Alameda County Behavioral Health (ACBH)
Module 3- Progress Notes & Procedure Codes

ACBH Quality Assurance Department

Amy Saucier, LMFT, Clinical Review Specialist Supervisor

Cammie Duvall, LMFT, Clinical Review Specialist

Danielle Pence, LPCC, LMFT, Clinical Review Specialist

Alameda County Behavioral Health Care Services

2000 Embarcadero Cove, Suite 400, Oakland, CA 94606
http://www.acbhcs.org/

Progress Notes Defined:

- Progress notes are evidence of a provider's services to or on behalf of a client and relate to the client's progress in treatment.
- Progress notes describe how services provided addressed the:
  Reduction of impairment(s)
  Restoration of functioning, and/or
  Prevention of significant deterioration in an important area of life functioning as outlined in the client plan.
- Document both direct services such as therapy provided to clients as well as indirect services such as completing an assessment form or a treatment plan.

Progress Note Timeline

- Must be done prior to submission of a claim
- Best practice is to complete it the same day/within one working day,
- Must be designated as “late note” after 5 working days.
  - Noting that a progress notes is late is still out of compliance for timeline documentation. It merely highlights that the service was documented late.

Required Elements Of A Progress Note

- InSyst 3 digit, and/or CPT (Remember not all services have an equivalent CPT code and in that case the InSyst code will need to be used), Procedure Code (or exact name per ACBH) claimed.
- Date of Service
- Primary FF Time and Total Time

  If you are claiming for a time based code (such as psychotherapy or crisis where the specific code selection is based on time duration) and the work is done on the telephone, it is ok to enter phone time in Primary FF Time as long as the Service Location field indicates Phone.
- Includes travel and documentation time.
- Written documentation of the service that supports documentation time claimed
- Indicates what language the service was provided in (unless Assessment indicates "client is English speaking and all services will be provided in English").
- Legible provider signature of person providing service with M/C credential and date signed.

  *Progress notes can not be written by any other person than the person providing the service.

ACBH Guidelines for Scope of Practice Credentialing (MH)

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

"Sample Provider Signature Sheet" (Kept in the Client Medical Record when written signatures are utilized).

NAME	AGENCY POSITION TITLE	MEDI-CAL CREDENTIAL	SIGNATURE REQUIREMENT
BETTY TSU	PHYSICIAN	MD (LICENSE #)	*Betty Tsu, MD*
IRMA CALLOWAY, BS	MENTAL HEALTH SPEC.	MHRS	*Irma Calloway, MHRS*
GENOVEVA MARTINEZ, PhD	MENTAL HEALTH SPEC.	MHRS (Has PhD but not licensed or waivered.)	*Genoveva Martinez, MHRS*
JANEY MILLER	PEER COUNSELOR or FAMILY PARTNER	ADJUNCT STAFF	*Janey Miller, Adjunct Staff*
DANIELLE BOGGEMAN, MS	STUDENT TRAINEE	TRAINEE	*Danielle Boggeman, Trainee*
DREW MANUEL	NURSE	LVN (LICENSE #)	*Drew Manuel, LVN*
ROBERT ALMANZA	ADV PRACTICE NURSE	NP	*Robert Almanza, NP*
TANIKA WILLIAMS	MH CLINICIAN	LMFT (LICENSE #) & LPCC (LICENSE #)	*T. Williams, LMFT, LPCC*

Medi-Cal Credentials

Every signature in chart must indicate one of these in **bold** *(See page #1 Medi-Cal credentials in green.)*:

- Licensed: **MD, DO, NP, CNS, PA, RPh, RN, LVN, or Psych Tech**
- **PhD** or **PsyD** (licensed); **LMFT, LCSW, LPCC,** or **LPCC-F** (includes family counseling)
- Board Registered Interns: **AMFT/RAMFT, ASW, APCC/RAPCC,**
- **MHRS;**
- **MFT Waivered** or **MSW Waivered** or **PCC Waivered or PhD Waivered** or **PsyD Waivered**
- **MFT/SW/PCC/Psychology Student Trainee** (Student in MH program Masters/Doctoral); **NP/CNS/PA Student Trainee; RPh Student Trainee, or RN/LVN/PT Student Trainee**
- **Adjunct Staff** (Peer or Family providers)

Progress Notes

- Quality of writing in progress notes should be:
  - Concise
  - Clear
  - Cohesive
  - Reader-centered
  - Written in language anyone can understand

- Abbreviations may be used:
  - Utilize the ACBH abbreviation list or
  - State the word to be abbreviated. In parentheses state the abbreviation to be utilized. This abbreviation may be used on this document only. For any other documents you will need to repeat the same steps for that document

Always keep in mind that the clinical record belongs to, and is about, the client.

