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

RUDY ARRIETA, MSW
QUALITY MANAGEMENT PROGRAM DIRECTOR

DONNA FONE, LMFT, LPCC
QUALITY ASSURANCE ADMINISTRATOR

TONY SANDERS, PH.D
INTERIM QA ASSOCIATE ADMINISTRATOR

JEFF SAMMIS, PSY.D
CLINICAL REVIEW SPECIALIST SUPERVISOR

CLINICAL REVIEW SPECIALISTS:
JENNIFER FATZLER, LMFT
BRION PHIPPS, LCSW
PHUONG LAI, PSY.D
AMY SAUCIER, LMFT

QA Technical Assistance Contacts

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

Agency/Clinic <u>Lead QA Contacts</u> may contact:

CBO's by Parent Agency Name, or County Clinic by Program Name	QA Technical Support Staff
A – I: CBO's *and* All Child County Clinics	Jennifer Fatzler, LMFT Jennifer.Fatzler@acgov.org
J - Z: CBO's *and* All Adult County Clinics	Brion Phipps, LCSW Brion.Phipps@acgov.org

Agenda
9:00 am – 4:00 pm

09:00 - 09:15

- **Introductions**
- **System of Care Highlights and Auditing**

10:30 - 10:45 Break

- **Medical & Service Necessity**
- **MH Assessment Requirements, including SOGIE Data Collection**
- **Client Plan Requirements**

12:15 – 12:45 Lunch

- **Client Plan Requirements (cont)**
- **Progress Notes**
- **Procedure Codes**

2:30 - 2:45 Break

- **Lock-outs, Claims Disallowances, Minor Consent, Emergency Contact**
- **Post Test/Evaluation for Level I Providers**

_____

3:00-3:45

Guidelines for Master Contract Organizations that also are Mental Health Plan Fee-For-Service Providers (MHP FFS) (formerly "Network" or Level III Providers)

- **Post Test/Evaluation for MHP FFS (Level III Providers)**

Introductions

- Name, Agency, Role
- Last time you attending this Clinical Doc Training
- Are you a Mental Health Fee for Service (MHP FFS) formerly known as Level III provider?
- Housekeeping
- Icebreaker

BHCS QA uses a *Train the Trainer* Model
Train to Scope of Practice at Agency

This training is designed for agency QA staff who are then expected to provide ongoing trainings to their clinical staff

(See Scope of Practice Handout)

- **LPHA**—Licensed
- LPHA—Board Registered Interns or DHCS/ACBHCS Waivered Interns
- MH Graduate **Students *(aka Trainees)***

- **Medical**

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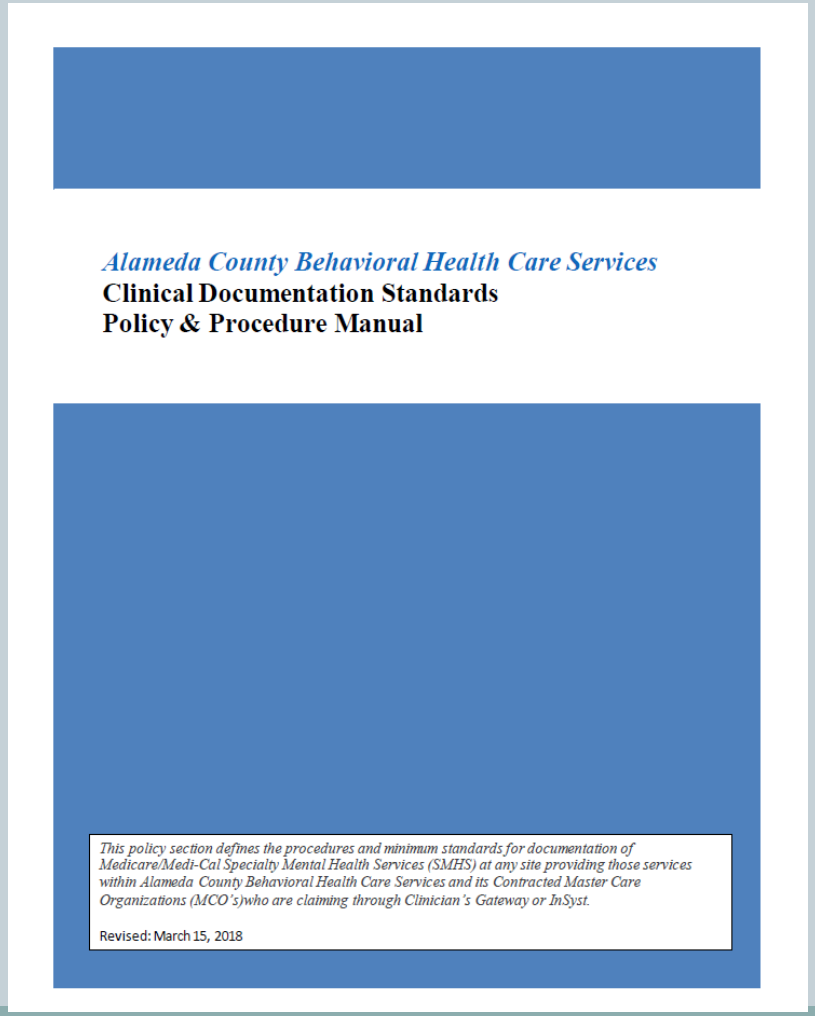
- **MHRS**
- **Adjunct** & Other Staff
  - Consumer /Peer Workers
  - Family Partners

Updated ACBHCS Clinical Documentation Standards Manuals – Coming Soon!



SOC AUDITS – Q1/Q2 2017

***Executive Summary:* ACBHCS System of Care Audit**

Audits Conducted 2nd and 4th Quarter of 2017

- Random selection of Medi-Cal Children's and Adult Mental Health (MH) services claimed by Master Contract Organizations (MCO, aka CBO) & County Owned and Operated Clinics.

- ***Claims compliance for Q4 2016 was 63%***
- ***Claims compliance for Q2 2017 was 84%***
- ***Claims compliance for Q4 2017 (pending) was 80%***

DHCS has indicated that they are moving towards implementing fines, sanctions, and penalties for Mental Health Plans that have low claims compliance rates. They are currently developing a tiered system to determine what sort of non-compliance % will result in fines, sanctions, and penalties.

Anything below an 80% claims compliance rate will most likely result in such actions.

The next DHCS triennial audit of Alameda County will occur in 2020. The audit will most likely look at claims during the time period of 10/1/18-12/31/18 or 1/1/19 - 3/31/19.

How to Get into Compliance

- Please use the information in this presentation to train your staff on proper Medi-Cal Documentation requirements.
- Please review Alameda County's new and updated Documentation Manual.
  - As the manual has been recently updated, please check back routinely to see if the manual gets additional updates.
- If your agency has not recently been audited in Alameda County's System of Care audit, consider running an internal audit using the same audit tools that ACBHCS uses. (See next slide.)
- Conduct regular CQRT chart reviews and back out claims that were claimed in error.
  - Backing out a claim that do not meet medical necessity and would be disallowed in an audit is requirement of agencies once they are aware of the claims/errors and can save your agency (and the whole County Mental Health Program) money in the long run.

Audit Tools on Provider Website
http://www.acbhcs.org/providers/QA/audit.htm

Audit Tools for Mental Health Services

- Audit Tools
  1. Regulatory Compliance Tool
  2. Plan of Correction and Quality Improvement Plan Template
  3. DHCS & ACBHCS Reasons for Recoupment - updated 7/1/16
  4. Standard Abbreviations
  5. SMHS SOC Audit
- Diagnoses Lists and Crosswalks:
  1. ACBHCS SMHS Outpatient Medi-Cal Included List Alpha by Name revised 2-21-18
  2. ACBHCS SMHS Outpatient Medi-Cal Included List by ICD_10 Code revised 2-21-18
  3. ACBHCS SMHS Outpatient Medi-Cal Included Crosswalk Alpha by ICD-10 Name revised 2-21-18
  4. ACBHCS SMHS Outpatient Medi-Cal Included Crosswalk by ICD-10 Code revised 2-21-18
  5. ACBHCS SMHS Inpatient Medi-Cal Included List Alpha by Name revised 2-21-18
  6. ACBHCS SMHS Inpatient Medi-Cal Included List Alpha by ICD-10 Code revised 2-21-18
  7. ACBHCS SMHS Inpatient Medi-Cal Included Crosswalk Alpha by ICD-10 Name revised 2-21-18
  8. ACBHCS SMHS Inpatient Medi-Cal Included Crosswalk by ICD-10 Code revised 2-21-18
  9. ACBHCS General Medical Codes
  10. ACBHCS Psychosocial Dx List Alpha by DSM-5 Name
  11. ACBHCS Psychosocial Dx List Numeric By ICD-10 Code
- MH Authorization and Audit Tools:
  1. ACBHCS M/C Claiming Lock-Out Grid
  2. DHCS & ACBHCS Reasons for Recoupment
  3. ACBHCS MH CQRT Form Adult Child
  4. Regulatory Compliance Tool
  5. Plan of Correction and Quality Improvement Plan Template
  6. ACBHCS SMHS FAQ's
- Mental Health Provider Manuals:
  1. Quality Assurance Manual
  2. ACBHCS MH Clinical Documentation Standards Manual for Master Contract Providers
  3. ACBHCS MH Clinical Documentation Standards for SMH Fee – For- Service Providers (MHP Network Providers)
  4. ACBHCS MH CQRT Manual
- Medi-Cal Compliant Clinical Forms and Templates
  1. Sample Medi-Cal Compliant Initial or Annual MH Assessment—Long Form
  2. Sample Medi-Cal Compliant Initial MH Assessment—Short Form
  3. Sample Medi-Cal Compliant Psychiatric Mental Health Assessment: PDF Word
  4. Sample Medi-Cal Compliant Psychiatric Mental Health Client Plan: PDF Word
  5. Sample Medi-Cal Compliant Outpatient MH Progress Note: PDF Word
  6. Sample Medi-Cal Compliant MH Treatment Plan: PDF Word

CQRT Update

All agencies must conduct CQRT

- **CQRT consists of two essential components**
  - **Record review to assure clinical documentation meets Medi-Cal requirements**
  - **Authorization of SMHS services**
    - **Initial**
    - **Annual**

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

For Agency CQRT meetings

- Licensed, waivered, or registered LPHAs (Licensed Practitioner of the Healing Arts), and MH Student Trainees with the Scope of Practice to Diagnose can participate in chart reviews.

- Only Licensed LPHAs (Licensed Practitioner of the Healing Arts) may authorize treatment services.

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

- Charts are reviewed based on the date of the case episode opening
  - Initial CQRT – Charts undergo CQRT review and authorization when the complete full MH Assessment and Plan are initially due (for outpatient this is 60 days)
  - Annual CQRT – Prior to treatment plan due date (1st day of month of opening)

Some other program types may have different CQRT timeline requirements

Month Episode is **Opened**	**Cycle**	Bring the Chart to Initial CQRT before the due date.	Bring the Chart to annual CQRT **during** the month	With a new annual TX plan to cover services beginning	And Treatment plans should not be signed/finalized **before** this date
January (e.g. 1/15)	Jan 1-Dec 31	Review Before March 15	December	1/1	12/1
February (e.g.2/2)	Feb 1-Jan 31	Review Before April 2nd	January	2/1	1/1
March (e.g. 3/30)	Mar 1-Feb 28	Review Before May 30th	February	3/1	2/1

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

- DHCS has indicated that new guidelines and clarification on the required Authorization process will be released in July 2018.
- ACBHCS has stopped updating the CQRT Manual and updating CQRT forms pending the release of this new update.
- Providers are expected to conduct CQRT and authorize charts as usual.
- Providers should contact their QA Technical Assistance Contact if they would like training on the CQRT process.

Additional County CQRT Review

- Providers that receive low claims compliance scores in system of care audits will be required (per their Plans of Correction) to submit CQRT forms for the next 6 months.
- The QA department will randomly select cases and request a copy of the chart and conduct a 2nd review of the chart.
- This process will be used as ACBHCS evidence that our county is monitoring that Plans of Corrections are being followed and changes made in our system and that we are providing Technical Assistance to Providers.

Establishing Medical Necessity

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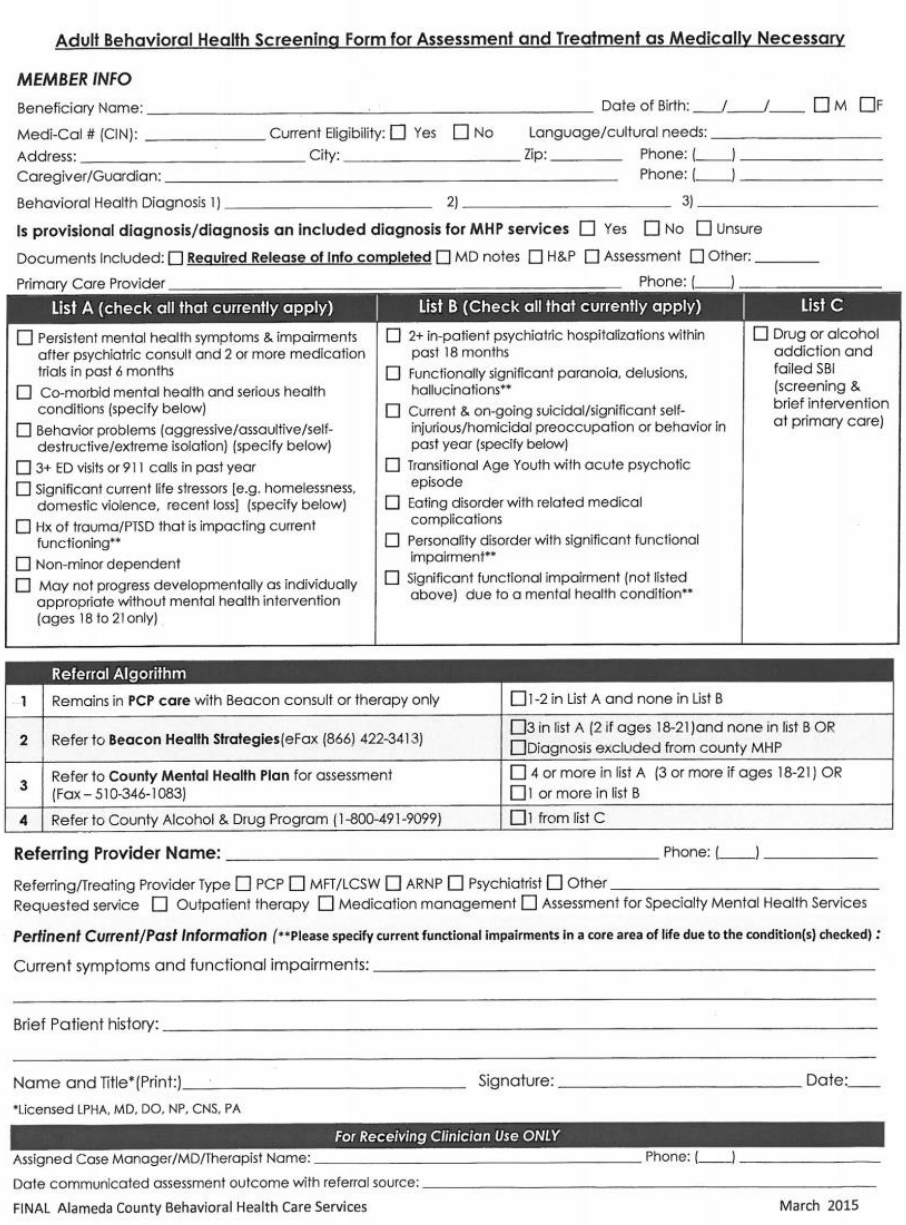
THE GOLDEN THREAD

Initial Required Forms

- Brief Screening Tool (*non-billable service*)
- Informing Materials (*Reviewing informing materials and obtaining consents with clients as part of the assessment is a billable service.*)
- Release of Information- when necessary (*Discussing release of information with client as part of the assessment is a billable service.*)

Brief Screening Tool

- All clients must be screened for *Mild-to-Moderate (referred to Beacon for MH Services)* vs. *Moderate-to-Severe* (seen by ACBHCS Providers) criteria.
  - Screening is done upon referral, at Plan Update, 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.**
  - Only Exceptions: Out of County, TBS Workers, Crisis, Conservatorship, & Guidance Clinic
- Administration of the Brief Screening Tool is NOT A billable service.
- May be completed only by Licensed/Waivered/Registered LPHA.
  - Waivered or Registered LPHA require a Licensed LPHA co-signature.
- See ACBHCS Providers Website/Forms/Access/Screening for MH Services: http://www.acbhcs.org/providers/Forms/Forms.htm
- Use appropriate form based on age (0-5, 6-17, Adult)
- If Mild-to-Moderate, refer to (form needed) to Mild-Moderate Provider or seek authorization if your agency is contracted (with Beacon, Blue Cross, Kaiser) to provide those services.



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: (___) _____

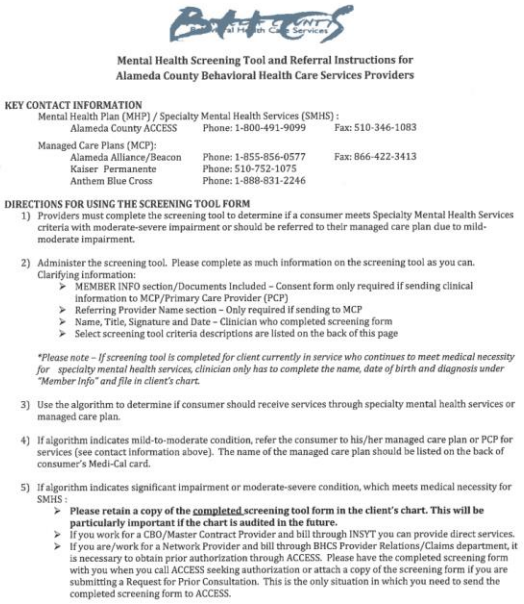
Date communicated assessment outcome with referral source: _____

FINAL Alameda County Behavioral Health Care Services March 2015

Note that this form does not have co-signature line, however if a co-signature is required, please ensure co-signature is present.

Forms and Instructions for Screening Forms can be found at http://www.acbhcs.org/providers/Forms/Forms.htm

- Screening for Specialty Mental Health Services (Moderate-Severe Criteria)
  Adult BH Screening Form
  Adult BH Screening Form (fillable)
  Child 6-17 BH Screening Form
  Child 6-17 BH Screening Form (fillable)
  Child 0-5 BH Screening Form
  Child 0-5 BH Screening Form (fillable)
  Medical Necessity for Specialty Mental Health Services
  Screening Tool and Referral Instructions for ACBHCS Providers
  Screening Tool Training FAQ's
  Bi-Directional Medi-Cal Mental Health Level of Care Transition Form
  Bi-Directional Medi-Cal Mental Health Level of Care Transition Form - fillable



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.

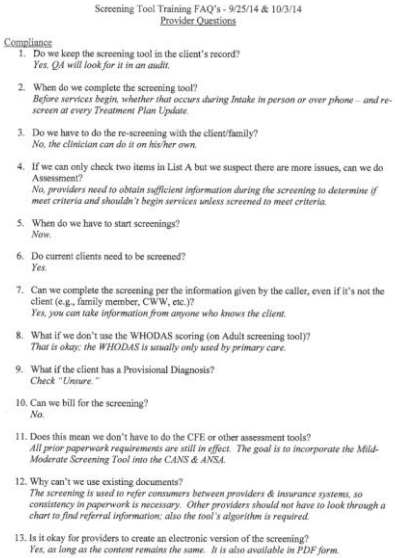
2) Administer the screening tool. Please complete as much information on the screening tool as you can. Clarifying information:
   - MEMBER INFO section/Documents Included – Consent form only required if sending clinical information to MCP/Primary Care Provider (PCP)
   - Referring Provider Name section – 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

**Please note – If screening tool is completed for client currently in service who continues to meet medical necessity for specialty mental health services, clinician only has to complete the name, date of birth and diagnosis under "Member Info" and file in client's chart.*

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, 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.

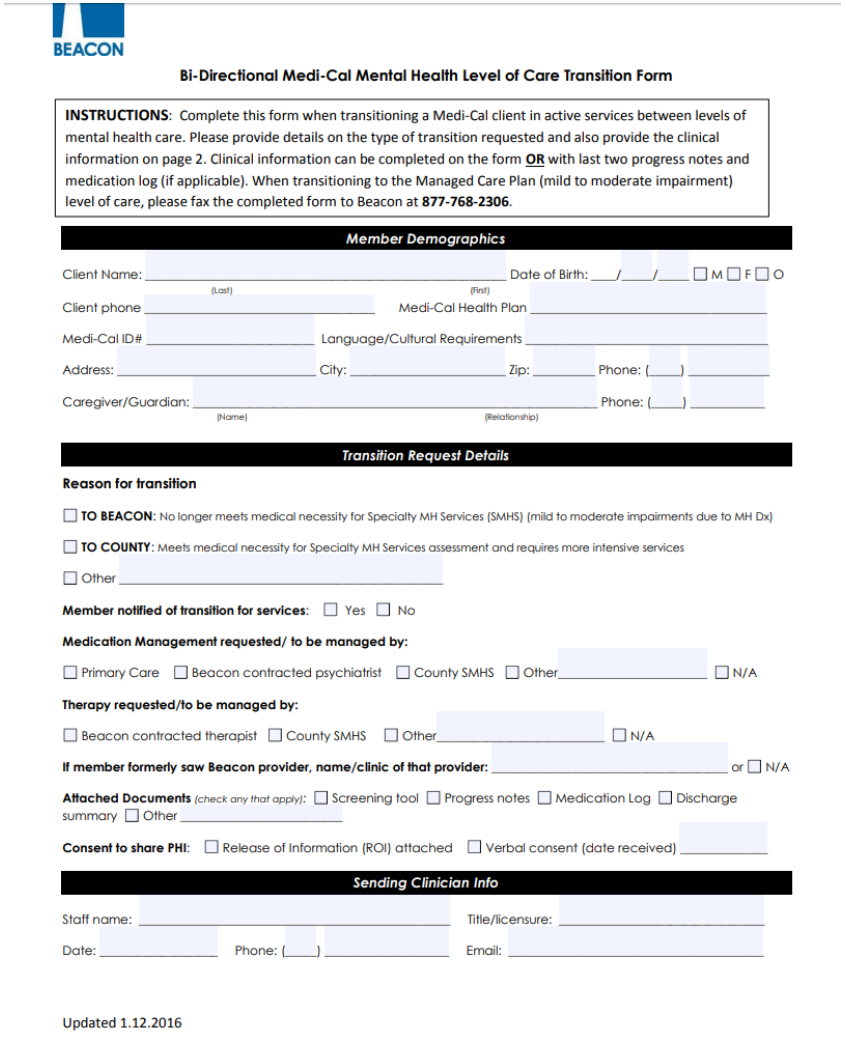


Screening Tool Training FAQ's - 9/25/14 & 10/3/14
Provider Questions

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 Diagnosis?
   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.

