
# Mental Health Plan Fee-For-Service (FFS) Provider Clinical Documentation Training

# Agenda: May 3, 2018

| TIME | TOPIC |
|---|---|
| 9:00am – 9:30am | • Introductions, Training Objectives, News & Updates |
| 9:30 am – 10:30 am | • Initial Authorization Timelines and Processes<br>• Re-Authorization Timelines and Processes |
| 10:30 am – 10:45 am | Break |
| 10:45 am – 12:15 pm | • Authorization continued<br>• Audit Highlights<br>• Medical Necessity<br>• Pre-Assessment & Assessment Requirements Documentation Requirements (including SO/GI data)<br>• Plan Documentation Requirements |
| 12:15 pm – 12:45 pm | Lunch |
| 12:45 pm – 1:45 pm | • Plan Documentation Requirements continued<br>• Progress Note Documentation Requirements |
| 1:45 pm – 2:00pm | Break |
| 2:00 pm – 3:00 pm | • Procedure Codes Documentation Requirements<br>• Activity |
| 3:00 pm – 4:00 pm | • Questions, Post Test, & Course Evaluation |

# Introductions & Housekeeping

- What is your name?
- What type of Mental Health Fee for Service Provider are you? (formerly known as Level III Network)
  - Individual, Group, or Organization
  - What is one question you want to get answered today?
- Housekeeping Reminders

# News and Updates

SEE PROVIDER WEBSITE: HTTP://WWW.ACBHCS.ORG/PROVIDERS/MAIN/INDEX.HTM

QA SECTION & SIGN UP FOR UPDATES: HTTP://WWW.ACBHCS.ORG/PROVIDERS/QA/QA.HTM

AUDIT NOTICES, REPORTS & TOOLS: HTTP://WWW.ACBHCS.ORG/PROVIDERS/QA/QA.HTM

# Training Objectives

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

# Mental Health Providers Fee For Service

# Network Providers (formerly known as Level III Providers)

This training is for mental health providers contracted by Alameda County who *claim via paper form CMS 1500*.

Currently these providers are known as:

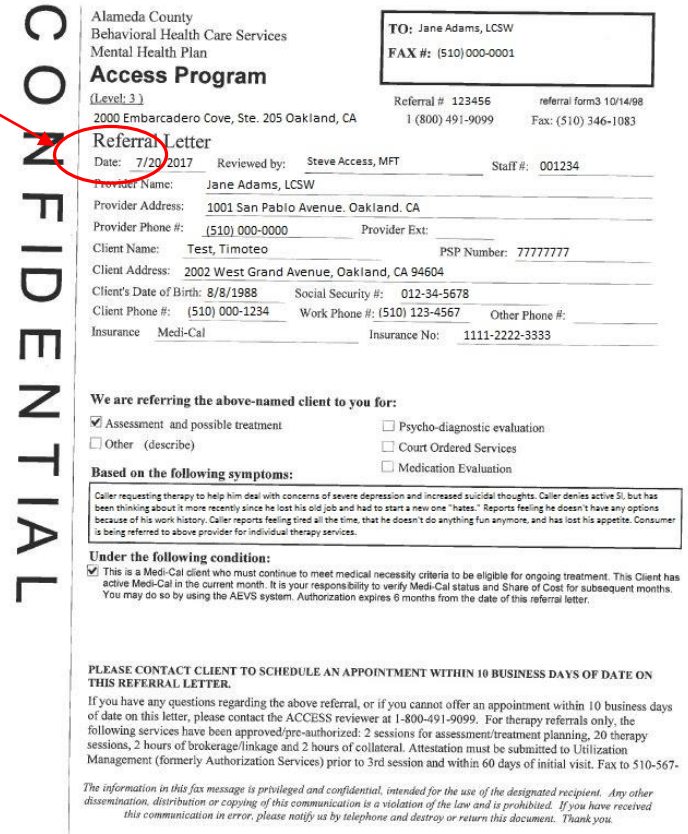
Mental Health Providers Fee For Service (MHP FFS) Providers

These providers are individual therapists, groups of therapists, and Organizations (Non-Master Contract Organizations).

There are some documentation related differences between these providers that will be described in this training.

# ACCESS Referral Letter & Episode Opening Date

- The provider must offer an appointment date within 10 business days of this date. If this is not possible, then the referral should be returned to ACCESS.
- The episode opening date (EOD) must be after this date.
- The assessment must be completed within 30 days of EOD. The treatment plan must be completed within 60 days of EOD. Both the assessment and plan must be completed before the 3rd session.
- If continued services are necessary, the Request For Continued Services (RCS) can be submitted up to 2 weeks before 6 months from EOD. See slide 15.
- Extensions packages start 6 months from EOD.
- If no extension is requested or approved all services will expire 6 months from EOD (even if not all the sessions were used).



CONFIDENTIAL

Alameda County
Behavioral Health Care Services
Mental Health Plan

**Access Program**

(Level: 3 )
2000 Embarcadero Cove, Ste. 205 Oakland, CA

**TO:** Jane Adams, LCSW
**FAX #:** (510) 000-0001

Referral # 123456 referral form3 10/14/98
1 (800) 491-9099 Fax: (510) 346-1083

Referral Letter

Date: 7/20/2017 Reviewed by: Steve Access, MFT Staff #: 001234
Provider Name: Jane Adams, LCSW
Provider Address: 1001 San Pablo Avenue. Oakland. CA
Provider Phone #: (510) 000-0000 Provider Ext:
Client Name: Test, Timoteo PSP Number: 77777777
Client Address: 2002 West Grand Avenue, Oakland, CA 94604
Client's Date of Birth: 8/8/1988 Social Security #: 012-34-5678
Client Phone #: (510) 000-1234 Work Phone #: (510) 123-4567 Other Phone #:
Insurance Medi-Cal Insurance No: 1111-2222-3333

**We are referring the above-named client to you for:**

☑ Assessment and possible treatment
☐ Other (describe)
☐ Psycho-diagnostic evaluation
☐ Court Ordered Services
☐ Medication Evaluation

**Based on the following symptoms:**

Caller requesting therapy to help him deal with concerns of severe depression and increased suicidal thoughts. Caller denies active SI, but has been thinking about it more recently since he lost his old job and had to start a new one "hates." Reports feeling he doesn't have any options because of his work history. Caller reports feeling tired all the time, that he doesn't do anything fun anymore, and has lost his appetite. Consumer is being referred to above provider for individual therapy services.

**Under the following condition:**

☑ This is a Medi-Cal client who must continue to meet medical necessity criteria to be eligible for ongoing treatment. This Client has active Medi-Cal in the current month. It is your responsibility to verify Medi-Cal status and Share of Cost for subsequent months. You may do so by using the AEVS system. Authorization expires 6 months from the date of this referral letter.

**PLEASE CONTACT CLIENT TO SCHEDULE AN APPOINTMENT WITHIN 10 BUSINESS DAYS OF DATE ON THIS REFERRAL LETTER.**

If you have any questions regarding the above referral, or if you cannot offer an appointment within 10 business days of date on this letter, please contact the ACCESS reviewer at 1-800-491-9099. For therapy referrals only, the following services have been approved/pre-authorized: 2 sessions for assessment/treatment planning, 20 therapy sessions, 2 hours of brokerage/linkage and 2 hours of collateral. Attestation must be submitted to Utilization Management (formerly Authorization Services) prior to 3rd session and within 60 days of initial visit. Fax to 510-567-

*The information in this fax message is privileged and confidential, intended for the use of the designated recipient. Any other dissemination, distribution or copying of this communication is a violation of the law and is prohibited. If you have received this communication in error, please notify us by telephone and destroy or return this document. Thank you.*

# MHP FFS Provider Types - Outpatient

All claims must be made with form CMS 1500

## Individual Clinician

- Licensed master's level (or greater) therapist, psychiatrist, or psychologist
- Only Licensed LPHAs can provide services

## Group of Clinicians

- Group of 2+ individual clinicians
- Licensed master's level (or greater) therapist, psychiatrist, or psychologist
- Only Licensed LPHAs can provide services

## Non-Master Contract Organizations

- Both Licensed and Board Registered or Waivered LPHAs may provide services (with Assessment and Plan restrictions and per your contract)

# Some Important Terms

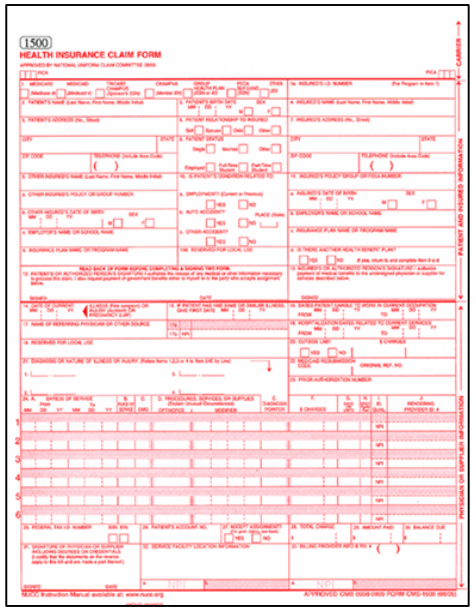
- CMS 1500 – Federal form used for medical claiming. Last updated 2012-02-01.
- Current Procedural Terminology or CPT Codes – Expansive medical billing code set published by American Medical Association.
- InSyst – California/Alameda County medical billing system. This system is only used by the County and Master Contract Organizations (MCOs).
- Level I Providers – Previous term used to categorize MCOs. These providers use InSyst for claiming.
- Level III Providers – Previous term to categorize contracted providers who use CMS 1500 for claiming.
- Specialty Mental Health Services (SMHS) – Service designation under which moderate-to-severe mental health services are provided to Medi-Cal beneficiaries in California.
- Non-MCOs (Non-Master Contract Organizations) – Also known as Organizational Providers. These are organizations that do not have a Master Contract and claim using the CMS 1500.

# CMS 1500 Claiming Rates & Codes

See July 1, 2016 Specialty Mental Health Rate sheets

- Organization, Community Clinic, and Multidisciplinary Group (MHP FFS Orgs) Rates
- Physician Rates
- LCSW, MFT, LPCC Rates
- PhD Rates (includes psychological testing)

*Remember to refer to the Rate/Code sheet for your license.*


1500
HEALTH INSURANCE CLAIM FORM

# New Forms for all Providers

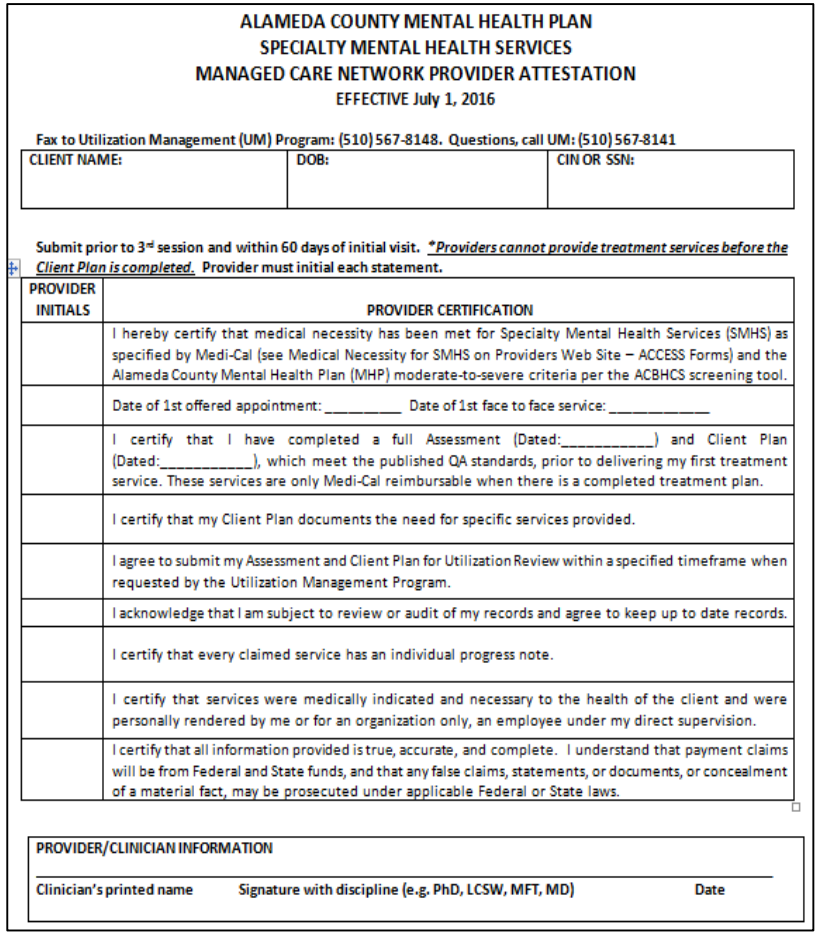
Beginning July 1, 2016 the old Request for Extended Services (RES) and Request for Concurrent Review (RCR) forms are no longer accepted. These forms are replaced by the following:

1. Medi-Cal compliant Assessment and Client Plan forms:
   URL: http://www.acbhcs.org/providers/Forms/ProviderNetwork.htm
2. Attestation Form
   URL: http://www.acbhcs.org/providers/Forms/Forms.htm#UM
3. The NEW Request for Continued Services (RCS) Form required to request services beyond the initial package.
   URL: http://www.acbhcs.org/providers/Forms/Forms.htm#UM

# MHP FFS Provider Attestation Form
# Required Form

By completing this form, the provider attests that they have completed and will continue to complete the required documentation to claim for services through Medi-Cal.

Follow all of the instructions on this form. The Attestation Form must be completed and submitted to UM prior to the third session AND within 60 days from the initial visit.



**ALAMEDA COUNTY MENTAL HEALTH PLAN**
**SPECIALTY MENTAL HEALTH SERVICES**
**MANAGED CARE NETWORK PROVIDER ATTESTATION**
**EFFECTIVE July 1, 2016**

Fax to Utilization Management (UM) Program: (510) 567-8148. Questions, call UM: (510) 567-8141

| CLIENT NAME: | DOB: | CIN OR SSN: |
|---|---|---|
| | | |

Submit prior to 3rd session and within 60 days of initial visit. **Providers cannot provide treatment services before the Client Plan is completed.* Provider must initial each statement.

| PROVIDER INITIALS | PROVIDER CERTIFICATION |
|---|---|
| | I hereby certify that medical necessity has been met for Specialty Mental Health Services (SMHS) as specified by Medi-Cal (see Medical Necessity for SMHS on Providers Web Site – ACCESS Forms) and the Alameda County Mental Health Plan (MHP) moderate-to-severe criteria per the ACBHCS screening tool. |
| | Date of 1st offered appointment: _____ Date of 1st face to face service: _____ |
| | I certify that I have completed a full Assessment (Dated:_____) and Client Plan (Dated:_____), which meet the published QA standards, prior to delivering my first treatment service. These services are only Medi-Cal reimbursable when there is a completed treatment plan. |
| | I certify that my Client Plan documents the need for specific services provided. |
| | I agree to submit my Assessment and Client Plan for Utilization Review within a specified timeframe when requested by the Utilization Management Program. |
| | I acknowledge that I am subject to review or audit of my records and agree to keep up to date records. |
| | I certify that every claimed service has an individual progress note. |
| | I certify that services were medically indicated and necessary to the health of the client and were personally rendered by me or for an organization only, an employee under my direct supervision. |
| | I certify that all information provided is true, accurate, and complete. I understand that payment claims will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws. |

**PROVIDER/CLINICIAN INFORMATION**

_____

**Clinician's printed name** **Signature with discipline (e.g. PhD, LCSW, MFT, MD)** **Date**

# New Assessment and Client Plan Forms Required for all MHP FFS Providers

## ASSESSMENT TEMPLATE

**Initial MH Assessment – Short Form**

| *For Provider Use* |
|---|
| ☐ Informing Materials signed (annually) |
| ☐ Release of Information Forms signed (annually) |

Name: _____

Insyst# _____

RU# _____

Page **1** of **8**

PROVIDER | ADDRESS | PHONE | FAX

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

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

*Circle Preferred Pronoun: He/Him, She/Her, They/Them, Other:_____*

EPISODE OPENING DATE

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

Gender Identity: ☐Male ☐Female ☐Intersex ☐ Gender Queer ☐Unknown ☐Male to Female ☐Female to Male

☐Decline to State ☐Gender non-conforming ☐Other

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

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

☐Release for Emergency Contact obtained for this time period:

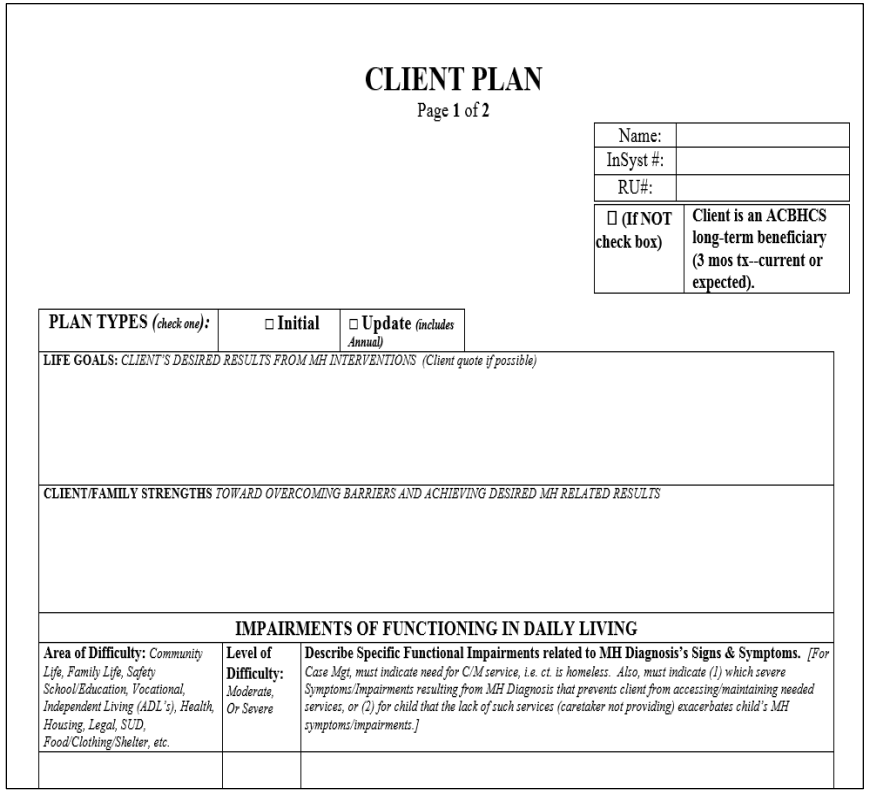
| **Assessment Sources of Information**(Check All that Apply): | ☐**Client** | ☐**Family Guardian** | ☐**School** | ☐**Other:** |
|---|---|---|---|---|

**REFERRAL SOURCE/ RESON FOR REFERRAL/ CLIENT COMPLAINT**

**Describe precipitating event(s) for Referral; Current Symptoms and Behaviors (intensity, duration, onset, frequency): Impairments in Life Functioning caused by the MH symptoms/Behaviors (from perspective of client and/or others):**

☐Narrative continued in Addendum

## CLIENT PLAN TEMPLATE



**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** *(includes 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 C/M service, i.e. ct. 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.]* |
|---|---|---|
| | | |

# New Request for Continued Services (RCS) Required Form

This form is required whenever an extension of services is being requested.

Additional services beyond six months of the most recent authorization may not be claimed without a RCS being approved by UM.

Follow the instructions on the form and submit to UM two weeks prior to current authorization.

Once services are approved, the provider must complete the updated plan and/or assessment within authorized timeframes.

**REQUEST FOR CONTINUED SERVICE (RCS)**

SUBMIT 2 WEEKS PRIOR TO CURRENT AUTHORIZATION EXPIRATION DATE TO:
Utilization Management Program (UM)
Alameda County Behavioral Health Care Services
2000 Embarcadero Cove, Suite 400
Oakland, CA 94606
Phone (510) 567-8141 FAX (510) 567-8148

Client Name: _____
Client DOB: _____
Client CIN or SSN: _____
Provider Name: _____
Agency, if applicable: _____
Provider Phone:

**General Instructions**:

- This form is available online at http://www.acbhcs.org/providers/Forms/Forms.htm under "Utilization Management" section.
- If client has a Client Identification Number (CIN), the CIN must be used, per State regulations. (CIN is on the Medi-Cal card and AEVS)
- Indicate "N/A" or "none" if the question is not relevant to client.
- Incomplete or illegible forms will be returned to sender.
- Please note: Only one age-appropriate screening form is required. Your signature is required on page 6.
- Submit extra pages, if needed, and check the following box to alert UM staff: ☐

**RELATED TO YOUR REIMBURSEMENT**

- **Date of first face-to-face contact with client:** _____
- **If you have multiple sites, at which site does this client receive services?** _____

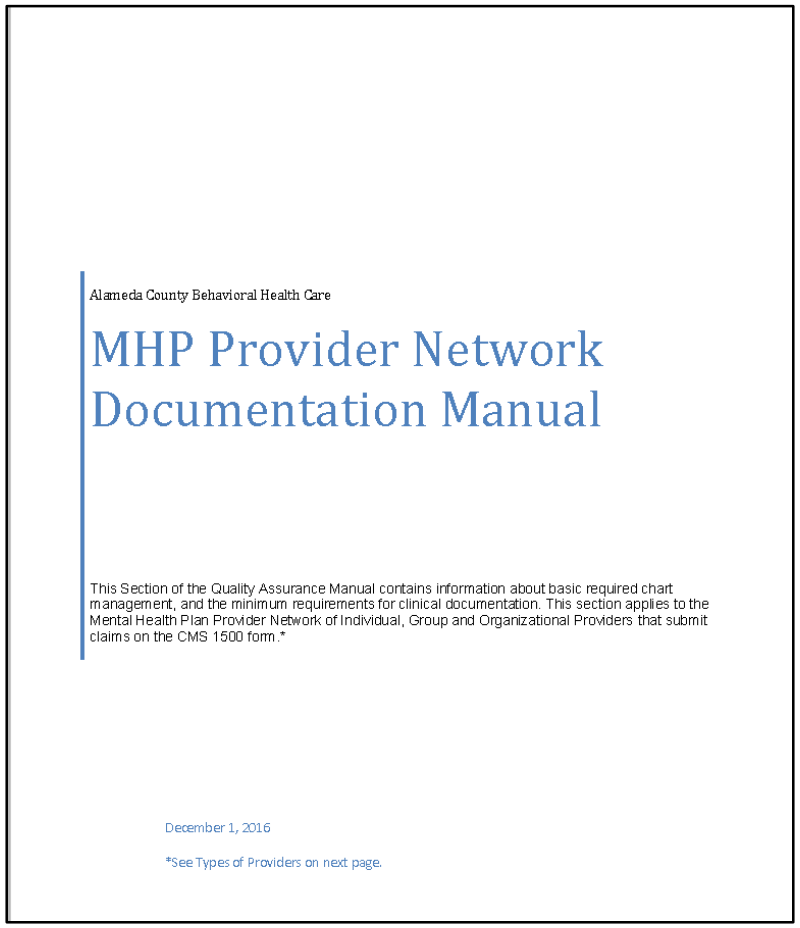
**CLIENT ASSESSMENT INFORMATION:**

1. **Please describe your client's current presenting problems. Include specific risks, symptoms, and diagnosis(es), and the specific, current impairment(s) in daily functioning that result. What are the specific maladaptive behaviors in important areas of daily functioning that result from your client's mental illness?** (e.g. suicidal ideation, poor sleep, poor eating, low energy and social isolation due to a major depressive episode puts the client at risk for self-harm and loss of housing, and prevents ability to work and hinders ability to find community support)

# Doc Training Guidelines

- Providers are expected to attend a minimum of one (1) ACBHCS clinical documentation training every three (3) years, as well as any additional ACBHCS required trainings.
- The expectation is for providers to keep up to date with all current policies, procedures and regulations.

