Clinical Documentation Training: Mental Health Medi-Cal Specialty Mental Health Services

Adult/Older Adult System of Care
Outpatient & Adult Residential Behavioral Health Services

October 2016
**Requirements & Resources**

### Requirements:

- **Mental Health Plans (MHPs) are responsible for** setting standards and implementing processes that support the understanding of and compliance with documentation standards set forth by DHCS and the MHP *(p23, MHP-DHCS Boilerplate Contract)*

- **Providers/organizations are required to:** (a) maintain certification and/or licensure for services; (b) maintain client records in accordance with Federal/State/Local standards & (c) meet the MHP Quality Management Program standards *(CCR Title 9, §1810.435)*
Requirements & Resources

- **BHS Resources:**
  - *Clinical documentation support:* BHS’ QM Clinical Documentation Improvement Program
  - *Regulatory compliance support:* DPH’s Office of Compliance and Privacy Affairs
  - *Contract compliance support:* DPH’s Business Office of Contract Compliance
# Chapters in this Training Curricula

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Chapter 1:

Clinical Documentation in an Electronic Health Record (Avatar Example)
It’s easy to get overwhelmed and/or disoriented in a clinical documentation training!

**REMEMBER**: if you read the sentence prompts that appear on the Avatar EHR screen and answer them specifically, then you are on the right track!
Adult/Older Adult-Short/Long Assessment:

- 11 Sections—respond to the prompts on the screen

1A. PRESENTING PROBLEM

Include A) identifying info, B) criteria to justify DSM dx including current SYMPTOMS, BEHAVIOR, IMPAIRMENTS IN FUNCTIONING, duration, frequency and severity, C) impact on life / behavior leading to the client to seek services, D) client's chief goal, E) cultural explanation problem in client's own words. (if EPSDT, state why child/youth will not progress developmentally as appropriate without treatment)

1. Identifying information related to treatment: Client is [age], [sex], [gender identity], [sexual orientation identity], [language spoken], [relationship status], [family status]...

2. Client meets criteria for DSM-5 _______ as evidenced by:
   a. Current symptoms: _____ (duration =___; frequency =___; severity =___)
   b. Current behaviors: _____ (duration =___; frequency =___; severity =___)
   c. Current impairments: ___________ ((duration =___; frequency =___; severity =___))
TPOC (All Clients):
- 4 Levels: Respond to the prompts on the screen

Indicate the observable and/or quantifiable outcome; objective should relate to mental health needs and functional impairments.

Objective (Expected Behavioral Change)
Review of Chapter 1:
Clinical Documentation in an Electronic Health Record (Avatar Example)
“Read the prompts on the screen” is a front-line approach for teaching staff how to correctly document their work.

BHS has two tools for you:

1. Assessment Prompts (from Avatar)
2. TPOC Prompts (from Avatar)
Chapter 2:

Logic of Mental Health Medi-Cal

Chapter 2:

Logic of Mental Health Medi-Cal Insurance
Chapter 2: Logic of Mental Health Medi-Cal

Customer/Client
(they buy insurance policy)

Insurance Company
(they sell the insurance policy)

Managed Care Org
(they operate/implement the benefits)

Provider
(they contract for/provide services)
Chapter 2: Logic of Mental Health Medi-Cal

“Medi-Cal Insurance”

Physical Health Medi-Cal
- San Francisco Health Plan
- Blue Cross Partner. Plan
- Physical health care
- Mild/Moderate MH care
- Autism Spectrum/BHT

Mental Health Medi-Cal
- BHS (County MHP)
- SMHS
- Moderate to severe MH care

Drug Medi-Cal
- BHS (County SUDP)
- SUD Treatment Services
In CA, if a person has a significant mental health problem, they must get specialty services from the County. The County acts as a “Mental Health Plan” (MHP)

The County MHP is responsible for many SMHS (e.g., inpatient hospital), but today, we will focus on Outpatient and Adult Residential Treatment Services.
Rehab Model vs. Clinic Model:

- **Clinic Model/Medical Model**: Requires a medical doctor as head of service, office-based services, therapeutic interventions to cure disease and only MD/PhD/LCSW providers.

- **Rehabilitation model**: Requires a LPHA as head of service, office/phone/community-based services, interventions to reduce disability/restore functioning and broad provider types.
Logic of Medi-Cal reflects our clinical work!

Clinical Practice

I conduct an assessment:
“what is the problem?”

I create a treatment plan:
“why the problem exists”

I provide interventions:
“how we address the problem”

Establish Diagnosis & Functional Impairments

Create Treatment Plan/Client Plan

Provide Treatment Interventions

“The Golden Thread” of Clinical Practice & Mental Health Medi-Cal
### Logic of Medi-Cal determines the services you can bill:

<table>
<thead>
<tr>
<th>Clinical Practice</th>
<th>M-Cal Logic</th>
<th>I conduct an assessment:</th>
<th>I create a treatment plan:</th>
<th>I provide interventions:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>“what is the problem?”</td>
<td>“why the problem exists”</td>
<td>“how we address the problem”</td>
</tr>
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<td></td>
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</tr>
<tr>
<td>Establish Diagnosis &amp; Functional Impairments</td>
<td>Create Treatment Plan/Client Plan</td>
<td>Provide Treatment Interventions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Billable Services:**

1. Assessment
2. Plan Development
3. Crisis Intervention

**Billable Services:**

1. Plan Development
2. Crisis Intervention

**Billable Services:**

1. Planned Services
2. Crisis Intervention
Review of Chapter 2:

Logic of Mental Health Medi-Cal

(“the Golden Thread”)
Although we may be confused by insurance, managed care, and related jargon, we can be clear that:

- Medi-Cal is a publicly funded insurance program and the SMHS benefit it administered by a County entity (“Mental Health Plan”);

- The logic of Medi-Cal and clinical practice are similar… “The Golden Thread of MH Medi-Cal Insurance and Clinical Practice”
Rehabilitation Model:

- Rehabilitation = restoring functioning, improving functioning, reducing a disability
- Non-medical staff who are licensed professionals (e.g., LCSW, LMFT, LPCC, PhD) can be lead staff
Chapter 3: Medical Necessity for Mental Health Medi-Cal Specialty Mental Health Services (SMHS)
DHCS Requirements (FY16-17 Audit Protocol)

1. Covered Mental Health Diagnosis
2. Functional Impairments
3. Treatment Interventions
4. Not Responsive to Physical Health Care Treatment
Covered Mental Health Diagnosis

- In 2015, DHCS published updated list of **Covered/Included Diagnoses** for SMHS.
  - Formatted as “Crosswalk” from ICD-9 to ICD-10

- Client’s primary diagnosis must be covered/included mental health diagnosis
Covered Mental Health Diagnosis (cont.)

