Mental Health Fee for Service Provider Clinical Documentation Training

Amy Saucier, LMFT Clinical Review Specialist Supervisor
Tony Sanders, PhD, Clinical Psychologist Interim Associate Administrator
Quality Assurance Department

DK8
DK9

Introductions

- Who we are?
- Why we are here?
- Are you in the right training?

Slide 2

DK8 Deanna Kolda, 3/21/2019

DK9 Can we get a list of agencies/providers that should be attending this training?
Deanna Kolda, 3/21/2019

KC1

Psychological Testing

- Assessment and treatment plans are not required for psych testing only cases.
- Progress notes should detail which psychological tests were administered at each session.
- Time spent writing report is claimable and this should be documented within progress notes.
- If you only conduct psychological testing, the rest of this training will not be relevant to you. If you would like to leave at this time you may. Thank you for all of the great work you do for our consumers.

Fee For Service Providers

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

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

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

Slide 3

KC1 Any updates from new P&P?
Kimberly Coady, 5/13/2020

KC2

Agenda 6/24/20 9:00 am – 4:00 pm

TIME	TOPIC
9:00am – 9:30am	• Introductions, Logistics, Training Objectives, News & Updates
9:30 am – 10:30 am	• Initial Timelines and Processes • 6 month and 1 year Timelines and Processes
10:30 am – 10:45 am	Break
10:45 am – 12:15 pm	• Audit Highlights • Medical Necessity • Pre-Assessment & Assessment Requirements Documentation Requirements (including SO/GIE data) • Plan Documentation Requirements
12:15 pm – 1:15 pm	Lunch
1:15 pm – 1:45 pm	• Plan Documentation Requirements continued • Progress Note Documentation Requirements
1:45 pm – 2:00pm	Break
2:00 pm – 3:00 pm	• Procedure Codes Documentation Requirements
3:00 pm – 4:00 pm	• Questions, Post Test, & Course Evaluation

News and Updates

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

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

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

Slide 5

KC2 Kimberly Coady, 5/13/2020

Training Objectives

- Review Initial Approval & 6 month and 1 year Processes
- Understand Package of Services
- Review Clinical Documentation Requirements
  - Discuss the core elements of Medical Necessity and the Clinical Loop *aka* Golden Thread
  - Strengthen the ability to assess and document client problem areas, symptoms, strengths, and impairments in an Assessment.
  - Improve the ability to develop client goals and mental health objectives in compliance with Medi-Cal/DHCS requirements
  - Learn how to document Medi-Cal/DHCS Progress Notes

MHP FFS Provider Types - Outpatient

All claims must be made with form CMS 1500

Individual Clinician

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

Group of Clinicians

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

Master Contract Organizations – CMS HCFA 1500

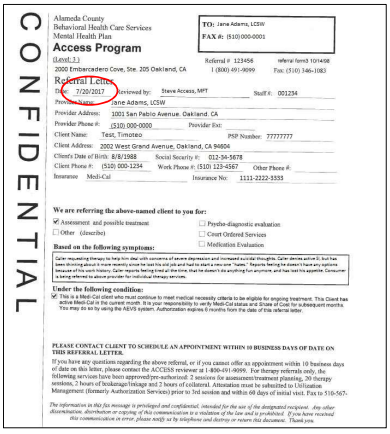
- Both Licensed and Board Registered or Waivered LPHAs may provide services (with Assessment and Plan restrictions and per your contract)

Documentation Training Requirements

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

ACCESS Referral Letter

- The **Referral Letter Date** marks the start of services. Providers reassess for continued services every 6 months.
- The provider must <u>offer</u> an appointment date <u>within 10 business days of the Referral Letter Date</u>. If this is not possible, consult with the ACCESS line on how to proceed.



CONFIDENTIAL

Alameda County
Behavioral Health Care Services
Mental Health Plan

Access Program

(Level 1)
2000 Embarcadero Cove, Ste. 205 Oakland, CA

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

Referral # 123456 referral form3 101408
1 (800) 491-9099 Fax: (510) 346-1083

Referral Letter

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

We are referring the above-named client to you for:
☑ Assessment and possible treatment
☐ Other (describe)
☐ Psycho-diagnostic evaluation
☐ Court Ordered Services
☐ Medication Evaluation

Based on the following symptoms:

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

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

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

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

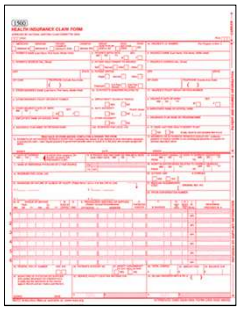
The information in this fax message is privileged and confidential, intended for the use of the designated recipient. Any other dissemination, distribution or copying of this communication is a violation of the law and is prohibited. If you have received this communication in error, please notify us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

CMS 1500 Claiming Rates & Codes

See July 1, 2016 Specialty Mental Health Rate sheets

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

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



Important Forms

Attestation form:

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

Medi-Cal compliant Assessment and Client Plan forms:

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

Request for Continued Services (RCS) form:

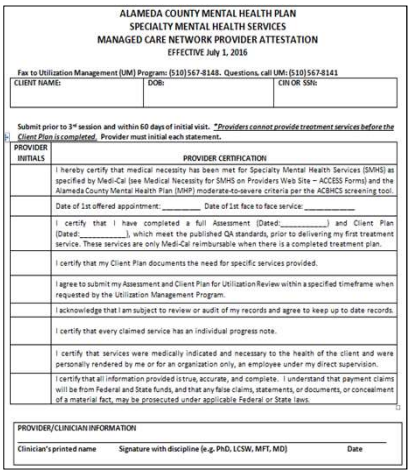
http://www.acbhcs.org/providers/Forms/Forms.htm#UM

Attestation Form

Follow all of the instructions on this form. The Attestation Form must be completed and submitted to UM prior to the third unit of service. Assessment codes are used for the first two units of service.

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

Attestation must also be completed annually by the same referral date cycle.



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

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

CLIENT NAME:	DOB:	CIN OR SSN:

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

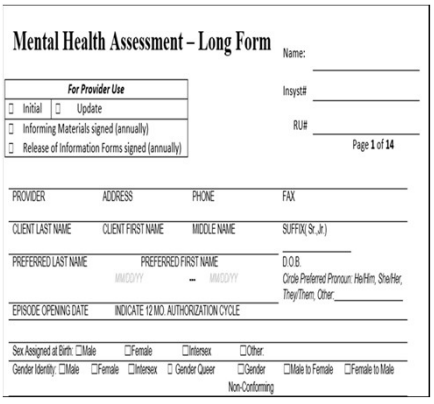
PROVIDER INITIALS	PROVIDER CERTIFICATION
	I hereby certify that medical necessity has been met for Specialty Mental Health Services (SMHS) as specified by Medi-Cal (see Medical Necessity for SMHS on Providers Web Site – ACCESS Forms) and the Alameda County Mental Health Plan (MHP) moderate-to-severe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

PROVIDER/CLINICIAN INFORMATION

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

Assessment—Long Form and Client Plan

ASSESSMENT TEMPLATE



Mental Health Assessment – Long Form

Name: _____

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

Insyst# _____

RU# _____

Page 1 of 14

PROVIDER | ADDRESS | PHONE | FAX

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

PREFERRED LAST NAME | PREFERRED FIRST NAME | D.O.B. MM/DD/YY -- MM/DD/YY | Circle Preferred Pronoun: He/Him, She/Her, They/Them, Other:_____

EPISODE OPENING DATE | INDICATE 12 MO. AUTHORIZATION CYCLE

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

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

CLIENT PLAN TEMPLATE

CLIENT PLAN
Page 1 of 2

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

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

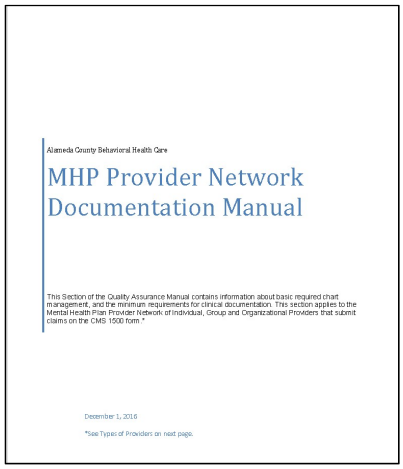
LIFE GOALS: *CLIENT'S DESIRED RESULTS FROM MH INTERVENTIONS (Client quote if possible)*

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 CM service, i.e. cl. 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.)*

ACBH Clinical Documentation Standards Manual for Network Providers


Alameda County Behavioral Health Care

MHP Provider Network Documentation Manual

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

December 1, 2016

*See Types of Providers on next page.

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

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

KC5

Insurance Eligibility Verification

Payment of claims is dependent on continued insurance eligibility, medical necessity, and timeliness of claim submission. DK11

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

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

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

See MHP FFS Documentation Standards Manual for more information.

Slide 16

DK11 This needs to be updated "retrospective payment authorization"
Deanna Kolda, 3/21/2019

KC5 In the event the provider and client are needing additional assistance, the provider can contact ACBH Help Desk (888-346-0605) which has HIT staff available to assist with the renewal or application process. The client will need to sign the attached form (MC382) which assigns ACBH as their authorized representative in order for HIT staff to submit an application on their behalf.

Please note that the Help Desk is for providers only.
Kimberly Coady, 5/13/2020

KC5

Insurance Eligibility Verification—cont.

DK11

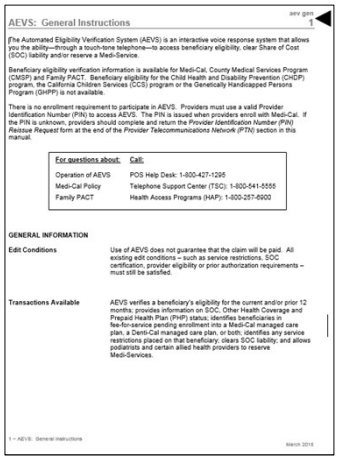
In the event the provider and client are needing additional assistance, the provider can contact ACBH Help Desk (888-346-0605) which has HIT staff available to assist with the renewal or application process.

The client will need to sign the MC382 form which assigns ACBH as their authorized representative in order for HIT staff to submit an application on their behalf.