# ACBHCS Clinical Documentation Standards Manual for Network Providers


Alameda County Behavioral Health Care

MHP Provider Network Documentation Manual

This Section of the Quality Assurance Manual contains information about basic required chart management, and the minimum requirements for clinical documentation. This section applies to the Mental Health Plan Provider Network of Individual, Group and Organizational Providers that submit claims on the CMS 1500 form.*

December 1, 2016

*See Types of Providers on next page.

http://www.acbhcs.org/providers/QA/docs/qa_manual/7-2_MHP_NETWK_PROVIDER_DOC_STANDARDS.pdf

- Documentation Standards manual for all providers that claim using the form CMS 1500

# Reminders

- All requests for outpatient services must be referred through ACCESS, including psychological testing
- In order to improve timeliness of connection to services, providers are expected to outreach to prospective clients to schedule appointments upon receipt of ACCESS referral letters.
- Providers are expected to carry a minimum caseload of three (3) MHP FFS Provider Network clients (some exceptions apply.)
- Because our beneficiaries typically benefit from connection to additional community resources, providers are expected to use the new "Brokerage/Linkage" billable service for assisting clients in connecting with community resources such as primary care physician, housing resources and social services.
- Organizational Providers must comply with OIG and Other Exclusion List Monitoring, Oversite and Reporting Policy

# Specialty Services

## Psychodiagnostic Evaluation/Psychological Testing

- Any provider may request psychological testing for their client by submitting Psychological Testing Authorization Request (PTAR) form to ACCESS
- Must be in treatment for a minimum of three (3) months before requesting testing
- http://www.acbhcs.org/providers/Forms/Forms.htm

## Children and Family Services (paid by Social Services) and Customized Services

- Child Welfare Worker (CWW) initiates referral to ACCESS
- For Customized Services, CWW must obtain supervisor approval
- Providers must submit progress reports or treatment summaries to assigned CWW once every six months or upon request. When authorized by CWW use approved code for claiming this activity.

## Probation and/or CalWORKS recipients

- All initial authorizations must come through ACCESS and use assigned CalWORK codes.

# Insurance Eligibility Verification

Alameda County is a retrospective payment authorization county. Service authorization is given for 6 months into the future but is not a guarantee of payment. Payment of claims is dependent on continued insurance eligibility, medical necessity, and timeliness of claim submission.

It is the provider's responsibility to check insurance eligibility monthly and understand medical necessity criteria for SMHS. Remember to verify eligibility prior to initially providing services and then on the first of each calendar month.

If Medi-Cal has been discontinued, alert the beneficiary to follow-up with the Medi-Cal Office so that hopefully their benefit will be reinstated (usually retroactively if alerted same/next month from discontinuation).

It is strongly recommended for the provider to know each of their beneficiary's Medi-Cal Managed Care Plan (MCP) to help ensure continuity of care as a beneficiary's condition improves from moderate-to-severe to mild-to-moderate.

*See MHP FFS Documentation Standards Manual for more information.*

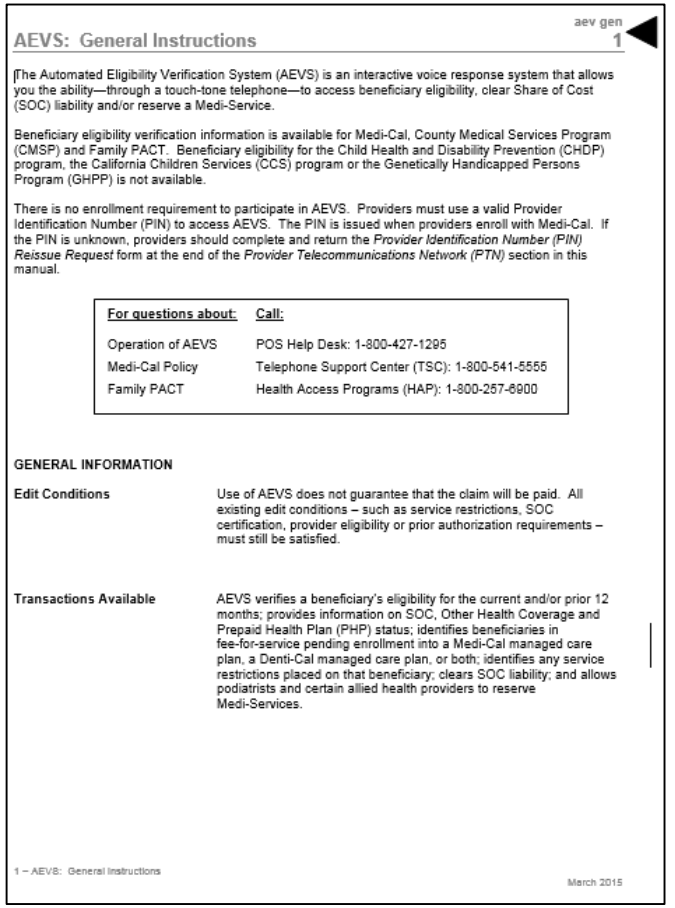
# Insurance Eligibility Verification

DHCS provides several options to verify Medi-Cal eligibility

*Automatic Eligibility Verification System (AEVS):*
*https://files.medi-cal.ca.gov/pubsdoco/AEVS_home.asp*

Or using the online DHCS system:
*https://www.medi-cal.ca.gov/eligibility/login.asp*

As these are DHCS systems, providers must contact DHCS for conditions of use and access to these systems.



aev gen 1

**AEVS: General Instructions**

The Automated Eligibility Verification System (AEVS) is an interactive voice response system that allows you the ability—through a touch-tone telephone—to access beneficiary eligibility, clear Share of Cost (SOC) liability and/or reserve a Medi-Service.

Beneficiary eligibility verification information is available for Medi-Cal, County Medical Services Program (CMSP) and Family PACT. Beneficiary eligibility for the Child Health and Disability Prevention (CHDP) program, the California Children Services (CCS) program or the Genetically Handicapped Persons Program (GHPP) is not available.

There is no enrollment requirement to participate in AEVS. Providers must use a valid Provider Identification Number (PIN) to access AEVS. The PIN is issued when providers enroll with Medi-Cal. If the PIN is unknown, providers should complete and return the *Provider Identification Number (PIN) Reissue Request* form at the end of the *Provider Telecommunications Network (PTN)* section in this manual.

| For questions about: | Call: |
|---|---|
| Operation of AEVS | POS Help Desk: 1-800-427-1295 |
| Medi-Cal Policy | Telephone Support Center (TSC): 1-800-541-5555 |
| Family PACT | Health Access Programs (HAP): 1-800-257-6900 |

**GENERAL INFORMATION**

**Edit Conditions** — Use of AEVS does not guarantee that the claim will be paid. All existing edit conditions – such as service restrictions, SOC certification, provider eligibility or prior authorization requirements – must still be satisfied.

**Transactions Available** — AEVS verifies a beneficiary's eligibility for the current and/or prior 12 months; provides information on SOC, Other Health Coverage and Prepaid Health Plan (PHP) status; identifies beneficiaries in fee-for-service pending enrollment into a Medi-Cal managed care plan, a Denti-Cal managed care plan, or both; identifies any service restrictions placed on that beneficiary; clears SOC liability; and allows podiatrists and certain allied health providers to reserve Medi-Services.

1 – AEVS: General Instructions

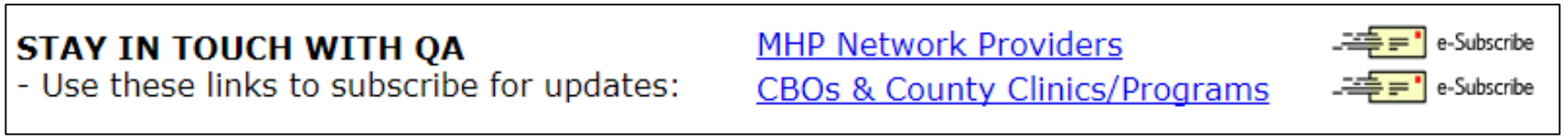
March 2015

# Who to ask….

- **ACCESS** for referral questions, (510) 346-1010
- **Utilization Management Program Daily Coordinator** for RCS & Attestation questions, (510) 567-8141
- **Provider Relations** for claims processing questions, (800) 878-1313
- **Network Office** for contract questions, (510) 567-8296
- **Quality Assurance** for documentation questions, (510) 567-8105
  - QA Technical Assistance (A-H) – cheryl.narvaez@acgov.org
  - QA Technical Assistance (J-Z) – brion.phipps@acgov.org

To stay up to date with Quality Assurance announcements:  Sign up for QA updates at:
http://www.acbhcs.org/providers/QA/QA.htm

Scroll down to “stay in touch with QA”, click on “e-subscribe” and enter your email contact information.



# Initial Authorization & Re-Authorization for MHP FFS Providers

# MHP FFS Overview – For outpatient services

**ACCESS**

- Authorizes the initial package of services (6 months)

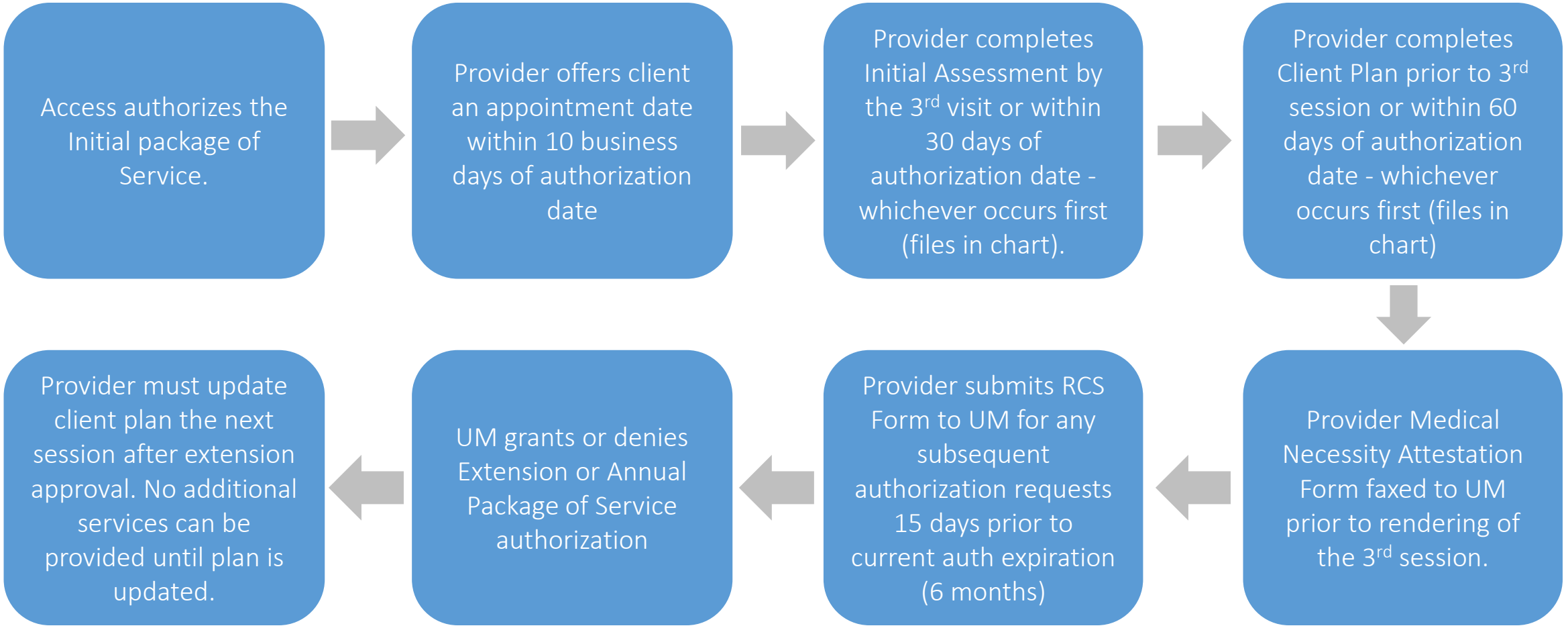
**UM**

- Authorizes the Extension/Annual Package of Services (6 month)

**Provider Relations**

- Provider submits claim within 60 days of the service date month
- BHCS remits payment to provider

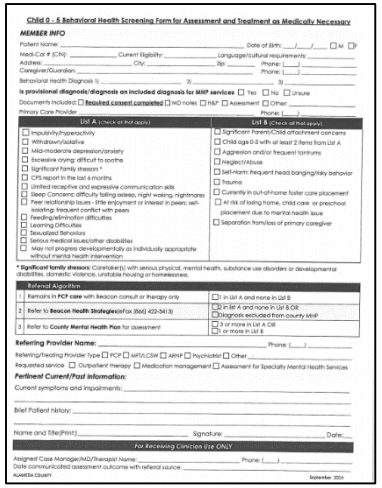
# Authorization/Documentation Timeline for MHP FFS providers

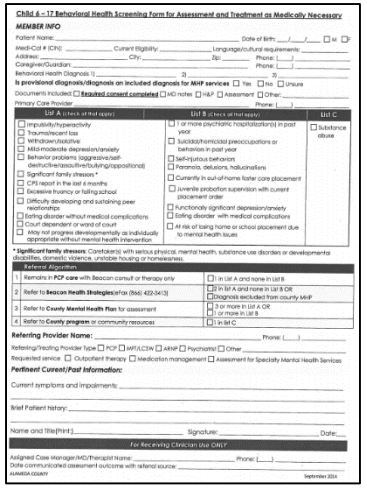


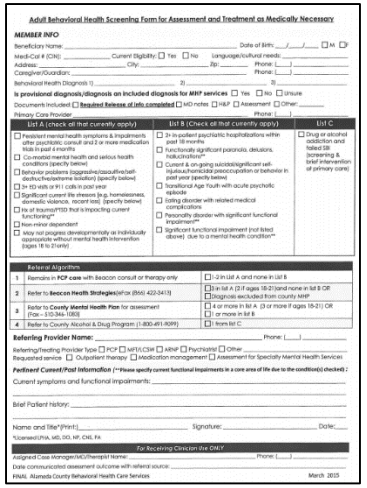
# ACBHCS Brief Screening Tool

For every new client, the appropriate ACBHCS Screening Tool is required. These tools are also embedded in the RCS form and are required at each extension request.

There are three (3) age specific versions for this tool; 0-5, 6-17, and Adult. Choose the one for the age of the client. If a client is determined to have mild-moderate severity or lower, they must be referred to a lower level of care, such as Beacon Health Options.







Standalone Screening Tools found here: http://www.acbhcs.org/providers/Access/referral.htm

# Initial/Annual Package of Services for MHP FFS Providers

## MHP FFS who claim via CMS 1500

- Two sessions* to complete both the Assessment and Plan (90791: indicate actual 60+ minutes in Progress Note)
  - Assessment must be completed within 30 days or before the 3rd visit, whichever comes first
  - Plan must be completed prior to the 3rd session and within 60 days of initial session, whichever comes first
  - Providers may not provide treatment services before both the initial/annual assessment and client plan are completed
  - See required Assessment and Client Plan forms at http://www.acbhcs.org/providers/Forms/Forms.htm
  - Short-form assessment template may be used for your initial assessment; however, the long-form is required for your annual assessments.
- Attestation must be submitted to Utilization Management Program (UM) prior to 3rd session and within 60 days of initial visit (whichever comes first). FAX to 510-567-8148.

*Assessment and Plan sessions are not minute-based, but reimbursement rate is similar to a 90 minute session

# Initial/Annual Package of Services for MHP FFS Providers

For MHP FFS Providers, a package of 26 services (over 6 months) consists of:

- 20 therapy sessions (combination of Individual, Family &/or Group Therapy)
  - Individual Therapy (indicate: 90832-30", 90834-60", or 90837-90" sessions in Progress Note)
    - Code Crisis Therapy (additional visit) as Individual Therapy—call UM if additional sessions required.
  - Family Therapy (indicate: 90846-60" or X9510-90" sessions in Progress Note)
  - Group Therapy (indicate: 90853-60" or Y9506-90" sessions in Progress Note)
  - Rehab services are not allowed
  - Each session regardless of length (30, 60, or 90) = 1 of 20 allowed sessions

PLUS

- *Up to 120 minutes of Brokerage/Linkage in (10173-30" in PN) and (10176-60 in PN) *Up to 120 minutes of Collateral in 10" (90887-10" in PN) and (90888-45" in PN)

*60 minutes of Brokerage/Linkage or Collateral is considered 1 session.

# Recommended Procedure for Completing Assessment/Plan in two sessions

Session 1

- Use first 90 min. session and meet with client face-to-face for 60 minutes focused on Assessment and developing Plan. Spend 30 minutes writing Assessment/Plan. If you don't complete Assessment or Plan in the first session, document in the session's Progress Note that you, "completed pages 1 & 2 in Plan" or "completed sections X, Y, & Z of Assessment."

- OR

- Use first 90 min. session and meet with client face-to-face for 90 mins. doing collaborative documentation. If you don't finish the Assessment or Plan in the first session, document in the session's Progress Note that you, "completed pages 1 & 2 in Plan" or "Sections X, Y, & Z of Assessment."

# Recommended Procedure for Completing Assessment/Plan in two sessions

**Session 2**

- Use second 90 min. session to meet with client face-to-face for 60 minutes focused on Assessment and developing Plan. Spend 30 minutes completing the Assessment and Plan. Obtain verbal consent agreement and document this in the session's progress note. Also, document that client will sign the typed plan at the next visit (unless signs written plan created today).

**OR**

- Use second 90 min. session and meet with client face-to-face for 90 mins. doing collaborative documentation and complete the Assessment and Plan. Obtain client's approval and signature on client plan **at end of session**.

*FYI: $112.80 for each Assessment/Plan session roughly equivalent to 90 minutes of therapy services ($108.80)*

# Re-Authorization for Network Providers

# Request for Continued Service (RCS) details for MHP FFS Providers

If additional services are needed beyond the initial 6 month specified Package of Service authorization by ACCESS, complete the Request for Continued Service (RCS form) two weeks prior to the authorization expiration date. This is also true for any other subsequent RCSs.

## MHP FFS Providers: submit to UM via FAX: (510) 567-8148

The RCS form is available online in two versions - one fillable and one printable at the UM Program Link: http://www.acbhcs.org/providers/Forms/ProviderNetwork.htm

- The RCS must document medical necessity for SMHS with **current** significant impairment.
- The RCS has a screening form and algorithm to help you make impairment severity determinations (i.e. moderate-to-severe vs. mild-to-moderate).
  - *Please complete only the screening form which is age appropriate for your beneficiary and fax all pages*
  - Must refer out if client is determined to be mild-moderate
- Four pages of the RCS are required, including the signature block, which requires a signature of a licensed for individual and group providers (MHP FFS Organizations may use Registered/Waivered for completion—but must be co-signed by Licensed).

# RCS – UM's response for MHP FFS Providers

- In response to the RCS, providers will receive a letter of approval or denial by a Clinical Review Specialist (CRS). Notification will also be sent to the beneficiary. Authorization is usually for a 6 month time span unless otherwise specified.
- A CRS from ACBHCS UM may request responses for additional information that does not impact the current authorization, such as "For beneficiary's current medications, please list dosage and frequency." These requests will be highlighted in yellow on the approval letter; *responses expected on the next RCS*.
- A Provider may receive a phone call from a licensed Clinical Review Specialist (CRS) requesting case consultation if continued need for services is not clearly documented on the RCS.
  - If, by the 14th calendar day, the Provider fails to respond to a telephone request to help determine medical necessity, the RCS will be considered withdrawn and no authorization will be processed. This will most likely result in returned claims.

# Standard 6 Month Extension Package

One (1) session to complete updated Client Plan (use Psychiatric Diagnostic Eval code)

- A new client plan must be completed in the first session after extension authorization.

- For next six months (see prior slides for codes and minutes to chart to):
  - 20 Therapy sessions – Any combination of Individual, Family &/or Group Therapy as long as the modality is specified in the plan.
    - Individual (30, 60, 90 minutes)
    - Family Therapy (60 or 90 minutes)
    - Group Therapy (90 minutes)
  - 3 hours - Brokerage/Linkage (30 and 60 minutes increments)
  - 2 hours – Collateral (10 and 45 minutes increments)

26 total services within the 6 month span

# Checklist for 6 Month Reauthorization

- ❑ Document medical necessity with current functioning impairment directly related to mental health symptoms on the RCS.
- ❑ Complete only the applicable screening form on the RCS. Choose one according to age of client.
- ❑ Sign the RCS & submit all pages 15 days prior to expiration date of current authorization.

  MHP FFS Providers fax RCS to (510) 567-8148
- ❑ If there has been a lapse in service or a new service is being requested, indicate the start date for the requested 6 month authorization period
- ❑ **Once authorization is approved, update the Client Plan with new goals/objectives for the next 6 months. Client must sign plan. File in chart – do not send. Use your one Psychiatric Diagnostic Eval code to update Assessment / Plan.**

# Standard Annual Extension Package: For an additional 6 months

Two (2) Sessions to complete Annual Assessment & Client Plan (use Psychiatric Diagnostic Eval code)

- Assessment update and new client plan must be completed in the first two (2) sessions after extension authorization.
- For next six months (see prior slides for codes and minutes to chart to):
- 20 Therapy sessions – Any combination of Individual, Family &/or Group Therapy as long as the modality is specified in the plan.
  - Individual (30, 60, 90 minutes)
  - Family Therapy (60 or 90 minutes)
  - Group Therapy (90 minutes)
- 2 hours - Brokerage/Linkage (30 and 60 minutes increments)
- 2 hours – Collateral (10 and 45 minutes increments)

26 total services within the 6 month span

# Checklist for Annual Reauthorization

- Document medical necessity with current functioning impairment directly related to mental health symptoms on the RCS.
- Complete only the applicable screening form on the RCS. Choose one according to age of client.
- Sign the RCS & Submit all pages 15 days prior to expiration date of current authorization.
  MHP FFS Providers fax RCS to (510) 567-8148
- If there has been a lapse in service or a new service is being requested, indicate the start date for the requested 6 month authorization period
- Once authorization is received complete Annual Assessment using the Long Form and new Client Plan. Client must sign Plan. One (1) Assessment/Plan session could be used for the write up for Annual Assessment and Annual Plan. File in chart – do not send.

# When are the Assessment and Plan due after the Initial one?

## AT EVERY 6 MONTH RE-AUTHORIZATION

- ✓ Make sure RCS is submitted in time to ensure that authorization to provide services is approved. RCS can be submitted up to two (2) weeks prior to 6 months from previous authorization date.
- ✓ New Plan with client approval and signature
- ✓ New Assessment is **not** required

## AT EVERY 12 MONTH/ANNUAL RE-AUTHORIZATION

- ✓ Make sure RCS is submitted in time to ensure that authorization to provide services is approved. RCS can be submitted up to two (2) weeks prior to 6 months from previous authorization date.
- ✓ New Plan with client approval and signature
- ✓ New Assessment (that includes any relevant updates). ACBHCS Long Form Assessment REQUIRED

# MHP FFS Additional Services

- The package of services is expected to cover the six (6) month authorization period. Services might need to be rationed in order to adequately provide coverage until reauthorization.
- Additional services (i.e. services beyond the package) can only be related to crisis situations. Depending on when the crisis happens, services frequency might need to be adjusted to provide consistent (but less frequent) therapy until reauthorization. Crisis services should be claimed as therapy.
- It is expected that 50% of clients served by MHP FFS providers will be extended beyond the initial 6 month authorization period.
- If services in addition to the standard package are clinically required and remaining services cannot be adjusted, please contact Utilization Management at (510) 567-8141 for approval.

