form to BHCS ACCESS at **510-346-1083**.

Member Demographics

Client Name: _____ Date of Birth: ___/___/___ ☐ M ☐ F ☐ O
(Last) (First)

Client phone _____ Medi-Cal Health Plan _____

Medi-Cal ID# _____ Language/Cultural Requirements _____

Address: _____ City: _____ Zip: _____ Phone: (___) _____

Caregiver/Guardian: _____ Phone: (___) _____
(Name) (Relationship)

Transition Request Details

Reason for transition

☐ **TO BEACON:** No longer meets medical necessity for Specialty MH Services (SMHS) (mild to moderate impairments due to MH Dx)

☐ **TO COUNTY.** Meets medical necessity for Specialty MH Services assessment and requires more intensive services

☐ Other _____

Member notified of transition for services: ☐ Yes ☐ No

Medication Management requested/ to be managed by:

☐ Primary Care ☐ Beacon contracted psychiatrist ☐ County SMHS ☐ Other_____ ☐ N/A

Therapy requested/to be managed by:

☐ Beacon contracted therapist ☐ County SMHS ☐ Other_____ ☐ N/A

If member formerly saw Beacon provider, name/clinic of that provider: _____ or ☐ N/A

Attached Documents (check any that apply): ☐ Screening tool ☐ Progress notes ☐ Medication Log ☐ Discharge summary ☐ Other _____

Consent to share PHI: ☐ Release of Information (ROI) attached ☐ Verbal consent (date received) _____

Sending Clinician Info

Staff name: _____ Title/licensure: _____

Date: _____ Phone: (___) _____ Email: _____

Updated 4.17.2015

BEACON

Clinical Information

Primary Diagnosis: _____ **Secondary Diagnosis:** _____

Admit Date: _____ **Discharge Date:** _____

Medication	Dose	Last Change Date

Services provided to member while in SMHS or Beacon level services:

☐ Medication Management ☐ Psychological Testing ☐ Individual/Group Therapy

☐ TBS ☐ Case Management ☐ Wrap services

☐ Crisis Intervention ☐ Other _____

Risk Factors:

☐ Psychiatric hospitalization within last year. If yes, date_____.

☐ Active S/I or H/I with plan or intent. If yes, please describe below.

☐ Recent trauma/loss. If yes, please describe below.

☐ Recent release from prison system. If yes, please describe below.

☐ Increased psychosocial issues exacerbating MH condition. If yes, please describe below.

Relevant Clinical information:

Updated 4.17.2015

Mental Health Screening Tool and Referral Instructions for Alameda County Behavioral Health Care Services Providers

KEY CONTACT INFORMATION

Mental Health Plan (MHP) / Specialty Mental Health Services (SMHS) :

Alameda County ACCESS Phone: 1-800-491-9099 Fax: 510-346-1083

Managed Care Plans (MCP):

Alameda Alliance/Beacon	Phone: 1-855-856-0577	Fax: 866-422-3413
Kaiser Permanente	Phone: 510-752-1075	
Anthem Blue Cross	Phone: 1-888-831-2246	

DIRECTIONS FOR USING THE SCREENING TOOL FORM

1) Providers must complete the screening tool to determine if a consumer meets Specialty Mental Health Services criteria with moderate-severe impairment or should be referred to their managed care plan due to mild-moderate impairment.

2) Administer the screening tool. Please complete as much information on the screening tool as you can. Clarifying information:
   - MEMBER INFO section/Documents Included – Consent form only required if sending clinical information to MCP/Primary Care Provider (PCP)
   - Referring Provider Name section – Only required if sending to MCP
   - Name, Title, Signature and Date – Clinician who completed screening form
   - Select screening tool criteria descriptions are listed on the back of this page

3) Use the algorithm to determine if consumer should receive services through specialty mental health services or managed care plan.

4) If algorithm indicates mild-to-moderate condition, refer the consumer to his/her managed care plan or PCP for services (see contact information above). The name of the managed care plan should be listed on the back of consumer's Medi-Cal card.

5) If algorithm indicates significant impairment or moderate-severe condition, which meets medical necessity for SMHS :
   - **Please retain a copy of the completed screening tool form in the client's chart. This will be particularly important if the chart is audited in the future.**
   - If you work for a CBO/Master Contract Provider and bill through INSYT you can provide direct services.
   - If you are/work for a Network Provider and bill through BHCS Provider Relations/Claims department, and the client is an adult 18-64, you can provide direct services.
   - If you are/work for a Network Provider and bill through BHCS Provider Relations/Claims department, and the client is a youth under 18 or an adult over 64, it is necessary to obtain prior authorization through ACCESS. Please have the completed screening form with you when you call ACCESS seeking authorization or attach a copy of the screening form if you are submitting a Request for Prior Consultation. This is the only situation in which you need to send the completed screening form to ACCESS.
   - Network providers seeking re-authorization from BHCS Authorization Services must send a completed, signed copy of the screening form with their RES/RCR.

ADULT SCREENING TOOL CRITERIA DESCRIPTIONS:

Persistent symptoms after 2 medication trials	Two failed attempts at symptom management with medication trials
Multiple co-morbid health and mental health conditions	Example: Diabetes, high blood pressure and bipolar disorder
+ ED visits or 911 calls in past year	Pattern of frequent visits to the emergency room or 911 calls due to mental health condition
Non-minor dependent	Age 18-21 who is a dependent of the court through the juvenile court system (WIC 300)
Transitional age youth with first psychotic episode	Age 16-25 with the first onset of psychotic symptoms
Significant Functional Impairment	Patient is has significant impairment in a core area of life functioning due to the mental health condition. If using the World Health Organization Disability Assessment Schedule, a score of 4-5 denotes a "severe" or "extreme" functional impairment
Eating disorder with medical complications	The eating disorder is so severe that it has led to medical complications.
Failed SBI	The PCP has tried brief interventions for SUD and failed, thus requiring referral for more

CHILD SCREENING TOOL CRITERIA DESCRIPTIONS:

Impulsivity/hyperactivity	May include but not limited to being fidgety, disruptive, impulsive in behaviors, difficult completing tasks or restlessness
Trauma/recent loss	Any incidents including but not limited to death, witness or victim of violence, recent illnesses or family changes that are impacting a child's ability to cope
Self-injurious behavior	Self-injury including cutting, burning and other self-harming behaviors
Eating disorder with medical complications	The eating disorder is so severe that it has led to medical complications.
Substance abuse	Pattern of substance use leading to problems or distress
Oppositional	Pattern of defiance, disobedience or argumentative behavior with adults

Screening Tool Training FAQ's - 9/25/14 & 10/3/14
Provider Questions

Compliance

1. Do we keep the screening tool in the client's record?
   Yes, QA will look for it in an audit.

2. When do we complete the screening tool?
   Before services begin, whether that occurs during Intake in person or over phone – and re-screen at every Treatment Plan Update.

3. Do we have to do the re-screening with the client/family?
   No, the clinician can do it on his/her own.

4. If we can only check two items in List A but we suspect there are more issues, can we do Assessment?
   No, providers need to obtain sufficient information during the screening to determine if meet criteria and shouldn't begin services unless screened to meet criteria.

5. When do we have to start screenings?
   Now.

6. Do current clients need to be screened?
   Yes.

7. Can we complete the screening per the information given by the caller, even if it's not the client (e.g., family member, CWW, etc.)?
   Yes, you can take information from anyone who knows the client.

8. What if we don't use the WHODAS scoring (on Adult screening tool)?
   That is okay; the WHODAS is usually only used by primary care.

9. What if the client has a Provisional Dingnosis?
   Check "Unsure."

10. Can we bill for the screening?
    No.

11. Does this mean we don't have to do the CFE or other assessment tools?
    All prior paperwork requirements are still in effect. The goal is to incorporate the Mild-Moderate Screening Tool into the CANS & ANSA.

12. Why can't we use existing documents?
    The screening is used to refer consumers between providers & insurance systems, so consistency in paperwork is necessary. Other providers should not have to look through a chart to find referral information; also the tool's algorithm is required.

13. Is it okay for providers to create an electronic version of the screening?
    Yes, as long as the content remains the same. It is also available in PDF form.

14. Who can sign the form?
    Since the screening tool includes a diagnosis, an LPHA must sign or co-sign, per BHCS Documentation Standards. Signature(s) that are acceptable on the screening tool are:

    -Licensed LPHA (PhD-Licensed, PsyD-Licensed, LCSW, LMFT, LPCC, LPCC-F)
    -Un-licensed LPHA must have a co-signature of a Licensed LPHA (Phd-Waivered, PsyD-Waivered, MFT-Intern, ASW, PCC-Intern)
    -Medical Providers (MD, DO, NP, CNS, PA)

    Graduate student interns or trainees or other staff are not allowed to fill out or sign the screening tool.

15. May we tell callers to contact ACCESS "for a referral to us" & have ACCESS do the screening?
    Network Managed Care providers (fee-for-service contracts) may refer callers to ACCESS for screening, however, they will need to do their own screening prior to submission of RES or Authorization Services requires a copy. Community Based Organizations (CBO's or master contracts) do their own screening.

Who Must Complete the Screening Tool?

1. How do we sign the screening tool if we are both the "screener" & "receiver" of the case?
   Complete the form as the "screener." The 'Referring Provider Name' section is only required if sending the screening tool to a Managed Care Plan.

2. Do SUD programs need to do screening?
   No, only providers that bill for mental health services.

3. Do Adult Level 1 programs do screening?
   Not at intake but at each Treatment Plan review.

4. Do Children's Level 1 programs do screening?
   Not at intake, if referred by ACCESS, but at each Treatment Plan review. If not referred by ACCESS, the screening should be done prior to intake.

5. Do Level 2 programs do the screening?
   Not at intake but at each Treatment Plan review.

6. Does the Guidance Clinic need to do screening for their mental health services billed to Medi-Cal?
   Not at this time for youth in Juvenile Probation supervision with current placement order.

7. Do EPSDT Probation (outpatient) providers do the screening?
   Yes.

8. Does a CalWorks provider need to do screening?
   No, CalWorks clients do not need to meet medical necessity.

9. Do Wellness Centers need to do screening?
   Only if billing Medi-Cal for Specialty Mental Health Services.

Questions about Certain Situations

1. If a client improves & is stable but gains may be temporary, do we need to transfer the case to the MCP or can we continue services to ensure stability?
   For clients ages 0-21, document clearly that EPSDT impairment criteria are met. For adults, document clearly that at least one medical necessity impairment criterion is met. In addition, develop a transition plan that takes into account the need to ensure the gains are solidified before transferring the client.

2. How long can a transition plan be in effect?
   As long as the chart documents the need/reason for a longer transition; the plan needs to be reviewed often to ensure the need/reason is still valid.

