CODING MANUAL

&

CLINICIAN HANDBOOK WITH DOCUMENTATION GUIDELINES

VERSION 10

January 2018

Orange County Health Care Agency
Behavioral Health Services

**Disclaimer: Orange County Electronic Health Record (OC EHR) refers only to County-Operated clinics

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SPECIALTY MENTAL HEALTH SERVICES

The County of Orange provides Specialty Mental Health Services (SMHS) to adults and children who have a severe and persistent mental health disorder.

Specialty Mental Health Services identified through Title IX are defined as:

1. Rehabilitative Mental Health Services including:
   a. Mental Health Services
   b. Medication Support Services
   c. Day Treatment Intensive
   d. Day Rehabilitation
   e. Crisis Intervention
   f. Crisis Stabilization
   g. Adult Residential Treatment Services
   h. Crisis Residential Treatment Services
   i. Psychiatric Health Facility Services
2. Psychiatric Inpatient Hospital Services
3. Targeted Case Management
4. Psychiatrist Services
5. Psychologist Services
6. EPSDT Supplemental Specialty Mental Health Services
7. Psychiatric Nursing Facility Services

Beneficiaries (clients/consumers) must meet criteria for Medical Necessity in order to bill for specialty mental health services.

Client Centered Care:

The County of Orange behavioral health system is committed to providing quality client centered care which actively involves both the client and family in the process. This type of care has received recognition as best practice in mental health services. The IOM (Institute of Medicine) defines patient-centered care as: "Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and
ensuring that patient values guide all clinical decisions.” We focus on the whole person, coordination and communication, support and empowerment, ready access, and autonomy.

The Recovery Model approach we provide to our clients and families is now widely recognized in the field of mental health. Recovery is “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential” (Substance Abuse and Mental Health Services Administration SAMHSA, December 2011). The key concepts of the Recovery Model include the following:

- **Hope** - The emotional state which promotes the belief in a positive outcome related to events and circumstances in one's life.

- **Self-Direction** - Being directed or guided by oneself, especially as an independent agent.

- **Individualized** - To mention, indicate or consider individually; specify; particularize.

- **Person-Centered** - To provide clients with an opportunity to develop a sense of self wherein they can realize how their attitudes, feelings and behavior are being negatively affected and make an effort to find their true positive potential. Clinicians create a comfortable, non-judgmental environment by demonstrating congruence (genuineness), empathy, and unconditional positive regard toward their patients while using a non-directive approach. This helps in finding their own solutions to their problems.

- **Empowerment** - Increasing the spiritual, political, social, educational, gender, or economic strength of individuals and communities.

- **Holistic** - All aspects of people's needs, psychological, physical and social should be taken into account and seen as a whole. Disease is a result of physical, emotional, spiritual, social and environmental imbalance.

- **Non-Linear** - Not of, in, along, or relating to a straight line.

- **Strengths-Based** - Emphasizes people's self-determination and strengths. Strengths based practice is client led, with a focus on future outcomes and strengths that the people bring to a problem/crisis.

- **Peer Support** - When people provide knowledge, experience, and emotional, social or practical help to each other. It commonly refers to an initiative consisting of trained supporters and can take a number of forms such as peer mentoring, listening, or counseling. Peer support is also used to refer to initiatives where colleagues, members of self-help organizations and others meet as equals to give each other support on a reciprocal basis. Peer in this case is taken to imply that each person has no more expertise as a supporter than the other, and the relationship is one of equality.

- **Respect** - Gives a positive feeling of esteem or deference for a person or other entity and also specific actions and conduct representative of that esteem.

- **Responsibility** - The state or act of being responsible, reliable or dependable. Personal responsibility is one’s ability to take care of oneself by means of keeping healthy, managing ones emotions, keeping a sound mind, treating oneself with respect.

The mental health system transformation involves increasing both the client and the staff’s hope and belief that every client can develop meaningful roles and responsibilities in life. We strive to have all interactions be positive with clients and families, even in our language and tone. We hold a strengths-based perspective of moving beyond the symptoms and capitalizing on client strengths. These strengths focus on areas such
as strong community, family support, or natural supports, as well as acknowledging the client’s best qualities, skill set, accomplishments and motivations. We identify client strengths throughout the treatment process to help overcome the barriers to reaching treatment goals.
COMPLIANCE

Compliance is the responsibility of every corporation to ensure that it complies with the law. For healthcare, this means having a plan to ensure that claims submitted for payment are accurate and that all necessary documentation exists for the services provided.

Compliance is the prevention, detection, and correction of billing improprieties.

The Health Care Agency (HCA) has an Office of Compliance and a Chief Compliance Officer. A complete orientation to the full compliance program is part of every new employee’s orientation, and it is also an annual requirement. This manual and accompanying trainings serve to address the items noted above.

COMPLIANCE IS NOT OPTIONAL

Disliking a rule, believing that a requirement is foolish, or any other reason, does not exclude anyone from following compliance initiatives. The following is a list of some things to consider in relation to compliance:

- Mistakes Happen. We don’t have to be perfect, but there must be a system in place to minimize, detect, and correct errors.
- Do all providers know what documentation is expected for the level of service or procedure they are billing for?
- Are providers aware of what services are being billed under their name?
- Are providers aware of their accountability relative to the claim attestation notice?
- Do coding and/or billing staff change a service without notifying the provider?
- Are the individuals who are billing services knowledgeable about coding, documentation and payer specific billing requirements?
- Do providers and staff know who to contact if a billing concern is identified?

Here is a summary of how these items are being handled in our system:

Mistakes Happen. We don’t have to be perfect, but there must be a system in place to minimize, detect, and correct errors. The system in place includes:

- Training on the “front end” (eligible service delivery programs) to ensure proper documentation of all completed activities or completed tasks.
- Training on the “back end” (billing) to ensure that billers have the most current and accurate information on current billing requirements.
- Strong communication between back end and front end with designated persons on both sides.
• A review process that results in Medicare and Medi-Cal bills having multiple levels of review and feedback, including pre-billing and paid claims reviews.

• Tracking of Provider Identification numbers to ensure that all necessary ID numbers are current and accurate.

Do all providers know what documentation is expected for the level of service or procedure they are billing for?

This Documentation Manual, Documentation Trainings, and the Annual Provider Trainings all address this issue.

Are providers aware of what services are being billed under their name?

No services will be billed under your name unless you have completed an Encounter Document (ED), except in instances where you have co-facilitated a group and your co-therapist completes the ED. You will not be expected to complete ED’s for services provided by anyone but yourself.

Are providers aware of their accountability relative to the claim attestation notice?

This manual is addressing the issue. You are attesting to the accuracy of the documents you completed. Every person involved in the documentation and billing of services is personally responsible for ensuring that such documentation and billings are accurate.

Does coding/billing staff change a service without notifying the provider?

All levels of review include a feedback loop to the clinician who provided the service, if the reviewer believes there may be a problem. If it is decided that the ED and/or the documentation need to be changed, it will be the responsibility of the clinician to change the ED and/or documentation in accordance with all standing rules related to making changes to clinical documents. It will be the responsibility of the coder/reviewer to notify the Service Chief or Manager if the changes are not made.

Some changes may be made by Service Chiefs. This exception is spelled out in BHS P&P 05.01.05 Corrections/Amendments to Encounter Documents When a Provider is No Longer a County Employee.

Are the individuals involved in billing services knowledgeable about coding, documentation and payer-specific billing requirements?

Billers, coders, reviewers, and certified Med-Cal reviewers utilize DHCS audit guidelines, feedback from tri-annual DHCS audits, reliability review, APT annual revisions, and attend regular training sessions. There are requirements for ongoing training of billing and review staff.

Do providers and staff know who to contact if a billing concern is identified?

Initial points of contact for providers may be the Service Chief or the coder/reviewer, with additional access to the Behavioral Health Services (BHS) Authority and Quality Improvement Services (AQIS) Division Manager and to the Medical Billing Office Manager. The Annual Provider Training reinforces the expectation that staff will make any concerns known and to whom they may make them known. In addition,
billing concerns may be anonymously reported directly to the Office of Compliance (714) 568-5614, to the Compliance Hotline (866) 260-5636 or through OC HCA intranet: [http://intranet/compliance/issuereport](http://intranet/compliance/issuereport).

Individual knowledge of how the documentation and billing process occurs, accompanied by individual knowledge of legal and regulatory requirements, is the best way to maintain a system that is consistent with legal and regulatory requirements.
CONFIDENTIALITY

Confidentiality refers to a general standard of professional conduct that obliges a health care provider not to discuss/disclose information about a client with anyone. Confidentiality is governed by federal and state statutes. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy, Security and Breach Notification Rules provides regulatory guidelines regarding the management of electronic patient records.


2. The HIPAA Breach Notification Rule requires covered entities and business associates to provide notification following a breach of unsecured protected health information.

3. The confidentiality provisions of the Patient Safety Rule protects identifiable information being used to analyze patient safety events and improve patient safety.

Privacy continues to be a rapidly growing area of compliance problems for health care providers and insurers across the country. Here at Behavioral Health Services we have both of these roles. Both federal and state agencies continue to dramatically increase the numbers of both financial and legal penalties related to HIPAA violations. Remember that HIPAA violations don’t just include inappropriate release or disclosure outside of our system.

HIPAA fines and penalties don’t just relate to accessing or disclosing records. Denying legally allowed access to records is also a HIPAA violation. If a client is seeking access to their records, you must know the proper procedures to follow. If you don’t know, ask your Service Chief or supervisor.
Because of the very high fines for every single person whose PHI is breached, loss of a small file or misdirection of a few faxes can rapidly escalate to major financial and legal issues.

Note that all aspects of client records and privacy are open to review. If anything comes up about management of records that you are unsure of, consult with your Service Chief or supervisor.

The implementation of documentation in the Orange County Electronic Health Record (OC EHR) will bring much greater opportunity for HIPAA violations. Whereas a staff person currently only has access to the information in the charts in their clinic, in the electronic environment there will be a greater opportunity to access information from other clinics. While there will be a variety of technical safeguards in place, it is essential that each staff person understands that it is a violation of internal policies and procedures as well as a violation of state and federal privacy regulations to access PHI for any reason other than work-related assignments.

The following Privacy Policies and Procedures exist at multiple levels in the Health Care Agency:

- 02.05.01 Notice of Privacy Practices
- 04.05.03 Use of Disclosure of Protected Health Information
- 05.01.07 Missing/Lost Charts
- 05.01.08 Transport of Clinical Records
- 05.05.02 Tracking Disclosures of PHI
- 05.05.03 Accounting for Disclosures of PHI

There are many practices that have been put into place to help manage the privacy of client records. Some of those that are related to mental health services are listed in this document and include processes that staff must be aware of for daily use. Some programs, such as Drug Medi-Cal Services, have varied requirements.

It is important that all staff understand that when a potential problem arises in the area of privacy or security of records, there is usually some action required at a level beyond just the actions taken in the clinic. There are now extensive reporting requirements from us to the federal and state government around these issues. We cannot meet those requirements if the persons responsible for the reporting do not know about an incident. Therefore, there is an expectation that potential breaches of privacy or violations of policies and procedures will be reported through the chain of command. This then allows the Office of Compliance Breach Response Protocol to be initiated, so that a comprehensive review of the situation and the related regulations can be conducted, and any necessary corrective actions taken.

Privacy and EHR

On-line documentation in the EHR presents many opportunities to improve care to our clients. This might be by better coordination of services, easier tracking of clinical changes over time, or just better treatment team communication. However, it also gives us a much larger opportunity to violate rules and procedures, for example the issue of “snooping” into records that one does not have a business reason to be in. Whereas simple physical distance will limit access in a paper chart world, that is not the case in an electronic chart world. In an EHR environment, each staff person has access to more records, including records from other clinics.

Protecting Records on EHR

Problems occur when people go into records (whether on line or in paper form) for a non-business reason. The practice of not accessing any records unless you have a business reason to do so will help minimize
many problems. There are all kinds of human motivations to look at records even if you don’t have a business need to do so. Curiosity is a natural human occurrence, but is also a huge risk. Curiosity about a relative you know is in treatment could lead to a temptation to snoop. Or you see a neighbor or acquaintance is getting services and you are just wondering why. Suppose another clinician on a team treating a client tells you that the MD treating that client made a negative comment about you in the chart. Do you go and look? No. You have no valid business reason to be looking, because your business role does not include investigating other people’s documentation for appropriateness. Your appropriate response would be to express your concern to your Service Chief, who could then review the chart from the business perspective of insuring quality of documentation. That is the Service Chief’s role, but it is not your role.

Revoking of Authorization to Use or Disclose Protected Health Information

Revocation of Authorization to Use or Disclose Protected Health Information is a form that is now required under HIPAA. Be aware that a client has a right to revoke a release of information for all or part of their patient record per Administrative P&P IV-7.04.

If the client decides that they want to again release their records, a new Authorization to Use or Disclose (ATD) form must be completed.

Health Records of Minors

The Privacy Rule generally allows a parent to have access to the medical records about his or her minor child, as long as it is not inconsistent with State or other law. California has laws allowing minors to receive certain medical treatment without a parent’s consent, and in these cases, a parent would not have the right to access to those records.

For minors who are treated as "adults" under the law for purposes of medical consent (emancipated and self-sufficient minors) and minors seeking sensitive services for which they are qualified to provide their own consent under the law, the minor must authorize the release of information even to their own parents or guardians.
FRAUD AND ABUSE

Medicare Abuse

Medicare abuse is defined as “Abuse that may, directly or indirectly, result in unnecessary costs to the Medicare or Medicaid program, improper payment for services which fail to meet professionally recognized standards of care, or that are medically unnecessary.”

Common Types of Medicare Abuse include:

1. Billing for services/items in excess of those needed by the client
2. Routinely filing duplicate claims, even if it does not result in duplicate payment
3. Inappropriate or incorrect information filed on cost reports

Inappropriate billing or reporting may be considered fraud rather than abuse, depending on the circumstances.