# A note about mild-moderate impairment

If a Provider is interested in continuing to work with a beneficiary whose condition improves to mild-to-moderate impairment, it is recommended that the Provider become a Beacon and/or Anthem Blue Cross provider.

Beacon Health Options (855) 856-0577

Anthem Blue Cross (888) 831-2246

Kaiser Permanante (510) 752-1075

# Audit Highlights


# ACBHCS Audits Claims Disallowance Rates

Target claims disallowance rate < 5%

January 2017 DHCS Triennial Audit: 18% disallowance

January 2013 DHCS Triennial Audit: 50% disallowance

Four Quarterly Internal ACBHCS System of Care Audits from 2015-Q4 to 2016-Q3 (four audits):

- Across all Provider (CBO & County): 28% disallowance

# Common Claims Disallowances: ACBHCS SOC 2015-16 Audits


The majority of disallowances (54%) were due to non-compliance with Initial and/or Annual Mental Health Assessments and Client Plans.

- Assessments were not signed by an appropriately credentialed staff, not completed on time, and/or did not have an included diagnosis.
- Client Plans did not include service modality, lacked client (or guardian) signatures, were not completed on time, and/or lacked objectives/interventions that were addressed in treatment.

# Common Claims Disallowances: ACBHCS SOC 2015-16 Audits


An additional 25% was due to non-compliance with Progress Notes.

- Progress Note contents did not support amount of time claimed, the progress note was absent or not completed, the time billed for documentation was excessive, a non-billable activity was claimed, duplication or services occurred, and/or a clinicians interventions were not documented.
- Group activities were incorrectly billed or documented

# Ten Important Quality Review Items Out of Compliance: ACBHCS SOC 2015-16 Audits


1. MH Assessments and Client Plans were not completed within required timeframes. This reason can also pose a potential disallowance.
2. MH Assessments and Client Plans were missing key required elements (such as service modalities, youth developmental history, allergies, medical history, 7 substance use areas, etc.).
3. Safety Plans (or objectives) were not completed for Danger to Self or Others.
4. Informed Consents for Medications were not done, or were missing elements.
5. Required signed Releases of Information were not present or renewed every 12 months.

# Ten Important Quality Review Items Out of Compliance: ACBHCS SOC 2015-16 Audits


6. Mild-Moderate-Severe Screening Tool
7. Cultural/Linguistic/Physical needs were not assessed and/or addressed.
8. Progress Notes did not include: the required components (P/BIRP). were late, or illegible.
9. The ACBHCS required “Informing Materials Signature Page” was not fully completed.
10. No documentation that client was offered a copy of, participated in the development, and agreed to the Client Plan (or updated when clinically indicated)

# Pre-Assessment

# Pre-Assessment – Brief Screening Tool

The **Brief Screening Tool (BST)** must be administered in order to determine the severity of client's sx's and if they are eligible for SMHS

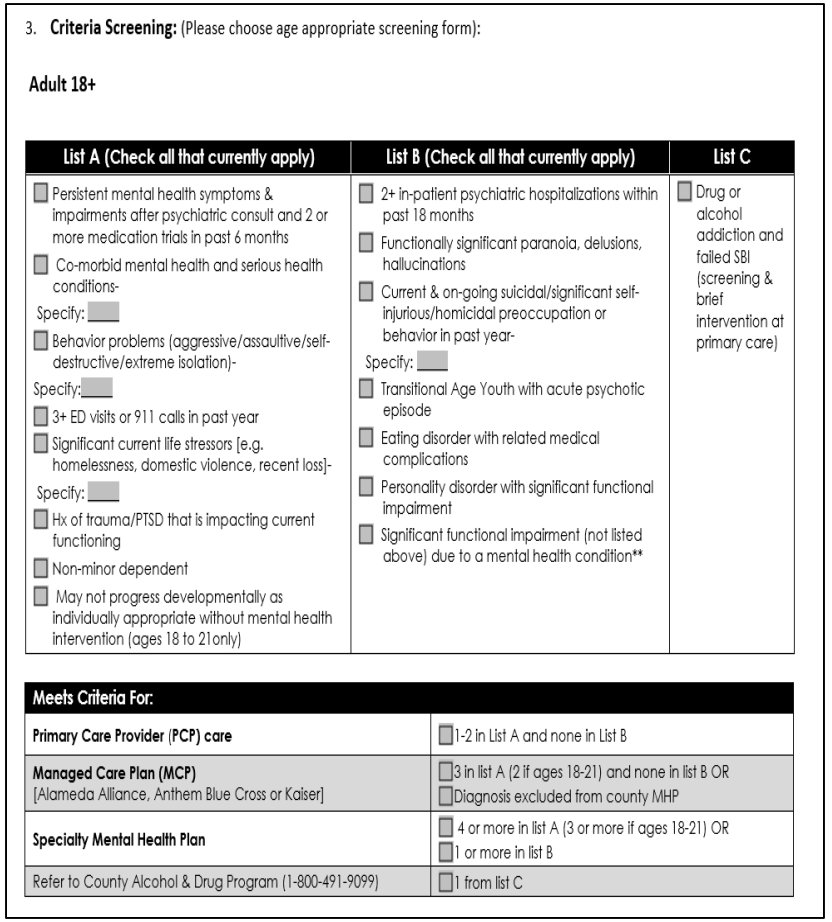
- This must be done before any services can be claimed and with every request for re-authorization.
  - BST is embedded in the RCS, complete the appropriate tool for the client's age
- For Individual and Group Providers the BST must be administered by a Licensed LPHA.
  - For Organizations a Waivered/Registered LPHA with a Licensed LPHA co-signature may also complete the BST.
- Completion of RCS is **not billable**. An informational/non-billable progress note should be completed.
- Client must continue to meet criteria for Moderate – Severe to be eligible for Specialty Mental Health Services. If client is not referred accurately, this may result in denial of authorization and claim disallowances.

# Pre-Assessment – Brief Screening Tool

- Screening Tools Forms are embedded within the RCS form

URL:

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



3. **Criteria Screening:** (Please choose age appropriate screening form):

**Adult 18+**

| 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<br>☐ Co-morbid mental health and serious health conditions-<br>Specify: ____<br>☐ Behavior problems (aggressive/assaultive/self-destructive/extreme isolation)-<br>Specify:____<br>☐ 3+ ED visits or 911 calls in past year<br>☐ Significant current life stressors [e.g. homelessness, domestic violence, recent loss]-<br>Specify: ____<br>☐ Hx of trauma/PTSD that is impacting current functioning<br>☐ Non-minor dependent<br>☐ May not progress developmentally as individually appropriate without mental health intervention (ages 18 to 21only) | ☐ 2+ in-patient psychiatric hospitalizations within past 18 months<br>☐ Functionally significant paranoia, delusions, hallucinations<br>☐ Current & on-going suicidal/significant self-injurious/homicidal preoccupation or behavior in past year-<br>Specify: ____<br>☐ Transitional Age Youth with acute psychotic episode<br>☐ Eating disorder with related medical complications<br>☐ Personality disorder with significant functional impairment<br>☐ 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) |

| Meets Criteria For: | |
|---|---|
| **Primary Care Provider (PCP) care** | ☐ 1-2 in List A and none in List B |
| **Managed Care Plan (MCP)**<br>[Alameda Alliance, Anthem Blue Cross or Kaiser] | ☐ 3 in list A (2 if ages 18-21) and none in list B OR<br>☐ Diagnosis excluded from county MHP |
| **Specialty Mental Health Plan** | ☐ 4 or more in list A (3 or more if ages 18-21) OR<br>☐ 1 or more in list B |
| Refer to County Alcohol & Drug Program (1-800-491-9099) | ☐ 1 from list C |

# Pre-Assessment – Informing Materials

**ACBHCS Informing Materials (in client's preferred threshold language)** must be given to and signed by the client

- Before services provided (recommended) and no later than 30 days after the EOD
- Annually by the 1st day of the EOD Month
- All areas must be addressed (indicated by checking ALL boxes)
- This service may be claimed as part of the MH Assessment process.

بروشور اطلاعاتی -- حقوق و مسئولیت های شما

به برنامه بهداشت روانی کالتی آلامیدا خوش آمدید

خوش آمدید! به عنوان یک عضو (استفاده کننده) برنامه بهداشت روانی کالتی آلامیدا (MHP) که از این ارائه دهنده خدمات بهداشت روانی درخواست می کند، ما از شما می خواهیم این بروشور اطلاعاتی که حقوق و مسئولیت های شما را توضیح می دهد مرور نمایید.

نام ارائه دهنده خدمات:

شخصی که مقدم شما به خدمات را گرامی می دارد همراه با شما این بروشور را مرور می کند. این بسته به شما داده می شود تا آن را به خانه ببرید و هر موقع مایل بودید آن را مرور کنید و از **شما خواسته خواهد شد آخرین صفحه این بسته را امضا کنید تا مشخص نمایید چه موضوعاتی مورد بحث قرار گرفت و ضمنا متذکر شوید که شما این بروشور را دریافت کردید.** ارائه دهنده خدمات، صفحه امضای اصلی را نگاه خواهد داشت. ارائه دهندگان خدمات همچنین موظفند شما را در مورد در دسترس بودن موارد بخصوصی در این بسته اطلاعاتی در هر سال آگاه سازند و آخرین صفحه این بسته جایی وجود دارد که به شما می گوید چه هنگام این آگاهی ها صورت می گیرد.

**صفحات بعد حاوی اطلاعات زیادی است بنابر این سر فرصت آن را مطالعه کرده و هر سوالی دارید بپرسید!**

**دانستن و فهمیدن حقوق و مسئولیت های شما کمک می کند تا مراقبتی را که شایسته آن هستید دریافت دارید.**

رضایت برای دریافت خدمات

به عنوان یک عضو این برنامه بهداشت روانی (MHP)، امضای شما در آخرین صفحه این بسته بدان معنا است که شما نسبت به ارائه خدمات معالجه بهداشت روانی که از ارائه دهنده دریافت می کنید به صورت داوطلبانه رضایت می دهید. اگر شما نماینده قانونی یک استفاده کننده از این MHP هستید، امضای شما نشان دهنده آن رضایت است.

رضایت شما برای دریافت خدمات همچنین بدان معنا است که این ارائه دهنده موظف است شما را از توصیه های مراقبتی خود آگاه سازد، بنابر این تصمیم شما برای شرکت از روی علم و آگاهی گرفته شده و دارای مفهوم است. علاوه بر داشتن حق متوقف ساختن خدمات در هر زمان، شما همچنین حق دارید از به کار بردن هر گونه توصیه، مداخلات روانشناسی یا مراحل معالجه خودداری نمایید.

این ارائه دهنده ممکن است رضایت نامه دیگری برای امضا به شما بدهد که انواع خدماتی که ممکن است دریافت کنید را با تفصیل بیشتری بیان می کند. این خدمات می تواند شامل اما نه محدود به موارد زیر باشد: برانوردها؛ ارزیابی ها؛ مداخله بحرانی؛ روان درمانی؛ مدیریت پرونده؛ خدمات توانبخشی؛ خدمات دارویی؛ معرفی به متخصصان دیگر بهداشت رفتاری؛ و مشورت با متخصصان

Alameda County Behavioral Health Care Services
Quality Assurance Office

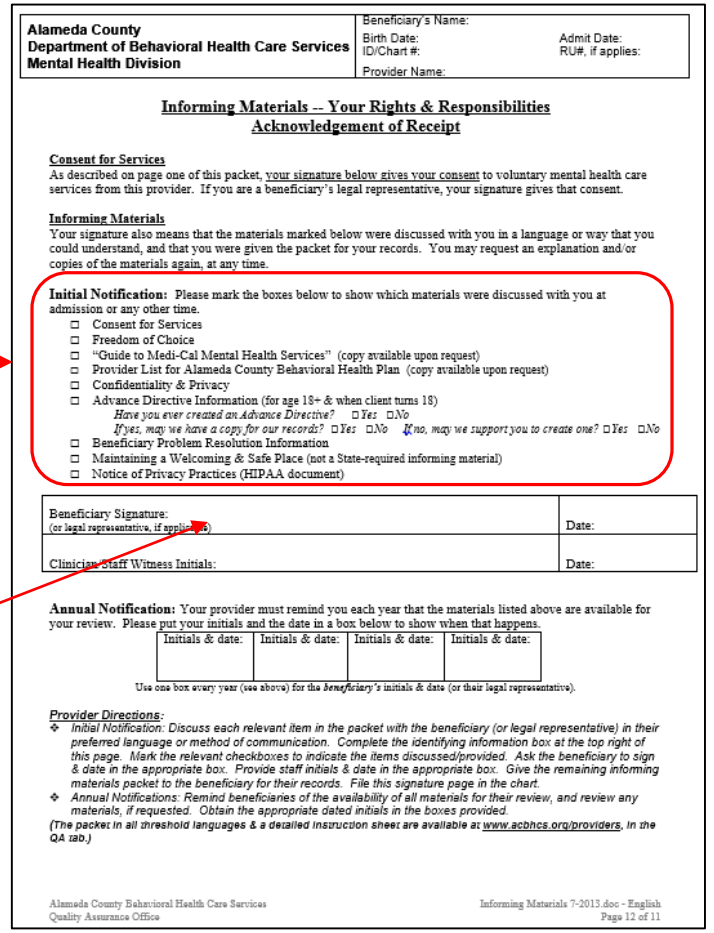
Informing Materials 8-2013 - Farsi
Page 1 of 13

# Pre-Assessment – Informing Materials

Forms are located on Provider Website > Quality Assurance > Informing Materials
http://www.acbhcs.org/providers/QA/General/informing.htm

The beneficiary must check all of these boxes, indicating that these materials were discussed.

The beneficiary then signs and dates here



**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

# Pre-Assessment – Releases of Information

- Must be signed by client
- Not required for other Alameda Health Care Services Providers—but recommended
- Not required to simply facilitate treatment referral to other MH Providers—but highly recommended
- By law, Releases of Information are valid for no longer than 12 months regardless if a longer timeframe is indicate

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

# Medical Necessity

# The Golden Thread

The “Golden Thread” is the sequence of documentation that supports the demonstration of ongoing medical necessity and ensures all provided services are reimbursable.

The sequence of documentation on which medical necessity requirements converge is:

- The Assessment
- The Client Plan
- The Progress Note

# Part 1 – Included Diagnosis

- DSM-5 diagnosis must be current (not historical)
- For Individual and Group Providers the diagnosis must be established by Licensed LPHA
  - See scope of practice grid for approved list of LPHAs
- For Organizations, if established by Waivered/Registered LPHA, the diagnosis must be co-signed by a Licensed LPHA.
- If co-signature is missing, then multiple claims may be disallowed until compliant.

# Part 1 – Included Diagnosis

- **See Lists & Crosswalk –** http://www.acbhcs.org/providers/QA/audit.htm
  - MH Outpatient M/C Included Dx List—Alpha
  - MH Outpatient M/C Included Dx List—Numeric
  - MH M/C Included Dx Crosswalk: DSM-IV to DSM-5
  - General Medical Codes List
  - Psychosocial Conditions List (may use any present in DSM-5).

# Part 2 – Qualifying Impairment

## 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*

# Part 2 – Qualifying Impairment

If the client has had recent (within the last 3 months of indication) HI/SI (no plans or means required), or other high risk conditions:

A comprehensive Risk Assessment and a formalized, and written Safety Plan – must be created for treatment purposes.

See the BHCS Provider website for resources:

http://www.acbhcs.org/providers/QA/docs/2013/TR_Suicide-Homicide_Risk_Assesment.pdf

# Risk Assessment & Safety Plan

http://www.acbhcs.org/providers/QA/docs/audit/ACBHCS_SMHS_FAQs.pdf

**Client and Others Safety**

**Q1.** If a client is found to have suicidal/homicidal/other significant risk *ideation* is a Safety Plan required?

**A1.** Yes, if at any point ideation is identified (having occurred anytime in the past 90 days)--both a comprehensive Risk Assessment AND a formal written Safety Plan must be developed in coordination with the client. Also, see Q2 below.

# Client & Others Safety Continued

http://www.acbhcs.org/providers/QA/docs/audit/ACBHCS_SMHS_FAQs.pdf

Q2. What if a client has a history of suicidal/homicidal/other significant risk ideation but is currently stable and has these symptoms controlled.

A2. ACBHCS requires that if a client has had any a suicidal/homicidal/other significant risk ideation *in the past 90 days* that both a comprehensive Risk Assessment AND a formal written Safety Plan must be developed in coordination with the client. *If it has been more than 90 days* since the client last experienced symptoms of suicidal/homicidal/other significant risk ideation the clinical situation must be considered carefully to determine if a comprehensive Risk Assessment AND a formal Safety Plan should be completed. Beyond 90 days of ideation, if it is determined that a Comprehensive Risk Assessment and formal written Safety Plan are not indicated, document the clinical reasoning for this decision.

# Client & Others Safety Continued

http://www.acbhcs.org/providers/QA/docs/audit/ACBHCS_SMHS_FAQs.pdf

Q3. What elements must be documented in a comprehensive Risk Assessment and formal Safety Plan?

A3. The Comprehensive Risk Assessment must be documented in the Clinical Record. The Safety Plan must also be documented in writing and provided to the client as a resource for reference as needed. It is crucial that the development of the Plan is a clinical process and that each step is embraced and endorsed by the client. Critical elements of each include:


# Client & Others Safety Continued

Comprehensive Risk Assessment (must be documented in Clinical Record):

*Reason for Comprehensive Assessment*

*Current Episode:* Current Intent (Subjective Reports & Objective Signs); Plans; Access to Means; and Ideation (Frequency, Intensity & Duration)

*History of Risks and Attempts* (Self-Harm, Risk to Others, & Hospitalizations related to Risk)

*Risk Factors* (Internal, & Environmental)

*Protective Factors* (Internal, & Environmental)

*Focused Symptom Severity* (Depression, Anxiety, Anger, Agitation, Insomnia, Hopelessness, Perceived Burdensomeness, Impulsivity/Self Control, Chronic Risk, Therapeutic Alliance, and Current Level)

*Status of Crisis Safety Plan*

*Comprehensive Risk Assessment Resource:*

http://www.acbhcs.org/providers/QA/docs/2013/TR_Suicide-Homicide_Risk_Assesment.pdf


# Client & Others Safety Continued

**Formal Crisis Safety Plan (written from client's perspective as their plan).**

*What are my Warning Signs* (Thoughts, Images, Thinking Processes, Mood & Behavior)?

*What Are My Triggers?*

*What Internal Coping Strategies may I Use* (Identification of, Likelihood of Use, Barriers and Problems Solving)?

*What Social Contacts May I Use* (For Distraction &/or for Support—multiple people in multiple settings)?

*When Will I contact my Family Members and/or Friends to Assist in the Resolution of the Crisis?*

*Which, and When Will I Contact, Professionals and Agencies for Assistance* (Priority & Expectations)?

*How May I Reduce the Potential for Use of Lethal Means?*

*The Implementation of Safety Plan* (Likelihood of Use and Problem Solve if Obstacles; Regular Review)

*Resource: www.mentalhealth.va.gov/docs/VA_Safety_planning_manual.doc*

# Part 3 – Treatment will address impairments

**The focus of treatment are the Signs/Sx's of the Included Dx's and address the following:**

a) Decrease the ***significant impairment*** in an important area of life functioning
b) Prevent the ***probability of significant deterioration*** in an important area of life functioning
c) (For Children - EPSDT) Will allow the child to ***progress developmentally as individually appropriate***.

# Assessment

# Who can create and complete an Assessment?

- For Individual and Group providers, Assessment must be completed by a Licensed LPHA.
- Non-MCO Organization claiming through a CMS 1500 paper form: Licensed LPHAs *OR* Waivered/Registered therapists with Licensed LPHA co-signature.

# Assessment Templates

- MHP FFS Individual, Group and Organizations that Claim with a CMS 1500 paper form MUST use Clinical Templates found on BHCS Provider Website:

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

**Provider Network**

- MH Initial or Annual Assessment—Long Form
- MH Initial Assessment—Short Form
- Client Plan (aka Treatment Plan)
- MH Progress Note

# Assessment Template – Short Form

## Use for Initial Assessment

**Initial MH Assessment – Short Form**

| *For Provider Use* |
|---|
| ☐ Informing Materials signed (annually) |
| ☐ Release of Information Forms signed (annually) |

Name: _____

Insyst# _____

RU# _____

Page **1** of **8**

PROVIDER | ADDRESS | PHONE | FAX

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

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

*Circle Preferred Pronoun: He/Him, She/Her, They/Them, Other:*_____

EPISODE OPENING DATE

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

Gender Identity: ☐Male ☐Female ☐Intersex ☐ Gender Queer ☐Unknown ☐Male to Female ☐Female to Male

☐Decline to State ☐Gender non-conforming ☐Other

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

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

☐Release for Emergency Contact obtained for this time period:

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

**REFERRAL SOURCE/ RESON FOR REFERRAL/ CLIENT COMPLAINT**

# Assessment Template – Long Form

May be used for the initial assessment, but is optional.

The Assessment Long Form is required for 12 month/Annual Assessment

Both the Long and Short forms capture the same information, the long form has additional prompts for the assessor.

**Mental Health Assessment – Long Form**

Name: _____

Insyst# _____

RU# _____

Page 1 of 14

| For Provider Use | |
|---|---|
| ☐ Initial | ☐ Update |
| ☐ Informing Materials signed (annually) | |
| ☐ Release of Information Forms signed (annually) | |

PROVIDER | ADDRESS | PHONE | FAX

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

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

MM/DD/YY ... MM/DD/YY

*Circle Preferred Pronoun: He/Him, She/Her, They/Them, Other:* _____

EPISODE OPENING DATE | INDICATE 12 MO. AUTHORIZATION CYCLE

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

Gender Identity: ☐Male ☐Female ☐Intersex ☐ Gender Queer ☐Gender Non-Conforming ☐Male to Female ☐Female to Male

# Discussing SO/GI Sensitively

## What's in a Word?

*Policy Focus: Why Gather Data on SO and GI in Clinical Settings; The Fenway Institute*

http://www.lgbthealtheducation.org/

# Discussing SO/GI Sensitively

The ACBHCS EHR (CG) has been modified to include Sexual Orientation and Gender Identity (SOGI) 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 LGB or LGBT people from health surveys.

