**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 MD), **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.

**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).

**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).

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**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

- Included Medi-Cal Primary Diagnosis Categories

- 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

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**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.
- Treatment Plan—Initial is due within 60 days of admission to a new program and good for 1 year.
- Treatment Plan—Initial is due within 60 days of admission to a new program and good for 1 year.
- Medication Consent—good for 1 year.
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 SS

LOCATION CODE (double check!)
- Clients location is primary

TREATMENT PLAN BARRIER
- Address Treatment Goal, select Barrier

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

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

NOTE FIELD
- Use Template (right click, select system templates)
- Do not paste Emails into note
- Behavior/goal—diagnosis, behavior, MH issue addressed
- Intervention—What you did (MH related)
- Response—What happened, client’s response
- Plan 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

Mental Health Services

$ ASSESSMENT(5), GROUP(50)
- Non MD/Non NP-- Working on Assessment
- 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

$ TARGETED CASE MANAGEMENT (51) VRS-51, Katie A-ICC-51
- Communicate with others to assess, refer, monitor, evaluate services
- Coordinate w/other 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
- Behavioral or Needs Assessment
- CA/LOCUS
- Co-Occurring Assessment
- Conduct Psych Test (by PhD/PsyD)
- Review external information for assessment

$ CRISIS INTERVENTION (2)
- Assess immediate crisis
- Danger to Self/Other addressed/resolved
- Gravely Disabled addressed/resolved
- Stabilize immediate crisis

$ ASSESSMENT OF (9), FAMILY (41) & GROUP (10)
- LPHA, Trainee, RN w/Psych MS
- Address Treatment Plan goals—therapy

$ THERAPY INDIVIDUAL (9), FAMILY (41) & GROUP (10)
- MD, NP, RN, LVN or LPT
- Injection

$ 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

$ CRITICALLY ILL (12)
- Non MD/Non NP-- Working on Assessment
- 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

$ THERAPY INDIVIDUAL (9), FAMILY (41) & GROUP (10)
- LPHA, Trainee, RN w/Psych MS
- Address Treatment Plan goals—therapy

$ MD/NP INITIAL ASSESSMENT (14)
- Physician Initial Assessment

$ MD TIME NOT MEDICARE BILLABLE (17)
- Not face to face MD or NP

$ MD/NP INITIAL ASSESSMENT (14)
- Physician Initial Assessment

$ MD/NP INITIAL ASSESSMENT (14)
- Physician Initial Assessment

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
- Tarassof 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

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