Medicare Fraud

Medicare fraud is defined as, “Knowingly and willfully executing, or attempting to execute a scheme or artifice to defraud any health care benefit program or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.”

Common Types of Medicare Fraud include:

1. Billing for services that were not rendered
2. Representing non-covered or screening services as medically necessary by reporting covered procedure/revenue codes
3. Signing blank records or certification forms or falsifying information on records or certification forms for the sole purpose of obtaining payment
4. Consistently using procedure/revenue codes that describe more extensive services than those actually performed
5. Soliciting, offering, or receiving kickbacks

Submission of Accurate Bills for Services Rendered to Medicare and/or Medicaid Clients

It is required of all staff that every effort must be made to ensure that bills are submitted accurately and reflect the services provided. If a staff member notices an error in a document related to billing that could result in an inaccurate bill going out, it is the personal responsibility of that staff member to take steps to correct the error, such as calling the error to the attention of the responsible person or a supervisor.

BHS' Billing Process and the Provider's Role in Documentation of Services
While all staff who have anything to do with documentation and billing of services are considered crucial to the process, it is the individual provider who knows exactly what went on when a service was provided. The provider’s documentation of the service will drive the billing of that service. BHS has multiple levels of checks and reviews of billing; however, no set of safeguards, reviews, or double checks can result in an accurate bill being submitted if the documentation does not accurately represent the service provided. The provider is personally responsible to accurately and thoroughly document the service provided.

Policies, Procedures, and Other Requirements Applicable to the Documentation of Medical Records

Behavioral Health Services (BHS) has numerous Policies and Procedures that pertain to daily operations and documentation. P&Ps applicable to the documentation of medical records are located on the County Intranet and/or in the P&P manual at your clinic.

Behavioral Health Services (BHS)  
http://intranet/policies

Adult and Older Adult Behavioral Health Service (AOABHS)  
http://intranet/policies

Children, Youth & Prevention Services (CYPBHS)  
http://intranet/policies

Personal Obligation of Each Individual Involved in Documentation and Billing to Ensure that Such Documentation and Billings are Accurate

Every person involved in the documentation and billing of services is personally responsible for ensuring that such documentation and billings are accurate. Providers are liable for Medicare and/or Medi-Cal abuse for all claims submitted that violate the Medicare program guidelines. Providers are liable for Medicare and/or Medi-Cal fraud when their intent to purposely obtain money or property owned by the federal government (Medicare or Medicaid) through false or fraudulent pretenses has been clearly determined. While less likely to occur in Behavioral Health Services, providers may also be held responsible for fraudulent or abusive claims submitted in those instances where they are noted as the “Referring Physician” for the service performed (e.g., as claims submitted by clinical laboratories).

Applicable Reimbursement Rules and Statutes, Including Regulations Related to Medical Necessity

Title XVIII of the Social Security Act, Section 1862(a) (1) (A) states that no Medicare payment shall be made for items or services which “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”

Title XVIII of the Social Security Act, Section 1833 (e) prohibits Medicare payment for any claim which lacks the necessary documentation to process the claim.

California Code of Regulations, Title 9, Chapter 11, Sections 1820.205, 1830.205, and 1820.210 also set out requirements for medical necessity to be met in order to be reimbursed for mental health services under Medi-Cal. The sections detail the definition of medical necessity in various categories.
Legal Sanctions for Improper Documentation and Billings

Suspected cases of fraud and abuse are identified and investigated through a coordinated network of federal and state agencies and local Medicare contractors. The Office of the Inspector General (OIG) is primarily responsible for Medicare fraud investigations and provides support to the U.S. Attorney’s Office for cases which lead to prosecution. In addition, the OIG coordinates their efforts and the efforts of other entities such as the Federal Bureau of Investigation, the Internal Revenue Service, Medicaid, other state agencies, and Medicare contractors.

Fraud can result in criminal prosecution for individuals and/or entities. Those found guilty may be subject to substantial penalties, fines, and restitution as well as imprisonment. The U.S. Attorney’s Office may decide that the interests of the Medicare program are best served through the civil courts. Individuals and/or entities face substantial penalties for each violation of the program rules, including repayment of up to three times the amount of damages to the Medicare program and large fines. Individuals and/or entities may be excluded from participating in any federal health care program. Individual practitioners may have their licenses revoked by the state.

In addition to the above definition of “fraud,” it is noted that there are civil penalties for actions that are much broader than the above noted definition of “fraud.” The Civil False Claims Act can impose significant penalties if a provider is found to “have knowledge” of inappropriate billing. Under this act a person can be said to have knowledge if they act with actual knowledge, deliberate ignorance, or reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required. Penalties may include fines of up to $21,562.80 per false claim, loss of license, and restriction from participation in any federally funded healthcare program. This includes Medi-Cal which is partially funded by federal money.

Examples of Proper and Improper Client File Documentation

As you go through this manual you will find examples of clinical documentation. You will be provided with information on documentation requirements. Your documentation must accurately describe the service provided. You will find information on coding of services that describes proper and improper ways to select a code. Additional examples are provided during live training sessions.

What to Do If You Have Concerns

Employees have a personal obligation to report in good faith known or suspected violations of any statute, regulation or guideline applicable to the federal healthcare programs, any law or regulation, or policies and procedures to their supervisor, manager or other management staff within their chain of command. If an employee is uncomfortable reporting a suspected violation to the above referenced resources or if they believe that the issue has not been handled appropriately, he or she is encouraged to call HCA’s toll-free Compliance Telephone Hotline.

The Compliance Hotline (866) 260-5636 provides a confidential means to report compliance related concerns. Another reporting option is through the OC HCA intranet (http://intranet/compliance/issuereport) which will allow for an issue to be submitted online. Both of these options are handled by a third party to ensure confidentiality. Employees are not required to identify themselves when reporting a concern.
MEDICAL NECESSITY

In order to qualify for services, individuals must meet Medical Necessity. Occasionally, an administrative decision may be made to provide services even when medical necessity is not met. For example, transition to another location. In these cases, services will not be billed to Medi-Cal or Medicare. Additionally, some programs are designed to provide services to persons who do not meet medical necessity. Other funding sources are used for these persons and again, services rendered in these cases are not billed to Medi-Cal or Medicare. For example, MHSA funded programs such as Innovations.

The State's Medical Necessity criteria is clearly documented in Title IX, Article 2, Section 1830.205.

Title IX outlines specific criteria to identify those consumers who would be responsive to Specialty Mental Health Services (SMHS).

Medical Necessity is demonstrated by the following three elements:

1. An included diagnosis.
2. A significant impairment in an important area of life functioning.
3. An intervention that will significantly diminish the impairment or prevent a deterioration in an important area of life functioning.

All three elements listed above need to be present in order to establish medical necessity.

Each beneficiary (client/consumer) must meet the criteria outlined above in order for the services provided to be reimbursed by a third-party payer.

Medical Necessity is NOT:

1. The clinician writing in the chart, “Client meets medical necessity.”
2. A “one shot” statement or event. In fact, the establishment of medical necessity is continuous and should be demonstrated throughout the chart.
INCLUDED AND EXCLUDED DIAGNOSES

As providers of Specialty Mental Health Services, we treat persons diagnosed with chronic, severe and persistent mental illnesses. In general, we treat the mental illnesses listed within the DSM-5. However, there are five general categories that we do not treat as part of a specialty mental health program, when these diagnoses are the only reason for the client being seen.

**Five General Categories of Excluded Diagnoses:**

1. Substance Abuse and Dependence Disorders  
   (e.g., Amphetamine Dependence, Inhalant-Induced Psychotic Disorder with Hallucinations)
2. Developmental Disabilities and Delays  
   (e.g., Autistic Disorder, Mild Mental Retardation)
3. Problems due to a General Medical Condition  
   (e.g., Psychotic Disorder due to Head Trauma, Dementia Due to …)
4. Antisocial Personality Disorder
5. V-Codes  
   (e.g., Uncomplicated Bereavement, Parent-Child Relational Problem)

For a complete list of included/excluded diagnoses, please refer to the Included/Excluded Diagnosis List.

**What If My Client Has a Co-Occurring Disorder?**

Your client may have a co-occurring disorder. For example, along with a mental health condition, your client may also be experiencing alcohol dependence. In these cases, you can work on the substance abuse problem, but in order to be billable to third-party payers, the substance abuse issue should never be the only focus of the session.

**Provisional vs. Rule-Out Diagnoses**

It is acceptable to have a provisional diagnosis, but never a “Rule Out” diagnosis, as your only diagnosis. The sole exception to this rule is during the 60-day assessment period.

A Provisional Diagnosis means “I think this is the right diagnosis, but I need a bit more information to be certain.”

A Rule-Out Diagnosis means “I don’t think this is the diagnosis, but I need a bit more information to be certain.”

**Diagnoses that are Unspecified**

Generally, clinicians use an unspecified diagnosis when there is not enough information to make a more exact diagnosis. For example, there is sufficient evidence to indicate the presence of an Anxiety Disorder, but it remains unclear that criteria are met for one or more specific diagnoses (e.g., Separation Anxiety Disorder, Panic Disorder) within the anxiety classification. In this case, it would be appropriate to use 300.00 Unspecified Anxiety Disorder.
When you are able to determine a more specific diagnosis, the unspecified diagnosis should be updated.

In some instances, an atypical clinical presentation of the disorder may not adequately match any of the specific diagnostic codes found in the DSM-5. In this case, the continued use of the unspecified diagnosis would be most appropriate.
SCOPE OF PRACTICE

Staffing Qualifications for Service Delivery

In order to provide and bill for services, staff is expected to follow the standards and scope of practice defined by the California Code of Regulations, Title 9, and the Mental Health Plan (MHP). Scope of practice refers to the range of activities and services licensed professionals may do in their licensed practice. It is expected that within their scope of practice, professionals will provide those services for which they have been adequately trained.

Some services are provided under the direction of another licensed professional. This means that services can be provided under the direction of a physician, a licensed psychologist, a licensed waivered psychologist, a registered clinical social worker, a licensed clinical social worker, a registered marriage and family therapist, a licensed marriage and family therapist, a registered nurse or a nurse practitioner.

The Medi-Cal waiver or registration refers to the period of time an unlicensed clinician is able to bill Medi-Cal for services. For registered clinical social workers and registered marriage and family therapists, the SIX-YEAR RULE applies. This means that the California Board of Behavioral Sciences (BBS) will not accept hours of experience toward licensure older than six years from the time the clinician applied for licensure.

All eligible psychology interns or doctoral level psychologists must obtain a Medi-Cal waiver. This waiver is for five years, and it is not renewable. In order to be eligible for this waiver, the psychologist candidate must have successfully completed 48 semester or 72 quarter units of graduate coursework, not including thesis, internship or dissertation. All services provided without a Medi-Cal waiver shall be recouped.

Behavioral Health Professional Licenses and Classifications

The categories below describe the most common licenses or professional classifications in Behavioral Health services. These should be helpful in clarifying the scope of practice of particular professionals.

AA, Bachelor’s, and/or Accrued Experience:

1. Mental Health Rehabilitation Specialist (MHRS). A MHRS must meet one of the following requirements:
   - Has a bachelor’s degree and four years of experience in a mental health setting as a specialist in the fields or physical restoration, social adjustment, or vocational adjustment.
   - Up to two years of graduate education may be substituted for the experience requirement on a year-for-year basis.
• Up to two years of post associate arts clinical experience may be substituted for the required educational experience in addition to the requirement of four years’ experience in a mental health setting.
• Can claim for mental health services (except psychotherapy), unplanned services and targeted case management within their training and scope of practice.

Graduate School:

1. Practicum level psychology interns:
   • Currently enrolled in a Masters or Doctoral degree program.
   • Not collecting hours toward licensure.
   • Can bill for those service functions within their training and scope of practice.
   • Can bill for services only during the duration of his/her internship.
   • Supervisor’s co-signature is required.

2. Internship level psychology interns:
   • Currently enrolled in a Masters or Doctoral degree program.
   • Collecting hours toward licensure.
   • Can bill for those service functions within their training and scope of practice.
   • Can bill for services only during the duration of his/her internship.
   • Psychology interns who have earned 48 semester units or 72 quarter units must apply for a DMH waiver.
   • Regardless of the DMH waiver status, supervisor’s co-signature may be required.

3. Marriage and Family Therapy Trainees:
   • Currently enrolled in an accredited Master’s degree in Psychology program.
   • May or may not be collecting hours toward licensure.
   • Can bill for those service functions within their training and scope of practice.
   • Can bill for services only during the duration of his/her internship.
   • Supervisor’s co-signature is required.

4. Social Work Student Interns:
   • Enrolled in an accredited Masters in Social Work program.
   • Not collecting hours toward licensure.
   • Can bill for those service functions within their training and scope of practice.
   • Can bill for services only during the duration of his/her internship.
   • Supervisor’s co-signature is required.

5. Professional Clinical Counselor Trainee:
   • Enrolled in an accredited Masters in Counseling program.
   • Not collecting hours toward licensure.
   • Can bill for those service functions within their training and scope of practice.
   • Can bill for services only during the duration of his/her internship.
   • Supervisor’s co-signature is required.
Post Graduate School (Masters or Doctoral):

1. **Registered Psychologist:**
   - Has completed a doctoral degree in Psychology.
   - Has completed at least 1,500 hours of qualifying supervised professional experience.
   - Psychologist works for a non-profit community agency that receives a **minimum of 25% of its funding** from some governmental sources.
   - This is a two and a half year, non-renewable credential.
   - Must obtain a DMH waiver.
   - Can bill for those service functions within training and scope of practice.
   - Registration with the Board of Psychology must be in place before employments starts.
   - Supervisor’s co-signatures may be required.

2. **Marriage and Family Therapy Interns:**
   - Have completed a Masters degree in Psychology.
   - Collecting hours toward licensure.
   - Must have a valid registration with the Board of Behavioral Sciences before employment starts.
   - Can bill for those service functions within their training and scope of practice.
   - Supervisor’s co-signature may be required.