When transitioning a Medi-Cal client to lower level of care, complete the transition Form. Forms and Instructions for Screening Forms can be found at http://www.acbhcs.org/providers/Forms/Forms.htm



BEACON

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 **877-768-2306**.

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) _____

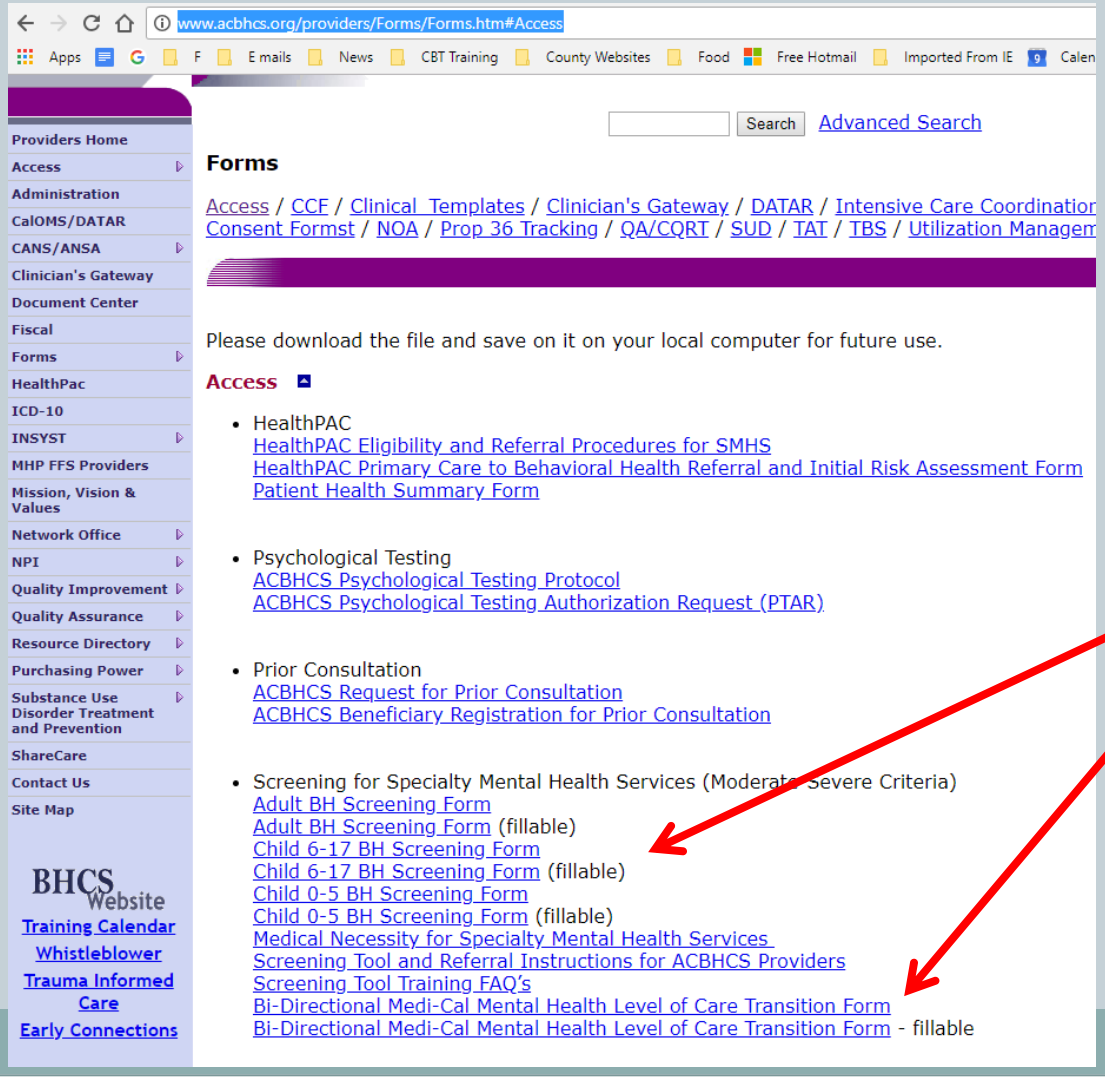
Sending Clinician Info

Staff name: _____ Title/licensure: _____

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

Updated 1.12.2016

http://www.acbhcs.org/providers/Forms/Forms.htm#Access



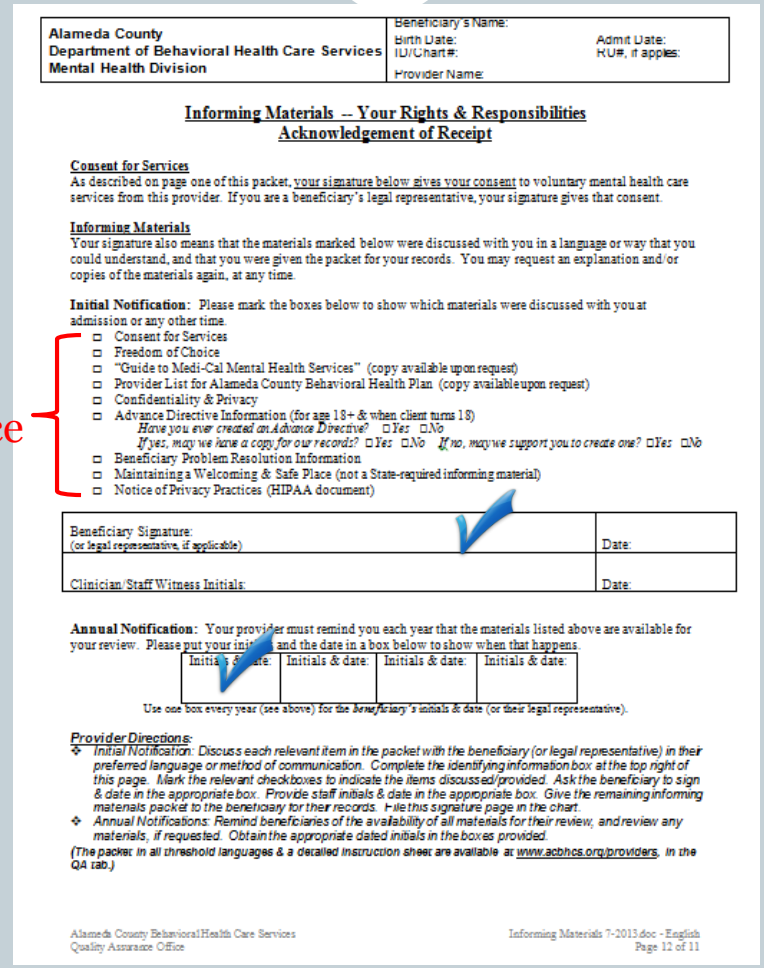
These forms are found here on the BHCS providers site

Informing Materials

- Informing Materials required at Initial and Annual Assessments.
  - Recommended at first visit as includes Consent to Treatment
- If a client's primary language is not English, you must review informing materials in the client's primary language.
  - Alameda County provides translated Informing materials for all threshold languages. These forms must be provided to the client and the signature page present in the client's medical record.
  - If a client does not speak a threshold language, you can verbally interpret an English packet to the client and place an English signature page in the medical record and indicate that it was verbally reviewed with them in a language they understand.
- All elements present in ACBHCS' Informing Materials Packet are required.
  - http://www.acbhcs.org/providers/QA/General/informing.htm
  - Provider may add additional forms as needed.
- ACBHCS' Informing Materials Signature Page is highly recommended to be used and must be maintained in client record.
  - If agency form is used—all county form elements must be present and readily identifiable.
  - Note all boxes must be checked (as addressed) and signed.
  - May utilize form by client initial for four additional occurrences.

Informing Materials Signature Page

All items must be reviewed with client and checked once reviewed.



Alameda County Department of Behavioral Health Care Services Mental Health Division	Beneficiary's Name: Birth Date: Admit Date: ID/Chart#: RU#, if applies: Provider Name:

Informing Materials -- Your Rights & Responsibilities
Acknowledgement of Receipt

Consent for Services
As described on page one of this packet, your signature below gives your consent to voluntary mental health care services from this provider. If you are a beneficiary's legal representative, your signature gives that consent.

Informing Materials
Your signature also means that the materials marked below were discussed with you in a language or way that you could understand, and that you were given the packet for your records. You may request an explanation and/or copies of the materials again, at any time.

Initial Notification: Please mark the boxes below to show which materials were discussed with you at admission or any other time.

- ☐ Consent for Services
- ☐ Freedom of Choice
- ☐ "Guide to Medi-Cal Mental Health Services" (copy available upon request)
- ☐ Provider List for Alameda County Behavioral Health Plan (copy available upon request)
- ☐ Confidentiality & Privacy
- ☐ Advance Directive Information (for age 18+ & when client turns 18)
  Have you ever created an Advance Directive? ☐*Yes* ☐*No*
  If yes, may we have a copy for our records? ☐*Yes* ☐*No* *If no, may we support you to create one?* ☐*Yes* ☐*No*
- ☐ Beneficiary Problem Resolution Information
- ☐ Maintaining a Welcoming & Safe Place (not a State-required informing material)
- ☐ Notice of Privacy Practices (HIPAA document)

Beneficiary Signature: (or legal representative, if applicable)	Date:
Clinician/Staff Witness Initials:	Date:

Annual Notification: Your provider must remind you each year that the materials listed above are available for your review. Please put your initials and the date in a box below to show when that happens.

Initials & date:	Initials & date:	Initials & date:	Initials & date:

Use one box every year (see above) for the *beneficiary's* initials & date (or their legal representative).

Provider Directions:

- *Initial Notification: Discuss each relevant item in the packet with the beneficiary (or legal representative) in their preferred language or method of communication. Complete the identifying information box at the top right of this page. Mark the relevant checkboxes to indicate the items discussed/provided. Ask the beneficiary to sign & date in the appropriate box. Provide staff initials & date in the appropriate box. Give the remaining informing materials packet to the beneficiary for their records. File this signature page in the chart.*
- *Annual Notifications: Remind beneficiaries of the availability of all materials for their review, and review any materials, if requested. Obtain the appropriate dated initials in the boxes provided.*

(The packet in all threshold languages & a detailed instruction sheet are available at www.acbhcs.org/providers, in the QA tab.)

Alameda County Behavioral Health Care Services
Quality Assurance Office

Informing Materials 7-2013.doc - English
Page 12 of 11

Release of Information

Informed Releases of Information (ROI)

- DHCS 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).
- Must be signed by client
- Client's may limit data that will be shared including dates that information can be shared.
- Not required for Alameda Health Care Services Providers—but recommended
- Not required to simply facilitate treatment referral to other MH Providers—but highly recommended

To avoid gaps in consent, obtain signatures on relevant ROIs annually during re-authorization of Assessment & Plan so that they fall in-sync with authorization cycle

Establishing Medical Necessity

THE GOLDEN THREAD

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:
    - Brief Screening Tool
    - 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 (*Includes DHCS Audit Protocol)*, 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 criteria:

<u>Criteria #1</u>: An included diagnosis ***(See Medical Necessity for Specialty Mental Health Services handout)***

All Dx must indicate:

1) ***The ICD-10 Code***
2) ***The DSM-5** Description (name) WITH all specifiers***

   *****for included diagnoses not in DSM-5, such as F84.5, F84.9, F84.2, F84.3 & F84, list the ICD-10 Descriptor (Dx Name)***
3) ***DHCS also recommends indicating the ICD-10 Descriptor (Dx Name)—but not required by ACBHCS at this time***

A client may also have a non-included diagnosis as long as the focus of treatment must address the signs and symptoms of the included diagnosis.

- The Primary Diagnosis in the clinical record must match the Primary Diagnosis in INSYST to ensure an accurate clinical snapshot'
- If the Diagnosis is revised you must update INSYST

Medical Necessity Criteria (2 of 3)

<u>Criteria #2</u>: 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*

Medical Necessity Criteria (3 of 3)

<u>Criteria #3</u>: A qualifying intervention (meets ***<u>all three</u>*** 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 <u>one</u> 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 alone.

Medical Necessity & Key Documents

- Medical Necessity is documented throughout the client's chart.
- The mental health assessment and client plan must establish medical necessity for all planned services.
- Progress Notes must contain evidence that the services claimed for reimbursement meet Medical Necessity by linking to a specific current MH Objective.

Medical Records Dx Documentation

- For MH Clients the diagnosis is maintained in the MH Assessment.
- See attached NEW Medi-Cal Included Dx Lists for:
  - *Outpatient MH Services M/C Included Dx Lists (by ICD-10 Code and DSM Name)*
  - *Inpatient MH Services M/C Included Dx Lists (by ICD-10 Code and DSM Name) and Cross-Walk*
- It is not recommended to use the DHCS Medi-Cal Included Lists on their website as they include more diagnoses than may actually be utilized. County Clinics and Clinician Gateway Users will not have the option of using the DHCS lists of Included Dx.

Medical Records Dx Documentation Cont.

- *Crosswalk for Outpatient MH Services: DSM-IV-TR to DSM-5/ICD-10*
  - This crosswalk offers alternatives for Included Dx's when the client's Dx was on the prior Included M/C List (DSM-IV-TR) but has dropped off the current Included M/C List (ICD-10).
  - It only has possibilities, the clinician must ensure than the ICD-10 Included Dx's DSM Criteria is consistent with the client's current signs and symptoms.

Medical Records Dx Documentation Cont.

- Medical Record Documentation will follow DSM-5 guidelines utilizing DSM-5/ ICD-10 codes (Which are now the same).
- DSM-IV-TR codes (Which were different than ICD Codes) and conventions (such as 5 Axis system) will no longer be followed.
- *Medi-Cal requires that documentation for each Dx that is the focus of treatment within the Assessment clearly documents the diagnostic criteria established in the DSM-5 (or DSM-IV when applicable).*

Medical Records Dx. Documentation Cont.

- The Primary Diagnosis and focus of treatment can not be a historical diagnosis. The primary diagnosis must be made during the current episode.
  - For example, diagnoses made during recent psychiatric hospitalizations may be used to inform the current diagnosis but may not simply be referenced
- Any additional diagnoses (that will not be the primary focus of treatment) that the client has received in the past may be documented without indicating the full criteria. Indicate “by history” and the source of the data (such as for an excluded or physical health dx).

Medical Records Dx Documentation Cont.

- When documenting the diagnosis include both the ICD-10 Dx Code and the full DSM Descriptor/Name with Specifiers
  - If there is no DSM-5 descriptor—use the ICD-10 descriptor (name) Do not use the DSM-IV descriptor.
- *DHCS also recommends* additionally including the ICD-10 Description (Dx name).
- Clinician's Gateway has both.

Medical Records Dx Documentation Cont.

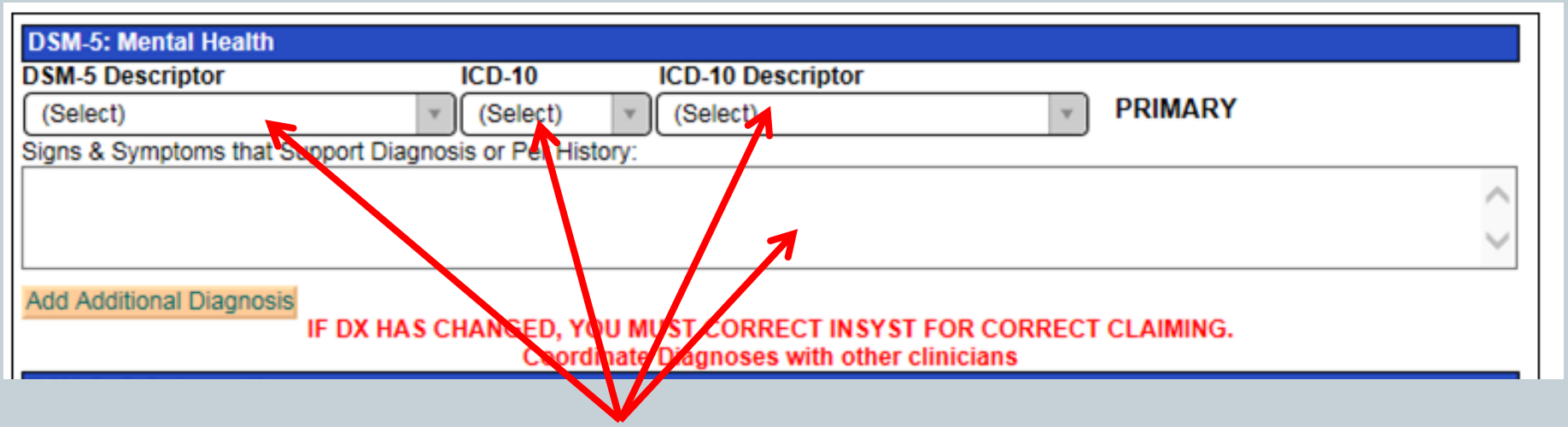
- Each contracted agency is required to have their own process (as described in a Policy and procedure manual) to resolve discrepant diagnoses.
- It is best practice to align diagnoses within an agency.
  - When there is a discrepant diagnoses and it can not be resolved, the client record should indicate what attempts were made to align them and how the decision was reached to keep discrepant diagnoses.
- It is best practice for providers to collaborate across agencies regarding conflicting diagnoses.

Diagnosing for CG Users

- The Assessment template in Clinician's Gateway has an embedded crosswalk and continues to separate diagnoses into categories
    - Mental Health Diagnoses
    - Substance Use Disorder Diagnoses
    - General Medical Codes
    - Psychosocial

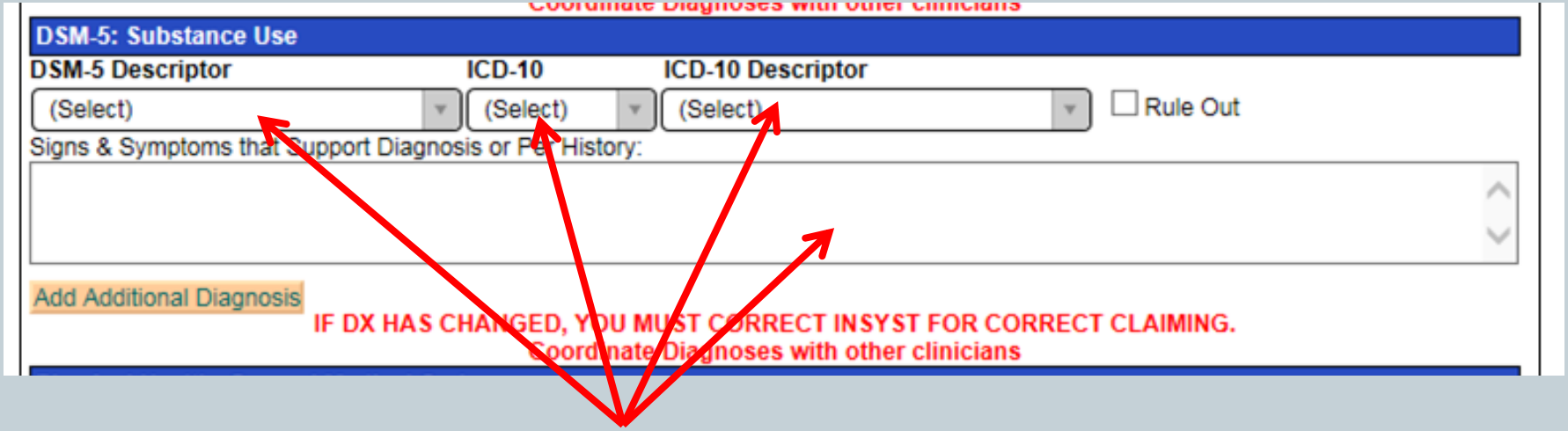
CBOs using their own EHR or other assessment templates are not required to separate diagnoses into these categories.

