Specialty Mental Health Services Clinical Documentation Training for Clinician Gateway - Electronic Health Record (CG EHR) Users

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Agenda 4/12/18

TIME	TOPIC
9:00 am – 9:15 am	• Introductions, Housekeeping
9:15 am – 10:30 am	• Audit Highlights • Pre-Assessment Requirements • Assessment Documentation Requirements, including SO/GI
10:30 am – 10:45 am	Break
10:45 am – 12:15 pm	• Plan Documentation Requirements • Activity
12:15 pm – 12:45 pm	Lunch
12:45 pm – 1:45 pm	• Progress Note Documentation Requirements • Activity
1:45 pm – 2:00 pm	Break
2:00 pm – 3:00 pm	• Procedure Codes Documentation Requirements • Activity
3:00 pm – 4:00 pm	• Questions, Post Test, & Course Evaluation

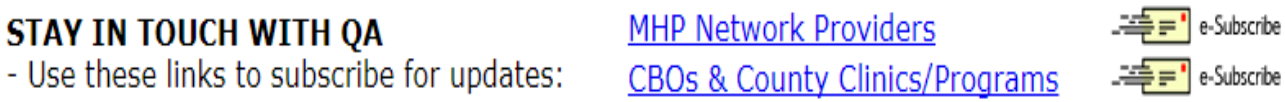
Introductions

- Name, Agency/Clinic, Role at Agency/Clinic
- What part of Clinician's Gateway do you use?
- What is one documentation related question you want to get answered today?
- Housekeeping

Images used in presentation

To stay up to date with 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.



Training Objectives

- Agency Internal CQRT Chart Auditing & Authorization Process— **ATTEND March 2nd Training for New REQUIRED Processes**
  - Be able to facilitate and/or improve ongoing internal Clinical Quality Review Teams.
    - Understand the purpose of the CQRT and its function in improving compliance with documentation standards.
    - Understand the distinction between the Clinical & Quality Review.
    - Understand the expectations of how to prepare and run Agency CQRT meetings. Understand the forms and paperwork necessary for Agency CQRT meetings.
    - Understand the Clinical Review Cycles of charts and how they guide clinical practices.

Revised and New Forms

- Implemented 4/1/17:
  - Revised MH Assessment Form
    - Dx and SO/GI data collection
  - New Assessment Addendum
  - New Universal Client Plan
  - New Psychiatric Assessment Form
  - New Psychiatric MH Assessment Form
- New CG MH Assessment Form Expected in late in 2017. These new forms are currently available in print only (Samples, Short & Long Form) on Provider's Website/Forms/Clinical

Training Objectives

After this training participants will be able to:

- State the timelines to complete: Brief Screening Tool, Informing Materials, MH Assessment, CANS/ANSA, Client Plan & Progress Note documentation
- Identify and document key components of establishing Medical Necessity for the provision of Specialty Mental Health Services (SMHS)
- Identify and document key components of the Mental Health (MH) Assessment utilizing the newly revised forms and templates

Training Objectives Continued

- Collect Sexual Orientation and Gender Identity (SOGI) data during the MH Assessment process in sensitive manner
- Identify and document key components of the Client Plan utilizing the new forms and templates
- Identify and document the key requirements of Progress Notes and frequently used Mental Health Service & Procedure Codes

Training Objectives Cont.

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

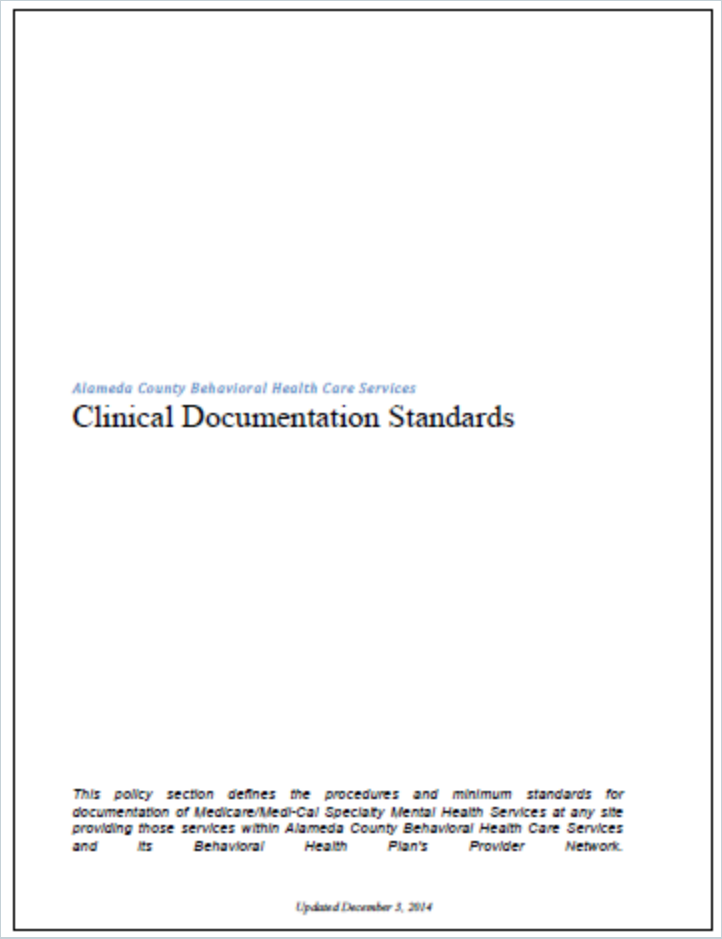
ACBHCS Audits Claims Disallowance Rates

- Target claims disallowance rate < 5%
- Jan 2017 DHCS Triennial Audit: 18%
- Jan 2013 DHCS Triennial Audit: 50%
- Four Quarterly Internal ACBHCS System of Care Audits from 2015-Q4 to 2016-Q3 (four audits):
  - Across all Provider (CBO & County): 28% disallowance
  - Across all County TAY, Adult and Older Adult Clinics: 45% disallowance
  - Across all County Early Childhood and Child Clinics: 16% disallowances

DHCS Sanctions, Fines & Penalties

- In 2017, CA Department of Health Care Services (DHCS) is required by the Center for Medicare and Medicaid Services (CMS) to levy Sanctions, Fines & Penalties for poor County Mental Health Plans Audit Findings.
- Possibilities include:
  - Treble penalties: a $5,000 audit disallowance results in an additional $15,000 penalty
  - Extrapolating 45% disallowance rate from 30 charts in a specific Audit to all Medi-Cal claims billed to DHCS for up to three years, resulting in 45% recoupment for all Medi-Cal claims received in the past 1 - 3 years
  - DHCS Audits to be held every year (or two years) rather than three years
  - Worse case: not authorizing the Waiver for Counties being the sole Provider of MH Services (privatizing Mental Health Medi-Cal)

ACBHCS Clinical Documentation Standards Manuals-**Update Pending**



Alameda County Behavioral Health Care Services

Clinical Documentation Standards

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

Updated December 3, 2014

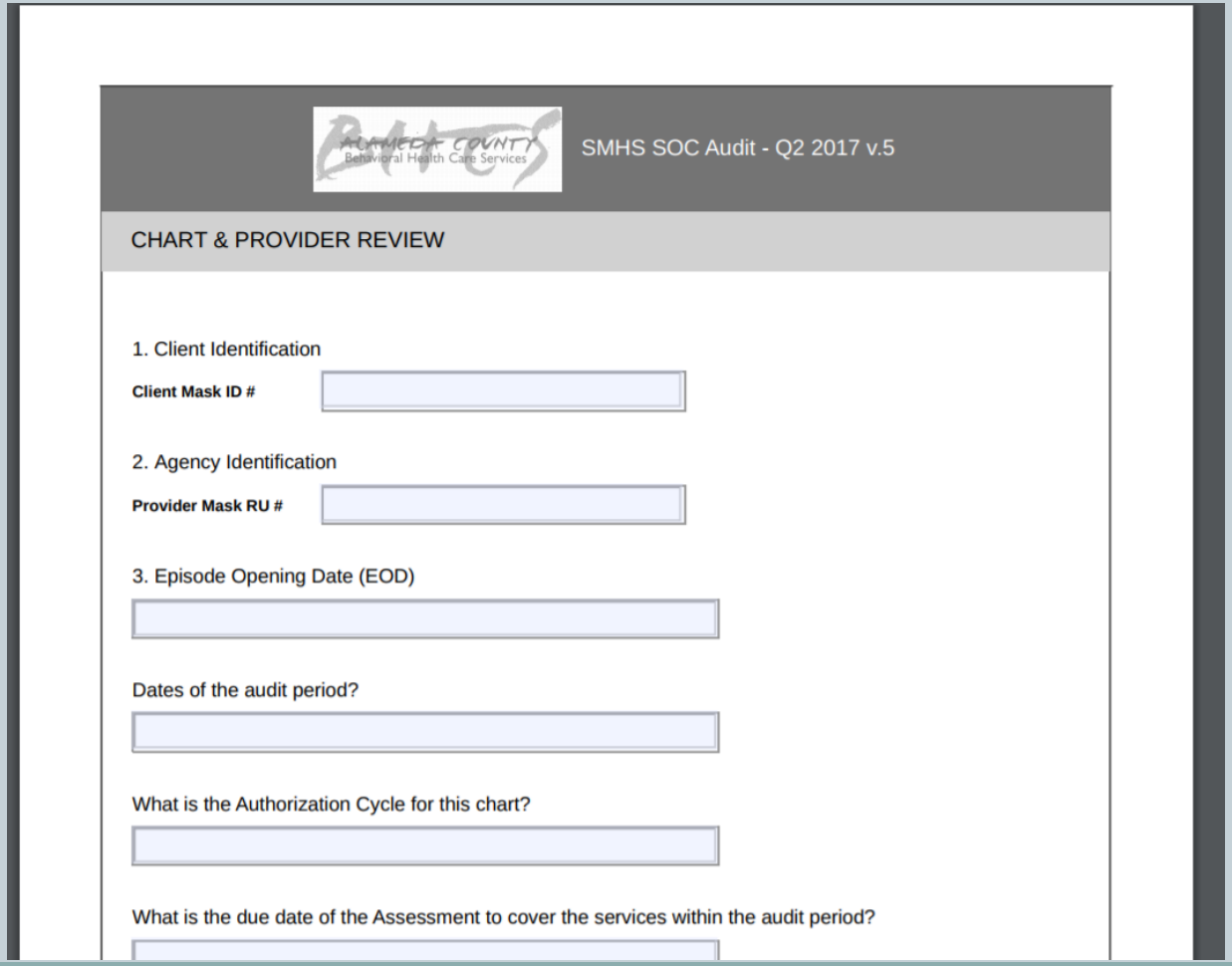
Quality Tools on Provider Website

http://www.acbhcs.org/providers/Main/Index.htm

Audit Tools for Mental Health Services

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

Audit Tool



SMHS SOC Audit - Q2 2017 v.5

CHART & PROVIDER REVIEW

1. Client Identification

Client Mask ID #

2. Agency Identification

Provider Mask RU #

3. Episode Opening Date (EOD)

Dates of the audit period?

What is the Authorization Cycle for this chart?

What is the due date of the Assessment to cover the services within the audit period?

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

ATTEND March 2nd Training for New REQUIRED Processes

- The primary purpose of the Agency CQRT is to review medical necessity, service necessity, review the quality of the chart documentation, and authorization of services for the next treatment cycle.
- **For Agency CQRT meetings**: licensed, waivered, or registered LPHA's (Licensed Practitioner of the Healing Arts), and MH Student Trainees with the Scope of Practice to Diagnose participate in chart reviews.
- **For Agency CQRT meetings:** only Licensed LPHA's (Licensed Practitioner of the Healing Arts), authorize treatment services.

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

- Charts are reviewed based on the date of the case episode opening. The review cycle begins on the first of the month in which the episode was opened.
  - Outpatient services are reviewed at 60 days (unless Complete Assessment and Client Plan done or DUE earlier) and annually.

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

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

- Charts must contain all of the elements required by Medi-Cal Documentation Guidelines. The **required form is the CQRT Chart Review Checklist**. (It may be maintained outside the chart and is requested when a chart is pulled for an Audit.)
- The chart is then authorized with the **required SMHS Authorization Form**. This must be maintained in the Client Record.
- The **Clinical Review** ensures that ongoing Medical & Service Necessity has been documented.
  - *Is there an completed Assessment with Medi-Cal Necessity & a Treatment Plan?*
  - *Is there evidence that progress is being made toward the goals/objectives and is the client is benefitting from treatment?*
  - *Are the required dated signatures on the Brief Screening, Informing Materials Page, Assessment/CANS/ANSA, Treatment Plans, and Progress Notes.*
  - *The CQRT Clinical Review Chart Checklist is required and utilized for this level of review.*

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

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

- The chart is reviewed using the required CQRT Clinical Review Chart Checklist .
- There must be a continuity *("Golden Thread")* between the **Assessment** & Included Medi-Cal Diagnosis, the **Treatment Plan** Mental Health Goals & Objectives, and the interventions documented in the **Progress Notes.**

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

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


F.Y.I.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SO/GI Data Collection
Required at time of MH Assessment

- 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 LGBT people from health surveys.

