Assessment & Diagnosis

- Substance Abuse **CANNOT** be Primary Diagnosis.
- Only licensed, waivered, registered staff and RNs with Masters' degree in Mental Health can finalize assessment.
- **SCOPE of PRACTICE WARNING—** Community Workers, Family Partners, RN (without Psych MS), **CANNOT** complete the Diagnosis– EVEN WITH co-signature.
- The assessment MUST *Include* Medi-Cal Diagnosis (see below), AND document significant functional impairment resulting from diagnosis.
- For new clients an assessment is required within 60 days of admission.
- Re-assessment is required every three years for continuous clients or when there is a significant change.
- Addendums can be made when there is additional information gathered or a change occurs. This will not restart the timeline for a new Assessment.

Included Medi-Cal Primary Diagnosis Categories
USE THESE CATEGORIES

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

Excluded Medi-Cal Primary Diagnosis Categories
DO NOT USE THESE CATEGORIES

- Substance-Related Disorder
- Mental Retardation
- Communication Disorders
- Autistic Disorder
- Tic Disorders
- Delirium, Dementia, and Amnestic and Other Cognitive Disorders
- Mental Disorders due to a general medical condition
- Motor Skills Disorder
- Sexual Disorders
- Sleep Disorders
- Antisocial Personality Disorder
- Other Conditions that may be a focus of clinical attention

Treatment Plans

- Develop the plan with the client/family and write it in their language & English (if needed).
- Write a Progress Note documenting how the client/family participated in the formulation of the plan & the completion of the Treatment Plan.
- **Initial Treatment Plans are due within 60 days of the client's entry into the program.**
- All Treatment Plans are good for 1 year.
- Addendum Treatment Plans can be used at any time. They can be used to collect a signature, add/modify a goal, objective or intervention. This does not restart the annual Treatment Plan timeline.

Start Date is the LPHA's signature/approval date- **Do Not Back Date—That is Fraud.**

End Date is the last day before the new treatment plan is due.

Verify the *Included* Primary Mental Health Diagnosis in the Assessment — (not Substance Abuse).

Barrier- State the MH Primary Diagnosis being treated.

Goals—Reduce the symptoms of diagnosis to improve functioning.

Objectives are behavioral measurable simple steps client will take to address MH Diagnosis. **Symptoms related to the diagnosis must be addressed.**

- NOT just "*will take meds*" – "Explore barriers to medication compliance *and attend medication support groups 2x per month.*"
- NOT just "*will attend visits*"– "*Discuss anxiety issues and develop 2 coping skills to lessen discomfort from attending appointments.*"

Interventions - list all MH, case management and medication– detail how case management and rehab will address the MH Dx.

Monolingual client – Provide language services when developing & reviewing Treatment Plan. Document in Progress Notes.

Obtain Client Signature

- If the client DID NOT sign/refuses, write a clear note explaining why and document all attempts to obtain signature.
- If the client gave verbal approval, write a clear note indicating that and obtain client signature at next appointment. Please document attempts.
- If the client signs a paper copy, it must be scanned into the record.
- If the client is under age 12, the Parent/Guardian must sign.

Using a signature pad? MAKE SURE you **Save Signature.**

Finalize Plan - Must be signed by licensed/waivered/registered staff.

Pending - Send to supervisor for signature.

PAPERWORK TIMELINES

- Initial Assessment— due within 60 days of admission.
- Re-Assessment—For continuous clients, must be completed every 3 years or when there is significant change in clinical condition.
- Treatment Plan—Initial is due within 60 days of admission to a new program and good for 1 year.
- Authorizations to Release/Exchange Information— good for 1 year.
- Medication Consent— good for 1 year.

Mental Health Medi-Cal

DOCUMENTATION CHECKLIST

ASSESSMENTS

Include Primary diagnosis and significant impairment.

TREATMENT PLANS

Address the significant functional impairment resulting from the Primary diagnosis listed in the Assessment.

PROGRESS NOTES

Services listed in the Progress Notes address Treatment Plan and Barrier (Diagnosis).

BEHAVIORAL HEALTH AND RECOVERY SERVICES
Quality Management - May 2016

Progress Notes

PROGRESS NOTE FOR

- Independent Note (Not an Open Client)
- New Service (Open Client)

DATE OF SERVICE

- One note, for each service for each day (not multiple days of service)
- Write notes on day of service, or no later than 3 days after
  - Verify year

SERVICE DURATION

- Use actual # service minutes, do not round up

SERVICE ACTIVITY (check below)

- No Show, voice mail, email: Use 55

LOCATION CODE (double check!)