Your assessment will describe the symptoms, behaviors and differential diagnosis using DSM.

- Primary **MH** Diagnosis = Mental Health Medi-Cal
- Primary **SUD** Diagnosis = Drug Medi-Cal
- Primary **Medical** Diagnosis = Physical Health M-Cal
- MH problems **2° to Medical** = Physical Health M-Cal
- Mild/Moderate **MH** problems = Physical Health M-Cal

Tip: **SMHS** = **Special** Diagnosis—not just any old dx!
Functional Impairments as a result of the qualifying diagnosis:

- **Symptoms** = behavioral *expressions/actions* associated with the disorder
  - **Distractibility** in client with ADHD diagnosis...

- **Impairments** = the *consequences/outcomes* that ensue for the individual as a result of these behaviors
  - ...causes poor *academic* performance (Functioning)
  - ...causes loss of *friendships* (Functioning)
- **Functional Impairments** as a result of the qualifying diagnosis (cont.):

  - DHCS Requirements (FY16-17 Audit Protocol): **Meet at least one of the following criteria:**
    - A significant impairment in an important area of life functioning
    - A probability of significant deterioration
    - A probability that the child will not progress developmentally as individually appropriate
    - If full-scope Medi-Cal, under age of 21 years and has a condition as a result of the mental disorder that SMHS can correct or ameliorate
DHCS Requirements (FY16-17 Audit Protocol): Treatment Interventions meet two criteria:

- The focus of the proposed/actual interventions must address the functional impairment identified as a result of the qualifying mental health diagnosis

- **Focus** = functional impairments
- **Proposed** interventions = creating Client Plan
- **Actual** interventions = creating Progress Notes
DHCS Requirements (FY16-17 Audit Protocol): Treatment Interventions meet two criteria (cont):

- **Expectation** that proposed/actual interventions must do **one of the following**:
  - **Significantly diminish** the functional impairment
  - **Prevent** significant **deterioration** in functioning
  - Allow for a child to **progress developmentally** as individually appropriate
  - **Correct/ameliorate** the condition for FS-MC, <21 years
Tip: These are **clinical stories**… line up your functional impairments & interventions.

<table>
<thead>
<tr>
<th>Functional Impairment Pathway</th>
<th>Treatment Interventions Pathway</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1: Client has current <strong>significant impairments</strong>…</td>
<td>…my interventions will <strong>significantly diminish</strong> impairments</td>
</tr>
<tr>
<td>#2: Client has <strong>probability of significant deterioration</strong>…</td>
<td>…my interventions will <strong>prevent significant deterioration</strong> in functioning</td>
</tr>
<tr>
<td>#3: Child client has probability of child <strong>not progressing developmentally</strong>…</td>
<td>…interventions <strong>allow the child to progress developmentally</strong></td>
</tr>
<tr>
<td>#4: Child client has Full-scope Medi-Cal + &lt;21yrs + a <strong>condition that SMHS can correct or ameliorate</strong>…</td>
<td>…interventions <strong>correct or ameliorate the condition</strong></td>
</tr>
</tbody>
</table>
DHCS Requirements (FY16-17 Audit Protocol): The Condition Would Not Be Responsive to Physical Health Care-Based Treatment:

- The **condition** (that exists as a result of a covered diagnosis) **would not be responsive** to physical health care based treatment.

Examples:

- Depression related to a **thyroid** condition.
- Traumatic brain injury that leads to **violent behaviors**.
Review of Chapter 3:
Medical Necessity in SMHS
What have we just discussed?

**Overall Medical Necessity for SMHS**

- You conduct an **assessment** = **DIAGNOSIS**
- Your assessment reveals **MH needs** = **IMPAIRMENTS**
- Your mental health **interventions** will help = **INTERVENTIONS**
- Primary care is not the correct **setting** = **NOT RESPONSIVE**
What have we just discussed (cont.)?

- **DHCS FY16-17 Chart Audit Protocol**
  - This is the chart audit tool published by DHCS; auditors from DHCS as well as SFDPH-BHS Compliance use this tool.

- **SFDPH-BHS Outpatient Services Documentation Standards & Practices (2012)**
  - This is the current documentation manual published by SFDPH-BHS
What are the four required elements for medical necessity for SMHS?

What are the four “clinical stories” or pathways that get you to medical necessity?

- Two pathways for Adults
- Four pathways for Children (up to age 21)
4 Required Elements: (1) Covered Mental Health Diagnosis; (2) Functional Impairments; (3) Treatment Interventions; (4) Not Responsive to Physical Health Care Treatment

4 Pathways: (1) current significant impairments in functioning; (2) probability of significant deterioration in functioning; (3) probability child will not progress developmentally; (4) FSMC-<21-condition
Chapter 4:

Credentialing, Qualifications and Billing Privileges
Scope of Practice: the health care services a physician/health care practitioner is authorized to perform by virtue of a professional license, registration or certification.

Credentialing: based on your education/licensure and status, the Mental Health Plan (MHP) will “credential” you with “privileges” to bill specific services.

MH Medi-Cal: you will be “credentialed” by the County MHP and this restricts services you provide.
Chapter 4: Credentialing/Qualifications/Privileges

- **Licensed Practitioner of the Healing Arts (LPHA):**
  - Physician/Medical Doctor (Licensed)
  - PhD (Licensed, Registered or Waived)
  - PsyD (Licensed, Registered or Waived)
  - MFT (Licensed, Registered or Waived)
  - MSW (Licensed, Registered or Waived)
  - Professional Counselor (Licensed, Registered or Waived)
  - Registered Nurse (if Psych Masters, CNS, or NP; Licensed, Registered or Waived)

- **Only LPHA can establish diagnosis!**
- **LPHA must sign/co-sign Client Plan/Tx Plan!**
Not LPHA:
- 2 year/Bachelor’s Registered Nurse
- LVN
- Mental Health Rehabilitation Specialist (MHRS)
- “Case managers”