Insurance Eligibility Verification

- DHCS provides several options to verify Medi-Cal eligibility
- Automatic Eligibility Verification System (AEVS):
  - https://files.medi-cal.ca.gov/pubsdoco/AEVS_home.asp
  - Or call 1-800-427-1295 and enter your PIN
- Or using the online DHCS system:
  - https://www.medi-cal.ca.gov/eligibility/login.asp
- Use the AEVS system provider number that you were assigned. Contact your QA Technical Assistance contact if you need help.

Department of Health Care Services Medi-Cal



AEVS: General Instructions

aev gen 1

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

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

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

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

GENERAL INFORMATION

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

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

1 – AEVS: General Instructions — March 2018

Slide 17

DK11 This needs to be updated "retrospective payment authorization"
Deanna Kolda, 3/21/2019

KC5 In the event the provider and client are needing additional assistance, the provider can contact ACBH Help Desk (888-346-0605) which has HIT staff available to assist with the renewal or application process. The client will need to sign the attached form (MC382) which assigns ACBH as their authorized representative in order for HIT staff to submit an application on their behalf.

Please note that the Help Desk is for providers only.
Kimberly Coady, 5/13/2020

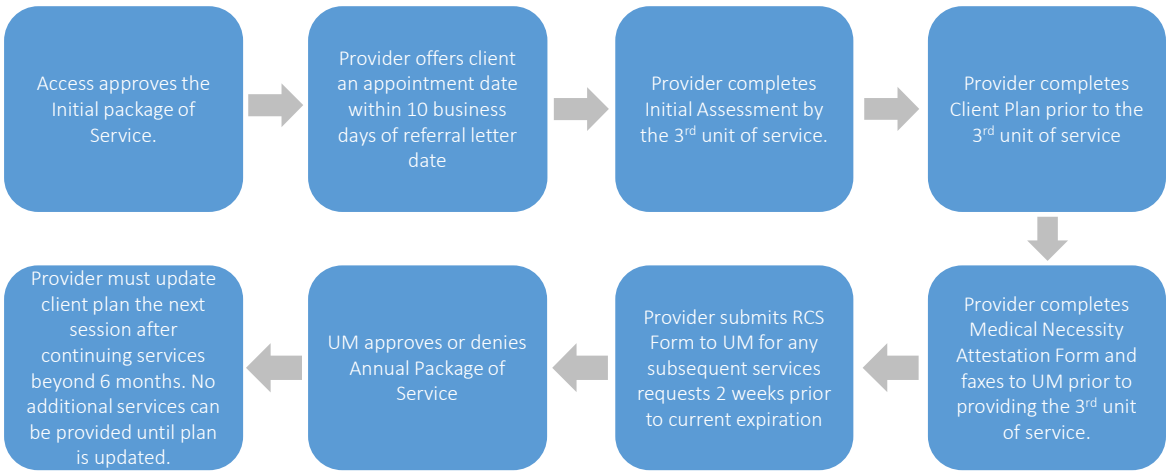
MHP FFS Overview – For outpatient services

ACCESS
- Approves the initial package of services (6 months)

UM
- Approves the Annual Package of Services (6 month)

Provider Relations
- Providers submit claims within 60 days of the end of the service date month
- BHCS remits payment to provider

Documentation Timeline



Initial Approval & 6 month and 1 year Continuation of Services

Initial/Annual Package of Services

- Two units of service to complete both the Assessment and Plan (code 90791)
  - Assessment must be completed before the 3rd unit of service
  - Plan must be completed before the 3rd unit of service
  - Providers may not provide therapy services before the initial/annual assessment and client plan are completed
  - Short-form assessment template may be used for your initial assessment; however, the long-form is required for your annual assessments.
- Attestation must be submitted to Utilization Management (UM) before the 3rd unit of service. FAX to 510-567-8148.
- Call UM if medical necessity requires additional assessment/plan services.

ACBH Brief Screening Tool

For every new client, the ACBH Screening Tool is required, regardless if ACCESS has included a completed screening tool or not.

An abbreviated version of these tools are embedded in the RCS form and are required upon continuation of services.

A copy of these forms must be kept in the chart.



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

See slide #34 if client's Screening Tool indicates a Mild-Moderate level of service is indicated.

Initial/Annual Package of Services

The package of 26 services (over a 6 month period) consists of:

- 20 therapy sessions (combination of Individual, Family &/or Group Therapy)
  - Individual Therapy - indicate: 90832-30", 90834-60", or 90837-90"(contact UM if 90 minute sessions are needed)

    Code Crisis Therapy (additional visit) as Individual Therapy—call UM if additional sessions required.
  - Family Therapy - indicate: 90846-60" or X9510-90"
  - Group Therapy - indicate: 90853-60" or Y9506-90"
  - Each session regardless of length (30, 60, or 90) = 1 of 20 allowed sessions

PLUS

- *Up to 120 minutes of Brokerage/Linkage in increments of 30" or 60". Up to 120 minutes of Collateral in increments of 10" (90887-10") or 45" (90888-45").

Slide 24

KC8 detail about travel time if approved?
Kimberly Coady, 5/13/2020

Request for Continued Services (RCS)

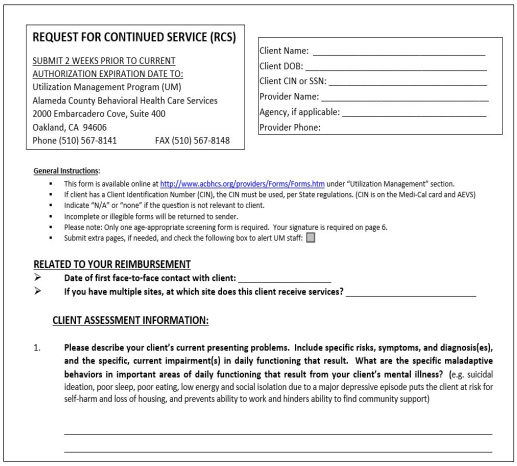
This form is required whenever an extension of services is being requested.

The RCS can be submitted up to 2 weeks before the 6 months from the ***Referral Letter Date***.

Follow the instructions on the form and submit to Utilization Management FAX: (888) 860-8068

If no extension is requested or approved, all remaining services will expire 6 months from ***Referral Letter Date*** (even if not all the sessions were used).

All pages of the packet are required to be faxed.



REQUEST FOR CONTINUED SERVICE (RCS)

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

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

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

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

CLIENT ASSESSMENT INFORMATION:

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

_____
_____

Medical Necessity for Continued Services

Therapy will continue for our beneficiaries as long as:

A. Meets the moderate-severe medical necessity criteria
B. Beneficiary is benefiting from therapy
C. The appropriate documentation is in place demonstrating continued need for therapy.

AS3

When outpatient therapy is no longer clinically warranted the beneficiary will be referred to a higher or lower level of care.

ACBH wants to ensure that beneficiaries remain stable in the community.

There are no length of stay limits; everything is tied to medical necessity.

Slide 26

AS3 would you like this information also in the medical necessity section?
Amy Saucier, 5/14/2020

Request for Continued Service (RCS)

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

AS6

Continued Service Package

Providers have one unit of service to complete the updated Client Plan (use Psychiatric Diagnostic Eval code)

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

- For next six months:
  - 20 Therapy sessions – Any combination of Individual, Family &/or Group Therapy as long as the modality is specified in the plan.
    - Individual (30, 60, 90 minutes – if approved by UM)
    - Code Crisis Therapy (additional visit) as Individual Therapy—call UM if additional sessions required.
    - Family Therapy (60 or 90 minutes)
    - Group Therapy (90 minutes)
  - 3 hours - Brokerage/Linkage (30 and 60 minutes increments)
  - 2 hours – Collateral (10 and 45 minutes increments)

- Call UM if medical necessity requires additional services.

Slide 28

AS6 revise as needed with new info regarding units of service limits
Amy Saucier, 5/20/2020

AS2

Crisis Services

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

Utilize Individual Therapy Code and indicate in PN that there was a crisis intervention.

Relevant clinical details leading to the crisis

The identified crisis must be the client's crisis, not a significant support person's crisis. (CCR24)

The urgency & immediacy of the situation must be clearly documented and describe each of the following medical necessity requirements: (CCR06) (CCR10) *(CCR15)*

- How the crisis is related to a mental health condition
- How the client is imminently or currently a danger to self or to others or is gravely disabled
- Why the client either requires psychiatric inpatient hospitalization or psychiatric health facility services or that without timely intervention, why the client is highly likely to develop an immediate emergency psychiatric condition.

Interventions done to decrease or eliminate or alleviate danger, reduce trauma and/or ameliorate the crisis.

The aftercare safety plan.

Collateral and community contacts that will participate in follow-up.

Providers should be tracking how often crisis services are being utilized and assessing whether a higher level of care is indicated.

*There is no need to get crisis services authorized by Utilization Management.

Call UM if medical necessity requires additional assessment/plan services.

Recommended Procedure for Completing Initial Assessment/Plan with one client visit

Unit 1

- Use first unit of service and meet with client face-to-face for 45 minutes focused on Assessment and developing Plan. Spend 15-30 minutes writing Assessment/Plan. If you don't complete Assessment or Plan in the first session, document in the session's Progress Note that you, "completed pages 1 & 2 in Plan" or "completed sections X, Y, & Z of Assessment." Claim one unit of 90791.

Unit 2

- Without client present, complete assessment and plan. Claim a unit of 90791. Document that the client will sign the plan at the next visit.

Slide 29

AS2 this information is also in the procedure codes section.
Amy Saucier, 5/14/2020

AS5

Recommended Procedure for Completing Initial Assessment/Plan in two visits with client present

Unit 1

- Use one unit of service to meet with client face-to-face for 45 minutes focused on Assessment and developing Plan. Spend 15-45 minutes completing the Assessment and Plan without client present. Claim one unit of 90791. Obtain verbal consent and document this in the session's progress note.

Unit 2

- Use second unit of service to meet with client face-to-face for 60 minutes doing collaborative documentation and complete the Assessment and Plan. Obtain client's approval and signature on client plan **at end of session**. Claim one unit of 90791.

