BHRS MH Documentation
Updates 2019

Assessments & Treatment Plans
Main Points to Take Away

- The Assessment and Treatment Plan **must** be completed before **Planned Services** are provided.
- All **Planned Services** **must** be on the Treatment Plan.
- Assessment, Treatment Plan, & BILLED Progress Notes **must** address a billable diagnosis and impairment (this is “Medical Necessity”).
Main Reasons for *Not* Getting Paid for Services

**LOST REVENUE due to NO Treatment Plan for Service Date:**

$1.2 million in loss revenue for 2018

- Treatment Plan left in DRAFT or NOT co-signed
- No Treatment Plan completed
- Treatment Plan dates are incorrect

**AUDIT RISK AREA:**

- Service is *NOT* on the Treatment Plan
- No Client Signature on Treatment Plan
- No billable diagnosis
- Assessment or Treatment Plan does NOT address the client’s impairment related to diagnosis
Assessment/Tx Plan Timeline

Follow these steps:

► **Step 1** - Complete the Assessment within the **first 3 sessions**.

► **Step 2** - Then, develop the Treatment Plan **with the client**.

► **Step 3** - Then, you may provide **Planned Services**.
Do We Still have 60 days?

- You have 60 days but...

- Caution- Assessments & Treatment Plans **must be completed BEFORE** you can provide Planned Services.
Assessment Still in Draft at DC?

- All Assessments **must** be finalized and submitted.
- You are responsible for ensuring that Assessments are **NOT left in Draft**.
Assessment Still in Draft?

- Fill in the areas of the Assessment that you were able to gather information in and still finalize.
- If you were NOT able to complete the Assessment due to loss of contact with the client:
  - “unable to assess”

- Clinical Formulation
  - Include any diagnostic details that were gathered and any information regarding the inability to complete the Assessment (ex: client disengaged in services).

- Progress Notes- document reasons
  - Discharge PN - why you were unable to complete the Assessment (ex: made multiple attempts to reach client, client not engaged in services, client moved out of county etc.).
Who is Responsible For Making Sure there is an Assessment & Treatment Plan?

- **All staff:** billing for Planned Services must ensure the Assessment and Treatment Plan are completed.

- **Clinicians/Supervisors:** are responsible for oversight of Assessment & Treatment Plan completion, and that all Planned Services are on the Treatment Plan.
You Must Establish Medical Necessity

ASSESSMENTS must document that BECAUSE of the billable diagnosis the client needed services due to:

- a) A significant impairment in life functioning due to DX
- b) A probability of significant deterioration in an important area of life functioning;
- c) A probability the child will not progress developmentally as individually appropriate; or
- Age 21 and under years- can correct or improve MH condition
Client: TEST, JOLLY (000938760)

M, 55, 12/05/1962

Ep: 25 Ep
Location: 1950 A
Problem: -
Attn. Pract.: No Entry
DX P: 296.24 Adm. Pract.: MONTO...

Allergies (5):

Chart: Client Treatment and Recovery Plan

Client Treatment Plan Items

Diagnosis/Problems/Impairments:

- Major depressive disorder, with psychotic features, interferes with the client's ability to remain living in the community.

Medical Necessity Goal?
- Yes
- No

Add/EU diagnosis/problems:
Signs, symptoms, and behavioral problems resulting from the diagnosis that impede the client from achieving. Impairments related to the diagnosis must be addressed in all medical necessity goals.

Diagnosis:
- Major depressive disorder, with psychotic features, interferes with the client's ability to remain living in the community. Client has been hospitalized 2 times in the last due to development of psychotic features.

Primary Dx:
- HEALEY

GOAL - Development of new skills/behaviors and reduction, stabilization, or removal of symptoms/impairments.

Progress Notes:

I want to keep from feeling so guilty about everything that I do. I want to stop feeling so sad and worried about what others are thinking about me.

OBJECTIVE 1 - Client's next steps to achieving goal. Must be observable, measurable, and time-limiting objects linked to the primary diagnosis.

Identify at least one thing I can do each day to help myself feel better. I will develop/modify my crisis plan when I become worried about what other people are thinking about me.

Medication Goal:
1. I will report increase in symptoms and changes in thoughts/behaviors/feelings

INTERVENTIONS - Describe in detail the interventions proposed for each service type. E.g., Clinician will p
Understanding the PRIMARY diagnosis......

