



Got questions? We're here to help!

Visit our main QM webpage for access to many of our resources: <https://www.smchealth.org/bhrs/qm>

Commonly accessed documents on our website: [Documentation Manual](#), [Progress Note Guide](#)

Email your question to HS_BHRS_ASK_QM@smcgov.org

From Assessment to Treatment

Step 1 — Complete Assessment within the first 3 Face-to-Face Sessions, if possible.

Step 2 — Develop the Treatment Plan with client.

Step 3 — Then provide Planned Services.

Assessment FAQ

Can an assessment be finalized if I only spoke to the client over the phone but didn't see them in-person?

Yes, the full assessment may be completed in-person, via video conferencing, or over the phone.

How long do I have to complete the assessment?

For new clients, the assessment or the Assessment Review* should be completed within 60 days of admission or before you start providing planned services.

When do I need to complete a reassessment?

Re-assessment is required every three years for continuous clients, or when there is a significant change, or if the client has not received any billable services for 180 days and is re-engaging in services.

Can I just do an assessment addendum instead of a reassessment?

Addendums are completed when there is additional information gathered or a change occurs. This will not restart the timeline as a new Assessment. For more information on *reassessment* versus *addendum* versus *update*, see the Assessment section of QM's [Documentation Manual](#).

SCOPE OF PRACTICE WARNING

- Only licensed, waived, registered staff, MDs, Psychiatric NPs, and RNs with Master's degree in Mental Health may finalize an assessment.
- Community Workers, Family Partners and RNs (without Psych MS) CANNOT complete the Diagnosis section – EVEN with co-signature.

For more about scope of practice, please see the Scope of Practice section of QM's [Documentation Manual](#).



Developing a Treatment Plan

Step 1 — Complete the Treatment plan with the client/family.

Step 2 — Write a Plan Development Progress Note documenting how the client/family participated in the formulation of the plan and their agreement with the plan.

Treatment Planning FAQ

Is there a set time by which I need to complete the treatment plan?

Initial Treatment Plans are due within 60 days of the client's entry into the program, and before planned services are provided.

What if I haven't finished the treatment plan after 60 days (for instance, because it's a particularly complex case)?

On the rare occasion that the assessment and treatment plan have not been completed within 60 days, continue to code using the appropriate service codes; do not code (55) unless it is a non-billable service.

What if I already finalized the plan but realized later that I need to add a new goal or service?

Treatment Plan Addendums may be used at any time. They can be used to collect a signature or add/modify a goal, objective or intervention. This does not restart the annual Treatment Plan timeline.

If you have been providing a Planned Service that is not on the Treatment Plan, add it to the Treatment Plan with a Client Treatment Plan Addendum as soon as possible.

For how long is a treatment plan valid?

All Treatment Plans are valid for a maximum of 1 year. A new Treatment Plan is required when a client transfers to a new program/episode.

For more information about treatment planning, see the Treatment Plan section of QM's [Documentation Manual](#).

Language Considerations

Treatment Plans should be written in the client's preferred language, if possible.

If the preferred language is not English, the treatment plan must be translated into English as well.

For a **Monolingual, non-English speaking client**: Provide language services when developing and reviewing Treatment Plan and document this in a Progress Note.

Medical Necessity

Every Medi-Cal client needs to have BOTH a Medical Necessity Diagnosis (a.k.a. “Included” or “Billable” diagnosis) in the Assessment and a Medical Necessity Goal in the Treatment Plan, or notify BHRS QM to block Medi-Cal billing.

Medical Necessity (Diagnosis) FAQ

What is an “included” diagnosis?

An included diagnosis means that the diagnosis is included on the list of diagnosis that can be billed through Medi-Cal. Every Medi-Cal client MUST have an included/billable Medi-Cal Diagnosis (see below), AND document significant symptoms/functional impairments resulting from the diagnosis.

Are there any recent changes to the list of included diagnoses I should be aware of?

Yes! **UPDATE on Autism Spectrum: This is now a billable diagnosis (as of November 2019).** Many diagnoses have been added to the billable list. Do not trust what you have been told in the past; review the current list (see link below) to determine if the diagnosis is billable.

Use the diagnosis listed in the DSM-5 column to diagnose, and then check the ICD-10 code.