3. For a Level 1 adult client who has been stable for several years with medication & some case management, must we refer out to a MCP?
   If they continue to have four items checked in List A or one item in List B, they can be transitioned to a lower level of Specialty Mental Health Services (level 3) as a step-down to the higher level of care. If the client doesn't meet criteria for Specialty MHS, a transition plan must be developed to step-down to the MCP.

4. How should providers of Level 1 services and programs like CHOICES, where the goal is to increase independence, decide when a client is Mild-Moderate?
   Use the screening tool.

5. If a client is stable regarding their primary diagnosis but are diagnosed with a substance use disorder (List C is checked), can they stay with provider?
   No- list C is specific to substance use disorders.

6. Can Language/Culture be added to the list?
   No, and cases may not be retained for that reason. If the consumer does not meet specialty mental health criteria the MCP's are expected to provide such services.

7. Can a case be retained if a client is screened to be Mild-Moderate but the MCP doesn't provide the most appropriate treatment model (e.g., needs home visits, needs Parent-Infant work)?
   No.

8. If a client has private insurance but is screened as Moderate-Severe, can we serve them?
   No, their private insurance is responsible for providing their mental health services.

9. Providers cannot always discern from the insurance look-up screen whether the insurance plan is private or Medi-Cal.
   If unsure about a specific case, call BHCS Provider Relations at 1-888-346-0605 to verify insurance eligibility.

10. What if the managed care plan screens a client as Mild-Moderate?
    They are required to provide services.

11. For children who receive Level 1 services, can their sibling with Mild-Moderate needs continue to be referred by ACCESS to the Level 1 program so that the family has just one provider?
    No, if Mild-Moderate, the sibling must be served by their MCP. However, ACCESS can continue to make a Level 1 referral if the sibling is screened as Moderate-Severe but not severe enough to require Level 1 services.

12. What if a provider is contracted with both BHCS & Beacon and a consumer needs to shift to Beacon to see the same provider?
    Call Beacon – they may want the provider to complete & submit a current Screening Tool, or they may just begin service authorization to the provider.

MH Assessment
Step 1 of the Golden Thread *continued*

- Must Assess for Substance Use in 7 Areas:
  - Tobacco, ETOH, Caffeine, CAM, Rx, OTC & Illicit Drugs
- Assess for Substance Use Disorders (SUD):
  - Document past and current use in record.
  - For children/adolescents also document the caregivers' use and impact upon the client.
- If appropriate establish SUD Diagnosis
  - Cannot be primary (FOCUS OF TX) Diagnosis
  - **May include in Client Plan—by addressing the underlying MH Dx's signs, Sx, and behaviors through the MH Objectives.**

MH Assessment
Step 1 of the Golden Thread *continued*

- Initial Assessment must be completed within 30 days* of the Episode Opening Date (EOD) *based on a soft count*.
- Annual Assessments after that must be completed within the 30 day* period prior to the first day of the Episode Opening Month (EOM).
  - *E.G.* Episode Opening Date (EOD) 8/28/14 and Assessment due by 9/27/14.
  - Annual Assessment must be completed in August 2015 and all required signatures must be obtained no later then 8/31/2015
- See Due Dates Chart

**For outpatient specialty MH services, see Clinical Doc Manual for exceptions: FSP, & time limited programs.*

Assessment & Plan Due Dates[i]

Episode Opening Month	Initial Assessment Due	Initial Plan Created, Signed, and Due in:	Annual Plan & Assessment Created And Signed In:
January	30 Days	60 Days	Dec.
February	30 Days	60 Days	Jan.
March	30 Days	60 Days	Feb.
April	30 Days	60 Days	March
May	30 Days	60 Days	April
June	30 Days	60 Days	May
July	30 Days	60 Days	June
August	30 Days	60 Days	July
September	30 Days	60 Days	Aug.
October	30 Days	60 Days	Sept.
November	30 Days	60 Days	Oct.
December	30 Days	60 Days	Nov.

MH Assessment
Step 1 of the Golden Thread *continued*

- A Licensed LPHA may: 1.) established a diagnosis, 2.) complete a MH Assessment, & 3.) sign a MH Assessment.

- A Waivered/Registered LPHA: 1.) may establish a diagnosis (with licensed LPHA co-signature), 2.) May complete a MH Assessment and 3.) may sign a MH Assessment.

- Graduate Students: 1.) may not establish a diagnosis*, 2.) may complete a MH Assessment and 3.) may sign a MH Assessment with a Licensed LPHA co-signature.
  - **May indicate in the Assessment that a diagnosis was previously made by a licensed LPHA within their program--if they indicate who made the Diagnosis, their LPHA designation (LMFT, MD, LCSW, etc.), and the date Dx was made.*

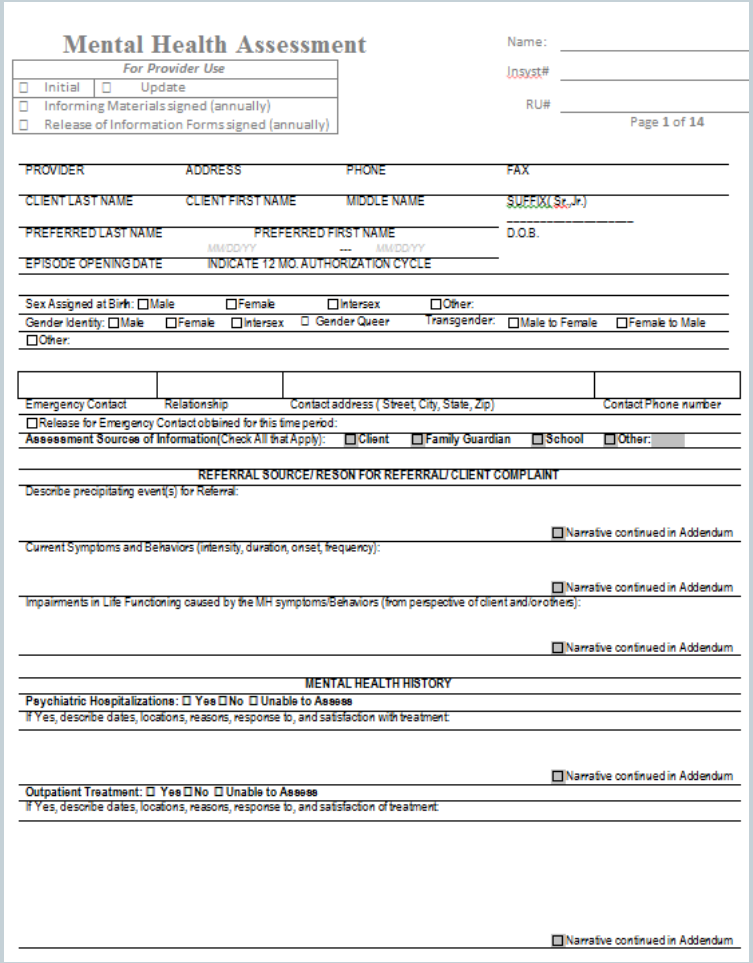
- An MHRS may ONLY gather demographic & client/family reported non-clinical assessment information.
  - Must enter information into the progress note, not into the assessment.
  - Note will generally indicate: *"Client/Family Member/Other reports _____."*

MH Assessment
Step 1 of the Golden Thread *continued*

- If information is gathered AFTER the initial assessment has been completed, an Assessment Update MUST be used instead of adding to the original Assessment
  - An Assessment Update should be used to update/confirm information on the original Assessment.
  - An Assessment Update may be documented in a Progress Note, or in a formal Addendum to the Assessment (recommended), and then incorporated into the next Annual Assessment.

M/C Compliant MH Assessment Form Templates

ACBHCS/Forms/ Clinical/Adult or Child/ Assessment http://www.acbhcs.org/providers/Forms/AdultForm.htm



Mental Health Assessment

Name: _____

Insyst# _____

RU# _____

Page 1 of 14

For Provider Use

☐ Initial ☐ Update

☐ Informing Materials signed (annually)

☐ Release of Information Forms signed (annually)

PROVIDER | ADDRESS | PHONE | FAX

CLIENT LAST NAME | CLIENT FIRST NAME | MIDDLE NAME | SUFFIX(Sr.,Jr.)

PREFERRED LAST NAME | PREFERRED FIRST NAME | D.O.B.

EPISODE OPENING DATE | INDICATE 12 MO. AUTHORIZATION CYCLE

Sex Assigned at Birth: ☐Male ☐Female ☐Intersex ☐Other:

Gender Identity: ☐Male ☐Female ☐Intersex ☐ Gender Queer Transgender: ☐Male to Female ☐Female to Male ☐Other:

Emergency Contact | Relationship | Contact address (Street, City, State, Zip) | Contact Phone number

☐Release for Emergency Contact obtained for this time period:

Assessment Sources of Information(Check All that Apply): ☐Client ☐Family Guardian ☐School ☐Other:

REFERRAL SOURCE/ RESON FOR REFERRAL/ CLIENT COMPLAINT

Describe precipitating event(s) for Referral:

☐Narrative continued in Addendum

Current Symptoms and Behaviors (intensity, duration, onset, frequency):

☐Narrative continued in Addendum

Impairments in Life Functioning caused by the MH symptoms/Behaviors (from perspective of client and/or others):

☐Narrative continued in Addendum

MENTAL HEALTH HISTORY

Psychiatric Hospitalizations: ☐ Yes ☐No ☐ Unable to Assess

If Yes, describe dates, locations, reasons, response to, and satisfaction with treatment:

☐Narrative continued in Addendum

Outpatient Treatment: ☐ Yes ☐No ☐ Unable to Assess

If Yes, describe dates, locations, reasons, response to, and satisfaction of treatment:

☐Narrative continued in Addendum

CANS / ANSA-T / ANSA

- **The CANS, ANSA-T, ANSA is completed after (or during) the MH Assessment and informs the Client Plan.**
  - **The CANS and ANSA-T is also completed at, or about 6 months after EOD (twice annually).**
- **CANS & ANSA-T Implementation Date: 9/1/15 (CFE discontinued for children/TAY)**
- **ANSA pending—continue using CFE**
- **ACBHCS Provider Website/CANS**
- http://www.acbhcs.org/providers/CANS/cans.htm

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?"

Client Plan
Step 2 of the Golden Thread continued

- **Treatment Plan Cycle:** Treatment Plans are due* Initially (within 60 calendar days of episode opening date—EOD is day 1) and on an annual basis. The cycle must be kept in sync with the Episode Opening Date (EOD).
- Every Treatment Plan after that would be due on a 12 month cycle, completed within the 30 day period prior to the first day of the EOD month.
  - Example: EOD 8/18/14, then the Initial Plan is due: 10/16/14
  - The 2nd treatment plan is due by 8/1/15 and to be completed no earlier than 7/1/15.