Clinician's Gateway MH Dx Fields



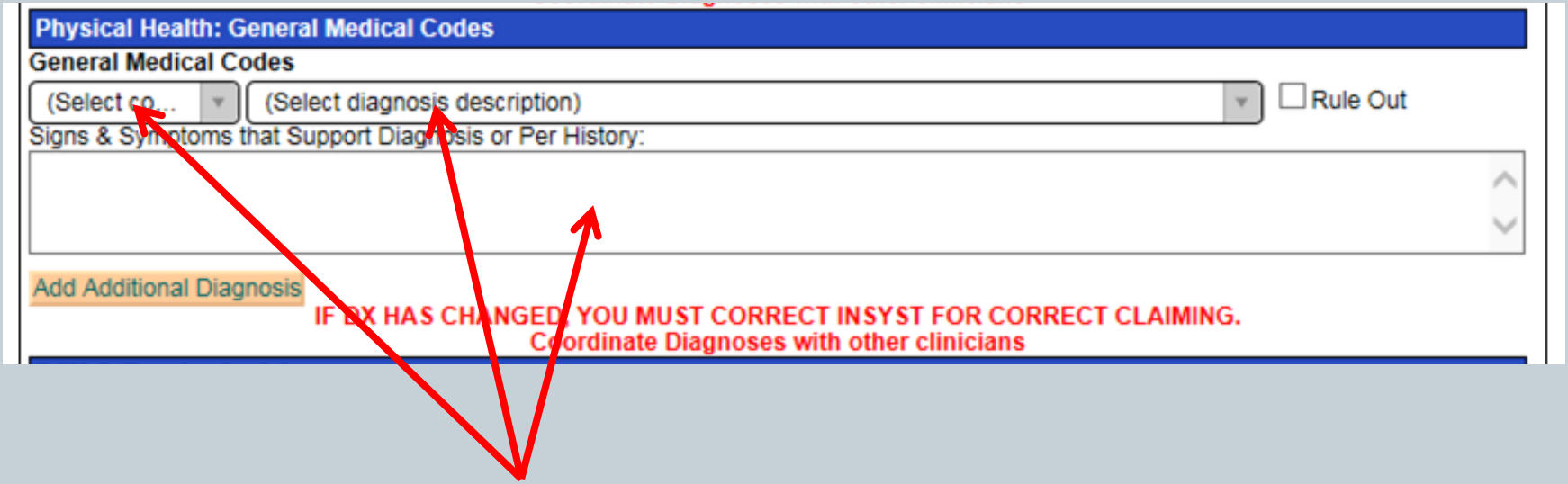
In CG all of these fields must be completed.

Clinician's Gateway MH Dx Fields Cont.



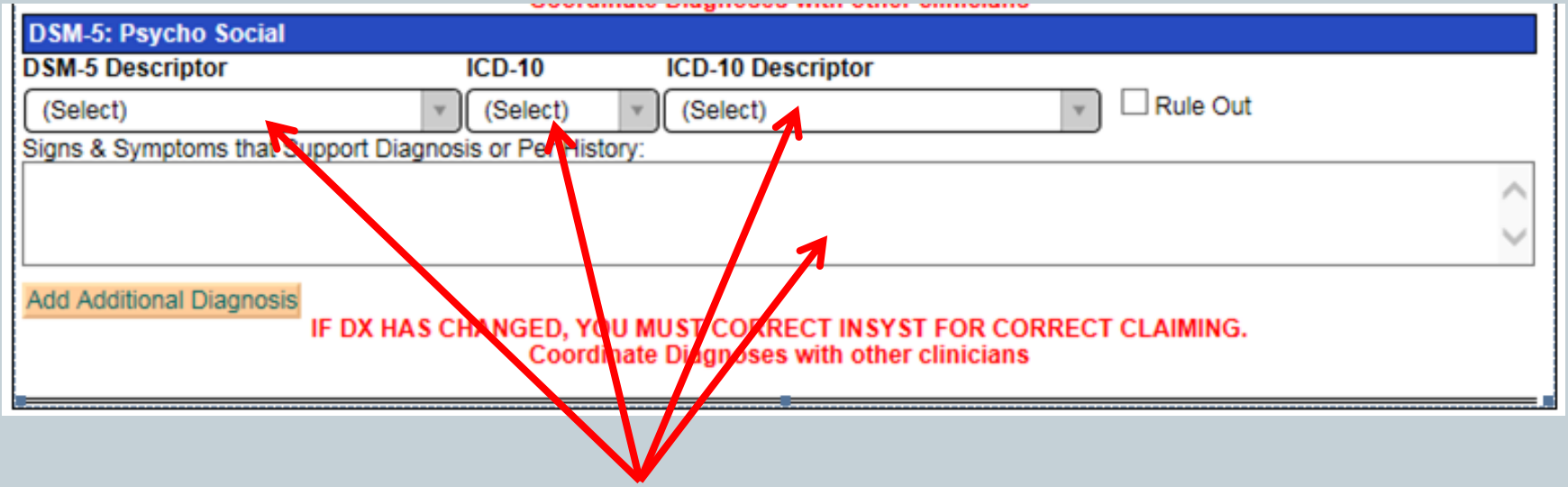
In CG all of these fields must be completed.

Clinician's Gateway MH Dx Fields Cont.



In CG all of these fields must be completed.

Clinician's Gateway MH Dx Fields Cont.



In CG all of these fields must be completed.

IS Help Desk Contact

- For assistance with entering ICD-10 codes into InSyst, please contact the Information Systems Help Desk @ 510.567.8181 or HIS@acgov.org

Mental Health Assessment

MH Assessment
Step 1 of the Golden Thread

Assessments are a collection of information and clinical analysis that are designed to evaluate the current status of a client's mental, emotional, or behavioral health.

- What is the purpose?
  - To learn about client's story
  - Gather information about the client 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:
    - Do they have an "included" diagnosis and an impairment in life functioning due to their mental health symptoms?

Who may establish a diagnosis and/or complete a mental health assessment

- A Licensed LPHA may: 1) Conduct MSE and establish a diagnosis and 2) May complete and sign the mental health assessment form.

- A Waivered/Registered LPHA: 1) Conduct MSE and establish a diagnosis (must have a licensed LPHA co-signature) and 2) May complete a mental health assessment form.

- A Second Year FTE MH Graduate Student/Trainee with written attestation (placed in personnel file by the current Licensed Clinical Supervisor that the student trainee has sufficient education, training and experience to diagnose independently with the Licensed Supervisor's on-going full record review, supervision and co-signature) 1) May conduct a MSE and establish diagnosis (with licensed LPHA co-signature) and 2) May complete mental health assessment form (with a licensed LPHA co-signature).

- A First Year Graduate Students: 1) May not establish a diagnosis, 2) May complete and sign a MH Assessment form (with a Licensed LPHA co-signature).
  - When a first year graduate student completes an assessment, they may not complete the diagnosis section of the assessment form. Only a clinician with the proper scope of practice may meet with a client to conduct a MSE and establish a diagnosis. That clinician must complete and sign (with required co-signatures) the diagnosis section of the assessment.

Mental Health Assessment
MHRS Activities

If the agency determines it is within their scope of ability, training, and experience **MHRS & Adjunct Staff** may collect self-report information in the areas of:

- Mental health and medical history
- Substance exposure and use
- Identifying strengths, risks, and barriers to achieving goals
- Demographic information

- MHRS & Adjunct Staff may not enter information into the Assessment form. This information must be documented in progress notes.

- Progress Notes will generally indicate:
  - *"Client/Family Member/Other reports _____."*

Mental Health Assessment Dates

- The Initial Mental Health Assessment is due within 60 days of the Episode Opening Date (EOD).
- Annual Assessments after that are due within the 30 day period prior to the first day of the Episode Opening Month (EOM).
  - *Example:*
    - Episode Opening Date (EOD) 8/28/16 and Assessment due by 10/26/16 (actual 60 day count) before claiming for planned services.
    - Annual Assessment is due in July 2017 and all required signatures must be obtained no later then 7/31/2017 (in order to claim planned services).

- Programs with earlier assessment due dates:
  - DTI, DR, Adult Residential, Crisis Residential by day seven (7)
  - Psychiatric Health Facility Services - 72 hours (actual count)
  - Psychiatric Inpatient Services - 72 hours (excluding Sat. & Sun)
  - TBS Services – Prior to any TBS claiming

Completing the Mental Health Assessment

- If it is not possible to address all required elements of the assessment due to issues of client participation or inability to obtain a full history, but medical necessity has been established, the Assessment should be completed within the required deadlines, with notations of when addendums with missing information are expected.
- If medical necessity can not be established (due to clinical reasons) do not complete the assessment until this information can be obtained.
  - You may continue to bill for assessment (and other unplanned services) until you complete an assessment.

Required Items of a Mental Health Assessment

- Identifying Information (now includes SOGIE)
- Communication Needs
- Medical History
- Presenting Problem(s) / Referral Reason
- Relevant Conditions & Psychosocial Factors
- Risks
- Client / Family Strengths
- Medications
- Allergies / Adverse Reactions / Sensitivities
- Substance Exposure/Use
- Mental Health History
- Other History (Employment, living situation, etc.)
- For Clients Under Age 18
  - Prenatal/Perinatal Events and Complete Developmental History
- Mental Status Exam (MSE)
- Complete Diagnosis with required signatures
- Complete Signature of Individual Completing the Assessment (with required co-signatures)

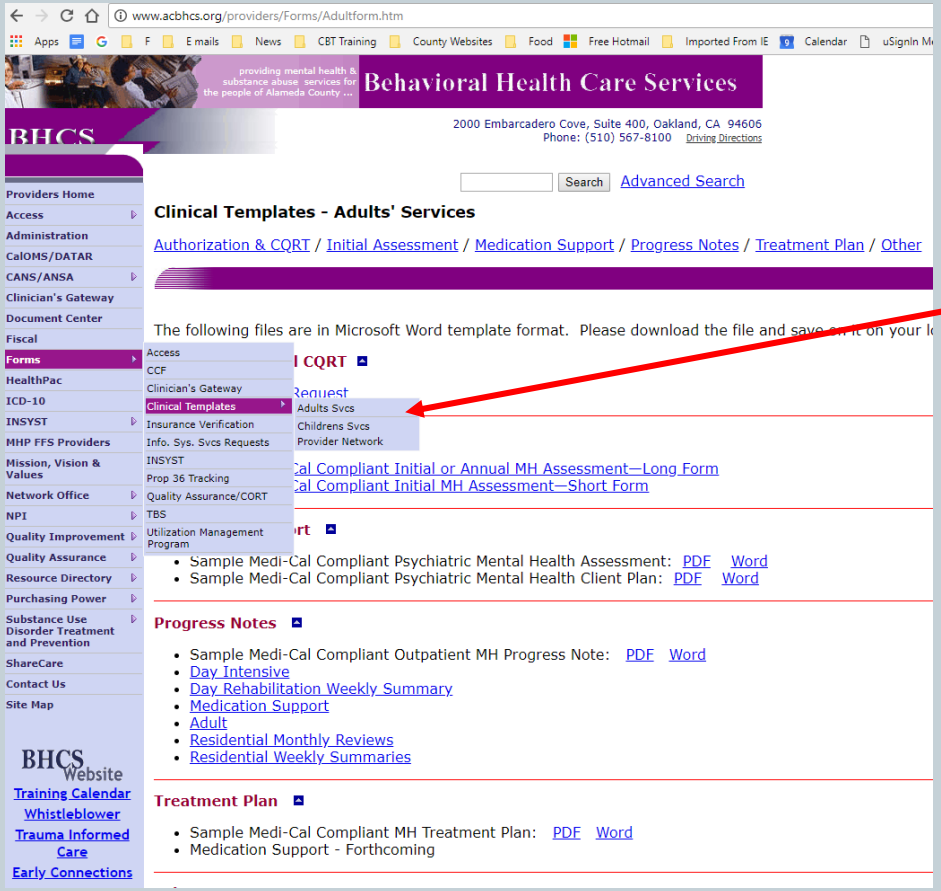
BHCS SMHS Documentation Manual provides specific information about the minimum required elements for each of these items

Assuring Form Compliance

- It is the provider's responsibility to keep their forms (including EHR forms) up to date with all Medi-Cal documentation requirements.

- Clinician's Gateway is in the process of being updated, however it is the responsibility of each agency using CG to follow current SMHS documentation standards by including the required information into CG, for example into narrative fields.

Clinical Forms on BHCS Provider Site



http://www.acbhcs.org/providers/Forms/

Cultural Considerations

- Identified during the Assessment Process and addressed in the Plan if appropriate
    - Language & Physical Limitations
    - Race, Ethnicity, Socio-Economic Status, Class, Religion, Immigration status/Citizenship, Geography,
    - CG now includes SOGIE (Sexual Orientation/Gender Identity)

SOGIE Data Collection
Required at time of MH Assessment

- The ACBHCS EHR (CG) has been modified to include Sexual Orientation and Gender Identity (SOGIE) data collection.
- The Data collection will serve to identify LGBTQQI2-S populations which have historically been underserved as well as to assist the provider in providing culturally sensitive & responsive services.
- Gathering such data in clinical settings will allow providers to better understand and treat their clients, and to compare their clients' health outcomes with national samples of LGBT people from health surveys.

Why Collect SOGIE Data?

- Lesbian, gay, bisexual, and transgender (LGBT) clients have unique health needs and experience **numerous health disparities**
- They are an underserved population that is largely **invisible** in the health care system
- Routine and standardized collection of Sexual Orientation and Gender Identity Expression (SOGIE) information in medical and electronic health records (EHRs) will help assess**, satisfaction with, quality of care**, **inform the delivery of appropriate health services**, and begin to **address health disparities**

Why Collect SOGIE Data?

Use of national data, if local does not exist, to identify health inequities:
Example ***HEALTHY PEOPLE 2020:***
http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=25

LGBT youth are 2 to 3 times more likely to attempt suicide.

LGBT youth are more likely to be homeless.

Transgender individuals have a high prevalence of HIV/STDs, victimization, mental health issues, suicide and are less likely to have health insurance than heterosexual or LGBT individuals.

70% report being harassed at school.
90% report feeling unsafe at school

Elderly LGBT individuals face additional barriers to health because of isolation and a lack of social services and culturally competent providers.

LGBT populations have the highest rates of tobacco, alcohol, and other drug use.

National Resource Ctr for Youth Development: Fact Sheet & Healthy People 2020

Why Collect SOGIE Data?

Statewide data: Building Partnerships: Conversations with LGBTQ Youth About MH Needs and Community Strengths: UC Davis Center for Reducing Health Disparities, 3/2009, cont:

- LGBTQ youth reported being harassed and bullied in their schools, homes, and neighborhoods on an almost-daily basis.
- Many youth shared that they had received death threats.
- LGBTQ youth identified social factors as major causes of mental illness in their communities including challenging economic and physical living conditions.
- LGBTQ youth described their struggles with rejection by their families and peers and harassment at school by students, teachers, and administrators, and how it often leads to feelings of isolation, hopelessness, despair, self-destructive behaviors, suicidal thoughts, attempts, and completed suicides.

Why Collect SOGIE Data?

Understanding LGBT People

- It is important for health care providers to understand who are LGBT people and to have a common understanding of terms and definitions
- This allows for effective and respectful communication and the delivery of culturally competent care
- Health care providers will be better equipped to serve their clients and LGBT communities
- L,G,B,T people are a very diverse group with many unique issues, and many common bonds

Discussing SOGIE Sensitively

- **What's in a Word?**

Discussing SOGIE Sensitively Cont.

Recommendations for Assessment Clinician--Barriers (cont.):

During provider-client interaction there are several potential barriers to gathering this information.

- Providers may not be comfortable asking these questions, or lack knowledge on how to elicit this information.
- Some worry LGBT people will be reluctant to disclose due to anti-LGBT stigma and prejudice.
- This may be true, and as a result not all LGBT clients will disclose their sexual or gender identity.

Discussing SOGIE Sensitively Cont.

Recommendations for Assessment Clinician--Barriers (cont.):

- However, this should not prevent providers from asking such questions and trying to gather such data.
- As society becomes more tolerant and accepting of LGBT people, more and more LGBT clients will self-disclose.
- In the meantime, the data we get from those who do self-disclose allows us to better understand the unique health needs and experiences of LGBT people.

Discussing SOGIE Sensitively Cont.

Sex Assigned at Birth: ☐Male ☐Female ☐Intersex ☐Other: ☐Declined to State

Gender Identity: ☐Male ☐Female ☐Intersex ☐ Gender Queer Transgender: ☐Male to Female [(Ctrl) e to Male

☐Decline to State ☐Gender non-conforming ☐Unknown ☐Other

SEXUAL ORIENTATION: ☐Unknown ☐Heterosexual/Straight ☐Lesbian ☐Gay ☐Bisexual ☐ Queer ☐Gender Queer ☐Questioning ☐Declined to State ☐Other:

What is your Pronoun? ☐Unknown ☐She/her ☐He/him ☐They/them ☐Declined to State ☐Other:

- For Gender Identity, Sexual Orientation and "My Pronoun" *select all that apply*.
- When collecting "*caretaker/guardian*" information—use that label rather than mother/father (may be same-sex household), parent (may be extended family members), etc. Only exception would be biological parents if genetic information is needed.
- If spouse is being requested: indicate *"spouse or significant-other"*

SOGIE

- Assessing for and Collecting SOGIE information is required.
- If a client does not wish to disclose such information, or a comprehensive collection of this information is not possible due to time constraints or extenuating circumstances, or it is clinically counter indicated to do so, you must document the reasons the information was not collected and what plan you have to collect this information in the future.

SOGIE

All providers should seek ongoing Continuing Education and consultation to gain skills and knowledge to serve this population.

MH Assessment
Step 1 of the Golden Thread *continued*

- Medical Necessity is established in the assessment by documenting the:

- 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. Community Life, Family Life, Safety School/Education, Vocational, Independent Living (ADL's), Health, Housing, Legal, SUD, Food/Clothing/Shelter, etc.

  - Best practice to document both the client's activity level both **prior to** and **at the onset** of symptoms.

The Mental Health Assessment

- 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 clinically indicated refer client to SUD treatment/provider.
- If appropriate establish SUD Diagnosis
  - Cannot be primary (FOCUS OF TX) Diagnosis
  - May only be addressed in the Client Plan by addressing the underlying MH Dx's signs, Sx, and behaviors through the MH Objectives.

What to Include in the Assessment for Case Management Services

- Within the MH Assessment
  1) Indicate areas of need regarding community supports (housing, vocational, educational, medical, SUD, etc.)
  2) MH Impairments
     a. Link that the ADULT client's inability to access and utilize needed community supports (in the area of need such as housing) is due to the specific (state which and how impacts) severe MH Impairments of Included Dx. OR
     b. Link that the CHILD'S lack of housing, medical, educational, etc. services exacerbates their MH Sx's of x, y,& z and MH impairments of a, b, & c.
  3) The third requirement—that successful Case Management is expected to decrease a client's MH symptoms and impairments and is usually in the Client Plan.
  4) Alternatively, all of the above three items may be in each PN.

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

MH Assessment
Step 1 of the Golden Thread *continued*

- If assessment information is gathered AFTER the initial assessment has been completed, an Assessment addendum may be created. The original Assessment, once signed may not be altered in any way.
  - The additional information MUST BE added via a formal Addendum (including required signatures) to the Assessment, and then incorporated into the next Annual Assessment.
  - Recommended components of the MH Assessment Addendum include:
    - The interim history,
    - Any changes in all of the areas of the MH Assessment previously collected,
    - A current included (aka "Covered") diagnosis,
    - Signs and symptoms of the Diagnosis that meet DSM criteria,
    - Functional impairments as a result of that Diagnosis,
    - Level of impairment, and
    - Client's ability to benefit from treatment.
    - Date of Completed MH Assessment of which this Addendum is addressing

Mental Health Assessment

- Only unplanned services may be claimed prior to the completion of the mental health assessment
- Unplanned services include:
  - Assessment (includes CANS/ANSA)
  - Plan Development
  - Interactive Complexity
  - Crisis Psychotherapy
  - Intensive Care Coordination (ICC) (referral and linkage only)
  - Case Management / Brokerage (referral and linkage only)
  - Urgent Medication Services only*

*Record must clearly document services are urgent in order to be claimed

Risk Categories as Identified by DHCS

Each of these areas must be assessed, however only those categories identified as risk to the client need to be documented in the assessment

- History of Danger to Self (DTS) or Danger to Others (DTO)
- Previous inpatient hospitalizations for DTS or DTO
- Prior suicide attempts
- Lack of family or other support systems
- Arrest history, if any
- Probation status
- History of alcohol/drug abuse
- History of trauma or victimization
- History of self-harm behaviors (e.g., cutting)
- History of assaultive behavior
- Physical impairments (e.g. limited vision, deaf, wheelchair bound) which makes the beneficiary vulnerable to others
- Psychological or intellectual vulnerabilities [e.g., intellectual disability (low IQ), traumatic brain injury, dependent personality]

Documenting Risk in the Assessment

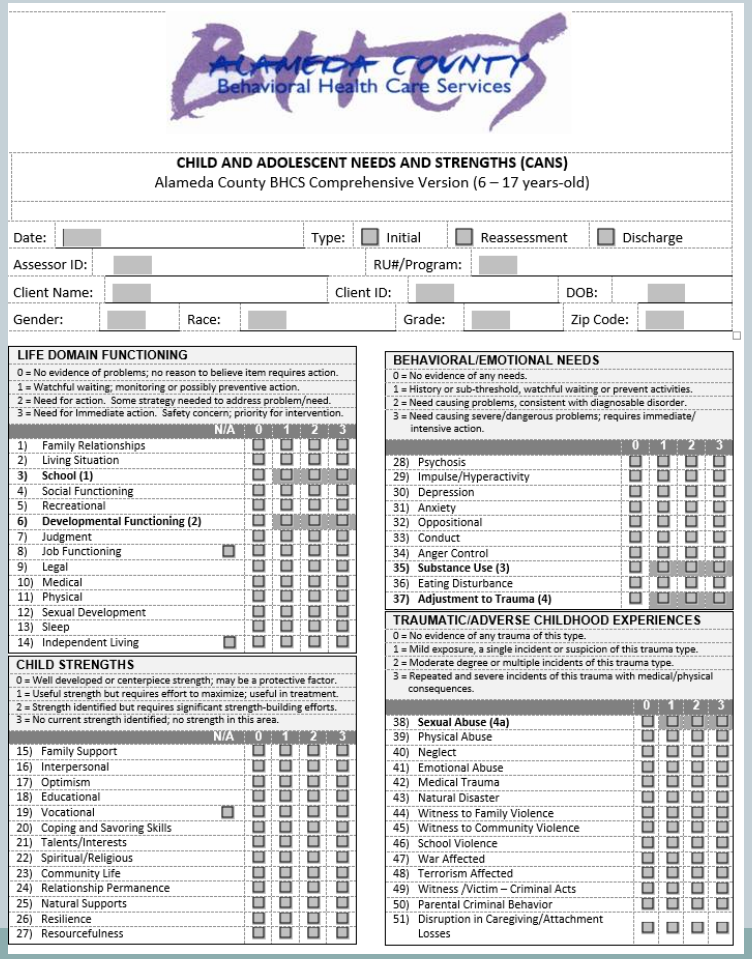
- When these categories exist for the client, they should be addressed in the MH Assessment

- If in the past 90 days there has been suicidal or homicidal ideation or any other significant risk (including above examples) BOTH a Comprehensive Risk Assessment AND a Formal Written Safety Plan must be created and documented in the medical record

CANS / ANSA

- The CANS is a performance outcome assessment tool

- The CANS is used for identifying and prioritizing youth and family actionable needs and useful strengths to inform treatment plans. It provides a framework for developing and communicating about a shared vision and uses youth and family information to inform planning, support decisions, and monitor outcomes.