List of Medi-Cal billable ICD diagnoses:

https://www.smchealth.org/sites/main/files/file-attachments/billabledx-enclosures_2_in_18-053_icd-10.pdf?1563303359

Diagnosis	ICD-9	ICD-10	DSMIV	DSM5
Autistic disorder	299.00	F84.0	Autistic disorder	Autism spectrum disorder
Rett's syndrome	330.8	F84.2	Rett's disorder	Other specified neurodevelopmental disorder
Other childhood disintegrative disorder	299.10	F84.3	Childhood disintegrative disorder	Other specified neurodevelopmental disorder
Asperger's syndrome	299.80	F84.5	Asperger's disorder	Autism spectrum disorder
Other pervasive developmental disorders	299.80	F84.8	Asperger's disorder	Other specified neurodevelopmental disorder
Pervasive developmental disorder	299.90	F84.9	Pervasive developmental disorder NOS	Other specified neurodevelopmental disorder
Pervasive developmental disorder, unspecified	299.90	F84.9	Pervasive developmental disorder NOS	Other specified neurodevelopmental disorder
Active autistic disorder	299.00	F84.0	Autistic disorder	Autism spectrum disorder
Active autistic disorder with active but odd behavior	299.00	F84.0	Autistic disorder	Autism spectrum disorder
Active infantile autism	299.00	F84.0	Autistic disorder	Autism spectrum disorder
Active neuritis in child	299.00	F84.0	Autistic disorder NOS	Unspecified autism spectrum and other

Annotations: A red 'X' is drawn over the ICD-9 column. Red boxes highlight the ICD-10 and DSM-5 columns. A red arrow points to the DSM-5 column.

WHAT IF THERE IS NO BILLABLE DIAGNOSIS?

- Talk with your supervisor about the diagnosis and decide if treatment will continue.
- Notify ASK QM if there is NO billable diagnosis. If there is a billable diagnosis at a later time, notify QM.
- QM will block Medi-Cal billing if there is no billable diagnosis, but we will continue to bill other payors.



Medical Necessity (Treatment Plan) FAQ

Do I have to do anything with the treatment plan to demonstrate medical necessity?

Yes. Every plan MUST have a Medical Necessity Goal that addresses the diagnosis. If one is not present, inform BHRS QM to block Medi-Cal billing.

Documenting Medical Necessity in the Treatment Plan

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

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

Barrier – State the MH Primary Diagnosis and specify the symptoms/impairments directly related to the MH primary diagnosis being treated. **Verify that the *Included* Primary Mental Health Diagnosis is in the Assessment.**

Goals – Reduce the symptoms of the diagnosis to improve functioning. This is the client's desired goal – what the client wants out of treatment.

Objectives are behavioral simple steps (that are observable/measurable) that the client will take to address the MH diagnosis. **Symptoms related to the diagnosis must be addressed.**

Examples:

- ✓ *Explore barriers to medication compliance and attend medication support groups 2x per month.*
- ✓ *Discuss anxiety issues and develop 2 coping skills to lessen discomfort while attending appointments.*

Interventions – List all that will be used: Therapy (Group, Family, Individual), Case Management, Collateral, Rehab, Medication Support, TBS, and include detail as to how each modality will address the Mental Health diagnosis.

HOW IS MEDICAL NECESSITY ESTABLISHED?

Medical Necessity is established by adherence to three primary tests or criteria:

1. An Eligible Mental Health Diagnosis;
2. A Significant Impairment present (or expected if untreated);
3. Intervention proposed (on a *Client Plan*) and actual (on a *Progress Note*) that addresses the Impairment.

For more information about how to establish medical necessity, please see the Medical Necessity section of QM's [Documentation Manual](#).

More about Treatment Plan Interventions

For each intervention/service type include:

- ✓ Duration (usually 12 months)
- ✓ Frequency (weekly, monthly, daily, 2x weekly...etc.) DO NOT use “AS NEEDED” or “PRN”

Describe how the intervention will address the diagnosis. Examples:

- ✓ (Med Support) *Address psychotic symptoms to stabilize the client in the community, reduce need for hospitalization. Continue to manage depression with mood stabilizer.*
- ✓ (Group Therapy) *CBT group treatment to improve daily functioning and address ongoing symptom management of depression.*
- ✓ (Case Management) *Assist client with linkage and coordination of services to support the client to reduce paranoia and maintain living in the community without needing a higher level of care.*
- ✓ (Collateral) *Assist parent in understanding the need for structure at home to reduce child's acting out behaviors resulting from ADHD.*

Client Signature on Treatment Plans FAQ

When completing a treatment plan, make sure to OBTAIN CLIENT AGREEMENT AND/OR SIGNATURE ON TREATMENT PLANS.