S/P/BIRP Format

Situation**/P**urpose/**P**roblem/**B**ehavior/Assessment

Describe the client's current presentation and reported functioning since last encounter especially in terms of progress towards goals and objectives. This highlights the medical necessity " why" for providing the service today.

Identify the purpose of the contact (e.g., to link, assess, plan, provide skill building, provide therapy, etc)

Illustrate narrative description of the contact – who, what, where, when, and why, and the purpose of the service and/or situation requiring the service.

Intervention by Staff

Identify what specific intervention was provided toward the mental health objectives – interventions, and/or linkage to services consistent with achieving client objectives.

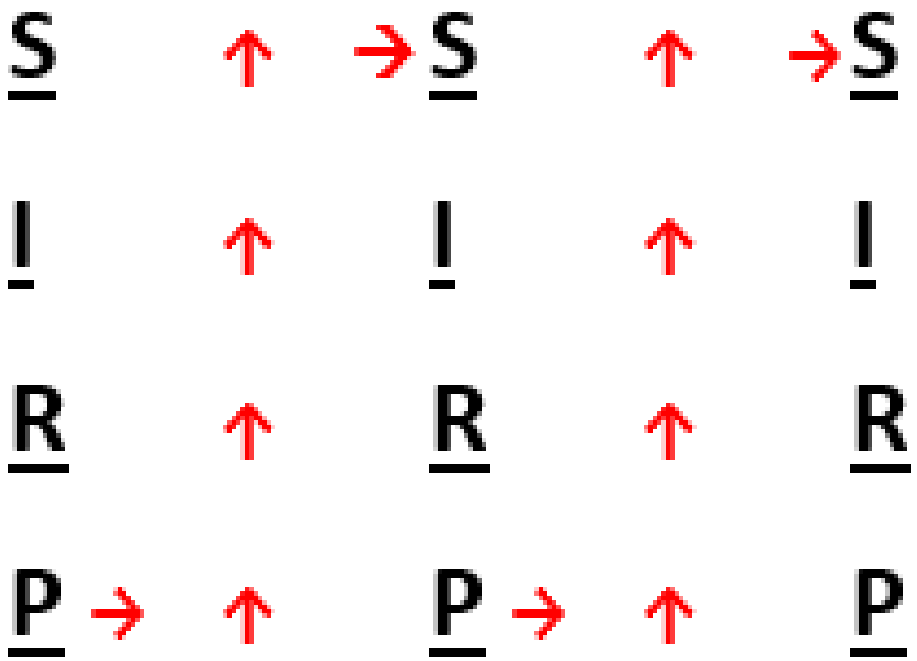
Response of Client to Intervention

Identify client's response today toward the interventions and impact/progress toward their objectives

Plan for future services

Include collaterals, coordination of care, continue with CBT techniques or any follow up by the provider or client.

Golden Thread Narrative



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Modifying Progress Notes for Case Management Services

- Within the Progress Note

  Identify which MH objective that this Case Management service is targeting for improvement. (Indicate number—best to also include statement as well. I.e., "case management service will result in a decrease in MH symptoms of x, y, & z and an increase in adaptive functioning of a, b, & c [per MH Objective(s) # and #".)

- Modifying the P/BIRP Format for Case Management
  - "P/B" = Client reported that they believe the government has been monitoring phone calls and is scared to call the housing authority to put in an application for support. Client has not been able to access housing support services in spite of desire to do so. It is expected that successful case management service to link client to housing support will result in a decrease in paranoid symptoms and an increase in adaptive functioning of being able to successfully carry out desired activities of independent living skills.
  - "I" = Called housing provider with referral and provided linkage to needed housing support services. Appointment made and provided to client.
  - "R" = Client agreed to make scheduled housing support intake appointment and to report back to this provider at our next scheduled appointment.
  - P = Client will make scheduled housing support appointment and will follow up with this writer at next week's meeting to monitor their success in participating in service linked to today.

A word about cloning…

- No, not this kind of cloning

Cloning or 'copy/paste'

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

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

Be mindful of not cloning sibling notes especially for family therapy/therapeutic visitation services. Each child has unique mental health needs and you want to be clear that you are targeting the unique needs in the service tailored to each child.