Why Collect SO/GI Data?

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

http://www.lgbthealtheducation.org/

- Refer to Training Slides in Resource Power point
- For providers who do not use CG, see the sample M/C compliant MH Assessments (Short & Long forms)on the Provider Website.
- **Clinical Templates links:**
  - Adult's Services
  - Children's Services

Why Collect SO/GI Data?

- Lesbian, gay, bisexual, and transgender (LGBT) clients have unique health needs and experience **numerous health disparities**
- They are an underserved population that is largely **invisible** in the health care system
- Routine and standardized collection of sexual orientation and gender identity (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**

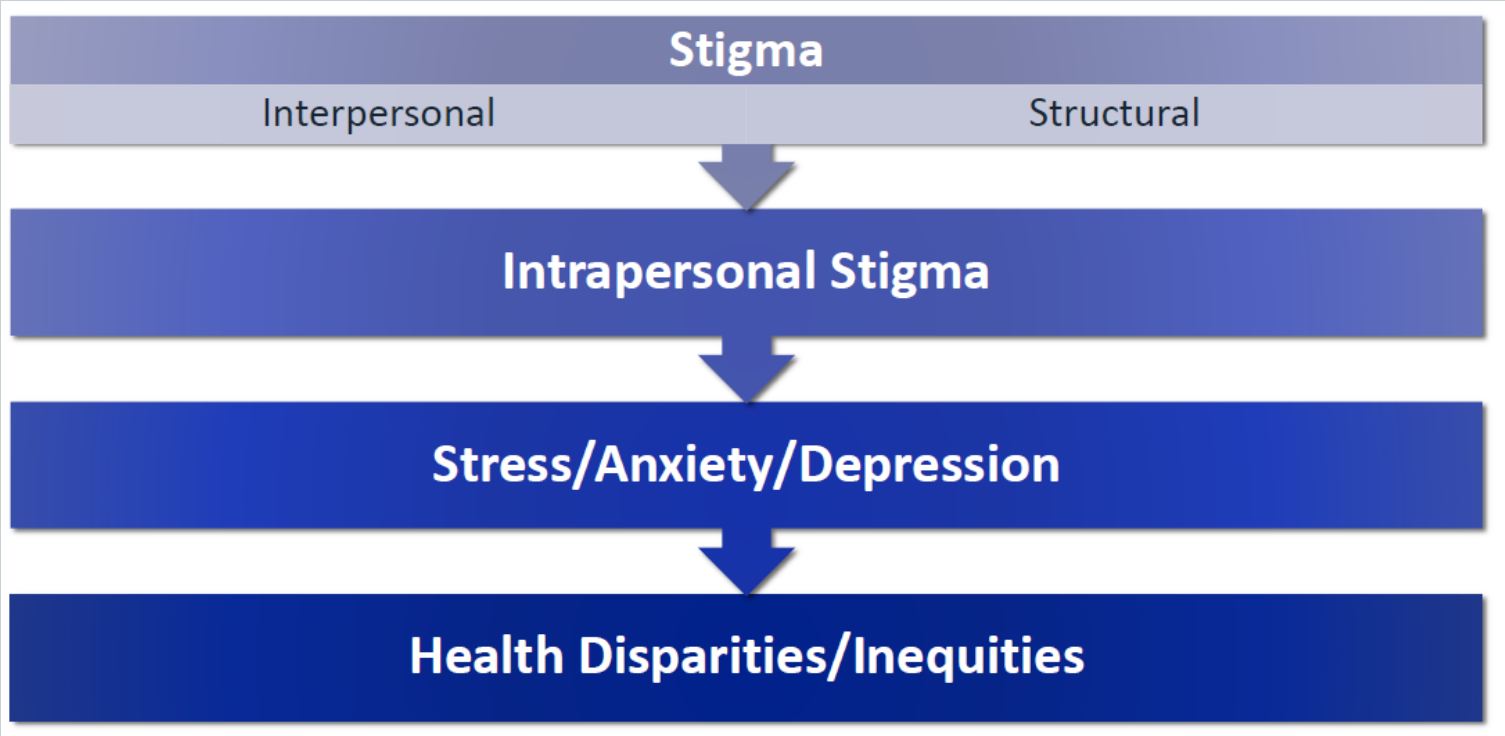
Why Collect SO/GI Data?

A lifetime of challenges and discrimination

- Social determinants affecting the health of LGBTQ individuals largely relate to **systemic oppression and discrimination.**
- 2004-2005 national behavioral surveillance system found that 61% of Men who have sex with Men (MSM) in NYC **did not disclose** same-sex behaviors to their medical providers.

Why Collect SO/GI Data?

Stigma, Discrimination & Health



Hatzenbuehler, ML, Link, BG. 2014

Why Collect SO/GI Data?

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

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

LGBT youth are more likely to be homeless.

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

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

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

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

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

Why Collect SO/GI Data?

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

- The most common mental health concerns described by LGBTQ youth were isolation, depression, suicide, and drug and alcohol abuse.
- Most of the mental health issues faced by LGBTQ youth were directly related to the harassment and bullying they face in their daily lives, and rejection and isolation by their families, peers, and social organizations (e.g., churches).
- Isolation and the feeling of "not belonging" were particularly salient for the transgendered community.

Why Collect SO/GI Data?

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

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

Why Collect SO/GI Data?

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

- LGBTQ youth related experiences of not being understood and not being taken seriously by counselors and therapists.
- Participants also described experiences of discrimination with health care providers—doctors, nurses, and office staff—who had been disrespectful or had expressed antagonism and discomfort because of the sexual orientation of the person seeking care.
- These experiences create a sense of mistrust in LGBTQ youth and a reluctance to seek services.
- LGBTQ youth of color present a special challenge for service providers in that therapists need to be able to relate to both their experiences faced as LGBTQs and also as LGBTQs of color.

Why Collect SO/GI Data?

Understanding LGBT People

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

Discussing SO/GI Sensitively

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

Discussing SO/GI Sensitively

Avoiding Assumptions

- You cannot assume someone's gender or sexual orientation based on how they look or sound
- To avoid assuming gender or sexual orientation with new clients:
  - Instead of: *"How may I help you, sir?"*
    - Say: *"How may I help you?"*
  - Instead of: *"He is here for his appointment."*
    - Say: *"The client (or preferred name) is here in the waiting room."*
  - Instead of: *"Do you have a wife?"*
    - Say: *"Are you in a relationship?"*
  - Instead of: *"What are your mother and fathers' names?"*
    - Say: *"What are your parents' names."*

Discussing SO/GI Sensitively

IDENTIFYING BEST PRACTICES

1. Creating the right team for SO/GI data collection (MH Staff, Registration/Support Staff, medical records, EHR).
2. Privacy & sensitivity issues (awareness of legal protections).
3. Appropriate language and client safety.
4. 2-step gender question.

Discussing SO/GI Sensitively Cont.

Questions vetted and recommended by national LGBTQ organizations include:

Two-step sex/gender question:

1. *What is your current gender identity: male, female, transgender, or other? (For written—select from list.)*
2. *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 Cont.

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.

Discussing SO/GI Sensitively Cont.

Recommendations for Assessment Clinician—Confidentiality & Privacy (cont.):

- 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 the fact that one hands a filled out intake/registration form to a reception staff person
- 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.

Discussing SO/GI Sensitively Cont.

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

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

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

Discussing SO/GI Sensitively Cont.

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

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

Discussing SO/GI Sensitively Cont.

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

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

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

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

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

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

The Golden Thread

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

Medical Necessity for Outpatient Specialty Mental Health Services

- Medical Necessity criteria for outpatient Specialty Mental Health Services are set forth in the California Code of Regulations, Title 9, Title 22; Code of Federal Regulations, Title 42, MHSD Information Notices (*Includes DHCS Audit Protocol)*, and DHCS/MHP Contract.

- In order for outpatient Specialty Mental Health Services to be reimbursable through the Medi-Cal Program, all three of the required medical necessity elements must be applicable and be documented in the beneficiary's record.

Medical Necessity Criteria (1 of 3)

Must meet the following three criteria:

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

All Dx must indicate:

1.) ***The ICD-10 Code.***

2.) ***The DSM-5* Description (name) WITH all Specifiers***

for Codes that do not have a DSM-5 descriptor, such as F84.5, F84.9, F84.2, F84.3 & F84, list the ICD-10 Descriptor (Dx Name)

3.) ***DHCS also recommends indicating the ICD-10 Descriptor (Dx Name)—but not required by ACBHCS at this time.***

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

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

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

Must have all, A, B, and C:

A. Diagnoses

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

Included Diagnoses:

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

Excluded Diagnoses:

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

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

B. Impairment Criteria

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

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

C. Intervention Related Criteria

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

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

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


F.Y.I.

Medical Necessity Criteria (2 of 3)

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

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

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

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

- **<u>If the client has had recent (within the last 3 months of indication) H/I, S/I, or other high risk conditions, a comprehensive safety MH objective – or preferably Safety Plan – must be created for treatment purposes.</u>**

Medical Necessity Criteria (3 of 3)

<u>Criteria #3</u>: A qualifying intervention (meets ***<u>all three</u>*** of the following)

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

Medical Necessity & Key Documents

- The **Initial Assessment** (due* within 60 days of EOD) & the ongoing **Annual Assessment** (done within the month preceding the EOD anniversary month) documentation establishes Medical Necessity.
- 'The **Client Plans** due* within 60 days (include EOD as day 1) and annually thereafter which are based on the Initial Assessment and ongoing assessments.
- **Note, Planned Services MAY NOT be provided until a Client Plan is in place and at least a Interim MH Assessment.**
- **Progress Notes** must contain evidence that the services claimed for reimbursement meet Medical Necessity by linking to a specific current MH Objective.

**For outpatient specialty MH services, see Clinical Doc Manual (and agency contracts) for exceptions:*

Brief Screening Tool

- All clients must be screened for *Mild to Moderate (referred to Beacon for MH Services)* vs. *Moderate to Severe* (seen by ACBHCS Providers) criteria.
  - Screening is done upon referral, at Plan Update and before Annual Assessment, at either point:
    - **If the client does not meet *Moderate to Severe* criteria they must be referred out to a Beacon Provider.**
  - Only Exceptions: Out of County, TBS Workers, Crisis, Conservatorship & Guidance Clinic

- Administration of the Brief Screening Tool is NOT A billable service.
- May be completed only by Licensed/Waivered/Registered LPHA.
  - Waivered or Registered LPHA require a Licensed LPHA co-signature.
- See ACBHCS Providers Website/Forms/Access/Screening for MH Services: http://www.acbhcs.org/providers/Forms/Forms.htm
- Use appropriate form based on age.
- If Mild – Moderate, claim to, or refer to (form needed) to Mild-Moderate Provider

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

MEMBER INFO

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

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

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

Caregiver/Guardian: _____ Phone: (___) _____

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

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

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

Primary Care Provider _____ Phone: (___) _____

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

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

Referring Provider Name: _____ Phone: (___) _____

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

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

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

Current symptoms and functional impairments: _____

_____

Brief Patient history: _____

_____

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

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

For Receiving Clinician Use ONLY

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

Date communicated assessment outcome with referral source: _____

FINAL Alameda County Behavioral Health Care Services March 2015

ALAMEDA COUNTY
Behavioral Health Care Services

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

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

Member Demographics

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

Client phone _____ Medi-Cal Health Plan _____

Medi-Cal ID# _____ Language/Cultural Requirements _____

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

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

Transition Request Details

Reason for transition

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

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

☐ Other _____

Member notified of transition for services: ☐ Yes ☐ No

Medication Management requested/ to be managed by:

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

Therapy requested/to be managed by:

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

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

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

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

Sending Clinician Info

Staff name: _____ Title/licensure: _____

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

Updated 4.17.2015

BEACON

F.Y.I.

Clinical Information

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

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

Medication	Dose	Last Change Date

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

☐ Medication Management ☐ Psychological Testing ☐ Individual/Group Therapy

☐ TBS ☐ Case Management ☐ Wrap services

☐ Crisis Intervention ☐ Other _____

Risk Factors:

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

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

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

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

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

Relevant Clinical information:

Updated 4.17.2015

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

KEY CONTACT INFORMATION

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

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

Managed Care Plans (MCP):

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

DIRECTIONS FOR USING THE SCREENING TOOL FORM

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

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

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

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

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

ADULT SCREENING TOOL CRITERIA DESCRIPTIONS:

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

CHILD SCREENING TOOL CRITERIA DESCRIPTIONS:

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

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

Compliance

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

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

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

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

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

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

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

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

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

10. Can we bill for the screening?
    No.

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

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

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

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

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

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

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

Who Must Complete the Screening Tool?