Assessment and Plan Due Dates

AT EVERY 6 MONTHS

- ✓ Make sure RCS is submitted in time to ensure continued services are granted. RCS can be submitted up to two (2) weeks prior to 6 months from referral letter date.
- ✓ New Plan with client and signature
- ✓ New Assessment is **not** required

AT EVERY ANNUAL

- ✓ Make sure RCS is submitted in time to ensure continued services are granted. RCS can be submitted up to two (2) weeks prior to 6 months from start date.
- ✓ New Plan with client and signature
- ✓ ACBH Long Form Assessment REQUIRED

Slide 31

AS5 alter these slides based on the information about increased assessment time/explain doc time strategies
Amy Saucier, 5/20/2020

Specialty Services

Psychological Testing

- Any provider may request psychological testing for beneficiaries by contacting ACCESS

Children and Family Services and Customized Services

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

AS7

Probation and CalWORKS recipients

- All referrals come through ACCESS and use assigned CalWORK codes.

Mild-moderate impairment

If a Provider is interested in continuing to work with a beneficiary whose condition improves to mild-to-moderate impairment, it is recommended that the Provider become a Beacon and/or Anthem Blue Cross provider. If you choose not to join their panel, you could request a single case agreement to serve a particular client in need for continuity of care. If this is not successful, you will need to refer out to their provider panel.

Beacon Health Options (855) 856-0577

Anthem Blue Cross (888) 831-2246

Kaiser Permanente (510) 752-1075

Slide 33

AS7 checking on new psych test policy
Amy Saucier, 5/20/2020

Audits

Auditing of Charts

To assure compliance with documentation and treatment planning requirements, ACBH will occasionally request treatment documentation for claims review.

When ACBH contacts you please submit the requested documents promptly.

Assessment

DK3

Brief Screening Tool (BST)

The Brief Screening Tool must be administered in order to determine eligibility for SMHS

- This must be done before any services can be claimed and with every request for continued services
- For Individual and Group Providers the Brief Screening Tool must be administered by a Licensed LPHA.
  - For Organizations a Waivered/Registered LPHA with a Licensed LPHA co-signature may also complete the BST.
- Completion of Request for Continued Services is not billable. An informational/non-billable progress note should be completed.
- Client must continue to meet criteria for Moderate – Severe to be eligible for Specialty Mental Health Services.

Slide 38

DK3 same issue as slide 28, what are the requirements for when these are due.
Deanna Kolda, 10/17/2018

DK4

Informing Materials

ACBH Informing Materials (IM) must be reviewed with and signed by the beneficiary in their preferred threshold language

- Before services are provided
- If unable to cover IM in 30 days after the referral letter date contact Quality Assurance.
- Annually
- All areas must be addressed
- This service is claimed as part of the MH Assessment process.
- Need to have all languages of informing materials in the lobby.


بروشور اطلاعاتی – حقوق و مسئولیت های شما

به برنامه بهداشت روانی کانتی آلامدا خوش آمدید

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

نام ارائه دهنده خدمات:

شخصی که نقش شما به خدمات را گرامی می دارد، همراه با شما این بروشور را مرور می کند. این بسته به شما داده می شود تا آن را به خانه ببرید و هر موقع مایل بودید آن را مرور کنید و از شما خواسته خواهد شد آخرین صفحه این بسته را امضا کنید تا نشخص نمایید چه موقع فایل مورد بحث قرار گرفت و شما متقد شدید که شما این بروشور را دریافت کردید. ارائه دهنده خدمات صفحه امضای اصلی را نگاه خواهد داشت. ارائه دهندگان خدمات همچنین موظفند شما را در مورد حق دسترس بودن مزایا، تخصیص این بسته اطلاعاتی در هر سال نگاه دارند و آخرین صفحه این بسته جایی وجود دارد که به شما می گوید چه هنگام این اتفاقی ها صورت می گیرد.

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

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

رضایت برای دریافت خدمات

به عنوان یک عضو این برنامه بهداشت روانی (MHP) تعهدی شما در تعریف صفحه این بسته بدان معنا است که شما تمایل به ارائه خدمات مطابقه بهداشت روانی که ارائه دهنده دریافت می کنید به صورت داوطلبانه رضایت می دهید. اگر شما نمایند قانونی یک مشتری هستید، اضمای شما نشان دهنده رضایت است.

رضایت شما برای دریافت خدمات همچنین بدان معنا است که این ارائه دهنده موظف است شما را از توصیه های مراقبتی خود، نگاه دارد، بنابر این تصمیم شما برای شرکت از روی علم و آگاهی گرفته شده و دارای مفهوم است. تمامی در داخل حل موقف، تمامی خدمات در هر زمان، شما همچنین حق دارید از راه های درمانی هر گونه توصیه، مداخلات و/یا شکایی را در حال مطابقه خود داری نمایید.

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

Alameda County Behavioral Health Care Services — Informing Materials 8-2013 - Farsi
Quality Assurance Office — Page 1 of 11

6/24/2020 39

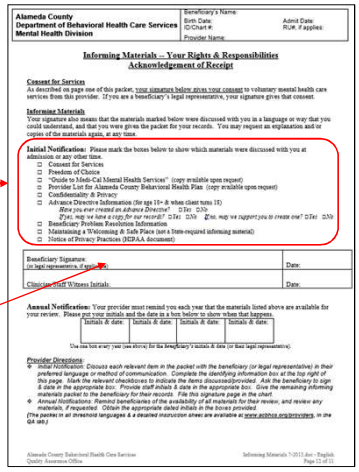
Pre-Assessment – Informing Materials

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

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

Retain this signature page in the client record and give the beneficiary the rest of the Informing Materials packet.

The beneficiary then signs and dates here


Alameda County
Department of Behavioral Health Care Services
Mental Health Division

Beneficiary's Name:
Birth Date:
ID/Chart #:
Provider Name:
Admit Date:
RUK, if applies:

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 at any year (see above) for the beneficiary's initials & date (or their legal representative).

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

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

Alameda County Behavioral Health Care Services — Informing Materials 7-2013 dot – English
Quality Assurance Office — Page 11 of 11

6/24/2020 40

Slide 39

DK4 will need updating when new informating materials are issued.
Deanna Kolda, 10/17/2018

Pre-Assessment – Releases of Information

- Must be signed by client
- Not required for other Health Care Services Providers for treatment purposes—but recommended
- Not required to simply facilitate treatment referral to other Health Care Providers—but highly recommended
- Releases are valid for as long as the client indicates, if no date indicated, default is 12 months.
- An actual date is recommended rather than an event such as "until the end of treatment."

Medical Necessity

The Golden Thread

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

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

- The Assessment
- The Client Plan
- The Progress Note

Part 1 – Included Diagnosis

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

Part 1 – Included Diagnosis

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

Part 2 – Qualifying Impairment

A Qualifying Impairment (meets one 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*

Indicate the most severe one on the MH Assessment (listed A-B in order of descending severity). Ex. 1: If A & B—then indicate A;

Ex. 2: If B & C—then indicate B.

Part 2 – Qualifying Impairment

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

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

See the BHCS Provider website for resources:
http://www.acbhcs.org/providers/QA/docs/2013/TR_Suicide-Homicide_Risk_Assesment.pdf

Part 3 – Treatment will address impairments

The focus of treatment are the signs/sx's of the Included Dx's and address the following:

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

Indicate the most severe one on the MH Assessment (listed A-B in order of descending severity). Ex. 1: If A & B—then indicate A; Ex. 2: If B & C—then indicate B.

Assessment

Who can create and complete an Assessment?

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

Assessment Templates

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

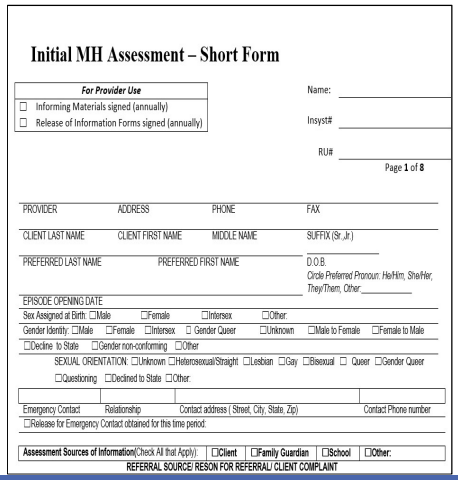
http://www.acbhcs.org/providers/Forms/ProviderNetwork.htm

Provider Network

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

Assessment Template – Short Form

May use for Short or Long Form for the Initial Assessment



Initial MH Assessment – Short Form

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

Name: _____

Insyst# _____

RU# _____

Page 1 of 8

PROVIDER | ADDRESS | PHONE | FAX

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

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

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

EPISODE OPENING DATE

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

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

☐Decline to State ☐Gender non-conforming ☐Other

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

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

☐Release for Emergency Contact obtained for this time period:

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

REFERRAL SOURCE/ RESON FOR REFERRAL/ CLIENT COMPLAINT

Assessment Template – Long Form

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

The Assessment Long Form is <u>required</u> for 12 month/Annual Assessment

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

Mental Health Assessment – Long Form

Name: _____

Insyst# _____

RU# _____

Page 1 of 14

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

PROVIDER | ADDRESS | PHONE | FAX

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

PREFERRED LAST NAME | PREFERRED FIRST NAME | D.O.B. MM/DD/YY -- MM/DD/YY | *Circle Preferred Pronoun: He/Him, She/Her, They/Them, Other:* _____

EPISODE OPENING DATE | INDICATE 12 MO. AUTHORIZATION CYCLE

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

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

Discussing SOGIE Sensitively

What's in a Word?

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

http://www.lgbthealtheducation.org/

Discussing SOGIE Sensitively

The Data collection will serve to identify LGBTQQI2-S populations which have historically been underserved as well as to assist the provider in providing culturally sensitive & responsive services.

Gathering such data in clinical settings will allow providers to better understand and treat their clients, and to compare their clients' health outcomes with national samples of LGB or LGBT people from health surveys.

Why are we collecting this information?

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

Lesbian, gay, bisexual, and transgender (LGBT) clients have unique health needs and experience **numerous health disparities**

They are an underserved population that is largely **invisible** in the health care system

Routine and standardized collection of sexual orientation and gender identity (SOGIE) information in medical and electronic health records (EHRs) will help assess **access, satisfaction with, quality of care**, **inform the delivery of appropriate health services**, and begin to **address health disparities**

Why are we collecting this information?

