ALCOHOL, DRUG & MENTAL HEALTH SERVICES
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Mental Health Service Definitions & Examples

(Also see ACBHCS InSyst Procedure Code Table)

Case Management
Service Code 571

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

What it is:

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

Client Plan Case Management Impairments Should Describe:

- *Identify the realm of community resources that are being addressed: i.e. housing or substance abuse, etc. Then document:*

    1. *The reason why the client requires the service being accessed needs to be documented in the Client Plan*
    2. *A description that justifies why client requires the clinician's assistance to access the needed service, i.e., why can't they do it themselves? The reason(s) need to be related to their mental health condition. This needs to be documented in the Client Plan. (I.e. "Client's inability to access housing support services is due to their symptoms of depression including amotivation, anergy and hopelessness.")*
    3. *Address if Case Management services will include linkage and/or monitoring.*
    4. *Explicitly document that provision of the Case Management service is expected to result in the client achieving their Mental Health Objective. (I.e. "Case Management service is expected to allow client to meet their Mental Health Objective #1—to*

decrease their social isolation and anergy while increasing their motivation and hopefulness.")

Progress Notes Should Describe:

- *The reason why the client requires the service being accessed needs to be documented in the record, and ideally documented in each note.*
- *A description that justifies why the client requires the clinician's assistance to access the needed service, i.e., why can't they do it themselves? The reason(s) need to be related to their mental health condition. This needs to be documented in the record, and ideally documented in each note. (I.e. "Client's inability to access housing support services is due to their symptoms of depression including amotivation, anergy and hopelessness.")*
- *Describes the linkage or monitoring to community supports or progress (monitoring) in a residential program or other service setting that the individual was placed in or referred to.*
- *Explicitly documents that provision of the Case Management service is expected to result in the client achieving their Mental Health Objective. (I.e. "Case Management service is expected to allow client to meet their Mental Health Objective #1—to decrease their social isolation and anergy while increasing their motivation and hopefulness.")*

Example Interventions:

1. Client would like a job. Client's paranoia prevents client from setting up appointment with Job Coach. Arranged for job coach familiar with client's mental health conditions to assist client with employment. Case Management is expected to diminish client's paranoia (Mental Health Objective #).
2. Client would like to attend College. Client's depression makes it difficult to be motivated to sign-up for classes. Assisted the client to make connection to Disabled Student Services to assist with enrollment and supports at community college. Case Management is expected to result in Client obtaining their MH Objective # to increase motivation and decrease social isolation.
3. Client's behaviors of arguing with peers (symptom of their diagnosis) results in difficulties with their placement. Monitored the effectiveness of interventions by residential treatment provider and insured client objectives are addressed. Case Management is expected to result in client's MH Objective of increasing pro-social behaviors while decreasing argumentative behaviors.

Scope of Practices that may provide Case Management services:

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

Assessment
Service Code 323-90791 (Non Face-to-Face: 325-90899)

Service Definition:
A service activity, which includes a clinical analysis of the history and current status of a beneficiary's mental, emotional, or behavioral disorder; relevant cultural issues; and history, diagnosis, and the use of testing procedures.
Assessments can be conducted over several days. Either licensed or unlicensed staff may conduct assessment activities, however, only a licensed / waivered staff person may complete the MH Assessment and provide a diagnosis. *For example, an MHRS may gather demographic information and write a progress note which the clinician will utilize when completing the MH Assessment.*

What it is:
- Systematic evaluation of a client's mental health in multiple domains of functioning.
- Contact requirements state that there must be face-to-face (in-person) contact in order to use this activity code (323-90791). Documentation of this activity is included. For non face-to-face (no client contact, or on telephone) assessment activity use code 325-90889.