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

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

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

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

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

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

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

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

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

Questions about Certain Situations

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

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

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

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

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

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

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

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

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

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

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

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

MH Assessment – Informing Materials

- Informing Materials required at Initial and Annual Assessments.
  - Recommended at first visit as includes Consent to Treatment
- ACBHCS' Informing Materials Packet is required to be used.
  - http://www.acbhcs.org/providers/QA/General/informing.htm
  - Provider may add additional forms as needed.
- ACBHCS' Informing Materials Signature Page is highly recommended to be used and must be maintained in client record.
  - If agency form is used—all county form elements must be present and readily identifiable.
  - Note all boxes must be checked (as addressed) and signed.
  - May utilize form by client initial for four additional occurrences.

MH Assessment – Informing Materials Signature Page

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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.)

MH Assessment
Step 1 of the Golden Thread *continued*

- Initial Assessment must be completed within 60 days* of the Episode Opening Date (EOD) *based on a soft count*.
- Annual Assessments after that must be completed within the 30 day* period prior to the first day of the Episode Opening Month (EOM).
  - *E.G.* Episode Opening Date (EOD) 8/28/16 and Assessment due by 10/26/16 (actual 60 day count) before claiming for planned services.
  - Annual Assessment must be completed in July 2017 and all required signatures must be obtained no later then 7/31/2017 (in order to claim planned services).
- See Due Dates Chart
- **Unplanned Services:**
- **No services other than Assessment (includes CANS/ANSA), Interactive Complexity, Plan Development and Crisis Psychotherapy (Intervention) may be claimed until both the MH Assessment and Client Plan are completed. In addition, DHCS has added two new categories of Unplanned Services: TCM/ICC Case Management Brokerage for Referral and Linkage purposes only, and Urgent Medication services. Record must clearly document these purposes in order to be claimed (at any time a Client Plan is not in place).**

MH Assessment
Step 1 of the Golden Thread *continued*

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

- A Waivered/Registered LPHA: 1.) may conduct a MSE and establish a diagnosis (with licensed LPHA co-signature), 2.) May complete a MH Assessment and 3.) may sign a MH Assessment.
  - Assessment do not require a co-signature by a Licensed LPHA unless within the MH Assessment the waivered/registered Intern is establishing the Dx

- Graduate Students: 1.) may not establish a diagnosis, 2.) may complete a MH Assessment and 3.) may sign a MH Assessment with a Licensed LPHA co-signature.
  - *Must indicate* in the Assessment *that a diagnosis was recently made by a licensed LPHA (best within their program), if they name who made the Diagnosis, their LPHA designation (LMFT, MD, LCSW, etc.), and the date Dx was made. A co-signature to the Assessment does not suffice!*
  - ***New Exception: A Second Year (FTE) MH Graduate Student/Trainee may conduct a MSE and diagnose WITH Written attestation (placed in personnel file) by the current Licensed Clinical Supervisor of the Trainee that the student has sufficient education, training and experience to diagnose independently with the Licensed Supervisor's on-going full record review, supervision and co-signature.***

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

MH Assessment
Step 1 of the Golden Thread *continued*

- An MHRS and Adjunct Staff may ONLY gather demographic & client/family reported non-clinical assessment information.

- ***New:*** **MHRS & Adjunct Staff may collect self-report information in the areas of: mental health and medical history; substance exposure and use; identifying strengths, risks and barriers to achieving goals; and demographic information IF the agency determines this is within their Scope of Ability, training & experience.**

  - Must enter information into the progress note, not into the assessment.
  - Note will generally indicate: *"Client/Family Member/Other reports _____."*

Medical Records Dx Documentation

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

Medical Records Dx Documentation Cont.

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

Medical Records Dx Documentation Cont.

- Medical Record Documentation will follow DSM-5 guidelines (utilizing DSM-5/ ICD-10 codes). DSM-IV-TR codes and conventions will no longer be followed.
- *Medi-Cal will require that documentation for each Dx within the Assessment clearly documents the diagnostic criteria established in the DSM-5.*
- The only exception is if an additional (non-Primary) Dx is listed as "by history" (such as for an excluded or physical health Dx). In that case, indicate "by history" and the source of the data.

Medical Records Dx Documentation Cont.

- Note, than when entering the ICD-10 Dx Code—the full DSM Description (Dx name) with Specifiers ALSO must be noted.
  - If there is no DSM-5 descriptor—use the ICD-10 descriptor (name)
- *DHCS also recommends* additionally including the ICD-10 Description (Dx name).
- Clinician's Gateway will have both.

Medical Records Dx Documentation Cont.

- **For MH Services, these are the required fields:**
  - ICD-10 Primary **Included Medi-Cal MH Diagnosis** (see attached) ICD-10 Code, DSM-5 Description w/ Specifiers (If no DSM-5 descriptor—use ICD-10 descriptor.)
  - ICD-10 For any additional MH Diagnoses (start with any additional Included, followed by any additional Excluded Dx's—in order of priority for MH treatment) ICD-10 Code, DSM-5 Description w/ Specifiers (If no DSM-5 descriptor—use ICD-10 descriptor.)
  - ICD-10 SUD Diagnoses (**all** are Excluded Dx) ICD-10 Code, DSM-5 Description w/ Specifiers (If no DSM-5 descriptor—use ICD-10 descriptor.)
  - ICD-10 Medical Diagnoses (or General Medical Codes—see earlier slide. If GMC Codes are utilized in the Medical Record they must also be described by name.)
  - ICD-10 Psycho-Social Conditions' Diagnoses-principal listed first (see attached)
  - Optional Disability Score: WHODAS or other.

Clinician's Gateway MH Dx Fields

DSM-5: Mental Health

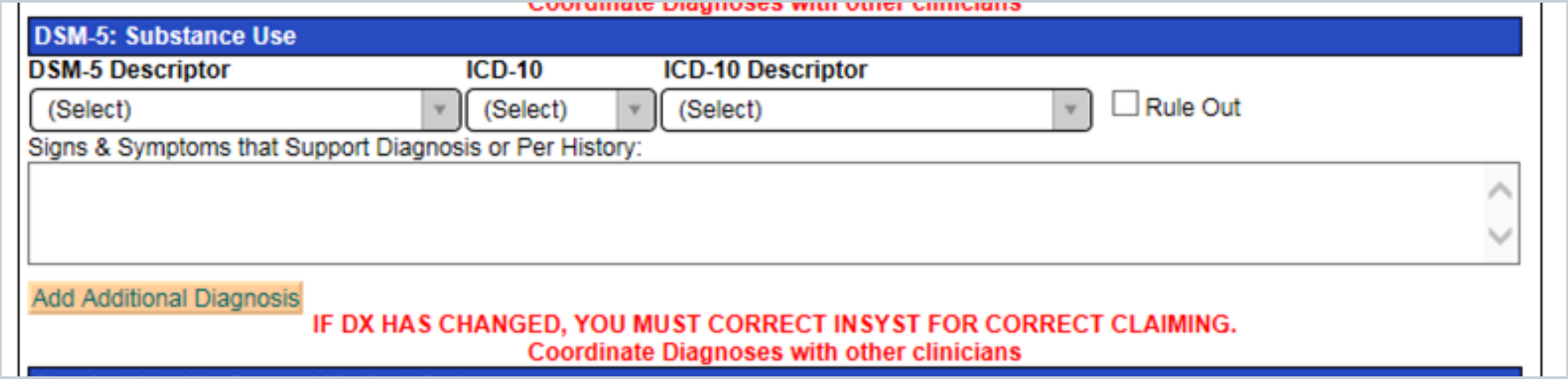
DSM-5 Descriptor	ICD-10	ICD-10 Descriptor	
(Select)	(Select)	(Select)	PRIMARY

Signs & Symptoms that Support Diagnosis or Per History:

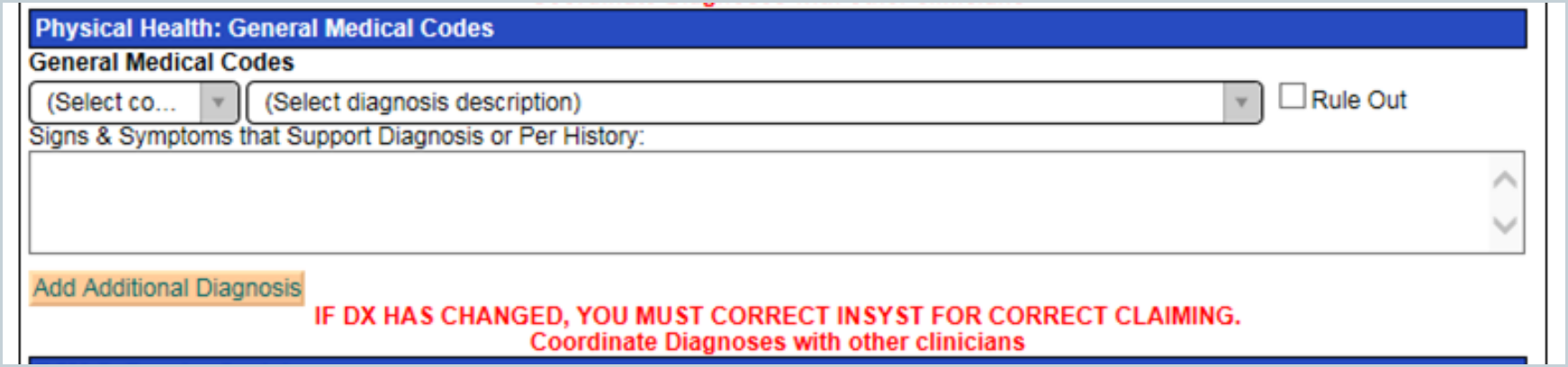
Add Additional Diagnosis

IF DX HAS CHANGED, YOU MUST CORRECT INSYST FOR CORRECT CLAIMING.
Coordinate Diagnoses with other clinicians

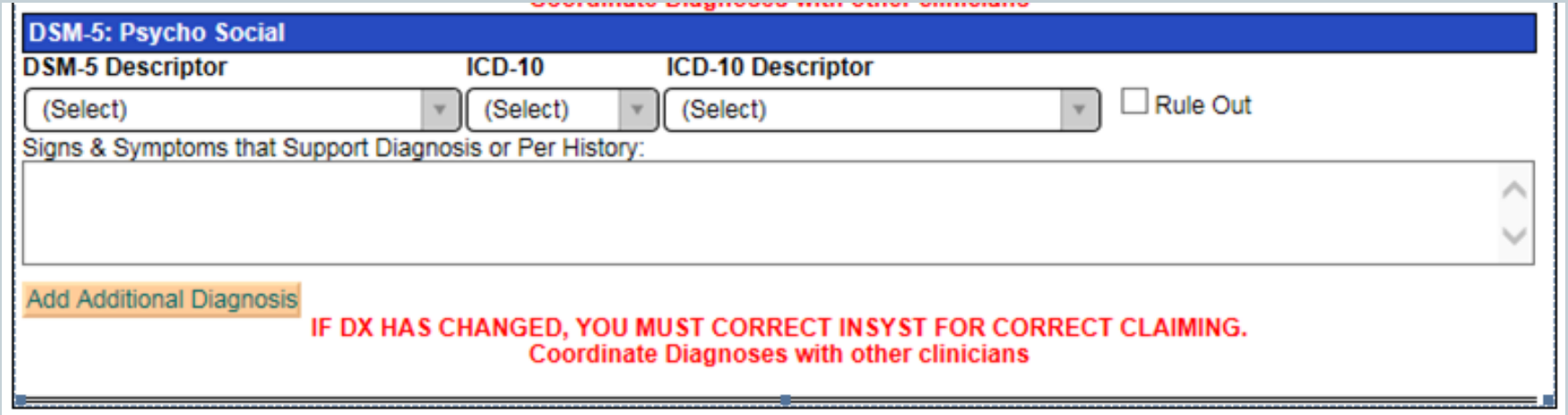
Clinician's Gateway MH Dx Fields Cont.



Clinician's Gateway MH Dx Fields Cont.



Clinician's Gateway MH Dx Fields Cont.



Clinician's Gateway MH Dx Fields Cont.

From the tops of the notes and assessments:

Instructions and Pre-Existing Diagnoses

Respond to problems/goals/objectives of treatment plan and signs and symptoms related to diagnosis. Include treatment interventions and address changes in the client's functioning. If there is little progress, include an explanation of the limited progress.

Primary FF Time 00:24 Hours:Minutes

Services were provided in English

by ☐ interpreter or ☐ clinician

Episode Diagnosis Information

	Primary	Secondary	Tertiary	GMC	SU
ICD-10:	F31.2	R69	A99.99	00.00.00	A99.99

IS Help Desk Contact

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

DSM-5 & ICD-10 Cont.

DSM-5 & ICD-10 Training Resources

- **YouTube Videos (search for DSM-5):**
  - **Recommended**:
    - Introduction: Using DSM-5 in the Transition to ICD-10: https://www.psychiatry.org/psychiatrists/practice/dsm/icd-10
    - Comprehensive: Changes from DSM-IV to DSM-5: https://youtu.be/7XIFqSm_eEA
  - Additional:
    - DSM-5 Update for Mental Health Counselors: https://youtu.be/48gDxzlmzEM
    - Clinical Assessment DSM-5 Part 1 (Family Therapy): https://youtu.be/BjnPfFS4-yo

- **American Psychiatric Association DSM-5 Texts: https://www.appi.org/products/dsm-manual-of-mental-disorders**
  - **Recommended for each clinic**: DSM-5 Texts: Desk Reference, Study Guide & Clinical Cases,
  - **Readily access recommended to assessment clinicians**: DSM-5 Pocket Guide (paper or mobile guide):

DSM-5 & ICD-10 Cont.