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

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

LGBT youth are more likely to be homeless.

Transgender individuals have a high prevalence of HIV/STIs, 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.

Discussing SOGIE Sensitively

Recommendations for Assessment Clinician—Confidentiality & Privacy

- LGBT clients may be hesitant to disclose information about their sexual orientation or gender identity due to fears about confidentiality and privacy.
  - These fears may have to do with not knowing what will happen with this information
  - Clients may be reluctant to provide such personal information to office staff in a waiting room, because it feels less private than answering the question of a provider in a private office.
- During provider-client interaction there are several potential barriers to gathering this information.
  - Providers may not be comfortable asking these questions, or lack knowledge on how to elicit this information.
  - Some worry LGBT people will be reluctant to disclose due to anti-LGBT stigma and prejudice.
  - This may be true, and as a result not all LGBT clients will disclose their sexual or gender identity.

Discussing SOGIE Sensitively

Questions recommended by national LGBTQ organizations include:

Two-step sex/gender question

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

And

A sexual orientation question

- How do you identify?

Discussing SOGIE Sensitively

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

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

Client Information & SOGIE (Sexual Orientation and Gender Identity Expression)

Preferred Last Name:		**Preferred First Name:**		**D.O.B.:**		
What is your Pronoun:	☐ She/Her	☐ He/Him	☐ They/Them	☐ Unknown/ Not Reported		
	☐ Other					
Sex Assigned at Birth:	○ Unknown	○ Male	○ Female	○ Intersex	○ Other	
Gender Identity:	☐ Unknown	☐ Male	☐ Female	☐ Intersex	☐ Gender Queer	☐ Decline to State
	☐ Other					
	Transgender:	☐ Male to Female		☐ Female to Male		
SEXUAL ORIENTATION:	☐ Unknown	☐ Bisexual	☐ Declined to State	☐ Gay	☐ Gender Queer	
	☐ Heterosexual/Straight	☐ Lesbian	☐ Questioning	☐ Queer		
	☐ Other:					

For Gender Identity, Sexual Orientation and "My Pronoun" *select all that apply*.

When collecting *"caretaker/guardian"* information—use that label rather than mother/father (may be same-sex household), parent (may be extended family members), etc. Only exception would be biological parents if genetic information is needed.

If spouse is being requested: indicate *"spouse or significant-other".*

SOGIE Resources and Suggested Email Signature

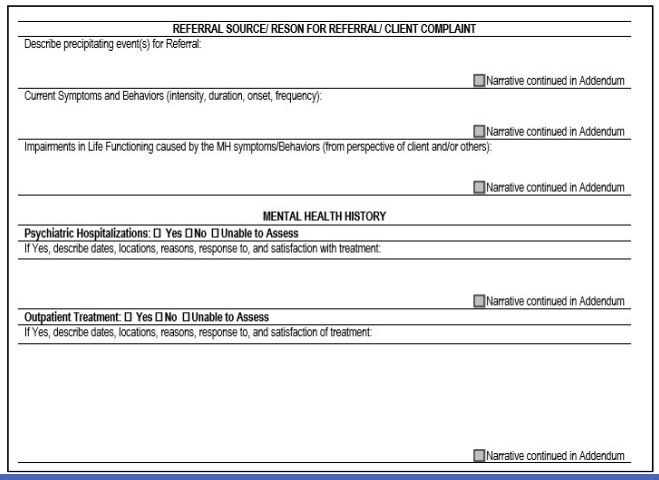
www.EastBayPride.com

Symbols of LGBTQQI2-S Support such as email signature line with pronouns:

- Thank you,
  Tony
  Tony Sanders, PhD
  Pronouns: He/Him/His (What is this?)

- *"What is this" link: https://www.mypronouns.org/*

Referral Source, Mental Health History



REFERRAL SOURCE/ RESON FOR REFERRAL/ CLIENT COMPLAINT

Describe precipitating event(s) for Referral:

☐ Narrative continued in Addendum

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

☐ Narrative continued in Addendum

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

☐ Narrative continued in Addendum

MENTAL HEALTH HISTORY

Psychiatric Hospitalizations: ☐ Yes ☐ No ☐ Unable to Assess

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

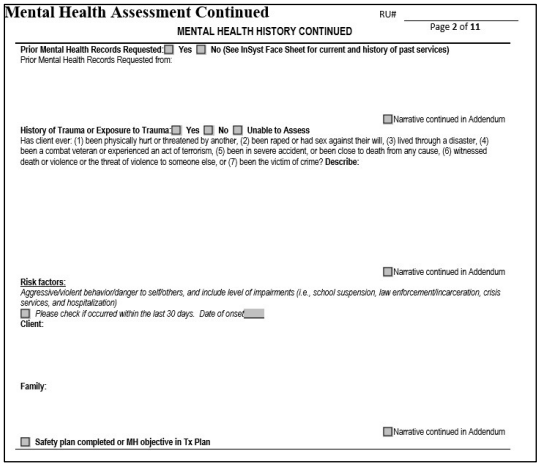
☐ Narrative continued in Addendum

Outpatient Treatment: ☐ Yes ☐ No ☐ Unable to Assess

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

☐ Narrative continued in Addendum

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



Mental Health Assessment Continued RU# _____

Page 2 of 11

MENTAL HEALTH HISTORY CONTINUED

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

Prior Mental Health Records Requested from:

☐ Narrative continued in Addendum

History of Trauma or Exposure to Trauma ☐ **Yes** ☐ **No** ☐ **Unable to Assess**

Has client ever: (1) been physically hurt or threatened by another, (2) been raped or had sex against their will, (3) lived through a disaster, (4) been a combat veteran or experienced an act of terrorism, (5) been in severe accident, or been close to death from any cause, (6) witnessed death or violence or the threat of violence to someone else, or (7) been the victim of crime? **Describe:**

☐ Narrative continued in Addendum

Risk factors:

Aggressive/violent behavior/danger to self/others, and include level of impairments (i.e., school suspension, law enforcement/incarceration, crisis services, and hospitalization)

☐ *Please check if occurred within the last 30 days. Date of onset* ____

Client:

Family:

☐ Narrative continued in Addendum

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

Risk Assessment & Safety Plan

- If suicidal, homicidal or other significant risk is found during the assessment and occurred within the last 90 days, both a comprehensive risk assessment and a formal written safety plan must be developed in coordination with the client.

- Beyond 90 days of suicidal, homicidal or other significant risk ideation, if it is determined that a Comprehensive Risk Assessment and formal written Safety Plan are not indicated, document the clinical reasoning for this decision.

Risk Assessment & Safety Plan

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

Reason for Comprehensive Assessment

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

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

Risk Factors (Internal, & Environmental)

Protective Factors (Internal, & Environmental)

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

Status of Crisis Safety Plan

Comprehensive Risk Assessment Resource:

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

Risk Assessment & Safety Plan

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

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

What Are My Triggers?

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

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

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

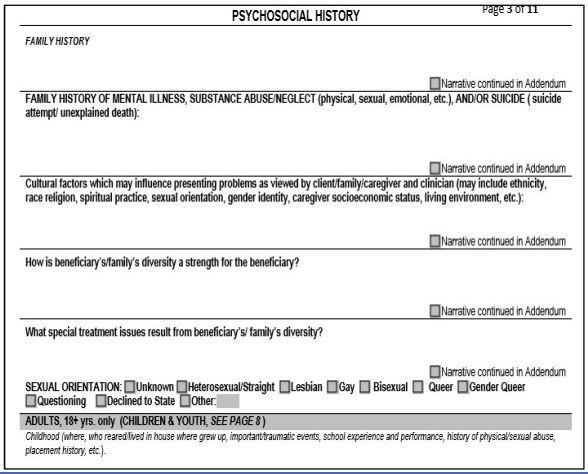
Which, and When Will I Contact, Professionals and Agencies for Assistance (Priority & Expectations)?

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

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

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

Psychosocial History



PSYCHOSOCIAL HISTORY Page 3 of 11

FAMILY HISTORY

☐ Narrative continued in Addendum

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

☐ Narrative continued in Addendum

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

☐ Narrative continued in Addendum

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

☐ Narrative continued in Addendum

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

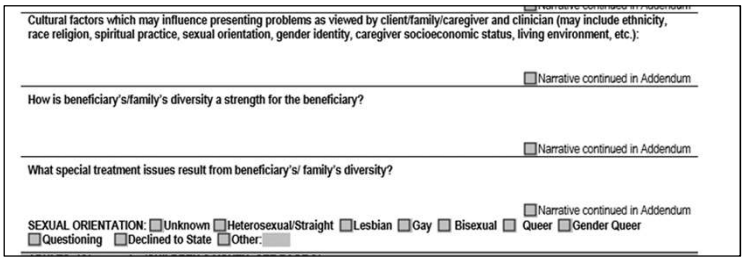
☐ Narrative continued in Addendum

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

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

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

Cultural Considerations


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

☐ Narrative continued in Addendum

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

☐ Narrative continued in Addendum

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

☐ Narrative continued in Addendum

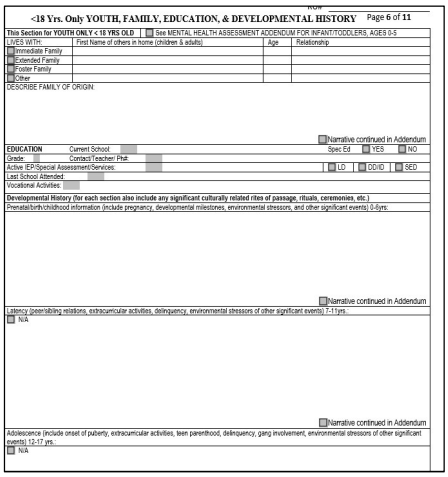
SEXUAL ORIENTATION: ☐ Unknown ☐ Heterosexual/Straight ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Queer ☐ Gender Queer ☐ Questioning ☐ Declined to State ☐ Other:

Cultural Considerations

Identified during the Assessment Process and addressed in the Plan if appropriate

- Language & Physical Limitations
  - If a client or family member requires an Interpreter—call the ACCESS line for authorization.
- Race, Ethnicity, Socio-Economic Status, Class, Religion, Immigration status/Citizenship, Geography,
- Assessment template forms now include SO/GIE (Sexual Orientation/Gender Identity/Expression) fields