ALAMEDA COUNTY
Behavioral Health Care Services

CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS)
Alameda County BHCS Comprehensive Version (6 – 17 years-old)

Date: | Type: ☐ Initial ☐ Reassessment ☐ Discharge
Assessor ID: | RU#/Program:
Client Name: | Client ID: | DOB:
Gender: | Race: | Grade: | Zip Code:

LIFE DOMAIN FUNCTIONING
0 = No evidence of problems; no reason to believe item requires action.
1 = Watchful waiting; monitoring or possibly preventive action.
2 = Need for action. Some strategy needed to address problem/need.
3 = Need for Immediate action. Safety concern; priority for intervention.

	N/A	0	1	2	3
1) Family Relationships		☐	☐	☐	☐
2) Living Situation		☐	☐	☐	☐
3) School (1)		☐	☐	☐	☐
4) Social Functioning		☐	☐	☐	☐
5) Recreational		☐	☐	☐	☐
6) Developmental Functioning (2)		☐	☐	☐	☐
7) Judgment		☐	☐	☐	☐
8) Job Functioning	☐	☐	☐	☐	☐
9) Legal		☐	☐	☐	☐
10) Medical		☐	☐	☐	☐
11) Physical		☐	☐	☐	☐
12) Sexual Development		☐	☐	☐	☐
13) Sleep		☐	☐	☐	☐
14) Independent Living	☐	☐	☐	☐	☐

CHILD STRENGTHS
0 = Well developed or centerpiece strength; may be a protective factor.
1 = Useful strength but requires effort to maximize; useful in treatment.
2 = Strength identified but requires significant strength-building efforts.
3 = No current strength identified; no strength in this area.

	N/A	0	1	2	3
15) Family Support		☐	☐	☐	☐
16) Interpersonal		☐	☐	☐	☐
17) Optimism		☐	☐	☐	☐
18) Educational		☐	☐	☐	☐
19) Vocational	☐	☐	☐	☐	☐
20) Coping and Savoring Skills		☐	☐	☐	☐
21) Talents/Interests		☐	☐	☐	☐
22) Spiritual/Religious		☐	☐	☐	☐
23) Community Life		☐	☐	☐	☐
24) Relationship Permanence		☐	☐	☐	☐
25) Natural Supports		☐	☐	☐	☐
26) Resilience		☐	☐	☐	☐
27) Resourcefulness		☐	☐	☐	☐

BEHAVIORAL/EMOTIONAL NEEDS
0 = No evidence of any needs.
1 = History or sub-threshold, watchful waiting or prevent activities.
2 = Need causing problems, consistent with diagnosable disorder.
3 = Need causing severe/dangerous problems; requires immediate/ intensive action.

	0	1	2	3
28) Psychosis	☐	☐	☐	☐
29) Impulse/Hyperactivity	☐	☐	☐	☐
30) Depression	☐	☐	☐	☐
31) Anxiety	☐	☐	☐	☐
32) Oppositional	☐	☐	☐	☐
33) Conduct	☐	☐	☐	☐
34) Anger Control	☐	☐	☐	☐
35) Substance Use (3)	☐	☐	☐	☐
36) Eating Disturbance	☐	☐	☐	☐
37) Adjustment to Trauma (4)	☐	☐	☐	☐

TRAUMATIC/ADVERSE CHILDHOOD EXPERIENCES
0 = No evidence of any trauma of this type.
1 = Mild exposure, a single incident or suspicion of this trauma type.
2 = Moderate degree or multiple incidents of this trauma type.
3 = Repeated and severe incidents of this trauma with medical/physical consequences.

	0	1	2	3
38) Sexual Abuse (4a)	☐	☐	☐	☐
39) Physical Abuse	☐	☐	☐	☐
40) Neglect	☐	☐	☐	☐
41) Emotional Abuse	☐	☐	☐	☐
42) Medical Trauma	☐	☐	☐	☐
43) Natural Disaster	☐	☐	☐	☐
44) Witness to Family Violence	☐	☐	☐	☐
45) Witness to Community Violence	☐	☐	☐	☐
46) School Violence	☐	☐	☐	☐
47) War Affected	☐	☐	☐	☐
48) Terrorism Affected	☐	☐	☐	☐
49) Witness /Victim – Criminal Acts	☐	☐	☐	☐
50) Parental Criminal Behavior	☐	☐	☐	☐
51) Disruption in Caregiving/Attachment Losses	☐	☐	☐	☐

CANS / ANSA

- The current ACBHCS CANS (96 items) has been modified to come in alignment with the CANS 50 required by the state (areas added but not removed). The changes to the CANS have be made within Objective Arts.

- The ACBHCS website is in the process of updating the manual and rating sheets. They will be available shortly.

CANS / ANSA

- **The CANS (0-5, 6-17) ANSA (T, 25+) is completed after the MH Assessment and before (informs) the Client Plan.**
  - **Required timeframes (all based on Episode Opening Date): by 60 days, every 6 months, at annual authorization, with every Plan update, and at discharge.**
    - **Any unscheduled or additional treatment plan updates that are done do not change the required CANS/ANSA 6 month and annual requirements.**
- **For Adults, ANSA**
  - **Same required timeframes.**
- **ACBHCS Provider Website/ CANS/ANSA**

http://www.acbhcs.org/providers/CANS/cans.htm

CANS /ANSA

- **The CANS and ANSA are Assessment Tools which may only be completed by the following CANS/ANSA certified individuals:**
  - **Licensed LPHA**
  - **Waivered or registered LPHA**
    - ***(if not diagnosing—diagnosis requires Licensed LPHA co-signature).***
  - **Graduate student/trainee in a recognized MH Master's or PhD program**
    - ***(if not diagnosing—may only reference Dx established by a Licensed LPHA, unless meets Scope of Practice requirements for diagnosing).***

Please note that MHRS and Adjunct staff may not complete the CANS/ANSA.

CANS /ANSA

- The only programs which will be exempt from administering the CANS are those providing ancillary services (such as Medication Clinics, Katie A services, and TBS services) where the child has another SMHS provider who is administering the CANS (usually the psychotherapist).
- Several Program Types are exempt from administering the ANSA.
- Contact ACBHCS QA department if you have questions about whether your agency/program is exempt from completing the CANS/ANSA.

Pediatric Symptom Checklist (PSC-35)

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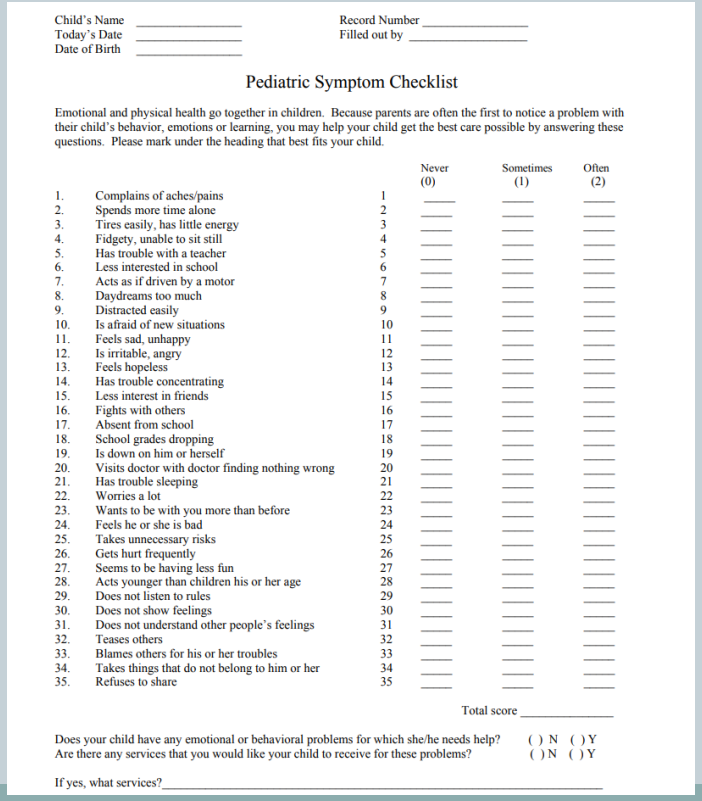
- The PSC-35 is a psychosocial screening tool designed to facilitate the recognition of cognitive, emotional, and behavioral problems so appropriate interventions can be initiated as early as possible. Parents/caregivers will complete PSC-35 (parent/caregiver version) for children and youth ages four (4) up to age eighteen (18).

- Implementation Date: July 1, 2018

- The PSC-35 should be offered at the beginning of treatment (by the completion of the full MH assessment) semi-annually (starting at the 5th month of service and every six months after that), each time the Client Plan is updated, and at the end of treatment. DHCS (and ACBHCS) may revisit the administration methodology in the future if it is determined this timeframe is insufficient.



Child's Name _____ Record Number _____
Today's Date _____ Filled out by _____
Date of Birth _____

Pediatric Symptom Checklist

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these questions. Please mark under the heading that best fits your child.

			Never (0)	Sometimes (1)	Often (2)
1.	Complains of aches/pains	1	____	____	____
2.	Spends more time alone	2	____	____	____
3.	Tires easily, has little energy	3	____	____	____
4.	Fidgety, unable to sit still	4	____	____	____
5.	Has trouble with a teacher	5	____	____	____
6.	Less interested in school	6	____	____	____
7.	Acts as if driven by a motor	7	____	____	____
8.	Daydreams too much	8	____	____	____
9.	Distracted easily	9	____	____	____
10.	Is afraid of new situations	10	____	____	____
11.	Feels sad, unhappy	11	____	____	____
12.	Is irritable, angry	12	____	____	____
13.	Feels hopeless	13	____	____	____
14.	Has trouble concentrating	14	____	____	____
15.	Less interest in friends	15	____	____	____
16.	Fights with others	16	____	____	____
17.	Absent from school	17	____	____	____
18.	School grades dropping	18	____	____	____
19.	Is down on him or herself	19	____	____	____
20.	Visits doctor with doctor finding nothing wrong	20	____	____	____
21.	Has trouble sleeping	21	____	____	____
22.	Worries a lot	22	____	____	____
23.	Wants to be with you more than before	23	____	____	____
24.	Feels he or she is bad	24	____	____	____
25.	Takes unnecessary risks	25	____	____	____
26.	Gets hurt frequently	26	____	____	____
27.	Seems to be having less fun	27	____	____	____
28.	Acts younger than children his or her age	28	____	____	____
29.	Does not listen to rules	29	____	____	____
30.	Does not show feelings	30	____	____	____
31.	Does not understand other people's feelings	31	____	____	____
32.	Teases others	32	____	____	____
33.	Blames others for his or her troubles	33	____	____	____
34.	Takes things that do not belong to him or her	34	____	____	____
35.	Refuses to share	35	____	____	____

Total score _____

Does your child have any emotional or behavioral problems for which she/he needs help? ( ) N ( ) Y
Are there any services that you would like your child to receive for these problems? ( ) N ( ) Y

If yes, what services?_____

PSC-35

- The PSC-35 does not require training because it is completed by the parent/caregiver. For more information about the tool, including implementation, scoring and clinical utility, please visit the Pediatric Symptoms Checklist webpage at:

http://www.massgeneral.org/psychiatry/services/psc_home.aspx.

PSC-35

- Once the PSC-35 has been completed by parents/caregivers, the results should be entered into Objective Arts.
- Time spent reviewing the PSC-35 for the first time is a billable assessment activity.
- If client's caregivers need help completing the PCS-35, time spent reviewing and completing the questions with the client's caregivers is a billable assessment activity.
  - Indicate in the progress note what barrier prevented the caregivers from completing the PSC-35 on their own and what interventions you did.

Medical Necessity & Assessment Review

What are the only MH services that may be provided before completion of the MH Assessment and Client Plan?

- MH Assessment (with & w/o medical component, & behavioral eval)
- Plan Development
- Crisis Intervention
- Crisis Stabilization (in CSU only)
- Case Management and ICC (linkage and referral only)
- Urgent medication services

When must an agency's chart go to CQRT for authorization and Quality Review purposes?

- Initially and Annually. We recommend that CQRT happen after the Assessment and Plan are completed, but before their due dates. This gives the clinician time to address any concerns identified in the assessment or plan before the authorization due date. This helps to preserve billings.
- All Charts must be reviewed for authorization before 60 days, and before the annual due date.

Medical Necessity & Assessment Review Cont.

What are the three requirements for Medical Necessity?

1. An Included Dx which is the Primary Focus of Tx
2. A Qualifying Impairment
3. A Qualifying Intervention

When must a client be screened with the Brief Screening Tool

- Before starting treatment, Annually and with every Client Plan Update.

What are the usual due dates for the MH Assessment and Client Plan?

- 60 days

Who may complete (and sign a MH Assessment) and formulate a Dx, but requires co-signature for the Dx?

- Waivered or Registered LPHA, qualified 2nd year MH graduate students, and certain nursing staff (see Guidelines for Scope of Practice Credentialing for requirements)

Who may not formulate a Dx and as well requires a Licensed co-signature on the Assessment?

- 1st year Graduate trainee/students

Client Plans

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PART OF THE GOLDEN THREAD

Introduction to Client Plans

- Client Plans are plans that outline the goals and objectives of treatment based upon the diagnosis, areas of functioning, and medical necessity

- Selected services address identified mental health needs, consistent with the diagnosis that are the focus of the mental health treatment.

Getting Ready to Write Plan with Client

- ✓ Established Medical Necessity
- ✓ Completed Assessment with required co-signatures
- ✓ Completed CANS/ANSA
- ✓ Completed PSC 35
- ✓ Documented the need for case management in the Assessment if considering providing case management services
- ✓ Considering completing a Safety Plan if you have assessed any risk factors within the past 90 days and including an objective related to containment
- ✓ Considering addressing any cultural, linguistic, physical limitations in Plan

Who can create and complete Plans?

- ✓ All Staff with appropriate training and experience may complete Plans.
- ✓ Trainee, MHRS & Adjunct Staff require Licensed co-signatures.
- ✓ If Medical Provider prescribes to the client, they must co-sign (currently no claim disallowance if late).

Services that Require a Treatment plan

- An approved Client Plan must be in place prior to service delivery for the following Specialty Mental Health Services:
  - Planned Mental Health Services: Individual, Group, and Family Psychotherapy; Individual and Group Rehabilitation; Collateral; and Medication Services.
  - Intensive Home Based Services (IHBS)
  - Monitoring activities of Intensive Care Coordination (ICC)
  - Monitoring activities of Targeted Case Management/Brokerage
  - Therapeutic Foster Care
  - Therapeutic Behavioral Services (TBS)
  - Day treatment intensive
  - Day rehabilitation
  - Adult residential treatment services
  - Crisis residential treatment services
  - Psychiatric Health Facilities
  - Psychiatric Inpatient Services

Client Plan - Cycles

- **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 in sync with the Episode Opening Date (EOD).

- Every subsequent Treatment Plan is due on a 12 month cycle, completed within the 30 day period prior to the first day of the EOD month.
  - Example: EOD 8/18/18, then the Initial Plan is due: 10/16/18
  - The 2nd treatment plan is due by 8/1/19 and to be completed no earlier than 7/1/19.

Programs with Earlier Plan Due Dates

- Day Treatment Intensive / Day Rehab - first billed day, signed (or co-signed) by LPHA and client (or reason client refused)
- Adult Residential / Crisis Residential / Psychiatric Health Facility Services – 72 hours (actual count) signed (or co-signed) by LPHA and client (or reason client refused)
- Psychiatric Inpatient Services - 72 hours (excluding Sat. & Sun) signed by MD and client (or reason client refused)
- TBS Services – Prior to any TBS claiming

Interim Assessments to Allow Earlier Development of Treatment Plans

- If staff/programs do not have enough time to complete full Mental Health Assessments (with all required elements) before completing a treatment plan, an Interim Assessment can be completed.

- An Interim Assessment must include the essential medical necessity components:
  - A current included ("covered") diagnosis
  - Signs and symptoms of the Diagnosis that meet DSM criteria
  - Functional impairments as a result of that diagnosis
  - Level of impairment
  - Client's ability to benefit from treatment
- An Interim Assessment does not meet Medi-Cal requirements for a full completed assessment. A Full assessment with all required elements must be completed by the due date.

Programs with Different Time Requirements

Type of Program	Interim Assessment Due Date	Treatment Plan Due Date (a full or Interim Assessment must be completed before TP is completed)	Full Mental Health Assessment (With All components)
Day Treatment Intensive	1st Day	1st Day	By Day 7
Day Rehabilitation	1st Day	1st Day	By Day 7
Adult Residential Treatment Services	72 Hours	72 Hours	By Day 7
Crisis Residential Treatment Services	72 Hours	72 Hours	By Day 7
Psychiatric Health Facility Services	72 Hours	72 Hours	72 Hours – Actual Count
(Acute) Psychiatric Inpatient Services	72 Hours	72 Hours	72 Hours – excluding Saturday and Sunday

Interim Assessments and Treatment Plans

- Programs that determine it is clinically indicated to provide certain planned services before they are able to complete a full assessment (Example: Want to get client into a group therapy session within the first week), may complete both an interim assessment and treatment plan to allow for those planned services.
  - An Interim Assessment does not meet Medi-Cal requirements for a full completed assessment. A Full assessment with all required elements must be completed by the due date.
  - Any treatment plan must always have the required Medi-Cal documentation components.
  - Any treatment plan that is informed/created by an Interim Assessment will usually need to be rewritten after the full assessment is complete.

Client Plan - Goals

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 optional *Long Term Mental Health Goals* which support the *Client Life Goals* by linking them to the specific MH Objectives.
- 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 – Mental Health Objectives

All Plan Objectives MUST BE Mental Health focused (not housing, employment, SUD tx, etc.)

- 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

How to create a strong Mental Health Objective that measures a reduction in symptoms.

- Questions to ask the client and yourself:
  - Consider the client's Diagnosis. Example: Bipolar II F31.81
  - Identify with client which symptoms/behaviors/impairments that are associated with the client's primary diagnosis they would like to work on. (Example: "Diminished ability to think or concentrate nearly every day.") Note: It helps to use the criteria from the DSM 5.
  - Ask the client to estimate the number of times that symptoms and/or behaviors happen on a daily, weekly, or monthly basis? (Example: Client reports that client experiences difficulty concentrating on tasks on a daily basis because they worry that they are going to start a depressive episode or not be able to manage mood swings.)
  - Ask the client how many times they want the symptoms/behaviors/impairments to decrease. Encourage the client to set realistic numbers. (Example: Client will reduce the number of times that they experience difficulty concentrating on tasks from 7 days a week to 4 days or less.)
  - Develop a way to measure the change. (Example: …as evidenced by client report.)
  - Develop a time frame. (Example: … in the next 12 months.)

Examples of Good Mental Health Objectives

- Example of an objective to reduce an impairment/symptom:
  - In the next 12 months, client will reduce the number of times that they experience difficulty concentrating on tasks from 7 days a week to 4 days or less as evidenced by client's self report.

Example of a strength based objective to increase positive behavior:

- In the next 12 months, client will increase the number of times that they use positive coping skills when they have difficulty concentrating from 1 out of 10 times to 8 out of 10 to times as evidenced by clients daily journal.

Client Plan – Service Modalities

Service Modalities

- Identify the proposed type(s) of service modalities to be provided along with a proposed frequency and duration.

- If a *planned* service modality is not in the client plan it MAY NOT BE CLAIMED and will be disallowed.
  - Unplanned services do not need to be listed in the plan.
    - Note that monitoring activities of ICC and Case Management / Brokerage are considered planned services and must be listed in the plan

Example:

- Individual Psychotherapy 1x per week, and as needed, for 12 months
- Case Management 1x per month, and as needed, for 12 months
- Group Therapy 1x per week , for 12 months
- Collateral 1x per month, and as needed, for 12 months.

