ALCOHOL, DRUG & MENTAL HEALTH SERVICES
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Date: October 20, 2014

To: Clinical Documentation Standards 9/23/14 Training Participants

From: ACBHCS QA Office

Re: Follow-up to questions asked at the training.

Q1: Can MH Providers bill Collateral and Case Management Brokerage services when they are collaborating with another staff person within the same RU?

A1: --No
--Provider's may bill if the other staff person is in a different RU—or in an outside program that does not have an RU Provider # with ACBHCS. (This includes providers who are in a different RU within the same agency or building.)

Q2: Can MH Providers bill Plan Development services when they are collaborating with another staff person within the same RU?

A2: --Yes
--Please see attached "Plan Development and Plan Monitoring" Memo.

Q3: Do Medication Consents expire within a specific time frame?

A3: --No, unless an expiration date is noted on the Consent form itself.

Q4: Do Release of Information Consents automatically expire within a specific time frame?

A4: --Yes, 12 months is the maximum time frame that is allowed and the specific time frame must be specified on the form itself (even if it is the maximum 12 month period).

Q5: Has the authorization process changed now that the Treatment Plan cycle is annual?

A5: --No. Except that, InSyst will now default to a 12 month authorization period rather than the previous six month time period. If the client remains on the 6 month cycle (until the chart reaches it's Episode Opening Month annual

anniversary)—the record will be converted to a 6 month authorization period in the 24 – 48 hours following data entry.
--Please note that the first 485 InSyst report will not be generated for a client until the 30 days prior to the first day of the client's Episode Opening Month's (EOM) anniversary. Therefore, it is highly recommended that the QA staff review the quality of the client's Initial Assessment and Treatment Plan at 60 – 90 days after the EOD so that a year does not pass before it is confirmed that these items meet clinical documentation standards.

Q6: May a MH Provider claim for specialty Mental Health Services when attending an IEP meeting.

A6: --No, this is currently considered a situation in which MH services may not be claimed. If there is a change in this rule in the future all providers will be notified.

Q7: May a MH Provider claim for specialty Mental Health Services when attending other types of interdisciplinary meetings held in the school setting.

A7: --Yes
--Plan Development services may be billed when a change is being considered to the Treatment Plan. See attached "Plan Development & Plan Monitoring" Memo.
--Brokerage services may be billed when a client is linked with other services as a result of the meeting (and this is an objective on their MH Treatment Plan). (However--only if the Providers are in different RU's.)
--Collateral services may be billed when participants are working on implementation of the client's MH Treatment Plan's objectives. (However—only if the Providers are in different RU's.)

Q8: May there be more than one Clinical Supervisor routinely co-signing documents in one client's chart (whether the Supervisors are, or are not, in the same RU)?

A8: --No. For continuity of care only one Clinical Supervisor may be responsible for a single client's chart. Exceptions may occur when: a Supervisor is out on vacation or leave, or when the case is transferred from one Supervisor to another.

Q9: When is "Face-to-Face" (FF) time selected for a service?

A9: --FF time is the amount of time that either the client, family member, or other person is seen face-to-face during service provision.
When the service is provided on the phone—contact time is indicated as the FF time AND the location of "phone" must be indicated in the Progress Note (PN).
--This applies to all MH billing codes.

Q10: What types of time must be broken out for a PN?

A10: --FF and Total Time must both be indicated in the PN.
--It is recommended that FF, Documentation Time, Travel Time and Total Time all be broken out.

Q11: When an Assessment or Treatment Plan is being written up by the Provider without the client present—how is the time broken down for the writing of the Assessment or Tx Plan vs. the writing of the actual Progress Note?

A11: --The time taken to write up the Assessment or Treatment Plan, and the time taken to write up the PN are summed and indicated under *Documentation Time.*

Q12: What service code do Medical Providers (Psychiatrists, Advanced Practice Nurses and Physician Assistants) use for their Initial and Annual Psychiatric Diagnostic Evaluations?