Developmental History (Child, Youth only)



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

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

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

DESCRIBE FAMILY OF ORIGIN:

Narrative continued in Addendum

EDUCATION Current School Spec Ed YES NO

Grade Contact/Teacher/ Ph#

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

Last School Attended

Vocational Activities:

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

Prenatal/birth/childhood information (include pregnancy, developmental milestones, environmental stressors, and other significant events) 0-5yrs:

Narrative continued in Addendum

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

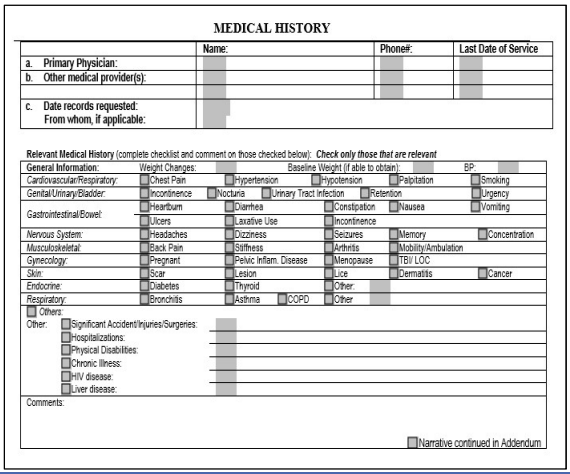
N/A

Narrative continued in Addendum

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

N/A

Medical History



MEDICAL HISTORY

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

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

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

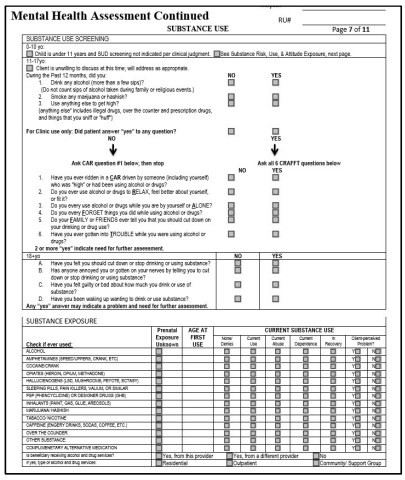
Others:

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

Comments:

Narrative continued in Addendum

Substance Use



Mental Health Assessment Continued — RU#

SUBSTANCE USE — Page 7 of 11

SUBSTANCE USE SCREENING

5-10 yo

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

11-17yo

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

During the Past 12 months, did you: — NO / YES

1. Drink any alcohol (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.)
2. Smoke any marijuana or hashish?
3. Use anything else to get high? (anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff").

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

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

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

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

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

18+yo

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

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

SUBSTANCE EXPOSURE

Check if ever used:	Prenatal Exposure Unknown	AGE AT FIRST USE	CURRENT SUBSTANCE USE: None Ever	Current Use	Current Abuse	Current Dependence	In Recovery	Client-perceived Problem?
ALCOHOL	☐		☐	☐	☐	☐	☐	Y☐ N☐
AMPHETAMINES (SPEED,UPPERS, CRANK, ETC.)	☐		☐	☐	☐	☐	☐	Y☐ N☐
COCAINE/CRANK	☐		☐	☐	☐	☐	☐	Y☐ N☐
OPIATES (HEROIN, OPIUM, METHADONE)	☐		☐	☐	☐	☐	☐	Y☐ N☐
HALLUCINOGENS (LSD, MUSHROOMS, PEYOTE, ECSTASY)	☐		☐	☐	☐	☐	☐	Y☐ N☐
SLEEPING PILLS, PAIN KILLERS, VALIUM, OR SIMILAR	☐		☐	☐	☐	☐	☐	Y☐ N☐
PCP (PHENCYCLIDINE) OR DESIGNER DRUGS (2M-B)	☐		☐	☐	☐	☐	☐	Y☐ N☐
INHALANTS (GLUE, GAS, GLUE, AIRSOLOL)	☐		☐	☐	☐	☐	☐	Y☐ N☐
MARIJUANA/ HASHISH	☐		☐	☐	☐	☐	☐	Y☐ N☐
TOBACCO/NICOTINE	☐		☐	☐	☐	☐	☐	Y☐ N☐
CAFFEINE (ENERGY DRINKS, SODAS, COFFEE, ETC.)	☐		☐	☐	☐	☐	☐	Y☐ N☐
OVER THE COUNTER	☐		☐	☐	☐	☐	☐	Y☐ N☐
OTHER SUBSTANCE	☐		☐	☐	☐	☐	☐	Y☐ N☐
COMPLEMENTARY ALTERNATIVE MEDICATION	☐		☐	☐	☐	☐	☐	Y☐ N☐

Is beneficiary receiving alcohol and drug services? ☐ Yes, from this provider ☐ Yes, from a different provider ☐ No

If yes, type of alcohol and drug services: ☐ Residential ☐ Outpatient ☐ Community/ Support Group

Substance Use Considerations

Must Assess for Substance Use in 7 Areas:

- Tobacco, Alcohol (ETOH), Caffeine, Complimentary Alternative Medicine (CAM), Prescription (Rx), Over The Counter (OTC), and Illicit Drugs

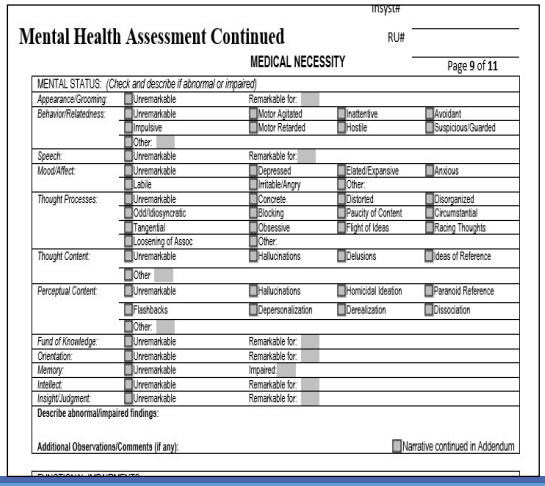
Assess for Substance Use Disorders (SUD):

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

If appropriate establish SUD Diagnosis

- Cannot be primary (FOCUS OF TX) Diagnosis
- Best to also include in Client Plan. However, this is only done so by addressing the underlying MH Dx's signs, Sx, and behaviors through the MH Objectives.
- Refer to substance use treatment services through the Substance Use Access and Referral Helpline at 1-844-682-7215 x2

Medical Necessity
Mental Status Exam (MSE)



Insyst#

Mental Health Assessment Continued RU#

MEDICAL NECESSITY Page 9 of 11

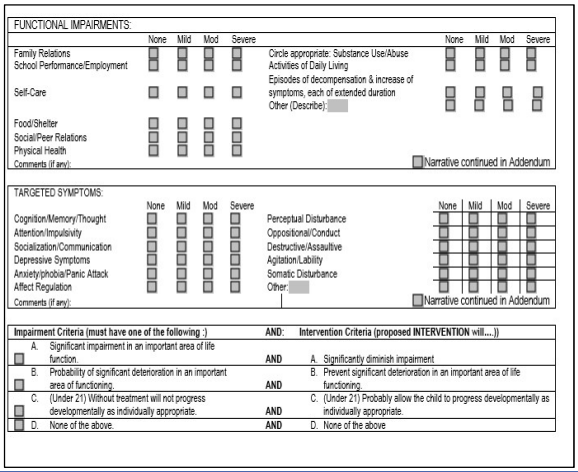
MENTAL STATUS: *(Check and describe if abnormal or impaired)*

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

Describe abnormal/impaired findings:

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

Medical Necessity
Functional Impairments



FUNCTIONAL IMPAIRMENTS:

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

Comments (if any): ☐ Narrative continued in Addendum

TARGETED SYMPTOMS:

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

Comments (if any): ☐ Narrative continued in Addendum

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

Medical Necessity
Diagnostic Summary and ICD 10/DSM 5 Dx

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

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

☐ Narrative continued in Addendum

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

Dimensions:	ICD-10 Code:	DSM –5® Description WITH all specifiers: **for Codes F84.5, F84.9, F84.2, F84.3 & F84: list DSM-IV-TR Descriptor (Dx Name)*	Primary & Secondary Dx's
MH Diagnoses:			**PRIMARY DX**
			Secondary Dx
			Secondary Dx
			Secondary Dx
Substance Use Diagnoses:			Secondary Dx
			Secondary Dx
			Secondary Dx
Psychosocial Conditions Diagnoses:			
General Medical Conditions:			
Optional Disability Measures (WHODAS, etc.)		Diagnosis est. by (with license):	On date:

6/24/2020 77

Assessment Signatures

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

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

6/24/2020 78

No Planned Services Before Assessment and Plan Are Complete

MAY BE CLAIMED	MAY BE NOT BE CLAIMED*
• MH Assessment/Plan Development Services	•Psychotherapy (Individual or Group)
• Crisis Intervention (must be at immediate risk of hospitalization due to danger to self, danger to others or grave disability.) MHP FFS Providers use Individual Therapy code.	• Rehabilitative Services (Individual or Group)
• Medical Providers - prescribers (as needed may prescribe while claiming Psychiatric MH Assessment if PN indicates "urgent" need)	• Collateral
• Case Management – Linkage Only	• Case Management - Monitoring
	•Non-urgent medication services
	•*list not exhaustive

Medication Services—Prescribers Only

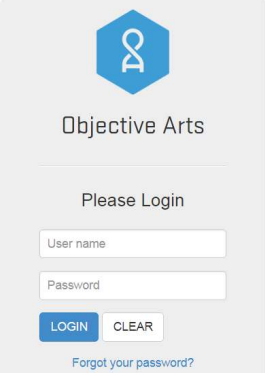
- For children who are wards or dependents of the juvenile court and living in an out-of-home placement or in foster care prescribers are required request permission from the court before any psychotropic medications are administered.
- See http://www.courts.ca.gov/documents/jv217info.pdf for more specific information about JV-220 requirements.
- In addition to a completed JV-220, prescribers must also complete medication consent forms, as described on the following slide.

Medication Services—Prescribers Only cont.