**For outpatient specialty MH services, see Clinical Doc Manual for exceptions: FSP, & time limited programs.*

Client Plan
Step 2 of the Golden Thread continued

- Providers *MUST* be attentive to the need to update changes in the treatment plan through-out the year. DHCS (and QA) will disallow notes if the treatment plan has not been updated to reflect new client goals, mental health objectives, and events in the client's life.
  - Examples of events requiring a change to the Treatment Plan include, but are not limited to: hospitalization, new thoughts or behaviors of self-harm or dangerousness to others, additions of new service modalities (i.e. case management or groups.)

Client Plan
Step 2 of the Golden Thread *continued*

Goals

- The Client **Goals** are the **long-term hopes** of the consumer and/or caregiver/parent . Goals should focus upon their personal vision of recovery, wellness, and the life they envision for themselves.
- You may include Long Term Mental Health Goals which support the Client Life Goals by linking them to the specific MH Objectives (see slides 44 – 68).
- Invaluable for client engagement and buy-in to services.
- Providers assist the client in developing the short term Mental Health objectives to his/her long term goal which are targets of interventions.

Client Plan
Step 2 of the Golden Thread *continued*

Mental Health Objectives

- A way to see if the CLIENT is improving
- Measurable change in helping the client achieve his/her long-term goals
  - Can address symptoms, behaviors or impairments identified in the Assessment
  - *Strength based MH objectives* replace problematic Sx with positive coping skills/behaviors/etc.
- Should be based upon the client's abilities and be meaningful to the client
  - What is he/she identifying as the problem? Why did he/she reach out for help?
- SMART (Specific, Measurable, Attainable, Realistic and Time-Bound)
- Important to look at how they might impact and build upon strengths and supports

Client Plan
Step 2 of the Golden Thread *continued*

Service Modalities

- Identify the proposed type(s) of service modalities to be provided along with a proposed frequency and duration.
- If the *planned* service modality for a claimed service is not in the client plan it must be disallowed.

Example:

Individual Psychotherapy 1x per week, or as needed, for 12 months;

Case Management 1x per month, or as needed, for 12 months;

Group Therapy 1x per week ("or as needed" probably not necessary here as all groups are scheduled), for 12 months.

Adding "as needed" to the frequency of the service modality allows flexibility in the scheduling—however "as needed" alone will not suffice for frequency of modality.

Client Plan
Step 2 of the Golden Thread *continued*

Detailed Interventions

For each service modality include a detailed description of interventions to be provided. See examples.

- Interventions must focus upon and address the identified functional impairments as a result of the mental disorder.
- Interventions must be consistent with the client plan mental health objectives and the qualifying diagnoses

Client Plan
Step 2 of the Golden Thread *continued*

Detailed Interventions (General enough to be inclusive, but specific enough to be illustrative) Examples:

- **Individual Rehab:**
  - *"Assist the client in re-engaging in pleasant activities and learning new ways of dealing with distress"*
  - *"Teach and reinforce active problem-solving skills in order to increase client's self-efficacy and improve his/her mood."*
  - *"Help the client to identify early warning signs of relapse, review skills learned during therapy, and develop a plan for managing challenges 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*

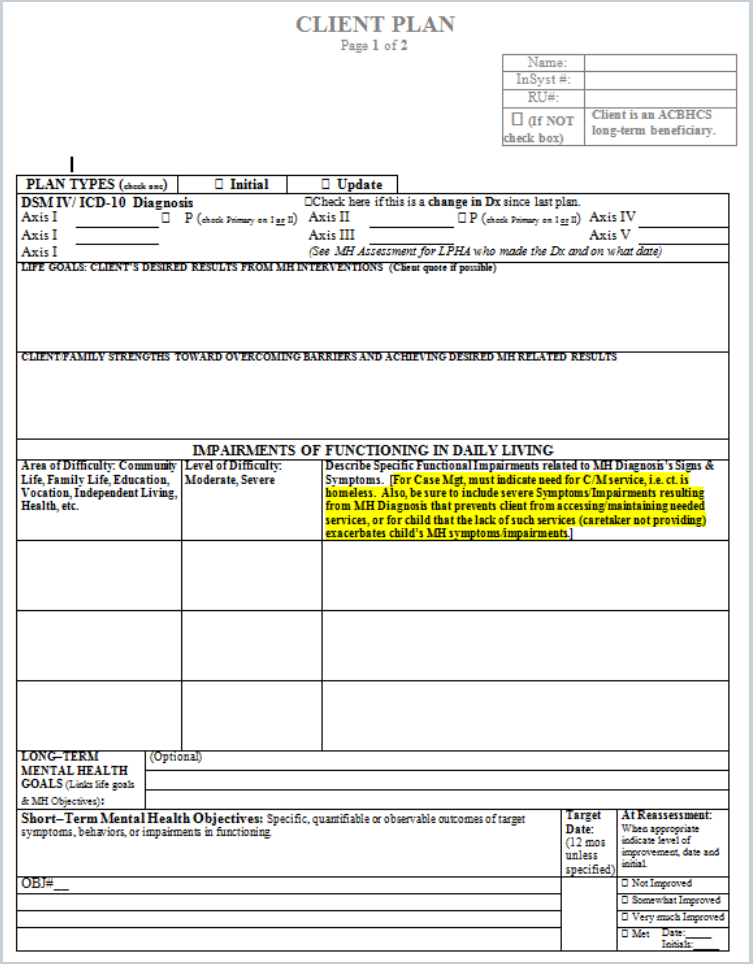
- Plans MUST be updated as client functioning improves or will likely deteriorate. Events such as a psychiatric hospitalization may trigger the need for a Plan Update.
  - **DHCS (per Jan. 2013 Triennial Audit) is now disallowing all claims after the date the Plan should have been updated.**
- All signatures are required on any addendum to a current Client Plan. (i.e. All required staff signatures & client/caretaker signature)

Client Plan
Step 2 of the Golden Thread *continued*

- If the client does not sign or refuses to sign the Client Plan, regular efforts must be attempted to obtain the client's approval.
  - Note the issue on the client signature line in the Client Plan with a reference to a Progress Note. Then elaborate in the Progress Note the rationale or reason why a signature was not obtained, and when the next attempt will occur.
  - **DHCS (per Jan. 2013 Triennial Audit) is now disallowing all notes after the date the Plan should have been signed by the Client and until all required signatures are obtained.**

M/C Compliant Client Plan Form Templates

ACBHCS/Forms/
Clinical/Adult or Child/
Plan
http://www.acbhcs.org/providers/Forms/AdultForm.htm



CLIENT PLAN

Page 1 of 2

Name:	
InSyst #:	
RU#:	
☐ (If NOT check box)	Client is an ACBHCS long-term beneficiary.

PLAN TYPES (check one)	☐ Initial	☐ Update

DSM IV/ ICD-10 Diagnosis ☐Check here if this is a **change in Dx** since last plan.

Axis I _____ ☐ P (check Primary on 1 or II) Axis II _____ ☐ P (check Primary on 1 or II) Axis IV _____

Axis I _____ Axis III _____ Axis V _____

Axis I *(See MH Assessment for LPHA who made the Dx and on what date)*

LIFE GOALS: CLIENT'S DESIRED RESULTS FROM MH INTERVENTIONS (Client quote if possible)

CLIENT/FAMILY STRENGTHS TOWARD OVERCOMING BARRIERS AND ACHIEVING DESIRED MH RELATED RESULTS

IMPAIRMENTS OF FUNCTIONING IN DAILY LIVING

Area of Difficulty: Community Life, Family Life, Education, Vocation, Independent Living, Health, etc.	Level of Difficulty: Moderate, Severe	Describe Specific Functional Impairments related to MH Diagnosis's Signs & Symptoms. [For Case Mgt, must indicate need for C/M service, i.e. ct. is homeless. Also, be sure to include severe Symptoms/Impairments resulting from MH Diagnosis that prevents client from accessing/maintaining needed services, or for child that the lack of such services (caretaker not providing) exacerbates child's MH symptoms/impairments.]

LONG–TERM MENTAL HEALTH GOALS (Links life goals & MH Objectives): (Optional)

Short–Term Mental Health Objectives: Specific, quantifiable or observable outcomes of target symptoms, behaviors, or impairments in functioning.	**Target Date:** (12 mos unless specified)	**At Reassessment:** When appropriate indicate level of improvement, date and initial.
OBJ#__		☐ Not Improved
		☐ Somewhat Improved
		☐ Very much Improved
		☐ Met Date:____ Initials:____

CLIENT PLAN

Name:	
InSyst #:	
RU#:	
☐ (If NOT check box)	Client is an ACBHCS long-term beneficiary.

PLAN TYPES (check one)	☐ Initial	☐ Update

DSM IV & ICD-10 Diagnosis ☐Check here if this is a **change in Dx** since last plan.

Axis I _____ ☐ P (check Primary on I or II) Axis II _____ ☐ P (check Primary on I or II) Axis IV _____

Axis I _____ Axis III _____ Axis V _____

Axis I _____ *(See MH Assessment for LPHA who made the Dx and on what date)*

LIFE GOALS: CLIENT'S DESIRED RESULTS FROM MH INTERVENTIONS (Client quote if possible)

CLIENT/FAMILY STRENGTHS TOWARD OVERCOMING BARRIERS AND ACHIEVING DESIRED MH RELATED RESULTS

IMPAIRMENTS OF FUNCTIONING IN DAILY LIVING

Area of Difficulty: Community Life, Family Life, Education, Vocation, Independent Living, Health, etc.	Level of Difficulty: Moderate, Severe	Describe Specific Functional Impairments related to MH Diagnosis's Signs & Symptoms. [For Case Mgt, must indicate need for C/M service, i.e. ct. is homeless. Also, be sure to include severe Symptoms/Impairments resulting from MH Diagnosis that prevents client from accessing/maintaining needed services, or for child that the lack of such services (caretaker not providing) exacerbates child's MH symptoms/impairments.]