Assessment should describe:
- What you are systematically evaluating: history of disorder, current status of disorder, or both?
- What new information is gathered as a result of this activity?
- What new conclusion(s) or insight(s) have you reached about this client's mental, emotional, or behavioral disorder as a result of this contact?
- Where a diagnosis must be provided to meet medical necessity (initial, comprehensive, and reassessment), it must be done by a licensed /registered/waivered clinician. *Waivered/registered staff requires a licensed LPHA co-signature for the Diagnosis.*

Scope of Practices that may provide MH Assessment services:
- LPHA, Medical Providers, Unlicensed LPHA, & Graduate Trainee/Students may complete a Mental Health Assessment.
    - Notes:
        - Unlicensed LPHA require a co-signature for any diagnosis made. Graduate Trainee/Students require a co-signature by an LPHA for the MH Assessment and may not provide a Diagnosis.
        - Mental Health Rehabilitation Specialists & Adjunct Staff may gather Assessment information (such as demographics) and enter the information into a Progress Note for use by the Clinician performing the MH Assessment
        - *For additional information, and requirements, see the ACBHCS Guidelines for Scope of Practice Credentialing document.*

Plan Development
Service Code 581

Service Definition:

Plan Development is a service activity, which consists of development of client plans, approval of service plans by participants (client and providers—not supervisor's co-signature), and/or monitoring of an individual's progress toward their mental health objectives.

What it is:

- Working with client or Significant Support Person (SSP)--primarily for youth--on development of client's objectives, discussion when mental health objectives are reviewed, and authorized and periodically monitoring progress toward objectives.
- Also, the code is used when there is no face-to-face contact (or phone contact) and service activities are being provided to gather and review written clinical information in order to initiate, implement, or monitor a service plan. *The relevant information gathered must be specified in the progress note*.
- When Plan Development is coded for service activities contributing to the actual development of formal client plans, progress notes require a description of your activities to formulate, engage client participation, negotiate, modify, and/or write elements of client's MH service plan.
- Elements of a client's plan include: describing the outcomes of services, needs, barriers to achieving outcomes, strengths and resources in achieving them, measurable objectives, detailed interventions, responsible parties and target dates.
- Monitoring progress requires a description of contacts with client and significant support person such as parent or other caregiver, to elicit their evaluation of client's clinical progress toward achieving their client plan objectives.
- Monitoring Progress occurs if the progress note primarily describes your clinical efforts to evaluate (please note this evaluation is usually a part of each MH service provided):
  - ✓ Whether the clinical services are in accordance with the client plan;
  - ✓ Whether services "fit" with client MH needs and are effective;
  - ✓ Changes in the needs/status of the client;
- See ACBHCS Memo dated 10/15/2014 for documentation requirements for Plan Monitoring.

Progress Notes Should Describe

- Reviewing, or formulating, a client plan/objectives via face-to-face or telephone contact.
- Developing new, revised or annual client plan.
- Collaborating and reviewing client plan with client and family.

Example Interventions:

1. Met with client to discuss client plan and identify behavioral objectives that client wishes to work on. (Describe.)

2. Spoke with mother about client's objectives and objectives to be identified in client plan. (Describe.)
3. Reviewed client progress towards objectives and determined need for additional treatment. For example, added new MH Objective to existing client plan. (Describe.)
4. While attending IEP, formulated MH objectives that incorporated input from teacher, Resource Specialist, and family. (Describe.)

Scope of Practices that may provide Plan Development services:

- LPHA, Medical Providers, Nurses, Unlicensed LPHA without a co-signature.
- Graduate Trainee/Student, Mental Health Rehabilitation Specialists & Adjunct Staff with a licensed LPHA co-signature.
- *For additional information, and requirements, see the ACBHCS Guidelines for Scope of Practice Credentialing document.*

Individual, Group or Family Therapy
Service Codes: 441-90832, 442-90834, 443-90837, 413-90846, 449-90847, 455-90849, 456-90853

Service Definition:
A psycho-therapeutic intervention that focuses primarily on symptom reduction/behavioral change as a means to improve functional impairments. Therapy may be delivered to an individual or group and may include family therapy at which the individual is or is not present. **Provided by licensed, registered, waivered, and graduate trainee-student staff only.**

Progress Notes Should Describe:

- Who participated and at what level?
- Focus of the session and symptoms/behaviors being addressed.
- Approach of interventions used (e.g., narrative, play therapy, cognitive-behavioral restructuring, sand tray, etc.).
- Client's level of engagement (openness to change, level of engagement, defenses, willingness to attempt new coping skills).
- Movement (positive, negative) toward desired outcomes.
- Service provided by licensed or waivered clinician.
- Focus on feelings, thinking, or behaviors, with the intent of reducing symptoms/ maladaptive behaviors.
- Symptom(s)/behaviors being addressed as identified in the Service Plan. Symptoms/behaviors should be consistent with the diagnosis, or, if not, explain new symptoms identified.