You are an eye doctor. The client has cancer & the client needs a new pair of glasses for far vision. You address the need for glasses. What is the Diagnosis?

Vision Impairment
You are an Nurse Practitioner at the Mental Health Clinic #1.

Your client is diagnosed with autism and bipolar. You are treating the bipolar illness with medications.

What is the primary diagnosis?

Bipolar Disorder
You are a clinician at the Mental Health Clinic #1. Your client is diagnosed with Alcohol Use Disorder, and this is clearly the client’s biggest impairment. He is also diagnosed with bipolar illness. You are treating the bipolar illness. What is the primary diagnosis?

Bipolar Disorder
Understanding How to Select the DX

In general, look at the diagnosis in the DSM5 column to diagnose. For Autism Spectrum diagnoses, however, use DSMIV column to diagnose.

Autism Spectrum:
- We **were** able to update Avatar to correct the Autism Spectrum.
- If the diagnosis is one of the following included diagnoses...
  - Rett’s Disorder (F84.2)
  - Childhood Disintegrative Disorder (F84.3)
  - Asperger’s Disorder (F84.5)
  - Other Pervasive Developmental Disorder (F84.8)
  - Pervasive Developmental Disorder Unspecified (F84.9)

Please use the codes below to correctly diagnose. You **MUST** also write in the name of the specifier in the diagnosis comment box—e.g., Rett’s Disorder. Use the DSM IV to diagnose Autism Spectrum.

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autistic disorder</td>
<td>299.00</td>
<td>F84.0</td>
</tr>
<tr>
<td>Rett’s syndrome</td>
<td>330.0</td>
<td>F84.2</td>
</tr>
<tr>
<td>Childhood Disintegrative Disorder</td>
<td>299.10</td>
<td>F84.3</td>
</tr>
<tr>
<td>Asperger’s syndrome</td>
<td>299.80</td>
<td>F84.5</td>
</tr>
<tr>
<td>Other Pervasive developmental disorders</td>
<td>299.80</td>
<td>F84.8</td>
</tr>
<tr>
<td>Pervasive Developmental disorder NOS</td>
<td>299.90</td>
<td>F84.9</td>
</tr>
</tbody>
</table>

Look at this column for Diagnosing - We diagnose with DSM 5

Ignore this column

Look at this column for Autism Spectrum specifier
What is a Billable Diagnosis?

Check the ICD10 codes if you are not sure if it is billable.

What if there is NO Billable Diagnosis?

- Make sure that you understand what the Primary DX is.
- Talk with your supervisor about DX and decide if treatment will continue.
- Notify ASK QM if there is NO billable diagnosis.
- If there is a billable DX at some time- Notify QM.
Updating or Changing the Diagnosis

To UPDATE a diagnosis, complete the Reassessment v2 and check **Update**.

- Fill in the diagnosis
- Describe signs and symptoms that meet criteria for that diagnosis in the Clinical Formulation.

**REMEMBER:** An UPDATE does NOT count for a Reassessment and therefore does NOT change the timeline of the next due date for the 3 year Reassessment.
Treatment Plan
Process
Client Plan: Over the Phone

- Clients should be seen in person, whenever possible to develop the Treatment Plan.

- If there is an exception, there must be very good documentation in a Progress Note.

Examples

The client has severe agoraphobia, is sick, or unable to leave the home for some reason & not able to make it in-person to the appointment.

- Do the plan over the phone. When they come in, review the plan, and sign the plan.

Sample Progress Note for Tx Plan over phone:

- “Ct was unable to come in person to the appointment due to being sick. Clinician and Ct completed treatment plan over the phone and developed goals & objectives. Ct agreed to the plan and gave verbal approval.”
Treatment Plans – The Due date is 60 days after admission for a new client and by the annual Anniversary date for an existing client. If the Treatment Plan is late, enter the Start Date as the date completed not a previous date.