Is your current “workflow” set up to ensure that a LPHA establishes the diagnosis? To ensure that a LHPA (co)signs the Client Plan/Treatment Plan?
### SFDPH-BHS; Mental Health Staffing Qualifications for Service & Billing Privileges Matrix (2016):

<table>
<thead>
<tr>
<th>Mental Health Services</th>
<th>LPHA (Excluding LPFT, NP, LVN, Licensed Psychologist)</th>
<th>Staff Registered with Licensing Boards (LPHA, NP, MD, Psychologist)</th>
<th>GRADUATE STUDENT (Unlicensed MA, MSW, MID-PDD, MA Psychology, Clinical Psychologist)</th>
<th>RN (BA or AA) / LVN / PT</th>
<th>MFARS (Exempt exp AA/3 yrs exp)</th>
<th>BA Degree in a Mental Health Related Field (Unlicensed)</th>
<th>HS Degree / GED (5 yrs exp or less required at which time the BA in RH is in the RA Field)</th>
<th>BA in RH Related Field</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient</td>
<td>X</td>
<td>X</td>
<td>LPHA must co-sign</td>
<td>X</td>
<td>X</td>
<td>No privilege</td>
<td>No privilege</td>
<td>No privilege</td>
</tr>
<tr>
<td>Inpatient</td>
<td>X</td>
<td>X</td>
<td>LPHA must co-sign</td>
<td>Cannot establish diagnosis</td>
<td>Cannot establish diagnosis</td>
<td>No privilege</td>
<td>No privilege</td>
<td>No privilege</td>
</tr>
<tr>
<td>Individual Psychotherapy</td>
<td>X</td>
<td>X</td>
<td>LPHA must co-sign</td>
<td>X</td>
<td>X</td>
<td>No privilege</td>
<td>No privilege</td>
<td>No privilege</td>
</tr>
<tr>
<td>Group Psychotherapy</td>
<td>X</td>
<td>X</td>
<td>LPHA must co-sign</td>
<td>X</td>
<td>X</td>
<td>LPHA must co-sign</td>
<td>No privilege</td>
<td>No privilege</td>
</tr>
<tr>
<td>Group Group Therapy</td>
<td>X</td>
<td>X</td>
<td>LPHA must co-sign</td>
<td>X</td>
<td>X</td>
<td>LPHA must co-sign</td>
<td>No privilege</td>
<td>No privilege</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>X</td>
<td>X</td>
<td>LPHA must co-sign</td>
<td>X</td>
<td>X</td>
<td>LPHA must co-sign</td>
<td>No privilege</td>
<td>No privilege</td>
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<tr>
<td>Pain Management</td>
<td>X</td>
<td>X</td>
<td>LPHA must co-sign</td>
<td>X</td>
<td>X</td>
<td>LPHA must co-sign</td>
<td>No privilege</td>
<td>No privilege</td>
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<tr>
<td>TMS/Tranquillization</td>
<td>X</td>
<td>X</td>
<td>LPHA must co-sign</td>
<td>X</td>
<td>X</td>
<td>LPHA must co-sign</td>
<td>No privilege</td>
<td>No privilege</td>
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<tr>
<td>Opioid Support - MD</td>
<td>X</td>
<td>X</td>
<td>LPHA must co-sign</td>
<td>X</td>
<td>X</td>
<td>LPHA must co-sign</td>
<td>No privilege</td>
<td>No privilege</td>
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<td>Opioid Support - LVN</td>
<td>X</td>
<td>X</td>
<td>LPHA must co-sign</td>
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<td>X</td>
<td>LPHA must co-sign</td>
<td>No privilege</td>
<td>No privilege</td>
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<td>Non-Hospital Services</td>
<td>X</td>
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<td>LPHA must co-sign</td>
<td>X</td>
<td>X</td>
<td>LPHA must co-sign</td>
<td>No privilege</td>
<td>No privilege</td>
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<tr>
<td>Home Health Services</td>
<td>X</td>
<td>X</td>
<td>LPHA must co-sign</td>
<td>X</td>
<td>X</td>
<td>LPHA must co-sign</td>
<td>No privilege</td>
<td>No privilege</td>
</tr>
</tbody>
</table>

**Case Management**

- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign

**Crisis Intervention**

- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign

**Day Treatment**

- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign

**Intensive Half Day**

- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign

**Intensive Full Day**

- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign

**Rehabilitation**

- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign

**Miscellaneous Services**

- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign
- X: LPHA must co-sign

**Endnotes**

- *No restrictions*
- *California Psych Interns must receive a waiver from SMHCS, which is granted for up to 9 yrs. Out-of-State Interns must receive a waiver from SMHCS or respective board, which can be granted for up to 3 yrs. Application for the waiver must go through the SMHCS Compliance Officer. Contact HR/MSPA at (415) 390-2800.*

vOctober2016
Review of Chapter 4:

Scope of Practice
Are you a LPHA? YES or NO

Is your supervisee a LPHA? YES or NO or N/A

Only LPHA can establish diagnosis? YES or NO

LPHA must sign/co-sign Client Plan? YES or NO
Chapter 5: Assessments

What is the problem?
“Assessment” in SMHS: Words Matter!

Assessment Service: as you conduct your clinical assessment, some of your activities will meet the DHCS definition of “Assessment Service” and you can bill for that Assessment Service by writing a progress note.

We will learn the DHCS definition of “Assessment Service”!
“Assessment” in SMHS (cont.)

Assessment **Document**: you will use an electronic health record (EHR) to create a document—that document contains all of your clinical assessment information. DHCS requires that **your Assessment Document include 11 items**.

- We will learn the 11 required items!
- SFDPH-BHS’ EHR is Avatar (by Netsmart Technologies)
“Assessment” in SMHS (cont):

- **Assessment Phase of Treatment**: One phase of mental health treatment is the “Assessment Phase.”

- Outpatient = initial assessment due by Day 60; Adult Residential Treatment = initial assessment due by “72 hours” (three full days after Episode Opening).

- You must conduct an **assessment annually (or whenever there is a change in the client’s condition)**. These are just two examples of “due dates” that you need to track.
“Assessment” means a service activity designed to evaluate the current status of a beneficiary’s mental, emotional, or behavioral health. Assessment includes but is not limited to one or more of the following: mental status determination, analysis of the beneficiary’s clinical history; analysis of relevant cultural issues and history; diagnosis; and the use of testing procedures.

(CCR, Title 9, Chapter 11 §1810.204)
Did I provide an assessment service?