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

- For more words of caution about EHRs check out this link:
  - www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-ehr-providerfactsheet.pdf

Example Progress Note

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

Date of Service: 2/1/21

Face to Face Time: 45 Minutes

This service was provided in English

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

Challenges/Barriers

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

Overcoming Barriers/Challenges

- Time management (setting up schedules, reminders, personal "tickler" system)
- Training, practice - reinforcing the recommended way
- Reframing the purpose of documentation – seeing client's record as part of client care and collaboration, as an objective measure of progress that can be helpful to see how far the client has come and how they got there. For others, reminding them that it is an invoice for payment so that the agency can continue to be funded and programs continue to be accessible for their clients because they document may be helpful
- Be careful as payment is not always motiving to the front line staff as they may hear they are not as important only making money is important.
- Tips and advice from co-workers
- Using "tip sheets" (like slides or checklist)
- Supervision for support

Progress Note Review Questions

- What are the five components of a Progress Note?
  - Linked to a specific MH Objective (state or indicate #).
  - Today's Problem/Behavior/Assessment/Evaluation
  - Today's Staff Intervention
  - Today's Client's Response to Intervention
  - Plan for f/u, homework, additional services, etc.
- Would an auditor allow a PN that repeated the staff's MH intervention almost verbatim from the previous encounter?

  No

Progress Note Review Questions

- What are the M/C Credentials that must always be used when signing a PN or other document in the Medical Record?
  - Medical Providers:
    MD, DO, NP
  - Licensed LPHA Clinicians:
    PhD-L, PsyD-L, LCSW, LMFT, LPCC, LPCC-F
  - Waivered/Registered LPHA Clinicians
    PhD-W, PsyD-W, ASW, APCC, AMFT, MSW-W (out of state), PCC-W (out of state)
  - Practicum Students in MH approved programs:
    Trainee
  - Others:
    MHRS, OR Adjunct Staff

Lockout Claims

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

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

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

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

Find3 Type of Service You Want to Provide Then Look at Service Site or Claimable Time for SMHS to Find Restrictions (if any)	Are MH Services locked-out (includes IHBS)?	Are Medication Svcs Locked out?	Are Case Management (C/M) Brokerage Svcs Locked out (includes ICC)?
Woodroe Place, Jay Mahler Recovery Center, Amber House (Crisis Residential Treatment)	MH Svcs locked out (1)except *allowed day of admit & d/c*	Med Svcs Allowed	C/M Svcs Allowed
Sausal Creek, Willow Rock CSU, John George CSU (Crisis Stabilization)	MH Svcs Allowed (2)except *not allowed during same time period of CSU*	Med Svcs Allowed (2)except *not allowed during same time period of CSU*	C/M Svcs Allowed
Day Rehab (DR) **Programs & Day Treatment Intensive** (DTI) **Programs**	MH Svcs Allowed (2) except *not allowed during same time period of Day Pgm*	Med Svcs Allowed (2) except *not allowed during same time period of Day Pgm*	C/M Svcs Allowed (2) except *not allowed during same time period of Day Pgm*
Juvenile Hall, Jail or Similar Detention (not adjudicated)	MH Svcs locked out (1) except *allowed day of admit & d/c AND* (3) *allowed if minor adjudicated (release order) awaiting placement*	Med Svcs locked out (1) except *allowed day of admit & d/c AND* (3) *allowed if minor adjudicated (release order) awaiting placement*	C/M Svcs locked out (1) except *allowed day of admit & d/c AND* (3) *allowed if minor adjudicated (release order) awaiting placement*
Willow Rock PHF (Acute Psychiatric Inpatient Hospital/PHF <17 beds for minors)	MH Svcs locked out (1) except *allowed day of admit & d/c*	Med Svcs locked out (1) except *allowed day of admit & d/c*	C/M Svcs locked out (1) except *allowed day of admit & d/c AND* (4) *allowed 30 days prior to planned d/c for placement purposes*
John George Psychiatric Hospital (SD/MC Hospital), **Alta-Bates Herrick** (FFS Hospital) [Non-Free Standing Acute Psychiatric Inpatient Hospitals]	MH Svcs locked out (1) except *allowed day of admit & d/c*	Med Svcs locked out (1) except *allowed day of admit & d/c*	C/M Svcs locked out (1) except allowed day of admit & d/c AND (4) allowed 30 days prior to planned d/c for placement purposes
Physical Health Hospitalizations	MH Svcs Allowed	Med Svcs Allowed	C/M Svcs Allowed

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Non-Reimbursable Services/Activities

- No service provided: missed appointment
- Solely transportation of an individual to or from a service
- Services provided which include payee related activities (Indicate payee portion of visit in a separate—non-billable service note.)
- Services provided which include: clerical activities, leaving or listening to voice mail, or email, or texting, etc.
- Socialization Group

  generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors of the clients involved
- Translation and/or interpretive services
- Activities or interventions that include vocational training, academic education or recreational activities
- Calling in/completing CPS/APS reports.
- Writing SSI disability report
- Services provided after client's death.