# Why are we collecting this information?

Social determinants affecting the health of LGBTQ individuals largely relate to **systemic oppression and discrimination.**

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 (SO/GI) information in medical and electronic health records (EHRs) will help assess **access, satisfaction with, quality of care**, **inform the delivery of appropriate health services**, and begin to **address health disparities**

# Why are we collecting this information?

*National Resource Center for Youth Development - Fact Sheet & Healthy People 2020:*

**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 LGB individuals.

70% report being harassed at school

90% report feeling unsafe at school

The risk is very real, already in 2017, thirteen African American transgender women have been murdered

**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.

# Discussing SO/GI Sensitively

## Recommendations for Assessment Clinician—Confidentiality & Privacy

- LGBT clients may be hesitant to disclose information about their sexual orientation or gender identity due to fears about confidentiality and privacy.
  - These fears may have to do with not knowing what will happen with this information
  - Clients may be reluctant to provide such personal information to office staff in a waiting room, because it feels less private than answering the question of a provider in a private office.
- 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 SO/GI Sensitively

Questions recommended by national LGBTQ organizations include:

Two-step sex/gender question

- What is your current gender identity: male, female, transgender, or other? (For written—select from list.)
- What was your sex at birth: male or female? (For written—select from list.)

And

A sexual orientation question

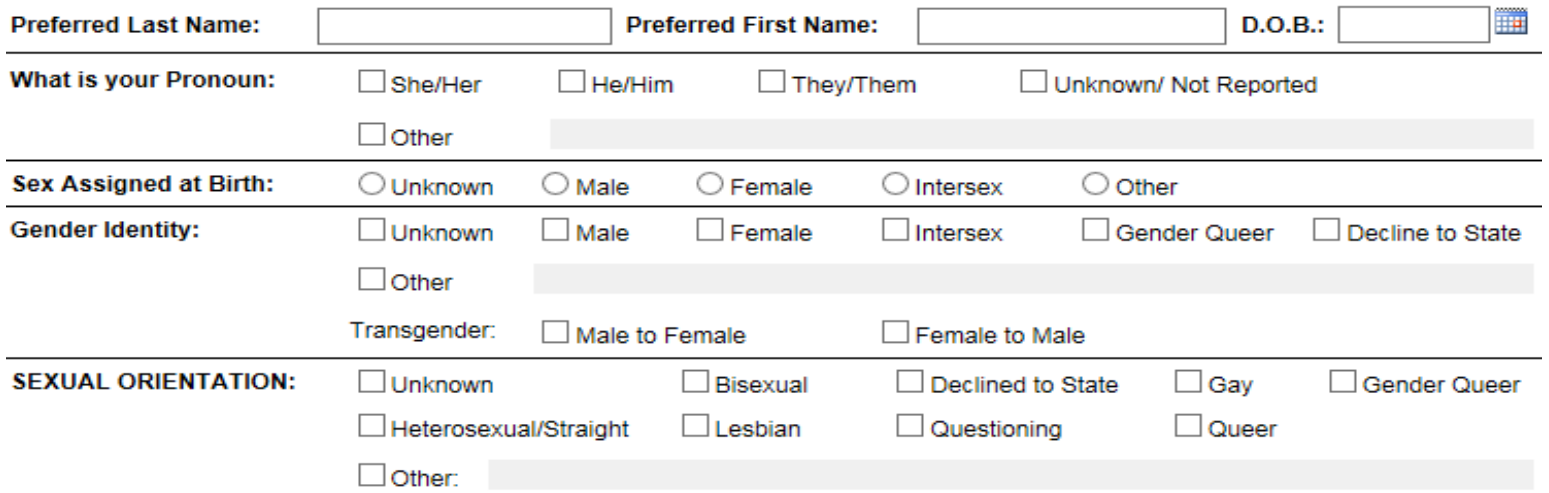
- Do you consider yourself to be: Straight or Heterosexual; Gay or Lesbian, Bisexual, another sexual orientation or don't know? (For written—select from list.)

# Discussing SO/GI Sensitively

**Recommendations for Assessment Clinician—Language and Client Choice to Disclose:**

- Providers can also use inclusive or neutral language, such as “Do you have a partner?” instead of asking “Are you married?” which to most people still refers to heterosexual relationships.
- Providers should ask permission to include information about a client’s sexual orientation and gender identity in the medical record, and assure confidentiality.
- If self-disclosure does not come up in response to general questions such as those proposed above, further questions can be embedded in the sexual history. Such a history should address sexual risk behavior as well as sexual health, sexual orientation (including identity, behavior, and attraction), and gender identity.
  - I.e. Many men may disclose they have sex with a man but not identify as LGBTQ.

# Client Information & SO/GI (Sexual Orientation and Gender Identity)



**Preferred Last Name:** | **Preferred First Name:** | **D.O.B.:**

**What is your Pronoun:** ☐ She/Her ☐ He/Him ☐ They/Them ☐ Unknown/ Not Reported ☐ Other

**Sex Assigned at Birth:** ○ Unknown ○ Male ○ Female ○ Intersex ○ Other

**Gender Identity:** ☐ Unknown ☐ Male ☐ Female ☐ Intersex ☐ Gender Queer ☐ Decline to State ☐ Other

Transgender: ☐ Male to Female ☐ Female to Male

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

# Referral Source, Mental Health History

**REFERRAL SOURCE/ RESON FOR REFERRAL/ CLIENT COMPLAINT**

Describe precipitating event(s) for Referral:

☐ Narrative continued in Addendum

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

☐ Narrative continued in Addendum

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

☐ Narrative continued in Addendum

**MENTAL HEALTH HISTORY**

**Psychiatric Hospitalizations: ☐ Yes ☐ No ☐ Unable to Assess**

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

☐ Narrative continued in Addendum

**Outpatient Treatment: ☐ Yes ☐ No ☐ Unable to Assess**

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

☐ Narrative continued in Addendum

# Mental Health History, Risk Factors (including reminder about Safety Plan)

**Mental Health Assessment Continued** RU# _____

Page 2 of 11

**MENTAL HEALTH HISTORY CONTINUED**

**Prior Mental Health Records Requested:** ☐ **Yes** ☐ **No (See InSyst Face Sheet for current and history of past services)**
Prior Mental Health Records Requested from:

☐ Narrative continued in Addendum

**History of Trauma or Exposure to Trauma:** ☐ **Yes** ☐ **No** ☐ **Unable to Assess**
Has client ever: (1) been physically hurt or threatened by another, (2) been raped or had sex against their will, (3) lived through a disaster, (4) been a combat veteran or experienced an act of terrorism, (5) been in severe accident, or been close to death from any cause, (6) witnessed death or violence or the threat of violence to someone else, or (7) been the victim of crime? **Describe**:

☐ Narrative continued in Addendum

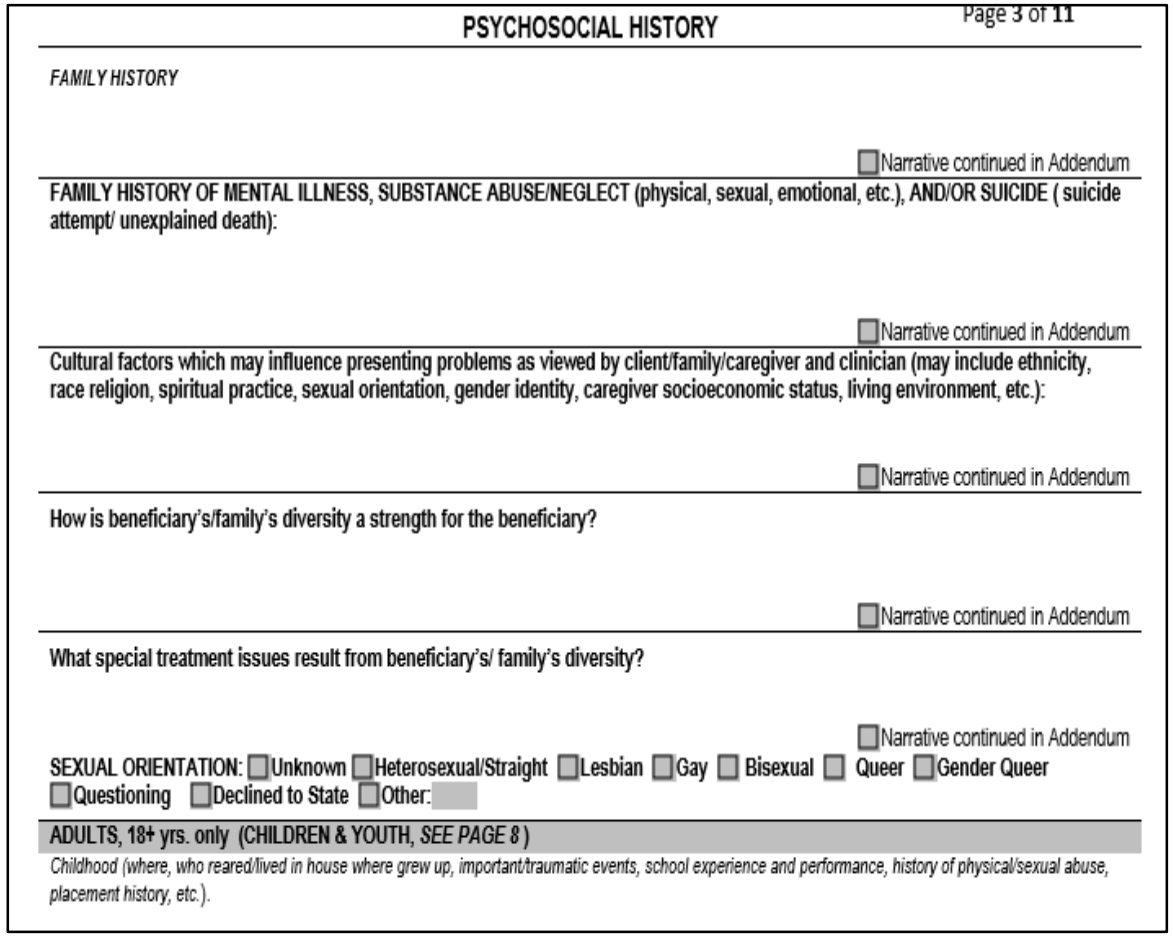
**Risk factors:**
*Aggressive/violent behavior/danger to self/others, and include level of impairments (i.e., school suspension, law enforcement/incarceration, crisis services, and hospitalization)*
☐ *Please check if occurred within the last 30 days. Date of onset:* ____
**Client**:

**Family**:

☐ Narrative continued in Addendum

☐ **Safety plan completed or MH objective in Tx Plan**

# Psychosocial History



PSYCHOSOCIAL HISTORY

Page 3 of 11

*FAMILY HISTORY*

☐ Narrative continued in Addendum

**FAMILY HISTORY OF MENTAL ILLNESS, SUBSTANCE ABUSE/NEGLECT (physical, sexual, emotional, etc.), AND/OR SUICIDE ( suicide attempt/ unexplained death):**

☐ Narrative continued in Addendum

**Cultural factors which may influence presenting problems as viewed by client/family/caregiver and clinician (may include ethnicity, race religion, spiritual practice, sexual orientation, gender identity, caregiver socioeconomic status, living environment, etc.):**

☐ Narrative continued in Addendum

**How is beneficiary's/family's diversity a strength for the beneficiary?**

☐ Narrative continued in Addendum

**What special treatment issues result from beneficiary's/ family's diversity?**

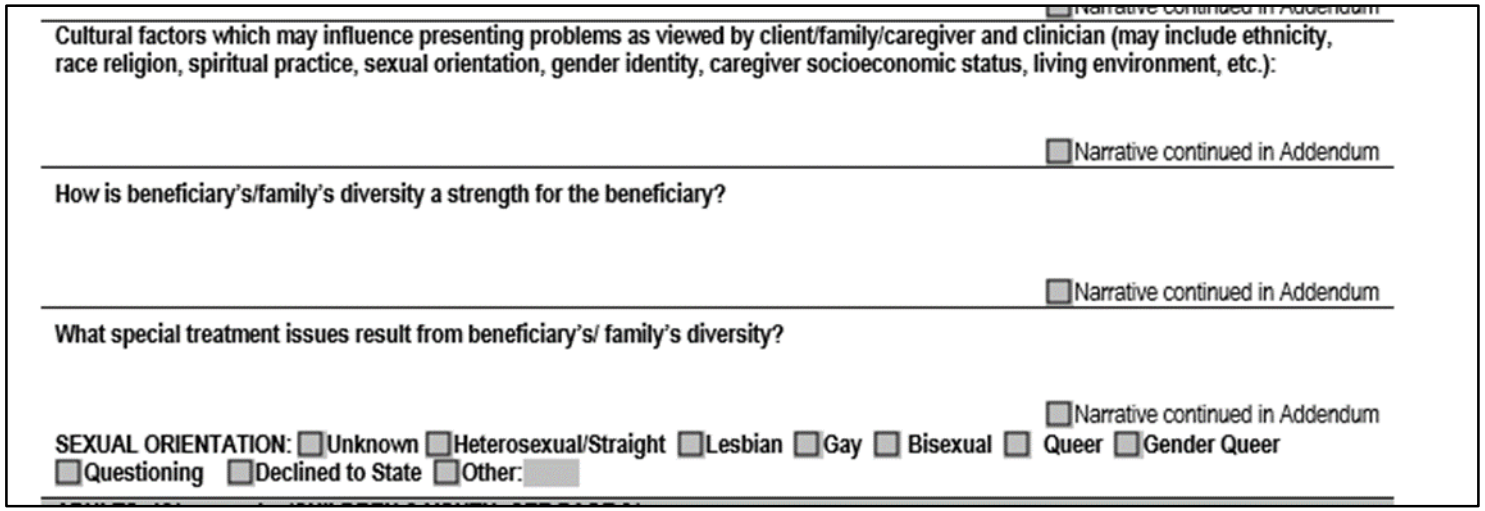
☐ Narrative continued in Addendum

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

**ADULTS, 18+ yrs. only (CHILDREN & YOUTH, *SEE PAGE 8* )**

*Childhood (where, who reared/lived in house where grew up, important/traumatic events, school experience and performance, history of physical/sexual abuse, placement history, etc.).*

# Cultural Considerations



Cultural factors which may influence presenting problems as viewed by client/family/caregiver and clinician (may include ethnicity, race religion, spiritual practice, sexual orientation, gender identity, caregiver socioeconomic status, living environment, etc.):

☐ Narrative continued in Addendum

How is beneficiary's/family's diversity a strength for the beneficiary?

☐ Narrative continued in Addendum

What special treatment issues result from beneficiary's/ family's diversity?

☐ Narrative continued in Addendum

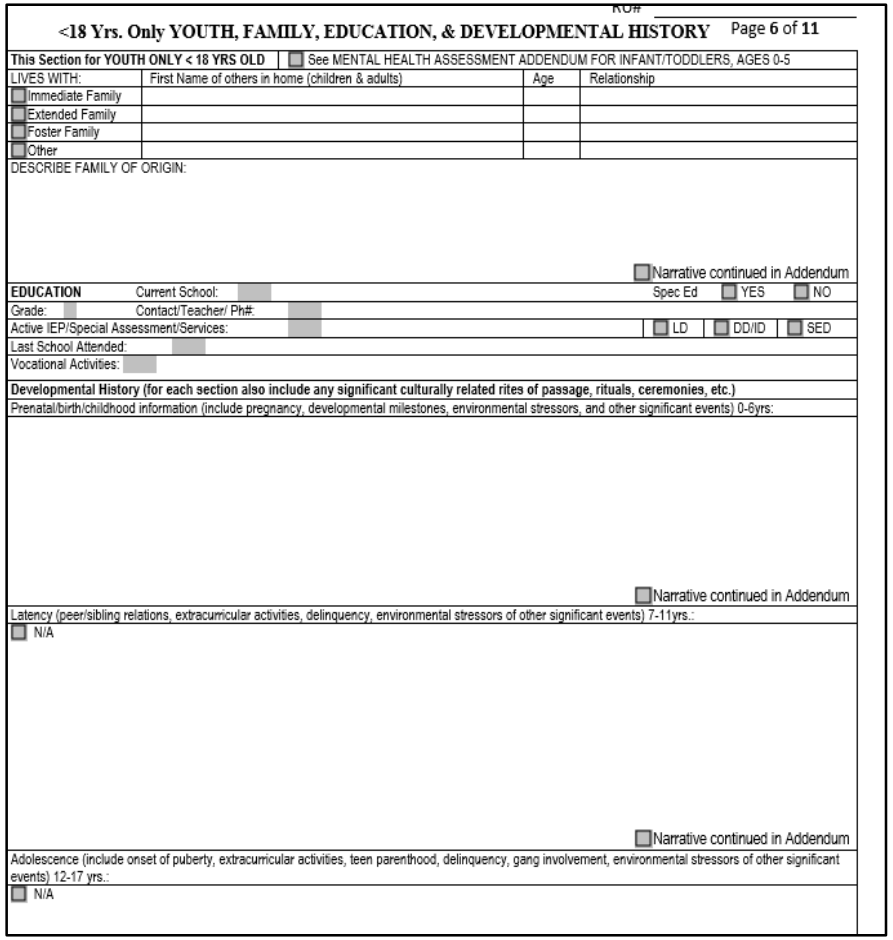
SEXUAL ORIENTATION: ☐ Unknown ☐ Heterosexual/Straight ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Queer ☐ Gender Queer ☐ Questioning ☐ Declined to State ☐ Other:

# 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,
- Assessment template forms now include SO/GI (Sexual Orientation/Gender Identity) fields

# Developmental History (Child, Youth only)



KO#

**<18 Yrs. Only YOUTH, FAMILY, EDUCATION, & DEVELOPMENTAL HISTORY** Page 6 of 11

**This Section for YOUTH ONLY < 18 YRS OLD** ☐ See MENTAL HEALTH ASSESSMENT ADDENDUM FOR INFANT/TODDLERS, AGES 0-5

| LIVES WITH: | First Name of others in home (children & adults) | Age | Relationship |
|---|---|---|---|
| ☐ Immediate Family | | | |
| ☐ Extended Family | | | |
| ☐ Foster Family | | | |
| ☐ Other | | | |

DESCRIBE FAMILY OF ORIGIN:

☐ Narrative continued in Addendum

**EDUCATION** Current School: Spec Ed ☐ YES ☐ NO

Grade: Contact/Teacher/ Ph#:

Active IEP/Special Assessment/Services: ☐ LD ☐ DD/ID ☐ SED

Last School Attended:

Vocational Activities:

**Developmental History (for each section also include any significant culturally related rites of passage, rituals, ceremonies, etc.)**

Prenatal/birth/childhood information (include pregnancy, developmental milestones, environmental stressors, and other significant events) 0-6yrs:

☐ Narrative continued in Addendum

Latency (peer/sibling relations, extracurricular activities, delinquency, environmental stressors of other significant events) 7-11yrs.:

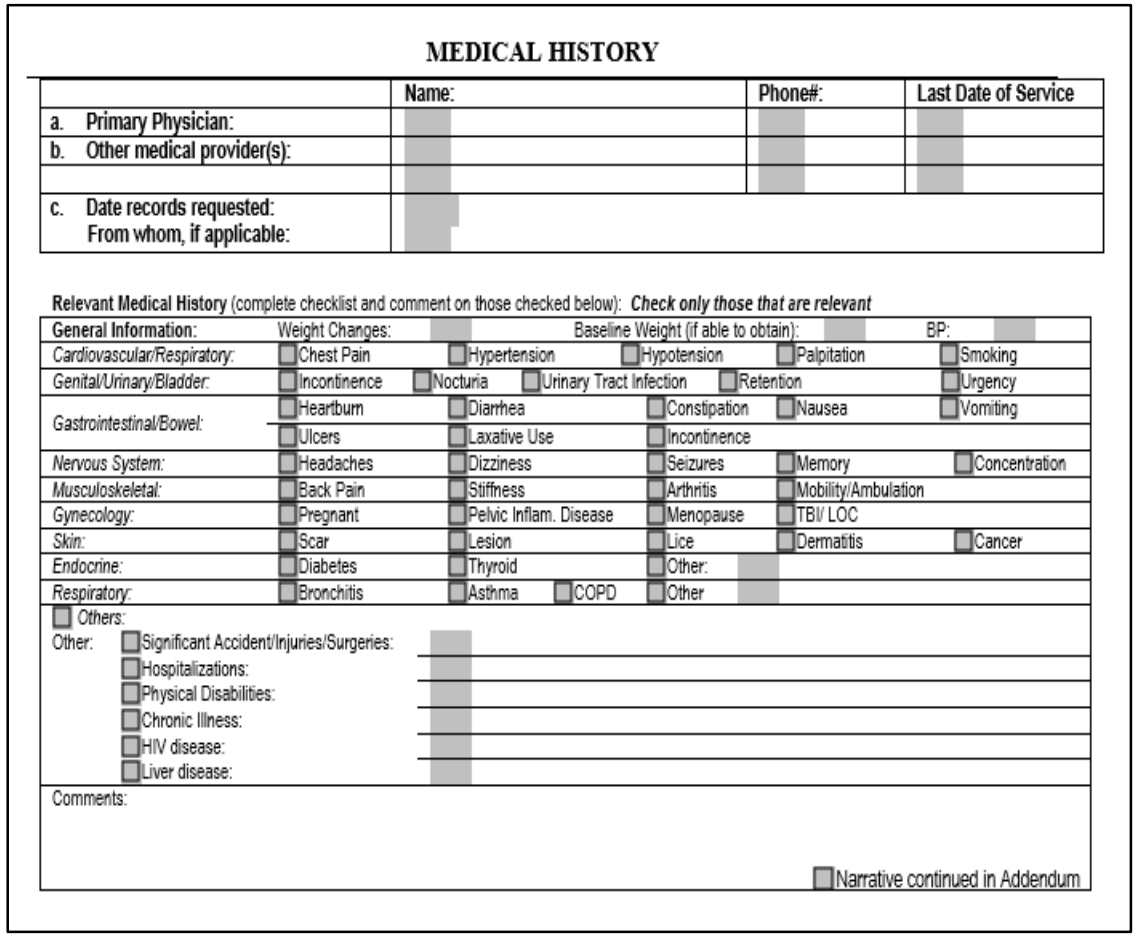
☐ N/A

☐ Narrative continued in Addendum

Adolescence (include onset of puberty, extracurricular activities, teen parenthood, delinquency, gang involvement, environmental stressors of other significant events) 12-17 yrs.:

☐ N/A

# Medical History



**MEDICAL HISTORY**

| | Name: | Phone#: | Last Date of Service |
|---|---|---|---|
| a. Primary Physician: | | | |
| b. Other medical provider(s): | | | |
| | | | |
| c. Date records requested: From whom, if applicable: | | | |

**Relevant Medical History** (complete checklist and comment on those checked below): ***Check only those that are relevant***

| | | | | | |
|---|---|---|---|---|---|
| **General Information:** | Weight Changes: | | Baseline Weight (if able to obtain): | | BP: |
| *Cardiovascular/Respiratory:* | ☐ Chest Pain | ☐ Hypertension | ☐ Hypotension | ☐ Palpitation | ☐ Smoking |
| *Genital/Urinary/Bladder:* | ☐ Incontinence | ☐ Nocturia | ☐ Urinary Tract Infection | ☐ Retention | ☐ Urgency |
| *Gastrointestinal/Bowel:* | ☐ Heartburn | ☐ Diarrhea | ☐ Constipation | ☐ Nausea | ☐ Vomiting |
| | ☐ Ulcers | ☐ Laxative Use | ☐ Incontinence | | |
| *Nervous System:* | ☐ Headaches | ☐ Dizziness | ☐ Seizures | ☐ Memory | ☐ Concentration |
| *Musculoskeletal:* | ☐ Back Pain | ☐ Stiffness | ☐ Arthritis | ☐ Mobility/Ambulation | |
| *Gynecology:* | ☐ Pregnant | ☐ Pelvic Inflam. Disease | ☐ Menopause | ☐ TBI/ LOC | |
| *Skin:* | ☐ Scar | ☐ Lesion | ☐ Lice | ☐ Dermatitis | ☐ Cancer |
| *Endocrine:* | ☐ Diabetes | ☐ Thyroid | ☐ Other: | | |
| *Respiratory:* | ☐ Bronchitis | ☐ Asthma ☐ COPD | ☐ Other | | |

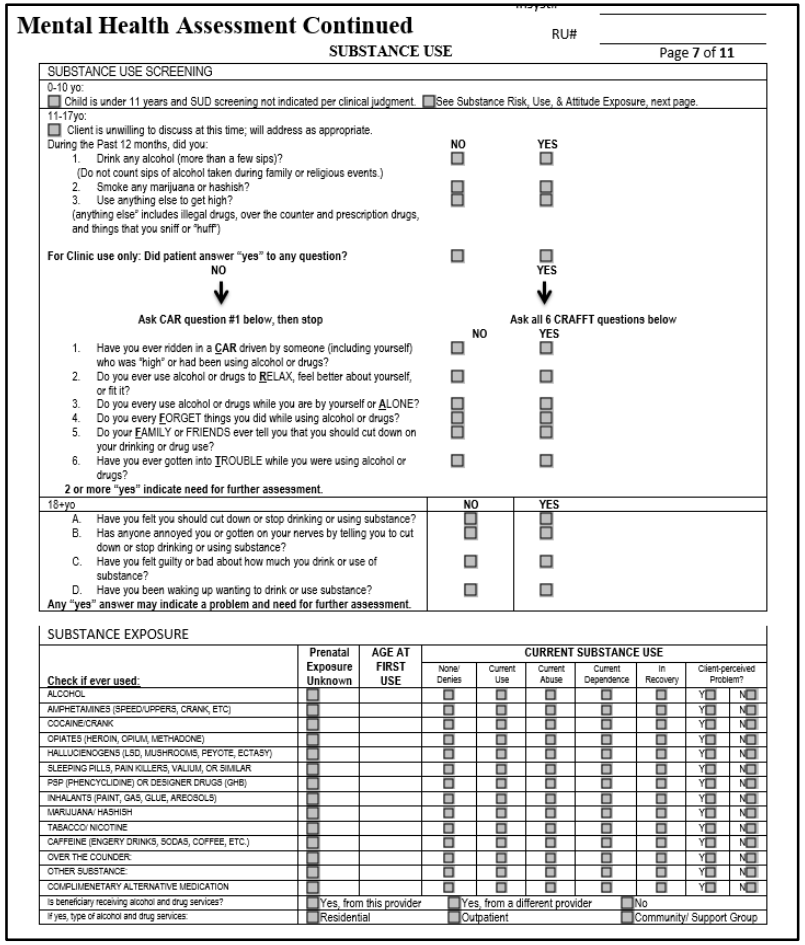
☐ *Others:*

Other:
- ☐ Significant Accident/Injuries/Surgeries:
- ☐ Hospitalizations:
- ☐ Physical Disabilities:
- ☐ Chronic Illness:
- ☐ HIV disease:
- ☐ Liver disease:

Comments:

☐ Narrative continued in Addendum

# Substance Use



**Mental Health Assessment Continued** RU#

**SUBSTANCE USE** Page 7 of 11

SUBSTANCE USE SCREENING

0-10 yo:

☐ Child is under 11 years and SUD screening not indicated per clinical judgment. ☐ See Substance Risk, Use, & Attitude Exposure, next page.

