ASSESSMENT & DIAGNOSIS

- Substance Abuse CANNOT be Primary Diagnosis.
- Only licensed, waivered, registered staff, MDs, Psychiatric NPs, and RNs with Master’s 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.
- Assessment MUST have an included Medi-Cal Diagnosis (see below), AND document significant symptoms/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 as 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 is in the Assessment — not Substance Abuse.

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 should sign.
- Using a signature pad? MAKE SURE you Save Signature.
- To 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.

ASSESSMENTS

Include Primary Diagnosis and its Symptoms/Functional Impairments

TREATMENT PLANS

Address the Significant Symptoms/Functional Impairments resulting from the Primary Diagnosis listed

PROGRESS NOTES

Interventions/Services listed in the Progress Notes address Treatment Plan and Diagnosis

BEHAVIORAL HEALTH AND RECOVERY SERVICES

Quality Management - February 2020
**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: S5
- Non-billable groups: S50

**Location code** (double check!)
- Client's 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
- 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)

**Co-Sign**
- Interns - pick your supervisor

**Language**
- Always use for non-English

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**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 services
- Locate funding for living arrangement
- Referral, Access, and/or Monitor needed for services e.g., Medical Needs, MH Services, Social Support, Vocational
- Provide linkage to other services

### $ 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

### $ Assessment(5), Group(50)
- Non MD/Non NP - Working on Assessment
  - Address Behavioral Health goal
  - Address Behavioral symptoms & impact of/on health
  - Coping skills development
  - Daily living skills development
  - Social skills development

### $ Crisis Intervention (2)
- Assess immediate crisis
- Danger to Self/Other addressed/resolved
- Gravely Disabled addressed/resolved
- Stabilize immediate crisis

### $ Rehabilitation (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

### $ Therapy Individual (9), Family (41) & Group (10)
- Address Treatment Plan goals—therapy

### $ Medication Sup (15), Group (150)
- Address health issues impacted by psychotropic meds or symptoms/
  functional impairments
- Address psychiatric symptoms
- Evaluate meds side effect(s)
- Medication education
- Obtain Med Consent
- Physician Update Assessment
- Develop Treatment Plan with medication support

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

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**Unbillable Services S5 (550 groups)**

- Clerical task
- Close a chart
- CPS/APS report
- Discharged 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
- Non-billable Group use code S50