Documenting Non-billable services = Importance of Documenting Billable Services

- Missed appointments and cancellations if not documented can look like lack of continuity of care.
- Lack of documenting clerical activities such as voice mails, faxes etx can appear as though tasks and plans were not followed through or lack of effort at collaboration with other providers and stake holders.
- Lack of translation/interpretation services not documented can appear as poor quality of care not meeting the clients cultural needs.
- Lack of documenting reports to CPS/APS can appear as poor quality of care and liability on the provider for not making mandated reports
- Lack of documenting creating reports for SSI disability reporting can appear as poor quality of care or unethical treatment by not supporting client in meeting their needs.

Record Retention

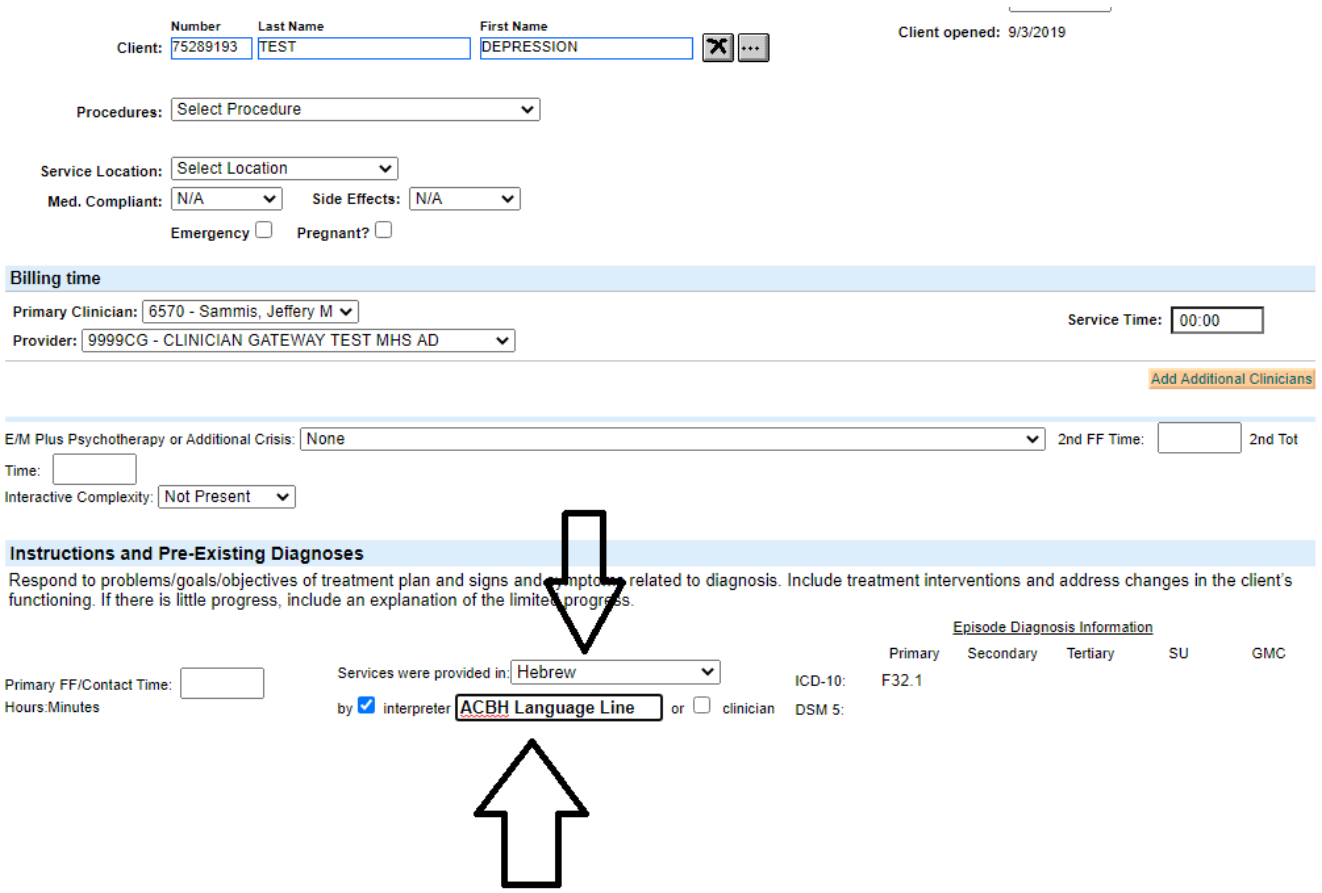
- For all clients, records (paper and electronic) must be maintained for a minimum of: ten (10) years after the last service OR ten (10) years after their eighteenth (18) birthday, whichever is later.
- If later, records must also be retained until DHCS does a final cost settlement with ACBH for the FY in which the last date of service occurred. The last cost settlement which has been finalized occurred for FY 07/01/08-6/30/09.
- On the date of the ten year anniversary (after no services, or the client's 18th birthday—whichever is later), the record shall be retained until the then current DHCS contract with ACBH expires. The current contract terminates 6/30/23.
- Audit situations: Records shall be retained beyond the ten (10) year period if an audit involving those records is pending, and until the audit findings are resolved. The obligation to maintain the records beyond the ten (10) year period exists only if the Mental Health Plan notifies the contractor of the commencement of an audit prior to the expiration of the ten (10) year period.