Medication Consent Forms

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

CANS / ANSA



CANS & ANSA are not required at this time.

DK10

Assessment Finalization Timelines

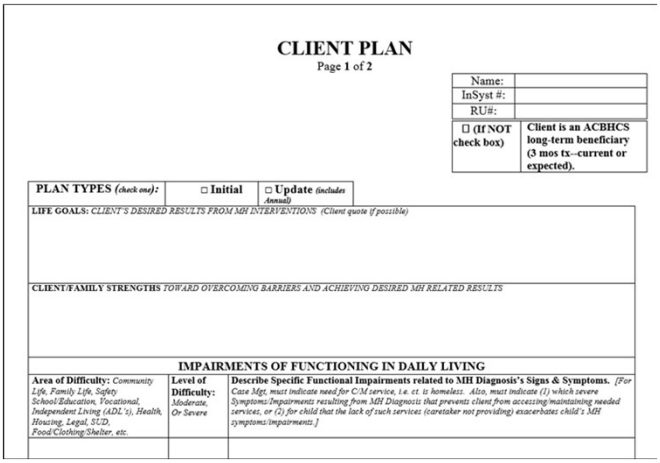
- The **Initial Assessment** – Short or Long form - is due **prior** to the client's 3rd unit of service.
- If client is seen for more than 12 months, the **Annual Assessment – Long Form is required** and must be completed within the first two units of service.

Client Plans

Slide 83

DK10 insert chart here
Deanna Kolda, 3/21/2019

Client Plans



CLIENT PLAN
Page 1 of 2

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

PLAN TYPES *(check one):*	☐ **Initial**	☐ **Update** *(includes Annual)*

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

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

IMPAIRMENTS OF FUNCTIONING IN DAILY LIVING

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

Getting Ready to Write Plan with Client

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

Who can create and complete Plans?

- Individual or Group of Providers
  - Licensed LPHAs only
- Organizations
  - Licensed LPHAs OR Waivered/Registered Interns

Plan Finalization Timelines

- The **Initial Client Plan** is due within 60 days of the referral letter date **AND** prior to the 3rd unit of service.
  - If a case is closed before the third unit of service, a completed plan is NOT required.
- Client plan must be updated immediately following any extension and annual update
  - Six month plan updates are due before the 2nd unit of service after the 6 month RCS approval.
  - Annual/Yearly plans are due by anniversary of the referral letter date. How is this if they are given longer time for the Annual Assessment—see slide #83 "within the first two service units of renewal date"
- Once the client signs the plan no changes can be made to that plan.
- Client's/Representative approval and signature must be obtained each time plan is updated.

Plan Signatures

The Plan finalization date is the when the licensed LPHA signs and is not considered completed until the Client/Representative signs—or indicates why not.

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

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

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

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

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

If the client does not sign or refuses to sign the Client Plan, regular efforts should be attempted and documented to obtain the client's approval. If client was simply unavailable—then must attempt at next scheduled appointment.

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

Additional Client Plan Updates

- Providers must update the treatment plan through-out the year when clinical changes occur. DHCS (and QA) will disallow notes if the treatment plan has not been updated to reflect new client goals, mental health objectives, and events in the client's life.
- Examples of events requiring a consideration of change to the Plan be documented in the PN include, but are not limited to:
  - Hospitalization, new thoughts or behaviors of self-harm or dangerousness to others, additions of new service modalities (i.e. medication services, case management, group rehab, individual therapy, etc.), school suspension, placement risk, etc.
- As needed plan updates are claimed as an Individual Therapy session and each counts as one of the allotted therapy sessions.
- Remember, with every plan update, Brief Screening Tool and new plan signatures are needed

Client's Life Goals Section

PLAN TYPES (check one)	□ Initial	□ Update
LIFE GOALS: CLIENT'S DESIRED RESULTS FROM MH INTERVENTIONS (Client quote if possible)		
CLIENT/FAMILY STRENGTHS TOWARD OVERCOMING BARRIERS AND ACHIEVING DESIRED MH RELATED RESULTS		

Client Goals

The Client Goals are the long-term hopes of the consumer and/or caregiver/parent. Goals…

- Should focus upon their personal vision of recovery, wellness, and the life they envision for themselves
- Can be in the client's own words
- Increase client engagement and buy-in to services

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

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

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

Impairments / Area of Challenges

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

Impairments / Area of Challenges

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

Indicate Level of Challenges

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

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

- For Case Mgt, it is best to indicate the need for C/M service, i.e. ct. is homeless. Also, to indicate: (1) which severe Symptoms/Impairments resulting from MH Diagnosis that prevent client from accessing/maintaining needed services, or (2) for child that the lack of such services (caretaker not providing) exacerbates child's MH symptoms/impairments.

Discharge Plan

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

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

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

Mental Health Objectives

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

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

Mental Health Objectives

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

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

OR

  - *Be Strength-Based mental health objectives* replace problematic Sx with positive MENTAL HEALTH coping skills/behaviors/etc.
- Should be based upon the client's abilities and be meaningful to the client
  - What are they identifying as the problem? Why did they reach out for help?

SMART Objectives

- SMART (Specific, Measurable, Attainable, Realistic and Time-Bound)
- Important to look at how they might impact and build upon strengths and supports
- Must include duration: at least 6 months
  - **Special note about duration**: At least one mental health objective must be valid for 6 months or the plan will need to be updated due to not having any current objectives after the last stated duration (such as only having a MH Objective with a 3 month duration).

Service Modality

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

Service Modality

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

Note: Individual Rehab and Group Rehab are NOT available AND Individual Therapy is available.

Also, Other can include Collateral

Service Modalities

- Identify the proposed type(s) of service modalities to be provided along with a proposed frequency and duration.
- If the planned service modality for a claimed service is not in the client plan it MAY NOT BE CLAIMED and MUST be disallowed if it is claimed. This includes Case Management and Collateral.
- Don't include Assessment/Plan Development/Crisis modalities in the plan.

Detailed Interventions

Detailed Interventions are required for each Modality

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

Detailed Interventions

For each service modality include a detailed description of interventions to be provided. Interventions must focus upon and address the identified functional impairments as a result of the mental disorder.

- Interventions must be consistent with the client plan mental health objectives and the qualifying diagnoses.
- Interventions for Collateral should include listing significant others (by names and/or roles) for whom contact is planned and indicating "and others as needed."
- Detailed Interventions for Case Management would best indicate that successful C/M (linkage and monitoring) will result in the client's MH Symptoms being reduced (i.e. achievement of Client's MH Objectives).

Detailed Interventions - Examples

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

Examples:

Individual Therapy

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

Collateral

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

Med Services

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

Plan Example #1: Client with Moderate/Severe Symptoms

Billable example: Treatment Plan Goal

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

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

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

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

Plan Example #1 Continued: Client with Moderate/Severe Symptoms

Billable example cont.:

Mental Health Objective(s):

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

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

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

Plan Example #1 Continued: Client with Moderate/Severe Symptoms

Billable example cont.:

Service Modality:

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

Detailed Interventions:

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

Plan Example #2: Client with Severe Symptoms

Billable example: Treatment Plan Goal

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

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

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

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

Plan Example #2 Continued: Client with Severe Symptoms

Billable example cont.:

Mental Health Objective(s):

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

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

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

Plan Example #2 Continued: Client with Severe Symptoms

Billable example cont.:

Service Modality:

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

Detailed Interventions:

- Psychotherapy – CBT to help client link feelings of worthlessness to depressive symptoms, to explore roots of low self-esteem and areas of competence.
- Case Management – Successful linkage of client to housing resources in community. Connecting client to resources is expected to decrease client's sadness and depression.
- Collateral – Will provide psychoeducation to client's mother regarding client's symptoms and how to best support client in managing his depression.

Progress Notes

Claiming to Medi-Cal

- Every claim made to Medi-Cal must have a corresponding progress note in the client's chart
- All assessment and plan development sessions require progress notes in order to be claimed. The assessment and plan are not enough to complete the claiming process. Use the appropriate Assessment / Psychiatric Diagnostic Evaluation Codes to claim for these services.
- When writing notes documenting the Assessment and Plan sessions, if each are completed in one session, the progress note may include a reference to the completed form. For example, "This therapist gathered information to complete the Assessment. See Assessment dated…"
- If the Assessment or Plan spans multiple sessions, then the progress note may reference completed sections in the assessment or plan, as long as what sections were completed in that session are specified.
- If it is not possible to reference specific sections of the assessment or plan, then the content of the session must be included in the progress note.

Progress Notes Must…

Progress Notes must contain:

- Procedure Code of service provided to client
- Date of Service
- Indicate what language the service was provided (unless English Speaking client and in the MH Assessment it indicates: "English speaking client and all services will be provided in English").
- Legible Provider Signature with Medi-Cal credential and date signed (not date of service) unless written and finalized with signature on the same day.

Only use ACBH approved abbreviations—if you use an additional abbreviation, or acronym, the first time it is used in each PN it must be spelled out.

Progress Notes Must…

- Indicate code and exact minutes designated from Code/Rate Sheet.
- Default to the code closest (rounding up and down) to the minutes it took for f-f or phone contact time and documentation time.
- Do not put the actual total minutes or break down face-to-face and doc time for example.
  - e.g. 60 minute Ind. Psychotherapy with 10 minutes documentation should be documented as 90834-60".

- 90 minute Psychotherapy requires provider to call UM to confirm medical necessity is met for providing this service at Network Provider level of care.

B/PIRP Format – Progress, Not Process

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

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

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

Plan for future services = Provides plan for continued services i.e. collaterals, coordination of care, continue with CBT techniques etc. Can include any follow up by the provider or client—not simply and always: "next session on mm/dd/yy"

- Always indicate which MH Objective (restate or reference # of Objective in Plan) is being addressed

Modifying Progress Notes for Case Management Services

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

DK7

Progress Notes FAQs

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

Can I combine two of the same services on the same day, for example two collateral phone calls to different people?
Yes, but it may be clearer to the auditor to claim separately if talking to different people. Most likely these discussions will have different purposes.