A12: --565-90792 Psychiatric Diagnostic Evaluation with Medical Component.

Q13: May any MH services provided be billed if the episode was closed before the client was served face-to-face (f-f).

A13: --Yes—for the first 30 days—if appropriate as Assessment.
--If the client has not been seen by 30 days—the time at which the MH Assessment is due—no additional services may be billed until the client is seen f-f for the MH Assessment or Crisis Intervention.

Q14: In the Client Treatment Plan what is the difference between (Long Term) Goals and Mental Health Objective.

A14: --The Goal may be broken down into both a Long Term Client Goal (required) and a Long Term Mental Health Goal.

--The Long Term Client Goal is the client's overall hopes and dreams regarding the outcome of services (use client's own words when possible).

--The Long Term MH goal is the overall MH goal that will lead to the attainment of Long Term Client Goals.

-The Mental Health Objectives are the smaller specific steps (SMART: Specific, Measurable, Attainable, Realistic and Time Bound) that lead to the success of both the Client's Long Term Goals and Long Term MH Goals.

--See examples at the end of this FAQ.

Q15: When is a progress note late?

A15: -Per the current "Clinical Record Documentation Standards" Manual (pg. 16): "(Outpatient) Progress Notes (PN) must be entered in the clinical record within one (1) working day of each service provided. Approval by the

supervisor and clinician finalization must be completed within five (5) business days. Late Entries: In the infrequent situation when an emergency prevents timely recording of services, the service must be entered in the clinical record as soon as possible. The beginning of the note must clearly identify itself as a late entry for the date of service (e.g. "Late entry for date of service"). Signatures for late entries *(and all Progress Notes)* must include the date the note is written. The note must be filed chronologically in the clinical record per the date it was written, not per the date of service." This is being re-visited by ACBHCS and if it changes all Providers will be notified.

Q16: If we trained to the 3 day standard for a late note (which was briefly posted on the website), may we continue with that standard until ACBHCS updates their current standard?

A16: No—please continue to use the current standards.

Q17: Are any other types of Objectives—other than MH Objectives--allowed in the Client's Treatment Plan such as those regarding Co-occurring Substance Use Disorders, Housing, School, and Work Objectives?

A17: --No, all objectives must be MH related. (That is, all Objectives must be MH Objectives.) One may be working on Impairments in non-mental health areas (co-occurring, housing, school and/or employment) however the impairment must be due to the Medi-Cal Included Dx's signs, symptoms and/or behaviors.
--These signs, symptoms and/or behaviors must then be specifically addressed in the MH objectives and MH Interventions. See examples in boxes below.

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

Billable example:

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

Goals: Client states: "I want my own place to live". Long Term MH Goal: Decrease depression symptomology, and increase coping, so that client's depressive signs and symptoms do not negatively impact his ability to obtain housing.

Mental Health Objective(s):
-Client's depressive symptoms are reduced as evidenced by an increase in sleep from 2-3 hours per night to 6-8 hours per night by 6 months; and an increase in energy from 0 energy now to 6-8 on a 0-10 scale (10 being high energy) per self-report by 6 months.
-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 months.
-Client's lack of interest and indecisiveness will decrease as evidenced by an increase in action steps taken by client towards obtaining stable housing from 0 to 4 or more action steps taken within the next 3 months.

Service Modality: Psychotherapy 1x/week, or as needed, for 1 year; Case Management 1x/week, or as needed, for 1 year; Group Rehab 1x/week for 6 months

Detailed Interventions: Psychotherapy – CBT to help client link feelings of worthlessness to depressive symptoms, to explore roots of low self-esteem and areas of competence. Group Rehab – build client's awareness to track and manage depressive symptoms, teach coping skills such as relaxation techniques, and build client's self-care skills. Case Management – Link client to psychiatric services.

Non-billable example:

Mental Health Objective: Client will obtain stable housing within 6 months; temporarily living with a friend.
Service Modality: Case management 1x/week or as needed for 1 year
Detailed Interventions: Case management - Case manager will work with client to apply for housing and assist client in filling out necessary forms.