- Evaluate the client’s **current status**?
- The **current mental, emotional or behavioral health**?
- **Activities** including…
  - **Mental status** determination?
  - Analysis of **clinical history**?
  - Analysis of **relevant cultural issues/history**?
  - **Diagnosis**?
  - Use of **testing procedures**?
The Assessment Document is important!

- The Assessment Document will show and communicate that the client has a current mental health diagnosis (Element #1-Medical Necessity-What).

- The Assessment Document will show and communicate the client’s functional impairments in an important area of life functioning (Element #2-Medical Necessity-What).

- The Assessment Document and the client’s input will drive the creation of a Client Plan/Treatment Plan (Element #3-Medical Necessity-Why & How).
You will fill out every section of the Assessment Document. Do not leave blanks—if you don’t have the info, then say when/how you expect to get it.

SFDPH-BHS has designed their Assessment Document to capture the 11 items that must be present on every Assessment Document (per DHCS).
The 11 Required Items for Every Assessment Document (from FY16-17 DHCS Chart Audit Protocol):

1. **Presenting problem:** The beneficiary’s chief complaint, history of presenting problem(s) including current level of functioning, relevant family history and current family information;

2. **Relevant conditions & psychosocial factors:** Those factors affecting the beneficiary’s physical health and mental health including, as applicable; living situation, daily activities, social support, cultural and linguistic factors, and history of trauma or exposure to trauma;
3. **Mental Health History.** Previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions. If possible, include information from other sources of clinical data such as previous mental health records and relevant psychological testing or consultation reports;

4. **Medical History.** Relevant physical health conditions reported by the beneficiary or a significant support person. Include name and address of current source of medical treatment. For children and adolescents the history must include prenatal and perinatal events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports;
The 11 Required Items for Every Assessment Document (cont.):

5. **Medications.** Information about *medications* the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration of medical treatment. The *assessment must include documentation of the absence or presence of allergies* or adverse reactions to medications *and documentation of an informed consent for medications*;

6. **Substance Exposure/Substance Use.** Past and present use of *tobacco, alcohol, caffeine, CAM* (complementary and alternative medications) and *over-the-counter drugs, and illicit drugs*;
The 11 Required Items for Every Assessment Document (cont.):

7. **Client Strengths.** Documentation of the beneficiary’s strengths in achieving client plan goals related to the beneficiary’s mental health needs and functional impairments as a result of the mental health diagnosis;

8. **Risks.** Situations that present a risk to the beneficiary and/or others, including past or current trauma;

9. **A mental status examination;**
The 11 Required Items for Every Assessment Document (cont.):

10. A Complete Diagnosis: A diagnosis from the current ICD-code must be documented, consistent with the presenting problems, history, mental status examination and/or other clinical data; including any current medical diagnoses.

11. Additional clarifying formulation information, as needed
### Billing: Only bill Assessment and Plan Development services until you finalize the assessment form in Avatar. You can bill “Crisis Intervention” if there is a crisis.

<table>
<thead>
<tr>
<th>Billable Services:</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1. Assmt+Plan Devel</td>
<td>1. Assmt+Plan Devel</td>
<td>1. Planned Services</td>
</tr>
<tr>
<td>2. Crisis Intervention</td>
<td>2. Crisis Intervention</td>
<td>2. Crisis Intervention</td>
</tr>
</tbody>
</table>

#### Clinical Practice

- **I conduct an assessment:**
  - “*what* is the problem?”

- **Establish Diagnosis & Functional Impairments**

#### M-Cal Logic

- **I create a treatment plan:**
  - “*why* the problem exists”

- **Create Treatment Plan/Client Plan**

#### I provide interventions:

- **how we address the problem**

- **Provide Treatment Interventions**
Review of Chapter 5:
Assessment Service vs. Form vs. Phase of Treatment
What have we just discussed (cont.)?

“Assessment” in SMHS:

- A billable service activity (*DHCS defines “Assessment Service”*)
- A document that contains all assessment info (*11 required items*)
- A initial/subsequent phase of treatment (for OUTPATIENT programs, 60 day/annual “due dates”; Adult Residential 72hrs/annual)

11 Required Items for Every Assessment Document:

- You must address every item
- **Remember:** *Only LPHA can establish diagnosis!*
What have we just discussed (cont.)?

Services you may bill:

The logic of Medi-Cal (and regulation) requires that you only bill “Assessment” and Plan Development services until both of the following are true:

1. Finalize the Assessment Form in Avatar;
2. Demonstrate medical necessity (Included Diagnosis; Functional Impairments; Interventions).

If there is a client crisis (i.e., harm to self/others), then you are permitted to provide “Crisis Intervention”
Chapter 6:

Client Plans
(Treatment Plan of Care/TPOC)

*Why does the problem exist?*
Let’s take a Peek at the Avatar TPOC:

- SFDPH-BHS has designed their Client Plan/TPOC to capture the **11 items that must be present on every Client Plan/TPOC** (per DHCS).

- **Avatar TPOC Worksheet**: IT has created a field-by-field replication of the Avatar TPOC.
Client Plans in SMHS (CCR, Title 9, Chapter 11 §1810.205.2):

- “Client Plan” means a plan for the provision of specialty mental health services to an individual beneficiary who meets the medical necessity criteria in Sections 1830.205 or 1830.210
The Client Plan is important!

- The Client Plan must **address the mental health needs** identified in the **current assessment** (*The Golden Thread*...assessment → impairments).

- The Client Plan must **have Goals/Objectives that address the functional impairments** (*The Golden Thread*...assessment → impairments).

- The Client Plan **must be updated** when there are **significant changes in the client’s condition** (at a minimum, updated **Annually**).
Client Plan Timeliness & Frequency (from FY16-17 DHCS Chart Audit Protocol):

- Initial Client Plan must be finalized by Day 60/OP or 72hrs/Adult Residential (BHS Policy).
- The Client Plan must be reviewed and updated when there are significant changes in the client’s condition.
- At a minimum, the Client Plan must be reviewed and updated annually.
The 11 Required Items for Every Client Plan/TPOC (from FY16-17 DHCS Chart Audit Protocol):

1. **Client Plan Updates**: The Initial Client Plan is finalized by Day 60 for Outpatient/72hrs for Adult Residential). The client plan been updated at least annually and/or when there are significant changes in the beneficiary's condition.