Example Interventions:

1. Play therapy where client is present, therapist documents working on socialization and symptom reduction through use of games or sand tray. (Describe.)

2. Family therapy, where client is/is not present along with family members. Therapist documents working on relationship issues and symptom reduction of client within the context of the family she is in. (Describe.)
3. Individual therapy with client, where therapist and client work on issues of emotions, behaviors, impulse control, cognitive distortions, mental health education, symptom management, etc. and therapist documents client's progress in symptom reduction/extinguishing maladaptive behaviors. (Describe.)

Scope of Practices that may provide Therapy services:

- LPHA, Medical Providers, Unlicensed LPHA, & Graduate Trainee/Students may provide Therapy services.
    - Notes:
        - Graduate Trainee/Students require a co-signature on their Therapy Progress Notes by a licensed LPHAQ.
        - *For additional information, and requirements, see the ACBHCS Guidelines for Scope of Practice Credentialing document.*

Rehabilitation Individual & Group
Service Code 381, 391

Service Definition:
A service activity that addresses individual's mental health condition to improve, maintain, or restore functional skills, daily living skills, social and leisure
skills, grooming and personal hygiene skills, support resources, and psycho-education. Service Code may be used by non-licensed staff.

What it is:

- Specific skill-building in the areas of functioning (moods, emotions, thoughts, behaviors, impulse control), daily living skills (keeping a clean house, shopping, paying bills), social and leisure skills (interpersonal relationships, volunteering, making friends), grooming and personal hygiene skills (bathing, washing clothes), budgeting, nutrition (choosing foods that do not interfere with health condition such as diabetes), support resources (Boy's & Girls Club, self-help groups).

Progress Notes Should Describe:

- What is the impairment (behaviors, moods, emotions, thoughts, impulse control, activities of daily living, social activities, meaningful daily activities [school or work], and substance use) that affects the client's skill(s)? (Describe.)
- How the impairment is tied-in with the symptoms/behaviors associated with of his/her MH diagnosis? (Describe.)
- What are you attempting to do: improve, maintain, or restore the skill(s)? (Describe.)
- Is it clear that you are assisting the client in improving, maintaining, or restoring the skill(s), rather than performing some functional task(s) **FOR** the client? (Describe.)

Example Interventions:

1. Worked with client on appropriately initiating conversation with a new peer. Client has not been able to initiate contact and has been anxious and withdrawn. Client was able to sustain contact for 10 minutes, an improvement over baseline of not at all.
2. Worked with client on personal hygiene issues. Client has historically taken a shower only once a week. Client agreed to contract taking a shower at least three times a week for a month using a chart. Client has met this standard for two weeks in a row.
3. Assisted client with healthy food selection skills to improve mood by increasing self - image (had been overweight and depressed). Client made appropriate selections with little prompting.

Scope of Practices that may provide Rehabilitation services:

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

Collateral
Service Code 310, 311, 317

Service Definition:

A service activity delivered to a significant support person in the individual's life with *the intent of achieving the mental health objectives of the client*. This may include consultation and training with the SSP about the individual's mental health condition to improve understanding as well as family counseling to support the client's objectives. The client may or may not be present for this activity. *Contacts with SSP in the beneficiary's life are directed exclusively to the mental health needs of the client.*

What it is:

- A service provided to someone who has a significant role in the successful outcome of treatment who has been identified by the client (or person providing services) as having a significant role in the positive outcome of treatment**.**
- SSP most likely will be: Family members such as parent(s) or other relatives; foster parent, social worker, school counselor, legal guardian, close friend, client's co-worker, sponsor, coach, spiritual advisor, etc.