3. **Associate Clinical Social Workers:**
   - Have completed a Masters degree in Social Work.
   - Collecting hours toward licensure.
   - Must have a valid registration with the Board of Behavioral Sciences before employment starts.
   - Can bill for those service functions within their training and scope of practice.
   - Supervisor’s co-signature may be required.

4. **Professional Clinical Counselor Intern:**
   - Have completed a Masters degree in Counseling
   - Collecting hours toward licensure.
   - Must have a valid registration with the Board of Behavioral Sciences before employment starts.
   - Can bill for those service functions within their training and scope of practice.
   - Supervisor’s co-signature may be required.

Licensed:

1. **Licensed Psychologist:**
   - Possesses a valid psychologist license issued by the California Board of Psychology.
2. **Licensed Clinical Social Worker (LCSW):**
   - Possesses a valid LCSW license issued by the California Board of Behavioral Sciences.

3. **Licensed Marriage and Family Therapist (MFT):**
   - Possesses a valid MFT license issued by the California Board of Behavioral Sciences.

4. **Licensed Professional Clinical Counselor (LPCC):**
   - Possesses a valid LPCC license issued by the California Board of Behavioral Sciences.

5. **Nurse Practitioner (NP):**
   - Possesses a valid RN license issued by the California Board of Registered Nursing.
   - A registered nurse who possesses additional preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, and who has been prepared in a program conforming to board standards.

6. **Physician (MD, DO):**
   - Possesses a valid MD/DO license issued by the Medical Board of California.

### Billable Services According to Job Classification

<table>
<thead>
<tr>
<th>MD, DO, NP</th>
<th>Licensed, Registered Psychologists and Psychology Interns¹</th>
<th>LCSW, ASW, MFT and MFT Interns</th>
<th>Social Work Student Interns, and MFT Trainees</th>
<th>Rehabilitation Specialists</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessment</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Medication</strong></td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>Psych Testing</strong></td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>Psychology</strong></td>
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<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Crisis Intervention</strong></td>
<td>Yes</td>
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<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Crisis Psychotherapy</strong></td>
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<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Rehabilitation Services</strong></td>
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<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Intensive Home-Based Services</strong></td>
<td>Yes</td>
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<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Case Management</strong></td>
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<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Intensive Care Coordination</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

¹ Supervisor’s co-signature is required for CYBH programs. If co-signature is not obtained, this would not be a reason for recoupment, but it would be out of compliance.

This table provides an outline, but does not authorize any clinician to work outside his or her scope of practice.

As determined by the MHP, some staffing classifications require a co-signature where the clinical supervisor provides clinical supervision using the co-signature as a supervision tool per written agreement between the provider and an accredited school. A co-signature does not enable anyone to provide services beyond their training and scope of practice.
THE FLOW

Evaluation

During the initial session with a client, the provider performs a face-to-face assessment to determine whether medical necessity is met in order to continue with specialty mental health services. The assessment to determine medical necessity could take several sessions not to exceed the 60-day rule.

If the client does not meet the criteria for medical necessity, then the provider must document the reason and complete the necessary paperwork to close the case. This is called an open/close case. The provider is also responsible for explaining the denial of service and providing the Medi-Cal beneficiary with a Notice of Action-A (NOA-A). The NOA-A can only be provided during the assessment period and never during the treatment phase.

If no medical necessity is found and future services are provided anyway, those services must be coded non-billable and not be billed to any third-party payer.

Course of Treatment

If medical necessity is found, the client shall be admitted following an established protocol. Documentation requirements are listed in other parts of this document at which point the client is considered a “long-term client.”

BHS’ Definition of a Long-Term Client

A “long-term client” is defined as a person who receives services for more than 60 days. It is an expectation that if services will be provided for longer than 60 days, a Care Plan will be completed that meets all requirements.

Throughout the Journey

Throughout the chart, all of the information documented should be consistent. All documents within the chart should tie together to give a clear, clinical picture of the client and demonstrate strong clinical interventions with the client. The Initial Assessment should relate to the Care Plan, and both should relate to all the progress notes that follow. There is a relationship between the medical necessity established in the Initial Assessment, the Care Plan, and the planned services provided.

Discharge

This is the process by which a provider makes a determination that the client is ready to move out of the current Level of Care (LOC).

At the time of intake, the clinician should already be thinking about discharge. More specifically, the clinician needs to work with the client to determine how it is that they will know that the client is ready to move on out of the clinic. Discharge criteria should be established from the outset so that the client knows what is expected for his/her course of treatment. This should be documented in the discharge section of the Care Plan. Never leave this section blank.
As a reminder, Discharge Summaries completed purely for administrative purposes are not billable. However, a Discharge Summary may be billed if it is completed as a part of the termination session with the client and it is clinically relevant.

**Discharge Planning vs. Placement Services from a Psychiatric Hospital**

**DISCHARGE PLANNING**
- Client is ready for discharge from the hospital
- Consultation and assessment involves contacting and coordinating with the hospital
- Purpose of placement services is to identify appropriate placement and to arrange for placement services

Discharge planning for a client on an inpatient psychiatric unit is **not** billable.

However, it is permissible to bill for **placement services** while a client is on an inpatient psychiatric unit during the 30 days prior to the discharge. This is different from discharge planning, which again, is a non-billable service.

**PLACEMENT SERVICES**
To document placement services, the progress note must meet the following requirements.
1. The client is about to be released from the hospital.
2. The assessment is for the **sole purpose of identifying and arranging for appropriate placement** following discharge. We cannot bill for case management or planning if the client is not ready to be discharged. Any other type of discharge service, including follow-up care while the client is psychiatrically hospitalized, is not billable.

If the note includes any activities that are not clearly placement services, then the time for those other activities must not be billed. The note should make it clear that the time for any non-billable activities was not billed. Notes should be labeled “**placement services**” if this is the service provided.
EPISODE OF CARE

The former concept of the Episode of Care (EOC) has taken a shift in recent times. In the past, Children, Youth & Prevention Behavioral Health Services (CYPBHS) and Adult and Older Adult Behavioral Health (AOABHS) have operated slightly differently according to their program needs. The implementation of our Orange County Electronic Health Record (OC EHR) has required that a unified approach be taken and adapted by all county-operated programs. The outcome of this change resulted in two EOCs: MHP County Treatment EOC and a Facility EOC.

MHP County Tx EOC

The MHP County Treatment EOC is an overarching EOC and begins when a client starts services with any of our BHS outpatient clinics, including the Crisis Assessment Team (CAT). This MHP County Treatment EOC will follow the client throughout their journey in our programs. This treatment episode should be closed when the client leaves services and is no longer open at any of our BHS outpatient facilities or CAT.

In the first 60 days of a MHP County Treatment EOC, all the initial assessment paperwork including a full Initial Assessment and valid Care Plan should be completed.

*The concept of cycle dates relating to the EOC have gone away.* Care Plan due dates are no longer tied to the EOC date as Care Plans are good for 365 days as of the day the plan became valid.

Facility EOC

A facility EOC is the date on which the client began services with your program. This may or may not be the same date as the MHP County Tx EOC. The purpose of this EOC is best noted when there are two county clinics providing services to the client at the same time. This EOC should be closed when the client leaves your program. If the client is open at another county-operated program at the time of discharge from your program, the MHP County Tx EOC should remain open.
INTERIM CARE PLAN (ICP)

In the event that the client’s need for planned services is urgent enough that the beginning of services should not wait until a full Initial Assessment and Care Plan are completed, services may begin as soon as the Interim Care Plan (ICP) is complete. It is to be used when there is a strong clinical need to provide services quickly, before the full 60 days until Initial Assessment and Care Plan are completed, but after you have enough information to, at least provisionally, document that medical necessity is met. The urgency for services must be clearly documented in the narrative section of the ICP. It should be noted that the ICP is not a routine document.

The ICP has historically only been allowed for use by the first clinic starting the timeline. This will continue to be the practice whenever there is more than one clinic involved and one of those clinics is an OC EHR clinic. The only exception to this will be when two paper clinics have opened the case during the same treatment episode, and both are completing their own set of intake documents, beginning with Initial Assessment. In this situation, each clinic may use the ICP within the assessment period (the first 60 days) if services other than assessment and crisis intervention are needed.

A determination that medical necessity criteria appear to be met with the following:

- At least sufficient diagnostic certainty for a provisional included diagnosis to be made.
- Impairment in functioning caused by the included diagnosis.
- The level of impairment is such that services should not wait until the full Initial Assessment and Care Plan are completed.
INITIAL ASSESSMENT

The purpose of an assessment is to evaluate whether the client meets the criteria for medical necessity for specialty mental health services. It is the responsibility of the provider during the intake to assess whether the client is a new client, a returning client or an existing client which can guide the provider to establish the appropriate timelines when developing the Care Plan. The Care Plan shall be developed with the client.

Intake Assessment Paperwork

This refers to the Initial Assessment including the Care Plan. While the paper forms are not exactly the same as the e-forms, the content is essentially the same. The Initial Assessment includes a Psychosocial History, Community Functioning Assessment (CFE), and Mental Status Exam (MSE). The Initial Assessment and Care Plan should be completed within 60 days of opening the case. In the event that the intake documents cannot be completed within 60 days, the reason(s) should be documented in the progress notes and services other than assessment and crisis cannot be billed.

A Brand New Admit:

A provider has 60 days to complete an Initial Assessment (and Care Plan) for any new client to our system. Upon entry, the client begins a new Episode of Care. Once the Care Plan becomes valid, it is good for 365 days or until a new CP becomes valid, whichever comes first.

Re-Admission after Discharge:

If a client is discharged and returns to our system of care a brand new Initial Assessment and Care Plan will be completed within 60 days following the re-admit. The client will start a new Episode of Care. Irrespective of whether a client is admitted the very next day from discharge or a few months after discharge, the documentation requirements for admission remain the same. Once the Care Plan becomes valid, it is good for 365 days or until a new CP becomes valid, whichever comes first.
CARE PLANS

Care Plan (CP)

Care Plan is the term for what was formally known as the Client Service Plan or the Master Treatment Plan. Care Plans are to be developed within 60 days of admission and updated every 365 days of the date the Care Plan became valid.

In the event that a client is seen in the intake process but becomes unavailable to complete the assessment process within the first 60 days from admission, it should be indicated in a progress note. In addition, efforts made to contact the client should be documented. In this instance, completion of the Initial Assessment and Care Plan will be done within 60 days, with all required assessment documentation completed in the required order, and prior to planned services being billed.

The provider should involve the client when updating the Care Plan. In addition, it is expected that all necessary signatures are obtained. If a client is unable or unwilling to sign a Care Plan due to the mental illness, a corresponding progress note must document the circumstances of this situation at the time of the update. The provider should revisit this with the client at subsequent visits and at least at every update of the Care Plan. If the client continues to refuse to sign, then a corresponding progress note should document the attempts and outcome. The best practice is to document efforts to obtain a signature in an assessment note. The former guidance requiring the provider to ask the client to sign the plan at every face-to-face visit no longer applies.

Care Plan Expectations

A Care Plan is developed based on the impairments obtained during the Community Functioning Evaluation. These may include, but are not limited to the following: living situations, housing, daily activities, social networks, occupation, finances, mental illness management, and physical health care. The Care Plan is developed in collaboration with the client and should be completed within the documented time frames. Treatment objectives can be based on symptoms, behaviors and/or impairments identified during the assessment.

Interventions to be provided by the treatment team will address the covered diagnosis as identified in CCR, Title 9, Chapter 11, Section 1830.205(b)(2), also known as the list of Medi-Cal included diagnoses.

Interventions should: 1) significantly diminish the impairment and/or 2) prevent significant deterioration in an important area of life functioning as delineated in the CCR, Title 9, Chapter 11, Section 1830.205(b)(3), and as indicated on the Community Functioning Evaluation Form.

Care Plans must be individualized and all clients will be notified that they may have a copy of the plan if they so request.

OC EHR clinics will require that additional assessments be completed in conjunction with each Care Plan and include a Mental Status Exam (MSE), Community Functioning Evaluation (CFE), and Diagnosis form. At intake, a Psychosocial Evaluation is also required. At each yearly update, the Periodic Re-Evaluation is required.

There are various versions of the paper documents still in use throughout the agency, but all contain the required assessments indicated above. In AOABHS, Care Plans are due at 12 months. CYPBHS Care Plan
expectations have not changed, and plans are still due annually. For CYPBHS, a 6-month review continues to be an expectation for all clients in the mental health plan to demonstrate good quality of care. The 6-month review is an internal procedure of CYPBHS and not a DHCS requirement. If a 6-month review is not completed, nor done on time, the claims are not subject to recoupment, nor does this require claims to be coded as non-compliant.

The purpose of the 6-month review in CYPBHS is to assess for the client’s progress toward the treatment goals or barriers and make any modifications to the Care Plan if necessary. The 6-month update is to be completed 6 months from the date the Care Plan becomes valid.

For programs still utilizing a paper record, the following procedures are required:

- Complete a progress note summarizing the client’s progress or barriers in treatment. Label the note as a 6-month review and code it as a billable assessment service.
- Update the Care Plan (CP) and sign it. List the date of the progress note referencing the 6-month review at the top of the CP.
- On the Care Plan check the 6 month update box, write a brief update (of objectives met, not met or in progress) on each of the objectives and list the date of the 6-month review progress note on the adjacent line.

For programs now using the Electronic Health Record, the following procedure is required:

- Complete a progress note summarizing the client’s 6-month progress in treatment and code it as a billable assessment service.
- If applicable, the Care Plan should be updated if needed and this update can only be done by the Plan Coordinator.
- If applicable, the diagnosis and problem may be updated using the BH Diagnosis Form in the PowerForms widget.

If you have any questions about what is required, please consult with your Service Chief.