- Clients location is primary

TREATMENT PLAN BARRIER

- Address Treatment Goal, select Barrier

NOTE FIELD

- Use Template (right click, select system templates)
- Do not paste Emails into note
- **B**ehavior/goal—diagnosis, behavior, MH issue addressed
- **I**ntervention—What you did (MH related)
- **R**esponse- What happened, client's response
- **P**lan for future– What needs to happen

NOTE TYPE

- Restricted - indicates review needed before release, i.e., 42cfr, CPS
- Disclosure (without consent)

COSIGN

- Interns - pick your supervisor

LANGUAGE

- Always use for non-English

Group Notes

- Must address MH issue - not just health or substance use
- Only 2 Providers can bill, do not bill for a third provider
- If more providers/staff - do not write a separate note, just note additional provider in text field

- **Number of Clients in Group** - number of open client's represented
- **Co-Practitioner/Duration** - Both providers must be able to bill for service (Meds both must be MD/NP/RN)

Location Codes

If the client is in one of these locations you must choose the correct location or you will bill inappropriately!

- 26.5 Out-of-State, IMD, Jail/YSC
- Voicemail
- Missed Visit (No Show/Client not home)
- Psychiatric Hospital & PES
- Redwood House—Lockout
- Redwood House (MedSup/CM)
- Skilled Nursing Facility-Psych

Billing Code References & Descriptions

$ TARGETED CASE MANAGEMENT (51) VRS-51, Katie A-ICC-51

- Communicate with others to assess, refer, monitor, evaluate services
- Coordinate w/others to access service
- Locate funding for living arrangement
- Referral/Access/ or Monitor needed services e.g.., Medical Needs, MH Services, Social Support , Vocational
- Provide linkage to other services

$$$ CRISIS INTERVENTION (2)

- Assess immediate crisis
- Danger to Self/Other addressed/resolved
- Gravely Disabled addressed/resolved
- Stabilize immediate crisis

Mental Health Services

$$ ASSESSMENT(5), GROUP(50)

Non MD/Non NP– Working on Assessment

- Assessment/Medical Necessity
- Assessment/Diagnosis/MSE (by LPHA)
- Re-Assessment
- Assessment Addendum
- Behavioral or Needs Assessment
- CA/LOCUS
- Co-Occurring Assessment
- Conduct Psych Test (by PhD/PsyD)
- Review external information for assessment

$$ PLAN DEVELOPMENT (6)

Non MD/Non NP - Working on Treatment Plan

- Develop client's Treatment Plan
- Gain Treatment Plan approval
- Evaluate Treatment Plan goal, progress
- Update/Modify client's Treatment Plan
- Treatment Plan Addendum

$$ REHAB (7), VRS-07, Katie-A-IHBS-7, REHAB GROUP (70)

- Address Behavioral Health goal
- Address Behavioral symptoms & impact of/on health
- Coping skills development
- Daily living skills development
- Social skills development

$$ COLLATERAL (12), GROUP (120)

- Not for working with other professionals
- Address client's MH w/support person/family
- MH Related-Parent/support person training
- MH Related- Psycho-educate support person

Billing Code References & Descriptions

$$ THERAPY INDIVIDUAL (9), FAMILY (41) & GROUP (10)

LPHA, Trainee, RN w/Psych MS

- Address Treatment Plan goals–therapy

$$$$ MEDICATION SUP (15), GROUP (150)

MD, NP, RN, LVN or LPT

- Address health issues impacted by psychotropic meds or functional impairments
- Address psychiatric symptoms
- Evaluate med side effects/effect
- Medication education
- Obtain Med Consent
- Physician Update Assessment
- Develop Treatment Plan with medication support

$$$$ MD/NP INITIAL ASSESSMENT (14)

- Physician Initial Assessment

$$$$ RN INJECTIONS (16)

MD, NP, RN, LVN or LPT

- Injection

$$$$ RN INJECTIONS (19)

MD, NP, RN, LVN or LPT

- Injection of Risperdal Consta or Invega Sustenna

$$$$ MD TIME NOT MEDI-CARE BILLABLE (17)

Not face to face MD or NP

- Billable to Medi-Cal without client present– Not any of the things listed under (55)
- Chart review for medication
- Reports/letters- not SSI, not court
- Clinical Paperwork

Unbillable Services (55)

- ⊗ Clerical task
- ⊗ Close a chart
- ⊗ CPS/APS report
- ⊗ Deceased client
- ⊗ Discharge Note
- ⊗ Family member referral
- ⊗ Preparation for service
- ⊗ Rep-Payee functions
- ⊗ Review/Prepare chart for release of information
- ⊗ SSI paperwork no client present
- ⊗ Tarasoff Report—making report
- ⊗ Translation only
- ⊗ Transportation of client – driving to appointment
- ⊗ Prepare, Testify, Wait in court
- ⊗ Write a letter for court
- ⊗ No service - missed visit - no show
- ⊗ Schedule appointments
- ⊗ Send or receive email, voicemail, fax