Adding "AND 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 and "or as needed" IS NOT ALLOWED. Both would result in Disallowances.***

Client Plan – Required Services Modalities

Required Service Modalities to be listed in the Client Plan with Common Frequencies and Timeframes:

- **Collateral** (Includes: Collateral, Collateral-Caregiver, & Collateral-Health Care Provider) – Weekly and as needed, for 12 months
- **Case Management** (Planned F/U Services) – Weekly and as needed, for 3 – 12 months
- **Medication Services (NON-URGENT)**– Monthly and as needed, for 12 months
- **Individual Therapy** – Weekly and as needed, for 12 months
- **Individual Rehabilitation** – Weekly and as needed, for 12 months
- **Group Psychotherapy** – Weekly for 12 months
- **Group Rehabilitation** – Weekly for 12 months
- **Family Therapy** – Weekly for 12 months
- **Collateral Family Counseling** – 2x month and as needed for 12 months
- **Multi-Family Group Therapy** – Weekly for 12 months
- **Collateral Family Group** – Weekly for 12 months
- **TBS** – Weekly and as needed, for 3 – 12 months
- **ICC** – Weekly and as needed, for 3 – 12 months
- **IHBS** – Weekly and as needed, for 3 – 12 months
- **Child Family Team (Katie A. Coordinators only) -** Weekly and as needed, for 3 – 12 months
- **Day Rehabilitation (1/2 or Full Day)** – Daily, for 6 months
- **Day Treatment Intensive (1/2 or Full Day)** – Daily, for 6 months
- **Psychological Testing** (Includes Psych Test, Developmental & Neuropsych) – Weekly and as needed, for 3 months
- **Adult Residential** – Daily for 6 – 12 months
- **Crisis Residential** – Daily for 3 – 12 months
- **Crisis Stabilization** – Daily for 3 months

Client Plan – Detailed Interventions

Detailed Interventions

For each service modality it is best practice to 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.
- Interventions for Collateral should include listing significant others (by names and/or roles) for whom contact is planned and indicating “and others as needed”.

Client Plan – Detailed Interventions

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

Examples:

- **Individual Rehab:**
  - *"Assist the client in re-engaging in pleasant social activities through the use of an activities chart in order to address the impairment of having lost all interest in previous enjoyable social activities as a direct result of her symptom of anhedonia of her Major Depression."*
  - *"Teach and reinforce active problem-solving skills in order to increase client's self-efficacy in order to address the impairment of poor self-esteem which is a direct result of her Major Depression."*
  - *"Help the client to identify early warning signs of relapse, review skills learned, and develop a plan for managing challenges (WRAP tools) in order to help prevent the relapse of depressive symptoms."*
- **Collateral:**
  - *Contact with significant support persons of client including parents, teacher and school counselor (others as needed) to assist client in meeting his/her MH Goals and Objectives.*
- **Med Services:**
  - *Med Mgt. strategies to engage client in collaboration to find, and optimize the dosage for effective anti-depressive medications.*

Developing Client Plans to Include Case Management Services

If Case Management Services (Brokerage/ICC) will be provided, the Detailed Interventions section of the plan, should document the following:

1) Successful case management (linkage and monitoring) is expected to result in the client's mental health symptoms being reduced and client's mental health objectives being achieved.
    1) Specific community resources that client will be linked to should be identified and documented.

Treatment Plan Required Signatures

- Treatment Plans must be finalized (unable to be further edited) and signed by all required clinical staff (including supervisor) before it is effective.
- All Treatment Plans must also be signed by the client and/or guardian.
  - Clinical judgment should be used to determine if it is appropriate to review treatment plans with young children. If appropriate obtain a client's signature. If not appropriate obtain a client's guardian's signature.

Treatment Plan Required Signatures

- 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.
- If the client's mental health symptoms (such as paranoia caused by schizophrenia) prevent client from reviewing and signing the treatment plan and it is determined that ongoing attempts are not clinically appropriate, this must be documented in a progress note and the unsigned treatment plan should reference this note.
- If a client does not sign a treatment plan due to unavailability (such as client no-showing to an appointment) future attempts must be made to obtain the client's signature. Unavailability (without other mental health mitigating factors) is not a reason to stop attempts at obtaining signatures on treatment plans.

Required Signature Dates on Treatment Plans

- All required staff signatures on Treatment plans require dates of signatures.
  - Treatment plans are considered effective once a form is finalized (and can not be altered) and the required staff signatures are present on the document.
  - See other slides for information on client signature requirements.
- Client signatures do not require a date to indicate when it was signed.
  - It is best practice to have clients date their signature
  - If a client does not date their signature, a provider may add the date and include their initials.

Exceptions to Signature Requirements

- A beneficiary's signature on the treatment plan is not required when:
  - The client is not expected to be in long term treatment (beyond 60 days)
  - Is only receiving one Specialty Mental Health Service (modality)
    - Currently, the only ACBHCS programs claiming one modality are Medication Services and TBS
    - Remember that Collateral is considered a modality

Note that even if one these exceptions is met, it is highly recommended that the client sign their plan.

Participation in Creation of Treatment Plan

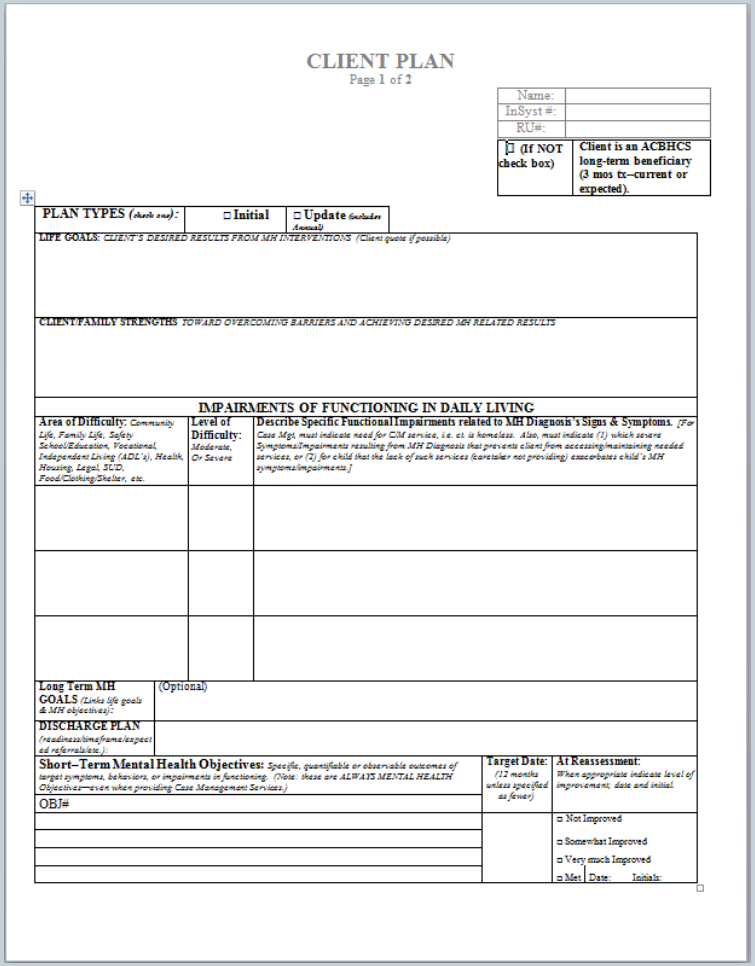
- The clinical record must document the client's participation in the development of the plan, agreement with the client's plan, and that the client was offered a copy of their plan.
  - The client's signature on the plan alone DOES NOT meet these requirements
- This information may be documented in progress notes and/or in the body of the treatment plan itself.

Updating Client Plans

- 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. medication services, case management, group rehab, individual therapy, etc.)

Medi-Cal 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 (3 mos tx–current or expected).

PLAN TYPES (check one):	☐ Initial	☐ Update (exclude Annual)

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, Safety School/Education, Vocational, Independent Living (ADL's), Health, Housing, Legal, SUD, Food/Clothing/Shelter, etc.*	Level of Difficulty: *Moderate, Or Severe*	Describe Specific Functional Impairments related to MH Diagnosis's Signs & Symptoms. *[For Case Mgt, must indicate need for CiM service, i.e. ex is homeless. Also, must indicate (1) which severe Symptoms/Impairments resulting from MH Diagnosis that prevents client from accessing/maintaining needed services, or (2) for child that the lack of such services (caretaker not providing) exacerbates child's MH symptoms/impairments.]*

Long Term MH GOALS *(Links life goals & MH objectives):*	(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. (Note: these are ALWAYS MENTAL HEALTH Objectives—even when providing Case Management Services.)*	**Target Date:** *(12 months unless specified as fewer)*	**At Reassessment:** *When appropriate indicate level of improvement, date and initial.*
OBJ#		
		☐ Not Improved ☐ Somewhat Improved ☐ Very much Improved ☐ Met Date: Initials:

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 participate in daily activities and to complete tasks including securing and maintaining housing due to: his severe symptoms of Major Depression of diminished interest and pleasure in daily activities, low energy, insomnia, indecisiveness, feelings of worthlessness and poor self-care.**
- **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 meet his life goals.**

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

Billable example cont.:

Mental Health Objective(s):

- **#1) Client currently experiences overwhelming feelings of depression (feelings of worthlessness and low energy) all day 6 days per week. The number of days that client gets overwhelmed by depression will decrease from 6 days per week to 3 days or less in the next 12 months.**

- **#2) 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;**

- **#3) Client reports being overwhelmed (due to low energy, disorganized planning, depressed mood) and reports that they only complete weekly living activities/tasks 25% of the time. Client will increase completion rate of daily living activities to 50% or more for the next 3 – 12 months. Client will keep a journal or task list to help measure their success.**

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

Billable example cont.:

- **Service Modality:**
  - **Psychotherapy 1x/week, and as needed, for 1 year;**
  - **Case Management 1x/week, and 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 skills to successfully overcome low energy and complete tasks.**
  - **Case Management – Successful linkage and monitoring/providing support to client to maintain needed housing community support services will decrease client's depressive symptoms. Client is currently very sad and depressed about their living situation and linking client to housing support services should significantly improve clients symptoms.**

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. ***[Not a MH Objective]***
- **Service Modality:** Case management 1x/week and 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.]***

Client Plan Review

May Collateral services be claimed before completion of the Client Plan?

- No

Name three reasons that all PLANNED services may be disallowed in a chart:

- Assessment not done Initially and Annually
- Client Plan not done Initially and Annually and when Clinically Indicated—or not signed by Provider and Client/Representative
- Service Modality not listed in Client Plan (Case Management, Collateral, etc.)

Client Plan Review

When must the CANS/ANSA be completed?

- After completion of the MH Assessment and before completion of the Client Plan
- Every 6 months
- When a treatment plan is changed/updated.
- At discharge.

What is the Authorization Cycle for a case that is opened on August 23rd?

- August 1st – July 31st each year.

When a Case Management need arises before completion of the MH Assessment and/or Client Plan may it be claimed as such?

- Only if it for the purposes of Referral and Linkage

When must all services of a certain type (i.e. Ind Rehab) be disallowed across the whole chart (episode of care)?

- When the service modality is not listed in the Client Plan.

Sharing Assessments and Treatment Plans

- Agencies with multiple RUs that share a medical record are allowed to share one mental health assessment and treatment plan for concurrent services. *(Example: If a client is receiving therapy services in one RU, and begins to receive medication services in a different RU, both RUs/providers may share the Assessment and Treatment Plan.)*
  - Open each RU with the date the client was first opened at the agency
- Any documentation that is in need of updating must be addressed within the agency
  - For example, informed consent must be completed when new modalities are added to the plan
  - Multiple RUs within an agency may decide to share a plan or create separate plans. **Adding an additional modality will always require an update to the treatment plan.**

Sharing Assessments and Treatment Plans

- All client records must contain required forms.
- If multiple RUs (in one agency) do not share a chart, all shared documentation must be copied into each chart. This includes documents from the initial Episode Opening Date Such as:
  - Screening Form (with associated progress notes.)
  - Informing Materials (with associate progress notes.)
  - Mental Health Assessments (with associate progress notes.)
  - CANS/ANSA (with associate progress notes.)
  - Client Treatment Plan (with associate progress notes.)
  - Release of Information (with associate progress notes.)
- For BHCS county owned and operated programs, “one agency” is considered one program which has a unique folder in the Laserfiche database.

Sharing Assessments and Treatment Plans

For Initial Assessments Only

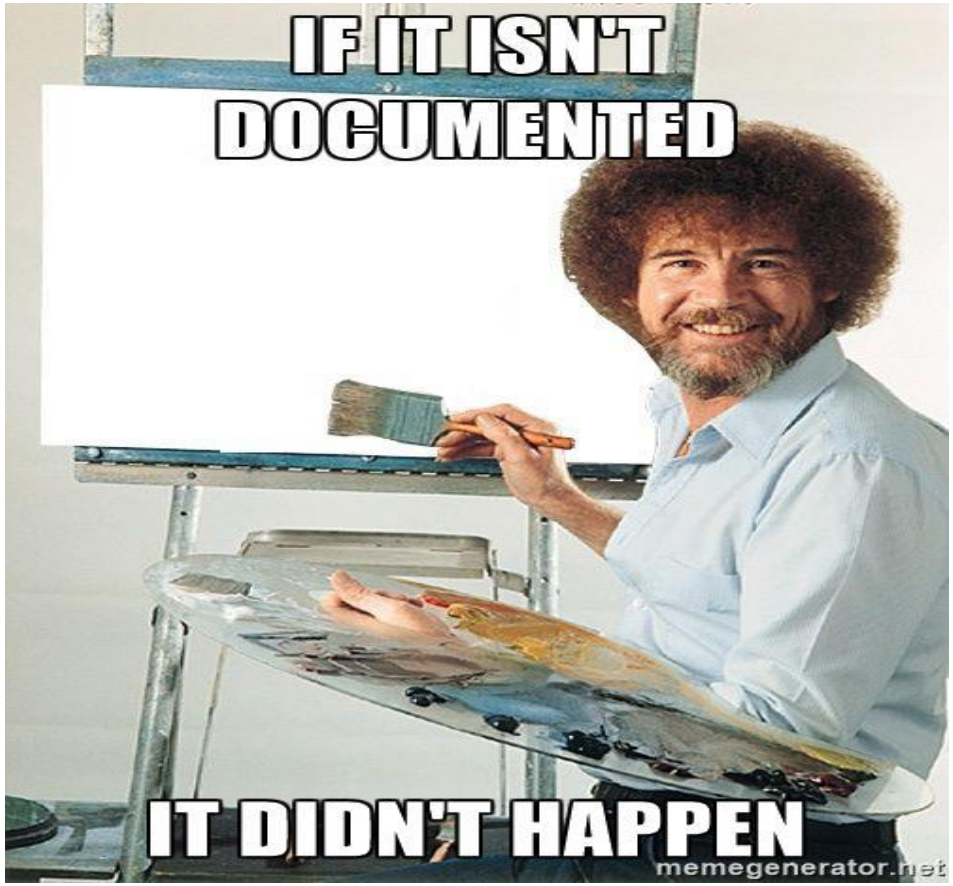
If a full assessment has been completed for a client it is possible for providers to use this assessment and update it under the following circumstances:

- Full Assessment Completed within the same agency in last 12 months.
- Full Assessment Completed by another agency in the last 6 months.

Sharing Assessments and Treatment Plans

- To use a previously completed Assessment, the following should occur:
  - A Copy of the Assessment should be placed into the chart
  - The Assessment should be reviewed with the client to assure accuracy
  - An Assessment Addendum must be completed that includes:
    - Interim History
    - Any changes in all of the areas of the MH Assessment Previously collected
    - A current included diagnosis
    - Signs and symptoms of the Diagnosis that meet DSM criteria
    - Functional impairments as a result of the diagnosis
    - Level of impairment
    - Client's ability to benefit from treatment.

Progress Notes


IF IT ISN'T
DOCUMENTED
IT DIDN'T HAPPEN
memegenerator.net

Progress Notes

- Progress notes are evidence of a provider's services to or on behalf of a client and relate to the client's progress in treatment.
- Progress notes describe how services provided addressed the:
  - Reduction of the impairment(s), restoration of functioning, and/or prevention of significant deterioration in an important area of life functioning as outlined in the client plan.
- In order to submit a service for reimbursement, there must be a complete, signed, and filed progress note for that service.
- Progress notes document both direct services (such as therapy) provided to clients as well as indirect (such as completing an assessment form or treatment plan).

Progress Notes
Step 3 of the Golden Thread

- Progress Notes must contain:
  - InSyst 3 digit, and/or CPT (*Remember not all services have an equivalent CPT code and in that case the InSyst code will need to be used*), Procedure Code (or exact name per ACBHCS) claimed.
  - Date of Service
  - Face-to-Face (in-person) and Total Time
    - If you are claiming for a time based code (such as psychotherapy codes where the specific code selection is based on time duration) and the work is done on the telephone: indicate f-f time = 0 and IN THE BODY OF THE PN indicate: telephone contact time = 20 mins (for example).
  - Preferably also includes Travel and Documentation Time.
  - Indicates what language the service was provided in (unless Assessment indicates "client is English speaking and all services will be provided in English").
  - Legible Provider Signature with M/C credential and date signed.
  - See next slide for content required (such as P/BIRP).
  - **DOCUMENTATION TIME DOES NOT EXCEED 25% OF TOTAL TIME, OR 10 MINUTES—WHICHEVER IS HIGHER. Or results in disallowance.**

Progress Notes
Step 3 of the Golden Thread

123

- Always indicate which MH Objective (restate or reference # of Objective in Plan) is being addressed.
- P/BIRP Format (document that service date's): ***(Also, See Handout.)***
  - **P**urpose/**P**roblem/**B**ehavior/Assessment
    - P/B = Documents what is presently going on with the client (brief narrative) , especially in terms of progress towards MH goals and objectives.
  - **I**ntervention by Staff,
    - I = Identifies what you did today (i.e., what specific intervention was provided toward the mental health objectives)
  - **R**esponse of Client to Intervention,
    - R = Identifies client's response today toward the interventions and impact/progress toward their MH 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.

Modifying Progress Notes for Case Management Services

- Within the 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., *"case management service will result in a decrease in MH symptoms of x, y, & z and an increase in adaptive functioning of a, b, & c [per MH Objective(s) # and #".)*
  - Modifying the B/PIRP Format for Case Management
    - "B/P" = Client reported that he believes the government has been monitoring his phone calls and is scared to call the housing authority to put in an application for support. Client has not been able to access housing support services in spite of desire to do so. It is expected that successful *case management service to link client to housing support will result in a decrease in paranoid symptoms and an increase in adaptive functioning of being able to successful carry out desired activities of independent living skills.*
    - "I" = Called housing provider with referral and provided linkage to needed housing support services. Appointment made and provided to client.
    - "R" = Client agreed to make scheduled housing support intake appointment and to report back to this provider at our next scheduled appointment.
    - P = Client will make scheduled housing support appointment and will f/u with this writer at next week's meeting to monitor their success in participating in service linked to today.

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—see next slide
- Only use ACBHCS abbreviations!
  - (See ACBHCS Abbreviations Handout)

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

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

Sample Provider Signature Sheet

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

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

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

Progress Notes
Step 3 of the Golden Thread *continued*

- Progress Notes:
  - Must be linked/connected to a MH objective on the Client Plan
  - *Best practice to complete same day/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 (i.e.. Case Management when combined with any other service), or if all services are claimed at the same rate—claim to the predominant service.*

A word about cloning

No, not this kind of cloning

Cloning or copy/paste

- https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-ehr-providerfactsheet.pdf

"This practice involves copying and pasting previously recorded information from a prior note into a new note, and it is a problem in health care institutions that is not broadly addressed …

The medical record must contain documentation showing the differences and the needs of the patient for each visit or encounter …

The U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG) indicated that due to the growing problem of cloning, its staff would be paying close attention to EHR cloning."

Example Progress Note

130

- Procedure Code/Name: 442 Psychotherapy 45 minutes
- Location: Office
- Total Time: 55 Minutes

Date of Service: 2/1/17
Face to Face Time: 45 Minutes
This service was provided in English

Mental Health Objective #	Objective #3 from the Client Plan
Behavior/Purpose or Problem	Client presents today for individual therapy. Client continues to have sleep problems and negative thoughts due to depression. Client reports sleeping about 3-4 hours per night since our last session. Today client appears tired, flat affect, and depressed mood.
Intervention	Practiced Cognitive Behavioral relaxation techniques with client – visualized tranquil places relaxing to client. Practiced breathing techniques. Replaced negative thought of "I am constantly screwing things up and making mistakes" to "I sometimes make mistakes but it is not all the time and I often do things right."
Response	Client was able to identify negative thoughts and replace with alternative thoughts. Client had some anxiety but was eventually able to relax and practice breathing techniques and visualization.
Plan	During the next week client will practice new skills before bed and keep track of hours slept per night.