Electronic Signature
- Start the Treatment Plan 42 days before the Anniversary Date
  - Develop goals with the client and enter into Avatar
  - Agree
  - Staff check Signed Electronically and enter the client signature date by the signature
  - Staff check Final (Pending if co-signature needed) for Treatment Plan Status
  - Staff complete detailed Progress Note for completing Treatment Plan (6)
  - Finalize with signature by Due Date

Refused Signature
- Refuse
- Staff check Did Not Sign and document reasons provided in Comments
- Check Final for the Treatment Plan Status
- Staff complete detailed Progress Note for completing Treatment Plan (6) explaining why client refused

Verbal Approval Client unable to come in
- Call Client to develop Verbal Approval and document reasons provided in Comments
- Check Final for the Treatment Plan Status
- Staff complete detailed Progress Note for completing Treatment Plan (6), explain why client unable to sign and indicate the client’s involvement
  - Set an Avatar Alert (by selecting “Client Signature needed on Tx Plan” in Urgent Care Plan Bundle) to review with the client at the next session and attempt to gain signature

Field Based
- Bring hard copy Treatment Plan for field visit
- Complete hard copy Treatment Plan with client
- Client and clinician sign and date Treatment Plan
- Staff enter Treatment Plan exactly as agreed into Avatar, check Signed Printed Copy and enter how it was completed in Comments
- Check Final for the Treatment Plan Status
- Admin scan Treatment Plan into Avatar
- Staff complete detailed Progress Note for completing Treatment Plan (6) and reference scanned copy

Unable to Meet with Client
- Complete Treatment Plan in Avatar based on clinical experience with client by Due Date
- Check Did Not Sign and Comments
- Check Final for the Treatment Plan Status
- Staff complete detailed Progress Note for completing Treatment Plan (6) explaining why client was not involved
- Set an Avatar Alert to review with the client at the next session and attempt to gain signature
- Print (by selecting Report) and review with client in the next session
- Client and clinician sign and date Treatment Plan
- Admin scan Treatment Plan into Avatar

** Completing without the client is the last resort and should only occur if the client is in a crisis or in a locked facility. If there are challenges with engagement, consider a goal around engaging the client or discuss with your Supervisor for potential discharge.

Detailed Progress Note – Explain circumstances for lack of client involvement, electronic or hard copy signature. Do not write will obtain signature at next session.

Late Treatment Plan – The Start Date on a Treatment Plan cannot be changed. If a draft was started but not finalized, add a New Treatment Plan, click Yes to default plan information and finalize so the Start and Sign date match. Email QM to remove the draft version.

V1 QM 07/14
Treatment Plan Requirements
### Interventions

**Describe in detail the interventions proposed for each service type. E.g. Clinician will provide individual cognitive-behavioral techniques, to assist client with decreasing his depressive symptoms.**

- **Medication Support**
- **Group Therapy**
- **Individual Therapy**
- **Case Management**
- **Rehab/Rehab Group**
- **Family Therapy**
- **Collateral**
- **TBS**
- **Day Treatment**

#### Medication Support Duration
- 12 Months
- 9 Months
- 6 Months
- 3 Months

**Medication Support Frequency**
- Monthly

**Medication Support Agency/Provider**
- Hung-Ming Chu MD

**Medication Support Intervention Details**
- Address psychotic symptoms to stabilize the client in the community, reduce need for

#### Individual Therapy Duration
- 12 Months
- 9 Months
- 6 Months
- 3 Months

**Individual Therapy Frequency**
- Weekly

**Individual Therapy Agency/Provider**
- Jeannine Mealy LMFT

**Individual Therapy Intervention Details**
- Short-term CBT to develop a safety plan and coping strategies to deal with depression and...
To ADD Interventions or gain signature use the Client Treatment Plan Addendum
How to PRINT the plan
People are Forgetting to Write Progress Notes

In all cases:

- Write a Progress Note
- Describe the client’s participation in the development of, and agreement with the Treatment Plan.
Client Plan:
People are Forgetting to Write Progress Notes

Example Progress Note:

“The Client participated in treatment planning meetings on (date(s)). The client participated in developing their treatment plan goals and interventions; in particular, the goals for (state goal or goals that the client gave specific input for). The client was satisfied with the client plan and stated agreement at the meeting held on (date). The client signed the Treatment Plan and accepted/denied a copy of the plan.”
Questions
Resources


- Updated Treatment Plans can be found at: [http://www.smchealth.org/post/bhrs-client-treatment-recovery-plan](http://www.smchealth.org/post/bhrs-client-treatment-recovery-plan)

- For San Mateo County Contractor: [http://www.smchealth.org/bhrs/providers/soc](http://www.smchealth.org/bhrs/providers/soc) and for Out-Of-County Youth Contractors [http://www.smchealth.org/bhrs/providers/oocy](http://www.smchealth.org/bhrs/providers/oocy)