LT MH GOALS (Links life goals & MH obj's):	(Optional)
DISCHARGE PLAN (readiness/timeframe/expected referrals/etc.):	

Short–Term Mental Health Objectives: Specific, quantifiable or observable outcomes of target symptoms, behaviors, or impairments in functioning.	**Target Date:** (12 mos unless specified)	**At Reassessment:** When appropriate indicate level of improvement, date and initial.
OBJ#___		☐ Not Improved
		☐ Somewhat Improved
		☐ Very much Improved
		☐ Met Date:_____ Initials:

Name:	
Insyst#:	
RU#:	

Short–Term Mental Health Objectives: Specific, quantifiable or observable outcomes of target symptoms, behaviors, or impairments in functioning.	**Target Date:** (12 mos unless specified)	**At Reassessment:** When appropriate indicate level of improvement, date and initial.
OBJ#___		☐Not Improved
		☐Somewhat Improved
		☐Very much Improved
		☐Met Date:_____ Initials:_____

Short–Term Case Management Objective: [After stating C/M Objective—i.e. client will access and participate in 3 of 4 scheduled housing support appointments, be sure to explicitly state that the successful outcome of C/M is expected to diminish the specified MH Sx's Impairments. I.E. Stable permanent housing will result in decrease of depression as indicated in (SMART) MH Obj #___.]		☐Not Improved
OBJ#___		☐Somewhat Improved
		☐Very much Improved
		☐Met Date:_____ Initials:_____

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:**

☐ **MEDICATION SERVICES** ☐ **OTHER:**_____ ☐ ICC ☐ IHBS

DESCRIBE SPECIFIC AND DETAILED INTERVENTIONS FOR EACH MODALITY:

Provider(s): (☑ ALL THAT APPLY)	**Detailed Intervention(s):**	**MODALITY:**
☐ Case Manager ☐ Clinician ☐ MD/NP/PA ☐ Peer ☐ Family Partner ☐ Other:_____		
☐ Case Manager ☐ Clinician ☐ MD/NP/PA ☐ Peer ☐ Family Partner ☐ Other:_____		
☐ Case Manager ☐ Clinician ☐ MD/NP/PA ☐ Peer ☐ Family Partner ☐ Other:_____		

Client/Conservator Signature
By signing, I agree that I have: 1) participated in the development of the Treatment Plan, and 2) have been offered a copy of the plan.

		DATE
CLIENT (IF NO SIGNATURE, PLEASE SEE PROGRESS NOTE DATED_____ FOR EXPLANATION & WHEN NEXT ATTEMPT WILL BE)		
GUARDIAN/PARENT (IF NO SIGNATURE, PLEASE SEE PROGRESS NOTE DATED_____ FOR EXPLANATION & WHEN NEXT ATTEMPT WILL BE)		
PROVIDER COMPLETING PLAN	INDICATE M/C CREDENTIAL	
LICENSED LPHA SUPERVISOR (IF NEEDED)	INDICATE M/C CREDENTIAL	
PSYCHIATRIST/ OTHER PRESCRIBER (REQUIRED WHEN PRESCRIBING)	INDICATE M/C CREDENTIAL	

Modifying Assessment, Tx Plan and PN for Case Management Services

- MH Assessment
  - Indicate areas of need regarding community supports (housing, vocational, educational, medical, SUD, etc.)
  - MH Impairments
  - Link that the client's inability to access and utilize needed community supports is due to their severe MH Impairments of Included Dx.
- Client Plan
  - MH Impairments which result in inability to access and utilize needed community supports.
  - MH objectives
  - Case Management Objectives—which must include which specific MH objectives will be met (improved functioning) when client successfully accesses/utilizes that specific community support.

Modifying Assessment, Tx Plan and PN for Case Management Services

- Progress Note
  - Identify which MH objective that this Case Management service is targeting for improvement. (Indicate number—best to also include statement as well…i.e., client's successful participation in _____ service will result in a decrease in _____ symptoms and an increase in _____ adaptive functioning [per MH Objective(s)].
  - Modifying the B/PIRP Format for case mgt
    - "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.)*

MH Plan Example #1:
Impairment: Inability to maintain housing/placement

Billable example:

- **Dx: Major Depressive DO (lack of interest in all areas of life, low energy, insomnia, indecisiveness, feelings of worthlessness, and poor self-care)**
- **Impairments include Client's inability to follow through with housing support services due to his severe symptoms of Major Depression**
- **Goals: Client states: "I want my own place to live".**
- **Long Term MH Goal: Decrease depression symptomology, and increase coping, so that client's depressive signs and symptoms do not negatively impact his ability to obtain housing. AND, securing housing is expected to reduce client's depressive symptoms of anergy, insomnia, indecisiveness, feelings of worthlessness and poor self-care.**

MH Plan Example #1: Impairment: Inability to maintain housing/placement cont.

Billable example cont.:

Mental Health Objective(s):

- **#1) Client's depressive symptoms are reduced as evidenced by an increase in sleep from 2-3 hours per night to 6-8 hours per night by 6 months; and an increase in energy from 0 energy now to 6-8 on a 0-10 scale (10 being high energy) per self-report by 6-12 months.**
- **#2) Client is engaged and invested in his self-care as evidenced by increased # of showers per week from 0 to 2 or more; and increased brushing of teeth from 0x daily to once daily within the next 6-12 months.**
- **#3) Client's lack of interest and indecisiveness will decrease as evidenced by an increase in action steps taken by client towards obtaining stable housing from 0 to 4 or more action steps taken within the next 3-12 months. *(This is example of MH symptoms resulting in a housing impairment.)***

MH Plan Example #1:
Impairment: Inability to maintain housing/placement cont.

Billable example cont.:

- **Required Case Management documentation elements include:**
  - **Case Management services are short term (generally 3 – 6 months, if longer is anticipated as a possibility indicate both the minimum and maximum duration—i.e. 6 – 12 months).**
  - **Careful documentation:**
    - **Clients' severe depressive MH impairments results in inability to self-refer and effectively follow-through with needed housing, medical, SUD, educational, and vocational services. (must indicate each needed service specifically).**
    - **Securing housing (or indicated specific service) is expected to reduce client MH impairments (specify—see MH Objectives #___).**

MH Plan Example #1:
Impairment: Inability to maintain housing/placement cont.

Billable example cont.:

- **Service Modality:**
  - Psychotherapy 1x/week, or as needed, for 1 year;
  - Case Management 1x/week, or as needed, 6 – 12 months;
  - Group Rehab 1x/week for 6 months

- **Detailed Interventions:**
  - Psychotherapy – CBT to help client link feelings of worthlessness to depressive symptoms, to explore roots of low self-esteem and areas of competence.
  - Group Rehab – build client's awareness to track and manage depressive symptoms, teach coping skills such as relaxation techniques, and build client's self-care skills.
  - Case Management – Link and monitor/provide support to client to maintain any needed housing services. **Success in achieving housing is expected to decrease depressive symptomology and increase coping abilities.**

MH Plan Example #1: Impairment: Inability to maintain housing/placement cont.

***Non-billable* example:**

- **Mental Health Objective:** Client will obtain stable housing within 6 months; temporarily living with a friend.
- **Service Modality:** Case management 1x/week or as needed for 1 year
- **Detailed Interventions:** Case management - Case manager will work with client to apply for housing and assist client in filling out necessary forms. ***[Case mgt is not acting as a housing support specialist—but is linking to and monitoring client's participation in such services.]***

MH Plan Example #3: Impairment: Cocaine dependence and abuse

Billable example:

- **Included M/C Dx & Impairments: Schizophrenia, Paranoid Type—Paranoid delusions, paranoid auditory hallucinations with negative symptoms of flat affect, poor planning and follow-through, social withdrawal, amotivational and neglect of personal hygiene.**
- **Impairments: delusions, poor planning & follow-through prevent client from accessing and successfully participating in SUD tx (required for C/M).**
- **Goal: Client states: "To stop using cocaine and landing in the hospital."**
- **Long Term MH Goal: Prevent Psych Decompensation which usually leads to coping with paranoia by using cocaine, which then often results in psychiatric hospitalizations. Successful participation in SUD tx is expected to decrease client's delusions, flat affective and paranoia.**

MH Plan Example #3: Impairment: Cocaine dependence and abuse cont.

Billable example cont.:

Mental Health Objectives:

- **#1) Client will identify paranoid ideation when it arises 3 out of 4 times/week (currently 0 of 4 x per week) over the next 3-12 months.**
- **#2) Client will learn 3 – 4 alternative coping skills (currently 1) to manage paranoid symptoms when they arise over the next 6-12 months.**
- **#3) Client will increase the number of times she uses the 3 – 4 learned alternative healthy coping skills in response to paranoid thoughts from 0 x per day to 3 x per day, as reported by client, within the next 6-12 months.**

MH Plan Example #3: Impairment: Cocaine dependence and abuse cont.

Billable example cont.:

Case Management Objectives:

- **Client will connect with Substance Use Disorders Treatment and maintain participation to decrease using illicit substances in response to symptoms of his psychiatric condition as evidenced by attending 8 out of every 10 scheduled SUD treatment activities (currently 0) over the next 12 months. Successful engagement in SUD treatment is expected to result in decreased paranoia and improved coping skills (MH Objectives # 1, 2, & 3).**

MH Plan Example #3: Impairment: Cocaine dependence and abuse cont.

Billable example cont.:

- **Service Modality:**
  - Individual Rehabilitation 1 time per week, or as needed, for the next 12 months and
  - Group Rehabilitation 1x per week for the next 12 months.
  - Case Management 1x per week, or as needed, for the next 3 – 12 months.

- **Detailed Interventions: Utilize skill building to:**
  - Rehab (Ind & Group):
    - **Increase client's reality testing by helping client identify paranoid thoughts and his reactions. –Assist client to identify behaviors that have led to hospitalization and teach client about alternative behaviors.**
    - **Teach and practice with client relaxation techniques, social skills, and other alternative coping strategies to be used in response to paranoid thoughts.**
  - Case Management: Link client to, and monitor/provide support for on-going participation in Substance Use Disorder Treatment **which will decrease mental health paranoid symptomology and increase positive coping strategies.**

MH Plan Example #3: Impairment: Cocaine dependence and abuse.

Non-billable example:

- **Mental Health Objective**: Decrease client's use of cocaine from daily to 0 xs per week as reported by client over the next 12 months.
- **Service Modality**: Individual Rehabilitation
- **Detailed Interventions**: Provide psycho-education on substance use. Teach relapse prevention techniques. Help client monitor use of cocaine. ***[Ind Rehab is not acting as a SUD Counselor but is providing skill building in decreasing MH symptomology which will likely support client's participation in SUD treatment.]***

MH Plan Example #5: Child 0-5

Billable example:

- **Included M/C Dx: Reactive Attachment Disorder of Infancy or Early Childhood, Inhibited Type** – fails to initiate and respond in a developmentally appropriate way to social interactions; avoids eye contact, doesn't smile, doesn't reach out to be picked up, rejects efforts to calm, sooth, or connect, cries inconsolably, isn't interested in interactive play.
- **Impairments** and symptoms are exacerbated by an unstable environment due to housing problems, sporadic medical care, and ineffective parenting strategies.
- **Goal:** Mother states "I want my child to be a normal child, love me, and stop crying".
- **Long Term MH Goal:** decrease client's symptomology, e.g. crying, inappropriate or lack of social responses, avoidance, etc., and increase appropriate social responses and bonding so that client can form an attachment and respond to mother.

MH Plan Example #5: Child 0-5 cont.

Billable example cont.:

Mental Health Objectives:

- #1) The frequency that the client cries inconsolably will decrease from 10x to 2x per day in the next 6-12 months.
- #2) The frequency that the client will reach out to be picked up will increase from 0x to 5x per day in the next 6-12 months.
- #3) Client will be calmed or soothed when crying or upset 2 out of 3 times (current 0x) in the next 6-12 months.