Challenges/Barriers

- Not enough time/productivity pressures
- Crisis situations add more paperwork
- Technology challenges – slow internet connection, old computers
- Exhausted, overwhelmed, tired after seeing clients
- Remembering all the rules of Medi-Cal documentation
- Case load deadlines– tracking treatment plans, annuals due
- Lack of training in clinical writing
- Not a fun part of the job – didn't become a clinician to do paperwork
- Can't bill for a lot of what we actually do or want to do for our clients
- Writing 1 note can take a long time due to feedback/style/corrections
- Secondary trauma – writing notes can be triggering
- Hard to balance "client friendly" vs "professional, clinical" writing
- Not being in the office because of traveling to meet with clients

Overcoming Barriers/Challenges

- Time management (setting up schedules, reminders, personal "tickler" system)
- Training, Practice - Reinforcing the right way!
- Reframing the purpose of documentation – seeing client's record as part of client care and collaboration, how our agencies get paid, how we get paid means we can continue to provide services
- Tips and Advice from co-workers
- Using "tip sheets" (like slides or checklist)
- Supervision for support

Progress Note Review Questions

- What are the five components of a Progress Note?
  - Linked to a specific MH Objective (state or indicate #).
  - Today's Problem/Behavior/Assessment/Evaluation
  - Today's Staff Intervention
  - Today's Client's Response to Intervention
  - Plan for f/u, homework, additional services, etc.
- Would an auditor allow a PN that repeated the Staff's MH Intervention almost verbatim from the previous encounter?
  - No
- What are the M/C Credentials that must always be used when signing a PN or other document in the Medical Record?
  - Medical Providers:
    - MD, DO, NP
  - Licensed LPHA Clinicians:
    - PhD-L, PsyD-L, LCSW, MFT, LPCC, LPCC-F
  - Waivered/Registered LPHA Clinicians
    - PhD-W, PsyD-W, ASW, PCC-Intern, MFT-Intern, MSW-W (out of state), PCC-W (out of state)
  - Practicum Students in MH approved programs:
    - Trainee
  - Others:
    - MHRS, OR Adjunct Staff

Procedure Codes

Procedure Codes

Key things to ask yourself when choosing a Procedure Code

- *"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) constitutes face-to-face time.
- *See ACBHCS Procedure Code Handout, Scope of Practice Handout, and MH Service Definitions & Examples.*
  - following slides

Alameda County Behaviorial Health Care Services Agency
InSyst Procedure Code Table as of March 2018

InSyst Proc Code		CPT Code Medicare /Ins	HCPC CODE Medi-Cal	E/M	Actual Time	SFC	MD DO	Lic PhD	PA	Nurse Pract	CL Nurse Spec	Nurse	LCSW	MFT	LPCC	LPCC wFam	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	
413	90846 Collateral FamCounseling	90846	H2015			10	X	X	X	X	X		X	X		X	X	X			
614	Collateral Healthcare Provider		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/face)	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 + PsyThpy 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 + PsyThpy 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 + PsyThpy with E/M 60 min	90838***	H2010	X	53 >	60	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 Multi FamGrp Client Pres	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			

ACBHCS Guidelines for Scope of Practice Credentialing (MH & SUD)

SERVICE ACTIVITY	LICENSED PRACTITIONER OF THE HEALING ARTS (LPHA) (Same as below**)	MEDICAL PROVIDERS (NON-PHARMACIST) (Same as below**)	MEDICAL PROVIDERS-PHARMACIST	NURSING (Nurse**)	UNLICENSED LPHA (Intern**)	GRADUATE TRAINEE / STUDENT (Intern**)	MENTAL HEALTH REHAB SPECIALIST (RHB Counselor**)	ADJUNCT STAFF (Unlicensed Staff**)	SUD COUNSELOR (Unlicensed Staff**)
* Requires co-signature by licensed LPHA. (For Trainee's to Dx requires Attestation on file.) # Cannot provide diagnosis — may indicate current dx with source. + May claim assessment but only to gather non-clinical, client-report, assess info to be utilized in the MH assessment or CANS/ANSA. May not complete/write/sign the MH assessment nor CANS/ANSA ~ Licensed co-signatures not required, but recommended. = If within scope of practice/ability and with appropriate training and experience. % No co-sig required for RN with Master's in Psych or Public Health and 2 years MH experience, or BS/BA + 4 years MH experience > Must meet MHRS or Adjunct criteria. < Psychology Interns must be registered with the CA Board of Psychology & Requires MD/DO co-signature ^ If meds not prescribed PsyD may co-sign	• PhD-Licensed • PsyD-Licensed • LCSW • LMFT • LPCC OR • 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 LPCC-F (in training) and gaining such experience under the supervision of an LMFT or LPCC-F).	• Psychiatrist (MD) • DO • Psychiatric Physician Assistants (PA) • Advanced Practice Psychiatric Nurses (APN): NP, CNS, & APN Student Interns (with appropriate training, experience and required co-signatures) PAs and all APNs (must operate under a formal medication management protocol / formulary with psychiatric supervision.	• Advanced Practice Pharmacist (Psychiatric) Operating under a formal medication management protocol / formulary with psychiatric supervision.	• RN • LVN • Psych Tech	• PhD-Waivered • PsyD-Waivered • AMFT or RAMFT • ASW • APCC or RAPCC (may perform family therapy services if under the supervision of a LMFT or LPCC-F) Supervision requirements—see Clinical Documentation Manual	Students in educational Mental Health programs granting an MSW, MA, MS, or PhD/PsyD degree which lead to an LPHA. May have existing: AA, AS,BA, BS, MA, MS Co-signatures required Supervision requirements—see Clinical Documentation Manual	(MHRS)(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 Supervision requirements—see Clinical Documentation Manual	The Agency or Program must document qualifications, provide supervision, and ensure staff works within scope of ability. May indicate: • PSR • Peer Specialist • Family Partner Co-signatures highly recommended Supervision requirements—see Clinical Documentation Manual	Certified - or Board Registered < 5yrs CA Consortium of Addiction Programs & Professional (CCAPP): LAADC, CADC, & RADT Credentials CA Association of DUI Treatment Programs (CADTP): CAODC Credential California Association for Alcohol/Drug Educators (CAADE): CATC Credentials through 6/15/2018
SMHS Assessment	Yes	Yes	Yes	Yes * %	Yes	Yes *	Yes + =	Yes + =	>
SMHS DSM Diagnosis	Yes	Yes	No #	Yes * %	Yes *	1st Yr #; 2+ Yr * =	No	No	No
SMHS Evaluation-CANS/ANSA	Yes	Yes	Yes	Yes	Yes	Yes *	No	No	No
SMHS Brief Screening Tool	Yes	Yes	Yes	Yes	Yes *	No	No	No	No
SMHS Plan Development	Yes	Yes	Yes	Yes	Yes	Yes *	Yes = *	Yes = *	>
SMHS Rehab (Ind/Group)	Yes	Yes	No	Yes	Yes	Yes *	Yes = ~	Yes = ~	>
SMHS Therapy (Ind/Family/Grp)	Yes	Yes	No	No	Yes	Yes *	No	No	No
SMHS Collateral	Yes	Yes	Yes	Yes	Yes	Yes *	Yes = ~	Yes = ~	>
Medication Services E/M	No	Yes	Yes	No	No	No	No	No	No
SMHS Psychological Testing	Yes =	Yes =	No	No	Yes =	Yes = *	No	No	No
SMHS Crisis Therapy	Yes	Yes	Yes	Yes =	Yes =	Yes *	Yes = ~	Yes = ~	>
SMHS CM/Brokerage	Yes	Yes	Yes	Yes	Yes	Yes *	Yes = ~	Yes = ~	>
Med Svcs RN/LVN/PT Only	No	No	No	Yes	No	No	No	No	N/A
SUD DMC (Ind/Grp/Collateral/Crisis)	Yes	No	No	No	Yes <	N/A	N/A	N/A	Yes
SUD DMC (Initial Dx)	Yes &	MD Yes, PA/NP & =	No	No	Yes & <	N/A	N/A	N/A	No
SUD DMC (Cont. Just.)	No	MD Only	No	No	No	N/A	N/A	N/A	No
SUD DMC (Plan)	Yes &	Yes	No	No	Yes & <	N/A	N/A	N/A	Yes &
SUD DMC (Plan Update)	Yes & ^	Yes	No	No	Yes & <	N/A	N/A	N/A	Yes & ^

AFTER SIGNATURE (OR PRINTED NAME) INDICATE: 1) **REQUIRED** MEDI-CAL CREDENTIAL, 2) **BEST PRACTICE:** LICENSE, REGISTRATION/CERTIFICATION WITH #, AND 3) **OPTIONAL**: MH DEGREE OR JOB TITLE

Sample Provider Signature Sheet

NAME	AGENCY POSITION TITLE	MEDI-CAL CREDENTIAL	SIGNATURE REQUIREMENT
BETTY TSU	PHYSICIAN	MD (LICENSE #)	Betty Tsu, MD
IRMA CALLOWAY, BS	MENTAL HEALTH SPEC.	MHRS	Irma Calloway, MHRS
GENOVEVA MARTINEZ, PhD	MENTAL HEALTH SPEC.	MHRS (Has PhD but not licensed or waivered.)	Genoveva Martinez, MHRS
JANEY MILLER	PEER COUNSELOR or FAMILY PARTNER	ADJUNCT STAFF	Janey Miller, Adjunct Staff
DANIELLE BOGGEMAN, MS	STUDENT TRAINEE	TRAINEE	Danielle Boggeman, Trainee
DREW MANUEL	NURSE	LVN (LICENSE #)	Drew Manuel, LVN
ROBERT ALMANZA	ADV PRACTICE NURSE	NP	Robert Almanza, NP
TANIKA WILLIAMS	MH CLINICIAN	MFT (LICENSE #) & LPCC (LICENSE #)	T. Williams, MFT, LPCC
ANTHONY SANCHEZ, MS	ALCOHOL & DRUG COUN.	LAADAC (LICENSE #)	A. Sanchez, LAADC
LASHANA JONES, AA	SUD COUNSELOR	CAODC-R (REGISTRATION #)	Lashana Jones, CADDC

Medi-Cal Credentials

Every signature in chart must indicate one of these *(additionally may also indicate designations in green on p.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)
LMFT, LCSW, LPCC, LPCC-F (includes family counseling)
AMFT/RAMFT, ASW, APCC/RAPCC, 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)

SUD services are shaded in blue

Procedure Codes continued

Assessment Codes

Not a Planned Service—May be Provided when Needed

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

Mental Status, Clinical History, Relevant cultural issues, Diagnosis, Use of testing procedures for assessment purposes (i.e. Beck)

- **323-90791 – Face to Face Psychiatric Diagnostic Evaluation**
- **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 CANS, ANSA-T, ANSA, or approved equivalent)
- **326-90899 – Non Face to Face Behavioral Evaluation** (CANS, ANSA, etc.)

Procedure Codes continued

Plan Development (581)

Not a Planned Service—May be Provided when Needed

Plan Development is defined as a service activity that consists of development of client plans (with client collaboration), and/or monitoring and recording of a client's progress towards their mental health objectives.

- Writing Client Plan in Collaboration with Client.
- Plan Monitoring– when considering updating Client Plan given trigger event, change in functioning, etc.
- Meetings with other providers in which they discuss alternative treatments or changes in treatment for client can be billed as plan development.
- Note: Supervision is never a billable service.

Procedure Codes continued

Plan Development (581) Cont.

- Intra-agency/clinic Plan Development only occurs when the Plan is being reconsidered and the *writer could not obtain the information from the written record*.

- This is *not done routinely* in-house such as a Case Manager meeting with the MD after she sees the client, or the clinician meeting with the Family Partner after the Partner sees the client/family.

- For example, clinician becomes aware client went off their anti-psychotic medication (historically linked to decompensation and hospitalization) and clinician needs to meet with the psychiatrist to modify the plan to address the issue immediately.
  - Both Staff can bill for the full time for these types of plan development meetings.

Procedure Codes continued

Individual (381) or Group Rehab (391)

PLANNED SERVICE—MUST BE IN CLIENT PLAN

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

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

Procedure Codes continued

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

PLANNED SERVICE—MUST BE IN CLIENT PLAN

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

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

Procedure Codes continued

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

MAY ONLY BE PROVIDED AFTER THE COMPLETION OF THE CLIENT PLAN

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

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

Procedure Codes continued

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

- Intra-agency/clinic Collateral does not occur. If necessary, it is most likely Plan Development.
- For example, family partner becomes aware client behavior at school has worsened and as it risk of suspension, and therefore needs to meet with the clinician to adapt interventions--possibly resulting in a change to the Plan to address the issue immediately.

Procedure Codes continued

Collateral Caregiver (310)

PLANNED SERVICE—MUST BE IN CLIENT PLAN

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

Procedure Codes continued

Collateral—Family Counseling (413)
(without Client Present)

PLANNED SERVICE—MUST BE IN CLIENT PLAN

- **DHCS has clarified that Family Therapy can never be claimed if the client is not present.**
- **A new code: Collateral- Family Counseling (413) has been created to use for the following situations:**
  - **A Client fails to show to a scheduled Family Therapy appointment and collateral interventions are provided to the family instead.**
  - **A client's family needs to be seen (without client) and collateral interventions are provided to prepare them for participation in Family therapy.**
  - **A Client's family needs to be seen (without client) and collateral interventions are provided to help them participate in family therapy in a more positive manner.**
- **(413) Has the same scope of practice requirements as therapy codes and should never be provided by Mental Health Rehab Specialist or Adjunct staff.**

Procedure Codes continued

Collateral Caregiver (310)
Or Collateral—Family Counseling (413)
(without Client Present)
PLANNED SERVICE—MUST BE IN CLIENT PLAN

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

Procedure Codes continued

Collateral Health Care Provider (614)

PLANNED SERVICE—MUST BE IN CLIENT PLAN

- Provided to improve the health and wellness of the client through the coordination of care between the behavioral health care provider and the client's health care provider(s) (physician, physician's assistant/nurse practitioner, registered nurse, licensed vocational nurse, speech pathologist or audiologist, occupational or physical therapist)
- Goal of care coordination across healthcare disciplines must be to support the client/consumer in achieving the Mental Health objectives of the client's/consumer's Client Plan
- Activities may include: gathering developmental and health information, consultation, care coordination, side effects of medication on behavior and/or prescription drug interactions. It may also be used to assess, in collaboration with the medical provider(s), the impact of the client's chronic health conditions on the behavioral health of the client and their family.

Procedure Codes continued

Collateral Family Group (317) –

may be with or without client present.

PLANNED SERVICE—MUST BE IN CLIENT PLAN

- **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.
- 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)

UNPLANNED SERVICE – for linkage and referral ONLY
PLANNED SERVICE — for follow-up which MUST BE IN CLIENT PLAN

- 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 (Adult), or without such services Child's MH Sx and Impairments would be exacerbated. Must also document, successful C/M is expected to decrease MH Sx's and Impairments. See prior slides for these documentation requirements.

Case Management/Brokerage (571)

UNPLANNED SERVICE – for linkage and referral ONLY

PLANNED SERVICE — for follow-up which MUST BE IN CLIENT PLAN

- Effective immediately, any time the ICC Coordinator facilitates CFT meetings the claiming code to be utilized is 578. (Only for coordination time spent in the CFT meeting.)
-
- All other Katie A. services claiming remains unchanged. For example, non-facilitator attendance at ICC meetings is claimed as code 577 and Intensive Home Based Services (IHBS) is claimed as 557. Facilitator time outside the CFT meeting continues to be claimed as 577.

Procedure Codes continued

Psychotherapy Codes

PLANNED SERVICE—MUST BE IN CLIENT PLAN

(Performed by Licensed/Registered/Waivered LPHA or MH Trainee)

Individual: (441/442/443)

May use +491-90785 for Interactive Complexity

Family: (449) (May only be WITH Client present.)

NOTE: Prior Family Psychotherapy Without Client Present (413) is NOW Collateral—Family Counseling

Multi-Family Group: (455) (May only be WITH Client present.)

Note: Multi-Family WITHOUT Client Present is now renamed as Collateral-Family Group

Group : (456)

May use +491-90785 for Interactive Complexity

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

Selecting the Code for Individual Psychotherapy

Individual Psychotherapy:

Time Based Code: (441/442/443)

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

See Choosing Time Based Codes on Next Slide.

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

Individual Psychotherapy: Choosing the time based on Face to Face Time Spent in Session

- **Always choose code based on the exact number of f-2-f minutes.**
  - Documentation time & Travel Time will be included in Total Time and therefore reimbursed.
  - Contact with client's by phone may be entered as face to face time, but the location of such service must be Location = phone. If any other location is claimed, the service will be disallowed during audit.

Procedure Codes continued

Family Psychotherapy with Patient (449)

(May only be WITH Client present)

NOTE: Prior Family Psychotherapy Without Client Present (413) is

NOW Collateral—Family Counseling

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

Procedure Codes continued

Multi-Family Group
Psychotherapy WITH Client Present (455)
PLANNED SERVICE—MUST BE IN CLIENT PLAN (see exceptions in Clin Doc Manual)
(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.
  - Client must be in attendance or contact with their family members may not be claimed.

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

Procedure Codes continued

Prorating Group Services

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

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

Group Psychotherapy: 456,

& Multi-Family Group Psychotherapy With Client Present : 455

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

Prorating Group Services, Example 1

1 Clinician Provides Group therapy to 6 clients:

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

Prorating Group Services, Example 2a

2 Clinicians Provide Group therapy to 6 clients:

You have three options on how to bill/document this.

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

Prorating Group Services, Example 2b

2 Clinicians Provide Group therapy to 6 clients:

- **Option 2:** One clinician can write the progress notes for all clients (in this case the writer indicates all group interventions—not just their own) and add a co-staff billing time to account for the other clinician's time.
- The one clinician would write a progress note and bill for each client:
- Primary Staff: Face to Face time 60 Documentation time: 60 Total time (Primary Staff): 120
- For Co-staff group time indicate: 60 (The co-staff time field is not present in InSyst until the RU for the service is entered.)
- Group count 6
- Notice that the co-staff time did not get entered into Total time. The Co-staff time acts like a secondary total time field for the 2nd staff. Since the second staff didn't do any progress notes, they only billed for their face to face time.
- When there is a second facilitator always indicate the clinical reason why such as: "A second clinician needed to address and individual client's crisis outside of the group 1:1 while the other clinician continues with the group."
- **Note, data entry into InSyst for this process will soon be changing—watch for memo. However, there will be no change in the clinical documentation charting.**

Prorating Group Services, Example 2c

2 Clinicians Provide Group therapy to 6 clients:

- **Option 3:** One clinician can write the progress notes for some of the clients and the co-staff writes the notes for the remainder of the clients. The other clinician would write a progress note for the remainder of the clients:
- Staff 1 (writes PN for three of the clients):
  - Primary Staff: Face to Face time 60, Documentation time: 30, Total time (Primary Staff): 90 (Only total time entered into InSyst).
  - For Co-staff group time indicate: Face to Face time 60 Documentation time: 30 Total time (Co-Staff): 90 (Only total time entered into InSyst).
  - Group count 6
- Staff 1 (writes PN for the other three clients):
  - Primary Staff: Face to Face time 60, Documentation time: 30, Total time (Primary Staff): 90 (Only total time entered into InSyst).
  - For Co-staff group time indicate: Face to Face time 60 Documentation time: 30 Total time (Co-Staff): 90 (Only total time entered into InSyst).
  - Group count 6
- **Note, data entry into InSyst for this process will soon be changing—watch for memo. However, there will be no change in the clinical documentation charting.**

Add-On Codes (+)

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

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

Crisis Add-on Codes: Time Ranges

Codes Used	Based on Face to Face time
377	30-75 minutes (Add Doc and Travel Time Here.)
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 Add-On Codes:

- Additional Time Spent: for Crisis Therapy—concept in general.
  - 377-90839 is used for the first 30-75”
    - Add all other time (documentation, travel, etc.) to the 377 code.
  - 378-90840 is used for each additional 16-45”
  - For paper charting (not Clinician’s Gateway): when you go beyond a 377 and use a 378--the 377 is indicated as 60” and the balance (16 – 45”) moves down to 378.
    - For InSyst purposes: Documentation & Travel Time is added into the Total Time for 377.
  - 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 Crisis Add-On (+) Codes in 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
      --Note, Clinician's Gateway uses a different methodology—see Training Slides.
- *When documenting for an add-on code, be sure that the note content reflects the service and/or time frame of the add-on.*

Crisis Codes continued

Crisis Therapy (*formerly*, Crisis Intervention)
377-90839 (First 60 Minutes of Face to Face Services)
+378-90840 (For each additional 16-30 Minutes of Face to Face Services)

(May be performed for such crisis activities by staff that their training and experience allows.)

- A service lasting no more than **8 hours (total for all providers)** in a 24-hour period: Immediate response to client's acute psychiatric symptoms in order to alleviate problems which, if untreated, would present an imminent threat to the client, others, or property.
- **Only use when the client is at imminent risk for danger to self/other and/or gravely disabled.** The purpose is to stabilize the client.
- Service activities include but are not limited to one or more of the following: Medication Support Services, Assessment, Collateral, and Therapy.

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):
  1) The need to manage maladaptive communication.
  2) Caregiver emotions or behaviors that interfere with implementation of the treatment plan.
  3) Evidence or disclosure of a Sentinel Event and mandated reporting to a 3rd party with initiation of discussion of the event.
  4) Use of play equipment to overcome barriers to diagnostic or therapeutic interaction.
     - This does not include routine play therapy (such as sand tray.)

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

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

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

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

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

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

Medication Support Services

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

Medication Support Services cont.

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

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

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

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

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

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

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

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

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

- **Documentation:**
  - 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

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

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

- Coordination of Care:
  - Services provided by the medical provider responsible for the direct care of a client when he or she **coordinates or controls access to care or initiates or supervises other healthcare services** needed by the client.
  - 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: ☐

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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. Maximum claim limit of 4 hours (240 minutes) per day

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

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

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

Procedure Code/Services

Case Management vs. Plan Development vs. Collateral

- Case Management/Brokerage (571)
  - Help clients to access medical, educational, social, vocational, rehabilitative, or other community services that are identified in the Client Plan and Assessment.
  - ***Linkage & Monitoring 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.
  - Must meet documentation requirements in earlier slides to claim

Procedure Code/Services

Case Management vs. Plan Development vs. Collateral

- Plan Development (581)
  - Used when developing treatment plan with client
  - Writing of client plans (with client/family collaboration)
  - Used for plan monitoring and recording of a client's progress towards their mental health objectives.
    - *Such as when considering updating Client Plan given trigger event, change in functioning, etc*.