2. **Objectives**: Client Plan objectives must be specific, observable, and/or specific quantifiable goals/treatment objectives related to the beneficiary’s mental health needs and functional impairments as a result of the mental health diagnosis.
The 11 Required Items for Every Client Plan/TPOC (from FY16-17 DHCS Chart Audit Protocol):

3. Interventions: The Client Plan contains the proposed type(s) of interventions/modalities. There must be a detailed description of the intervention to be provided.

4. Frequency of Interventions: The Client Plan includes the proposed frequency of the intervention(s).

5. Duration of Interventions: The Client Plan includes the proposed duration of the intervention(s).
The 11 Required Items for Every Client Plan/TPOC (from FY16-17 DHCS Chart Audit Protocol):

6. **Target of Interventions**: The Client Plan interventions focus on and address the identified functional impairments as a result of the mental disorder or emotional disturbance.

7. **Consistency of Interventions with Objectives & Diagnosis**: The Client Plan interventions are consistent with both: (1) Client Plan goal(s)/treatment objective(s) and (2) the qualifying diagnoses.
The 11 Required Items for Every Client Plan/TPOC (from FY16-17 DHCS Chart Audit Protocol):

8. Staff signatures: The Client Plan is signed by:

(1) Person providing the service(s) \textit{or}

(2) Person representing a team or program providing the service(s) \textit{or},

(3) A person representing the MHP providing the service(s) \textit{or}

(4) Co-signed by a LPHA (if the Client Plan is used to establish that services are provided under the direction of a LPHA, and if the signing staff is not a LPHA)
The 11 Required Items for Every Client Plan/TPOC (from FY16-17 DHCS Chart Audit Protocol):

9. Client Participation & Agreement with Plan:

The client's participation in and agreement with the Client Plan is documented by one of the following: (1) reference to the client's participation in/agreement written within the body of the Client Plan, (2) the client's signature* on the client plan or (3) a description of the client's participation in/agreement documented in the medical record.

The client's signature* (or client's legal representative's signature) must appear on the Client Plan if both of the following are true: (1) the client is expected to be in long-term treatment [defined by County MHP] and (2) the Client Plan includes more than 1 type of SMHS [e.g., “Therapy” and “Collateral”].

*If the client refuses or is unavailable to sign the Client Plan, then the Client Plan must include a written explanation of the refusal/unavailability of the signature.
The **11 Required Items for Every Client Plan/TPOC** (from FY16-17 DHCS Chart Audit Protocol):

10. **Evidence of Offering Client Copy of Plan**: The Client Plan will include documentation that the contractor offered a copy of the client plan to the beneficiary.

11. **Dates & Staff Degree/Title**: The Client Plan must include all of the following (1) the date of service; (2) the staff's signature, professional degree and title of job/licensure; and (3) the date the documentation was entered into the medical record.
Additional Details for the Client Plan

- Document your ongoing attempts to get the client’s signature on the Client Plan—get that signature!

- The Client Plan is officially “finalized” when all required staff signatures are in place and dated.

- You must finalize the Client Plan before providing treatment services. In other words, you cannot bill “planned services” until the Client Plan is finalized—you will only be able to bill “Plan Development” services.
Review of Chapter 6: TPOC ("Why Does the Problem Exist")

Review of Chapter 6:

Client Plan/TPOC
What have we just discussed?

“Client Plan” in SMHS

- If a client meets medical necessity, you create a treatment plan that describes the treatment objectives and the SMHS that will address the functional impairments.
- **Remember:** A LPHA must sign/co-sign the treatment plan!

11 Required Items for Every Client Plan:

- **Remember:** Clearly document the client’s involvement in and agreement with the Client Plan—get that signature!
What have we just discussed?

Due Dates for Client Plans

- Initial Plan due by Day 60/OP or 72hrs/Adult Residential.
- Update the Client Plan when there are significant changes in the client’s condition (at a minimum, Annually).

Billing:

- You may only use “Plan Development” until the Client Plan is finalized. If there is a crisis (i.e., harm to self/others), you are permitted to use “Crisis Intervention.”
Chapter 7:
Outpatient & Adult Residential Treatment Services and Notes

How We Address the Problem
Outpatient SMHS for SFDPH-BHS:

- SFDPH-BHS certifies and authorizes clinics and staff to provide a limited “package” of SMHS.
- For every billable service you provide, you must document the encounter in a progress note using the Avatar EHR.

Adult Residential SMHS for SFDPH-BHS:

- Adult Residential is a bundled service that requires Weekly Summaries using the Avatar EHR.
Outpatient SMHS for DHCS:

- Eleven required elements for every progress note!
The **11 Required Elements** (from FY16-17 DHCS Chart Audit Protocol):

1. **Relevant Aspects of Client Care:** Progress notes include documentation of relevant aspects of client care, including documentation of medical necessity;

2. **Details of the Encounter:** Progress notes include documentation of beneficiary encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions;
The **11 Required Elements** (from FY16-17 DHCS Chart Audit Protocol):

3. **Interventions & Details:** Progress notes include descriptions of interventions applied, client’s response to the interventions, [how interventions reduced impairment/restored functioning/prevented deterioration in an important area of life functioning outlined in the Client Plan], and the location of the interventions;

4. **Date of Service:** Progress notes include the date the services were provided;
The 11 Required Elements (from FY16-17 DHCS Chart Audit Protocol):

5. **Referrals**: Progress notes include documentation of referrals to community resources and other agencies, when appropriate;

6. **Follow-Up Care and/or Discharge Summary**: Progress notes include documentation of follow-up care or, as appropriate, a discharge summary (*more on this*...);

7. **Service Time**: Progress notes include documentation of the amount of time taken to provide services;
The **11 Required Elements** (from FY16-17 DHCS Chart Audit Protocol):

8. **Signature, Degree & Licensure/Title:** Progress notes include the *signature* of the person providing the service (or electronic equivalent); the person’s *type of professional degree*, and *licensure or job title*;

9. **Date of Documentation:** The *date* the documentation was *entered in the medical record*;
The 11 Required Elements (from FY16-17 DHCS Chart Audit Protocol):

10. Timeliness, Frequency & Legibility:

a) Every outpatient service contact/encounter must be documented as a progress note and (b) finalized in the medical record **within 5 days** from the date of service

b) Late progress notes (i.e., not finalized in the medical record **within 5 days from the date of service**), staff must **include the text "Late Entry"** at the beginning of the note

c) All documentation is legible.
The **11 Required Elements** (from FY16-17 DHCS Chart Audit Protocol):

11. **Multi-Provider Notes:** When services are being provided to, or on behalf of, a beneficiary by two or more persons at one point in time, do the progress notes include:

   a) Documentation of each person’s involvement in the context of the mental health needs of the beneficiary?

   b) The exact number of minutes used by persons providing the service?

   c) **Signature(s)** of person(s) providing the services?
Additional Details on Element #11: Multi-Provider Notes:

- **Principles** when two or more providers are rendering services:
  - Document *why multiple staff are needed* for the activity;
  - Document *the unique contribution* for each person’s involvement;
  - Prorate/apportion the staff service time across all clients in the room (regardless if Medi-Cal or other insurance)
Additional Details on Element #6: Follow-Up Care and/or Discharge Summary:

- **Billable service:**
  - Conducting a *therapeutic session* with a client to create a *discharge plan* (and/or a *therapeutic session* to review a *discharge plan* with client).