MH Plan Example #5: Child 0-5 cont.

Billable example cont.:

- **Service Modality:**
  - *Family Psychotherapy* 1x per week, or as needed for 12 months,
  - *Collateral services* with caretakers monthly or as needed for 9 - 12 months.
- **Detailed Interventions:**
  - *Family Psychotherapy* – Dyadic interventions w mother and client to help mother read, interpret, and respond to client's cues; model and facilitate practice of effective bonding and attachment activities; model and facilitate practice of effective soothing techniques; assess and work with mother to create a stable and consistent environment for the client to ensure physical safety and promote client's sense of safety.
  - *Collateral*– Link clt's mother to, and monitor/provide support for on-going participation in: parenting skills classes, medical services for the client, and housing resources. Mother's utilization of such support services will stabilize the ct's home environment resulting in a decrease in the child's MH symptomology (as described above) of Reactive Attachment Disorder.

MH Plan Example #5: Child 0-5 cont.

Non-billable example:

- **Mental Health Objectives:** Client's mother will secure stable housing in the next 6 months; client's mother will attend parenting classes 1x per week for the next 12 months; client's mother will learn and practice 3 soothing techniques with client per day in the next 12 months. ***[These are not the client's MH Objectives.]***
- **Service Modality:** *Family Psychotherapy* 1x per week, or as needed for 12 months; *Case Management/Brokerage services* monthly or as needed for 12 months ***[Cannot provide Case Mgt Services to Caretaker—only Collateral]***.

MH Plan Example #5: Child 0-5 cont.

Non-billable example cont:

- **Detailed Interventions:** *Family Psychotherapy* – Dyadic interventions w mother and client to help mother read, interpret, and respond to client's cues; model and practice affective bonding and attachment activities; model and practice effective soothing techniques; assess and create a stable and consistent environment with mother to ensure physical safety and sense of safety of client. NOTE: while these family psychotherapy interventions are the same in the billable example, this example becomes non-billable due to the mental health objectives. Also, non-billable: *Case management/Brokerage* – case manager will research and fill out housing applications for the client's mother (rather than link and monitor progress).

Progress Notes
Step 3 of the Golden Thread

- Always indicate which (#) MH Objective is being addressed.
- B/PIRP Format (document that service date's): ***(Also, See Handout.)***
  - **B**ehavior/Assessment, **P**urpose/**P**roblem
    - B/P = Documents what is presently going on with the client (brief narrative)
  - **I**ntervention by Staff,
    - I = Identifies what you did today (i.e., what intervention was provided toward the mental health objectives)
  - **R**esponse of Client to Intervention,
    - R = Identifies client's response today toward the interventions and progress toward his/her objectives, and
  - **P**lan for future services
    - P = Provides plan for continued services i.e. collaterals, coordination of care, continue with CBT techniques etc. Can include any follow up by the provider or client.

Progress Notes
Step 3 of the Golden Thread *continued*

Quality of Writing

- Concise
- Clear
- Cohesive
- Reader-centered
- Written in language anyone can understand
- Legible-including legible signatures (highly recommend using *Provider Signature Sheet* in each chart—see attached)
- Signatures require M/C Credential
- Only uses ACBHCS abbreviations
  - **(See ACBHCS Abbreviations Handout)**

Always keep in mind that the Clinical Record belongs to, and is about, the client!

Sample Provider Signature Sheet

F.Y.I.

NAME	AGENCY POSITION TITLE	MEDI-CAL CREDENTIAL	SIGNATURE REQUIRES M/C CREDENTIAL
BETTY TSU	PHYSICIAN	MD	B Tsu, MD
IRMA CALLOWAY, BS	MENTAL HEALTH SPEC.	MHRS	Irma, Calloway, MHRS
HENRY BAR-SMITH	MH CLIN SPEC	PSYD-W	H Bar-Smith, PsyD-Waivered
GENOVEVA MARTINEZ, PhD	MENTAL HEALTH SPEC.	MHRS (Has PhD but not licensed or waivered.)	Genoveva, Calloway, MHRS
JANEY MILLER	PEER COUNSELOR	ADJUNCT STAFF	J Miller, Adjunct Staff
BOB JONES	FAMILY SPECIALIST	ADJUNCT STAFF	B Jones, Adjunct Staff
DANIELLE BOGGEMAN, MS	STUDENT TRAINEE	TRAINEE	D Boggeman, Trainee
DREW MANUEL	NURSE	LVN	D Manuel, LVN
ROBERT ALMANZA	ADV PRACTICE NURSE	NP	R Almanza, NP
JAMIE LEONARD	MH SPECIALIST	MHRS	J Leonard, CADC, MHRS
TANIKA WILLIAMS	MH CLINICIAN	MFT	T Williams, MFT

Medi-Cal Credentials: Every signature in chart must indicate one of these. *(In addition, may also indicate designations from pg #1*	**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 NCAA-Certified or NCAA-Registered for AOD)

Progress Notes
Step 3 of the Golden Thread *continued*

- Progress Notes:
  - Must be linked/connected to a MH objective on the Client Plan
  - Should completed within one working day, and must be designated as "late note" after 5 working days. Completion requires finalization of all required signatures.
  - Must Be done prior to submission of a claim
  - May combine different types of services e.g., combining individual rehab and collateral in a single note (indicate service code for the predominant service).
    - *Alert, Claim to the lowest paid service (ie. Case Management), or if all services are claimed at the same rate—claim to the predominant service.*

Procedure Codes

Key things to ask yourself when choosing a Procedure Code

- ***(See ACBHCS Procedure Code Handout, Scope of Practice Handout, and MH Service Definitions & Examples.)***
- *"Does the Procedure Code reflect what is written in the Progress Note?"*
- *"Who was the service directed to/at?"*
  - Interaction with any other person (in-person or telephone) constitutes face-to-face time.

Alameda County Behavioral Health Care Services Agency
InSyst Procedure Code Table as of June 2015

InSyst Proc Code		Cpt Code Medicare/Inv	HCPCS CODE Medi-Cal	E/M	Actual Time	SFC	MD DO	Lic Ph D	PA	Nurse Pract	CL Nurse Spec	Nurse	LCSW	MFT	LPCC	LPCC uFam	PhD Intern	Intern	RHB Coun	Unlic	Req Serv Loc
121	PHF Contract Day		H2013			20-29	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
141	Crisis Residential Day		H0018			40-49	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
165	Adult Residential Day		H0019			65-79	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
221	Crisis Stabilization		S9484			20-24	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
281	Day Care Intens Half Day		H2012			81-84	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
282	Day Care Intens AB3632 Half		H2012			81-84	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
285	Day Care Intens Full Day		H2012			85-89	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
286	Day Care Intens Full-AB3632		H2012			85-89	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
291	Day Care Rehab Half Day		H2012			91	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
292	Day Care Rehab Half-AB3632		H2012			91	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
295	Day Care Rehab Full Day		H2012			95	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
296	Day Care Rehab Full-AB3632		H2012			95	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
310	Collateral-Caregiver		H2015			10	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
311	Collateral		H2015			10	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
317	Collateral Family Group		H2015			10	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
498	Therapeutic Behavioral Svcs		H2019			58	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
571	Brokerage Services		T1017			01-08	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
581	Plan Development		H0032			30	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
	EVALUATION																				
323	90791 Psychiatric Diag Eval (Assessment)	90791***	H2015			30	X	X	X	X	X		X	X	X	X	X	X	X	X	
565	90792 Psychiatric Diag Eval w/medical	90792***	H2015	X		60	X		X	X	X										
325	90889 Psy Diag Eval (non face/face)	90889	H2015			30	X	X	X	X	X		X	X	X	X	X	X	X	X	
324	90791 Behavioral Eval (CFE,ANSA,CANS)	90791***	H2015			30	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
326	90889 Behav Eval (CFE,ANSA,CANS non face/f	90889	H2015			30	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
	REHAB																				
381	Individual Rehabilitation	H2017**	H2017			40	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
391	Group Rehabilitation	H2017**	H2017			50	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
	THERAPY																				
441	90832 Psychotherapy 30 min	90832***	H2015		16-37	40	X	X	X	X	X		X	X	X	X	X	X			
465	90833 + Psy Thpy with E/M 30 min	90833***	H2010	X	16-37	60	X		X	X	X										
442	90834 Psychotherapy 45 min	90834***	H2015		38-52	40	X	X	X	X	X		X	X	X	X	X	X			
467	90836 + Psy Thpy with E/M 45 min	90836***	H2010	X	38-52	60	X		X	X	X										
443	90837 Psychotherapy 60 min	90837***	H2015		53>	40	X	X	X	X	X		X	X	X	X	X	X			
468	90838 + Psy Thpy with E/M 60 min	90838***	H2010	X	53>	60	X		X	X	X										
413	90846 FAMILY PSYCH W/O PATIENT	90846	H2015			10	X	X	X	X	X		X	X		X	X	X			
449	90847 FAMILY PSYCH W/ PATIENT	90847	H2015			40	X	X	X	X	X		X	X		X	X	X			
	GROUP THERAPY																				
455	90849 MULTIFAMILY GRP PSYCH	90849	H2015			50	X	X	X	X	X		X	X		X	X	X			
456	90853 GROUP PSYCHOTHERAPY	90853***	H2015			50	X	X	X	X	X		X	X	X	X	X	X			
	CRISIS INTERVENTION																				
377	90839 Crisis Thpy 60 min	90839**	H2011		30-75	70	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
378	90840 + Crisis Thpy ADD 30 min	90840**	H2011		16-45	70	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
690	90839 CCRP Mobile Crisis 60min (county only)	90839	H2011		30-75	70-78	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
	E & M																				

Alameda County Behavioral Health Care Services Agency
InSyst Procedure Code Table as of June 2015