Procedure Code/Services

Case Management vs. Plan Development vs. Collateral

- Collateral (311, 310, 317, or 614)
  - Services provided to significant support persons
    - Consultation, Training and Psychoeducation of significant support person in client's life where the
      - *Focus is always in achieving mental health Objectives in Client Plan—If Plan is not completed, there is no way to do so.
  - Collateral services by definition are to support Client Plan by:
    - Gathering information from, or
    - Explaining results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or
    - Advising significant support persons how to assist client(s)

Procedure Code/Services Review

Case Management vs. Plan Development vs. Collateral

- May Case Mgt, Plan Develop, or Collateral be provided across agencies (or in the same agency between RU's that do not share a medical record)?
  - YES — and such Coordination of Care is recommended.

- Which of these service types may be routinely provided within the same RU across staff, or between staff of different RU's who share a chart?
  - NONE

Procedure Code/Services Review

Case Management vs. Plan Development vs. Collateral

Which service may be provided *when needed* between the staff of the same RU, or staff of different RU's who share an agency chart?

- Plan Development

When is intra-agency staff claiming not needed?

- When one Provider may simply read the medical record without there being an unnecessary delay in treatment services.

How does this occur?

- In preparation for meeting with a client, that staff person reads the medical records entries from other staff since their last client intervention.
- As every staff is doing this, they are always up to date with the current status of the client—particularly in regards to their MH Objectives.

Procedure Code/Services

Case Management vs. Plan Development vs. Collateral

What is an example of this?

- Case Manager/Family Partner/Consumer Peer/Therapist meets with the client and finds they have discontinued their psychotropic medications prescribed by the MD (in the same clinic).
- Previously when this has occurred the client has rapidly decompensated and become hospitalized.
- The staff person then contacts the MD (claiming Plan Development) given this significant triggering event that may result in a change to the Client Plan.
- Even if a change does not occur—as long as the circumstances are documented in the PN that a Plan change was considered, claiming is appropriate.

Procedure Code/Services

Case Management vs. Plan Development vs. Collateral

What is another example of this?

- Clinician writing Annual Plan has read medical record on an on-going basis.
- The Clinician believes coordinating with the MD and Family Partner to finalize the Plan will facilitate the creation of MH Objectives that each of the Providers are focusing on with the client.

Procedure Code/Services

Case Management vs. Plan Development vs. Collateral

Examples of commonly incorrectly claimed intra-agency activities as Collateral.

- Clinician meets weekly with Family Partner after her home visits with parents of child client to coordinate their services to better meet the client's MH Objectives.
  - In non-urgent situations, reading each others' Progress Notes should be adequate. The above example is more like supervision.
  - Between outside agencies this would be quality Collateral services to support the Client's MH Objectives and is billable.
- Case Manager accompanies Client to Psychiatrist appointment to communicate updates in Client's progress with a medication trial.
  - Again, reading each other's notes is adequate unless an urgent matter arises that needs to be discussed promptly.
  - Between outside agencies this would be quality Collateral services to support the Client's MH Objectives.

Procedure Code/Services

Case Management vs. Plan Development vs. Collateral

- Examples of commonly incorrectly claimed (in red) intra-agency activities as Case Management.
  - Adult Team Vocational Counselor and Case Manager meet monthly to coordinate client's Vocational and MH Services.
    - Between outside agencies this would be quality Case Management to monitor client's success in Community Vocational Services.
    - Case Manager meets with Nurse Practitioner to refer client for a medication evaluation. CM's write up of last meeting with client that precipitated the referral with reasoning why should be adequate when routed to NP.
    - Between outside agencies this would be quality Case Management.

Procedure Code/Services

Case Management vs. Plan Development vs. Collateral

Examples of commonly incorrectly claimed intra-agency activities as Plan Development.

- MH Trainee writes up monthly summary of Client's progress in Psychotherapy and in a meeting distinct from weekly supervision shares this with the MFT for collaboration and monitoring of Client's success towards meeting MH Objectives.
  - Meeting with one's Clinical Supervisor (such as when collecting hours toward licensure) for any activity may never be claimed.
  - Meeting with an outside Therapist around on how to best proceed — with an Eating Disorders Case you rarely have the opportunity to treat — is a Consultation for Professional Development and never claimed.

Procedure Codes/Services

Individual (or Group) Rehab

Improving, Maintaining, OR Restoring skills (skill building) of impairments that are a DIRECT result of the included Dx signs, symptoms, or behaviors:

What is an Allowed Example for Rehab claiming (from DHCS)?

"The most common example would be a client with schizophrenia who has social skills deficits which are the direct result of the schizophrenic disorder. Training will focus on social skills development.

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

Procedure Codes continued

What is a Disallowed Example for Rehab Claiming from DHCS:

- *Client has Major Depression with symptoms of insomnia, depressed mood, anhedonia, indecisiveness, fatigue, feelings of worthlessness and psychomotor retardation which has resulted in poor attention to ADL's.*
- *Case Mgr or MHRS wishes to address the identified impairment (or skill deficit) of poor ADL's.*
- *"In this example , the 'deficit'—i.e., failure to perform ADLs—is not really a deficit at all. The client KNOWS how to bathe, brush teeth, comb hair, etc."*
  - *-John Griffith, PhD, DHCS Consulting Psychologist, email correspondence of 5/20/15*

Rehab services could be provided to address the deficits (of Major Depression) in the areas of: interest in life (anhedonia), self-worth (feelings of worthlessness) and energy (fatigue).

Procedure Code/Services

Individual Rehab (381) vs. Case Management/Brokerage (571)

How does individual Rehab differ from Case Management/Brokerage?

While monitoring client's ability to access resources (Case Management) it is often necessary to teach client skills (Individual rehab) to help them overcome the barriers that are preventing them from succeeding in the linkage and follow through.

Case Management and Individual Rehab interventions are likely to often be done during the same session with a client. In these cases, the lowest paying code (Case Management) must be used; unless the services are separately claimed. No Case Management/Brokerage interventions can be described in a progress note it Individual rehab code is chosen.

Note: If a staff helps assure successful linkage to an appointment/resource by going with client to the appointment they must document what interventions were done at each step and why it was clinically necessary for staff to assist client. Staff may not bill for any time in which they are not doing interventions (i.e. waiting for client, being present while another provider is providing services, etc.)

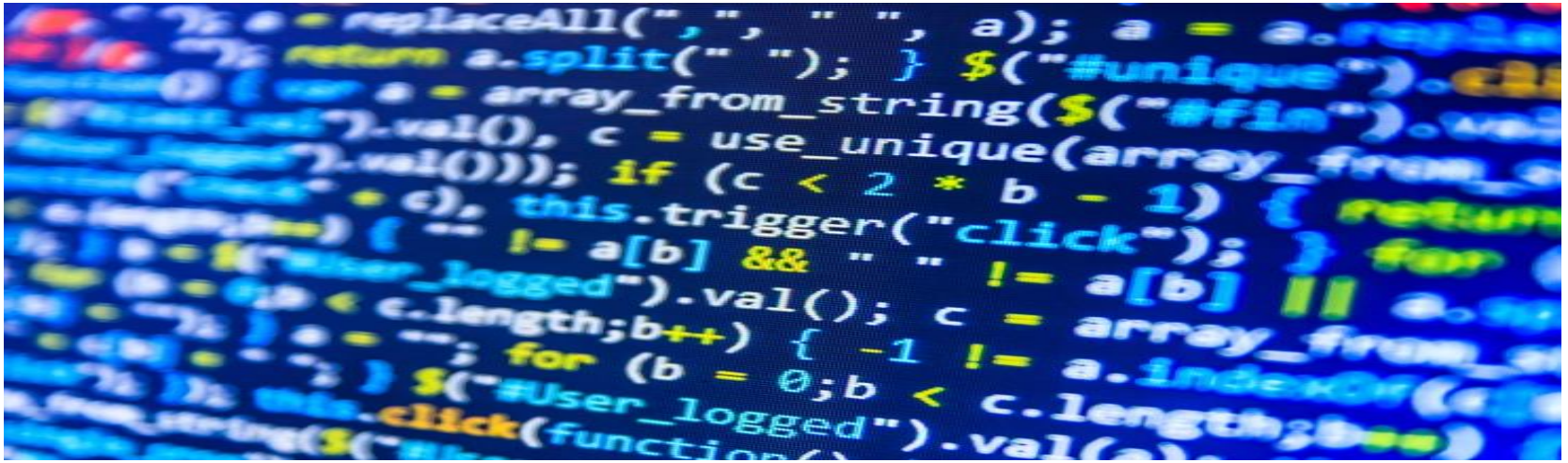
Procedure Code/Services

- Example: A client has depressive symptoms that prevent them from successfully going to the vocational office. Employment is expected to help improve client's symptoms of depression and low self worth. You determine that client has few coping skills to manage these depressive symptoms that are impairing his ability to access these much needed services.

- If staff provides a session in which skill building is provided for the purpose of helping client get connected to a community support resource, (where linking and monitoring is also provided) the staff should bill this as case management.

- If staff provides a session in which only skill building is provided to client with the intent/expectation that these skills will help all areas of client's impairment, the staff should bill individual rehab. No Case Management interventions should be provided during the same session in order to bill individual rehab.

What is the procedure code?



Procedure Code Review Questions

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

- Assessment and CANS/ANSA Behav Eval Codes

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

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

What is the difference between Collateral Codes 311 and 310

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

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

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

Procedure Code Review Questions Cont.

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

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

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

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

Interactive Complexity may be added to which 3 procedure codes?

- Assessment; & Group and Individual Psychotherapy

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

- 369

What codes does a medical provider (MD, NP) use for all services which are not f-f ?

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

Lockout Claims

MH Services Lockouts (see updated handout)

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

ACBHCS' Mental Health (MH) Medi-Cal Lockout Grid

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 OR regulation provides a maximum allowable claimable time for a SMHS. *(A staff may provide services within their scope of practice, but it would not be reimbursable.)*

NOTE: GREEN=ALLOWED & RED=LOCKED-OUT AND SIGNIFICANT CHANGES FROM PREVIOUS VERSION HIGHLIGHTED IN YELLOW

Find Type of Service You Want to Provide → Then Look at Service Site or Claimable Time for SMHS to Find Restrictions (if any) ↓	**Are MH Services locked-out (includes IHBS)?**	**Are Medication Svcs Locked out?**	**Are Case Management (C/M) Brokerage Svcs Locked out (includes ICC)?**
Woodroe Place, Jay Mahler Recovery Center, Amber House (Crisis Residential Treatment)	MH Svcs locked out (1)except *allowed day of admit & d/c*	Med Svcs Allowed	C/M Svcs Allowed
Sausal Creek, Willow Rock CSU (Crisis Stabilization)	MH Svcs Allowed (2)except *not allowed during same time period of CSU*	Med Svcs Allowed (2)except *not allowed during same time period of CSU*	C/M Svcs Allowed
Day Rehab (DR) **Programs & Day Treatment Intensive** (DTI) **Programs**	MH Svcs Allowed (2) except *not allowed during same time period of Day Pgm*	Med Svcs Allowed (2) except *not allowed during same time period of Day Pgm*	C/M Svcs Allowed (2) except *not allowed during same time period of Day Pgm*
Juvenile Hall, Jail or Similar Detention (not adjudicated)	MH Svcs locked out (1) except *allowed day of admit & d/c AND* (3) *allowed if minor adjudicated (release order) awaiting placement*	Med Svcs locked out (1) except *allowed day of admit & d/c AND* (3) *allowed if minor adjudicated (release order) awaiting placement*	C/M Svcs locked out (1) except *allowed day of admit & d/c AND* (3) *allowed if minor adjudicated (release order) awaiting placement*
Willow Rock PHF (Acute Psychiatric Inpatient Hospital/PHF <17 beds for minors)	MH Svcs locked out (1) except *allowed day of admit & d/c*	Med Svcs locked out (1) except *allowed day of admit & d/c*	C/M Svcs locked out (1) except *allowed day of admit & d/c AND* (4) *allowed 30 days prior to planned d/c for placement purposes*

Non-Reimbursable Services/Activities

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

Record Retention

- All Client Records must be retained as long as required by law (ten years past last date of service, or 18th birthday whichever occurs later), **AND then no sooner that 10 year date's current ACBHCS/DHCS contract's termination date** 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 6/30/2009—this will be updated in Clinical Documentation manual when needed.*

Minor Consent, ages 12 – 17 yrs.

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

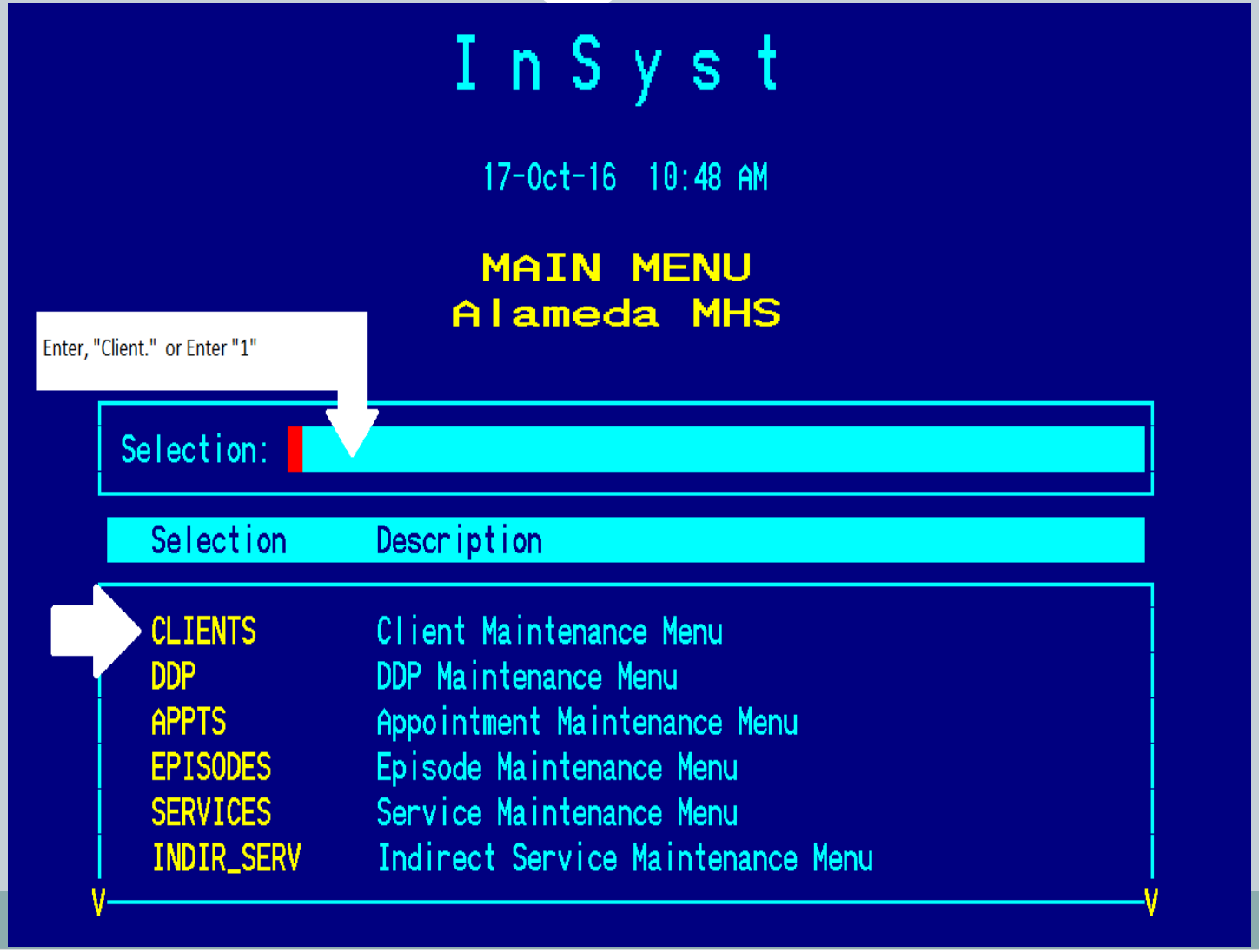
Updating or Inserting New Emergency Contact Information in INSYST

205

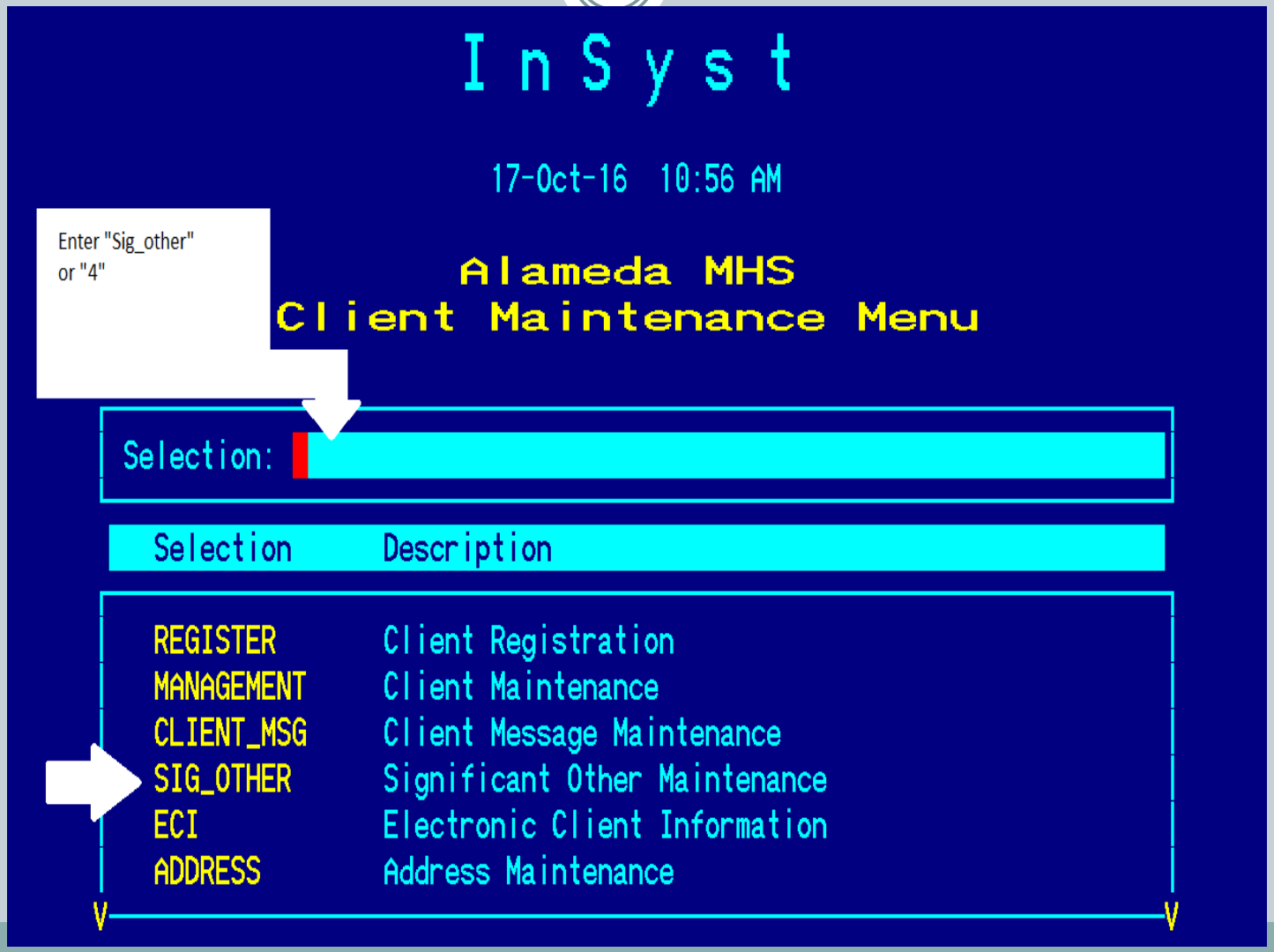
A CLIENT'S EMERGENCY CONTACT INFORMATION MUST BE ENTERED, AND KEPT UPDATED IN INSYST.