Use of Reference Paperwork

A problem arises when a clinic/program uses another clinic’s Initial Assessment, but creates its own Care Plan with its own timeline. That assessment may already be quite old. Creating a new Care Plan can appear as if the requirement that a plan be based on a thorough assessment is not met. To accommodate this, it is acceptable to get a copy of the previous program’s full Initial Assessment and then create a new assessment document referencing that original assessment. The new assessment should clearly update all changed information and confirm which parts of the previous information are still accurate. A copy of the old assessment must be in the chart if it is referenced on the new assessment document. If a program chooses to reference the previous assessment (and places a copy in the chart), the program could simply write in the appropriate sections something like, “See section 2b from assessment dated….” instead or re-writing the same information and as long as the information is current and accurate.

When any clinic is creating the first Care Plan in the OC EHR for a client, the full Initial Assessment must again be done in the OC EHR. This means completing a full OC EHR Psychosocial Assessment, even if an Initial Assessment was recently done on paper. This is because the OC EHR environment uses that information entered into the OC EHR form for a number of purposes that cannot be met simply by scanning in a paper document. This does not stop the Plan Coordinator from obtaining the paper Initial Assessment.
and using it to fill in much of the e-forms. When this is done, the paper forms should be referenced on the e-form and the paper form scanned into the OC EHR.

Coordination of Care

Throughout this process, it will be very important to know if the client is opened at any other clinic. At the time of intake, the opening Children’s clinic will need to run a BHS EOC Information Report, previously known as a Coordination of Care Report. Adult clinics will continue to run a Client History by Medical Record Number (MRN).

In addition to the time of intake, clinics that are on the OC EHR and creating their Care Plan for the first time will need to run the BHS EOC Information Report. The OC EHR clinic will need to know who all are involved with providing services to the same client. In the event that more than one clinic is providing care, it is extremely important for the OC EHR clinic to coordinate the care.

Revising Care Plans

Care Plans that require changes may be revised rather than completely re-done. It is expected that if a Care Plan is modified with significant changes (such as a new objective or adding a treatment intervention), the discussion of that modification with the client/responsible party, the collaboration with the client, and agreement of new objectives should be documented in a progress note. All revised Care Plans maintain the same end date as when the original Care Plan became valid.

LPHA Signature on the Care Plan

It is an expectation that the Care Plan will be signed by a Licensed Practitioner of the Healing Arts (LPHA) as soon as the plan is developed and signed by the client and clinician. If the client has a paper chart and the LPHA’s signature is obtained afterwards, all services provided prior to the LPHA’s signature will be billable once signed by the LPHA, provided that all other criteria are met. However, if the client’s chart is in the County EHR, the Care Plan cannot become valid until all required signatures are obtained. It is not possible to make services billable that were provided prior to the date of the signatures unless they are crisis or assessment services. For this reason, it is very important that the Plan Coordinator obtain the LPHA’s signature on the Care Plan before providing any services beyond assessment or crisis.

Language Appropriateness of the Care Plans

Care Plans must be in the client’s primary language or have a clear statement as to the fact that it was translated to the client, with the date on which it was translated, and the name of the person who did the translation for the client.

Introduction and Overarching Concepts

We are currently utilizing our Orange County Electronic Health Record (OC EHR) throughout the majority of Behavioral Health Services in order to capture clinical documentation at Orange County operated mental health clinics. Historically, different divisions of Behavioral Health Services (BHS) have had differing methods for managing some documentation requirements. One of the areas of difference revolves around what has historically been referred to as the Episode of Care (EOC) cycle dates. These are used to determine when documentation, such as Assessments and Care Plans (treatment plans/service plans) are due. Many of the requirements were hold-overs from state requirements at the time that services were provided under
the Rehab Option manual. When the regulations transitioned to what is referred to as “Consolidation, Phase II” (in the late 1990s), BHS chose to retain the requirements as an implementation methodology to which staff were accustomed.

Utilizing the OC EHR environment requires a greater degree of consistency in expectations and requirements between programs. In addition, some of what was retained in the transition during the consolidation simply doesn’t function well in an electronic environment. The change to the OC EHR presents an opportunity to improve how we coordinate care and ensure that documentation requirements for billing are met.

This document is to provide information on some of the changes that have accompanied the phasing in of the OC EHR at the county operated mental health clinics.

Because of the need to coordinate care across the system which includes contract operated clinics, those contract operated clinics will also be impacted.

- Contract opened cases providing services prior to June 2, 2014 will continue to follow the existing documentation timelines.
- For any new Care Plan and annual Care Plan needed on or after June 2, 2014 – each contract will develop their own Care Plan and this Care Plan will be good for 365 days from when it becomes valid.
- Contract programs within a single legal entity (LE) may, by written policy of the LE either share a CP, or have each program/clinic create its own CP.

**Definition of “Valid”**

The relevant “timeline” now revolves around the Care Plan (CP), not the EOC. A Care Plan developed on or after June 2, 2014 will be **valid for 365 days** from when it first becomes valid. A Care Plan is considered **valid** when all the requirements are met, including the content and all required signatures. Each individual Plan Coordinator (PC) must determine what signatures are required. For example:

- An LPHA signature (An LPHA is a Licensed, Waivered, or Board Registered Psychologist, MSW, MFT, MD, or RN).
- Client signature (or reason client refused) is required.
- Signature of the responsible party (e.g., the parent or conservator) if client is determined unable to sign for themselves.
- For Medicare, an MD signature is required.

There are a number of rules in the OC EHR system which will assist in determining if the CP is valid or not. If the OC EHR system determines that the CP is not valid, it will not allow billable planned services to be entered. Once the system thinks it is valid (and this does require some decision making input by the PC) the plan will be valid for 365 days. **NOTE: The system cannot determine the quality or appropriateness of the content of a Care Plan. It can only assist us in having technical requirements such as signatures met.**

**Contract Clinics**

If a contract Legal Entity (LE) has multiple clinics/programs and wishes to utilize a single Care Plan to cover all programs, this is permissible. The LE and each program must have this clearly documented in
their P&Ps and the process must be implemented across all clients (i.e., it is not a client by client choice as to whether to use a single Care Plan or for each program to have its own Care Plan).

**Diagnosis in the OC EHR**

In County Electronic Health Record, there are two terms associated with diagnoses: Problem and Diagnosis Treated Today. A “problem” is the diagnosis associated with the client and should be identified as such via the diagnosis/problems widget or the BH Diagnosis PowerForm. The OC EHR does not allow for a “problem” to be prioritized or selected as primary. In cases where there are multiple “problems,” the OC EHR will alphabetize the problems (a.k.a. diagnoses).

A “diagnosis treated today” is the “problem” (a.k.a. diagnosis) that the provider wishes to associate with the service being documented and treated on that day. The “diagnosis treated today” does allow for prioritization, and it is expected that if the provider is treating an included diagnosis (or primary diagnosis) that this be placed as a #1 priority.

**Transitioning between OC EHR and PAPER clinics**

**VARIATIONS of PAPER and OC EHR CLINICS**

**The following scenarios only apply to County Operated Clinics.**

**KEY:**

- = Paper Clinic
- = OC EHR Clinic

**Scenario #1: PAPER CLINIC BECOMES AN OC EHR CLINIC**

- Prior to the Paper Clinic going live in the OC EHR, all existing clients will have a Conversion Care Plan (CCP) created by the OC EHR Conversion Team. The Initial Assessment will also have been scanned into the OC EHR by the Conversion Team.
- The CCP will expire either 6 months after that clinic goes live or on the natural expiration date of the paper plan, whichever comes first.
- Prior to the CCP’s expiration date, the Plan Coordinator (PC) will need to create a new, full Initial Assessment and Care Plan (CP) within the OC EHR. Once done, the new CP is good for 365 days from the date it becomes valid.

**Scenario #2: OC EHR CLINIC TRANSFERS TO PAPER CLINIC**

Transfers to paper clinic. Paper clinic uses OC EHR clinic’s existing plan.
• If a client is at an OC EHR clinic and transfers to a paper clinic, the paper clinic can use the existing Initial Assessment and CP from the OC EHR clinic.
• The OC EHR clinic will print out a copy of the Initial Assessment and CP for the paper clinic’s Chart.
• The OC EHR clinic needs to handwrite on the CP the expiration date of the CP.
• If the paper clinic uses the CP of the OC EHR clinic, the expiration of the CP remains the same as when the plan was originally established.

Alternatively, the Paper Clinic may choose to redo the Initial Assessment and CP all together.
• However, while the new Initial Assessment and CP are being completed, the paper clinic will have to use the CP of the OC EHR clinic already in existence.
• The Paper Clinic may not use an ICP during this period of time. Services not on the OC EHR Clinic’s CP may be added if needed during this period.
• Once the new Initial Assessment and CP are completed by the Paper Clinic, the new CP will be good for 365 days from the date that it becomes valid.

Scenario #3: AN OC EHR CLINIC LATER JOINED BY A PAPER CLINIC

• The conversion process as described in scenario #1 will have already occurred to move the first clinic to an OC EHR clinic.
• The OC EHR clinic will function as the PC.
When a Children’s paper clinic commences services, it must coordinate care by running a BHS EOC Information Report, formerly the Coordination of Care Report. Adult clinics will run a Client History by MRN. Upon realizing that the client is also open at an OC EHR clinic, the paper clinic must coordinate care and ask to be added onto the OC EHR Clinic’s CP.

- The PC will add the services of the paper clinic onto the CP of the OC EHR clinic.
- The OC EHR clinic will print and give the paper clinic a copy of the Initial Assessment and CP for the paper clinic’s charts.
- The CP is good for 365 days from the date it becomes valid. When services for the paper clinic are added to the CP of the OC EHR clinic, the original expiration date of the CP remains the same.
- Whenever there is a change to the CP, it is the responsibility of PC to coordinate care.
- The OC EHR Clinic’s PC must ensure that all services provided by paper clinic are contained within the CP.
- If the paper clinic fails to be added onto the OC EHR clinic’s CP and does not have a copy of the CP in its charts, it must mark all services as non-compliant (with the exception of assessment and crisis services).

**Scenario #4: TWO PAPER CLINICS**

- Paper Clinic #1 will have its own paperwork, including CP. If the CP was completed before June 2, 2014, it will expire in accordance with its existing timeframe. If the CP is completed on or after June 2, 2014, it will be good for 365 days.
- During the 1st 60 days of the case opening, Paper Clinic #1 may use an ICP if services other than assessment and crisis need to be rendered.
- Paper Clinic #2, if providing services at the same time as Clinic #1, will also have its own paperwork, including CP. If the CP was completed before June 2, 2014, it will expire in accordance with its existing timeframe. If the CP is completed on or after June 2, 2014, it will be good for 365 days.
- During the 1st 60 days of the case opening, Paper Clinic #2 may use an ICP if services other than assessment and crisis need to be rendered.
- Each paper clinic will maintain its own timelines for the completion of the paperwork.
- The paper clinic that goes live with the OC EHR first will become the Plan Coordinator.
- All steps to move the paper clinic to the OC EHR will have occurred prior to the OC EHR clinic going live. For example, the CCP and a scanned copy of the Initial Assessment will already be in the OC EHR.
- The CCP will expire either 6 months after that clinic goes live or on the natural expiration date of the paper plan, whichever comes first.
• Prior to writing the new CP, the PC at the OC EHR clinic must coordinate care by running a BHS EOC Information Report and ensure that all other clinics providing services are added to the CP. This must be a standard practice every time a Plan Coordinator is writing the first electronic Care Plan.
• The PC at the OC EHR clinic will create a new, full Initial Assessment and CP. The CP will incorporate the services of the paper clinic.
• Until the OC EHR clinic completes the CP in the OC EHR, the paper clinic will continue to bill off its own existing CP.
• Once the OC EHR clinic completes its CP in the OC EHR, both the OC EHR and paper clinic will work off the OC EHR CP. The paper CP will become invalid.
• Steps for Scenario #3, as detailed above, will then occur.

Scenario #5: OC EHR CLINIC JOINED BY ANOTHER OC EHR CLINIC

• The first OC EHR clinic will have a CP good for 365 days.
• If a second OC EHR clinic opens, it must run a BHS EOC Information Report (Coordination of Care Report) or Client History by MRN.
• The two OC EHR clinics will need to decide who will be the PC.
• If the PC switches to the other clinic, the role change will need to be reflected by the Service Chief (SC) in the OC EHR.
• The OC EHR clinic that is the PC will need to add the services of the 2nd Clinic onto the CP.

Conversion Care Plan (CCP)

This exists only in the OC EHR. It is a “place holder” plan that is filled in by the Conversion Team that is at the clinic for the month prior to “go live.” The Conversion Team looks at the paper Care Plan that is on the chart and from that enters into the Conversion Care Plan (CCP) the types of services that have been approved on that paper plan and the date that paper plan is set to expire (a.k.a. end date).