11-17yo:

☐ Client is unwilling to discuss at this time; will address as appropriate.

| During the Past 12 months, did you: | NO | YES |
|---|---|---|
| 1. Drink any alcohol (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.) | ☐ | ☐ |
| 2. Smoke any marijuana or hashish? | ☐ | ☐ |
| 3. Use anything else to get high? (anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff") | ☐ | ☐ |

**For Clinic use only: Did patient answer "yes" to any question?** ☐ NO ☐ YES

**NO** → **Ask CAR question #1 below, then stop**

**YES** → **Ask all 6 CRAFFT questions below**

| | NO | YES |
|---|---|---|
| 1. Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs? | ☐ | ☐ |
| 2. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit it? | ☐ | ☐ |
| 3. Do you every use alcohol or drugs while you are by yourself or ALONE? | ☐ | ☐ |
| 4. Do you every FORGET things you did while using alcohol or drugs? | ☐ | ☐ |
| 5. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use? | ☐ | ☐ |
| 6. Have you ever gotten into TROUBLE while you were using alcohol or drugs? | ☐ | ☐ |

**2 or more "yes" indicate need for further assessment.**

| 18+yo | NO | YES |
|---|---|---|
| A. Have you felt you should cut down or stop drinking or using substance? | ☐ | ☐ |
| B. Has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using substance? | ☐ | ☐ |
| C. Have you felt guilty or bad about how much you drink or use of substance? | ☐ | ☐ |
| D. Have you been waking up wanting to drink or use substance? | ☐ | ☐ |

**Any "yes" answer may indicate a problem and need for further assessment.**

SUBSTANCE EXPOSURE

| Check if ever used: | Prenatal Exposure Unknown | AGE AT FIRST USE | CURRENT SUBSTANCE USE: None/ Denies | Current Use | Current Abuse | Current Dependence | In Recovery | Client-perceived Problem? |
|---|---|---|---|---|---|---|---|---|
| ALCOHOL | ☐ | | ☐ | ☐ | ☐ | ☐ | ☐ | Y☐ N☐ |
| AMPHETAMINES (SPEED/UPPERS, CRANK, ETC) | ☐ | | ☐ | ☐ | ☐ | ☐ | ☐ | Y☐ N☐ |
| COCAINE/CRANK | ☐ | | ☐ | ☐ | ☐ | ☐ | ☐ | Y☐ N☐ |
| OPIATES (HEROIN, OPIUM, METHADONE) | ☐ | | ☐ | ☐ | ☐ | ☐ | ☐ | Y☐ N☐ |
| HALLUCIENOGENS (LSD, MUSHROOMS, PEYOTE, ECTASY) | ☐ | | ☐ | ☐ | ☐ | ☐ | ☐ | Y☐ N☐ |
| SLEEPING PILLS, PAIN KILLERS, VALIUM, OR SIMILAR | ☐ | | ☐ | ☐ | ☐ | ☐ | ☐ | Y☐ N☐ |
| PSP (PHENCYCLIDINE) OR DESIGNER DRUGS (GHB) | ☐ | | ☐ | ☐ | ☐ | ☐ | ☐ | Y☐ N☐ |
| INHALANTS (PAINT, GAS, GLUE, AREOSOLS) | ☐ | | ☐ | ☐ | ☐ | ☐ | ☐ | Y☐ N☐ |
| MARIJUANA/ HASHISH | ☐ | | ☐ | ☐ | ☐ | ☐ | ☐ | Y☐ N☐ |
| TABACCO/ NICOTINE | ☐ | | ☐ | ☐ | ☐ | ☐ | ☐ | Y☐ N☐ |
| CAFFEINE (ENGERY DRINKS, SODAS, COFFEE, ETC.) | ☐ | | ☐ | ☐ | ☐ | ☐ | ☐ | Y☐ N☐ |
| OVER THE COUNDER: | ☐ | | ☐ | ☐ | ☐ | ☐ | ☐ | Y☐ N☐ |
| OTHER SUBSTANCE: | ☐ | | ☐ | ☐ | ☐ | ☐ | ☐ | Y☐ N☐ |
| COMPLIMENETARY ALTERNATIVE MEDICATION | ☐ | | ☐ | ☐ | ☐ | ☐ | ☐ | Y☐ N☐ |
| Is beneficiary receiving alcohol and drug services? | ☐ Yes, from this provider | | ☐ Yes, from a different provider | | | ☐ No | | |
| If yes, type of alcohol and drug services: | ☐ Residential | | ☐ Outpatient | | | ☐ Community/ Support Group | | |

# Substance Use Considerations

Must Assess for Substance Use in 7 Areas:

- Tobacco, ETOH, Caffeine, CAM, Rx, OTC, and Illicit Drugs

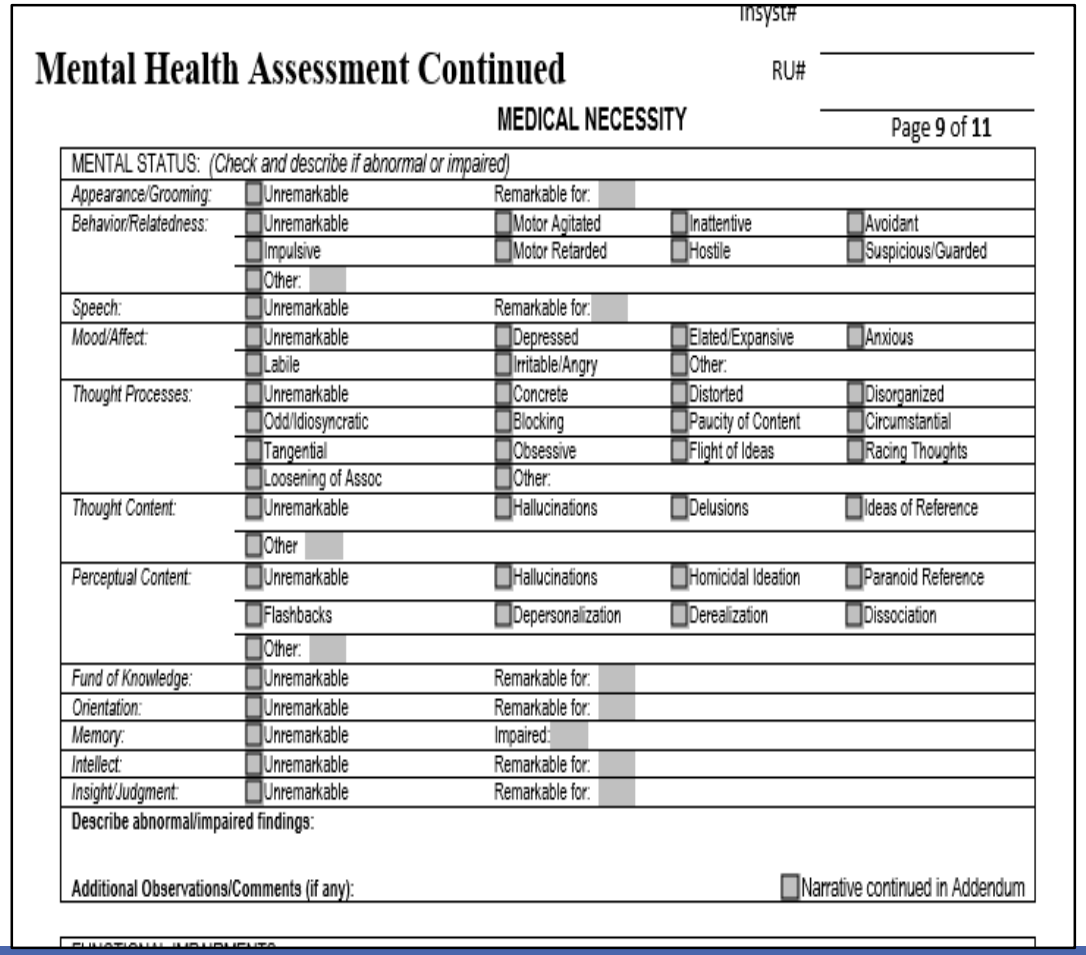
Assess for Substance Use Disorders (SUD):

- Document past and current use in record
- For children/adolescents also document the caregivers' use and impact upon the client

If appropriate establish SUD Diagnosis

- Cannot be primary (FOCUS OF TX) Diagnosis
- Best to also include in Client Plan. However, this is only done so by addressing the underlying MH Dx's signs, Sx, and behaviors through the MH Objectives.

# Medical Necessity
# Mental Status Exam (MSE)



Insyst#

**Mental Health Assessment Continued** RU# _____

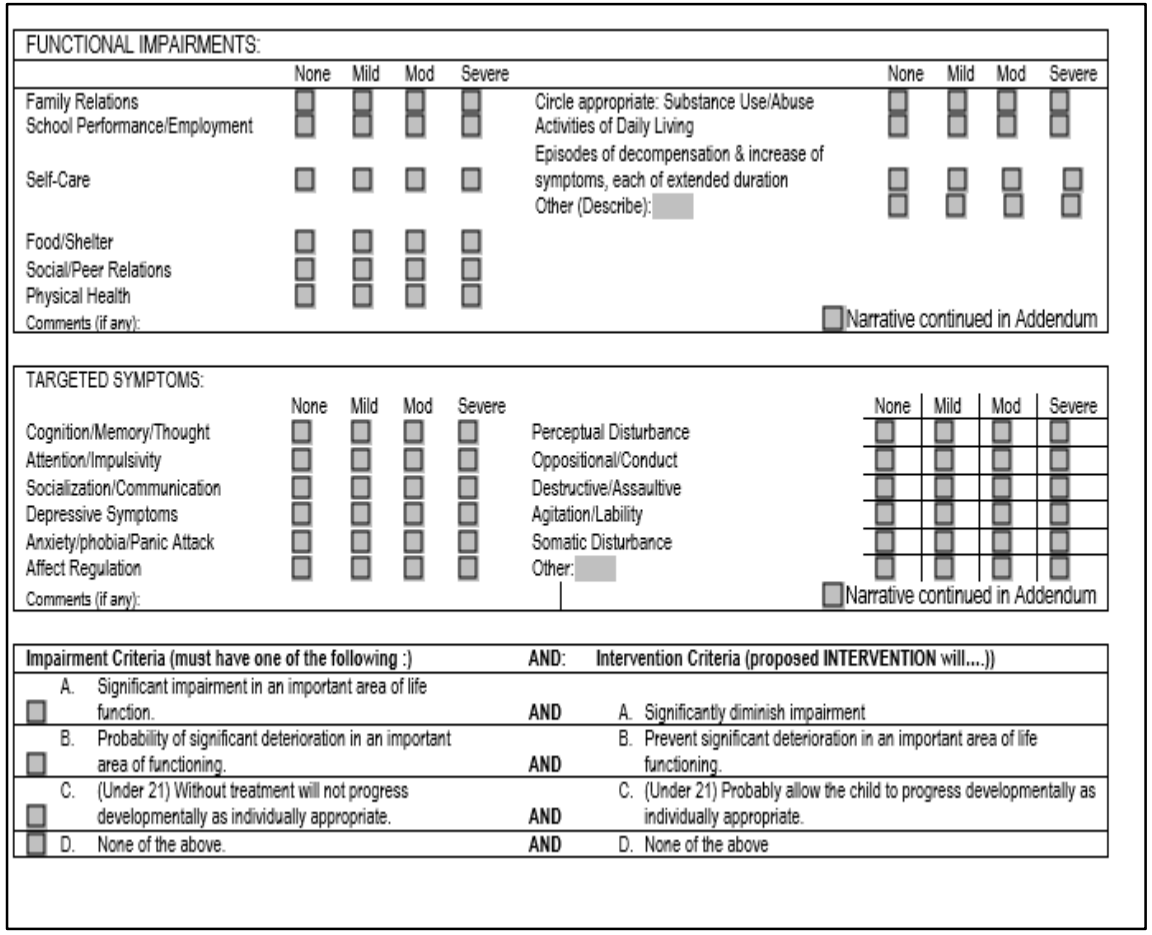
**MEDICAL NECESSITY** Page 9 of 11

| MENTAL STATUS: *(Check and describe if abnormal or impaired)* | | | | |
|---|---|---|---|---|
| *Appearance/Grooming:* | ☐ Unremarkable | Remarkable for: | | |
| *Behavior/Relatedness:* | ☐ Unremarkable | ☐ Motor Agitated | ☐ Inattentive | ☐ Avoidant |
| | ☐ Impulsive | ☐ Motor Retarded | ☐ Hostile | ☐ Suspicious/Guarded |
| | ☐ Other: | | | |
| *Speech:* | ☐ Unremarkable | Remarkable for: | | |
| *Mood/Affect:* | ☐ Unremarkable | ☐ Depressed | ☐ Elated/Expansive | ☐ Anxious |
| | ☐ Labile | ☐ Irritable/Angry | ☐ Other: | |
| *Thought Processes:* | ☐ Unremarkable | ☐ Concrete | ☐ Distorted | ☐ Disorganized |
| | ☐ Odd/Idiosyncratic | ☐ Blocking | ☐ Paucity of Content | ☐ Circumstantial |
| | ☐ Tangential | ☐ Obsessive | ☐ Flight of Ideas | ☐ Racing Thoughts |
| | ☐ Loosening of Assoc | ☐ Other: | | |
| *Thought Content:* | ☐ Unremarkable | ☐ Hallucinations | ☐ Delusions | ☐ Ideas of Reference |
| | ☐ Other | | | |
| *Perceptual Content:* | ☐ Unremarkable | ☐ Hallucinations | ☐ Homicidal Ideation | ☐ Paranoid Reference |
| | ☐ Flashbacks | ☐ Depersonalization | ☐ Derealization | ☐ Dissociation |
| | ☐ Other: | | | |
| *Fund of Knowledge:* | ☐ Unremarkable | Remarkable for: | | |
| *Orientation:* | ☐ Unremarkable | Remarkable for: | | |
| *Memory:* | ☐ Unremarkable | Impaired: | | |
| *Intellect:* | ☐ Unremarkable | Remarkable for: | | |
| *Insight/Judgment:* | ☐ Unremarkable | Remarkable for: | | |

**Describe abnormal/impaired findings:**

**Additional Observations/Comments (if any):** ☐ Narrative continued in Addendum

# Medical Necessity
# Functional Impairments



FUNCTIONAL IMPAIRMENTS:

| | None | Mild | Mod | Severe | | None | Mild | Mod | Severe |
|---|---|---|---|---|---|---|---|---|---|
| Family Relations | ☐ | ☐ | ☐ | ☐ | Circle appropriate: Substance Use/Abuse | ☐ | ☐ | ☐ | ☐ |
| School Performance/Employment | ☐ | ☐ | ☐ | ☐ | Activities of Daily Living | ☐ | ☐ | ☐ | ☐ |
| Self-Care | ☐ | ☐ | ☐ | ☐ | Episodes of decompensation & increase of symptoms, each of extended duration | ☐ | ☐ | ☐ | ☐ |
| | | | | | Other (Describe): | ☐ | ☐ | ☐ | ☐ |
| Food/Shelter | ☐ | ☐ | ☐ | ☐ | | | | | |
| Social/Peer Relations | ☐ | ☐ | ☐ | ☐ | | | | | |
| Physical Health | ☐ | ☐ | ☐ | ☐ | | | | | |

Comments (if any): ☐ Narrative continued in Addendum

TARGETED SYMPTOMS:

| | None | Mild | Mod | Severe | | None | Mild | Mod | Severe |
|---|---|---|---|---|---|---|---|---|---|
| Cognition/Memory/Thought | ☐ | ☐ | ☐ | ☐ | Perceptual Disturbance | ☐ | ☐ | ☐ | ☐ |
| Attention/Impulsivity | ☐ | ☐ | ☐ | ☐ | Oppositional/Conduct | ☐ | ☐ | ☐ | ☐ |
| Socialization/Communication | ☐ | ☐ | ☐ | ☐ | Destructive/Assaultive | ☐ | ☐ | ☐ | ☐ |
| Depressive Symptoms | ☐ | ☐ | ☐ | ☐ | Agitation/Lability | ☐ | ☐ | ☐ | ☐ |
| Anxiety/phobia/Panic Attack | ☐ | ☐ | ☐ | ☐ | Somatic Disturbance | ☐ | ☐ | ☐ | ☐ |
| Affect Regulation | ☐ | ☐ | ☐ | ☐ | Other: | ☐ | ☐ | ☐ | ☐ |

Comments (if any): ☐ Narrative continued in Addendum

| Impairment Criteria (must have one of the following :) | AND: | Intervention Criteria (proposed INTERVENTION will....)) |
|---|---|---|
| ☐ A. Significant impairment in an important area of life function. | AND | A. Significantly diminish impairment |
| ☐ B. Probability of significant deterioration in an important area of functioning. | AND | B. Prevent significant deterioration in an important area of life functioning. |
| ☐ C. (Under 21) Without treatment will not progress developmentally as individually appropriate. | AND | C. (Under 21) Probably allow the child to progress developmentally as individually appropriate. |
| ☐ D. None of the above. | AND | D. None of the above |

# Medical Necessity
# Diagnostic Summary and ICD 10/DSM 5 Dx

**MEDICAL NECESSITY CONTINUED** Page **10** of **11**

Diagnostic Summary: (Be sure to include assessment for risk of suicidal/homicidal behaviors, significant strengths/weaknesses, observations/descriptions, symptoms/impairments in life functioning, i.e. Work, School, Home, Community, Living Arrangements, etc. and justification for diagnosis)

☐ Narrative continued in Addendum

**ICD-10 DIAGNOSIS — NOT BY HISTORY, MUST BE CURRENT DIAGNOSTIC FORMULATION**

| Dimensions: | ICD-10 Code: | DSM –5* Description WITH all specifiers: *for Codes F84.5, F84.9, F84.2, F84.3 & F84: list DSM-IV-TR Descriptor (Dx Name) | Primary & Secondary Dx's |
|---|---|---|---|
| MH Diagnoses: | | | **PRIMARY DX** |
| | | | Secondary Dx |
| | | | Secondary Dx |
| | | | Secondary Dx |
| Substance Use Diagnoses: | | | Secondary Dx |
| | | | Secondary Dx |
| | | | Secondary Dx |
| Psychosocial Conditions Diagnoses: | | | |
| | | | |
| | | | |
| | | | |
| General Medical Conditions: | | | |

| Optional Disability Measures (WHODAS, etc.) | Diagnosis est. by (with license): | On date: |
|---|---|---|

Disposition / Recommendations/ Plan

# Assessment Signatures

Signatures (OR SEE PROVIDER _____ PROGRESS NOTE DATED:_____):

| | | | |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| Assessor's Signature & M/C Credential | Date | Co-Signature & M/C Credential | Date |
| _____ | _____ | _____ | _____ |
| Printed Name | Date | Printed Name | Date |

# No Planned Services Before Assessment and Plan Are Complete

## MAY BE CLAIMED

- MH Assessment/Plan Development Services
- Crisis Intervention (must be at immediate risk of hospitalization due to danger to self, danger to others or grave disability.) MHP FFS Providers use Individual Therapy code.
- Medical Providers - prescribers (as needed may prescribe while claiming Psychiatric MH Assessment)

## MAY BE NOT BE CLAIMED*

- Brokerage/Linkage
- Psychotherapy (Individual or Group)
- Rehabilitative Services (Individual or Group)
- Collateral

*list not exhaustive

# Medication Services—Prescribers Only

- For children who are wards or dependents of the juvenile court and living in an out-of-home placement or in foster care prescribers are required request permission from the court before any psychotropic medications are administered.

- See http://www.courts.ca.gov/documents/jv217info.pdf for more specific information about JV-220 requirements.