If the client signs a paper copy, it must be scanned into the record and noted on the plan. If the client is under age 12, the parent/guardian should sign when appropriate. Using a signature pad? MAKE SURE you **Save Signature.**

What if a client refuses or is not available to sign the treatment plan?

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, indicate “verbal approval” on the plan and in a progress note. You may obtain client signature at the next face-to-face appointment. Please document attempts to obtain client signature.

Should I still finalize a plan if I only got verbal approval?

Yes. All plans that will be used to provide and bill for services must be finalized, even if it was only verbally agreed to. **To Finalize Plan** – Must be signed by licensed/waivered/registered staff. Pending means that it was sent to supervisor for signature. The plan is not completed until signed by the LPHA.

Progress Notes and Billing

The Assessment or the Assessment Review* and the Treatment Plan MUST be completed BEFORE providing Planned Services.

All services to a client are documented and coded. Coding is how we indicate the service that was provided to the client. Billing means that we are billing a payer (insurance company or school district) to get paid. **Billing is determined by:**

- Service code
- Location code
- Type of services minutes (“Service Time Client Present in Person” vs. “Other Billable Service Time”)

Unplanned Services

You **MAY** provide these Unplanned Services **PRIOR** to the completion of the Assessment/Treatment Plan.

- Assessment (5)/TBS Assessment
- Plan Development (6)
- Crisis Intervention (2)
- Medication Support for Assess/Eval/Plan Dev or urgent need (14)
- Medication Support Urgent - RN (15u)
- Case Management/Plan Dev/Assess/Linkage (52)

Planned Services

These services should **ONLY** be provided **AFTER** the completion of the Assessment/Treatment Plan.

- Collateral (12), Group Collateral (120)
- Rehab (7), Group Rehab (70)
- Intensive Home-Based Services (IHBS)
- Therapy: Individual (9), Family (41), Group (10)
- Case Management (51); VRS-51, ICC-51
- Medication Support (15), (16), (17), (19)
- Therapeutic Behavioral Services (TBS)
- Adult Residential Treatment services
- Crisis Residential Treatment services

*ASSESSMENT REVIEW

An assessment review may be documented in lieu of completing a full assessment or reassessment ONLY if there is already a current and valid assessment in place.

If you determine after reviewing the assessment that you would like to add new information to the existing assessment, you can do so via an assessment addendum or an assessment update (Reassessment, Type: Update).

For information on when to complete *reassessment* versus *addendum* versus *update*, see the Assessment section of QM’s [Documentation Manual](#).

Progress Notes FAQ

Can I write one progress note that covers services that happened over the course of the week?

One note is written for each service for each day (not multiple days of service in one note).

How soon should I complete a progress note after delivering the service?

Write notes on the date of service if you can. The goal is to complete progress notes within 3 business days of providing the service. After 30 days, the progress note is considered excessively late and should be coded (55).

For more information about writing Progress Notes, see the Progress Notes section of QM's [Documentation Manual](#) and QM's [Progress Notes](#) guide.

Group Progress Notes FAQ

Do I need to mention in the progress note why a co-provider was in the group?

GROUP NOTES MUST justify co-providers in every progress note. Example: *Due to the unsafe behavior of several clients [include examples], two providers were required to maintain safety.*

Can all co-providers for a group service bill for that service?

Group Co-Practitioner/Duration: Both providers must meet requirements to be able to bill for the service—e.g., for Med Support, both must be MD/NP/RN. Only two (2) providers may bill for a group; do not bill a third provider. If there are more providers/staff, do not write a separate note; just document additional provider in text field.

**What number should I put in the “Number of Clients in Group” field in the progress note?
What if both parents of a client attended a group?**

Number of Clients in Group: this is the number of open clients represented. Family members of an open client are counted as one (1 client even if there are many family members present).