The end date on the CCP is the “natural end date” of that particular plan OR six (6) months from the start of the go-live date at that clinic location, whichever comes first. The “natural end date” will vary depending on what type of plan it is (regular Care Plan vs. Interim Care Plan), the program for which it was created and when it was created. Here are some examples:

FOR THIS GRID, PLEASE USE THE FOLLOWING EXAMPLE
Clinic Go-Live 11/17/14
6 months after Clinic Go-Live 5/17/15
<table>
<thead>
<tr>
<th>Type of plan</th>
<th>Date plan became valid</th>
<th>Natural End Date</th>
<th>CCP End Date</th>
<th>Reasoning</th>
</tr>
</thead>
<tbody>
<tr>
<td>ITP/ICP</td>
<td>3/1/14</td>
<td>4/29/14</td>
<td>4/30/14</td>
<td>• Since the ICP is valid for a short period (a full Assessment is due on day 60) the CCP end date will be the same as the natural end date, plus one day.</td>
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<tr>
<td></td>
<td>(EOC start 3/1/2014)</td>
<td>(59 days from start of EOC)</td>
<td>(60 days from start of EOC)</td>
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</tbody>
</table>
| Annual Care Plan (aka MTP) | 4/15/14 | AOABHS: 10/31/14 CHPBHS: 4/30/14 | AOABHS: 11/1/14 CYPBHS: 5/1/15 | • AOABHS plan would expire naturally on 10/31/14. This is before the 6 months of the go-live of the clinic (5/17/15). Therefore, the end date of the CCP is the same as the natural end date of the plan (but one day later so that the last day of the plan 10/31/14 can be billed).  
• CYPBHS plan would expire naturally on 4/30/15. This is before the 6 months after the go-live of the clinic (5/17/15). Therefore, the end date of the CCP is the same as the natural end date of the plan (but one day later so that the last day of the plan 4/30/15 can be billed). |
|             | May/November Cycle     |                  |              |          |
| Annual Care Plan (aka MTP) | 8/13/2014 | 8/12/15 | 5/17/2015 | • The CCP will end date before the natural expiration date of the plan because 6 months after the go-live of this clinic (5/17/15) is BEFORE the natural expiration date of this plan (8/12/15). |
|             |                        | Due to all the EOC cycles ceasing starting 6/2014, this plan is good for one year if interventions are authorized as such. |              |          |

The need for this Conversion Care Plan is that it allows the OC EHR to immediately begin to run the system rules which will only allow services approved on the plan to be entered as billable by the clinician. Given the nature of the conversion and the confusion around the determination of the end dates, we expect and understand that there may be end dates calculated in error. If errors are found, the clinic Service Chief can amend the conversion Care Plan and make the necessary corrections.
PROGRESS NOTES

Documenting a service is a requirement, not an option. The documentation within a progress note should be thorough enough to understand the nature of your service and meet the requirements outlined in this manual.

Progress Notes Need To:

1. **Be Individualized** – If notes are too generic and could fit any client, then it is probably not individualized enough. Rather than say, “We worked on coping skills today,” it is better to say, “We worked on counting to ten and taking deep breaths as a way of helping the client manage his anxiety.”

2. **Avoid “He said, She Said, I said, We said”** – Progress notes should not be a narrative and should not detail every exchange with the client. Progress notes reflect the client’s progress and are not meant to be process recordings of the interaction.

3. **Be relevant to the service provided that day.** Use progress note to document the service provided and not as an exercise in duplicating information already contained elsewhere in the chart. Moreover, a note should document the “service necessity” of the session. In other words, why did the service need to be provided that day?

4. **Demonstrate how interventions relate to the treatment of the diagnosis.** For example, if treating ADHD, services should be related to the treatment of ADHD. These interventions should be active, e.g., “taught client instances in which he is losing focus and ways to regain focus,” and not passive, e.g., “provided supportive listening.” Of course, at times more passive interventions can be used such as empathy and supportive listening. However, these techniques should not be all that are provided. Also, interventions should support time claimed.

5. **Relate back to the Care Plan** – Notes should detail how interventions are alleviating the impairments and working towards the goals/objectives agreed upon in the Care Plan.

6. **Progress notes should be legible** – This includes not only the content of the note, but also that of the provider’s signature, title and/or licensure.

   If a note in a paper chart is not legible, it may be re-written legibly. Once the re-written note is completed, it should be filed with the original note. On the re-written note, indicate “Note re-written on (date) for legibility. Sign the re-written note. Cross out the ED on the re-written note. Do not complete the ED on the re-written note as time may not be billed for re-writing the note and DSH may also not be claimed.

Progress Notes Should Answer “5 Questions”:

1. **Who did you see today?** – e.g., Client is a 26-year old single Chilean female diagnosed with Schizophrenia, Paranoid Type (295.30).

2. **Why did you see the client today?** – e.g., Client came in for a scheduled appointment to continue learning ways to manage her auditory hallucinations.
3. *What did you do?* – e.g., Clinician worked with the client on developing reality testing techniques, such as asking a trusted individual if she also heard what the voices had said. Clinician also helped the client minimize the voices by discussing ways to reduce the intrusiveness of the voices.

4. *What was the client’s response?* – e.g., Client reported that she could try reality testing with her mom as she trusts her mom. Client also noted that it helps her to listen to music and could wear headphones to reduce the intrusiveness of the voices.

5. *What is the plan for next time?* – e.g., The Clinician will meet with client again next week and will assess how the techniques discussed today have worked for the client.

**Format**

Ultimately, the format of your note does not matter as long as you answer the “5 questions” listed above. While your supervisor may ask you to write your notes in a particular format, it is not the format, but rather the content that matters. Make sure your notes clearly convey the clinical intervention that was performed and again, just answer the “5 questions.”

**Group Notes**

It is acceptable for group notes to contain a general statement about what the group was about. For example, “The purpose of today’s group was to process with clients feelings about having been recently diagnosed with Schizophrenia. Clinician helped clients accept the diagnosis and discussed common feelings such as anger, confusion, and denial.”

Although it is OK to have a general statement about what the group was about, each group note needs to be individualized to the client that is attending the group. For example, “John responded by stating that he is very confused by the diagnosis and does not believe that he has Schizophrenia.”

The total service time does not need to be divided when completing the billing portion of your document. The BHS billing system will split the total service time evenly between all clients who participated in the group, using the total number of clients information entered onto the ED. Simply enter the total time of the group into the “Service Time” box. For example, if your group was 90 minutes, enter “90” into the “Service Time” box of every note for every member of the group.

If there was billable travel time associated with the group, split up the travel time for every note manually. For example, if it took you 30 minutes to get to the board and care to provide a group to 5 clients, each note would have “6” minutes in the travel time box of the Encounter Document. The clinician should document the total number of participants even though they might not have the same health plan (i.e. 3 participants with Medi-Cal and 6 participants with Medicare, then the total number would be 9).

When a group is co-facilitated by another provider only one note needs to be written. The interventions of each therapist should be clearly documented and differentiated in the note. In order for the co-facilitator’s time to be billed, he/she must also be providing an intervention which is aimed at reducing the mental health impairment.

**Additional Reminders:**
• The time claimed and submitted for payment is to be accurate and consistent with the time documented on the progress note.
• Time cannot be claimed for services not provided.
• All billed services must have documentation supporting the provision of that service.
• Billable services must relate to the included diagnosis and functional impairments as documented and must be medically necessary.
CODES

In providing Specialty Mental Health Services, there are four general categories of services that we provide. These categories are:
1) Case Management Services
2) Mental Health Services
3) Medication Services
4) Crisis Intervention Services

It is imperative that the accurate selection of a code be made for billing purposes. Improper billing can result in high fines and penalties for the agency as well as for yourself. Please use the following sections as a guide in determining proper code selection. If you are confused or need more clarification, contact your Service Chief or a documentation specialist within the Authority and Quality Improvement Services (AQIS) division.
TARGETED CASE MANAGEMENT SERVICES (CMS)

Targeted Case Management (TCM) services help clients to access needed medical, educational, social, pre-vocational, vocational, rehabilitative or other community services. There should be documentation as to why the client is not able to access these resources on their own as a consequence of their mental illness.

Billable Codes – Case Management

90899-1 [HCPCS T1017] Case Management - Targeted

BHS has traditionally allowed a variety of services to be billed under case management as long as they referred to coordination of care, monitor service delivery and linkage access to community services.

Effective as of May 1, 2015, the criteria for billing case consultation is defined as the following:

- The documentation clearly indicates the specific need or purpose for case consultation, and
- The documentation is clearly related to addressing the mental health condition, and

In addition:

- The case consultation resulted in a change to the Care Plan, or
- The case consultation resulted in a change to the course/delivery of treatment, and
- The documentation clearly indicates how the client is likely to benefit from the case consultation

For additional information, please review the following specific case management examples:

1. Case Consultations and Treatment Team Meetings (Intra-Agency Team)

Case consultations are not billable unless it results in a documented change to treatment or to the Care Plan.

2. Review of Records

A review of any type of records is NOT billable to Medi-Cal at any time, effective May 1, 2015.

Please see examples of the activities below which are now considered to be non-billable per DHCSs directive.

- The client was transferred to a new clinician. The new clinician reviews the chart prior to meeting with the client as part of an assessment activity

- The client was transferred to a new MD. The new MD thoroughly reviews the chart to determine all the previous medications the client has been prescribed, goes through the client’s past labs to determine their reactions to the different medications and possibly reviews other significant records such as hospitalizations

- The MD or clinician reviews the last progress note just prior to a therapy session
• The clinician reviews the chart in preparation for completing an Assessment, a 6-month update or an update on the Care Plan

• The MD reviews labs and the progress notes of the clinician before meeting with the client. EHR captures non-billable services at the bottom of the progress note.

• Reviewing records from the client’s hospitalization

• Reviewing IEP reports from the school as part of an assessment activity or ongoing treatment activity

• The treating clinician reviewing a psychological evaluation conducted by a psychologist

• The treating clinician reviewing a report from Social Services

Please note that the scenarios listed above are not necessarily comprehensive of all the non-billable record review activities occurring in the clinics. As such, if there are questions regarding an activity not listed, please contact AQIS or consult with your Service Chief or supervisor.

3. Child, Elder, Dependent Adult Abuse Reporting

Programs have traditionally billed case management for calling and reporting suspected abuse to either Child Protective Services (CPS) or Adult Protective Services (APS). We have traditionally allowed the call to be billable, but the time spent completing the actual report form to be non-billable. Moving forward, the filing of abuse reports, both verbal and written, shall all be coded as non-billable.

Non-Billable Codes – Case Management

90899-5 Case Management Non-Billable

Non-billable case management services are those provided in the hospital (other than placement services during the last 30 days of hospitalization), in the jail at any time or in Juvenile Hall pre-adjudication. In addition, services that do not meet medical necessity criteria would also be non-billable.

This may be a valid and useful service, but it is not billable to most insurers, including Medi-Cal. Nevertheless, a progress note should be completed and signed in EHR with documented service time associated with this non-billable code.

• A Plan Coordinator goes to a psychiatric hospital for a session with a client to coordinate outpatient mental health services; a Plan Coordinator goes to Juvenile Hall for a session with an incarcerated client to coordinate TBS services upon release.

Other Non-Billable Services Include But Are Not Limited To:

• Any activity that is solely academic, vocational, recreational or social in nature.

• Appointment scheduling.

• Transporting clients.

• Clerical activities such as faxing or copying.
• Travel time from one Medi-Cal certified site to another Medi-Cal certified site.

• Leaving or receiving telephone messages.

• Time spent waiting for a client that “no showed” for a scheduled appointment.

• Records review of any kind

90899-112 Case Management Non-Billable Travel

The travel time associated with a billable case management service provided when the provider has traveled between two (2) Medi-Cal sites and provided a billable case management service. The travel time would be noted in the yellow box with the 90899-112 code in EHR. For more examples, please refer to the Travel Time section within this manual.

Non-Compliant Codes – Case Management

90899-106 Case Management Non-Compliant Chart

Case Management services should be marked non-compliant when the chart has been determined to be out of compliance with documentation requirements in a way that disallows billing of the service that would otherwise have been billable. For example, not having a valid Care Plan at the time a billable case management service is provided would result in the service being deemed non-compliant.

Case Management services that would otherwise be billable, except that the service is written after 14 days or longer from the date of service.
MENTAL HEALTH SERVICES (MHS)

Mental Health Services: This is an inclusive category that actually has several subcategories. Mental Health Services include Assessment, Individual Psychotherapy, Group Psychotherapy, Multi-Family Group Psychotherapy, Individual Rehabilitation, Family Rehabilitation, Group Education/Rehabilitation, and Psychological Testing. The core feature of these is the use of therapeutic interventions within one’s scope of practice.

ASSESSMENT

Assessment is a service activity designed to evaluate the current status of a beneficiary’s mental, emotional, or behavioral health. It includes a Mental Status Examination, analysis of clinical history, analysis of relevant cultural issues and history, diagnosis and may include testing procedures. In BHS, we typically do this type of service during the first 60 days of service and when we do our subsequent updates of the Care Plan. A PC should document assessment interventions provided.

Billable Codes - Assessment

**90899-6 [H2015] Mental Health Assessment – Other**

A mental health examination should include a history, Mental Status Exam (MSE) and disposition. This may involve communication with family or other sources who may be seen in lieu of the client.

If a clinician takes multiple sessions to complete the Initial Assessment, the code 90899-6 should be used for each of the sessions leading up to the completion of the intake process.

This code is typically used within the first 60 days for the initial evaluation. It is also used for Annual Reviews or at any point during the review cycle in which the focus is assessment. This code is used ONLY when services provided were not described in another CPT code.

Care Plan: The updating of the Care Plan is considered an assessment service because it is expected that this activity will include clinical assessment activities such as:

- Assessing with the client the progress and problems during the preceding months.
- Assessing the client’s current objectives and steps to take to meet them.
- The update is used as a clinical activity, not just as a paperwork requirement.

This code can also be used by a psychiatrist when completing a conservatorship evaluation, a disability assessment, or if an evaluation for medication services is being provided via the telephone.

Non-Billable Codes - Assessment

**90899-13 Mental Health Assessment – Non-Billable**
Non-billable mental health assessment services are those provided in the hospital, in the jail at any time, or in Juvenile Hall pre-adjudication. In addition, services that do not meet medical necessity criteria would also be non-billable.

Non-billable services may be a valid and useful service, but is not billable to most insurers, including Medi-Cal. Nevertheless, a progress note should be completed and submitted in IRIS with documented service time associated with this non-billable code.

**90899-113 Mental Health Assessment – Non-Billable Travel**

The travel time associated with a billable mental health assessment service provided when the provider has traveled between two (2) Medi-Cal sites and provided a billable mental health service. The travel time would be noted by selecting the mental health assessment non-billable travel 90899-113 code. For more examples, please refer to the Travel Time section within this manual.