- **Not billable:**
  - Typing the discharge summary;
  - Creating a discharge summary *after your last session with client*.
Additional Details on Element #11: Multi-Provider Notes:

- **Prorating Example:** Social Skills Group (60mins) with 2 Staff and 8 Clients…how many mins/client?

**Formula for Prorating Multi-Provider Services**

\[
\frac{(\text{#Staff}) \times (\text{# Minutes})}{\text{# of clients}}
\]

\[
(2 \text{ Staff}) \times (60\text{mins}) \div (8 \text{ Clients})
\]

120 Staff Minutes \div 8 clients

15 Staff Minutes Per Client
Outpatient SMHS:

- SFDPH-BHS certifies and authorizes clinics and staff to provide a limited “package” of SMHS.

- “Outpatient Bundle” (aka “OP Bundle”): in SF, we call the “package” of services the “OP Bundle:”

  - Mental Health Services (e.g., assessment, therapy)
  - Targeted Case Management (TCM)
  - Medication Support
  - Crisis Intervention
Chapter 7: Services ("How to Address the Problem")

Outpatient Bundle Services

- Mental Health Services
  - Assessment
  - Plan Development
  - Therapy
  - Rehabilitation
  - Collateral
- TCM
- Med Support
- Crisis Interv’n
“Mental Health Services” means individual or group therapies and interventions that are designed to provide reduction of mental disability and restoration, improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency...[s]ervice activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral.
#1: Assessment - Definition

“Assessment” means a service activity designed to evaluate the current status of a beneficiary’s mental, emotional, or behavioral health. Assessment includes but is not limited to one or more of the following: mental status determination, analysis of the beneficiary’s clinical history; analysis of relevant cultural issues and history; diagnosis; and the use of testing procedures.
“Initial meeting with client for the purposes of conducting an assessment to determine medical necessity for Specialty Mental Health Services.”

“Conducted mental status exam: client shows impaired Thought Processes (loose associations; flight of ideas) and Content (paranoid delusions) which are consistent with the reason for referral.”

“Will continue assessment process in next meeting.”
“Plan Development” means a service activity that consists of *development of client plans*, *approval of client plans*, and/or *monitoring of a beneficiary’s progress*. 
“Met with client for the purposes of developing Client Plan objectives to address functional impairments (social problems) that result from client’s mental health diagnosis (Schizophrenia, F20.9; inability to concentrate).”

“The client identified the following goals: ‘make food at home so I can save money’ and ‘meet more people so I can find someone to date.’”
“Therapy” means a service activity that is a therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments. Therapy may be delivered to an individual or group of beneficiaries and may include family therapy at which the beneficiary is present.
“Conducted individual therapy session to address Client Plan Objective (‘meet more people so I can find someone to date’).”

“Implemented behavioral rehearsal intervention with client. Client was able to introduce himself and ask an appropriate open-ended question with minimal prompts from therapist.”

“Mental status exam: no change in thought content/processes from initial meeting. No suicidality observed.”
“Rehabilitation” means a service activity which includes, but is not limited to assistance in improving, maintaining, or restoring a beneficiary’s or group of beneficiaries’ functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources; and/or medication education.
Conducted individual rehab session to address Client Plan Objective (‘make food at home so I can save money’).

Assisted client to create a weekly calendar of food shopping activities. Initially, client was resistant to the activity. We reviewed his goals and he confirmed this is his current goal. Client agreed that he ‘gets confused sometimes’ and then created a weekly calendar and we taped the calendar to the refrigerator.
“Collateral” means a service activity to a significant support person in a beneficiary’s life for the purpose of meeting the needs of the beneficiary in terms of achieving the goals of the beneficiary’s client plan. Collateral may include but is not limited to consultation and training of the significant support person(s) to assist in better utilization of specialty mental health services by the beneficiary, consultation and training of the significant support person(s) to assist in better understanding of mental illness, and family counseling with the significant support person(s). The beneficiary may or may not be present for this service activity.
“Conducted collateral session on phone with client’s mother, (a significant support person to the client) to address Client Plan Objective (‘make food at home so I can save money’).”

“Consulted with mother regarding client’s weekly calendar of food shopping. Explained why the calendar is an important tool for the client. Mother agreed that when she calls the client each morning, she will cue him to look at the calendar.”
“Targeted Case Management” means services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary’s progress; placement services; and plan development.
“Conducted TCM service on phone with vocational services staff to address Client Plan Objective (‘meet more people so I can find someone to date’).”

“Communicated with vocational program intake staff regarding referral to the program. I was informed that client cannot begin program for 2 weeks due to staffing shortage. The intake staff member confirmed that she will call the client to introduce herself and explain the delay. I will confirm client’s understanding of the delay in next session.”
“Medication Support” means those services that include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness. Service activities may include but are not limited to evaluation of the need for medication; evaluation of clinical effectiveness and side effects; the obtaining of informed consent; instruction in the use, risks and benefits of and alternatives for medication; and collateral and plan development related to the delivery of the service and/or assessment of the beneficiary.
“Provided Medication Support service to client to address Client Plan Objective (‘meet more people so I can find someone to date’).”

“Medication management meeting to monitor client’s clinical response to Risperidone. He reports that he takes meds as directed (‘my mom helps to remind me’). Minimal side effects reported. Client states he believes he is more ‘stable’ when I take my meds.’ Client also reports he feels more comfortable talking to people now “than I did last year.”
“Crisis Intervention” means a service, lasting less than 24 hours, to or on behalf of a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: assessment, collateral and therapy. Crisis intervention is distinguished from crisis stabilization by being delivered by providers who do not meet the crisis stabilization contact, site, and staffing requirements described in Sections 1840.338 and 1840.348.
“Provided Crisis Intervention service to client to intervene for suicidal ideation and need for safety.