For more information about providing and documenting Group Services, see the Group Services section of QM's [Documentation Manual](#).

Location Codes

If the client is NOT in a lockout: Use the appropriate location code.

LOCKOUT LOCATION CODES: If the client is in a lockout location, USE THE LOCKOUT, not your location. See below for list of lockout locations.

Location Codes: Common Non-Lockout Location Codes

OFFICE: When writing a progress note from home for tasks such as the write-up of an assessment (without client), use the location code “OFFICE” as your home is considered an extension of your office for now.

PHONE service with Client: Time with client on PHONE is entered in “Other Billable Service Time.” Location code is “PHONE” unless client is in a lockout location.

VIDEO CONFERENCING with Client: Time with client by VIDEO is entered in “Service Time Client Present in Person.” Location code is “TELEHEALTH” unless client is in a lockout location.

MISSED VISIT Use “missed visit” location code

VOICE MAIL/FAX/EMAIL- Use location code “Voice mail/Fax/Email-Non-billable”

Location Codes: Lockout

CODING SERVICES BY PHONE OR VIDEO: If the client is in a lockout location, use the lockout code even if the service is provided over the phone or via video conferencing. Use all regular service codes that you normally use—i.e, still use billable codes.

MH Lockout Locations:

- PES, Psych. Hosp., Serenity House, Redwood House, Jail or Jail-like setting, IMD.
- 26.5 Out-of-State, IMD, Jail/YSC
- Psychiatric Hospital & PES
- Redwood House/Serenity House—Lockout
- Redwood House/Serenity House—(MedSup/CM)
- Skilled Nursing Facility-Psych

For more information about Location and Lockout Location Codes, see the Location Code section of QM’s [Documentation Manual](#).

BILLING CODE REFERENCES & DESCRIPTIONS

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

- ▶ Communicate with others to assess, refer, monitor, evaluate services
- ▶ Locate funding for living arrangement
- ▶ Coordinate w/others to access services
- ▶ Provide linkage to other services
- ▶ Before TX Plan completed use (52) Case Management**

CRISIS INTERVENTION (2)

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

ASSESSMENT (5)

Non MD/Non NP – Working on Assessment

- ▶ Assessment/Medical Necessity
- ▶ Behavioral or Needs Assessment
- ▶ Assessment/Diagnosis/MSE (by LPHA)
- ▶ CANS/LOCUS
- ▶ Re-Assessment
- ▶ Co-Occurring Assessment
- ▶ Assessment Addendum
- ▶ 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
- ▶ Evaluate Treatment Plan goals, progress
- ▶ Gain Treatment Plan approval
- ▶ Update/modify client's Treatment Plan
- ▶ Treatment Plan Addendum

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

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

COLLATERAL (12), COLLATERAL GROUP (120)

- ▶ Not for working with other professionals
- ▶ MH-related parent/support person training
- ▶ Address client's MH w/support person/family
- ▶ MH-related psychoeducation for support person

THERAPY INDIVIDUAL (9), FAMILY (41) & GROUP (10) LPHA, Therapy Trainee, RN w/Psych MS

- ▶ Address Treatment Plan goals in therapy

MEDICATION SUPPORT (15), MED SUPPORTGROUP (150)

MD, NP, RN, LVN or LPT

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

Medication Support Urgent RN (15U) Urgent medication need before Tx Plan

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 MEDICARE 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
- ▶ Treatment reports/letters- (not SSI), not court
- ▶ Clinical Paperwork

UNBILLABLE SERVICES 55 (GROUP 550)

<p>Clerical task</p> <p>Close a chart</p> <p>CPS/APS report</p> <p>Deceased client</p> <p>Discharge Note</p> <p>Family member referral</p> <p>Preparation for service</p> <p>Rep-Payee functions</p>	<p>Review/Prepare chart for release of information</p> <p>SSI paperwork</p> <p>Tarasoff/Abuse Report</p> <p>Translation only</p> <p>Transportation of client</p>	<p>Prepare, Testify, Wait in court</p> <p>Write a letter for court</p> <p>Missed visit, no show</p> <p>Schedule appointments</p> <p>Send or receive email, voicemail</p>
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