**Non-Compliant Codes - Assessment**

**90899-110 Mental Health Assessment – Non-Compliant**

Mental Health Assessment services that would otherwise be billable, except that the service is written after 14 days or longer from the date of service.

**PSYCHOLOGICAL TESTING**

In order to bill for psychological testing services there must be a referral question justifying the need for the testing. Codes reflect who administered the testing. When testing is administered, scored, interpreted and reported by a psychologist, 96101 is used for the entire service. When testing is administered/scored by a computer and then interpreted and reported by a psychologist, 96103 is used for the entire time. A neurobehavioral status exam is billed using 96116 and typically does not utilize technicians or computers.

When a psychologist is explaining psychological testing results to another clinician, then this should be billed as case management targeted (90899-1). When a psychologist is conveying test results to a consumer or their legal guardian, then the psychological testing code 96101 can be used.

**Billable Codes – Psychological Testing**

**96101 [H2015] Psych Test by Psychologist**

Psychological testing (includes psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities) by a psychologist with interpretation and report.

Tests that fall under this category include WAIS-IV, Rorschach, MMPI-2 and other testing that evaluates the following:

- Relative intellectual strengths and weaknesses
- Psychodynamics
- Psychological mindedness
• Capacity for insight
• Affective response
• Self-destructive tendencies
• Motivation for change

** There are additional codes for other types of testing such as assessment of aphasia, developmental testing, neurobehavioral, neuropsychological, etc. If you believe the testing you are conducting falls outside of the category described above for code 96101, consult the CPT manual.

**96103 [H2015] Psych Test by Computer**

Psychological testing includes psycho-diagnostic assessment of personality, psychopathology, emotionality, intellectual abilities by a computer, as well as the psychologist’s time for interpretation and report.

**96116 [H2015] Neurobehavioral Status Exam with Interpretation and Report**

Clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, memory, visual spatial abilities, language functions, planning. This service is typically not conducted by a technician or computer.

**Non-Billable Codes – Psychological Testing**

**90899-13 Mental Health Assessment – Non-Billable**

Non-billable mental health assessment services are those provided in the hospital, in the jail at any time, or in Juvenile Hall pre-adjudication. In addition, services that do not meet medical necessity criteria would also be non-billable.

These services may be valid and useful, but are not billable to most insurers, including Medi-Cal. Nevertheless, a progress note should be completed and submitted in IRIS with documented service time associated with this non-billable code.

**90899-113 Mental Health Assessment – Non-Billable Travel**

The travel time associated with a billable mental health assessment service provided when the provider has traveled between two Medi-Cal sites and provided a billable mental health service. The travel time would be noted as the 90899-113 code. For more examples, please refer to the Travel Time section within this manual.

**Non-Compliant Codes – Psychological Testing**

**90899-110 Mental Health Assessment – Non-Compliant**

Mental health assessment services that would otherwise be billable, except that the service is written after 14 days or longer from the date of service.
PSYCHOTHERAPY

“Psychotherapy” means a service activity that is a therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments. Psychotherapy may be delivered to an individual or group of beneficiaries and may include family therapy at which the beneficiary is present.

Psychotherapy services are defined as “the treatment of a mental illness and behavioral disturbances in which the physician or other qualified health care professional, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development” (CPT Manual, 2013).

Providers should only select this code if the definition fits within their scope of practice and if the service provided meets the criteria indicated above.

The time spent providing this service can include the face-to-face time with the client and/or with family members, however, part of the session must include interaction with the client for at least part of the time. Interventions documented should focus on the client’s mental illness.

Should the provider use an interpreter during this session or engage in play therapy, the use of the Interactive Complexity add-on code would be necessary, in addition to the psychotherapy codes listed below. The add-on code for Interactive Complexity is 90785 and would be indicated in the Modifier section in the EHR.

INDIVIDUAL PSYCHOTHERAPY

Billable Codes – Individual Psychotherapy

90832 [H2015] Psychotherapy 16-37 minutes

Individual psychotherapy/counseling services, 16-37 minutes, face-to-face with client and/or family, with at least part of the service face-to-face with the client.

90834 [H2015] Psychotherapy 38-52 minutes

Individual psychotherapy/counseling services, 38-52 minutes, face-to-face with client and/or family, with at least part of the service face-to-face with the client.

90837 [H2015] Psychotherapy 53 + minutes

Individual psychotherapy/counseling services, 53 minutes or longer, face-to-face with client and/or family, with at least part of the service face-to-face with the client.

If psychotherapy was provided between 1-15 minutes, the provider would need to select the Rehab Counseling code 90899-17. Mental Health Specialists need to select the Rehab Counseling code and not Psychotherapy.
Non-Billable Codes – Individual Psychotherapy

90899-150 Individual Therapy/Counseling – Non-Billable

Non-billable mental health therapy services provided to individuals. The service may have been provided while the client was in the hospital, in the jail at any time, or in Juvenile Hall pre-adjudication. Services that do not meet medical necessity criteria would also be non-billable.

This service may be valid and useful, but it is not billable to most insurers, including Medi-Cal. Nevertheless, a progress note should be completed and submitted in IRIS with documented service time associated with this non-billable code.

90899-160 Individual Therapy/Counseling – Non-Billable Travel

The travel time associated with a billable mental health assessment service provided when the provider has traveled between two Medi-Cal sites and provided a billable mental health service. The travel time would be noted by selecting the 90899-113 code. For more examples, please refer to the Travel Time section within this manual.

Non-Compliant Codes – Individual Psychotherapy

90899-161 Individual Therapy/Counseling – Non-Compliant

Individual Therapy/Counseling services that would otherwise be billable, except that the chart has been determined to be out of compliance with documentation requirements in a way that disallows billing of the services.

Individual Therapy/Counseling services that would otherwise be billable, except that the service is written after 14 days starting with the day after the date of service in EHR.

COLLATERAL SERVICES

Billable Codes – Collateral Therapy

On August 24, 2017, DHCS released an Information Notice (No. 17-040) providing documentation requirements for Family Psychotherapy and Collateral Services. Based on Information Notice 17-040 and the feedback our county received from DHCS’s 2016 systems review that this is a reason for recoupment, BHS will comply with the State’s requirements on Family Psychotherapy and Collateral Services. By April 4, 2018, both County and Contract providers will no longer code to Family Psychotherapy and instead change to our new billing codes to reflect Collateral Services. Below is a crosswalk to identify which new codes to use.

<table>
<thead>
<tr>
<th>If you previously used:</th>
<th>It will change to:</th>
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</thead>
<tbody>
<tr>
<td>90899-157 Family Rehab Service</td>
<td>90899-157 Collateral Services</td>
</tr>
<tr>
<td>90846 Family Therapy without Patient (code will be discontinued)</td>
<td>90899-157 Collateral Services</td>
</tr>
<tr>
<td>90847 Family Therapy with Patient (code will be discontinued)</td>
<td>90899-157 Collateral Services</td>
</tr>
<tr>
<td>90899-149 Family Therapy with or without Patient Non-Billable</td>
<td>90899-149 Collateral No Fee</td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>90899-163 Family Therapy Non-Billable Travel</td>
<td>90899-163 Non-Billable Collateral Travel Time</td>
</tr>
<tr>
<td>90899-162 Family Therapy Non-Compliant Chart</td>
<td>90899-162 Collateral Non-Compliant Chart</td>
</tr>
</tbody>
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**90899-157 Collateral Therapy**

Collateral is defined as, “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 Care 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.” (Cal. Code Regs. tit. 9 § 1810.206)

“Significant Support Person” is defined as “persons, in the opinion of the beneficiary or the person providing services, who have or could have a significant role in the successful outcome of treatment, including but not limited to the parents or legal guardian of a beneficiary who is a minor, the legal representative of a beneficiary who is not a minor, a person living in the same household as the beneficiary, the beneficiary’s spouse, and relatives of the beneficiary.” (Cal. Code Regs. tit. 9 § 1810.246.1)

**Examples:**
- Collateral Therapy (client present), worked with client and mother on deescalating a tense situation by identifying appropriate rules for communicating with each other when tension is high. Therapist coached both to stay calm while practicing these rules through role plays in order to meet the goal of improving communication with authority figures as identified on the treatment plan.
- Collateral Therapy (client not present), assist the significant support person improve awareness of their aggressive communication patterns that trigger the client’s angry escalation. Identified alternative styles of communication that client receives well and practiced those in role plays in order to help the client reduce conflicts with authority figures as identified on the treatment plan.

**Non-Billable Codes – Collateral Therapy**

**90899-149 Collateral No Fee**

Non-billable collateral therapy services provided to a significant support person(s) with or without client present. The service may have been provided while the client was in the hospital, in the jail at any time, or in Juvenile Hall pre-adjudication. Services that do not meet medical necessity criteria would also be non-billable.

This services may be valid and useful, but it is not billable to most insurers, including Medi-Cal. Nevertheless, a progress note should be completed and submitted in IRIS with documented service time associated with this non-billable code.
**90899-163 Non-Billable Collateral Travel Time**

The travel time associated with a billable collateral service provided when the provider has traveled between two Medi-Cal sites and provided a billable mental health service. The travel time would be noted by selecting the 90899-113 code. For more examples, please refer to the [Travel Time section](#) within this manual.

**Non-Compliant Codes – Collateral Therapy**

**90899-162 Collateral Non-Compliant Chart**

Collateral therapy services that would otherwise be billable, except that the chart has been determined to be out of compliance with documentation requirements in a way that disallows billing of the services.

Collateral therapy services that would otherwise be billable, except that the service is written after 14 days starting with the day after the date of service.

**GROUP PSYCHOTHERAPY**

**Billable Codes – Group Psychotherapy**

**90853 [H2015] Group Psychotherapy**

Insight Oriented, Behavior Modifying and/or Supportive. CPT code 90853 is typically used when several clients meet in a group setting and discuss individual or group dynamics.

*Examples:*

- These services are designed to provide goal directed, face-to-face therapeutic intervention where the client and one or more additional clients are treated at the same time. The identified intervention(s) are consistent with the client’s diagnosis Care Plan and all components are clearly documented on the encounter document.

- The clinician leads a group therapy session for older adolescent females who repeatedly get into relationships with partners who abuse them. The group is geared toward developing insight into their own functioning with the goal of improving safety and choices.

Should the provider use an interpreter during this psychotherapy session or engage in play therapy, the use of the Interactive Complexity add-on code would be necessary, in addition to the psychotherapy codes listed below. The add-on code for Interactive Complexity is 90785 and would be indicated in the Modifier section in EHR.

**90849 [H2015] Multiple-Family Group Psychotherapy**

Insight Oriented, Behavior Modifying and/or Supportive. CPT code 90849 is used when there are multiple families and similar dynamics for the clients who are being treated. Clients may or may not be present, but the focus of the interventions must be assisting the family in working with their family member so the client’s functioning improves. The focus must not be solely on the family members’ problems. The therapist
would drop an Encounter Document for each client represented in the group, not for each of the family members present.

Add-on codes are not reported with a multi-family group psychotherapy service.

**Non-Billable Codes – Group Psychotherapy**

**90899-70 Group Therapy/Counseling Non-Billable**

Non-billable group services are those provided in non-billable locations such as Juvenile Hall or Institute for Mental Disease (IMD). In addition, services that do not meet medical necessity criteria would also be non-billable.

This service may be valid and useful, but it is not billable to most insurers, including Medi-Cal. Nevertheless, a progress note should be completed and submitted in IRIS with documented service time associated with this non-billable code.

**90899-114 Group Therapy/Counseling Non-Billable Travel**

The travel time associated with a billable group service provided when the provider has traveled between two Medi-Cal sites and provided a billable group service. The travel time would be noted by selecting the 90899-114 code. For more examples, please refer to the [Travel Time section](#) within this manual.

**Non-Compliant Codes – Group Psychotherapy**

**90899-108 Group Therapy/Counseling Non-Compliant Chart**

Group services that would otherwise be billable, except that the chart has been determined to be out of compliance with documentation requirements in a way that disallows billing of the services.

Group services that would otherwise be billable, except that the service is written after 14 days count starting the day after date of service in EHR.

**REHABILITATION**

“**Rehabilitation Services**” are an adjunct to psychotherapy and are designed to target specific problematic behaviors. Rehabilitation Services must restore, maintain, and/or teach the client or parent/caregiver new skills that will help improve and replace problematic behaviors and manage emotions. This code targets maladaptive behaviors and should not be used to interpret emotions or process underlying dynamics. Rehabilitation Services documentation may include terms such as; coach, problem solve, model, role play, teach, and identify.

Rehabilitation services are defined as “activities that include 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” (Title IX, CCR, Section 1810.243).

Rehabilitation services are subject to medical necessity. The client must have an included diagnosis, there must be an impairment resulting from the mental health condition, and the focus of the intervention is to
ameliorate the identified impairment. In order to provide rehabilitation services, there must be clinical evidence that the skills deficits are *caused by a mental health condition*.

Important: Rehabilitation services should always be coded by staff whose scope of practice does not include psychotherapy (e.g., Mental Health Specialist or Mental Health Rehabilitation Specialist).

**INDIVIDUAL REHABILITATION**

**Billable Codes – Individual Rehabilitation**

**90899-17 [H2015] Individual Rehabilitation Services**

Individual Rehabilitation services are provided to an individual client with the focus on developing the above named skills. Services can be provided either face-to-face or over the phone.

Add-on codes are not reported with any rehabilitation services, nor do time ranges apply.

**Non-Billable Codes – Individual Rehabilitation**

**90899-150 Individual Therapy/Counseling – Non-Billable**

Non-billable mental health therapy and rehab services provided to individuals. The service may have been provided while the client was in the hospital, in the jail at any time, or in Juvenile Hall pre-adjudication. Services that do not meet medical necessity criteria would also be non-billable.

This may be a valid and useful service, but is not billable to most insurers, including Medi-Cal. Nevertheless, a progress note should be completed and submitted in IRIS with documented service time associated with this non-billable code.