“Conducted Crisis Intervention session to client. Client called this writer to say he is ‘feeling suicidal.’ Conducted lethality assessment (low risk—client does not have a plan, is not using substances, has history of mild suicidal thoughts, but no attempts). Client agreed to go to his mother’s house (‘she will make me feel better’). Client contracted for safety and stated ‘I promise I will call you if I feel bad.’”
Adult Residential SMHS for BHS:

- Documentation must support the program requirements, the type of service, date of service and units of time claimed.
- Activities in which the client participated,
- Client's behaviors and staff intervention,
- Progress toward objectives or documentation of lack of progress,
- Involvement of family members, if appropriate,
- Contact with other programs/agencies/treatment personnel involved with the client's treatment.
“Adult Residential Treatment Service” means rehabilitative services, provided in a non-institutional, residential setting, for beneficiaries who would be at risk of hospitalization or other institutional placement if they were not in the residential treatment program. The service includes a range of activities and services that support beneficiaries in their efforts to restore, maintain and apply interpersonal and independent living skills and to access community support systems. The service is available 24 hours a day, seven days a week. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral.
## Domain of Adult Residential Treatment for Weekly Summary

### ACTIVITIES
The client participated in activities this week…

### BEHAVIORS
The client displayed behaviors that included…

### INTERVENTIONS
- The Family Advocate/Support Counselor provided…
- The MHRS staff provided…
- The LPHA provided…

### PROGRESS TOWARD GOALS
Client's progress is measured…based on this metric, the client's progress includes…the improvement and progress could be attributed to…

### LACK OF PROGRESS TOWARD GOALS
The client has not made progress/improvement on the following goals/objectives…the lack of progress could be attributed to…to address the lack of progress, staff and client will…

### FAMILY UN/INVOLVEMENT
The involvement of family and its impact on treatment progress was…the lack of family involvement of family and it's impact on treatment progress was…

### OTHER PROVIDER INVOLVEMENT
The client also received services from…we will help the client use/benefit from those services by…
Review of Chapter 7:

Outpatient & Adult Residential Treatment Services and Notes
What have we just discussed?

Specific categories of treatment interventions which are reimbursed through MH Medi-Cal/SMHS for many Outpatient Providers and Adult Residential Tx:

- Assessment
- Plan Development
- Therapy
- Collateral
- Targeted Case Management
- Medication Support
- Crisis Intervention
- Adult Residential Treatment Services
What have we just discussed?

- Each service is **defined by DHCS**!
  - Examples of activities as well as
  - Specific criteria that must be addressed in every progress note.

- **Golden Thread**!
  - The context for these services is the current Client Plan, objectives and the interventions described there.
Service Lockouts

- **Service lockout** = situation/circumstance when federal financial participation (FFP) is not available for the specific SMHS.

- See these as **logical inconsistencies!**

  - **Example:** My client is currently in a high-end placement (e.g., Adult Crisis Residential) and receiving services. I conduct a service activity while she is in Adult Crisis Residential (e.g., I speak with mother about concerns about how to support daughter’s safety).

  - This is a service lockout—you cannot provide services to your client (i.e., conduct a collateral session) when you client is already receiving services!
Chapter 8:

Special Topic - Insights from DHCS (2015)
“SMI” or “SED” ≠ Medical Necessity for SMHS:

- Our *Welfare & Institutions Code* (W&I Code) defines and provides criteria for “Serious Mental Disorder” adults “Seriously Emotionally Disturbed” children [W&I § 5600.3(a) and 5600.3(b) respectively].

Just because your client has been labelled “SMI” or “SED” does not mean that your client meets medical necessity for SMHS!
“Covered/Included” Diagnoses for Non-Hospital SMHS & Personality Disorders

- We tend to think about Covered/Included diagnoses as “Axis I” disorders, **but that is not entirely true...**

- **With the exception of Antisocial Personality Disorder (F60.2), Personality Disorders are Covered/Included diagnoses for SMHS.**

- **Reminder**—you have the list of the DHCS Outpatient SMHS Covered/Included Diagnoses!
“Covered/Included” Diagnoses & Personality Disorders (cont.)

“Personality disorder categories may be applied with children or adolescents in those relatively unusual instances in which the individual's particular maladaptive personality traits appear to be pervasive, persistent, and unlikely to be limited to a particular developmental stage or another mental disorder. It should be recognized that the traits of a personality disorder that appear in childhood will often not persist unchanged into adult life. **For a personality disorder to be diagnosed in an individual younger than 18 years, the features must have been present for at least 1 year. The one exception to this is antisocial personality disorder, which cannot be diagnosed in individuals younger than 18 years.** Although, by definition, a personality disorder requires an onset no later than early adulthood, individuals may not come to clinical attention until relatively late in life” (DSM-5, ps 647-648).
# Excluded Diagnoses for Outpatient SMHS

<table>
<thead>
<tr>
<th>“Deferred” or “by history”</th>
<th>Communication Disorders</th>
<th>Autism Spectrum Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>A stand-alone “Rule Out” diagnosis</td>
<td>Delirium</td>
<td>Tic Disorders</td>
</tr>
<tr>
<td>Provisional Diagnosis (either depression or bipolar)</td>
<td>Dementia</td>
<td>Cognitive Disorders (e.g., dementia with depressed mood)</td>
</tr>
<tr>
<td>“V” codes</td>
<td>Amnestic Disorders</td>
<td>Substance-Induced Disorders</td>
</tr>
<tr>
<td>Mental Retardation (aka Intellectual Disabilities)</td>
<td>Sleep Disorders</td>
<td>Intermittent Explosive Disorder</td>
</tr>
<tr>
<td>Learning Disorders</td>
<td>Mental Disorders due to a General Medical Condition</td>
<td>Pyromania</td>
</tr>
<tr>
<td>Motor Skill Disorders</td>
<td>Other condition that May be a Focus of Clinical Attention</td>
<td>Antisocial Personality Disorder</td>
</tr>
</tbody>
</table>
Excluded Diagnoses:

- “Deferred” or “by history”
- A stand-alone “Rule Out” diagnosis
- Provisional Diagnosis (either depression or bipolar)
- “V” codes
- Mental Retardation (aka Intellectual Disabilities)
- Learning Disorders
- Motor Skill Disorders
- Communication Disorders
- Delirium
- Autism Spectrum Disorder
Establishing a Diagnosis

- Only a LHPA can establish a diagnosis for SMHS.