DSM-5 & ICD-10 Training Resources Cont.:

- **American Psychiatric Association DSM-5 Educational Resources and Diagnostic & Coding Clinic https://www.psychiatry.org/psychiatrists/practice/dsm**
  - **Highlights of Changes from DSM-IV-TR to DSM-5**

    http://www.dsm5.org/Documents/changes%20from%20dsm-iv-tr%20to%20dsm-5.pdf

- **Fact Sheets (Overall Changes and Disorder Specific):**
  - **https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/dsm-5-fact-sheets**

DSM-5 & ICD-10 Cont.

DSM-5 & ICD-10 Training Resources Cont.:

- **Specific Fact Sheets (Overall Changes and Disorder Specific):**
- **Attention-Deficit/Hyperactivity Disorder**
- **Autism Spectrum Disorder**
- **Bereavement Exclusion**
- **Conduct Disorder**
- **Disruptive Mood Dysregulation Disorder**
- **Eating Disorders**
- **Gender Dysphoria**
- **Intellectual Disability**
- **Internet Gaming Disorder (Section III)**
- **Mild Neurocognitive Disorder**
- **Mixed Features Specifier**
- **Obsessive Compulsive Disorder**
- **Paraphilic Disorders**
- **Personality Disorders**
- **Posttraumatic Stress Disorder**
- **Schizophrenia**
- **Sleep-Wake Disorders**
- **Social Anxiety Disorder**
- **Social (Pragmatic) Communication Disorder**
- **Somatic Symptom Disorder**
- **Specific Learning Disorder**
- **Substance Use Disorder**

DSM-5 & ICD-10 Cont.

DSM-5 & ICD-10 Training Resources Cont.:

- **American Psychiatric Association DSM-5 Educational Resources and Diagnostic & Coding Clinic https://www.psychiatry.org/psychiatrists/practice/dsm Online**

- **Assessment Measures:** https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/assessment-measures

- **Webinars:**
  - **Transitioning to DSM-5 and ICD-10-CM (free)** http://education.psychiatry.org/Users/ProductDetails.aspx?Activityid=381&ProductID=381
  - **DSM-5: Substance Related and Addictive Disorders (free)** http://education.psychiatry.org/Users/ProductDetails.aspx?Activityid=375&ProductID=375

DSM-5 & ICD-10 Cont.

DSM-5 & ICD-10 Training Resources Cont.:

- **American Psychological Association Recommendations by topic (includes written and digital):** http://www.apa.org/search.aspx?query=dsm-5
- **National Association of Social Workers: CA Chapter, DSM-5 Resources:** http://www.naswca.org/?177
- **American Counseling Association DSM-5 Resources (free podcasts):** https://www.counseling.org/search-results?q=dsm-5
- **American Mental Health Counselors Association DSM-5 Resources:** http://www.amhca.org/search/all.asp?bst=dsm-5
- **Additional Resources for a fee:**
  - **APA: DSM 5: What You Need to Know**
    http://education.psychiatry.org/Users/ProductDetails.aspx?Activityid=1310&ProductID=1310

DSM-5 & ICD-10 Cont.

DSM-5 & ICD-10 Training Resources Cont.:

- **22 Hours of Online CEU Videos**
  - Understanding the DSM-5: Critical Issues and Diagnostic Revisions (6-hour version)
  - Understanding the DSM-5: Critical Issues and Diagnostic Revisions (4-hour version)
  - Understanding the DSM-5: Autism Spectrum Disorder & the Neurodevelopmental Disorders
  - Understanding Feeding and Eating Disorder in the DSM-5
  - Internet Addiction and the DSM-5
  - Understanding the DSM-5: Substance-Related and Other Addictive Disorders
  - The DSM-5 and the ICD-10-CM: Comparisons and Crosswalk

MH Assessment
Step 1 of the Golden Thread *continued*

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

Modifying Assessment for Case Management Services

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

MH Assessment
Step 1 of the Golden Thread *continued*

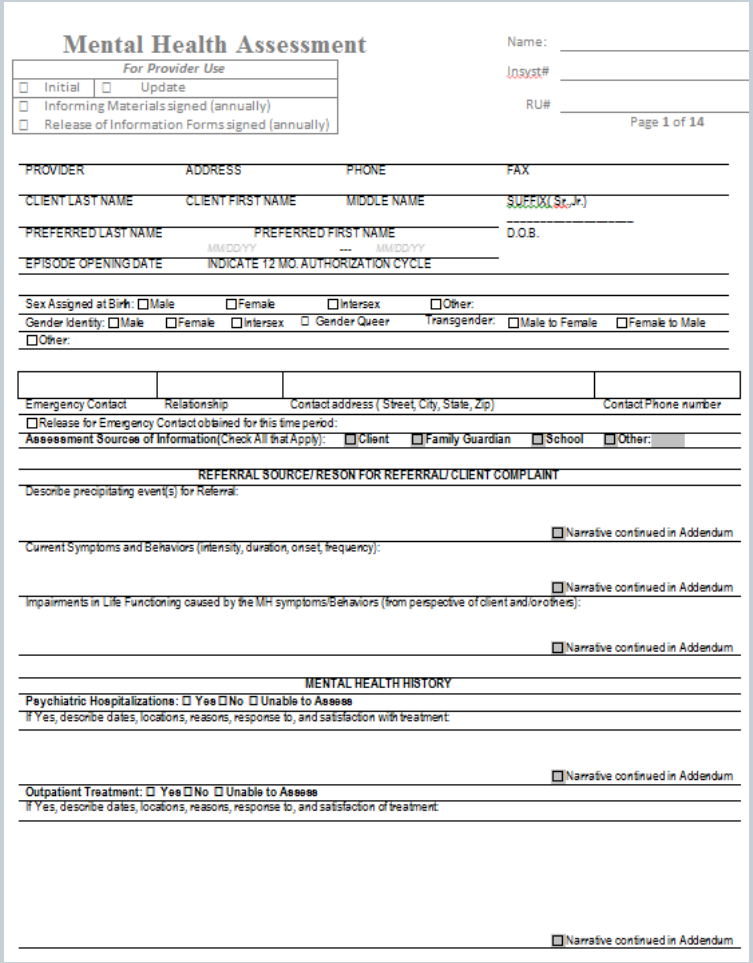
- If information is gathered AFTER the initial assessment has been completed, an Assessment Update MUST be used instead of adding to the original Assessment
  - An Assessment Update should be used to update (such as Dx) or to confirm information in the original Assessment.
    - An Assessment Update MUST BE IN A formal Addendum to the Assessment, and then incorporated into the next Annual Assessment.
    - Recommended components of the MH Assessment Addendum include:
      - the interim history,
      - any changes in all of the areas of the MH Assessment previously collected,
      - A current included (aka "Covered") diagnosis,
      - Signs and symptoms of the Diagnosis that meet DSM criteria,
      - Functional impairments as a result of that Diagnosis,
      - Level of impairment, and
      - Client's ability to benefit from treatment.
      - Date of Completed MH Assessment of which this Addendum is addressing

M/C Compliant MH Assessment Form Templates

ACBHCS/Forms/
Clinical/Adult or Child/
Assessment

Refer to the 06.08.2017 memo:

http://www.acbhcs.org/providers/QA/memos.htm



Mental Health Assessment

Name: _____

Insyst# _____

RU# _____

Page 1 of 14

For Provider Use

☐ Initial ☐ Update
☐ Informing Materials signed (annually)
☐ Release of Information Forms signed (annually)

PROVIDER | ADDRESS | PHONE | FAX

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

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

EPISODE OPENING DATE | INDICATE 12 MO. AUTHORIZATION CYCLE

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

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

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

☐Release for Emergency Contact obtained for this time period:

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

REFERRAL SOURCE/ RESON FOR REFERRAL/ CLIENT COMPLAINT

Describe precipitating event(s) for Referral:

☐Narrative continued in Addendum

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

☐Narrative continued in Addendum

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

☐Narrative continued in Addendum

MENTAL HEALTH HISTORY

Psychiatric Hospitalizations: ☐ Yes ☐No ☐ Unable to Assess

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

☐Narrative continued in Addendum

Outpatient Treatment: ☐ Yes ☐No ☐ Unable to Assess

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

☐Narrative continued in Addendum

CANS / ANSA

- **The CANS (0-5, 6-17) ANSA (T, 25+) is completed after the MH Assessment and before (informs) the Client Plan.**
  - **Required timeframes: by 60 days of EOD, in month preceding the 6th month mark, at annual authorization, with every Plan update, and at discharge.**
- **For Adults, ANSA**
  - **Same required timeframes.**
- **ACBHCS Provider Website/ CANS/ANSA**

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

CANS /ANSA

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

Medical Necessity & Assessment Review

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

- MH Assessment (with & w/o medical component, & behavioral eval)
- Plan Development
- Crisis Intervention
- Crisis Stabilization (in CSU only)

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

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

What is the recommended two tools to review and Authorize charts for Quality and Claims compliance?

- SMHS Authorization Form and CQRT Chart Review Checklist

Medical Necessity & Assessment Review Cont.

What are the three requirements for Medical Necessity?

- An Included Dx which is the Primary Focus of Tx
- A Qualifying Impairment
- A Qualifying Intervention

When must a client be screened with the Brief Screening Tool

- Before Treatment, Annually and at every Client Plan Update.

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

- 60 days

As a rule, may any planned services be provided before completion of both?

- **No**

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

- Waivered or Registered LPHA.

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

- Graduate trainee/student—unless meets additional Scope of Practice Requirements
- If they do not meet the additional Scope of Practice Requirements: even with a licensed co-signature on the MH Assessment—within the MH Assessment it must be indicated by name which licensed LPHA made the Dx and on which date.

Client Plan
Step 2 of the Golden Thread continued

- **Treatment Plan Cycle:** Treatment Plans are due* Initially (within 60 calendar days of episode opening date—EOD is day 1) and on an annual basis. The cycle must be kept in sync with the Episode Opening Date (EOD).

- Every Treatment Plan after that would be due on a 12 month cycle, completed within the 30 day period prior to the first day of the EOD month.
  - Example: EOD 8/18/14, then the Initial Plan is due: 10/16/14
  - The 2nd treatment plan is due by 8/1/15 and to be completed no earlier than 7/1/15.

- **No services other than Assessment, Plan Development, Interactive Complexity, and Crisis Psychotherapy (Intervention) may routinely be claimed until both the MH Assessment and Client Plan are completed.**

- **In addition, DHCS has added two new categories of Unplanned Services: TCM/ICC Case Management Brokerage for Referral and Linkage purposes only, and Urgent Medication services. Record must clearly document these purposes in order to be claimed (at any time a Client Plan is not in place).**

- ***Collateral may NEVER be claimed before the completion of the Client Plan (no exceptions apply) because the definition of a Collateral is contact with a significant support person to further the clients MH Objectives (listed in the Client Plan).***

Client Plan
Step 2 of the Golden Thread continued

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

Client Plan
Step 2 of the Golden Thread *continued*

Goals

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

Client Plan
Step 2 of the Golden Thread *continued*

Impairments of Functioning in Daily Life

- **Indicate Area of Difficulty:** *Community Life, Family Life, Safety School/Education, Vocational, Independent Living (ADL's), Health, Housing, Legal, SUD, Food/Clothing/Shelter, etc.*
- **Indicate Level of Difficulty**
  - **Mild, Moderate or Severe (Remember to rate accordingly 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.]*
  - *See "Detailed Interventions" section of the Client Plan for the third requirement for C/M Services—that when the C/M is successful the client's MH Sx's and resultant impairments will decrease.*

Client Plan
Step 2 of the Golden Thread *continued*

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

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

Client Plan
Step 2 of the Golden Thread *continued*

Service Modalities

- Identify the proposed type(s) of service modalities to be provided along with a proposed frequency and duration.
- **If the *planned* service modality for a claimed service is not in the client plan it MAY NOT BE CLAIMED and MUST be disallowed if it is claimed.**
  - **Exception Allowed Unplanned Services include (which may be provided while the Client Plan is pending): Case Management for Referrla and Linkage ONLY, URGENT Medication Services, Assessment, Plan Development, Interactive Complexity & Crisis Psychotherapy (Intervention).**

Example:

- Individual Psychotherapy 1x per week, and *(NOT "OR")* as needed, for 12 months;
- Case Management 1x per month, and as needed, for 12 months;
- Group Therapy 1x per week ("and as needed" probably not necessary here as all groups are scheduled), for 12 months;
- Collateral 1x per month, and as needed, for 12 months.