Example #2: Impairment: Inability to obtain/maintain employment: chronic periods of unemployment or underemployment

Billable example:

Dx: Schizophrenia—Paranoid delusions, paranoid auditory hallucinations with negative symptoms of flat affect, poor planning and follow-through which results in: social withdrawal, lack of motivation (such as ability to attend desired vocational services) and neglect of personal hygiene.

Goal: Client states: "I want a job so that I can support myself". Long Term MH Goal: Decrease positive and negative signs of schizophrenia so that they do not interfere with the client's ability to obtain and maintain meaningful employment.

Mental Health Objective(s):
-Client's current symptoms of schizophrenia will decrease by 6 months as evidenced by increased motivation to attend desired appointments by client/other's self-report.
-Client will attend appointments with psychiatrist consistently (5 of 6 monthly times, now 1 of 6 monthly times by 6 months.
-Client will attend to daily hygiene (as evidenced by taking a shower and wearing clean clothes) 6 of 7 days/week (now 0) by 6 months.
-Client will identify the role of 6 of his symptoms of schizophrenia that result in employment difficulties from 0 now by 9 months.
-Client will take antipsychotic medications consistently as prescribed (25 of 30 days, now 5 – 10 of 30 days) by 12 months as evidenced by self or others report.
-Client will learn and implement 4 - 6 assertiveness and other communication skills (now 0) by 12 months.
-Client will identify and challenge 5 -10 (currently 0) delusional beliefs and generate 5 – 10 (currently 0) reality-based alternatives regarding barriers to employment by 12 months.

Service Modality: Individual and group rehab 1x/week, or as needed, for 1 year; Case Management 1x/month, or as needed, for 1 year; Individual Psychotherapy 1x/week, or as needed, for 1 year; Medication Management 1x/month, or as needed, for 1 year.

Detailed Interventions: Psychotherapy – CBT to help identify paranoid thinking and to generate reality based alternatives. Individual & Group Rehab – build client's awareness to track and manage psychotic symptoms, teach coping skills such as relaxation techniques, and build client's self-care skills. Case Management – Link client to vocational services. Medication management strategies to engage client in collaboration to find anti-psychotic medications that he is able to tolerate without significant side-effects that have led him to discontinue medication regimen in the past.

Non-billable example:

Mental Health Objective: Client will obtain stable employment within 6 months.
Service Modality: Case management 1x/week or as needed for 1 year
Detailed Interventions: Case management - Case manager will work with client to job search and assist client in filling out necessary applications.

Example #3: Impairment: Cocaine dependence and abuse.

Billable example:

Included M/C Dx: Schizophrenia, Paranoid Type—Paranoid delusions, paranoid auditory hallucinations with negative symptoms of flat affect, poor planning and follow-through, social withdrawal, amotivational and neglect of personal hygiene.

Goal: Client states: "To stop using cocaine and landing in the hospital." Long Term MH Goal: Prevent Psych Decompensation which usually leads to coping with paranoia by using cocaine, and has also resulted in psychiatric hospitalizations.

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

Service Modality: Individual Rehabilitation 1 time per week, or as needed, for the next 12 months and Group Rehabilitation 1x per week for the next 12 months.

Detailed Interventions: Utilize skill building to:
--Increase client's reality testing by helping client identify paranoid thoughts and his reactions. –Assist client to identify behaviors that have led to hospitalization and teach client about alternative behaviors.
--Teach and practice with client relaxation techniques, social skills, and other alternative coping strategies to be used in response to paranoid thoughts.

Non-billable example:

Mental Health Objective: Decrease client's use of cocaine from daily to 0 xs per week as reported by client over the next 12 months.
Service Modality: Individual Rehabilitation
Detailed Interventions: Provide psycho-education on substance use. Teach relapse prevention techniques. Help client monitor use of cocaine.