**90899-160 Individual Therapy/Counseling – Non-Billable Travel**

The travel time associated with a billable mental health individual therapy or rehab service provided when the provider has traveled between two (2) Medi-Cal sites and provided a billable mental health service. The travel time would be noted in the section provided next to the 90899-113 code. For more examples, please refer to the Travel Time section within this manual.

**Non-Compliant Codes – Individual Rehabilitation**

**90899-161 Individual Therapy/Counseling – Non-Compliant**

Individual Therapy/Counseling/Rehab services that would otherwise be billable, except that the chart has been determined to be out of compliance with documentation requirements in a way that disallows billing of the services.

Individual Therapy/Counseling services that would otherwise be billable, except that the service is written after 14 days or longer from the date of service.
COLLATERAL REHABILITATION

Billable Codes – Collateral Rehabilitation Services

**90899-157 [H2015] Collateral Rehabilitation**

Collateral rehabilitation services are provided to a client’s significant support person(s) to benefit the client with the focus on developing the above named skills. Services can be provided either face-to-face or over the phone.

Add-on codes are not reported with any collateral rehabilitation services, nor do time ranges apply.

Non-Billable Codes – Collateral Rehabilitation Services

**90899-149 Collateral No Fee**

Non-billable collateral rehabilitation services provided to a significant support person(s) with or without client present. The service may have been provided while the client was in the hospital, in the jail at any time, or in Juvenile Hall pre-adjudication. Services that do not meet medical necessity criteria would also be non-billable.

This may be a valid and useful service, but is not billable to most insurers, including Medi-Cal. Nevertheless, a progress note should be completed and submitted in IRIS with documented service time associated with this non-billable code.

**90899-163 Non-Billable Collateral Travel Time**

The travel time associated with a billable collateral rehabilitation service provided when the provider has traveled between two (2) Medi-Cal sites and provided a billable mental health service. The travel time would be noted in the section provided next to the 90899-113 code. For more examples, please refer to the Travel Time section within this manual.

Non-Compliant Codes – Collateral Rehabilitation Services

**90899-162 Collateral Non-Compliant Chart**

Collateral rehabilitation services that would otherwise be billable, except that the chart has been determined to be out of compliance with documentation requirements in a way that disallows billing of the services.

Collateral rehabilitation services that would otherwise be billable, except that the service is written after 14 days starting with the day after the date of service.

GROUP REHABILITATION

Billable Codes – Group Rehabilitation

**99078 [H2015] Group Educational/Rehabilitation**
Psycho-educational services rendered to clients in a group setting (e.g., activities of daily living group, coping skills group).

In BHS, this code can be used for a didactic education group. The link to the mental health impairments must be evident and documented in both the plan and the note.

**Examples:**

- Service designed to provide goal directed, face-to-face rehabilitation or educational interventions related to reducing mental health impairments.

- The clinician leads a group rehab session for clients who have been identified as needing assistance with medication management. Clients in this group may all have disorganized thoughts as a result of the mental illness, which hinders medication compliance. In this group, the clinician works with the clients to teach him/her ways to better organize his/her thoughts so that medication compliance can be improved.

Add-on codes are not reported with any rehabilitation services, nor do time ranges apply.

**Non-Billable Codes – Group Rehabilitation**

**90899-70 Group Therapy/Counseling Non-Billable**

Non-billable group services are those provided in non-billable locations such as Juvenile Hall. In addition, services that do not meet medical necessity criteria would also be non-billable.

This may be a valid and useful service, but is not billable to most insurers, including Medi-Cal. Nevertheless, a progress note should be completed and submitted in IRIS with documented service time associated with this non-billable code.

**90899-114 Group Therapy/Counseling Non-Billable Travel**

The travel time associated with a billable group service provided when the provider has traveled between two (2) Medi-Cal sites and provided a billable group service. The travel time would be noted in the section provided next to the 90899-114 code.

**Non-Compliant Codes – Group Rehabilitation**

**90899-108 Group Therapy/Counseling Non-Compliant Chart**

Group services that would otherwise be billable, except that the chart has been determined to be out of compliance with documentation requirements in a way that disallows billing of the services.

Group services that would otherwise be billable, except that the service is written after 14 days or longer from the date of service.
MEDICATION SUPPORT SERVICES

It is a program expectation, for good quality of care, that a valid medication consent for every psychotropic medication be obtained. Please see the discussion of medication consents in the section entitled “Consents.”

ESTABLISHED OUTPATIENT

Although any appropriately documented E&M code may be entered on the BHS Encounter Document, generally, services provided within the community mental health setting typically do not mirror the broad range of services provided within the general medical community.

In BHS, E&M codes will only be used by a psychiatrist/nurse practitioner, and the psychiatrists/nurse practitioners will be seeing "established" patients (i.e., someone else in the HCA BHS group has already provided a clinical service). Accordingly, Established Outpatient are the only E&M codes on the current Encounter Document.

Evaluation & Management Codes in General

Within the CPT Manual, there are many Evaluation and Management (E&M) codes listed. E&M services include new and established client office visits, hospital observation services, hospital inpatient services, outpatient and inpatient consultations, emergency room visits, special critical care services (adult and neonatal), and nursing facility services.

Within each E&M service there are several levels which have very specific documentation requirements which must be included for good clinical care and to have legally compliant documentation. Below is a discussion of the elements which go into the decision on which E&M code and level of code to select. Each of these elements must be clearly and easily seen in the documentation of the service.

The documentation guidelines require that certain elements be present in each note. Listed below is an overview of those elements:

- History
- Chief complaint or reason for visit
- History of present illness or the status of three chronic conditions
- Review of systems
- Personal past, family and/or social history
- Examination
- Medical decision making

If needed, you will find further discussion on each of these required documentation elements at the end of this section. It is essential for providers of service to:

- Become intimately familiar with the expectations and details of existing documentation guidelines.
- Perform and document only what is clinically appropriate.
- Support medical necessity by including response to impairment.
- Provide specific and detailed diagnoses.
• If writing notes on paper, list only those diagnoses actually managed during the course of a client encounter under Diagnosis Treated Today in the billing section of your progress note. List all other diagnoses under Diagnoses Not Treated Today.
• If writing the note in the County EHR, all diagnoses will be listed under Diagnosis Treated Today but the first diagnosis listed should be the diagnosis that was the primary focus of the session.
• Use other clinical staff to help document appropriate information in the client medical record AND reference their notes (i.e., “see above note by <name> dated <date>;” or “as above on <date> by <name>,” with reference to specific date and author of referenced note).

Selecting the Correct E&M CPT Code

In general, the particular CPT code used to designate an E&M service will be based on either the presence of specified key components or time.

Time can only be used if more than 50% of the time spent in the session was used for “counseling.” “Counseling” as used here is not the same as psychotherapy. The definition of “counseling” as it relates to E&M codes is further discussed later in this section.

There are three methods by which a medical provider can select the proper E&M code and add-ons: Time Method, Key Component Method, and Key Component Method with Psychotherapy Add-Ons.

1. **E&M Code selected on the basis of more than 50% of the time being spent in “counseling” and/or "coordination of care." (a.k.a. – Time Method)**

In community mental health psychiatry “counseling” is part of all of the E&M visits and may include psychotherapeutic interventions. When greater than 50% of an E&M visit is spent counseling the client and/or family or coordinating care, the “level” of service can be selected based on total face-to-face time spent with the client and family.

*Counseling*, as it relates to Evaluation and Management (E&M) codes, is defined as a discussion with a client and/or family concerning one or more of the following:

- Diagnostic test results, impressions and/or recommended diagnostic studies
  - Advice and teaching
  - On-line review of registry or labs with patient present
- Prognosis
  - Reassurance and Encouragement
- Risks and benefits of treatment options
  - Advice and Teaching
  - Rationalizing and Reframing
  - Eliciting symptoms and impairment, and connecting the two
- Instructions for disease management and/or treatment options
  - Anticipatory Guidance
  - Reducing and Preventing Anxiety
  - Naming the Problem
  - Advice and Teaching
  - Cognitive Behavioral Interventions
- Side effects of treatment (drug reactions, for example)
- Importance of compliance with selected treatment options
  - Expanding the Patient’s Awareness
  - Motivational Interviewing
Risk factor reduction
- Naming the Problem
- Expanding the Patient’s Awareness
- Advice and Teaching
- Monitoring for metabolic syndrome

Client and family education as it relates to disease management, treatment options, lifestyle changes/adaptations.
- Praise
- Encouragement
- Advice and Teaching

Counseling should not be confused with psychotherapy. Counseling is what all psychiatrists should be engaging in. More specifically, all psychiatrists should be discussing and answering the patient’s questions about the condition and treatment.

**Coordination of Care (C of C), as it relates to Evaluation and Management (E&M) codes:**

1. No explicit definition or elaboration of Coordination of Care in the CPT manual
2. In the office, Coordination of Care typically includes collaboration with:
   - Social services agencies, case managers, family members, assistance with SSI/SSDI benefit issues
3. Must be provided during face-to-face time in order to count toward the E&M requirement

**If the E&M code is being selected based on the “time method,” then the following criteria must be present in the progress note:**

1. Encounter Document must state: “Face-to-Face time = # of minutes”
   and
   “Total time: # of minutes”
2. Statement that “More than 50% of the visit included counseling and/or coordination of care”
3. The nature of the counseling and/or coordination of care must be specified and individualized based on this particular interaction with the client
4. Medical/Medication management

2. **E&M code selected based on the Key Component Method**

For these four "levels" of Evaluation and Management CPT codes, determining which level to select is based primarily on three key components:

- History
- Examination
- Medical decision making

For the outpatient E&M codes, only two of the three key components (history, exam and medical decision making) are required to be documented.

The complexity for the first two areas, history and exam, from least complex to most complex, is rated as:

- Problem Focused (PF),
• Expanded Problem Focused (EPF),
• Detailed (Det), or
• Comprehensive (Comp)

The complexity of medical decision making from least complex to most complex, is rated as:
• Straightforward (SF),
• Low (Low),
• Moderate (Mod), or
• High (High)

Examples of these related to a psychiatrist’s work in community mental health are given in the examples that follow each of the CPT codes.

3. **E&M code selected based on the Key Component Method – with psychotherapy add-ons**

The criteria for the Key Component method is listed directly above in number 2 and all criteria should be met and documented if this method is selected. However, if a psychotherapy session is also provided by the psychiatrist/nurse practitioner during the same visit, the use of a psychotherapy add-on code would be appropriate. These are time based codes and would be used in addition to the principal service, never coded alone.

The E&M with psychotherapy add-on codes can ONLY be used if the psychiatrist/nurse practitioner selected the E&M code through use of the Key Component Method.

+90833 30 (16-37) min of psychotherapy provided in addition to E&M service
+90836 45 (38-52) min of psychotherapy provided in addition to E&M service
+90838 60 (53+) min of psychotherapy provided in addition to E&M service

**OUTPATIENT E&M CODES**

**Billable Codes – Medication Services**

**99212 – [H2010] PF/PF/SF/10**

Problem Focused, face-to-face, office-based client visit typically 10 minutes.

Unless the chart note documents that greater than 50% of an E&M visit is spent counseling the client and/or family or coordinating care, then there should be documentation of two of the three key components (history, exam and medical decision making). For this level, this would include two of the following three: a problem-focused history and exam and straightforward medical decision making.

Example of Time Method:

- A 10-minute, very brief, follow-up appointment focused on one problem with straightforward interventions.
  - Psychiatrist/Nurse Practitioner would need to indicate in the progress note that “more than 50% of the time was spent providing counseling and/or coordination of care.” The note would need to specify which elements of counseling and/or coordination of care were
provided. Counseling is considered a discussion with a patient and/or family member concerning one or more of the following: diagnostic results, impressions, and/or recommended diagnostic studies; prognosis; risks and benefits of management (treatment options); instructions for management (treatment) and/or follow-up; importance of compliance with chosen management (treatment) options; risk factor reduction; or patient and family education. Coordination of Care is considered collaboration with social service agencies, case managers, family members, or assistance with benefits issues through SSI/SSDI.

Example of Key Component Method:

- A 10-minute, very brief, follow-up appointment focused on one problem with straightforward interventions.
  - Two of the following three components would need to be documented: A problem-focused history would be the chief complaint and the brief history of depressed symptoms, a problem-focused exam would be eliciting today's symptom(s) and or side effect(s), and straightforward medical decision making would be affirming that the diagnosis of depression continues, the side-effects are the same or better and planning to continue with added medication or titration.

99213 – [H2010] EPF/EPF/Low/15

Expanded Problem Focused, face-to-face, office based client visit typically 15 minutes.

Unless the chart note documents that greater than 50% of an E&M visit is spent counseling the client and/or family or coordinating care, then there should be documentation of two of the three components. For this level, this would include an expanded problem-focused history and exam, and low-complexity medical decision making.

Example of Time Method:

- A 15-minute follow up appointment focused on one problem that needs clarification or slightly more than straightforward interventions.
  - Psychiatrist/Nurse Practitioner would need to indicate in the progress note that “more than 50% of the time was spent providing counseling and/or coordination of care.” The note would need to specify which elements of counseling and/or coordination of care were provided. Counseling is considered a discussion with a patient and/or family member concerning one or more of the following: diagnostic results, impressions, and/or recommended diagnostic studies; prognosis; risks and benefits of management (treatment options); instructions for management (treatment) and/or follow-up; importance of compliance with chosen management (treatment) options; risk factor reduction; or patient and family education. Coordination of Care is considered collaboration with social service agencies, case managers, family members, or assistance with benefits issues through SSI/SSDI.

Example of Key Component Method:

- A 15-minute follow up appointment focused on one problem that needs clarification or slightly more than straightforward interventions.
➢ Two of the following three components would need to be documented: An expanded problem focused history would be the chief complaint, brief history of psychotic symptoms and pertinent review of systems; an expanded problem focused exam would be eliciting today's symptom(s) specifically commenting on presence or absence of suicidal ideation, dangerousness to others, hallucinations, delusions, substance abuse, and co-morbid medical conditions; and a low-complexity medical decision-making would be where the diagnosis of a psychotic disorder continues, the plan to start the medication was initiated and a signed consent obtained.