Adding "AND as needed" to the frequency of the service modality allows flexibility in the scheduling—however ***"as needed" alone will not suffice for frequency of modality and "or as needed" IS NOT ALLOWED. Both would result in Disallowances.***

Client Plan
Step 2 of the Golden Thread *continued*

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

Collateral (Includes: Collateral, Collateral-Caregiver, & Collateral-Health Care Provider)– Weekly and as needed, for 12 months
Case Management (Planned F/U Services) – Weekly and as needed, for 3 – 12 months
Medication Services **(NON URGENT)**– Monthly and as needed, for 12 months
Individual Therapy – Weekly and as needed, for 12 months
Individual Rehabilitation – Weekly and as needed, for 12 months
Group Psychotherapy – Weekly for 12 months
Group Rehabilitation – Weekly for 12 months
Family Therapy **WITH CLIENT PRESENT** – Weekly for 12 months
FAMILY PSYCHOTHERAPY WITHOUT CLIENT PRESENT NOW D/C AND CHANGED TO COLLATERAL—FAMILY COUNSELING.
Multi-Family Group Therapy **WITH CLIENT PRESENT** – Weekly for 12 months
Collateral Family Group **(with or without client present)** – Weekly for 12 months
TBS – Weekly and as needed, for 3 – 12 months
Katie A. - ICC – Weekly and as needed, for 3 – 12 months NOW SEPARATED OUT FROM:
Katie A. - IHBS – Weekly and as needed, for 3 – 12 months
Day Rehabilitation (1/2 or Full Day) – Daily, for 6 months
Day Treatment Intensive (1/2 or Full Day) – Daily, for 6 months
Psychological Testing (Includes Psych Test, Developmental & Neuropsych) – Weekly and as needed, for 3 months
Adult Residential – Daily for 6 – 12 months
Crisis Residential – Daily for 3 – 12 months
Crisis Stabilization – Daily for 3 months

Client Plan
Step 2 of the Golden Thread *continued*

Detailed Interventions

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

- Interventions must focus upon and address the identified functional impairments as a result of the mental disorder.
- Interventions must be consistent with the client plan mental health objectives and the qualifying diagnoses.
- Interventions for Collateral should include listing significant others (by names and/or roles) for whom contact is planned and indicating "and others as needed".
- 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)—If not in the detailed interventions—it must be documented somewhere in the Plan.

Client Plan
Step 2 of the Golden Thread *continued*

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

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

Client Plan
Step 2 of the Golden Thread *continued*

- Plans MUST be updated as client functioning improves or will likely deteriorate. Events such as a psychiatric hospitalization may trigger the need for a Plan Update.
  - **DHCS is now disallowing all claims after the date the Plan should have been updated.**

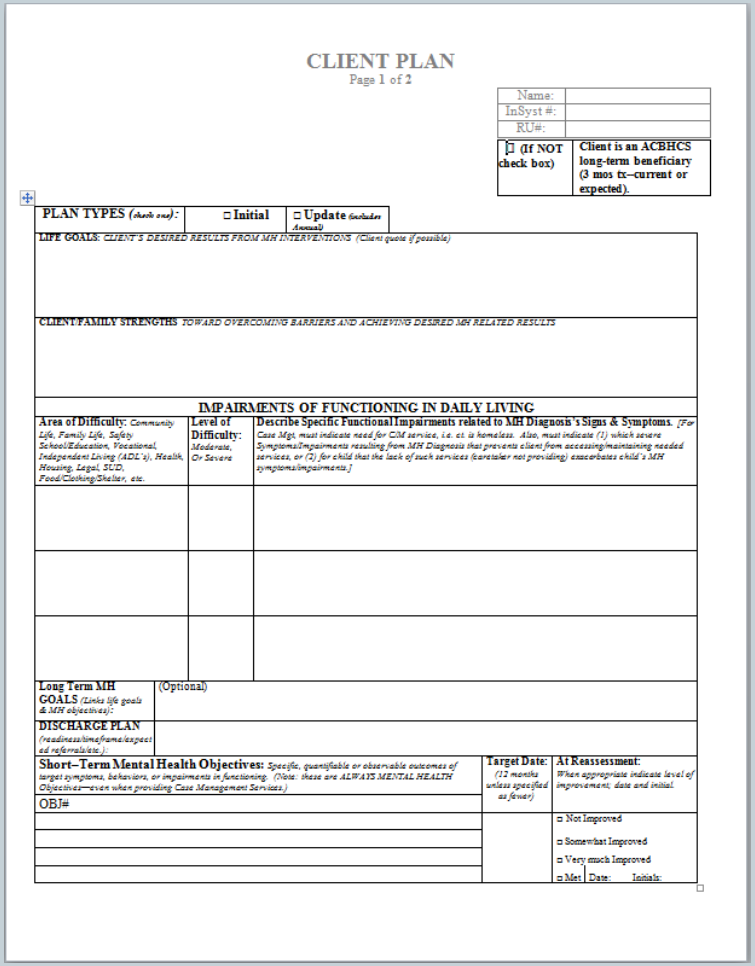
- All signatures are required on any Client Plan updates. (i.e. All required staff signatures & client/caretaker signature)
  - Therefore it is best to only have the Dx on the Assessment, as if it is on the Plan—when changed—the Plan must be modified and re-signed by all (MH Assessment only requires clinician's signature(s).)

Client Plan
Step 2 of the Golden Thread *continued*

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

Medi-Cal Compliant Client Plan Form Templates

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



CLIENT PLAN

Page 1 of 2

Name:	
InSyst #:	
RU#:	
☐ (If NOT check box)	Client is an ACBHCS long-term beneficiary (3 mos tx–current or expected).

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

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

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

IMPAIRMENTS OF FUNCTIONING IN DAILY LIVING

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

Long Term MH GOALS *(Links life goals & MH objectives):*	(Optional)
DISCHARGE PLAN *(readiness/timeframe/expected referrals/etc.):*	

Short–Term Mental Health Objectives: *Specific, quantifiable or observable outcomes of target symptoms, behaviors, or impairments in functioning. (Note: these are ALWAYS MENTAL HEALTH Objectives—even when providing Case Management Services.)*	**Target Date:** *(12 months unless specified as fewer)*	**At Reassessment:** *When appropriate indicate level of improvement, date and initial.*
OBJ#		
		☐ Not Improved ☐ Somewhat Improved ☐ Very much Improved ☐ Met Date: Initials:

Modifying Tx Plan for Case Management Services

- Within the Client Plan
  1) Identify ***MH*** objectives—do not indicate housing, job, SUD, etc.
  2) Indicate Service Modality: C/M Brokerage with frequency & timeframe.
     1) *Time Frame: Case Management services are short term (generally 3 – 6 months, if longer is anticipated as a possibility indicate both the minimum and maximum duration—i.e. 6 – 12 months).*
  3) For Detailed Interventions of C/M indicate linkage and monitoring for _____ (type of) community supports AND that successful C/M will result in the client's specific MH objectives being met (improved functioning).

Client Plan Review

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

- No

Is it NOW REQUIRED that Collateral be listed in the Client Plan before claiming for this service?

- Yes, Collateral activities support the Client Plan—and as such MUST be in place in the Plan before claiming.

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

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

Client Plan Review

101

When must the CANS/ANSA be completed?

- After completion of the MH Assessment and before completion of the Client Plan.
- At 30 days before 1st day of 6 months, at annual, when clinically indication results in revision to Client Plan, at discharge.

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

- August 1st – July 31st each year.

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

- Only if it for the purposes of Referral and Linkage

If planned services are immediately indicated, how would I address this?

- Do an abbreviated MH Assessment (in sections where the client cannot report—indicate such and your plan to seek the info elsewhere) and a Targeted Client Plan.
- Do an Interim MH Assessment and a (Interim) Client Plan
- Medical Provider may provide Psychiatric Assessment with Medical Component to complete Psychiatric Assessment and Meds Only Client Plan while prescribing, or document the "urgent" need for each medication service before the Plan is completed.

Client Plan Review Cont.

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

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

What two considerations must be further elaborated for each listed service modality, and which is highly recommended

- Frequency (required),
- Duration (required), and
- Detailed Interventions (best practice)

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

Billable example:

- **Dx: Major Depressive DO (lack of interest in all areas of life, low energy, insomnia, indecisiveness, feelings of worthlessness, and poor self-care)**
- **Impairments include Client's inability to participate in daily activities and to complete tasks including securing and maintaining housing due to: his severe symptoms of Major Depression of anhedonia, anergy, insomnia, indecisiveness, feelings of worthlessness and poor self-care.**
- **Goals: Client states: "I want my own place to live".**
- **Long Term MH Goal: Decrease depression symptomology, and increase coping, so that client's depressive signs and symptoms do not negatively impact his ability to meet his life goals.**
- **Detailed Intervention: The Successful provision of Case Management to link and monitor client's successful utilization of housing community supports is expected to reduce the client's depressive symptoms of anergy, anhedonia, insomnia, indecisiveness, feelings of worthlessness and poor self-care.**

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

Billable example cont.:

Mental Health Objective(s):

- **#1) Client's depressive symptoms are reduced as evidenced by an increase in sleep from 2-3 hours per night to 6-8 hours per night by 6 months; and an increase in energy from "2" energy level now to 6-8 on a 0-10 scale (10 being high energy) per self-report by 6-12 months.**
- **#2) Client is engaged and invested in his self-care as evidenced by increased # of showers per week from 0 to 2 or more; and increased brushing of teeth from 0x daily to once daily within the next 6-12 months.**
- **#3) Client 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 #1:
Impairment: Inability to maintain housing/placement cont.

Billable example cont.:

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

- **Detailed Interventions:**
  - Psychotherapy – CBT to help client link feelings of worthlessness to depressive symptoms, to explore roots of low self-esteem and areas of competence.
  - Group Rehab – build client's awareness to track and manage depressive symptoms, teach coping skills such as relaxation techniques, and build client's self-care skills.
  - Case Management – Successful linkage and monitoring/providing support to client to maintain needed housing community support services will decrease client's depressive symptomology of anergy, anhedonia, insomnia, indecisiveness, feelings of worthlessness and poor self-care.

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

Non-billable example:

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

MH Plan Example #2: Impairment: Cocaine dependence and abuse

Billable example:

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

MH Plan Example #2: Impairment: Cocaine dependence and abuse cont.

Billable example cont.:

Mental Health Objectives:

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

MH Plan Example #2: Impairment: Cocaine dependence and abuse cont.

Billable example cont.:

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

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

MH Plan Example #2: Impairment: Cocaine dependence and abuse.

Non-billable example:

- **Mental Health Objective**: Decrease client's use of cocaine from daily to 0 xs per week as reported by client over the next 12 months. ***[Not a MH Objective.]***
- **Service Modality**: Case Management
- **Detailed Interventions**: Provide psycho-education on substance use. Teach relapse prevention techniques. Help client monitor use of cocaine. ***[Case Management is not acting as a SUD Counselor but is providing linkage and monitoring/providing support of client to SUD community supports.]***

MH Plan Example #3—
Claiming Collateral rather than Case Mgt.

Case Management/Brokerage vs. Collateral

- **Case Management--Linking/Monitoring the client's caretaker to services for the purpose of furthering the client's treatment plan is technically allowed.**
- **Sometimes, alternatively a Provider could provide Collateral to the Caretaker instead.**
  - **Collateral may be claimed by providing Psychoeducation to the caretaker regarding the importance of housing, medical care, etc. to the child's MH health—as the lack of it exacerbates their MH impairments.**

MH Plan Example #3: Child 0-5. (Moving from Case Management to providing Collateral to Parent/Caregiver.)

Billable example:

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

MH Plan Example #3: Child 0-5. (Moving from Case Management to providing Collateral to Parent/Caregiver.) Cont.

Billable example cont.:

Mental Health Objectives:

- #1) The frequency that the client cries inconsolably will decrease from daily to weekly in the next 6-12 months.
- #2) The frequency that the client will reach out to be picked up will increase from none to daily in the next 6-12 months.
- #3) Client will be calmed in response to parental soothing when crying or upset 2 out of 3 times (current 0 out of 3 times) in the next 6-12 months.

MH Plan Example #3: Child 0-5. (Moving from Case Management to providing Collateral to Parent/Caregiver.) Cont.

Billable example cont.:

- **Service Modality:**
  - *Family Psychotherapy* 1x per week, and as needed for 12 months,
  - *Collateral services* with caretakers monthly and as needed for 9 - 12 months.
- **Detailed Interventions:**
  - *Family Psychotherapy* – provide detailed intervention here.
  - *Collateral*– Provide psychoeducation to Mother regarding the importance of on-going participation in: parenting skills classes, medical services for the client, and housing resources to improve her child's Mental Health. Psychoeducation which results in the Mother's successful utilization of such support services will stabilize the ct's home environment resulting in a decrease in the child's MH symptomology (fails to initiate and respond in a developmentally appropriate way to social interactions; avoids eye contact; doesn't smile; doesn't reach out to be picked up; rejects efforts to calm, sooth, or connect; cries inconsolably; and isn't interested in interactive play) of Reactive Attachment Disorder.

MH Plan Example #3: Child 0-5. (Moving from Case Management to Providing Collateral to Parent/Caregiver.) Cont.