*Given the above extensions beyond the 10 year period it is highly recommended that all providers simply maintain their client's records for fifteen (15) years after the last service OR fifteen (15) years after their eighteenth (18) birthday, whichever is later.

Documenting the Need for Interpreter Services

- **Each time** an intervention is provided to a client that is not in English, the corresponding progress note describing the intervention must also describe the mechanism that was used to communicate in the preferred language.
- Examples:
  - "For this session Alameda County's language interpreter line was used by phone to translate Farsi."
  - "Client's mother participated in treatment today and since she primarily speaks Spanish, this therapist had our agency's Spanish interpreter attend session to help with translation."
  - "Therapy was conducted in Mandarin as this is client's preferred language."

EHR Designated Language Locations



Clinician's Gateway uses a drop-down menu present on each progress note to indicate what language the services were provided in and how.

This must be completed for each progress note.

Note: In Clinician's Gateway, this menu defaults to English and as long as the client's preferred language is English, no additional steps need to be made.

What is not Allowed

- Family members or friends present in a session may not act as interpreters.

  The exception would be in a crisis while attempts to get an interpreter are being made and have not been obtained yet.

- A clinician that has some language proficiency but is not fluent enough to talk about complex mental health needs in the preferred language may not act as an interpreter.

- Interpreters used should convey to the client or to the clinician as accurately as possible exactly what is said.

- Interpreters should not engage in assessment or therapeutic interventions unless they themselves are the clinician.

Minor Consent, ages 12 – 17 yrs.

- Minors aged 12 – 17 years of age may consent to their own treatment under Family Code 6924 or Health & Safety Code 124260.

- If minor is consenting under Health & Safety Code 124260 – the provider must seek authorization from QATA@acgov.org to provide the service and thereby ensure that Medi-Cal is not claimed.

- If minor is consenting under Family Code 6924– the provider may document as such and serve the client without any additional authorization (if meets necessary requirements).
    - However, if the possibility of the caretaker being informed by Medi-Cal that services are being provided is a risk for the client—call QA and explain this so client may be authorized under 124260 instead without risk of the caretaker being alerted to treatment.

For more information:

www.youthlaw.org - Search in their website for "Minor Consent"

Frequently Asked Question

- Can I combine different services into one note?
  - Yes, one may combine different types of services e.g., combining individual rehab and collateral in a single note (indicate service code for the predominant service).
    - Claim to the lowest paid service (i.e.. Case Management when combined with any other service), or if all services are claimed at the same rate—claim to the predominant service.

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Assessment Codes

Not a Planned Service—May be Provided when Needed

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

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

- 323-90791 – Face to Face Psychiatric Diagnostic Evaluation
- 565-90792 – Face to Face Psychiatric Diagnostic Evaluation above with Medical Component—only performed by Medical Providers (MD, DO, APN—CNS or NP, & PA)
- 325-90889 Non Face to Face Psychiatric Diagnostic Evaluation with or without Medical Component
- 324-90791 – Face to Face Behavioral Evaluation (Completion of CANS, ANSA-T, ANSA, or approved equivalent)
- 326-90889 – Non Face to Face Behavioral Evaluation (CANS, ANSA, etc.)

Plan Development (581)

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

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

Plan Development (581) Cont.

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

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

- For example, clinician becomes aware client went off their anti-psychotic medication (historically linked to decompensation and hospitalization) and clinician needs to meet with the psychiatrist to modify the plan to address the issue immediately.