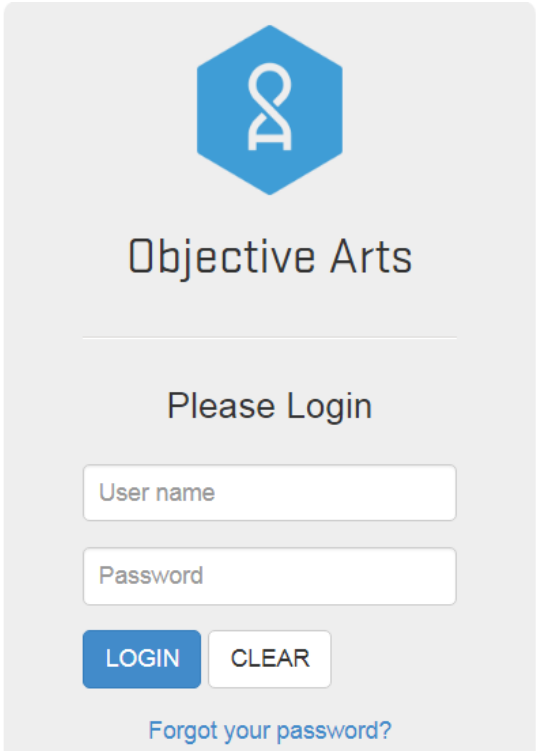
- In addition to a completed JV-220, prescribers must also complete medication consent forms, as described on the following slide.

# Medication Services—Prescribers Only

Medication Consent Forms

- Required for all medications prescribed by Medical Provider
- ACBHCS Medication Consent Forms Required—or equivalent—all sections completed. http://www.acbhcs.org/providers/Forms/Forms.htm#Med_consent
- Additional Medication Information Sheets are available online.
- If client's preferred language is other than English
  - If ACBHCS Threshold Language—use that Medication Consent Form.
  - Always offer to explain (or have interpretation) of the information contained in the Medication Consent Form in their preferred language if client speaks language other than threshold languages in which forms are translated—document this in the progress note.

# CANS / ANSA



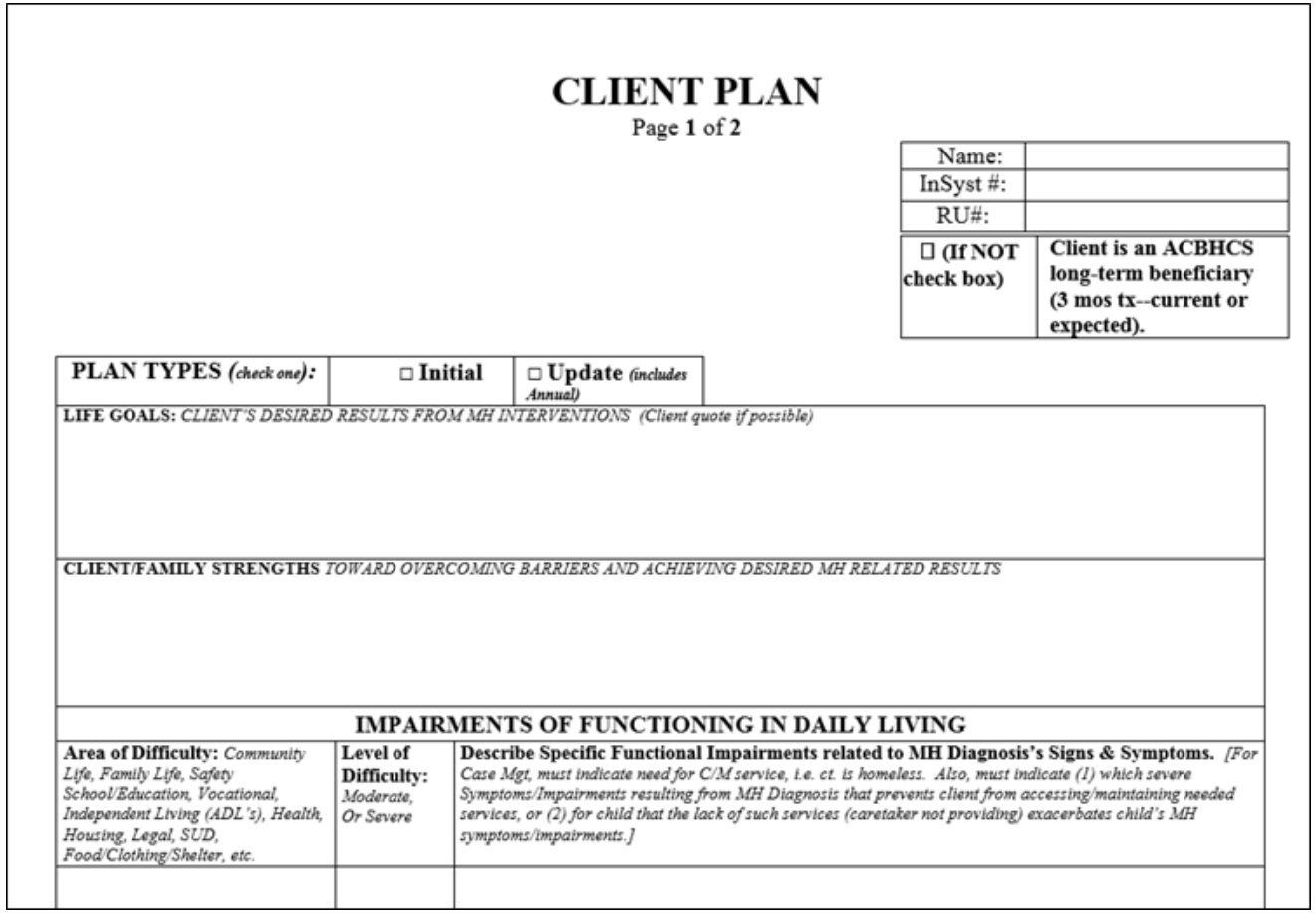

CANS & ANSA are not required at this time.

# Assessment Finalization Timelines

## For ALL MHP FFS Providers

- The **Initial Assessment** – Short or Long form - is due within 30 days of authorization date AND **prior** to the client's 3rd visit.
- If client is seen for more than 12 months, the **Annual Assessment – Long Form is required** and must be completed within the first two sessions AND within 30 days of authorization
- See Assessment and Plan Due Dates Chart—or initially by 3rd visit whichever comes first.

# Client Plans



**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** *(includes 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 C/M service, i.e. ct. 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.]* |
|---|---|---|
| | | |

# Getting Ready to Write Plan with Client

- ❑ Established Medical Necessity
- ❑ Completed Assessment (with required co-signatures if applicable)
- ❑ Documented the need for case management in the Assessment if considering providing case management services
- ❑ Have conducted a Risk Assessment and developed & written a Safety Plan if you have assessed any risk factors within the past 90 days and including an objective related to containment.
- ❑ Consider addressing any cultural, linguistic, physical limitations in Plan

# Who can create and complete Plans?

- Individual or Group of Providers
  - Licensed LPHAs only

- Organizations
  - Licensed LPHAs OR Waivered/Registered Interns

# Plan Finalization Timelines

- The **Initial Client Plan** is due within 60 days of Authorization **AND** prior to the client's 3rd visit.
  - If a case is closed before the third visit, a completed plan is NOT required.
- Client plan must be updated immediately following any extension and annual update
  - Six month plan updates are due before the 2nd session after the 6 month RCS approval.
  - Annual/Yearly plans are due by first day of the EOD Month. (Repeat 6 month & 12 month cycle)

*The Client Plan is not considered complete until the both client and therapist have signed the plan. Once the client signs the plan no changes can be made to that plan.

**Client's/Representative approval and signature must be obtained each time plan is updated.**

# Plan Signatures

Plan is considered finalized when Client/Representative

AND a Licensed LPHA signs

| **Client/Conservator Signature**<br>By signing, I agree that I have: 1) participated in the development of the Treatment Plan, and 2) have been offered a copy of the plan. | | |
|---|---|---|
| | | DATE |
| CLIENT (IF NO SIGNATURE, PLEASE SEE PROGRESS NOTE DATED:_____FOR EXPLANATION & WHEN NEXT ATTEMPT WILL BE). | | |
| GUARDIAN/PARENT (IF NO SIGNATURE, PLEASE SEE PROGRESS NOTE DATED:_____FOR EXPLANATION & WHEN NEXT ATTEMPT WILL BE.) | | |
| PROVIDER COMPLETING PLAN | INDICATE M/C CREDENTIAL | |
| LICENSED LPHA SUPERVISOR (IF NEEDED) | INDICATE LICENSED M/C CREDENTIAL | |
| PSYCHIATRIST/OTHER PRESCRIBER (REQUIRED WHEN PRESCRIBING) | INDICATE M/C CREDENTIAL: MD, DO, NP, CNS | |

# What if I can't obtain the client's signature?

If you are unable to obtain a client's signature, you must document either by writing on the plan or in a progress note the reasons why you cannot obtain client's signature and that you will attempt again at the next face to face session (or clinical reason why contraindicated).

- *"Client agreed verbally to Client Plan formulation at last visit. Client no showed for today's session. Will review plan and obtain written signature at next session."*
- *"Due to client's paranoia, client gave verbal consent, but refused to sign plan. Clinician will attempt to obtain signature within next three months.*

# What if I still can't obtain client's signature?

If the client does not sign or refuses to sign the Client Plan, regular efforts must be attempted and documented to obtain the client's approval.

If not fully documented per instructions above, DHCS/BHCS QA (per Jan. 2013 Triennial Audit) will disallow all claims made after the date the Plan should have been signed by the client and until all required signatures are obtained.

# Client Plan Updates (outside of 6 month cycle)

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 consideration of change to the Plan be documented in the PN 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.), school suspension, placement risk, etc.

Claim plan updates as an Individual Therapy session and each counts as one of the allotted therapy sessions.

**Remember, with every plan update, Brief Screening Tool and new signatures are needed**

# Client's Life Goals Section

| PLAN TYPES (check one) | □ Initial | □ Update |
|---|---|---|
| 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 | | |

# Client 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
- Can be in the client's own words
- Increase client engagement and buy-in to services

With the client's goals in mind, providers assist the client by "translating" their goals into short term Mental Health objectives.

Client says, ***"I want to live on my own someday."*** or ***"I want to have a better relationship with my family."***

To identify what mental health goals to work on, providers can ask ***"What gets in the way of you achieving these goals?"***

# Impairments / “Area of Challenges”

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

# Impairments / “Area of Challenges”

Impairments of Functioning in Daily Life

**Indicate Area of Challenges:** *Community Life, Family Life, Safety School/Education, Vocational, Independent Living (ADL’s), Health, Housing, Legal, SUD, Food/Clothing/Shelter, etc.*

**Indicate Level of Challenges**

- Moderate or Severe (remember to rate accordingly—severe—if documenting to a Significant Impairment in an Important Area of Life Functioning for Medical Necessity).

**Describe Specific Functional Impairments related to MH Diagnosis’s Signs & Symptoms.**

- *[For Case Mgt, must indicate need for C/M service, i.e. ct. is homeless. Also, must indicate: (1) which severe Symptoms/Impairments resulting from MH Diagnosis that prevent 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.]*

# Discharge Plan

Estimated treatment plan duration, describe criteria (readiness) that would indicate client could successfully transition to a lower level of care with possible referrals and discharge plan.

| | |
|---|---|
| **DISCHARGE PLAN** (readiness/timeframe/expected referrals/etc.): | |

*"Long Term Client w/o Discharge Expected"*
*Is never a discharge plan*

# Mental Health Objectives

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

Note that the BHCS Treatment Plan Template prompts for a 12 month Objective Target Date, however as treatment plans are required to be updated every 6 months, most objectives will need modification at 6 months.

# Mental Health Objectives

**All Objectives MUST directly address the client's mental health sx's and cannot focus on finding housing, getting a job, providing SUD counseling, etc.**

- A way to see if the client (not caregiver) is improving
- Measurable change in helping the client achieve his/her long-term goals
  - Can address MENTAL HEALTH symptoms, behaviors or impairments identified in the Assessment

  *OR*

  - *Be Strength-Based mental health objectives* replace problematic Sx with positive MENTAL HEALTH 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 Objectives

- SMART (Specific, Measurable, Attainable, Realistic and Time-Bound)
- Important to look at how they might impact and build upon strengths and supports
- Must include duration: at least 6 months
  - **Special note about duration**: At least one mental health objective must be valid for 6 months or the plan will need to be updated due to not having any current (or not-expired) objectives after the last stated duration (such as only having a MH Objective with a 6 month duration).

# Service Modality

| SERVICE MODALITIES | | |
|---|---|---|
| MODALITY | FREQUENCY | DURATION |
| ☐ Case Management | | |
| ☐ Medication Management | | |
| ☐ Individual Rehab | | |
| ☐ Group Rehab | | |
| ☐ Individual Therapy | | |
| ☐ Family Therapy | | |
| ☐ Other: | | |
| ☐ Other: | | |

# Service Modalities

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

- If the planned service modality for a claimed service is not in the client plan it MAY NOT BE CLAIMED and MUST be disallowed if it is claimed. This includes Case Management and Collateral.

- Don't include Assessment/Plan Development/Crisis modalities in the plan.

# Detailed Interventions

## Detailed Interventions are required for each Modality

| DESCRIBE SPECIFIC AND DETAILED INTERVENTIONS FOR EACH MODALITY: | | |
|---|---|---|
| **Provider(s):** (☑ ALL THAT APPLY) | **Detailed Intervention(s):** | **MODALITY:** |
| ☐ Case Manager<br>☐ Clinician<br>☐ MD/NP/PA<br>☐ Peer<br>☐ Family Partner<br>☐ Other:_____ | | |
| ☐ Case Manager<br>☐ Clinician<br>☐ MD/NP/PA<br>☐ Peer<br>☐ Family Partner<br>☐ Other:_____ | | |
| ☐ Case Manager<br>☐ Clinician<br>☐ MD/NP/PA<br>☐ Peer<br>☐ Family Partner<br>☐ Other: | | |

# Detailed Interventions

For each service modality include a detailed description of interventions to be provided. 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.”
- Detailed Interventions for Case Management should indicate that successful C/M (linkage and monitoring) will result in the client’s MH Symptoms being reduced (i.e. achievement of Client’s MH Objectives).

# Detailed Interventions - Examples

Detailed Interventions should be general and also specific to client's mental health needs

Examples (For purposes of presentation only):

### Individual Therapy

- Use CBT *techniques to help client identify triggering thoughts that lead to client's aggressive behaviors and replace with prosocial behaviors and other positive activities.*

### Collateral

- *Provide psychoeducation to significant support persons of client including parents, teachers, and school counselor (others as needed) to assist client in his/her MH Goals and Objectives of x, y & z.*

### Med Services

- *Medication management strategies to engage client in collaboration to find, and optimize the dosage for effective anti-depressive medications.*

# MH Plan Example #1: Client with Moderate Symptoms

*Billable example: Treatment Plan Goal*

Dx: Generalized Anxiety DO (Excessive worry that is persistent throughout the day regarding most situations, which occurs every day. Low energy, difficulty in concentration, feels irritable and tense.

Impairments: Relationship difficulty with partner (frequent arguments), difficulty completing work assignments, loss of enjoyment in daily activities ("polluted" by worry).

Goals:  Client states: "I don't want to feel this way…like something is wrong all the time."

(Optional) Long Term MH Goal: Learn to control worrisome thoughts and feelings and increase positive relationship with partner (gain more patience/less irritability).

# MH Plan Example #1: Client with Moderate Symptoms

*Billable example cont.:*

Mental Health Objective(s):

#1) # of times client has arguments with family, friends, co-workers, will decrease from 10 times per week to 3 or less per week as evidenced by partner and client report for the next 6 months.

#2) Increase the number of daily activities in which client feels they are able to control anxious feelings from 1-2 times per day (currently) to 5 times per day or more as evidenced by self report for the next 6 months.

#3) Client will increase the number of times they use coping skills learned in therapy to manage anxiety from (0 times per day) to 10 or more per day as evidenced by journal keeping for the next 6 months.

# MH Plan Example #1: Client with Moderate Symptoms

*Billable example cont.:*

## Service Modality:

- Psychotherapy 1x/week, and as needed, for 20 sessions.
- Case Management 2 sessions in next 6 months.
- Collateral 2 sessions in next 6 months.

## Detailed Interventions:

- Individual Psychotherapy – psychodynamic therapy to help client process through past traumatic events that precipitated the onset of anxious feelings. CBT therapy to help teach client coping skills to manage symptoms as they arise.
- Case Management – Successful linkage of client to primary care provider/psychiatrist to discuss possible medication options for client.
- Collateral – Will provide psychoeducation to client's partner regarding client's symptoms and how to best support client in managing anxiety.

# MH Plan Example #2: Client with Severe Symptoms

*Billable example: Treatment Plan Goal*

Dx:  Major Depressive Disorder (lack of interest in all areas of life, low energy, insomnia, indecisiveness, feelings of worthlessness, and poor self-care)

Impairments include Client's difficulty in maintaining employment, having positive social interactions, completing daily tasks, maintaining independent housing, and accessing resources in the community.

Goals:  Client states: "I want my own place to live."

(Optional) Long Term MH Goal:  Decrease depression and increase coping skills, so that client's depressive signs and symptoms do not negatively impact his ability to meet his life goals.

# MH Plan Example #2: Client with Severe Symptoms

*Billable example cont.:*

Mental Health Objective(s):

#1) Client's depressive symptoms are reduced as evidenced by an increase in energy from "1-2" energy level (current) to 6-8 on a 0-10 scale (10 being high energy) per self-report by 6-12 months.

#2) Client is engaged and invested in his self-care as evidenced by increased # of showers per week from 0 to 2 or more; and increased brushing of teeth from 0x daily to once daily within the next 6-12 months.

#3) Client will increase daily living activities and demonstrate successful self-identified task(s) completion 3 – 4 x's/week (now 0/week) for the next 3 – 12 months.

# MH Plan Example #2: Client with Severe Symptoms

*Billable example cont.:*

Service Modality:

- Psychotherapy 1x/week, and as needed, for 20 sessions.
- Case Management 2 sessions in next 6 months.
- Collateral 2 sessions in next 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.
- Case Management – Successful linkage of client to housing resources in community. Connecting client to resources is expected to decrease client's sadness and depression.
- Collateral – Will provide psychoeducation to client's mother regarding client's symptoms and how to best support client in managing his depression.

# Claiming Group Therapy for MHP FFS Providers who claim with CMS 1500

- For each group member, attending group counts as one session
- Group therapy modality must be listed in the treatment plan
- Facilitator must write individual progress notes for each group member
- Each group service for each client is claimed as 90853—60” or Y9506—90”

# Claiming to Medi-Cal

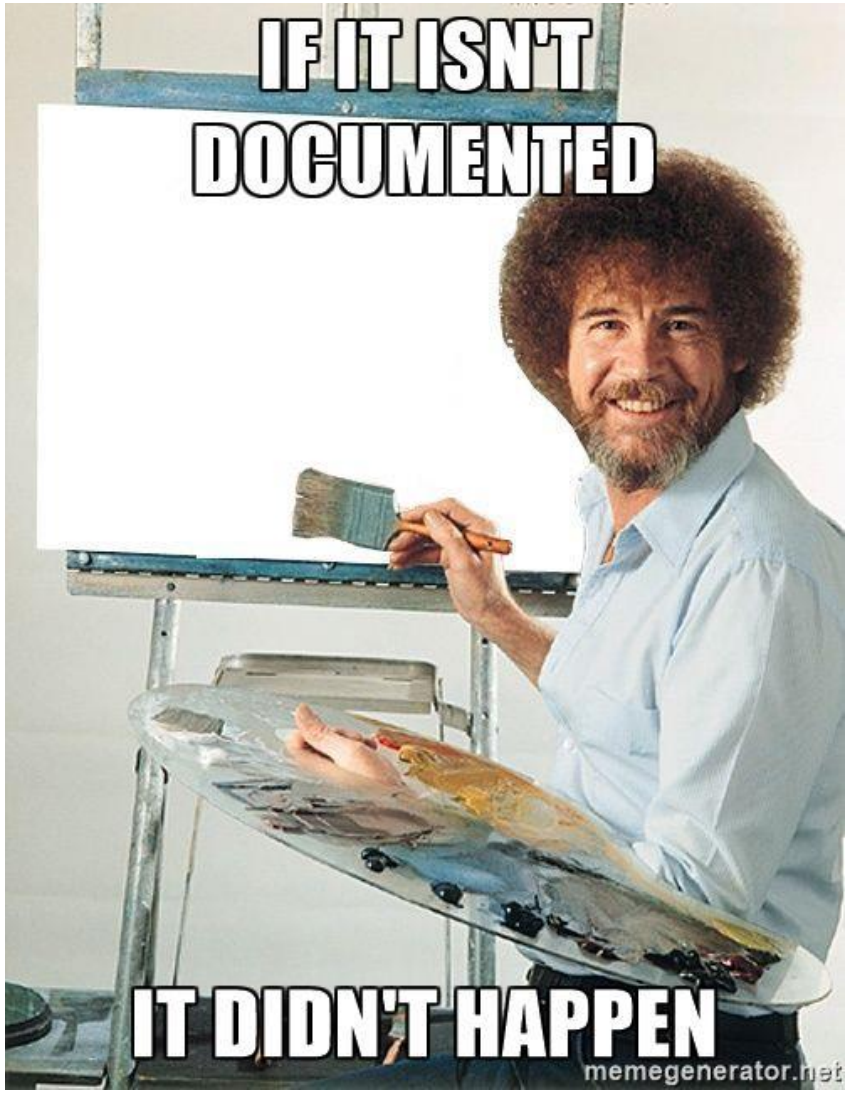
Every claim made to Medi-Cal MUST have a corresponding progress note in the client's chart

All assessment and plan development sessions require progress notes in order to be claimed. The assessment and plan are not enough to complete the claiming process. Use the appropriate Assessment / Psychiatric Diagnostic Evaluation Codes to claim for these services.

When writing notes documenting the Assessment and Plan sessions, if each are completed in one session, the progress note may include a reference to the completed form. For example, "This therapist gathered information to complete the Assessment. See Assessment dated…"

If the Assessment or Plan spans multiple sessions, then the progress note may reference completed sections in the assessment or plan, as long as what sections were completed in that session are specified.