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

How to Update Emergency Contact Information



How to Update Emergency Contact Information



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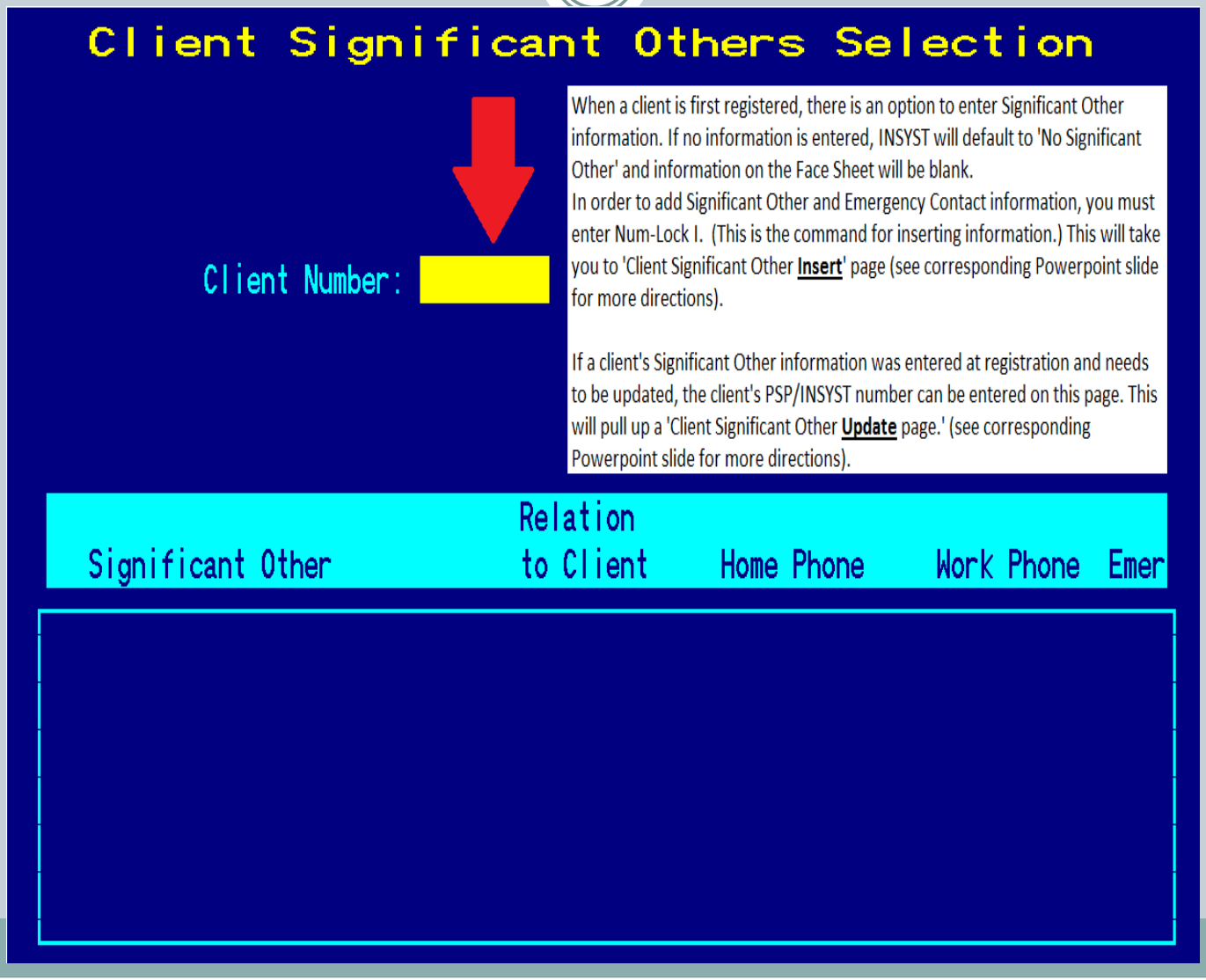
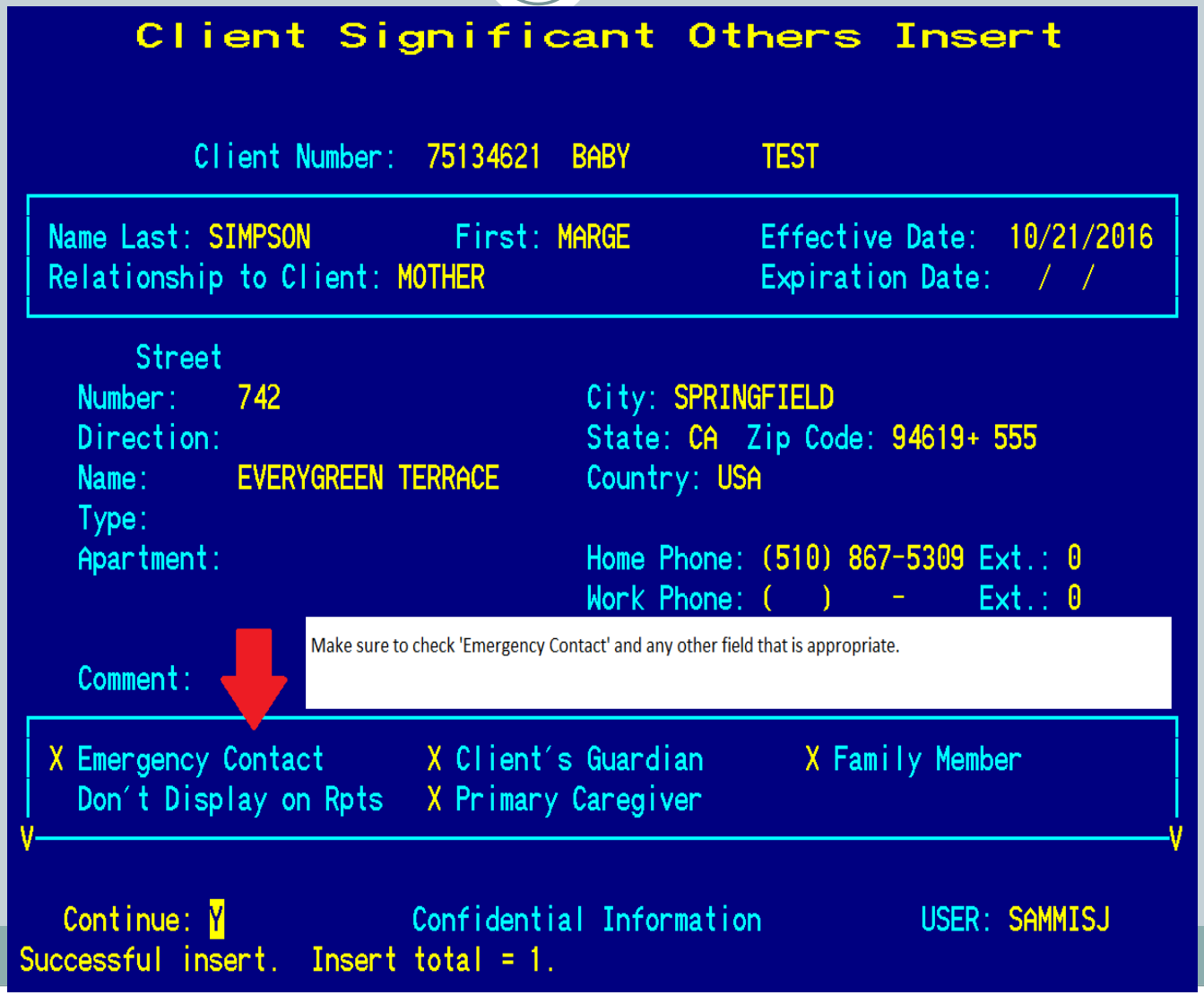
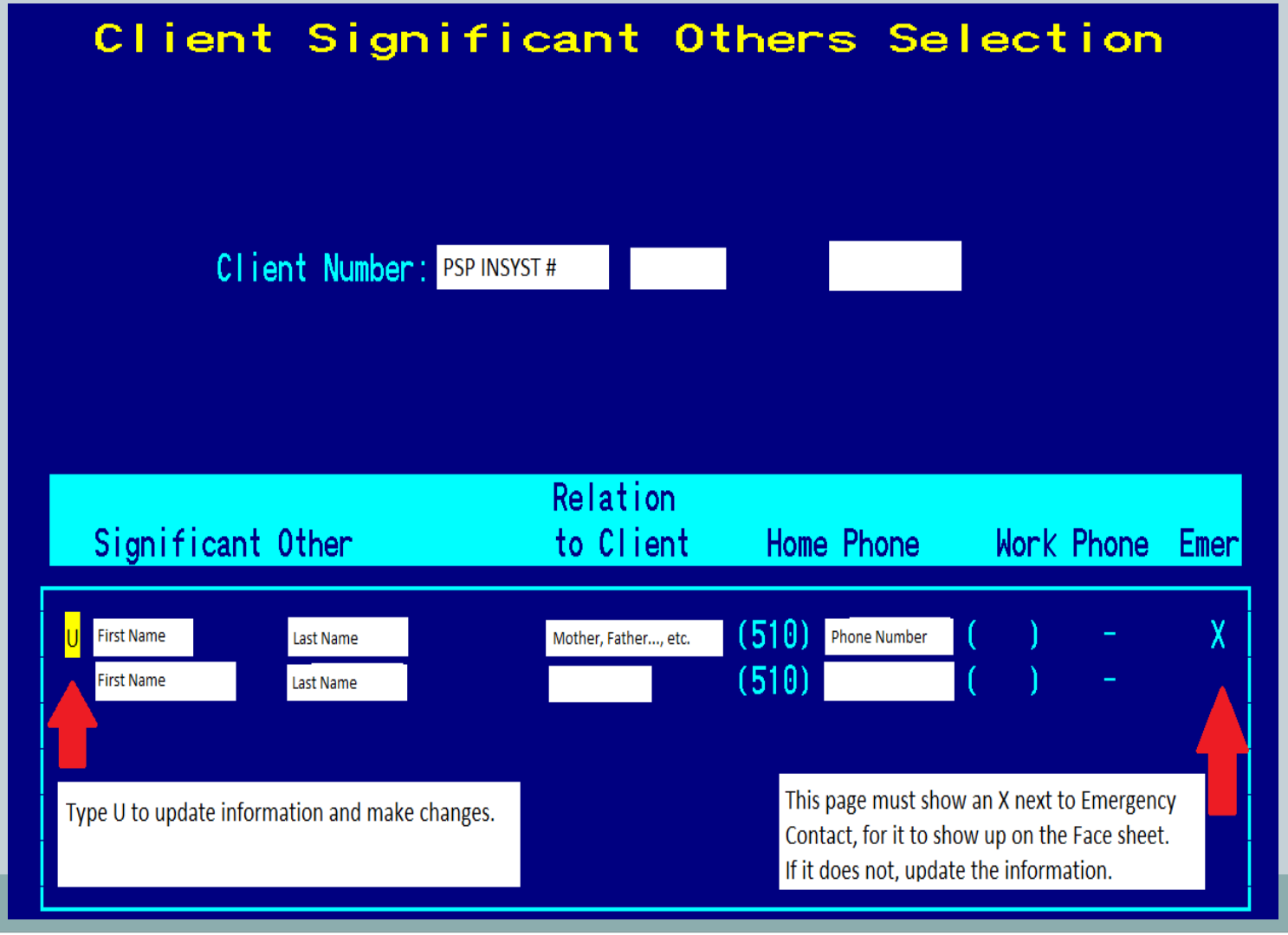


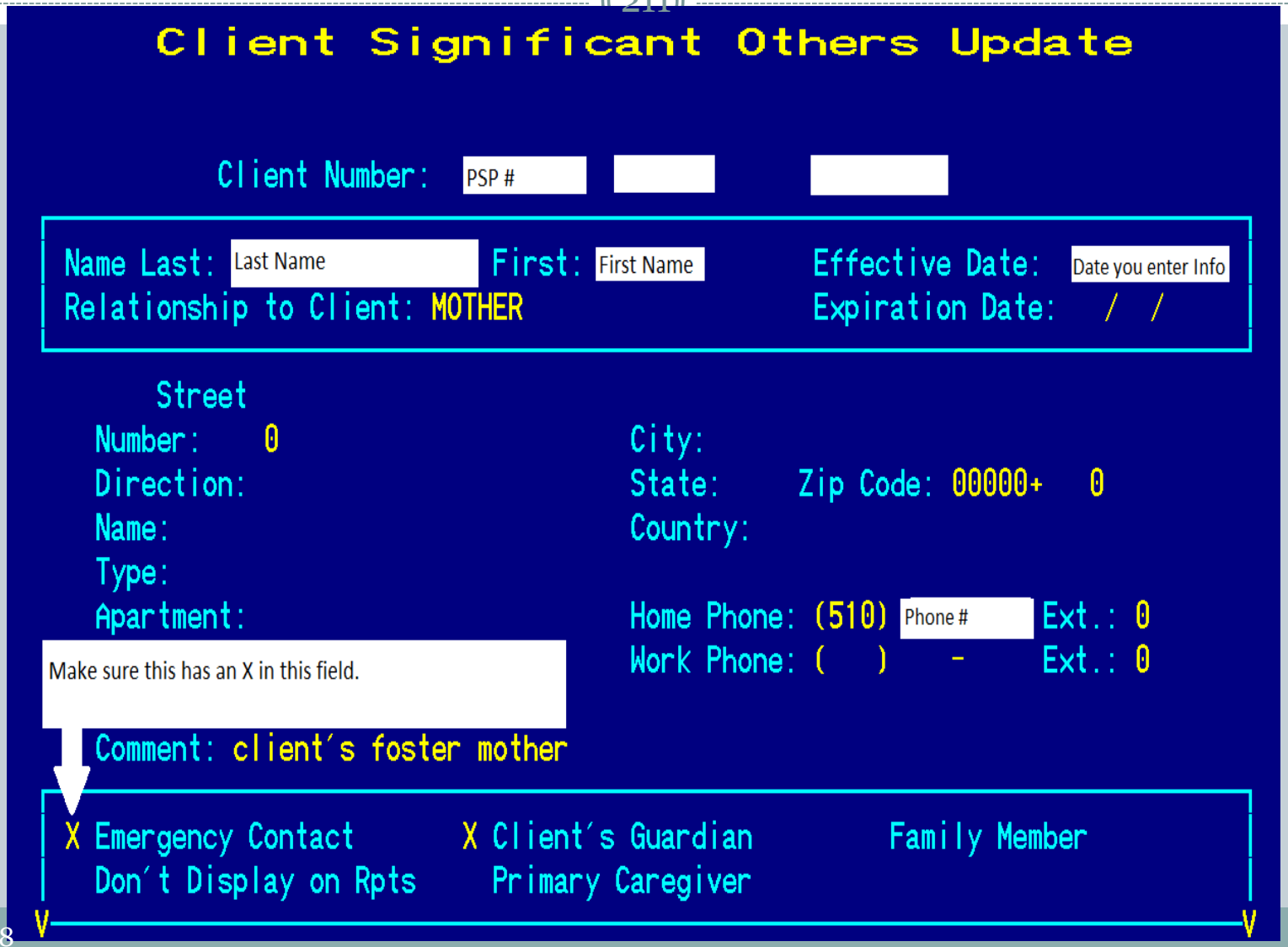
Inserting Significant Other Info if None was Entered at Episode Opening.



Updating Significant Other Information that has already been entered.

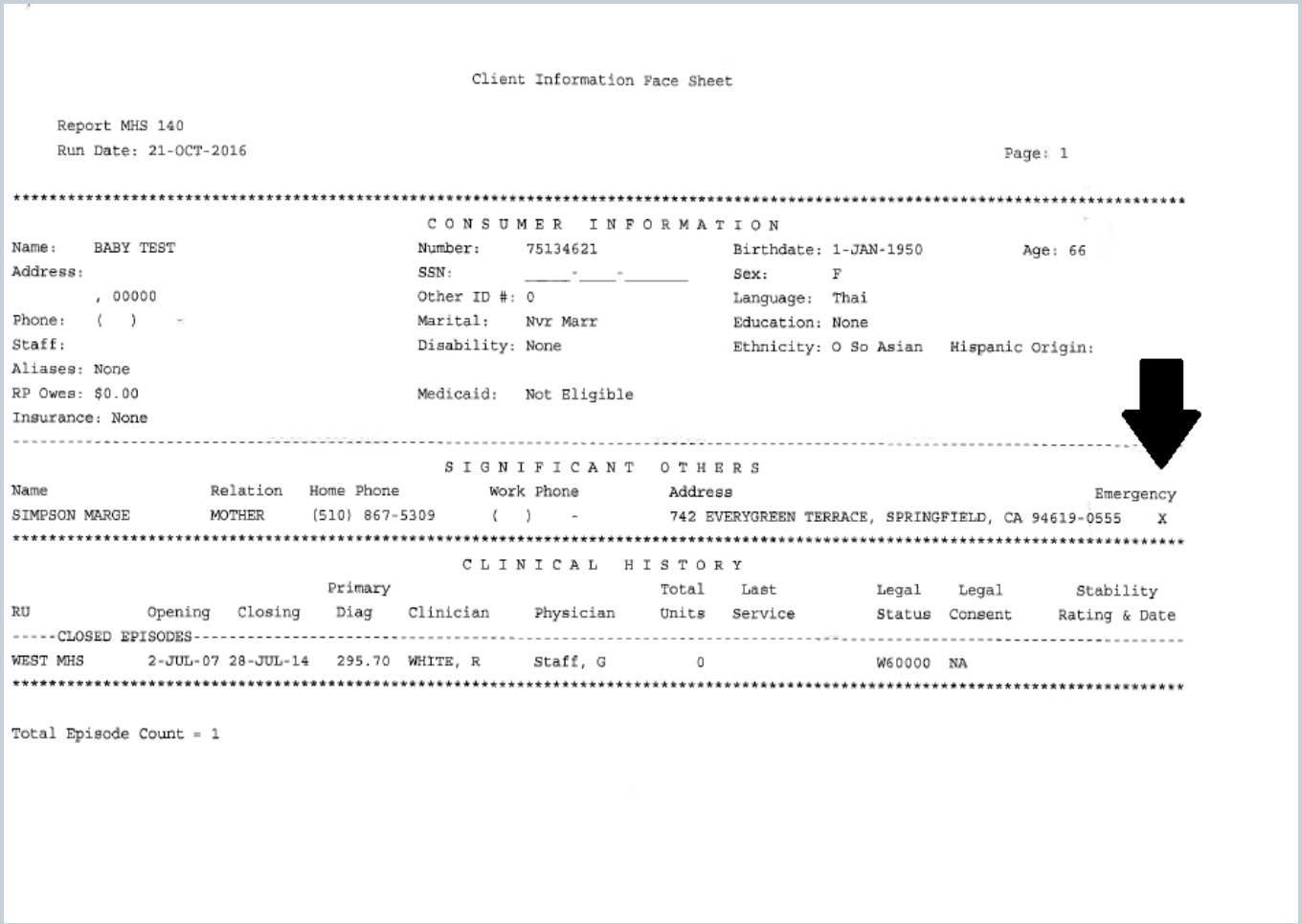


How to Update Emergency Contact Information



End Result Is a Face Sheet with Emergency Contact Info

212



Client Information Face Sheet

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

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CONSUMER INFORMATION

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

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

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

SIGNIFICANT OTHERS

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

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CLINICAL HISTORY

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

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Total Episode Count = 1

Additional Handouts

- Suicide/Homicide Comprehensive Risk Assessment & Written Formalized Safety Plan
- Medi-Cal Benefits Help Desk

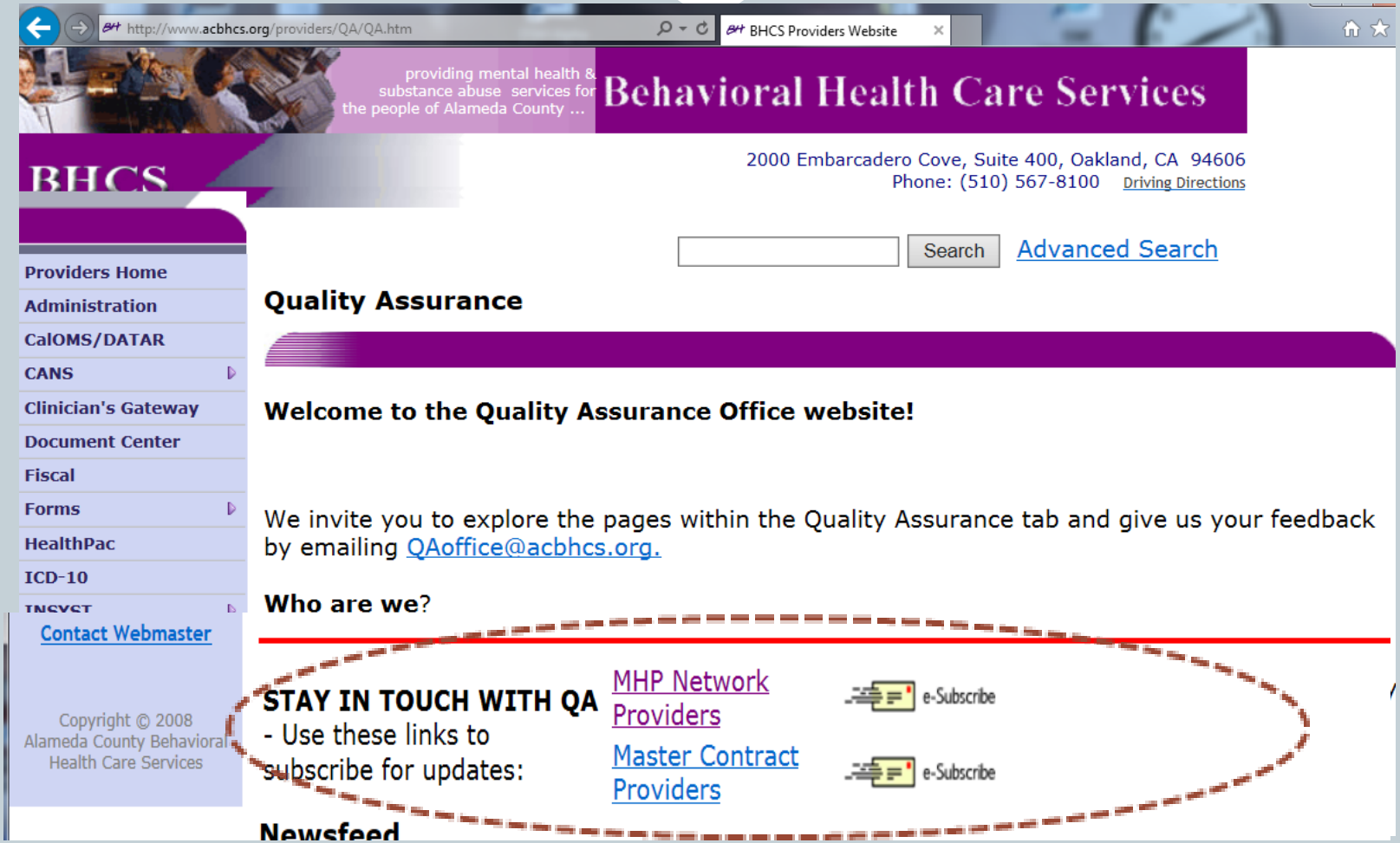
HIPAA Resources

- 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

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

End of presentation