Non-billable example:

- **Mental Health Objectives:** Client's mother will secure stable housing in the next 6 months; client's mother will attend parenting classes 1x per week for the next 12 months; client's mother will learn and practice 3 soothing techniques with client per day in the next 12 months. ***[These are not the client's MH Objectives—but Mother's own goals.]***
- **Service Modality:** *Family Psychotherapy* 1x per week, and as needed for 12 months; *Collateral* monthly and as needed for 12 months

Non-billable example cont:

- **Detailed Interventions:**
  - *Family Psychotherapy* – provide detailed interventions here
  - *Collateral*– provider will research and fill out housing applications for the client's mother ***[doing for the client is not Collateral such as providing psychoeducation to the mother in order to support the client's MH Objectives].***

Case Management & Collateral Review Questions

- What must be indicated in the Client Plan regarding Service Modality?
  - Case Management specifically indicated with frequency and duration.
  - Detailed Interventions with stated outcome (see below—If not in Detailed Intervention—as no longer required—must be elsewhere in the PLAN).
- What must the stated outcome of successful Case Mgt be?
  - Client will then meet MENTAL HEALTH Objectives
- What service modality may be substituted for Case Mgt when providing the service to a client's significant other/caretaker?
  - Collateral as psychoeducation regarding the caretakers' understanding the importance of the unmet need's (such as homelessness) impact upon the client's functioning.

Summary of Modifying Assessment, Tx Plan and PN's for Case Management Services

- **Summary of Required Case Management documentation elements include:**
  - **Careful documentation:**
    - **Within the MH Assessment:**
      - **For both Adults and Children you must indicate each needed service specifically, i.e. housing, medical, education, etc.**
      - **Adult clients' severe depressive MH impairments of included Dx results in inability to self-refer and effectively follow-through with needed housing, medical, SUD, educational, and vocational services (adults).**
      - **For children: families difficulties in such areas of housing, medical care, etc. exacerbates the child's MH Sx's.**
    - **Within the Client Plan:**
      - **Service Modality (with frequency and duration) & Detailed Interventions (or elsewhere as "successful Case Management linkage and monitoring is expected to reduce client MH Sx's of x, y, & z and MH impairments of a, b, & c (specify—see MH Objectives #___)".**
    - **Progress Notes:**
      - **Best to restate all of above (see previous slide and slide #)**

Case Management Review Questions

- Important documentation requirements unique to Case Management include:
  - How do you document the need for Case Management for Adult and Child?
    - Adult: Client's MH Impairments of Included Dx result in inability to access and/or successfully participate in community supports for …
    - Child: Client's MH Impairments are exacerbated by area of need (homelessness, parental unemployment, unmet medical needs, unmet SU Tx needs, etc.)
  - What types of Plan Objectives are documented for Case Management services?
    - Mental Health

Progress Notes
Step 3 of the Golden Thread

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

Progress Notes
Step 3 of the Golden Thread

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

Modifying Progress Notes for Case Management Services

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- Within the Progress Note
  - Identify which MH objective that this Case Management service is targeting for improvement. (Indicate number—best to also include statement as well. I.e., *"case management service will result in a decrease in MH symptoms of x, y, & z and an increase in adaptive functioning of a, b, & c [per MH Objective(s) # and #".)*
  - Modifying the B/PIRP Format for case mgt
    - "B/P" = Client's symptoms of severe paranoia today prevent him/her from accessing and utilizing needed housing support services—client has taken no action, in spite of desire to do so, to obtain housing services intake. It is expected that successful *case management service will result in a decrease in paranoid symptoms and an increase in adaptive functioning of being able to successful carry out desired activities of independent living skills*.
    - "I" = Called housing provider with referral and provided linkage to needed housing support services. Appointment made and provided to client.
    - "R" = Client agreed to make scheduled housing support intake appointment as scheduled and to report back to this provider at our next scheduled appointment.
    - P = Client will make scheduled housing support appointment and will f/u with this writer at next week's meeting to monitor their success in participating in service linked to today.

Progress Notes
Step 3 of the Golden Thread *continued*

Quality of Writing

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

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

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

F.Y.I.

Sample Provider Signature Sheet

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

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

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Progress Notes
Step 3 of the Golden Thread *continued*

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

A word about cloning

No, not this kind of cloning

Cloning or copy/paste

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

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

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

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

Progress Note Review Questions

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

Procedure Codes

Key things to ask yourself when choosing a Procedure Code

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

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

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

ACBHCS Guidelines for Scope of Practice Credentialing

SERVICE ACTIVITY * Requires co-signature by licensed LPHA. ** InSyst Discipline Designation. # Cannot provide Dx—may indicate with source. ^ Diagnosis may be made but must be co-signed by licensed LPHA. + May bill for assessment activities—but can only gather non-clinical, client-report, assess info to be utilized in the MH Assessment or CANS/ANSA. May not complete/write/sign the MH Assessment nor CANS/ANSA. ~ Licensed co-signatures not required, but recommended. = If within scope of practice/ability and with appropriate training and experience. > Must meet MHRS or Adjunct criteria. < Must meet AOD Counselor criteria.	LICENSED PRACTITIONER OF THE HEALING ARTS (LPHA) (Same as below**) *PhD-Licensed, PsyD-Licensed,* --- *LCSW,* --- *LMFT,* --- *LPCC OR LPCC-F (with Family Tx: 6 semester units or 9 quarter units of MFT related education and 500 hrs of documented supervised experience working directly with families- or is gaining such experience under the supervision of an LMFT or LPCC-F)*	MEDICAL PROVIDERS (Same as below**) *MD, DO, PA* ***Advanced Practice Nurses (APN):*** --- *NP, CNS, &* --- *APN Student Interns (with appropriate training, experience and required co-signatures).*	NURSING (Nurse**) RN, LVN, Psych Tech	UNLICENSED LPHA (Intern**) *PhD-Waivered, PsyD-Waivered, MFT-Intern, ASW, PCC-Intern (may perform family therapy services if under the supervision of a LMFT or LPCC-F)*	GRADUATE TRAINEE / STUDENT (Intern**) *Students in educational Mental Health programs granting an MSW, MA, MS, or PhD/PsyD degree which lead to an LPHA.* *May have existing: AA, AS, BA, BS, MA, MS* ***Co-signatures required.***	MENTAL HEALTH REHAB SPECIALIST (RHB Counselor**) *(Degree + MH experience): (1) AA, AS + 6yr (2) BA, BS + 4yr (3) MA, MS, PHD, PSYD+2yr but not waivered or registered with Board.* *Co-signatures highly recommended*	ADJUNCT STAFF (Unlicensed Staff**) *The Agency or Program must document qualifications, provide supervision, and ensure staff works within scope of ability.* *Co-signatures highly recommended* *May indicate: PSR, Peer Specialist, Family Partner*	SUD COUNSELOR (Unlicensed Staff**) *Certified - or Board Registered < 5yrs* *Addiction Counselor Certification Board of CA (aka CAADE): CATC Credentials.* *CA Consortium of Addiction Programs & Professional (CCAPP): LAADC, CADC, & RADT Credentials.* *CA Assoc of DUI Tx Programs (CADTP): CAODC Credential*
Assessment	Yes	Yes	No	Yes ^	Yes # ^	Yes +~	Yes +~	>
Evaluation-CFE Only	Yes	Yes	Yes	Yes	Yes ^	Yes ~	Yes ~	N/A
Evaluation-CANS/ANSA	Yes	Yes	Yes	Yes	Yes ^	No	No	Pending
Plan Development	Yes	Yes	Yes	Yes	Yes ^	Yes ~^	Yes ~^	>
Rehab (Ind / Group)	Yes	Yes	Yes	Yes	Yes ^	Yes ~	Yes ~	>
Therapy (Ind / Family/ Grp)	Yes	Yes	No	Yes	Yes ^	No	No	N/A
Collateral	Yes	Yes	Yes	Yes	Yes ^	Yes ~	Yes ~	>
Medication Services E/M	No	Yes	No	No	No	No	No	N/A
Psychological Testing	Yes =	Yes =	No	Yes =	Yes=^	No	No	N/A
Crisis Therapy	Yes	Yes	Yes=	Yes =	Yes ^	Yes ~	Yes ~	>
C/M: Brokerage/Linkage	Yes	Yes	Yes	Yes	Yes^	Yes ~	Yes ~	>
Med Svcs RN/LVN/PT Only	No	No	Yes	No	No	No	No	N/A
SUD Medi-Cal (Ind/Grp)	Yes	Yes	N/A	N/A	N/A	N/A	N/A	Yes
SUD Medi-Cal (Intake/Plan)	Yes w/ MD sig	Yes	N/A	N/A	N/A	N/A	N/A	Yes if MD req's met

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

F.Y.I.

Sample Provider Signature Sheet

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

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

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

Mental Health Service Definitions & Examples v.8.11.15

(Also see ACBHCS InSyst Procedure Code Table)

Case Management
Service Code 571

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

What it is:

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

Treatment Plan Case Management Objective Should Describe:

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

Progress Notes Should Describe:

- *The reason why the client requires the service being accessed needs to be documented in the record, and ideally documented in each note.*
- *A description that justifies why the client requires the clinician's assistance to access the needed service, i.e., why can't they do it themselves? The reason(s) need to be related to their mental health condition. This needs to be documented in the record, and ideally documented in each note.*
- *Describes the progress (monitoring) in a residential program or other service setting that the individual was placed in or referred to.*

Example Interventions:

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

Scope of Practices that may provide Case Management services:

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

Procedure Codes continued

323-90791– Face to Face Psychiatric Diagnostic Evaluation

(Performed by Licensed/Registered/Waivered LPHA or Trainee with Licensed LPHA Co-signature. Dx has additional requirements.)

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)

- **565-90792 – Face to Face Psychiatric Diagnostic Evaluation above with Medical Component—only** performed by Medical Providers (MD, DO, APN—CNS or NP, & PA)
- **325-90889 Non Face to Face Psychiatric Diagnostic Eval with or without Medical Component**
- **324-90791 – Face to Face Behavioral Evaluation** (Completion of CANS, ANSA-T, ANSA, or approved equivalent)
- **326-90899 – Non Face to Face Behavioral Evaluation** (CANS, ANSA, etc.)

Procedure Codes continued

Plan Development (581) (PD)

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

Not a Planned Service—May be Provided when Needed

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

- Writing Client Plan in Collaboration with Client.
- Plan Monitoring– when considering updating Client Plan given trigger event, change in functioning, etc.

Procedure Codes continued

Plan Development (581) Cont.

- Intra-agency/clinic PD only occurs when the Plan is being reconsidered and the *writer could not obtain the information from the written record*.
- This is *not done routinely* in-house such as a Case Manager meeting with the MD after she sees the client, or the clinician meeting with the Family Partner after the Partner sees the client/family.
- For example, clinician becomes aware client went off their anti-psychotic medication (historically linked to decompensation and hospitalization) and clinician needs to meet with the psychiatrist to modify the plan to address the issue immediately.

Procedure Codes continued

Individual (381) or Group Rehab (391)

(Performed by all with appropriate training and experience.)

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

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

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

Procedure Codes continued

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

(Performed by all with appropriate training and experience.)

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

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

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

Procedure Codes continued

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

(Performed by all with appropriate training and experience.)

CURRENT REQUIREMENT: PLANNED SERVICE—MAY ONLY BE PROVIDED AFTER THE COMPLETION OF THE CLIENT PLAN*

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

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

Procedure Codes continued

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

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

Procedure Codes continued

Collateral Caregiver (310)
(Performed by all with appropriate training and experience.)
Or Collateral—Family Counseling (413)
(without Client Present)
(Performed by License/Waivere/Registered LPHA or MH Trainee.)

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

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

Procedure Codes continued

Collateral Health Care Provider (614)

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

(Performed by all with appropriate training and experience.)

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

Procedure Codes continued

Collateral Family Group (317) –

may be with or without client present.

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

(Performed by all with appropriate training and experience.)

- **317 Collateral Family Group** is defined as a service activity provided in a group setting composed of two or more sets of family members, caretakers or significant support persons in the life of a client in treatment.
- Services may be provided by LPHA and/or MHRS level staff. Adjunct Staff, peers, and family partners may provide this service with documented evidence of ongoing supervision, education, and experience.
- Collateral Family Group services may be used in providing psycho-education, resources and skills to family members/significant support persons to assist clients in gaining or re-gaining emotional equilibrium and community and family functioning.

Procedure Codes continued

Case Management/Brokerage (571)

UNPLANNED SERVICE – for linkage and referral ONLY

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

(Performed by all with appropriate training and experience.)

- Help clients to access medical, educational, social, vocational, rehabilitative, or other community services that are identified in the Client Plan and Assessment.
- Services activities may include, but are not limited to:
  - Communication with client & other individuals.
  - Coordination of care
  - Referrals
  - Monitoring service delivery to ensure client's access to services.
  - Monitoring client's progress toward making use of services.
- MH Plan must document need for case management due to severe impairment due to MH Dx that results in client being unable to make and maintain other community service referrals (Adult), or without such services Child's MH Sx and Impairments would be exacerbated. Must also document, successful C/M is expected to decrease MH Sx's and Impairments. See prior slides for these documentation requirements.