InSyst Proc Code		CPT Code Medicare/Inr	HCPC CODE Medi-Cal	E/M	Actual Time	SFC	MD DO	Lic Ph D	PA	Nurse Pract	CL Nurse Spec	Nurse	LCSW	MFT	LPCC	LPCC uFam	PhD Intern	Intern	RHB Coun	Unlic	Req Serv Loc
472	99342 E/M HOME NEW EXPAND 30M	99342	H2010	X	26-37	60	X		X	X	X										4
473	99343 E/M HOME NEW DETAIL 45M	99343	H2010	X	38-52	60	X		X	X	X										4
474	99344 E/M HOME NEW COMPRE 60M	99344	H2010	X	53-67	60	X		X	X	X										4
475	99345 E/M HOME NEW COMPLEX 75M	99345	H2010	X	68>	60	X		X	X	X										4
476	99347 E/M HOME EST PROBFOC 15M	99347	H2010	X	1-20	60	X		X	X	X										4
477	99348 E/M HOME EST EXPAND 25M	99348	H2010	X	21-32	60	X		X	X	X										4
478	99349 E/M HOME EST DETAIL 40M	99349	H2010	X	33-50	60	X		X	X	X										4
479	99350 E/M HOME EST COMPLEX 60M	99350	H2010	X	51>	60	X		X	X	X										4
545	99201 E/M NEW OFC SIMPLE 10 MIN	99201*	H2010	X	1-15	60	X		X	X	X										
546	99202 E/M NEW OFC EXP 20 MIN	99202*	H2010	X	16-25	60	X		X	X	X										
547	99203 E/M NEW OFC DETAIL 30 MIN	99203*	H2010	X	26-37	60	X		X	X	X										
548	99204 E/M NEW OFC COMPRE 45 MIN	99204*	H2010	X	38-52	60	X		X	X	X										
549	99205 E/M NEW OFC COMPLEX 60MIN	99205*	H2010	X	53>	60	X		X	X	X										
641	99211 E/M EST OP SIMPLE 5MIN	99211	H2010	X	1-7	60	X		X	X	X										
643	99212 E/M EST OP PROBFOCUS 10MIN	99212	H2010	X	8-12	60	X		X	X	X										
644	99213 E/M EST OP EXPANDED 15MIN	99213	H2010	X	13-20	60	X		X	X	X										
645	99214 E/M EST OP MOD COMPL 25M	99214	H2010	X	21-32	60	X		X	X	X										
646	99215 E/M EST OP HIGHCOMPL 40M	99215	H2010	X	33>	60	X		X	X	X										
650	99306 SNF E/M INIT HGHCOMP 45M	99306	H2010	X	41>	60	X		X	X	X										23
653	99307 SNF SUB E&M STRAIGHTFWD 10	99307	H2010	X	1-12	60	X		X	X	X										23
654	99308 SNF SUB E&M LOW COMPLEX 15	99308	H2010	X	13-20	60	X		X	X	X										23
655	99309 SNF SUB E&M MODERATE COM 25	99309	H2010	X	21-30	60	X		X	X	X										23
656	99310 SNF SUB E&M HIGH COMPLEX 35	99310	H2010	X	31>	60	X		X	X	X										23
657	99304 SNF E/M INIT LOWCOMP 25M	99304	H2010	X	1-30	60	X		X	X	X										23
658	99305 SNF E/M INIT MODCOMP 35M	99305	H2010	X	31-40	60	X		X	X	X										23
660	99324 E/M BRDCAR NEW PROBF 20M	99324	H2010	X	1-25	60	X		X	X	X										24
661	99325 E/M BRDCAR NEW EXPD 30M	99325	H2010	X	26-37	60	X		X	X	X										24
662	99326 E/M BRDCAR NEW DETAIL 45	99326	H2010	X	38-52	60	X		X	X	X										24
663	99327 E/M BRDCAR NEW COMPR 60M	99327	H2010	X	53-67	60	X		X	X	X										24
664	99328 E/M BRDCAR NEW COMPX 75M	99328	H2010	X	68>	60	X		X	X	X										24
665	99334 E/M BRDCAR EST PROBF 15M	99334	H2010	X	1-20	60	X		X	X	X										24
666	99335 E/M BRDCAR EST EXPD 25M	99335	H2010	X	21-32	60	X		X	X	X										24
667	99336 E/MBRDCAR EST DETAIL 40M	99336	H2010	X	33-50	60	X		X	X	X										24
668	99337 E/M BRDCAR EST COMPX 60M	99337	H2010	X	51>	60	X		X	X	X										24
	MEDICATION																				
367	Medication Training & Support (non face/face)	H0034**	H0034			60	X		X	X	X										
369	Medr Mgmt by RN LVN Only	H2010**	H2010			60						X									
	TESTING																				
535	96111 EXT DEV TEST INTERP RPT	96111	H2015			30	X	X	X	X	X		X	X	X	X	X	X			
415	96101 PSYCH TESTING	96101	H2015			30	X	X	X	X	X		X	X	X	X	X	X			
417	96118 NEUROPSYCH TESTING	96118	H2015			30	X	X	X	X	X		X	X	X	X	X	X			
	Katie A																				
557	INT HOME-BAS SRV KATIE A (IHBS)		H2015			57	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
577	INTEN CARE CORD KATIE A (ICC)		T1017			07	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
491**	90785 + INTERACTIVE COMPLEXITY	90785	H2015			30	X	X	X	X	X		X	X	X	X	X	X			

ACBHCS Guidelines for Scope of Practice Credentialing

SERVICE ACTIVITY * Requires co-signature by licensed LPHA. ** InSyst Discipline Designation. # Cannot provide Dx—may indicate with source. ^ Diagnosis may be made but must be co-signed by licensed LPHA. + May bill for Assessment—but can only gather and provide assess info.—not write the assessment ~ Licensed co-signatures not required, but recommended. = If within scope of practice and with appropriate training and experience. > Must meet MHRS or Adjunct criteria. < Must meet AOD Counselor criteria.	**LICENSED PRACTITIONER OF THE HEALING ARTS (LPHA)** (Same as below**) *PhD-Licensed, PsyD-Licensed, LCSW, LMFT, LPCC* *LPCC-F (with Family Tx: 6 semester units or 9 quarter units of MFT related education and 500 hrs of documented supervised experience working directly with families- or is gaining such experience under the supervision of an LMFT or LPCC-F)*	**MEDICAL PROVIDERS** (Same as below**) *MD, DO, PA* ***Advanced Practice Nurses (APN):*** *NP, CNS, APN Student Interns (with appropriate training, experience and required co-signatures).*	**NURSING** (Nurse**) *RN, LVN, Psych Tech*	**UNLICENSED LPHA** (Intern**) *PhD-Waivered, PsyD-Waivered, MFT-Intern, ASW, PCC-Intern (may perform family therapy services if under the supervision of a LMFT or LPCC-F)*	**GRADUATE TRAINEE / STUDENT** (Intern**) *Students in educational Mental Health programs granting an MSW, MA, MS, or PhD/PsyD degree.* *May have existing: AA, AS, BA, BS, MA, MS*	**MENTAL HEALTH REHAB SPECIALIST** (RHB Counselor**) *(Degree + MH experience): (1) AA, AS + 6yr (2) BA, BS + 4yr (3) MA, MS, PHD, PSYD+2yr but not waivered or registered with Board.* *Co-signatures highly recommended.*	**ADJUNCT STAFF** (Unlicensed Staff**) *The Agency or Program must document qualifications, provide supervision, and ensure staff works within scope of ability.* *Co-signatures highly recommended* *May indicate: PSR, Peer Specialist, Family Partner*	**AOD COUNSELOR** (Unlicensed Staff**) *NCAA accredited organizational certification or registration:* *CAADE: CATC, AAHCPAD: CAS, CADTP: CAODS, CCAPP*
Assessment	Yes	Yes	No	Yes ^	Yes # *	Yes +=	Yes +=	>
Evaluation (CFE only)	Yes	Yes	Yes	Yes	Yes *	Yes = ~	Yes = ~	>
Plan Development	Yes	Yes	Yes	Yes	Yes *	Yes = *	Yes = *	>
Rehab (Ind / Group)	Yes	Yes	Yes	Yes	Yes *	Yes = ~	Yes = ~	>
Therapy (Ind / Family/Grp)	Yes	Yes	No	Yes	Yes *	No	No	>
Collateral	Yes	Yes	Yes	Yes	Yes *	Yes = ~	Yes = ~	>
Medication Services E/M	No	Yes	No	No	No	No	No	>
Psychological Testing	Yes =	Yes =	No	Yes =	Yes=*	No	No	>
Crisis Therapy	Yes	Yes	Yes=	Yes =	Yes *	Yes = ~	Yes = ~	>
C/M: Brokerage/Linkage	Yes	Yes	Yes	Yes	Yes*	Yes = ~	Yes = ~	>
Med Svcs RN/LVN/PT Only	No	No	Yes	No	No	No	No	>
Drug/Alcohol Medi-Cal	Yes	Yes for MD/DO	Yes	Yes	Yes	<	<	Yes

ACBHCS Guidelines for Scope of Practice Credentialing

SERVICE ACTIVITY * Requires co-signature by licensed LPHA. ** InSyst Discipline Designation. # Cannot provide Dx—may indicate with source. ^ Diagnosis may be made but must be co-signed by licensed LPHA. + May bill for Assessment—but can only gather and provide assess info.—not write the assessment ~ Licensed co-signatures not required, but recommended. = If within scope of practice and with appropriate training and experience. > Must meet MHRS or Adjunct criteria. < Must meet AOD Counselor criteria.	LICENSED PRACTITIONER OF THE HEALING ARTS (LPHA) (Same as below**) *PhD-Licensed, PsyD-Licensed, LCSW, LMFT, LPCC* *LPCC-F (with Family Tx: 6 semester units or 9 quarter units of MFT related education and 500 hrs of documented supervised experience working directly with families- or is gaining such experience under the supervision of an LMFT or LPCC-F)*	MEDICAL PROVIDERS (Same as below**) *MD, DO, PA* ***Advanced Practice Nurses (APN):*** *NP, CNS, APN Student Interns (with appropriate training, experience and required co-signatures).*	NURSING (Nurse**) *RN, LVN, Psych Tech*	UNLICENSED LPHA (Intern**) *PhD-Waivered, PsyD-Waivered, MFT-Intern, ASW, PCC-Intern (may perform family therapy services if under the supervision of a LMFT or LPCC-F)*	GRADUATE TRAINEE / STUDENT (Intern**) *Students in educational Mental Health programs granting an MSW, MA, MS, or PhD/PsyD degree.* *May have existing: AA, AS, BA, BS, MA, MS*	MENTAL HEALTH REHAB SPECIALIST (RHB Counselor**) *(Degree + MH experience):* *(1) AA, AS + 6yr* *(2) BA, BS + 4yr* *(3) MA, MS, PHD, PSYD+2yr but not waivered or registered with Board.* *Co-signatures highly recommended.*	ADJUNCT STAFF (Unlicensed Staff**) *The Agency or Program must document qualifications, provide supervision, and ensure staff works within scope of ability.* *Co-signatures highly recommended* *May indicate: PSR, Peer Specialist, Family Partner*	AOD COUNSELOR (Unlicensed Staff**) *NCAA accredited organizational certification or registration:* *CAADE: CATC, AAHCPAD: CAS, CADTP: CAODS, CCAPP*
Assessment	Yes	Yes	No	Yes ^	Yes # *	Yes +≈	Yes +≈	>
Evaluation (CFE only)	Yes	Yes	Yes	Yes	Yes *	Yes = ~	Yes = ~	>
Plan Development	Yes	Yes	Yes	Yes	Yes *	Yes = *	Yes = *	>
Rehab (Ind / Group)	Yes	Yes	Yes	Yes	Yes *	Yes = ~	Yes = ~	>
Therapy (Ind / Family/Grp)	Yes	Yes	No	Yes	Yes *	No	No	>
Collateral	Yes	Yes	Yes	Yes	Yes *	Yes = ~	Yes = ~	>
Medication Services E/M	No	Yes	No	No	No	No	No	>
Psychological Testing	Yes =	Yes =	No	Yes =	Yes=*	No	No	>
Crisis Therapy	Yes	Yes	Yes=	Yes =	Yes *	Yes = ~	Yes = ~	>
C/M: Brokerage/Linkage	Yes	Yes	Yes	Yes	Yes*	Yes = ~	Yes = ~	>
Med Svcs RN/LVN/PT Only	No	No	Yes	No	No	No	No	>
Drug/Alcohol Medi-Cal	Yes	Yes for MD/DO	Yes	Yes	Yes	<	<	Yes

Mental Health Service Definitions & Examples v.8.11.15

(Also see ACBHCS InSyst Procedure Code Table)

Case Management
Service Code 571

Service Definition:
Case Management is usually an *as needed service* that assists an individual to access needed medical, educational, social, prevocational, rehabilitative, or other community services. The service activities may include communication, coordination, and referral (linkage); monitoring service delivery to ensure individual access to services and the service delivery system; and monitoring of the individual's progress. The reason why the client requires the service being accessed needs to be documented in the record—that is why they cannot do it themselves. The reason must be related to their mental health condition and resultant impairments.