Progress Notes Should Describe:

- Name of Significant Support Person (SSP): family member, social worker, school counselor, doctor, clergyperson, etc. This should be in the initial note describing this person's relationship to the client and how they are an SSP if not implied by relationship.
- Brief description of why this person has been identified as significant to the outcome of treatment.
- Brief description of how this contact with this person is focused on improving utilization of MH services by the client or achieving objectives of their Client Plan.

What it's not:

- Providing therapy with a co-therapist.
- A conversation with an SSP about paperwork or travel arrangements.
- Solely providing support to a parent when s/he is having her/his own personal issues.

Example Interventions:

1. Provided education to Resource Specialist teacher about client's Attention Deficit Disorder and how it is manifested, as well as methods to address this mental health condition, for her. (Describe.)
2. Provided simple behavior management techniques to mom and stepfather to help child de-escalate when angry. (Describe.)
3. Assisted caregiver to recognize behaviors that were indicative of deterioration in mental health condition. (Describe.)

Scope of Practices that may provide Collateral services:

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

At a Minimum, Progress Note Documentation Must Contain:

- Purpose of that day's service:
    - Client's presentation and reported functioning since last encounter.
    - Purpose of the contact (e.g., scheduled, unscheduled, to monitor, link, assess, plan, etc.)
    - Narrative description of contact – Who, what, when, where and why you are making the contact?
    - What is the situation or context requiring contact?
- Staff's Intervention that day:
    - Clinician decisions, interventions, and referrals consistent with achieving client objectives; address/assessed functional impairments and symptoms/behaviors.
- Client's Response that day:
    - Client/family responses and progress and/or obstacles toward mental health objectives.
- Plan for follow-up and next steps.

Documentation of Non-Billable Services:
Activities performed that cannot be billed for but need to be documented (e.g. contact while individual is in lock-out setting such as juvenile hall, jail, or psychiatric inpatient setting)**.** *See ACBHCS Lock-out Chart for exceptions.*

Activities That Are Not Reimbursable:

- Reading and writing emails;
- Academic educational services;
- Vocational services that have as a purpose actual work or work training
- Recreation;
- Services provided were solely clerical (rescheduling appts etc.);
- Supervision of all staff (including clinical internship, clinical hours, discipline, etc.). Seeking expert advice;
- Service provided solely payee related (paying bills, requesting checks etc.);
- Personal care services provided to individuals. These include grooming, personal hygiene, assisting with medication, and meal preparation when performed for the individual;

- Socialization, if it consists of generalized group activities that do not provide systematic individualized feedback to the specific, targeted behaviors of the individuals involved;
- Solely transportation of an individual to or from a service;
- Translation or interpretive services including sign language;
- Services provided to individuals residing in institutional settings such as jail or an Institution for Mental Disease [IMD];
- Report writing (such as a child/elder abuse report); and
- Services provided while an individual is in a hospital mental health unit, psychiatric health facility, nursing facility, or crisis residential facility (except for the first day).

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[1]LPHA (licensed): PhD/PsyD, LCSW, LMFT, LPCC, LPCC-Family (may perform Family Therapy)

[2]Medical Providers (Prescribers): MD, DO, CNS, NP, PA

[3]Nursing (Non-Prescribers): RN, LVN, Psychiatric Tech

[4]Unlicensed LPHA (Registered or Waivered Interns): PhD/PsyD-Waivered, MFTI, ASW, PCCI

[5]Graduate Student/Trainee: Students in educational Mental Health programs granting an MSW, MA, MS, or PhD/PsyD who are working towards Licensure as a: Clinical Psychologist, Licensed Marriage and Family Therapist, Licensed Clinical Social Worker or Licensed Professional Clinical Counselor.

[6]Mental Health Rehabilitation Specialist: Requires a degree plus Mental Health Experience (AA/AS with 6 years'MH experience, BA/BS with 4 years' MH experience, or MA/MS/PhD/PsyD with 2 years' experience.)

[6]Adjunct MH Staff and Other Staff not meeting above Category Qualifications: The agency or MH program must document qualifications, provide supervision, and ensure staff works within scope of ability. May include: PSR, Peer Specialist & Family Partners.)