Procedure Codes continued

Case Management/Brokerage (571)

- Intra-agency/clinic Case Management rarely occurs.
- This is *not done routinely* in-house such as a Case Manager meeting with the MD after she sees the client, or the clinician meeting with the Family Partner after the Partner sees the client/family.
- If appropriate it is most likely plan development. I.e., clinician finds client's depression has worsened with suicidal ideation and asks to meet with the psychiatrist in order to explore adding a Medication Evaluation to the Client Plan (when the client had not been receiving Med Svcs).

Procedure Codes continued

Psychotherapy
PLANNED SERVICE—MUST BE IN CLIENT PLAN (see exceptions in Clin Doc Manual)
(Performed by Licensed/Registered/Waivered LPHA or MH Trainee)

Individual: (441/442/443)
May use +491-90785 for Interactive Complexity

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

Multi-Family Group: (455) (May only be WITH Client present.)
Note: Multi-Family WITHOUT Client Present is now Collateral-Family Group

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

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

Selecting the Code for Individual Psychotherapy

Individual Psychotherapy:

Time Based Code: (441/442/443)

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

See Choosing Time Based Codes on Next Slide.

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

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

- **Always choose code based on the exact number of f-2-f minutes.**
  - Documentation time & Travel Time will be included in Total Time and therefore reimbursed.

- **For non f-2-f [i.e. telephone, f-f = 0 min's] indicate the *client contact minutes* in the body of the note and select the time based code below. Also, indicate "phone" in the "location" field.**

- **FOR A TIME BASED CODE, AN AUDITOR CANNOT VERIFY IF THE CORRECT CODE IS CHOSEN IF F-F OR CONTACT TIME IS NOT INDICATED IN THE PN—AND THEREFORE WOULD DISALLOW.**

Procedure Codes continued

Multi-Family Group
Psychotherapy WITH Client Present (455)
PLANNED SERVICE—MUST BE IN CLIENT PLAN (see exceptions in Clin Doc Manual)
(Performed by LPHA—recommended & trainee—currently allowed.)

- **455 Multi-Family Group Psychotherapy** is defined as Psychotherapy delivered:
  - to more than one family unit each with at least one enrolled client.
  - Client must be in attendance or contact with their family members may not be claimed.

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

Procedure Codes continued

Prorating Group Services

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

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

Group Psychotherapy: 456,

& Multi-Family Group Psychotherapy With Client Present : 455

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

Prorating Group Services, Example 1

1 Clinician Provides Group therapy to 6 clients:

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

Prorating Group Services, Example 2a

2 Clinicians Provide Group therapy to 6 clients:

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

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

Prorating Group Services, Example 2b

2 Clinicians Provide Group therapy to 6 clients:

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

Prorating Group Services, Example 2c

2 Clinicians Provide Group therapy to 6 clients:

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

Add-On Codes (+)

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

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

Crisis Add-on Codes: Time Ranges

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

Crisis Add-On Codes:

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

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

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

Crisis Codes continued

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

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

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

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

- Refers to one or more, of 4 specific <u>communication factors</u> *during* a visit that complicate delivery of the primary psychiatric procedure (individual psychotherapy/group psychotherapy/assessment):
  1) The need to manage maladaptive communication.
  2) Caregiver emotions or behaviors that interfere with implementation of the treatment plan.
  3) Evidence or disclosure of a Sentinel Event and mandated reporting to a 3rd party with initiation of discussion of the event.
  4) Use of play equipment to overcome barriers to diagnostic or therapeutic interaction.

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

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

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

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

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

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

Medication Support Services

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

Medication Support Services cont.

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

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

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

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

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

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

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

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

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

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

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

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

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

- Coordination of Care:
  - Services provided by the medical provider responsible for the direct care of a client when he or she **coordinates or controls access to care or initiates or supervises other healthcare services** needed by the client.
  - outpatient **coordination of care must be provided while face-to-face with the client (or family)**.
- Provider must detail and thoroughly document what was discussed for each content topic covered!
  - E.g. for Compliance/Adherence discussion:
    - *"20 minutes of 25 minutes face-to-face time spent Counseling re: the importance of medication compliance with mood stabilizer for bipolar disorder. Explored impact of when client went off her medications—including recent 5150 and involuntary hospitalizations…"*

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

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

OUTPATIENT/OFFICE PSYCHIATRIC PROGRESS NOTE
COUNSELING AND/OR COORDINATION OF CARE

Patient's Name: _____ **Date of Visit:** _____

Interval History: _____

_____

_____

_____

Interval Psychiatric Assessment/ Mental Status Examination:

_____

_____

_____

Current Diagnosis: _____

Diagnosis Update: _____

Current Medication(s)/Medication Change(s) – No side effects or adverse reactions noted or reported ☐

_____

_____

Lab Tests: Ordered ☐ Reviewed ☐ : _____

_____

Counseling Provided with Patient / Family / Caregiver (circle as appropriate and check off each counseling topic discussed and describe below:

☐ Diagnostic results/impressions and/or recommended studies ☐ Risks and benefits of treatment options

☐ Instruction for management/treatment and/or follow-up options ☐ Importance of compliance with chosen treatment

☐ Risk Factor Reduction ☐ Patient/Family/Caregiver Education ☐ Prognosis

_____

Detailed discussion of Counseling (aka in psychiatry as Supportive Psychotherapy) topics:

Coordination of care provided (with patient present) with (check off as appropriate and describe below):

Coordination with: ☐ Nursing ☐ Residential Staff ☐ Social Work ☐ Physician/s ☐ Family ☐ Caregiver

Additional Documentation (if needed):

Duration of face to face visit w/patient : _____ min. Start Time _____ Stop Time _____ CPT _____

Greater than 50% of face to face time spent providing counseling and/or coordination of care: ☐

Psychiatrist's Signature:_____ Date:_____

Medication Support: RN/LVN/Psych Tech only **(Not an add-on)**

369 Meds Management by RN/LVN/Psych Tech's **Only**

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

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

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

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

Procedure Code Review Questions

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

- Assessment and CANS/ANSA Behav Eval Codes

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

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

What is the difference between Collateral Codes 311 and 310

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

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

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

Procedure Code Review Questions Cont

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

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

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

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

Interactive Complexity may be added to which 3 procedure codes?

- Assessment; & Group and Individual Psychotherapy

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

- 369

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

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

Lockout Claims

178

MH Services Lockouts (see updated handout)

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

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

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

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

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

Non-Reimbursable Services/Activities

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

Releases of Information/Record Retention

- DHCS has indicated that all Release of Information Consent Documents are only effective for 12 months (unless fewer than 12 months is specified in the Consent).
- *Recommend renewing ALL at Annual Episode Opening Date.*

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

- You may wish to research requirements for the HIPAA Management Practices for the Release of Information (ROI Log).

Minor Consent, ages 12 – 17 yrs.

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

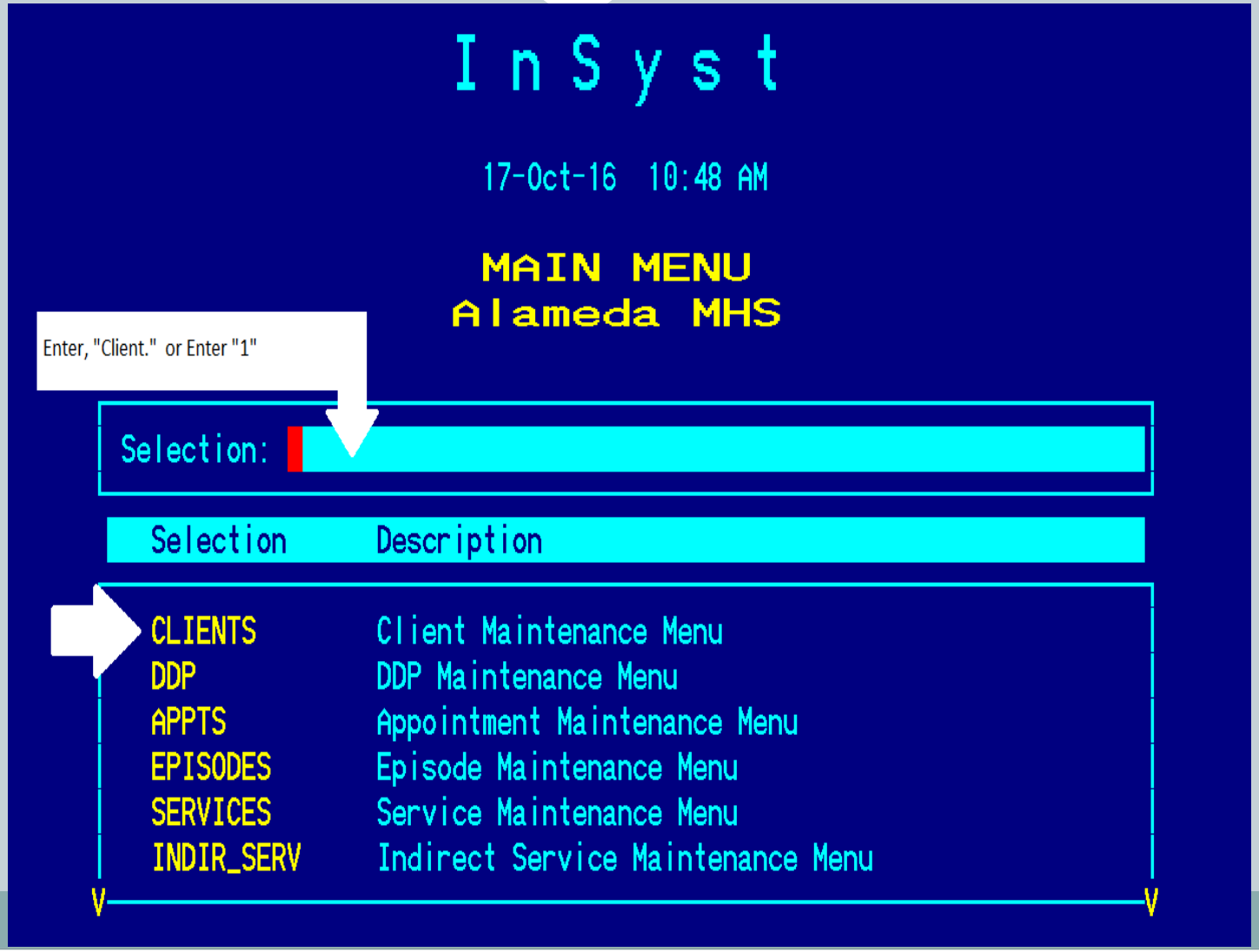
Updating or Inserting New Emergency Contact Information in INSYST

182

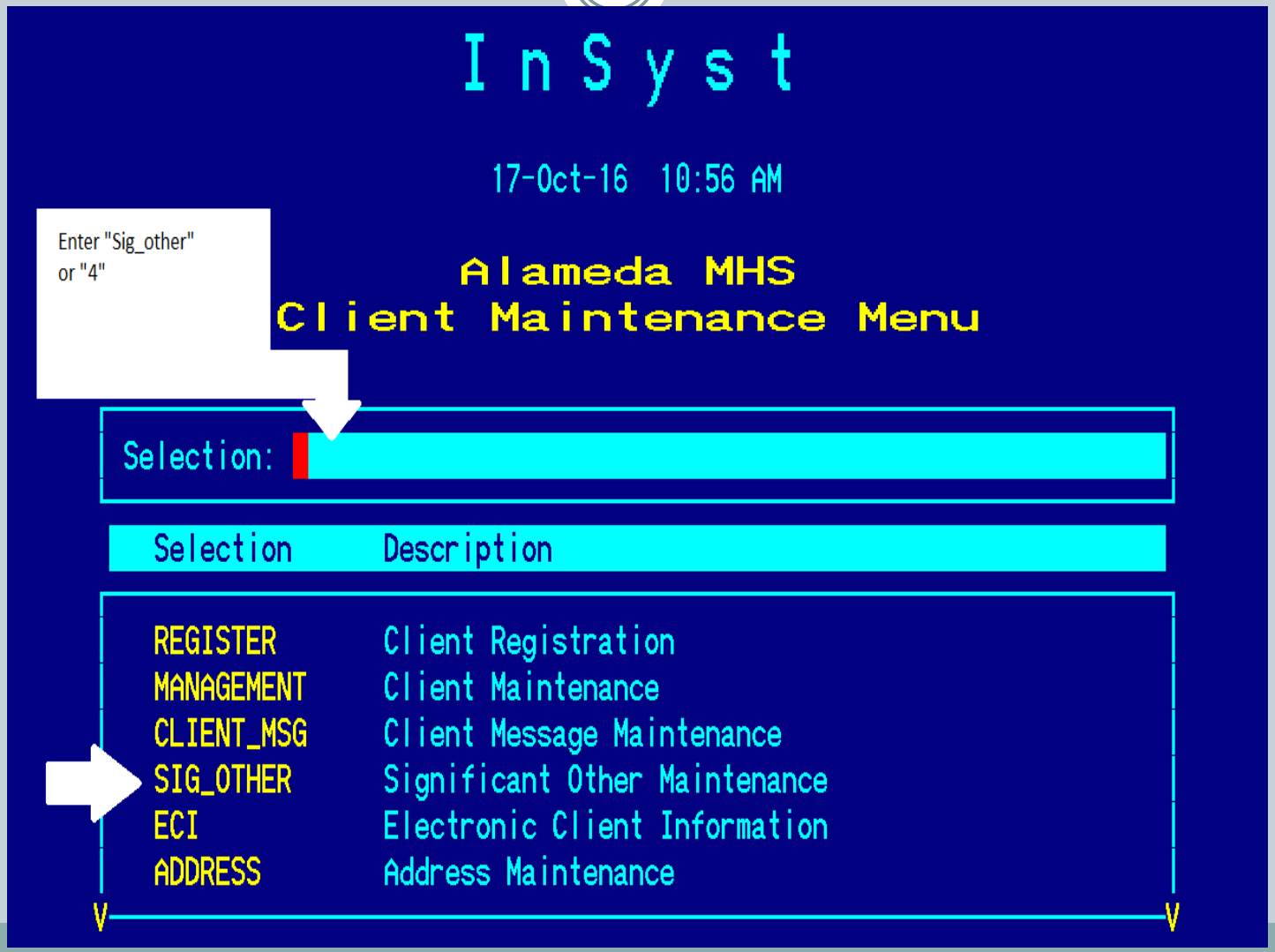
A CLIENT'S EMERGENCY CONTACT INFORMATION MUST BE ENTERED, AND KEPT UPDATED IN INSYST.