What it is:

- Specific services to connect a client with needed services such as medical care, schools, Boys & Girls club, support groups, residential programs, vocational/housing programs, substance use treatment, etc.
- Making sure client is able to receive services from other providers and there are no barriers.
- Monitoring progress to insure that services actually are helpful.

Treatment Plan Case Management Objective Should Describe:

- *Identify the realm of community resources that are being addressed: i.e. housing or substance abuse, etc. Then document:*
    1. *The reason why the client requires the service being accessed needs to be documented in the Client Plan*
    2. *A description that justifies why client requires the clinician's assistance to access the needed service, i.e., why can't they do it themselves? The reason(s) need to be related to their mental health condition. This needs to be documented in the Client Plan.*
    3. *Address if Case Management services will include linkage and/or monitoring.*

Progress Notes Should Describe:

- *The reason why the client requires the service being accessed needs to be documented in the record, and ideally documented in each note.*
- *A description that justifies why the client requires the clinician's assistance to access the needed service, i.e., why can't they do it themselves? The reason(s) need to be related to their mental health condition. This needs to be documented in the record, and ideally documented in each note.*

- *Describes the progress (monitoring) in a residential program or other service setting that the individual was placed in or referred to.*

Example Interventions:

1. Client would like a job. Client's paranoia prevents client from setting up appointment with Job Coach. Arranged for job coach familiar with client's mental health conditions to assist client with employment.
2. Client would like to attend College. Client's depression makes it difficult to be motivated to sign-up for classes. Assisted the client to make connection to Disabled Student Services to assist with enrollment and supports at community college.
3. Client's behaviors of arguing with peers (symptom of their diagnosis) results in difficulties with their placement. Monitored the effectiveness of interventions by residential treatment provider and insured client objectives are addressed.

Scope of Practices that may provide Case Management services:

- All (LPHA[1], Medical Providers[2], Nurses[3], Unlicensed LPHA[4], Graduate Trainee/Student[5], Mental Health Rehabilitation Specialists[6] & Adjunct Staff[7]).
- *For additional information, and requirements, see the ACBHCS Guidelines for Scope of Practice Credentialing document.*

Procedure Codes continued

- **323-90791– Face to Face Psychiatric Diagnostic Evaluation**
  (Initial & Reassessment performed by LPHA, & trainee—limited as no Dx allowed.)

  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.)

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

- Reporting Psychiatric Diagnostic Procedures
  - 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).
  - Cannot be reported with an E/M code on same day *by same individual provider*.
  - Cannot be reported with psychotherapy service code on same day *by any provider*. (Have psychiatric provider use E/M if needed.)
  - 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.

Procedure Codes continued

Plan Development (581)

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

- 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

Individual (381) or Group Rehab (391)
(Performed by all with appropriate training and experience.)

- Improving,
- Maintaining, OR
- Restoring:
  - Functional skills
  - Daily living skills
  - Social skills
  - Leisure skills
  - Grooming and Personal hygiene skills
  - Obtaining support resources and obtaining medication education

Procedure Codes continued

Collateral (311) ***for family engagement use Code 310***
(Performed by all with appropriate training and experience.)

- Services provided to Significant Support person
  - Consultation and Training support person
  - Focus is always in achieving mental health Objectives in Client Plan

- Definition:
  - 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 Caregiver (310)

(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.

Procedure Codes continued

Collateral Family Group (317)

(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)

(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.
- **Linking the client's caretaker to services for the purpose of furthering the client's treatment plan is not C/M—but is Collateral.**

Procedure Codes continued

Case Management/Brokerage (571) cont.

- Progress Notes Should Describe:
  - The reason why the client requires the service being accessed needs to be documented in the record, preferably in each note.
  - A description that justifies why client requires the clinician's assistance to access the needed service, i.e., why can't they do it themselves? The reason(s) need to be related to their mental health condition. This needs to be documented in the record, preferably in each note.
  - Monitoring progress in a residential program or other service setting that the individual was placed in or referred to.
  - **Specify which Mental Health objective will be improved as client is successfully linked and engaged with community support service.**

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.

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

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

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

- "A unit of time is attained when the mid-point of the time period is passed." *CPT Manual 2013* (See InSyst Procedure Code Handout)
- **Always choose code based on the exact number of f-2-f minutes. For non f-2-f [i.e. telephone, f-f = 0 min's] use *client contact minutes* and indicate "phone" in the "location" field.**
  - Supporting Documentation & Travel Time will be included in Total Time and therefore paid.

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

Procedure Codes continued

Multi-Family Group Psychotherapy (455)

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

- **455 Multi-Family Group Psychotherapy** 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

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 only the number of clients present (or # clients represented)
    - Include 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.)
    - INSYST will calculate the billable time per client

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*

Add-On Codes continued:

- Additional Time Spent: for Crisis Therapy—concept in general.
  - 377-90839 is used for the first 30-75”
  - 378-90840 is used for each additional 16-45”
  - For paper charting: 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

Documenting Add-On (+) Codes in Physical Chart's Progress Notes

- Each add-on code must be indicated in the progress note.
  - Example:
    - 377-90839 Crisis Therapy

      +378-90840 Crisis Therapy add-on

      +378-90840 Crisis Therapy add-on
- *When documenting for an add-on code, be sure that the note content reflects the service and/or time frame of the add-on.*

Procedure Codes continued

Crisis Therapy (*formerly*, Crisis Intervention)

337-90839 (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 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.

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

- Refers to one or more, of 4 specific communication factors *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**

<u>Cannot</u> be used with Crisis Therapy, Family Therapy, or with other E/M codes when no psychotherapy was provided.

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.

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:**
  - Outpatient--Indicate Face-to-Face time (Inpatient—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

- **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.
  - outpatient **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: 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.

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

Claims

MH Services Lockouts (see 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, Inpatient 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.

Lockout Situations

Lockout Situations: A "lockout" means that a service activity is not reimbursable through Medi-Cal because the beneficiary resides in and/or receives mental health services in one of the settings listed below. A staff may provide services within their scope of practice, but it would not be reimbursable.

Type of Service → Lock-Out Service Site or Lock-Out During Program Hours of Operation ↓	Claim Medi-Cal for Specialty Mental Health
Admitted to John George, Herrick, etc. (Psych inpatient unit within Medi-Cal certified hospital) *In PES or ER? If not admitted, no lock-out.*	**No** [1 & 2]
Villa Fairmont, Gladman (MHRC & IMD) (Mental Health Rehab Center; Institution for Mental Diseases)	**No** [1 & 2]
Willow Rock (PHF) (Psychiatric Health Facility)	**No** [1 & 2]
Garfield, Medical Hill (SNF) (Skilled Nursing Facility w/ Behavioral Health Component) **Morton Baker (SNF & IMD)** (Institution for Mental Diseases)	**No** [1 & 2]

Type of Service → Lock-Out Service Site or Lock-Out During Program Hours of Operation ↓	Claim Medi-Cal for Specialty Mental Health
Woodroe House, Willow Rock (Crisis Residential)	**No** [1 & 2]
Sausal Creek, Willow Rock (Crisis Stabilization)	**No** [1]
Day Rehab Programs & Day Treatment Intensive Programs	**No** [1]
County Jail, and State/Federal Prison	**No** [1]
Juvenile Hall	**No** [1 & 3]
State Hospital	**No** [1 & 2]

[1]Lockout applies except on the **day of admission prior to formal admittance** and on the **day of discharge following a formal discharge**.

[2] Lockout applies except to coordinate placement of the beneficiary during the 30 calendar days immediately prior to the day of discharge, for a maximum of three non-consecutive periods of 30 calendar days or less per continuous stay in the facility.

[3] Lockout applies except with evidence of court-ordered suitable placement (**post-adjudication** for placement) in a home setting other than a correctional institution (applicable only to youth).

Claims

Non-Reimbursable Services/Activities

- No service provided: Missed appointment
- Solely transportation of an individual to or from a service
- Service provided solely payee related *(Indicate payee portion of visit in a separate—non-billable service note.)*
- Services provided was solely 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 is solely to provide 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:

- 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).
- All Client Records must be retained as long as required by law, 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 6/30/2006—this will be updated in Clinical Documentation manual when needed.*
- HIPAA Management Practices for the Release of Information (ROI Log)

Minor Consent, ages 12 – 17 yrs.