If it is not possible to reference specific sections of the assessment or plan, then the content of the session must be included in the progress note.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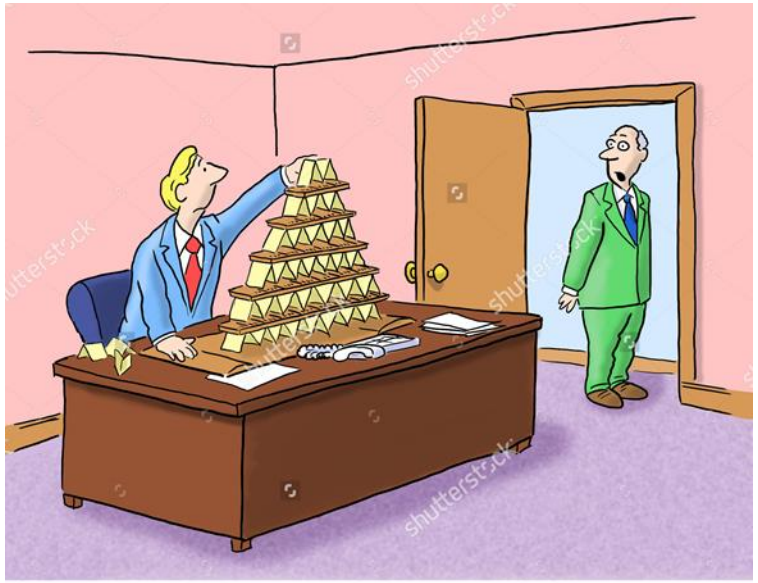
"Just one question: is it billable?"
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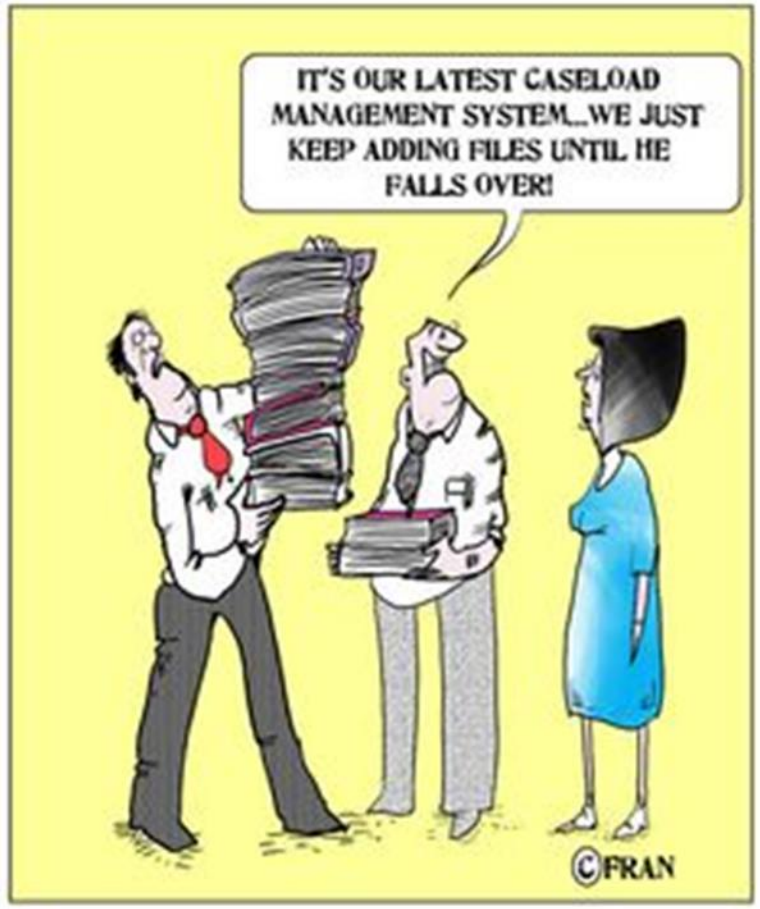
# What are some of the barriers/challenges of writing progress notes?



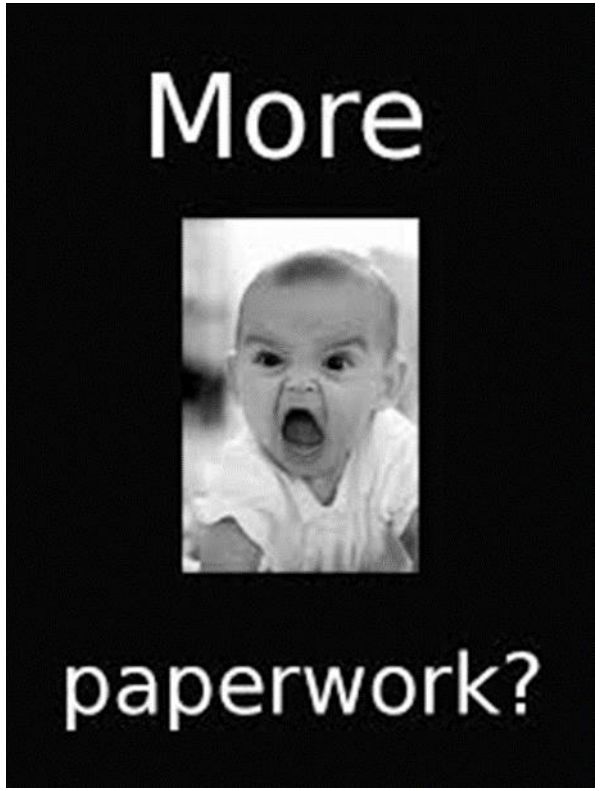

# Challenges/Barriers

- 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

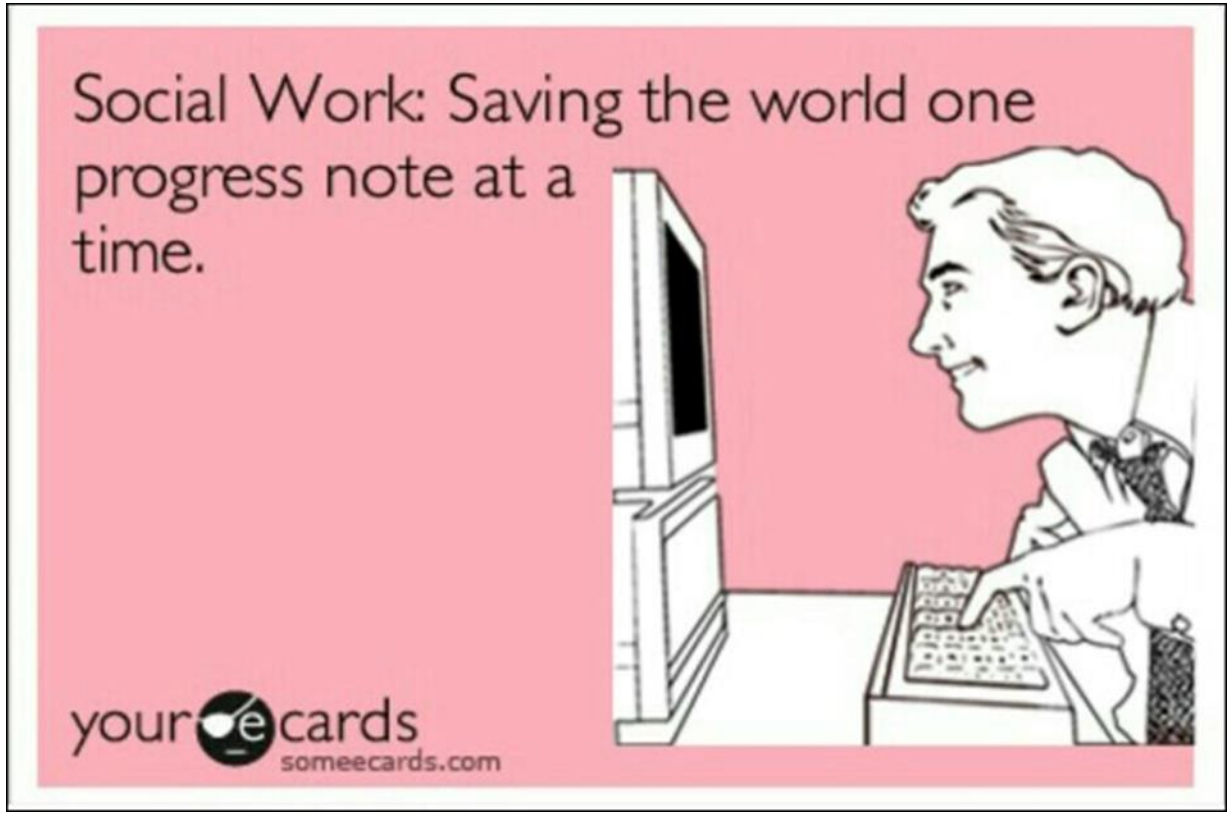
There are

Physical, Emotional, Mental, Programmatic, Technological, Systematic

challenges to writing progress notes!



# What are ways you as a clinician have overcome these barriers/challenges?



# 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 Notes Musts

Progress Notes must contain:

- Procedure Code of service provided to client
- Date of Service
- Indicate what language the service was provided (unless English Speaking client and in the MH Assessment it indicates: “English speaking client and all services will be provided in English”.
- Legible Provider Signature with Medi-Cal credential (see Scope of Practice Document—pg. 2 for credentials) and date signed (not date of service unless written and finalized with signature on the same day.
- Time as described on the next slide

Only use ACBHCS abbreviations. See ACBHCS Abbreviations Handout.

# Progress Notes
## MHP FFS Providers

- Simply indicate code and minutes designated from Code/Rate Sheet in Progress Note
- Default to the code closest (rounding up and down) to the minutes it took f-f or phone contact time and documentation time.
- Do not put the actual total minutes or break down face-to-face and doc time for example.
- e.g. 60 minute Ind. Psychotherapy with 10 minutes documentation is 90834-60” and 70 minute Ind. Psychotherapy with 12 minutes documentation is 90834-90”

# B/PIRP Format – Progress, Not Process

- Always indicate which MH Objective (restate or reference # of Objective in Plan) is being addressed
- Use B/PIRP Format

Behavior/Assessment, Purpose/Problem =documents what is presently going on with the client (brief narrative), especially in terms of progress towards MH goals and objectives

Intervention by Staff =Identifies what you did today (i.e., what specific intervention was provided toward the mental health objectives). Cut and paste interventions from previous session may result in a disallowance.

Response of Client to Intervention = Identifies client's response today toward the interventions and impact/progress toward their MH objectives

Plan for future services = 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—not simply and always: "next session on mm/dd/yy"


# Modifying Progress Notes for Case Management Services

- Modifying the B/PIRP Format for case mgt cont.
  - "B/P" Problem: ("Client reports they were evicted over the weekend. Cients symptoms of depressed mood & fatigue prevents client from contact the shelter for assistance in spite of desire to do so")
  - "I" = Identifies what you did (i.e., what intervention was provided toward the mental health objectives): provided or received info, etc. *(i.e. with client present, I called the shelter with a referral and made appointment for the client at 4pm today.)*
  - "R" = Identifies contact's response toward the interventions and progress toward the purpose above "B" *(i.e. client agreed to make the shelter appointment as scheduled and to report back to this provider of how it was going at our next scheduled appointment.)*
  - P = Provides plan for continued services as a result of this service: i.e. collaterals, coordination of care, etc. Can include any follow up by the provider or client. *(Successful housing of the client through case management is expected to result in the client of meeting their MH goals of reducing depression and associated fatigue")*

# Progress Notes FAQs

Can I combine different types of services in one progress note?
No, claim separately even if provided on the same date of service.

Can I combine two of the same services on the same day, for example two collateral phone calls to different people?
No, claim separately if talking to different people. Most likely these discussions will have different purposes.

Can I combine two 10 minute collateral services together for one 20 minute collateral service?
Yes, you would put two 10 min. collateral codes on form CMS 1500 and document this in one progress note for the chart.

# Non-Billable Services

- Travel time may not be incorporated for claiming purposes
- Voice mail, Email, Text messages (leaving or receiving)
- Faxing
- Non-Treatment related report writing (i.e. disability report for SSA or Abuse/Neglect reporting—phone or written)
- Scheduling
- No shows/ Missed Appointment
- Lock-outs – See Lockout Handout next slide
- Transporting the client
- Completing the Brief Screening Tool
- Non-SMHS services such as vocational, housing, payee.

If any part of the note includes such activities without indicating "did not claim for the time it took to do that activity," the claim will be disallowed.

# Non-Billable Services

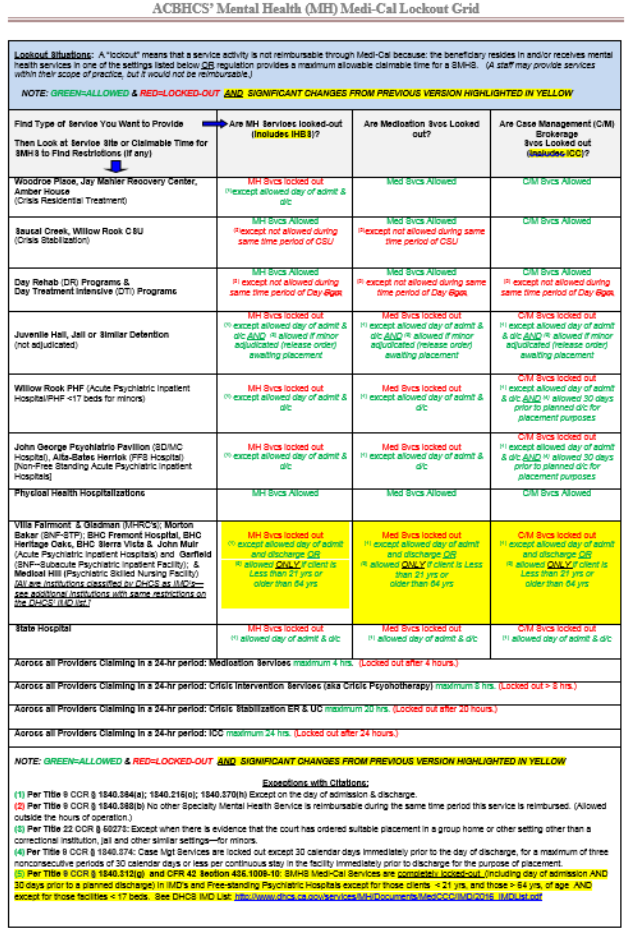
- Payee related (Indicate payee portion of visit in a separate—non-billable service note.)
- Socialization Group, which consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors of the clients involved
- Translation and/or interpretive services, including sign language
- Activities or interventions whose purpose includes providing vocational training, academic education or recreational activity
- After client's death

If any part of the note includes such activities without indicating "did not claim for the time it took to do that activity," the claim will be disallowed.

# Mental Health Services Lockout

See **updated handout:**
http://www.acbhcs.org/href_files/LockoutSituationsGrid_061517.pdf

"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 BMHS. *(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 BMHS 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 Plsoe, 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 |
| Spucal Creek, Willow Rook 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 Rehab | Med Svcs Allowed (2) except not allowed during same time period of Day Rehab | C/M Svcs Allowed (2) except not allowed during same time period of Day Rehab |
| Juvenile Hall, Jail or Similar Detention (not adjudicated) | MH Svcs locked out (3) except allowed day of admit & d/c AND (4) allowed if minor adjudicated (release order) awaiting placement | Med Svcs locked out (3) except allowed day of admit & d/c AND (4) allowed if minor adjudicated (release order) awaiting placement | C/M Svcs locked out (3) except allowed day of admit & d/c AND (4) allowed if minor adjudicated (release order) awaiting placement |
| Willow Rook PHF (Acute Psychiatric Inpatient Hospital/PHF <17 beds for minors) | MH Svcs locked out (3) except allowed day of admit & d/c | Med Svcs locked out (3) except allowed day of admit & d/c | C/M Svcs locked out (3) except allowed day of admit & d/c AND (4) allowed 30 days prior to planned d/c for placement purposes |
| John George Psychiatric Pavilion (SD/MC Hospital), Alta-Bates Herrick (FFS Hospital) [Non-Free Standing Acute Psychiatric Inpatient Hospitals] | MH Svcs locked out (3) except allowed day of admit & d/c | Med Svcs locked out (3) except allowed day of admit & d/c | C/M Svcs locked out (3) except allowed day of admit & d/c AND (4) allowed 30 days prior to planned d/c for placement purposes |
| Physical Health Hospitalizations | MH Svcs Allowed | Med Svcs Allowed | C/M Svcs Allowed |
| Villa Fairmont & Gladman (MHRC's); Morton Bakar (SNF-STP); BHC Fremont Hospital, BHC Heritage Oaks, BHC Sierra Vista & John Muir (Acute Psychiatric Inpatient Hospitals) and Garfield (SNF–Subacute Psychiatric Inpatient Facility); & Medical Hill (Psychiatric Skilled Nursing Facility) (All are institutions classified by DHCS as IMD's—see additional institutions with same restrictions on the DHCS' IMD list.) | MH Svcs locked out (3) except allowed day of admit and discharge OR (4) allowed ONLY if client is Less than 21 yrs or older than 64 yrs | Med Svcs locked out (3) except allowed day of admit and discharge OR (4) allowed ONLY if client is Less than 21 yrs or older than 64 yrs | C/M Svcs locked out (3) except allowed day of admit and discharge OR (4) allowed ONLY if client is Less than 21 yrs or older than 64 yrs |
| State Hospital | MH Svcs locked out (1) allowed day of admit & d/c | Med Svcs locked out (1) allowed day of admit & d/c | C/M Svcs locked out (1) allowed day of admit & d/c |
| Across all Providers Claiming in a 24-hr period: Medication Services maximum 4 hrs. (Locked out after 4 hours.) | | | |
| Across all Providers Claiming in a 24-hr period: Crisis Intervention Services (aka Crisis Psychotherapy) maximum 8 hrs. (Locked out > 8 hrs.) | | | |
| Across all Providers Claiming in a 24-hr period: Crisis Stabilization ER & UC maximum 20 hrs. (Locked out after 20 hours.) | | | |
| Across all Providers Claiming in a 24-hr period: ICC maximum 24 hrs. (Locked out after 24 hours.) | | | |

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

**Exceptions with Citations:**

(1) Per Title 9 CCR § 1840.384(a); 1840.216(o); 1840.370(h) Except on the day of admission & discharge.
(2) Per Title 9 CCR § 1840.368(b) No other Specialty Mental Health Service is reimbursable during the same time period this service is reimbursed. (Allowed outside the hours of operation.)
(3) Per Title 22 CCR § 50273: Except when there is evidence that the court has ordered suitable placement in a group home or other setting other than a correctional institution, jail and other similar settings—for minors.
(4) Per Title 9 CCR § 1840.374: Case Mgt Services are locked out except 30 calendar days immediately prior to the day of discharge, for a maximum of three nonconsecutive periods of 30 calendar days or less per continuous stay in the facility immediately prior to discharge for the purpose of placement.
(5) Per Title 9 CCR § 1840.312(g) and CFR 42 Section 438.1008-10: BMHS Med-Cal Services are completely locked-out (including day of admission AND 30 days prior to a planned discharge) in IMD's and Free-standing Psychiatric Hospitals except for those clients < 21 yrs, and those > 64 yrs, of age AND except for those facilities < 17 beds. See DHCS IMD List: http://www.dhcs.ca.gov/services/MH/Documents/MediCCC/IMD2015_IMDList.pdf

# Group Exercise: Putting on an Auditor's Hat

- Read note together
- Look for 'questionable' issues
- Group discussion

# Final Considerations

Always keep in mind that the Clinical Record belongs to, and is about, the client.  Write as if the client will be reading it and it will be therapeutic to do so.

# MHP FFS Procedure Codes

Choose the right one for your license:

EXHIBIT B-1
Alameda County Behavioral Health Care Services
Specialty Mental Health Services
Physician Rates
Effective for Services Provided as of July 1, 2016

| CPT | PROCEDURE DESCRIPTION | RATE | Comment |
|---|---|---|---|
| 90791 | OP Psychiatric Diag Eval | 112.80 | New Code, Old Code = 90802 |
| 90791 | Hosp Psychiatric Diag Eval | 112.80 | New Code, Old Code = 90802 |
| 90792 | OP Psychiatric Diag Eval w/Med Srv | 125.80 | New Code Old Code = 90803 |
| 90792 | Hosp Psychiatric Diag Eval w/Med Srv | 125.80 | New Code, Old Code = 90803 |
| 99212 | OP E/M EST Prob Focused 8-12 min | 27.45 | New code |
| 99213 | OP E/M EST Expd 13-20min | 56.00 | New minute range |
| 99214 | OP E/M EST Mod Complex 21-32 min | 86.10 | New code |
| 99215 | OP E/M EST Hgh Complex 33> | 121.85 | |
| 99221 | IP E/M New Low Comp 15 - 40 min | 88.25 | New code |
| 99222 | IP E/M New Mod Comp 41 - 60 min | 119.85 | New code |
| 99223 | IP E/M New High Comp 61- min | 177.25 | New code |
| 99231 | IP E/M Subseq Low Complex 7-20 min | 34.20 | New min range, Old Code = Y8101 |
| 99232 | IP E/M Subseq Mod Complex 21-30 min | 63.40 | New min range, Old Code = Y8104 |
| 99233 | IP E/M Subseq Hgh Complex 31-35 min | 91.60 | New min range, Old Code = Y8107 |
| 99238 | IP E/M Discharge (16 - 30 min) by MD | 64.50 | New code |
| 99239 | IP E/M Discharge (31> min) by MD | 95.65 | New code |
| 90833 | Individual Psychotherapy by MD 30 min | 64.25 | New code can only be used with an E/M code, Old Code =90805 |
| 90836 | Individual Psychotherapy by MD 60 min | 80.75 | New code can only be used with an E/M code, Old Code =90807 |
| 90838 | Individual Psychotherapy by MD 90 min | 115.00 | New code can only be used with an E/M code, Old Code =90809 |
| 90853 | Group Therapy (60 min) | 22.20 | Old code = Y9505 |
| Y9506 | Group Therapy (90 min) | 33.25 | |
| 90846 | Family Therapy (60 min) | 73.00 | Old code = X9508 |
| X9510 | Family Therapy (90 min) | 108.80 | |
| 90887 | Collateral Call (10 min) | 8.75 | |
| 90888 | Collateral Visit (45 min) | 39.25 | |
| 10173 | Brokerage/Linkage (30 min) | 44.25 | New code |
| 10176 | Brokerage/Linkage (60 min) | 58.40 | New code |
| Y9990 | CalWORKS Engagement Fee | 250.00 | For CalWORKS clients only |
| Y9995 | CalWorks Initial Reporting Fee | 50.00 | For CalWORKS clients only |
| Y9996 | CalWorks Quarterly Reporting Fee | 25.00 | For CalWORKS clients only |
| Y9997 | CFS Casework Report | 45.00 | For CFS clients only |
| Y9994 | CFS Casework Report (120 min and over) | 90.00 | For CFS clients only |
| Y9998 | CFS Customized Services | 100.00 | For CFS clients only |
| Y9999 | CFS Extended Customized Services | 200.00 | For CFS clients only |
| Y9991 | Supplemental Bilingual A Rate | 7.00 | Used with 90887, 90853 |
| Y9992 | Supplemental Bilingual B Rate | 28.00 | Used with all other billing codes, except Y0004 to Y0019 (see code Y9993) |

rev 6-1-16

EXHIBIT B-1
Alameda County Behavioral Health Care Services
Specialty Mental Health Services
Organization, Community Clinic and Multi-Disciline Group Rates
Effective for Services Provided as of July 1, 2016