    - Both staff can bill for the full time for these types of plan development meetings.

Individual (381) or Group Rehab (391)

PLANNED SERVICE—MUST BE IN CLIENT PLAN

- Includes Improving, Maintaining, OR Restoring Functional skills, Daily Living skills, Social and Leisure Skills, Grooming and Personal Hygiene Skills, Meal Preparation skills, and Medication Education. The impairments targeted must be a direct result of the included diagnosis signs, symptoms, or behaviors

- Allowed Example from DHCS:

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

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

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

PLANNED SERVICE—MUST BE IN CLIENT PLAN

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

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

Collateral (311) *for family engagement use Code 310

MAY ONLY BE PROVIDED AFTER THE COMPLETION OF THE CLIENT PLAN

- Services provided to significant support person/s
  - Consultation, training and psychoeducation of significant support person in client's life where the
    - Focus is always in achieving mental health Objectives in Client Plan—If Plan is not completed, there is no way to do so.
    - The provider may be receiving or providing information to the significant support person.
    - The client may or may not be present for this service activity.

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

Collateral (311) *for family engagement use Code 310

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

Collateral Caregiver (310)

PLANNED SERVICE—MUST BE IN CLIENT PLAN

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

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

PLANNED SERVICE—MUST BE IN CLIENT PLAN

- DHCS has clarified that Family Therapy can never be claimed if the client is not present.

- A code: Collateral - Family Counseling (413) has been created to use for the following situations:
  - A Client fails to show to a scheduled Family Therapy appointment and collateral interventions are provided to the family instead.
  - A client's family needs to be seen (without client) and collateral interventions are provided to prepare them for participation in Family therapy.
  - A Client's family needs to be seen (without client) and collateral interventions are provided to help them participate in family therapy in a more positive manner.

- (413) Has the same scope of practice requirements as therapy codes and should never be provided by MHRS or Adjunct staff.

Collateral Family Group (317)

PLANNED SERVICE—MUST BE IN CLIENT PLAN

- Service activity provided in a group setting composed of two or more sets of family members, caretakers or significant support persons in the life of a client in treatment.
- Collateral Family Group services may be used in providing psycho-education, resources and skills to family members/significant support persons to assist clients in gaining or re-gaining emotional equilibrium and community and family functioning.
- Could be with or without client present.

Case Management/Brokerage (571)

UNPLANNED SERVICE – for linkage and referral only
PLANNED SERVICE — for follow-up which must be in client plan

- Help clients to access medical, educational, social, vocational, rehabilitative, or other community services that are identified in the Client Plan and Assessment.

- Services activities may include, but are not limited to:
  - Communication with client & other individuals.
  - Coordination of care
  - Referrals
  - Monitoring service delivery to ensure client's access to services.
  - Monitoring client's progress toward making use of services.

- Client Plan must document need for case management (C/M) due to severe impairment due to mental health (MH) diagnosis (Dx) that results in client being unable to make and maintain other community service referrals (Adult), or without such services Child's MH symptoms (Sx) and Impairments would be exacerbated. Must also document, successful C/M is expected to decrease MH Sx's and impairments.

Katie A (578, 577, 557)

- The 578 Code Child Family Team (CFT) Intensive Care Coordination (ICC) is to be claimed by the clinician coordinating and leading the meeting for the amount of the meeting time only. The coordinator should use the 577 Code for any time spent including planning, coordinating, plan monitoring, needs assessment, and preparing outside of the meeting time.

- The 577 Code (ICC) is to be claimed for all other participants for the time they contributed to the meeting, up to the length of the meeting, plus documentation and travel time.

- The 557 Intensive Home Based Services (IHBS) are services that consist of skill-based interventions; development of functional skills; development of skills or replacement behaviors that are provided to child or youth that allow the child or youth to participate in the CFT.

Psychotherapy Codes

PLANNED SERVICE—MUST BE IN CLIENT PLAN

- A psycho-therapeutic intervention that focuses primarily on symptom reduction/behavioral change as a means to improve functional impairments. May be delivered to an individual or group and may include family therapy.
- Must be performed by Licensed/Registered/Waivered LPHA or MH Trainee
- Individual: (441/442/443)
  - May use +491-90785 for Interactive Complexity

- Family: (449) (May only be with Client present.)
  - NOTE: Prior Family Psychotherapy Without Client Present (413) is now Collateral—Family Counseling

- Multi-Family Group: (455) (May only be with Client present.)
  - provided to more than one family, each with at least one enrolled client present.
  - Note: Multi-Family without Client present is now renamed as Collateral-Family Group

- Group : (456)
  - May use +491-90785 for Interactive Complexity

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

- Always choose code based on the exact number of F-2-F minutes.
  - Documentation time & travel time will be included in total time and therefore reimbursed.
  - Contact with clients by phone may be entered as face to face time, but the location of such service must be phone. If any other location is indicated, the service will be disallowed during audit.