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

Non-Billable Services

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

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

Slide 119

DK7 needs revision. have to adjust these to these providers
Deanna Kolda, 10/17/2018

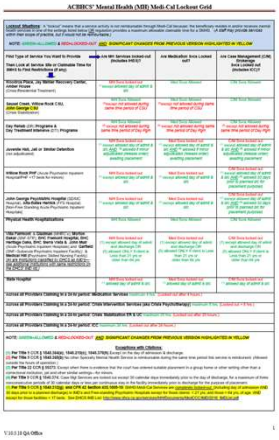
Non-Billable Services

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

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

Mental Health Services Lockout

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

http://www.acbhcs.org/providers/QA/docs/training/MH_Lockout_Grid.pdf

Group Exercise: Putting on an Auditor's Hat

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

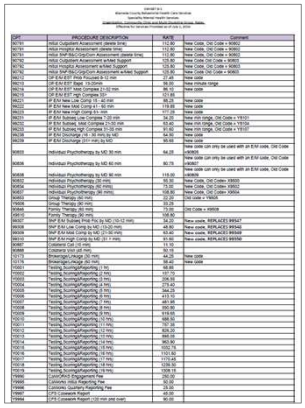
Final Considerations

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

Procedure Codes

MHP FFS Procedure Codes

Choose the right one for your license:



Procedure Code/Services

Assessment and Plan Development

- Use the same code for both assessment and plan development
- Most likely this will be *OP Psychiatric Diagnostic Eval (*90791) or, for prescribers, *OP Psychiatric Diagnostic Eval w/Med Srv* (90792).
  - Indicate code and actual minutes
  - Using these codes counts towards the two allotted initial Assessment/Plan Development units of service initially and annually.
  - At 6 month extension, one unit of service is available for plan development.

Procedure Code/Services

Individual Psychotherapy

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

See rate sheet for specific codes

Example: A 60 minute Individual Psychotherapy session by a LPHA with a client at a private practice office would be coded as 90834-60”

Procedure Code/Services

Family Therapy

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

Example: A 90 minute Family Therapy session by an LPHA is coded as X9510

Procedure Code/Services

Group Therapy

One facilitator can reasonably facilitate a group of up to six clients. For multiple facilitators, only one unit of group service is claimed for each client.

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

Group Therapy must be a modality in the treatment plan.

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

Claiming Group Therapy

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

Crisis Services

Use Individual Psychotherapy codes

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

Relevant clinical details leading to the crisis

The identified crisis must be the client's crisis, not a significant support person's crisis. (CCR24)

The urgency & immediacy of the situation must be clearly documented and describe each of the following medical necessity requirements: (CCR06) (CCR10) *(CCR15)*

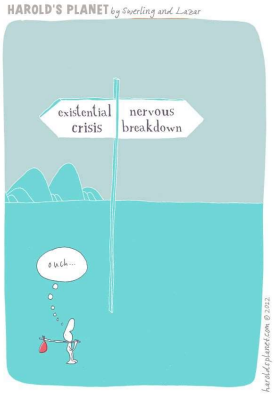
- How the crisis is related to a mental health condition
- How the client is imminently or currently a danger to self or to others or is gravely disabled
- Why the client either requires psychiatric inpatient hospitalization or psychiatric health facility services or that without timely intervention, why the client is highly likely to develop an immediate emergency psychiatric condition.

Interventions done to decrease or eliminate or alleviate danger, reduce trauma and/or ameliorate the crisis.

The aftercare safety plan.

Collateral and community contacts that will participate in follow-up. its of service.

If utilization of Individual Services is needed for Crisis Services, you may contact UM to provide medical necessity for additional therapy sessions.



Procedure Code/Services

Collateral

- Modality must be in the treatment plan to claim.
- Collateral services are to support the Client Plan by:
  - Gathering information from any significant support persons
  - Explaining results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or
  - Advising significant support persons how to assist client(s) in order for client to accomplish MH Objectives
  - 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.
- Maximum of 120 minutes TOTAL every 6 months
- Collateral Call 90887-10" or Collateral Visit 90888-45" (round to closest). Must use code/minutes as approved—cannot combine or separate into smaller units.
- If more sessions are needed, contact UM to provide medical necessity for additional services.

Procedure Code/Services

Brokerage / Case Management

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

- Help clients to access medical, educational, social, vocational, rehabilitative, or other community services that are identified in the Client Plan and Assessment.
- Service activities may include, but are not limited to:
  - Communication with client & other individuals
  - Coordination of care
  - Referrals
  - Monitoring service delivery to ensure client's access to services.
  - Monitoring client's progress toward making use of services.
  - Must meet documentation requirements in earlier slides to claim
- MH Plan – best to 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. Best to also also document, successful C/M is expected to decrease MH Sx's and Impairments.
- Case Management/Brokerage: 10173-30" or 10176-60" (round up or down to the closest time);
  - 30 or 60 minute increments
- Maximum TOTAL time is 120 minutes initial/annual and 180 mins. at 6 month reauthorization.
- If more sessions are needed, contact UM to provide medical necessity for additional services.

Psychological Testing Codes

- Providers can refer a client for psychological testing after 3 months of treatment, if believe an earlier referral meets medical necessity—contact ACCESS to consult.
- Psychological Test Authorization Request (PTAR) is required to be submitted to and approved by ACCESS.
- Includes Testing, Scoring, Reporting activities (1 – 19 hours total).

Other Procedure Codes

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

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

What is the procedure code?

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

What should you do?

This session counts as one of the assessment/plan development sessions. The time the therapist spends writing up the plan is included in the Psychiatric Diagnostic Evaluation rate. The therapist needs to get the plan signed at the beginning of the next session. The next session would be billed as Family Therapy.

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

What should you do?

Bill this service as Individual Therapy. Client should be assessed for the need for substance use services. If the plan is updated then it would still be coded as individual therapy and this would count as one of the individual therapy sessions. Make sure to refer the client to substance use services. In the body of the PN indicate Crisis Intervention service provided.

ACBH FAQs: Clinical Documentation Updates
During the Nationwide Public Health Emergency
June 1, 2020

All of these FAQs apply to both Mental Health (MH) and Substance Use Disorder (SUD) Services during the COVID emergency period, unless otherwise indicated.

For Questions & Technical Assistance, contact: QATA@ACgov.org

Principles:

ACBH recognizes that COVID-19 presents a myriad of challenges. ACBH is working collaboratively with Department of Healthcare Services (DHCS), providers, and other stakeholders to ensure we continue to protect access to care and services, while also minimizing COVID-19 spread.

Q1: May providers claim for telephone and telehealth services?

Yes, both SMHS and SUD services may be provided via telehealth. Please refer to the following ACBH and DHCS resources:
1. Leveraging Technology to Meet Client Needs – New Guidance from DHHS-OCR (issued on March 18, 2020)
2. Leveraging Technology to Meet Client Needs – Non-Licensed Staff Update (issued on March 19, 2020)
3. Specific guidance for providers regarding HIPAA and telehealth is available from the external resources listed on DHCS' Telehealth Resources page.

Q2: May providers claim for services provided via text messaging to clients during the COVID-19 emergency?

No. We have now received updated guidance from DHCS that there is no claiming for texting clients at this time. Texting is only allowed for scheduling appointments with clients. DHCS Legal is vetting any additional use of texting.

Q3: May providers claim for services provided via email messaging to clients during the COVID-19 emergency?

No. At this time, DHCS has not given permission for claiming for email communication. When a beneficiary consents to the use of email communication, and that consent has been documented, counties may send SMHS and SUD notices via email. Providers must remain HIPAA and 42 CFR Part 2 compliant.

Q4: May a LPHA provider whose license has expired continue to provide services if they are unable to renew their credential with their licensing board at this time?

Yes. for additional information, please see below:
1. Order Waiving License Renewal Requirements:
https://www.dca.ca.gov/licensees/continuing_ed.pdf
2. Order Waiving License Reactivation or Restoration Requirements:
https://www.dca.ca.gov/licensees/reinstate_licensure.pdf

Q5: Will late signatures (Informing Materials Consents, Client Plan and Medication Consents) be accepted as compliant for claiming purposes if verbal consent is provided?

Yes, for those documents listed above—but not for Release of Information forms (ROI). In the session's progress note, explain specifically what information was shared with the client, that the client verbally consented to the information provided, and that due to the COVID-19 emergency the client was unable to meet in-person and sign the document. As well, during this public health crisis ACBH has temporarily suspended the requirement for client signature for receipt of psychiatric medication during this time of emergency (Cal. Code. Regs. tit. 9 § 852).

Q6. May the platform DocuSign be utilized to obtain electronic signatures?

Yes, during the COVID emergency, HIPAA-compliant electronic signature platforms such as DocuSign may be used for both staff and client electronic signatures. However, a Business Associate Agreement must be in place with the electronic signature vendor in order to utilize HIPAA-compliant platforms.

Q7. When the emergency ends, does ACBH expect that providers will go back and obtain treatment or client plan signatures for clients that are still in treatment?

No, Providers are not expected to get signatures from beneficiaries who receive Specialty Mental Health Services and SUD services during the time period of the COVID-19 public health emergency. When the public emergency ends, providers shall resume compliance with all documentation and signature requirements and update all clinical records on a "go-forward" basis.

Q8: Can the client provide verbal consent for a Release of Information (ROI)?

No. The U.S. Department of Health and Human Services has not waived the signature requirements of written authorizations for client releases of information. You may discuss the release of information with the client and mail the forms to them for their signature (it is suggested you enclose a self-addressed stamped return envelope as well). A copy, fax, or photo sent by email or text will be acceptable for a signed ROI. A witness signature is not required on the ROI form.

Q9: (MH only) Under what circumstances could a provider disclose PHI to a family member, relative, close friend, or other person identified by the individual without an ROI?

A provider may disclose PHI to a family member, relative, close friend, or other person identified by the MH (not SUD) client as responsible for their care without an ROI under the following circumstances when the client is NOT present:

1. The family member, relative, close friend, or other person has already been identified by the client as responsible for their care;
2. The PHI is used to notify or assist in the notification of (i.e. identifying/locating) this family member/person responsible for the client's care of the client's location, general condition or death;
3. The provider determines in their professional judgment that the disclosure is in the best interest of the client; AND

4. The provider discloses ONLY the PHI directly relevant to the person's involvement with the client's care or payment related to the client's care or for notification (i.e. minimum necessary).
5. For example, the provider may infer that it is in the client's best interest to allow the other person to act on behalf of the client in picking up filled prescriptions, medical supplies, or other similar forms of PHI
6. See 45 CFR 164.510(b)(3)). https://www.law.cornell.edu/cfr/text/45/164.510

Q10: If a provider has lost contact with the client during the COVID-19 emergency, may they contact a family member (or another person) without a signed Release of Information in order to locate the client?