- You cannot conduct a Mental Status Exam (a primary element of assessment/diagnosis) unless you are a LHPA!

- **Reminder** - you have the SFDPH-BHS Mental Health Staffing & Qualifications Matrix for Service & Billing Privileges Matrix (2016).
Client Plan Interventions: “Expectation that interventions significantly diminish or prevent significant deterioration…”

DHCS’ Expectations = “Reasonable Mental Health Professional”

“Would a reasonable mental health professional (using community standards of care) expect that your intervention would cause a significant diminishment of a functional impairment (or prevent significant deterioration in functioning)?”
**Client Plan Interventions:** “…the type of intervention/modality including a detailed description of the intervention to be provided”

<table>
<thead>
<tr>
<th>Modality</th>
<th>Intervention</th>
<th>Written Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapy</td>
<td>Cognitive Reframing</td>
<td>Intervention #1: Therapy (including CBT interventions of cognitive reframing, pleasant activity scheduling and exposure) to improve client’s Vocational and Social impairments. Will occur weekly, for 50mins by…</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>Behavioral Modeling</td>
<td>Intervention #2: Rehabilitation (including behavioral modeling and social skills training) to improve client’s Social impairments. Will occur every other week for 30mins by…</td>
</tr>
<tr>
<td>Collateral</td>
<td>Psychoed &amp; Family Counseling</td>
<td>Intervention #3: Collateral to client’s mother (including psychoeducation on episodic schizophrenia) and family counseling with mother and client (developing a mutually agreed plan for mother to support son’s treatment) to address Vocational and Social Impairments. Will occur weekly for 40mins by…</td>
</tr>
<tr>
<td>Targeted Care Management</td>
<td>Brokerage</td>
<td>Intervention #4: TCM for client (specifically, brokerage and service monitoring) to access Supported Vocational Program. Will occur weekly for 15mins by…</td>
</tr>
<tr>
<td>Medication Support</td>
<td>Prescribing &amp; Monitoring</td>
<td>Intervention #5: Medication Support to client (including prescribing and monitoring) to alleviate symptoms of Schizophrenia and improve Social and Vocational functioning. Will…</td>
</tr>
</tbody>
</table>
What’s Up with Signatures?

Legal Documents:

- **Informed Consent**: the signature identifies the person who may legally provide consent for treatment (e.g., juvenile dependency court; conservatorship).
- **Release of Information**: the signature identifies the person who may legally control the personal health information (PHI).

“Full Disclosure” Documents:

- **Medication Consent**: the signature demonstrates the client has been advised of risks/benefits (even for dosage change!)}
What’s Up with Signatures (cont.)?

Assessment Form: LPHA signature/date confirms the mental status exam and differential diagnosis was conducted by a staff member with the appropriate scope of practice.

Client Plan:

- LPHA signature/date confirms that treatment interventions are expected to significantly reduce/prevent significant decline in functioning.

- Client signature/date confirms that the client participated in and agrees with the Client Plan.
Best Practices for Progress Notes?

- Clear, concise and succinct;

- Interventions are clearly linked to mental health functional impairments and included diagnosis;

- Client response to intervention is described:
  - When you provided the intervention, what was the response?

- If services are provided in the home, document why community-based services need to be offered to the client.
Collateral (Family Counseling) vs. Family Therapy?

- What is the focus of treatment—this is the key variable to consider!

  - Collateral = focus on the needs of the client in meeting the goals of their Client Plan
  - Family Therapy = focus is family system (as a whole) and what goes on between individuals in the family
Case Conferences:

- Document your contribution in the meeting (vs. listening).

- Document the time you participated in the meeting (vs. claiming the entire meeting).

- The progress note must meet medical necessity criteria!
Activities Not Billable to MH Medi-Cal:

- **Solely clerical** activities (e.g., faxing, filling out applications, leaving a voicemail)
- **Reviewing charts** or other **paperwork**
- Filling out **SSI forms, CPS reports**
- Filling out **forms for housing needs**
- **Grocery store trips** that do not include skills training or other linkage to functional impairments
- No shows
- Supervision
Activities Not Billable to MH Medi-Cal (cont.):

- Solely payee related activities
- Staff provides a service that is not in their scope of practice.
  
  An LCSW/PhD, etc. can talk with a client about medication compliance (e.g., barriers), but cannot assess side effects, the need for new meds, etc.
  
- Progress notes that have been “cloned” (i.e., copied/pasted from another chart and not individualized to client’s functional impairments).
Activities Not Billable to MH Medi-Cal (cont.):

- **Transportation** (vs. Billable Travel)
  
  If you **must provide a service in the community** (client’s home, school, work, park, etc.), **you will document the amount of time it takes to drive from your office to the community and return to the office.**

  - “**Service time**” in Mental Health Medi-Cal SMSH = (Face-to-Face Time) + (Documentation Time) + (Travel Time)

  - In contrast, transporting a client (e.g., taking them to a doctor’s appointment) is not a billable service.
Activities Not Billable to MH Medi-Cal (cont.):

- **Transportation** (vs. Billable Travel)—*continued*

  - Document the client’s mental health need that requires you to travel into the community (e.g., “client cannot access mental health services at office due to symptoms of agoraphobia”…”client does not have a car and does not have reliable access to mass transportation”…)

  - Consider adding this to your treatment plan
Cultural & Linguistic Requirements:

- Mental health interpreter services must be offered and provided.

- Refusal to accept interpreter services must be documented in the medical record.

- When applicable, information must be provided to clients in an alternative format (e.g., large font; audio).

- Service-related correspondence = preferred language
Cultural & Linguistic Requirements (cont.):

Title VI of the Civil Rights Act of 1964:

- **Prohibits the expectation** that family members provide interpreter services and minors should not be used as interpreters.

- **A client may choose** to use a family member/friend as an interpreter **after being informed** of the availability of free interpreter services.

- **In some cases, it may be necessary to use a family member or minor for interpretation services** (e.g., a paranoid client refuses to talk to anyone but the minor child). **In these instances, the justification should be documented.**
parting thoughts, next steps...