- Minor Consent Law:
  - www.youthlaw.org
  - http://www.teenhealthlaw.org/fileadmin/teenhealth/teenhealthrights/ca/CaMinorConsentConfChartFull11-11.pdf
- 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 contact QA to seek authorization to provide the service and to ensure that Medi-Cal is not claimed.*

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

QA Technical Assistance Contacts

- Master Contract Providers (CBO's) and County Clinics/Programs

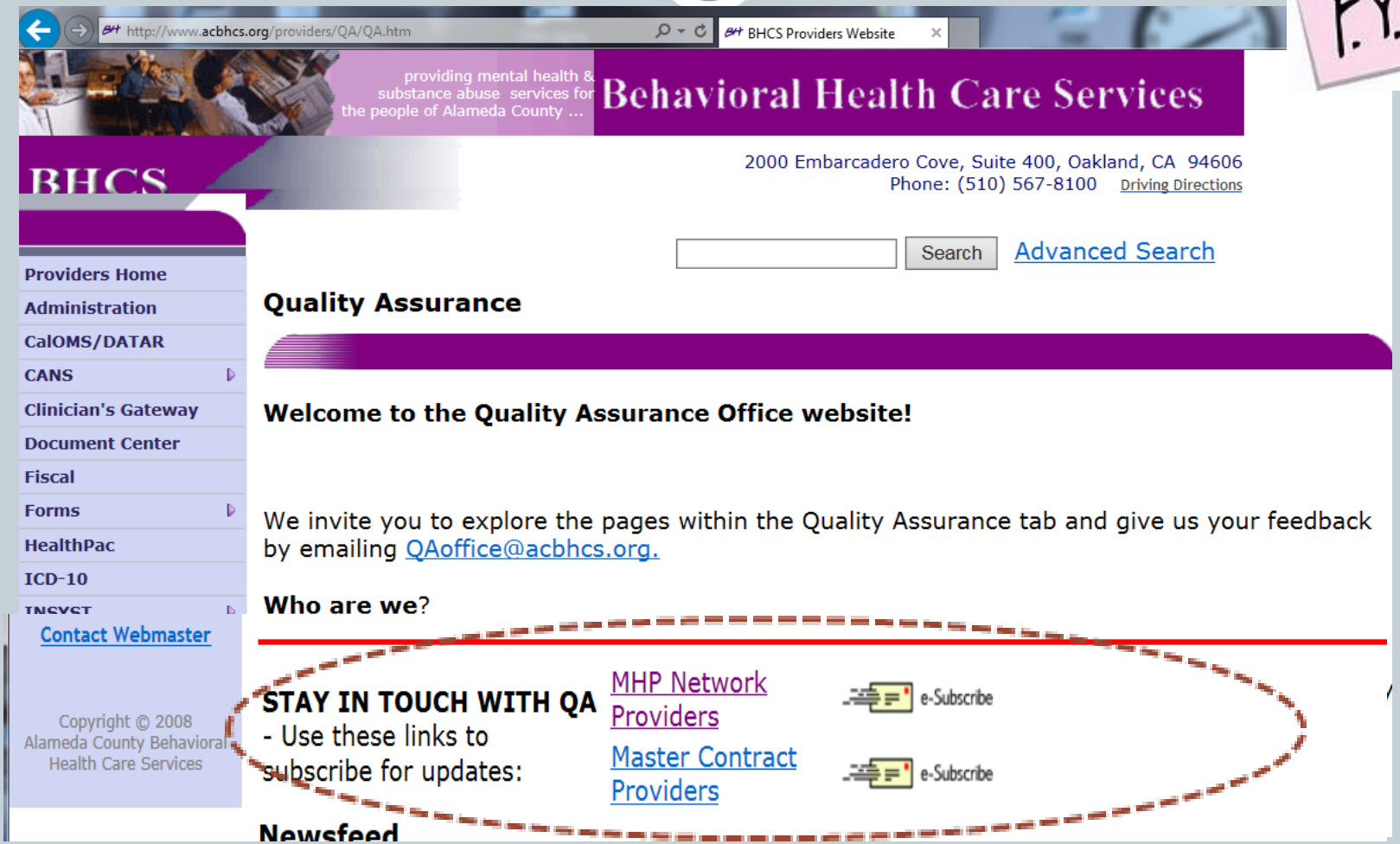
Agency/Clinic Lead QA Contacts may contact:

CBO's by Parent Agency Name, or County Clinic by Program Name	QA Technical Support Staff
A – I: CBO's All Adult County Clinics	Jeff Sammis, PsyD jSammis@acbhcs.org
J - Z: CBO's All Children County Clinics	Jennifer Fatzler, LMFT jFatzler@acbhcs.org

Contact Us:

- Contact QA Department at (510)567- 8105 or QAOffice@acbhcs.org
- If you feel that you are missing a procedure code that you are contracted for, that should be included in your RU, please call Jackie Mortensen @ (800)878-1313.
- For Clinicians Gateway questions, Please contact IS at (510)567-8181.
- For questions regarding your agency contract, please contact the Network Office at (510) 567-8296

Sign-up for QA Provider Website Updates



Train the Trainer Slides

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 symptoms as evidenced by an increase in the # of social interactions from 0x to 3x per week in the next # weeks/months"*
- **Service Modalities**
  - *"Individual Rehabilitation (weekly or as needed), & Psychiatric Medication Services (monthly or as needed) over the next 12 months"*
- **Detailed Clinical Interventions:**
  - **Individual Rehab:**
    - *"Assist the client in re-engaging in pleasant activities and learning new ways of dealing with distress"*
    - *"Teach and reinforce active problem-solving skills in order to increase client's self-efficacy and improve his/her mood."*
    - *"Help the client to identify early warning signs of relapse, review skills learned, and develop a plan for managing challenges 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

Client Plan
Step 2 of the Golden Thread *continued*

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.**

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

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, or as needed, for 1 year;**
  - **Case Management 1x/month, or as needed, for 9 – 12 months;**
  - **Individual Psychotherapy 1x/week, or as needed, for 1 year;**
  - **Medication Management 1x/month, or 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 or 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 or 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 or 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: _____

Objective Formulation Exercise:

Axis I Diagnosis: _____

Client's Stated Goal:

_____

_____

_____

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

_____

_____

_____

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

_____

_____

_____

Procedure Codes continued

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*.

Procedure Codes continued

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.
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- *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*.

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

182

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 Psychotherapy Time Ranges

Codes Used	Based on Face to Face time
377	30-75 minutes
377 + 378	76-105 minutes (60 + 16 – 45)
377 +378 +378	106-135 minutes (60 + 30 + 16 – 45)
377 +378 +378 + 378	136-165 minutes (60 + 30 + 30 + 16 – 45)
377 +378 +378 +378 +378	166-195 minutes (60 + 30 + 30 + 30 + 16 – 45)

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)

Clinicians Gateway

Service Entry, Individual

Clients | Search

Welcome: R. ANTHONY SANDERS-PFEIFER | Home | Menu | Log out

Interventions

Service #: New Title: Clinician's Progress Note

Service date: 05/15/2015

Client: Number: Unknown Last Name: First Name:

Util. review date::

Client Plan due date::

1

Procedures: 377 90839 Crisis Thpy 60 min

Service Location: Select Location

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

Emergency? ☐ Pregnant? ☐

Staff Time

Primary Clinician: 14219 - SANDERS-PFEIFER, R. ANTHONY Provider: Select Provider Primary Total Time: 01:00

3

E/M 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.

Primary FF Time 00:45 Hours:Minutes

2

Services were provided in English

by ☐ interpreter or ☐ clinician

Episode Diagnosis Information

Axis I Axis II Axis III Axis IV Axis V

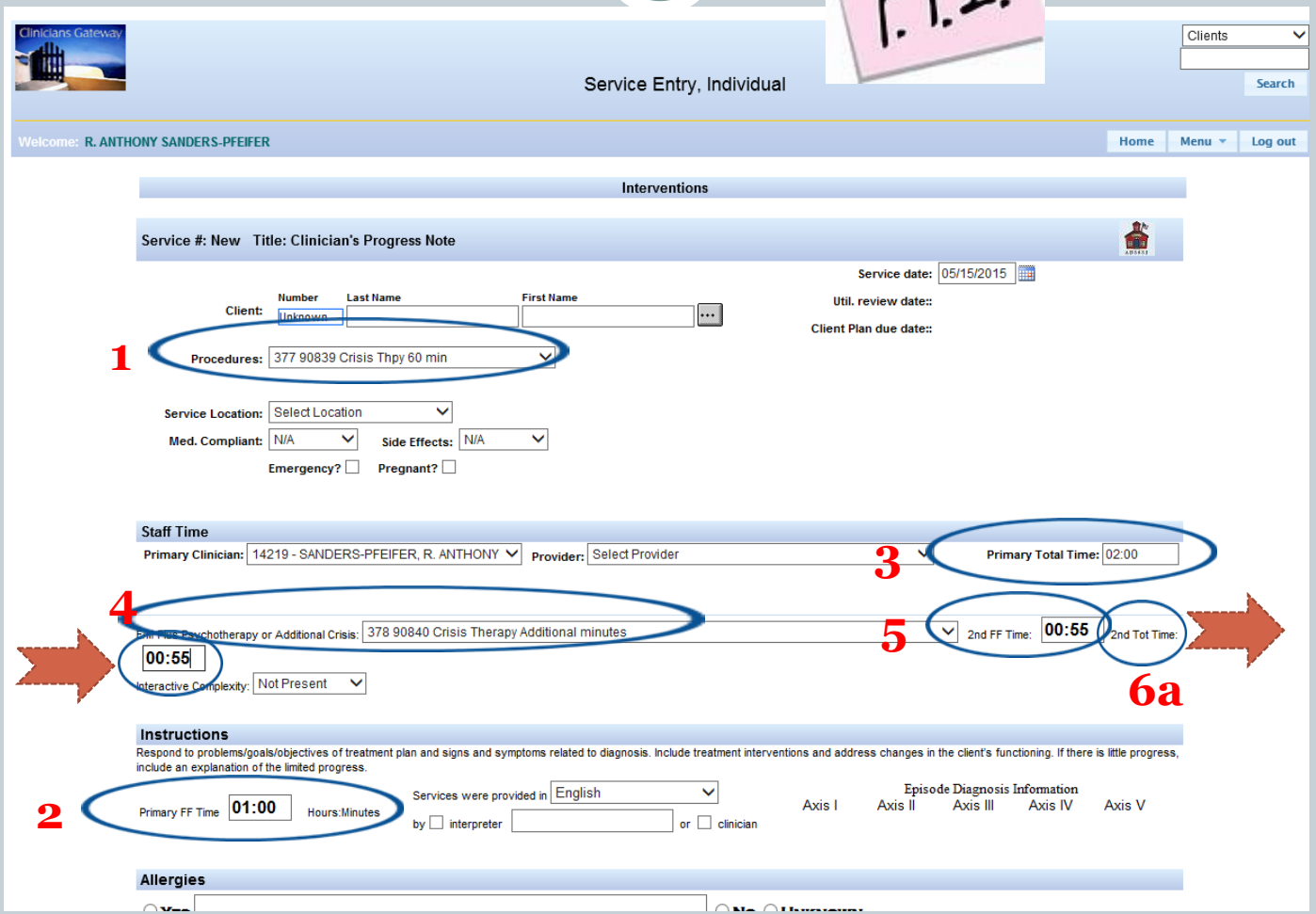
Crisis Code 377-90839 + 378-90840

- **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)

189



Crisis Therapy: 154”f-f + 8”doc time

190

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.**

192

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 communication factors *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.**

195

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 (Jul1 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

Add Additional Clinicians

3

Primary Total Time: 01:06

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 outpatient 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 outpatient 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 [outpatient] 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.*