Selecting the Code for Individual Psychotherapy

- Time Based Code: (441/442/443)
- Code selected based on the time of the time spent with the client.

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

Prorating Group Services

PLANNED SERVICE—MUST BE IN CLIENT PLAN (see exceptions in Clin Doc Manual)
Group Rehabilitation: 391, Collateral Family Group: 317 *(usually provided by Family Partners),*
Group Psychotherapy: 456,
& Multi-Family Group Psychotherapy With Client Present : 455

- Prorated Requirement:
  - When claiming for services in a group setting, time claimed must be prorated for each client represented within the Progress Note:
    - List all staff present with justification for their presence
    - List the number of clients present
    - Include the number of all clients regardless if they are being claimed to ACBH/Medi-Cal/etc.
    - List total time of group service, total documentation time, and total travel time. See specific examples for time breakdowns of different scenarios.
    - INSYST will calculate the billable time per client

Prorating Group Services, Example 1

1 Clinician Provides Group therapy to 6 clients:

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

Prorating Group Services, Example 2a

2 Clinicians Provide Group therapy to 6 clients:

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

Prorating Group Services, Example 2b

2 Clinicians Provide Group therapy to 6 clients:

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

Prorating Group Services, Example 2c

2 Clinicians Provide Group therapy to 6 clients:

- Option 3: One clinician can write the progress notes for some of the clients and the co-staff writes the notes for the remainder of the clients. The other clinician would write a progress note for the remainder of the clients:

- Staff 1 (writes PN for three of the clients):
  - Primary Staff: Face to Face time 60, Documentation time: 30, Total time (Primary Staff): 90 (Only total time entered into InSyst).
  - For Co-staff group time indicate: Face to Face time 60 Documentation time: 30 Total time (Co-Staff): 90 (Only total time entered into InSyst).
  - Group count 6

- Staff 2 (writes PN for the other three clients):
  - Primary Staff: Face to Face time 60, Documentation time: 30, Total time (Primary Staff): 90 (Only total time entered into InSyst).
  - For Co-staff group time indicate: Face to Face time 60 Documentation time: 30 Total time (Co-Staff): 90 (Only total time entered into InSyst).
  - Group count 6
- Note: data entry into InSyst for this process will soon be changing—watch for memo. However, there will be no change in the clinical documentation charting.

Add-On Codes (+)

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

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

Crisis Therapy (formerly, Crisis Intervention)

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

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

Crisis Add-on Codes: Time Ranges

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

Alameda County Behavioral Health Care Services

2000 Embarcadero Cove, Suite 400, Oakland, CA 94606
http://www.acbhcs.org/

Crisis Add-On Codes:

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

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

- Each add-on code must be indicated in the progress note.
  - Example:
    - 377-90839 Crisis Therapy
      + 378-90840 Crisis Therapy add-on
      + 378-90840 Crisis Therapy add-on
      --Note, Clinician's Gateway uses a different methodology—see Training Slides.
- When documenting for an add-on code, be sure that the note content reflects the service and/or time frame of the add-on.

Add-On Code for Additional Service Provided:

Interactive Complexity +491-90785

- Refers to one or more, of 4 specific communication factors during a visit that complicate delivery of the primary psychiatric procedure (individual psychotherapy/group psychotherapy/assessment):

  - The need to manage maladaptive communication.
  - Caregiver's emotions or behaviors that interfere with implementation of the treatment plan.
  - Evidence or disclosure of a Sentinel Event and mandated reporting to a 3rd party with initiation of discussion of the event.
  - Use of play equipment to overcome barriers to diagnostic or therapeutic interaction.
    - **This does not include routine play therapy**

Add-On Code for Additional Service Provided:

Interactive Complexity +491-90785 cont.

- Documentation Requirements:
  Indicate the specific type of communication complication (see previous slide).
  Document the specifics of the communication difficulty.

- Can only be used with these codes:
  323-90791 & 565-90792 Psychiatric Diagnostic Evaluation.
  441-90832, 442-90834, 443-90837 Ind. Psychotherapy
  456-90853 Group Psychotherapy (for the specific client)

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

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

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

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

Medication Support Services

- May be provided by Medical Providers (MD, DO, NP)

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

Medication Support Services cont.