Yes, but only if they do not disclose any PHI to the person with whom they are speaking. This includes NOT disclosing that the caller works for a behavioral health services provider.

Q11: Has ACBH issued any additional guidance on Telehealth and HIPAA privacy and security?

Yes, the Alameda County Health Services Agency Office of Compliance Services issued the following guidance: 1. Remote Work and HIPAA Privacy and Security: March 2020 COVID-10 Remote Work and HIPAA Privacy & Security Guidelines for HCSA Staff. 2. Telehealth and HIPAA Privacy and Security: March 2020 FAQs: COVID-19 Telehealth and HIPAA Privacy & Security

Q12: Are there any exceptions to obtaining client written consent before disclosing Protected Health Information (PHI)?

1. Specialty Mental Health Services (SMHS): Yes, a MH provider may disclose PHI to another HIPAA-covered health care professional (mental and/or physical health) for the purpose of treatment, and for health care operations activities including care coordination (e.g. referrals) for mutual clients

Q13: During the COVID-19 emergency many of our clients desperately need case management services to link them with critical community services. If I am unable to meet with the client in person to obtain a written ROI, how can I advocate on their behalf for services that do not meet the above exceptions?

If you are speaking with the client on the telephone or via telehealth, you may ask their consent to add another service provider to a multiparty conference call. An ROI is not required in this situation because the client is on the original phone call, implying consent.

Q15: Are written Telehealth Consents required before Telehealth Services begin?

No, during the emergency period, the requirement for written or verbal consent is suspended for Telehealth Services. The requirement for written consents for Telehealth Services will resume after the emergency ends. (See Executive Order N43-20.)

Q16: Is there an ACBH required Telehealth Consent form to use?

No. ACBH is in the process of developing a Telehealth Consent Form for future use.

Q17: During the COVID-19 emergency has there been any changes to the NOABD and State Fair Hearing Appeal process?

Yes, from March 1, 2020 through the conclusion of the COVID-19 emergency clients will have 240 days (rather than 120 days) to file for a State Fair Hearing when their Appeal is denied by ACBH. When NOABD's are issued to the client—an additional insert must be added. See: ACBH Grievance System

Q18: Where can I find COVID testing resources?

http://www.acphd.org/2019-ncov/testing.aspx
http://www.acphd.org/media/571443/alameda-county-covid-testing.pdf

Q22: Can group counseling services be conducted via telehealth and telephone

Yes. Group Counseling services may be provided for SUD and Specialty Mental Health Services

Q23: How can providers ensure their patients do not run out of medications?

1. Medi-Cal allows patients to fill up to 100 days of non-controlled medications. Narcotic treatment programs can receive exemptions to provide take-home medications for patients who are sick or quarantined. See DHCS COVID-19 FAQ: Narcotic Treatment Programs for more detail. Patients receiving buprenorphine products can currently receive 30-day supplies on Medi-Cal. 2. Utilization limits on quantity, frequency, and duration of medications may be waived by means of an approved Treatment Authorization Request (TAR) if there is a documented medical necessity to do so. See DHCS pharmacy guidance.

Q25: Does ACBH have specific expectations for documentation of services delivered by telephone or telehealth? Providers may indicate that telephone and telehealth services were provided in lieu of in-person services due to COVID-19 social distancing practices and continue following current documentation requirements.

Q27: Are facilities able to provide treatment or recovery services outside the facility service location if there are concerns about providing treatment at the location due to COVID-19? In some circumstances, DHCS shall consider and may allow facilities to provide treatment or recovery services off-site for any concerns related to COVID-19. Providers should contact their Licensing Analyst for questions. See COVID-19 Response website for information notices for treatment facilities.

Q28: (MH only) Can a licensed mental health professional provide direction to a Therapeutic Foster Care (TFC) parent through telehealth rather than in person? Yes. Telehealth and telephone may be used by licensed mental health professionals to provide direction to TFC parents during the emergency.

Q35: How do providers access federal grant opportunities?

1. Providers should stay updated by regularly checking the federal websites for grant opportunities. DHCS has a web page that reflects a compilation of websites that may be followed to search for grant funding opportunities. These links can provide more information on the following opportunities: provider relief fund; Grants.gov; telehealth; small business loans; and SAMHSA grant announcements
2. The Small Business Administration recently issued two interim final rules to supplement previously posted interim final rules on the Paycheck Protection Program (PPP) with additional guidance regarding disbursements, as well as guidance on the amount of PPP loans that any single corporate group may receive and criteria for non-bank lender participation in the PPP.

Q36: Where are up-to-date resources on COVID-19?

1. California Department of Public Health – COVID-19 Updates CDPH
2. Gathering/Meeting Guidance
3. CDC COVID-19 webpage
4. Guidance for the Elderly
5. Guidance for Employers
6. What to do if you are sick
7. Guidance for Workplace/School/Home Document
8. Steps to Prevent Illness
9. Guidance for use of Certain Industrial Respirators by Health Care Personnel Medicaid.gov, COVID-19 resource page
10. CMS: Emergency Medical Treatment and Labor Act (EMTALA) Requirements and Implications
11. Governor Newsom's 3/12/20 Order 12. CDPH: For Individuals with Access and Functional Needs

Q37: Does DHCS provide an outreach letter to Medi-Cal Beneficiaries regarding COVID-19?

Yes, see https://www.dhcs.ca.gov/Documents/Beneficiary-Outreach-Letter.pdf This is an excellent resource to provide to clients during the COVID emergency.

Q38: Are there COVID resources for Spanish speaking individuals?

Yes. MUA Publishes a COVID19 Resource Guide for the Immigrant Community https://bit.ly/MUAGuiaCOVID19

Q39: Are there support resources for staff and providers during the COVID emergency?

Yes. See local staff COVID support resources below.

1. In collaboration with Alameda County Psychological Association (ACPA), Crisis Support Services of Alameda County (CSS) is rolling out the Staying Strong Against COVID19 Support Line for Bay Area Workers in Healthcare Settings. It's Okay to Vent: 510-420-3222
2. The COVID19 Pro Bono Counseling Project is an organization offering free video and phone therapy to front-line healthcare workers in the Bay Area during the COVID19 crisis. See: https://sites.google.com/view/cpbc-proj/home and https://www.youtube.com/watch?v=5rgI5T1Vxgo&feature=youtu.be

Q40: How should behavioral health programs reduce transmission of COVID-19?

The CDC has provided interim infection prevention and control recommendations in health care settings. As well, all providers are now required to wear facial coverings inside their programs and sites.

Q41: How should behavioral health providers manage clients presenting with upper respiratory symptoms?

ACBH strongly encourages use of telehealth or telephone services to minimize infection spread. Programs should follow infection prevention and control recommendations in health care settings published by the CDC (please see Q35 for more details).

Q42: When should programs refer a patient to medical care?

See CDC guidelines for health care professionals on when patients with suspected COVID-19 should seek medical care.

Q44: If a former client is later found to have been diagnosed with COVID-19, what action should be taken?

1. Staff should inform individuals of possible exposure but must do so in a way that protects and maintains the other clients' confidentiality as required by law. Clients exposed to a person with confirmed COVID-19 should refer to CDC guidance on how to address their potential exposure, as recommendations are evolving over time.
2. It is the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases to report to the local health officer (17 CCR § 2500 (b)). For COVID-19, immediate reporting by phone (17 CCR § 2500 (b)). 3. Inpatient and residential facilities must also report to DHCS, within one (1) working day, any events identified in California Code of Regulations Title 9 Chapter 5 Section 10561(b)(1), which would include cases of communicable diseases such as COVID- 19.

Q46: What else can behavioral health programs do to prepare for or respond to COVID-19?

DHCS encourages providers to adhere to the CDC's and CDPH's recommendations to prepare for COVID-19.

Q47: How can behavioral health providers obtain personal protective equipment (PPE)?

Resources on infection mitigation in behavioral health facilities are as follows:

1. California Department of Public Health (CDPH) Health Care System Mitigation Playbook which provides helpful information to medical facilities on infection control and mitigation, and has useful information for BH facilities as well.
2. ASAM's, Infection Mitigation in Residential Treatment Facilities which provides helpful information on the same, designed for SUD residential treatment.
3. National Council on Behavioral Health COVID-19 guidance for behavioral health facilities

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

What should you do?

Bill this session as Individual Therapy. At your next session, you would develop a safety plan with the client and discuss whether any changes to the treatment plan are necessary. All of these service activities would be billed as individual therapy.

Reminders

- Providers are expected to carry a minimum caseload of three (3) MHP FFS Provider Network clients (some exceptions apply.)
- Because our beneficiaries typically benefit from connection to additional community resources, providers are expected to use the "Brokerage/Linkage" billable service for assisting clients in connecting with community resources such as primary care physician, housing resources and social services.
- Organizational Providers must comply with the OIG and Other Exclusion List Monitoring, Oversite and Reporting Policy

KC6

Who you gonna call....

- **ACCESS** for referral questions, (510) 346-1010
- **Utilization Management Program Daily Coordinator** for RCS & Attestation questions, (510) 567-8141
- **Provider Relations** for claims processing questions, (800) 878-1313
- **Network Office** for contract questions, (510) 567-8296
- **Quality Assurance** for documentation questions, (510) 567-8105
  - QATA@acgov.org

Slide 158

KC6 In the event the provider and client are needing additional assistance, the provider can contact ACBH Help Desk (888-346-0605) which has HIT staff available to assist with the renewal or application process. The client will need to sign the attached form (MC382) which assigns ACBH as their authorized representative in order for HIT staff to submit an application on their behalf.

Please note that the Help Desk is for providers only.
Kimberly Coady, 5/13/2020

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

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

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

STAY IN TOUCH WITH QA - Use these links to subscribe for updates:	MHP Network Providers CBOs & County Clinics/Programs	e-Subscribe e-Subscribe

Thank you for coming!