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

How to Update Emergency Contact Information



How to Update Emergency Contact Information



How to Update Emergency Contact Information

Client Significant Others Selection

Client Number:

When a client is first registered, there is an option to enter Significant Other information. If no information is entered, INSYST will default to 'No Significant Other' and information on the Face Sheet will be blank.
In order to add Significant Other and Emergency Contact information, you must enter Num-Lock I. (This is the command for inserting information.) This will take you to 'Client Significant Other **Insert**' page (see corresponding Powerpoint slide for more directions).

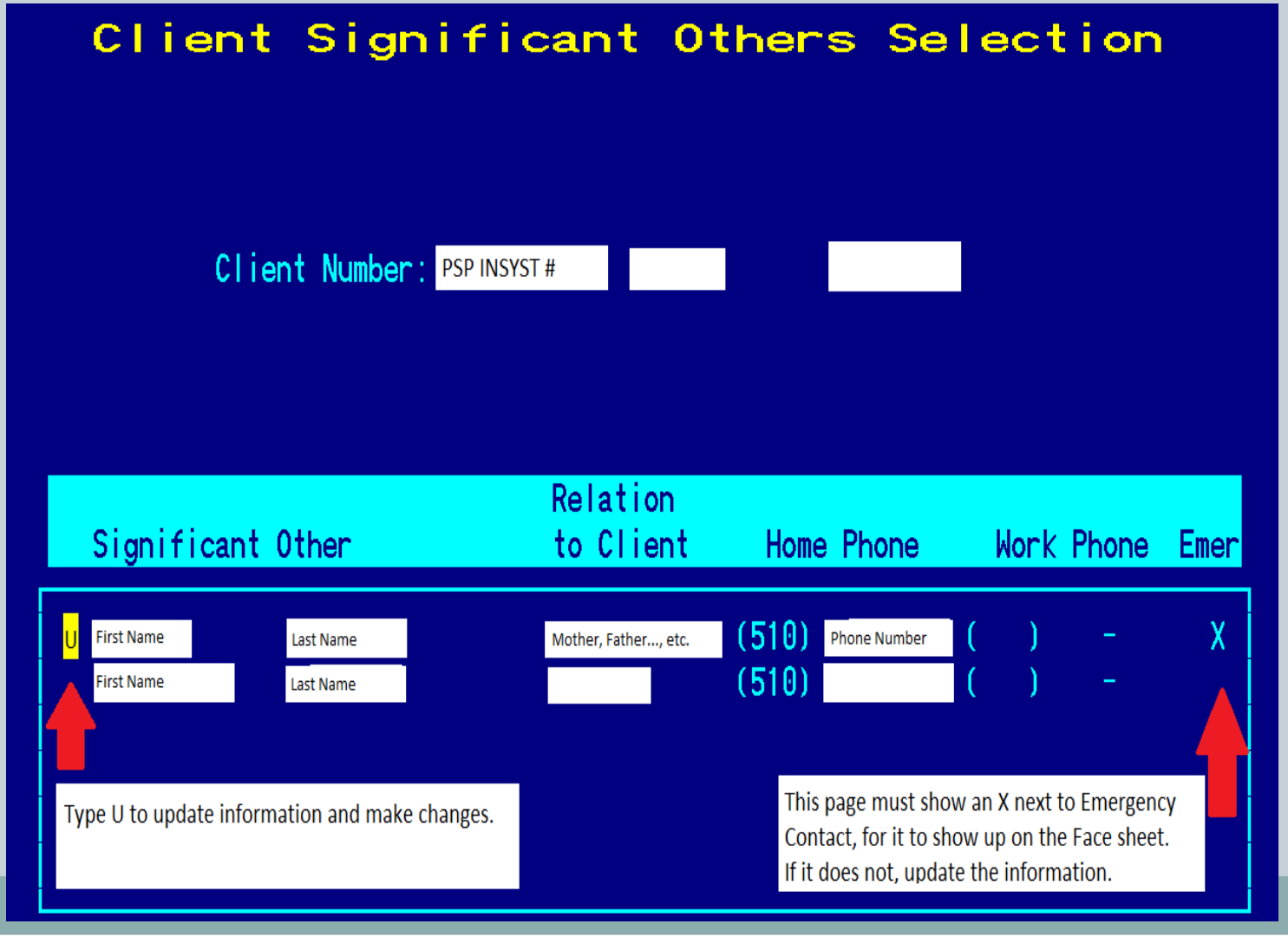
If a client's Significant Other information was entered at registration and needs to be updated, the client's PSP/INSYST number can be entered on this page. This will pull up a 'Client Significant Other **Update** page.' (see corresponding Powerpoint slide for more directions).

Significant Other	Relation to Client	Home Phone	Work Phone	Emer

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


```
                    Client Significant Others Insert

          Client Number:  75134621  BABY          TEST

 Name Last: SIMPSON          First: MARGE          Effective Date:  10/21/2016
 Relationship to Client: MOTHER                    Expiration Date:   /  /

      Street
   Number:    742                          City: SPRINGFIELD
   Direction:                              State: CA  Zip Code: 94619+ 555
   Name:      EVERYGREEN TERRACE           Country: USA
   Type:
   Apartment:                              Home Phone: (510) 867-5309 Ext.: 0
                                           Work Phone: (   )    -     Ext.: 0

   Comment:                  Make sure to check 'Emergency Contact' and any other field that is appropriate.

 X Emergency Contact       X Client's Guardian       X Family Member
   Don't Display on Rpts   X Primary Caregiver
V                                                                          V

   Continue: Y                  Confidential Information              USER: SAMMISJ
Successful insert.  Insert total = 1.
```

Updating Significant Other Information that has already been entered.



How to Update Emergency Contact Information

Client Significant Others Update

Client Number: PSP #

Name Last: Last Name First: First Name Effective Date: Date you enter Info

Relationship to Client: MOTHER Expiration Date: / /

Street

Number: 0 City:

Direction: State: Zip Code: 00000+ 0

Name: Country:

Type:

Apartment: Home Phone: (510) Phone # Ext.: 0

Work Phone: ( ) - Ext.: 0

Make sure this has an X in this field.

Comment: client's foster mother

X Emergency Contact X Client's Guardian Family Member

Don't Display on Rpts Primary Caregiver

End Result Is a Face Sheet with Emergency Contact Info

Client Information Face Sheet

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

****

CONSUMER INFORMATION

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

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

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

SIGNIFICANT OTHERS

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

****

CLINICAL HISTORY

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

****

Total Episode Count = 1

Additional Handouts

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

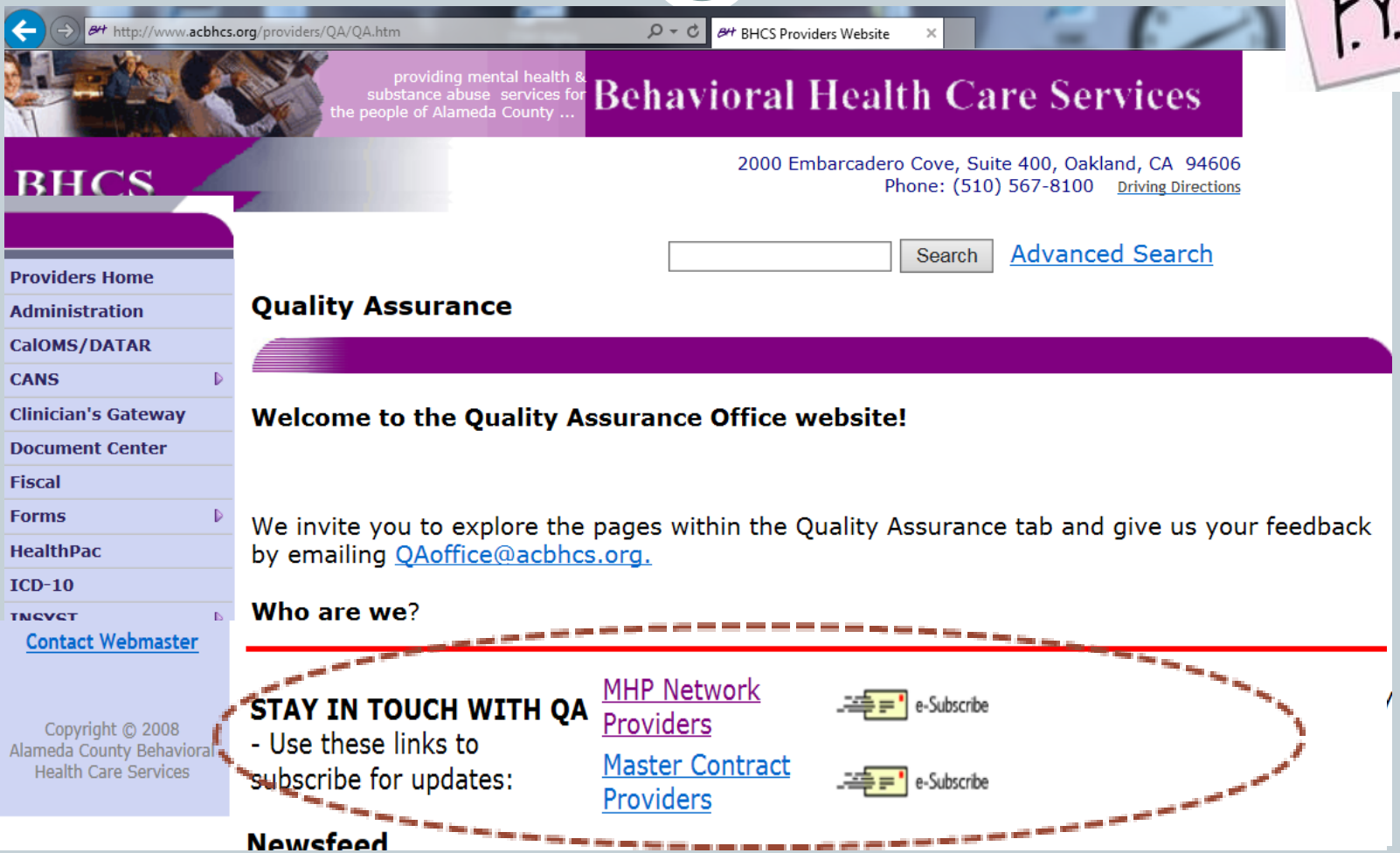
HIPAA Resources

- 42 USC 1395 US Department of Health and Human Services – www.hhs.gov
- Office of Civil Rights (enforces HIPAA Privacy & Security Rules) – www.hhs.gov/ocr/privacy/index.html
- CA Office of Health Information Integrity (CAL OHII) – www.Calohii.ca.gov
- CA Hospital Association- www.calhospital.org (publications include the CHA California Health Information Privacy Manual-2013)
- American Psychological Association http://apapracticecentral.org/business/hipaa/index.aspx
- NASW: http://www.socialworkers.org/hipaa/
- AAMFT: http://aamft.org/iMIS15/AAMFT/Content/Advocacy/HIPAA%20Resources.aspx
- American Psychiatric Association: http://psychiatry.org/psychiatrists/practice/practice-management/hipaa
- American Counseling Association: https://www.counseling.org/; http://www.counseling.org/docs/private-practice-pointers/meeting_hippa_requirements.pdf?sfvrsn=2

Contact Us:

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

Sign-up for QA Provider Website Updates



Train the Trainer Slides

End of presentation