| CPT | PROCEDURE DESCRIPTION | RATE | Comment |
|---|---|---|---|
| 90791 | Initial Outpatient Assessment (delete time) | 112.80 | New Code, Old Code = 90802 |
| 90791 | Initial Hospital Assessment (delete time) | 112.80 | New Code, Old Code = 90802 |
| 90791 | Initial SNF/B&C/Grp/Dom Assessment (delete time) | 112.80 | New Code, Old Code = 90802 |
| 90792 | Initial Outpatient Assessment w/Med Support | 125.80 | New Code Old Code = 90803 |
| 90792 | Initial Hospital Assessment w/Med Support | 125.80 | New Code, Old Code = 90803 |
| 90792 | Initial SNF/B&C/Grp/Dom Assessment w/Med Support | 125.80 | New Code Old Code = 90803 |
| 99212 | OP E/M EST Prob Focused 8-12 min | 27.45 | New code |
| 99213 | OP E/M EST Expd 13-20min | 56.00 | New minute range |
| 99214 | OP E/M EST Mod Complex 21-32 min | 86.10 | New code |
| 99215 | OP E/M EST Hgh Complex 33> | 121.85 | |
| 99221 | IP E/M New Low Comp 15 - 40 min | 88.25 | New code |
| 99222 | IP E/M New Mod Comp 41 - 60 min | 119.85 | New code |
| 99223 | IP E/M New High Comp 61- min | 177.25 | New code |
| 99231 | IP E/M Subseq Low Complex 7-20 min | 34.20 | New min range, Old Code = Y8101 |
| 99232 | IP E/M Subseq Mod Complex 21-30 min | 63.40 | New min range, Old Code = Y8104 |
| 99233 | IP E/M Subseq Hgh Complex 31-35 min | 91.60 | New min range, Old Code = Y8107 |
| 99238 | IP E/M Discharge (16 - 30 min) by MD | 64.50 | New code |
| 99239 | IP E/M Discharge (31> min) by MD | 95.65 | New code |
| 90833 | Individual Psychotherapy by MD 30 min | 64.25 | New code can only be used with an E/M code, Old Code =90805 |
| 90836 | Individual Psychotherapy by MD 60 min | 80.75 | New code can only be used with an E/M code, Old Code =90807 |
| 90838 | Individual Psychotherapy by MD 90 min | 115.00 | New code can only be used with an E/M code, Old Code =90809 |
| 90832 | Individual Psychotherapy (30 min) | 55.30 | New Code, Old Code= X9500 |
| 90834 | Individual Psychotherapy (60 mins) | 73.00 | New Code, Old Code= X9502 |
| 90837 | Individual Psychotherapy (90 mins) | 108.80 | New Code, Old Code= X9504 |
| 90853 | Group Therapy (60 min) | 22.20 | Old code = Y9505 |
| Y9506 | Group Therapy (90 min) | 33.25 | |
| 90846 | Family Therapy (60 min) | 73.00 | Old Code = X9508 |
| X9510 | Family Therapy (90 min) | 108.80 | |
| 99307 | SNF E/M Subseq Prob Foc by MD (10-12 min) | 34.20 | New code, REPLACES 99347 |
| 99308 | SNF E/M Low Comp by MD (13-20 min) | 48.80 | New code, REPLACES 99348 |
| 99309 | SNF E/M Mod Comp by MD (21-30 min) | 63.40 | New code, REPLACES 99349 |
| 99310 | SNF E/M High Comp by MD (31 > min) | 91.60 | New code, REPLACES 99350 |
| 90887 | Collateral Call (10 min) | 11.10 | |
| 90888 | Collateral Visit (45 min) | 50.15 | |
| 10173 | Brokerage/Linkage (30 min) | 44.25 | New code |
| 10176 | Brokerage/Linkage (60 min) | 58.40 | New code |
| Y0001 | Testing,Scoring&Reporting (1 hr) | 68.85 | |
| Y0002 | Testing,Scoring&Reporting (2 hrs) | 137.70 | |
| Y0003 | Testing,Scoring&Reporting (3 hrs) | 206.55 | |
| Y0004 | Testing,Scoring&Reporting (4 hrs) | 275.40 | |
| Y0005 | Testing,Scoring&Reporting (5 hrs) | 344.25 | |
| Y0006 | Testing,Scoring&Reporting (6 hrs) | 413.10 | |
| Y0007 | Testing,Scoring&Reporting (7 hrs) | 481.95 | |
| Y0008 | Testing,Scoring&Reporting (8 hrs) | 550.80 | |
| Y0009 | Testing,Scoring&Reporting (9 hrs) | 619.65 | |
| Y0010 | Testing,Scoring&Reporting (10 hrs) | 688.50 | |
| Y0011 | Testing,Scoring&Reporting (11 hrs) | 757.35 | |
| Y0012 | Testing,Scoring&Reporting (12 hrs) | 826.20 | |
| Y0013 | Testing,Scoring&Reporting (13 hrs) | 895.05 | |
| Y0014 | Testing,Scoring&Reporting (14 hrs) | 963.90 | |
| Y0015 | Testing,Scoring&Reporting (15 hrs) | 1032.75 | |
| Y0016 | Testing,Scoring&Reporting (16 hrs) | 1101.60 | |
| Y0017 | Testing,Scoring&Reporting (17 hrs) | 1170.45 | |
| Y0018 | Testing,Scoring&Reporting (18 hrs) | 1239.30 | |
| Y0019 | Testing,Scoring&Reporting (19 hrs) | 1308.15 | |
| Y9990 | CalWORKS Engagement Fee | 250.00 | |
| Y9995 | CalWorks Initial Reporting Fee | 50.00 | |
| Y9996 | CalWorks Quarterly Reporting Fee | 25.00 | |
| Y9997 | CFS Casework Report | 45.00 | |
| Y9994 | CFS Casework Report (120 min and over) | 90.00 | |

EXHIBIT B-1
Alameda County Behavioral Health Care Services
Specialty Mental Health Services
PhD Rates
Effective for Services Provided as of July 1, 2016

| CPT | PROCEDURE DESCRIPTION | RATE | Comment |
|---|---|---|---|
| 90791 | OP Psychiatric Diag Eval | 112.80 | New Code, Old Code = 90802 |
| 90791 | Hosp Psychiatric Diag Eval | 112.80 | New Code, Old Code = 90802 |
| 90832 | Individual Psychotherapy 30 min | 55.30 | New Code, Old Code= X9500 |
| 90834 | Individual Psychotherapy 60 min | 73.00 | New Code, Old Code= X9502 |
| 90837 | Individual Psycholtherapy 90 min | 108.80 | New Code, Old Code= X9504 |
| 90853 | Group Therapy (60 min) | 22.20 | New code, Old code = Y9505 |
| Y9506 | Group Therapy (90 min) | 33.25 | |
| 90846 | Family Therapy (60 min) | 73.00 | New Code, Old Code = Y9508 |
| X9510 | Family Therapy (90 min) | 108.80 | |
| 90887 | Collateral Call (10 min) | 5.55 | |
| 90888 | Collateral Visit (45 min) | 25.00 | |
| 10173 | Brokerage/Linkage (30 min) | 44.25 | New code |
| 10176 | Brokerage/Linkage (60 min) | 58.40 | New code |
| Y0001 | Testing,Scoring&Reporting (1 hr) | 68.85 | |
| Y0002 | Testing,Scoring&Reporting (2 hrs) | 137.70 | |
| Y0003 | Testing,Scoring&Reporting (3 hrs) | 206.55 | |
| Y0004 | Testing,Scoring&Reporting (4 hrs) | 275.40 | |
| Y0005 | Testing,Scoring&Reporting (5 hrs) | 344.25 | |
| Y0006 | Testing,Scoring&Reporting (6 hrs) | 413.10 | |
| Y0007 | Testing,Scoring&Reporting (7 hrs) | 481.95 | |
| Y0008 | Testing,Scoring&Reporting (8 hrs) | 550.80 | |
| Y0009 | Testing,Scoring&Reporting (9 hrs) | 619.65 | |
| Y0010 | Testing,Scoring&Reporting (10 hrs) | 688.50 | |
| Y0011 | Testing,Scoring&Reporting (11 hrs) | 757.35 | |
| Y0012 | Testing,Scoring&Reporting (12 hrs) | 826.20 | |
| Y0013 | Testing,Scoring&Reporting (13 hrs) | 895.05 | |
| Y0014 | Testing,Scoring&Reporting (14 hrs) | 963.90 | |
| Y0015 | Testing,Scoring&Reporting (15 hrs) | 1032.75 | |
| Y0016 | Testing,Scoring&Reporting (16 hrs) | 1101.60 | |
| Y0017 | Testing,Scoring&Reporting (17 hrs) | 1170.45 | |
| Y0018 | Testing,Scoring&Reporting (18 hrs) | 1239.30 | |
| Y0019 | Testing,Scoring&Reporting (19 hrs) | 1308.15 | |
| Y9990 | CalWORKS Engagement Fee | 250.00 | For CalWORKS clients only |
| Y9995 | CalWorks Initial Reporting Fee | 50.00 | For CalWORKS clients only |
| Y9996 | CalWorks Quarterly Reporting Fee | 25.00 | For CalWORKS clients only |
| Y9997 | CFS Casework Report | 45.00 | For CFS clients only |
| Y9994 | CFS Casework Report (120 min and over) | 90.00 | For CFS clients only |
| Y9998 | CFS Customized Services | 100.00 | For CFS clients only |
| Y9999 | CFS Extended Customized Services | 200.00 | For CFS clients only |
| Y9991 | Supplemental Bilingual A Rate | 7.00 | Used with 90887, 90853 |
| Y9992 | Supplemental Bilingual B Rate | 28.00 | Used with all other billing codes, except Y0004 to Y0019 (see code Y9993) |
| Y9993 | Supplemental Bilingual C Rate | 83.00 | Used for Psychodiagnostic Testing over 3 hours in duration (Y0004 to Y0019) |

Rev 6-1-16

EXHIBIT B-1
Alameda County Behavioral Health Care Services
Specialty Mental Health Services
LCSW/MFT/LPCC Rates
Effective for Services Provided as of July 1, 2016

| CPT | PROCEDURE DESCRIPTION | RATE | Comment |
|---|---|---|---|
| 90791 | OP Psychiatric Diag Eval | 112.80 | New Code, Old Code = 90802 |
| 90791 | Hosp Psychiatric Diag Eval | 112.80 | New Code, Old Code = 90802 |
| 90832 | Individual Psychotherapy 30 min | 55.30 | New Code, Old Code= X9500 |
| 90834 | Individual Psychotherapy 60 min | 73.00 | New Code, Old Code= X9502 |
| 90837 | Individual Psycholtherapy 90 min | 108.80 | New Code, Old Code= X9504 |
| 90853 | Group Therapy (60 min) | 22.20 | New code, Old code = Y9505 |
| Y9506 | Group Therapy (90 min) | 33.25 | |
| 90846 | Family Therapy (60 min) | 73.00 | New Code, Old Code = Y9508 |
| X9510 | Family Therapy (90 min) | 108.80 | |
| 90887 | Collateral Call (10 min) | 5.55 | |
| 90888 | Collateral Visit (45 min) | 25.00 | |
| 10173 | Brokerage/Linkage (30 min) | 44.25 | New code |
| 10176 | Brokerage/Linkage (60 min) | 58.40 | New code |
| Y9990 | CalWORKS Engagement Fee | 250.00 | For CalWORKS clients only |
| Y9995 | CalWorks Initial Reporting Fee | 50.00 | For CalWORKS clients only |
| Y9996 | CalWorks Quarterly Reporting Fee | 25.00 | For CalWORKS clients only |
| Y9997 | CFS Casework Report | 45.00 | For CFS clients only |
| Y9994 | CFS Casework Report (120 min and over) | 90.00 | For CFS clients only |
| Y9998 | CFS Customized Services | 100.00 | For CFS clients only |
| Y9999 | CFS Extended Customized Services | 200.00 | For CFS clients only |
| Y9991 | Supplemental Bilingual A Rate | 7.00 | Used with 90887, 90853 |
| Y9992 | Supplemental Bilingual B Rate | 28.00 | Used with all other billing codes, except Y0004 to Y0019 (see code Y9993) |

Rev 6-1-16

# Procedure Code/Services

## Assessment and Development of Plan

- Use same code for both assessment and plan development
- Most likely this will be *OP Psychiatric Diagnostic Eval (*90791) or *OP Psychiatric Diagnostic Eval w/Med Srv* (90792).
  - Indicate code and actual minutes between 60 – 90".
- Using these codes counts towards the authorized two (2) allotted initial Assessment/Plan Development sessions or one (1) reassessment/plan development reauthorization session
- Code is not time based, but flat reimbursement rate is similar to a 90 minute session.
- Can only be used for the first two sessions within the first 30 days and once every 6 month at reauthorization.

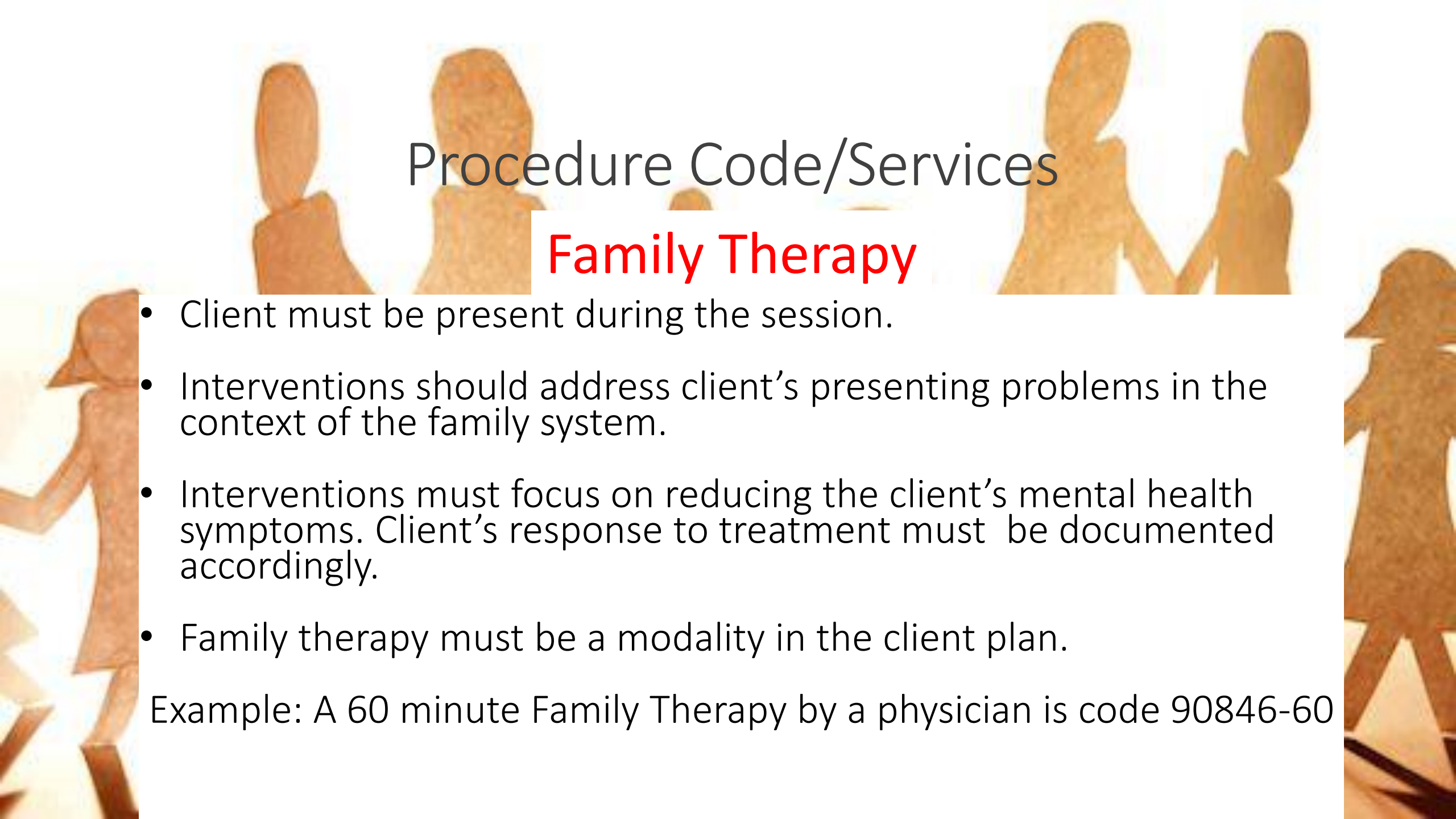
# Procedure Code/Services

## Individual Psychotherapy

- A therapeutic intervention
- Focus primarily on symptom reduction
- Individual Psychotherapy modality must be in the plan to claim for these services

## See rate sheet for specific codes

Example: A 90 minute Individual Psychotherapy session by a MD with a client at a Non-MCO Community Clinic would be coded as 90838-90



# Procedure Code/Services

## Family Therapy

- Client must be present during the session.
- Interventions should address client's presenting problems in the context of the family system.
- Interventions must focus on reducing the client's mental health symptoms. Client's response to treatment must be documented accordingly.
- Family therapy must be a modality in the client plan.

Example: A 60 minute Family Therapy by a physician is code 90846-60

# Procedure Code/Services

## Group Therapy

One facilitator can reasonably facilitate a group of up to six clients. For multiple facilitators see slides on how to claim co-facilitated groups.

One group therapy session counts as one session from client's package.

Group Therapy must be a modality in the treatment plan.

For example: A 90 minute Group Therapy session facilitated by a Ph.D. would used code Y9506-90.

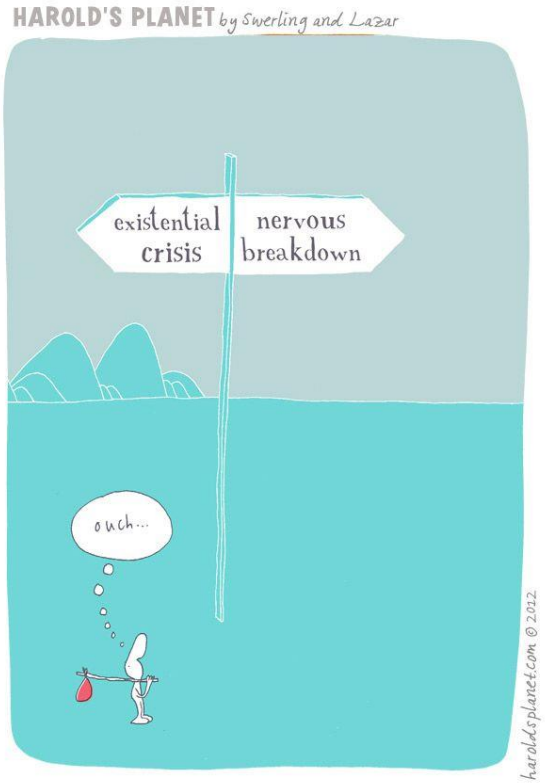
# Procedure Code / Services

## How do you document when your client has a crisis situation?

Use Individual Psychotherapy codes

This modality does not need to be in the treatment plan as crises are by definition not planned.

A crisis session counts as one of the allotted services.



# Procedure Code/Services

## Collateral

- 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) in order for client to accomplish MH Objectives
- Maximum of 120 minutes TOTAL every 6 months
- Collateral Call 90887-10” or Collateral Visit 90888-45” (round to closest);
  Services provided to (any) significant support persons
- Consultation, Training and Psychoeducation of significant support person in client’s life where the
- Modality must be in the treatment plan to claim.
- *Focus is always in achieving mental health Objectives in Client Plan—If Plan is not completed, there is no way to do so.

# Procedure Code/Services

## Brokerage / Case Management

- Case Management/Brokerage: 10173-30” or 10176-60” (round up or down to the closest time);
  - 30 or 60 minute increments
- Maximum TOTAL time is 120 minutes initial/annual and 180 mins. at 6 month reauthorization.
- 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
  - Brokerage modality must be described in the client plan in order to claim

# Psychological Testing Codes

Testing, Scoring, Reporting (1 – 19 hours)

Only available for approved psychological testing.

Providers can refer a client for psychological testing after 3 months of treatment.

All psychological testing must be approved by ACCESS.

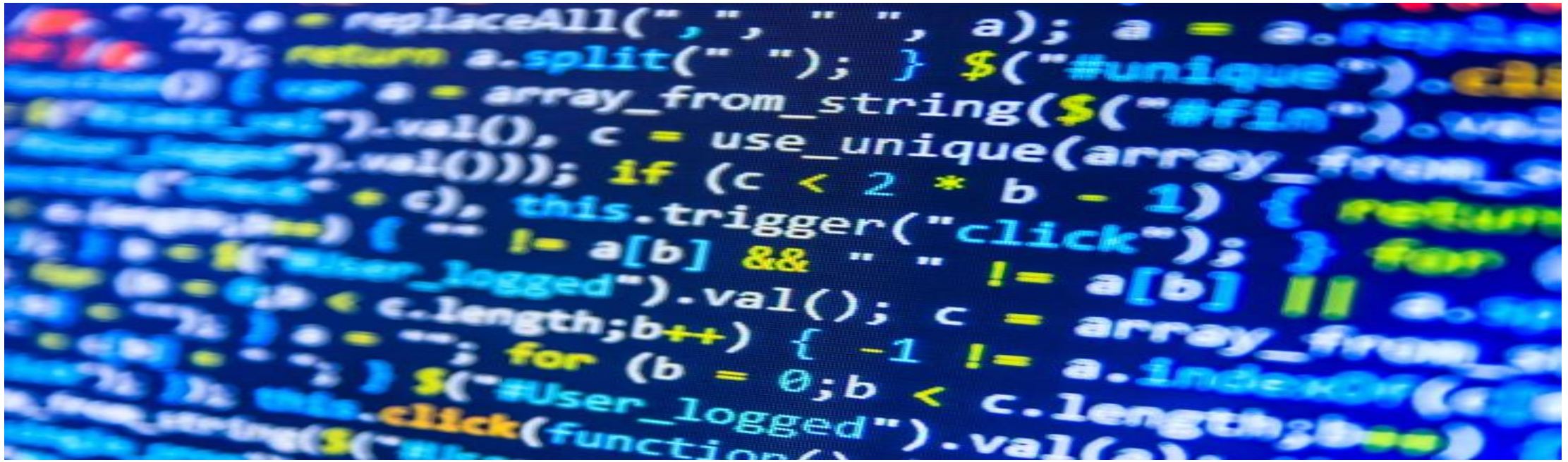
Psychological Test Authorization Request (PTAR) is required to be submitted to ACCESS

# Other Procedure Codes

Not common and must be specified in Provider contract before they can be used

- CFS Casework Report (Y9997)
- CFS Customized Services
- CalWorks related codes
- E/M Codes

# What is the procedure code?



You've been referred a client from ACCESS for family therapy. In the second session you finish the Assessment and start discussing the client plan. The session ends before you have a chance to write up the plan and get client's signature.

*Is this a claimable service? If so…*

What code do you bill for this service and why?

How do you document this in the progress note.

How should the therapist claim the next session?

In the Assessment and Plan you as the therapist determine that client is very anxious and disorganized and these symptoms are preventing them from seeking employment. One of the plan objectives focuses on reducing their anxiety related to finding a job. A referral to vocational services who will improve client's knowledge and skill set and is expected to lower the client's anxiety related to gaining employment. The next time you meet with client, you check in with client about their anxiety levels and if participating in the vocational program has helped lower them.

*Is this a billable service? If so…*

What code do you bill for these types of service

and why?

What is required in the assessment and plan to

claim these services?

You're meeting with a client who suffers from severe anxiety for an individual therapy session when they disclose that they use prescription painkillers regularly. They share that they were initially prescribed them after a car accident, but they help the client feel less anxious. They discuss how that their doctor won't prescribe them any more but they still, "need them to take the edge off." They tell you they have "a guy" who helps them get some, but they're starting to need more and more and it's getting very expensive. The "guy" has suggested they try a more potent version he has that's cheaper, but the client is concerned what that might mean.

*Is this a billable service? If so…*

What code do you bill for these types of service and why?

At the next session you decide that the client plan needs be updated, how would you document that session?

At the start of an individual therapy session, your client looks severely agitated. When you ask the client they report feeling suicidal. You start to assess the client for self-harm they abruptly get up and leave your office. You call their phone, but there is no answer. You don't have any emergency contacts listed on file. You are concerned that client has a high risk for self-harm and contact the police to request a safety check. In total you spent 45 minutes for this service.

*Is this a billable service? If so…*

What are some potential codes you can claims for this service?

Please explain.

The Assessment and Plan are completed and you have a conversation with your client's primary care doctor (at an outside health clinic) on the phone to gather information regarding how coping with depression is impacting her chronic pain and vice versa.

*Is this a billable service? If so…*

What needs to be in the plan for this to be claimed?

What are some potential codes that you can bill for this service? Please explain.


# Thank you for coming!

SEE RESOURCE SLIDES FOR ADDITIONAL INFORMATION