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

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

- Two Methodologies for charting:
  - Coding by the Elements—see QA Training Website for resources.
  - Counseling and Coordination of Care:
    - Make up the great majority of client medication support services in Community Mental Health.
    - See slides below and QA Training Website for additional resources.

Evaluation and Management (E/M) Codes

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

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

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

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

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

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

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

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

- Coordination of Care:
  - Services provided by the medical provider responsible for the direct care of a client when they coordinate or control access to care or initiates or supervises other healthcare services needed by the client.
  - Outpatient coordination of care must be provided while face-to-face with the client (or family).

- Provider must detail and thoroughly document what was discussed for each content topic covered
  - E.g. for Compliance/Adherence discussion:
    - "20 minutes of 25 minutes face-to-face time spent counseling re: the importance of medication compliance with mood stabilizer for bipolar disorder. Explored impact of when client went off her medications—including recent 5150 and involuntary hospitalizations…"

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

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

Medication Support: RN/LVN/Psych Tech only (369)

This procedure code was developed for RN's and LVN's who provide medication management but who cannot bill Medicare. This code is for Medi-Cal billable only. Maximum claim limit of 4 hours (240 minutes) per day

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

Medication Support: Medical Providers (MD, DO, NP, PA, CNS)

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

Procedure Code/Services Review

Case Management vs. Plan Development vs. Collateral

- May Case Management, Plan Develop, or Collateral be provided across agencies (or in the same agency between RU's that do not share a medical record)?
  - YES — Coordination of Care is recommended.
- Which of these service types may be routinely provided within the same RU across staff, or between staff of different RU's who share a chart?
  - NONE

Procedure Code/Services Review

Case Management vs. Plan Development vs. Collateral

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

- Plan Development

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

Procedure Code/Services

Case Management vs. Plan Development vs. Collateral

Another example of billable intra-agency Plan Development:

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

Procedure Code/Services

Case Management vs. Plan Development vs. Collateral

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

- MH Trainee writes up monthly summary of client's progress in psychotherapy and in a meeting distinct from weekly supervision shares this with the LPHA for collaboration and monitoring of client's success towards meeting MH Objectives.

  - Meeting with one's clinical supervisor (such as when collecting hours toward licensure) for any activity may never be claimed.

  - Meeting with an outside therapist around how to best proceed — with an eating disorders case you rarely have the opportunity to treat — is a consultation for professional development and never claimed.

Procedure Code/Services

Case Management vs. Plan Development vs. Collateral

When is intra-agency staff claiming not allowed?

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

- For example:
  - In preparation for meeting with a client, that staff person reads the medical record entries from other staff since their last client intervention.
  - Then they are up to date with the current status of the client's MH Objectives.

Procedure Code/Services

Case Management vs. Plan Development vs. Collateral

Examples of incorrectly claimed intra-agency activities as Collateral:

- Clinician meets weekly with family partner after the home visits with parents of a child client to coordinate their services to better meet the client's MH Objectives.
  - In non-urgent situations, reading each others' Progress Notes should be adequate. The above example is more like supervision.

- Case Manager accompanies client to psychiatrist appointment to communicate updates in client's progress with a medication trial.

  - Again, reading each other's notes is adequate unless an urgent matter arises that needs to be discussed promptly.

Procedure Code/Services

Case Management vs. Plan Development vs. Collateral

- Examples of incorrectly claimed intra-agency activities as Case Management:
  - Adult Team Vocational Counselor and Case Manager meet monthly to coordinate client's Vocational and MH Services.
  - Case Manager meets with Nurse Practitioner to refer client for a medication evaluation. Case Manager's write up of last meeting with client that precipitated the referral with reasoning why should be adequate when routed to NP.

Procedure Code/Services

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

How does individual Rehab differ from Case Management/Brokerage?

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

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

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

Procedure Code/Services Continued

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

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

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

Procedure Code Review Questions

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

- Assessment and CANS/ANSA Behavioral Evaluation Codes

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

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

What is the difference between Collateral Codes 311 and 310

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

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

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

Procedure Code Review Questions Continued.

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

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

2.) Interactive Complexity may be added to which 3 procedure codes?

- Assessment, Group, and Individual Psychotherapy

3.)What codes do RNs use?

- 369 Medication Management

4.)What codes do medical providers (MD, NP) use for all services which are not f-f ?

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

thank you.

Contact QATA@acgov.org.com for more information

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