Detailed, face-to-face, office based client visit typically 25 minutes.

Unless the chart note documents that greater than 50% of an E&M visit is spent counseling the client and/or family or coordinating care, there should be documentation of two of the three components. For this level, this would include a detailed history and exam, and moderate-complexity medical decision-making.

Example of Time Method:

Typically used for a 25-minute follow-up that is detailed in gathering history or examining patient and is significantly more than one straightforward intervention.

➢ Psychiatrist/Nurse Practitioner would need to indicate in the progress note that “more than 50% of the time was spent providing counseling and/or coordination of care.” The note would need to specify which elements of counseling and/or coordination of care were provided. Counseling is considered a discussion with a patient and/or family member concerning one or more of the following: diagnostic results, impressions, and/or recommended diagnostic studies; prognosis; risks and benefits of management (treatment options); instructions for management (treatment) and/or follow-up; importance of compliance with chosen management (treatment) options; risk factor reduction; or patient and family education. Coordination of Care is considered collaboration with social service agencies, case managers, family members, or assistance with benefits issues through SSI/SSDI.

Example of Key Component Method:

Typically used for a 25-minute follow-up that is detailed in gathering history or examining patient and is significantly more than one straightforward intervention.

➢ Two of the following three components would need to be documented: A detailed history would be the chief complaint, an extended history of anxious/physical symptoms, a review of systems commonly related to anxiety, a pertinent past history of treatment, family, and/or social history related to the symptoms; a detailed exam would be eliciting today's symptom(s) specifically commenting on presence or absence of suicidal ideation, dangerousness to others, hallucinations, delusions, substance abuse, co-morbid medical conditions, test of memory, blood pressure, pulse, review of laboratory results; and moderate-complexity medical decision making would be where the diagnosis of anxiety with accompanying physical symptoms continues, the plan to start medication(s) was initiated and a signed consent obtained. Recommendations on coordination of care for physical health symptom assessment would be made.
Comprehensive, face-to-face, office based client visit typically 40 minutes. This code is typically used for the initial medication evaluation, **whether or not medications are prescribed**.

Unless the chart note documents that greater than 50% of an E&M visit is spent counseling the client and/or family or coordinating care, then there should be documentation of two of the three components. For this level, this would include a comprehensive history and exam, and high-complexity medical decision-making.

Example of Time Method:

- Typically used for a 40-minute initial appointment that is comprehensive with medical/social/family history, ROS, complete MSE, and multiple interventions.
  - Psychiatrist/Nurse Practitioner would need to indicate in the progress note that “more than 50% of the time was spent providing counseling and/or coordination of care.” The note would need to specify which elements of counseling and/or coordination of care were provided. Counseling is considered a discussion with a patient and/or family member concerning one or more of the following: diagnostic results, impressions, and/or recommended diagnostic studies; prognosis; risks and benefits of management (treatment options); instructions for management (treatment) and/or follow-up; importance of compliance with chosen management (treatment) options; risk factor reduction; or patient and family education. Coordination of Care is considered collaboration with social service agencies, case managers, family members, or assistance with benefits issues through SSI/SSDI.

- Established client (maybe new to this provider) office appointment of any length (at least 40 minutes if using time/coordination of care) for a comprehensive evaluation of the need for a psychotropic medication for a client who has been assessed or evaluated by any HCA Plan Coordinator.
  - As indicated above, the Psychiatrist/Nurse Practitioner would need to indicate in the progress note that “more than 50% of the time was spent providing counseling and/or coordination of care.” The note would need to specify which elements of counseling and/or coordination of care were provided. Counseling is considered a discussion with a patient and/or family member concerning one or more of the following: diagnostic results, impressions, and/or recommended diagnostic studies; prognosis; risks and benefits of management (treatment options); instructions for management (treatment) and/or follow-up; importance of compliance with chosen management (treatment) options; risk factor reduction; or patient and family education. Coordination of Care is considered collaboration with social service agencies, case managers, family members, or assistance with benefits issues through SSI/SSDI.

Example of Key Component Method:

- Typically used for a 40-minute initial appointment that is comprehensive with medical/social/family history, ROS, complete MSE, and multiple interventions.
  - Two of the following three components would need to be documented: A **comprehensive history** would be the chief complaint and a thorough review of treatment history, response, side effects, evidence of risk for acute deterioration, and a review of all additional bodily
A comprehensive exam would be eliciting today's symptom(s) specifically commenting on presence or absence of suicidal ideation, dangerousness to others, hallucinations, delusions, substance abuse, co-morbid medical conditions, test of memory, blood pressure, pulse, review of laboratory results, assess ability of client to form a heightened therapeutic alliance with treatment team; and a high-complexity medical decision-making would be where the diagnosis of major depression with psychosis continues and there is a plan to make multiple adjustments to treatment (e.g., including medications, frequency of monitoring, nature of support and structure of client).

Established client (maybe new to this provider) office appointment of any length (at least 40 minutes if using time/coordination of care) for a comprehensive evaluation of the need for a psychotropic medication for a client who has been assessed or evaluated by any HCA Plan Coordinator.

As above, two of the following three components would need to be documented: A comprehensive history would be the chief complaint and a thorough review of treatment history, response, side effects: a comprehensive exam would be eliciting today's symptom(s) specifically commenting on presence or absence of suicidal ideation, dangerousness to others, hallucinations, delusions, substance abuse, co-morbid medical conditions, test of memory, blood pressure, pulse, review of previous records, assess ability of client to form a therapeutic alliance with treatment team; and a high complexity medical decision making would be the discussion of diagnosis and treatment options.

90899-8 – [H2010] Medication Service (w or w/o pt present)

Medication Services, client need not be present.

"Medication Services" as defined in Title IX are described as prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals which are necessary to alleviate the symptoms of mental illness. The services may include evaluation of clinical effectiveness and side effects, the obtaining of informed consent, medication education and plan development related to the delivery of the service and/or assessment of the beneficiary.

Includes "plan development" related to the delivery of this service and/or to the status of the individual's community functioning.

This code is used ONLY when services provided were not described in another CPT code.

Example:

Psychiatrist/Nurse Practitioner would use this (even if the client is not present), for services that require specialized medical knowledge for the purpose of informing the Plan Coordinator, pharmacy, board and care, family member for medication services.

RN, LVN, LPT would use this (even if the client is not present), such as giving an injection and administering medication.
Non-Billable Codes – Medication Services

90899-18 Comp Med Service Non-Billable

Non-billable medication services include any of the above services provided in the hospital prior to last 30 days of hospitalization or in the jail at any time. Services are also non-billable for clients that do not meet medical necessity.

This may be a valid and useful service, but is not billable to most insurers, including Medi-Cal. Nevertheless, a progress note should be completed and submitted in IRIS with documented service time associated with this non-billable code.

Example: If a patient does not show for scheduled appointments and IF a specific service is provided in the patient’s absence, then this code can be used. It will track the minutes of service, but no bill will be generated.

90899-115 Comp Med Svc Non-Billable Travel

The travel time associated with a billable medication service provided when the provider has traveled between two (2) Medi-Cal sites and provided a billable medication service. The travel time would be noted in the section provided next to the 90899-115 code. For more examples, please refer to the Travel Time section within this manual.

Non-Compliant Codes – Medication Services

90899-109 Comp Med Svc Non-Compliant Chart

Medication services that would otherwise be billable, except that the chart has been determined to be out of compliance with documentation requirements in a way that disallows billing of the service.

Medication services that would otherwise be billable, except that the service is written after 14 days or longer from the date of service.

MEDICATION ADD-ON CODES

Add-on codes identify an additional part of the treatment; something beyond the principal service. These codes are reported in conjunction with a main/principal service and should never be reported alone.

Prolonged E&M Add-Ons

If an E&M service is being provided and exceeds the typical time range for that code, then the use of a “prolonged visit” add-on code may be appropriate.
+99354 is used to report an additional hour of service but it should not be used until after the 1st 30 minutes of the prolonged service.

+99355 is used in conjunction with +99354 and is used to report an additional ½ hour of service, but it cannot be used until the time exceeds the first 15 minutes after the additional first prolonged hour.

<table>
<thead>
<tr>
<th>Total Duration of Prolonged Service</th>
<th>Codes to Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>(these are minutes in addition to the “typical” minutes associated with the E&amp;M code)</td>
<td></td>
</tr>
<tr>
<td>Less than 30 minutes</td>
<td>Not reported separately</td>
</tr>
<tr>
<td>30-74 minutes</td>
<td>+99354 once</td>
</tr>
<tr>
<td>75-104 minutes</td>
<td>+99354 once and +99355 once</td>
</tr>
<tr>
<td>105 minutes or more</td>
<td>+99354 once and +99355 twice or more for each additional 30 minutes</td>
</tr>
</tbody>
</table>

Below are examples of how and when one would use the prolonged add-on codes:

99215 – [H2010] Com/Com/High/40
- Typical visit would be between 35-69 minutes
- If the visit is between 70 - 114 minutes, use add-on code of +99354 in addition to the main E&M code 99215
- If the visit is between 115 – 159 minutes, use add-on codes of +99355 plus +99354 in addition to the main E&M code 99215

- Typical visit would be between 20-54 minutes
- If the visit is between 55 - 99 minutes, use add-on code of +99354 in addition to the main E&M code 99214
- If the visit is between 100 - 144 minutes, use add-on codes of +99355 plus +99354 in addition to the main E&M code 99214

E&M with Psychotherapy Add-Ons

If an E&M service is being provided and coded for on the Encounter Document and psychotherapy is also provided by the practitioner during the same visit, the use of a psychotherapy add-on code would be appropriate. These are time based codes and would be used in addition to the principal service, never coded alone.

The E&M with psychotherapy add-on codes can ONLY be used if the provider selected the E&M principle code through use of the Key Component Method.

+90833 30 (16-37) min of psychotherapy provided in addition to E&M service
+90836 45 (38-52) min of psychotherapy provided in addition to E&M service
+90838 60 (53+) min of psychotherapy provided in addition to E&M service

Interactive Complexity Add-On would only be used in addition to the psychotherapy add-on code, thereby resulting in two add-on codes for the same E&M service. This code cannot be used without the psychotherapy add-on.

+90785 Interactive Complexity

Interactive complexity involves factors that complicate the service delivery of a mental
health procedure. This includes:

- Psychotherapy with the use of an **interpreter**
- Psychotherapy which includes the use of **play therapy** to engage verbally underdeveloped children.
CRISIS INTERVENTION

Billable Services – Crisis Intervention

90899 [H2011] Crisis Intervention

A crisis is an unplanned event that results from the individual’s need for immediate service intervention which, if untreated, presents an imminent threat to the patient or others. This may include, but is not limited to assessment, evaluation, collateral and therapy. This code is used only when services provided were not described in another CPT code. No more than 8 hours (480 minutes) can be billed in a 24-hour period, per client.

If a crisis evaluation is handled by two clinicians, in order for each to bill, it would be necessary for each clinician to document separately what he/she did in the encounter. We cannot bill for two clinicians doing the same task(s). Further, if two clinicians are present and one is there for the sole purpose of providing safety, the one who is there for safety cannot bill for his/her time.

90839 [H2011] Crisis Psychotherapy

Crisis Psychotherapy is considered “an urgent assessment and history of a crisis state, a mental status exam, and a disposition. The treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic intervention to minimize the potential for psychological trauma. The presenting problem is typically life threatening or complex and requires immediate attention to a patient in high distress.” (CPT Manual, 2013)

This code is typically used when the client is seen for a crisis evaluation and the clinician is able to de-escalate the client through the use of psychotherapy and no further action is needed at that moment. As with all codes, a provider must operate within their scope of practice.

If the client requires hospitalization or the provider needs to complete 5150 evaluation paperwork, contact an outside provider regarding beds/placement, etc., then this code would not be the proper code to select. In a crisis assessment involving those types of activities, 90899 Crisis Intervention would be the accurate code to indicate.

Crisis Psychotherapy is computed by face-to-face time with patient and/or family member and cannot be a service provided over-the-phone. If these requirements are not met, code crisis service as Crisis Intervention (90899).

This code is a time based code. If a provider meets with the client between 1-29 minutes, this code cannot be used. Instead, the crisis intervention code 90899 would be used. The initial time range for this service is between 30-74 minutes. Should a provider exceed the 74 minutes, each additional 30 minutes can be authorized by the use of an add-on code.

The add-on code of +90840 would be specified with the number of units for each 30 minute block over the 74 minutes.

75-104 Crisis Psychotherapy minutes, the provider would indicate the main service as 90839 and use the add-on code +90840 and indicate 1 unit.

105-134 Crisis Psychotherapy minutes, the provider would indicate the main service as 90839 and use the add-on code +90840 and indicate 2 units.
Non-Billable Services – Crisis Intervention

**90899-14 Crisis Intervention Non-Billable**

Non-billable crisis services are those provided in non-billable locations such as Juvenile Hall/jail. In addition, services that do not meet medical necessity criteria would also be non-billable. This may be a valid and useful service, but is not billable to most insurers, including Medi-Cal. Nevertheless, a progress note should be completed and submitted in IRIS with documented service time associated with this non-billable code.

**90899-10 Med Escort Non-Billable**

This code is used when a client is placed on a 5150 hold and staff accompanies and remains with the client at a medical hospital until they are medically cleared for a psychiatric admission.

This code is used ONLY when services provided are not described in another CPT code.

**90899-116 Crisis Intervention Non-Billable Travel**

The travel time associated with a billable crisis service provided when the provider has traveled between two (2) Medi-Cal sites and provided a billable crisis service. The travel time would be noted in the section provided next to the 90899-116 code. For more examples, please refer to the Travel Time section within this manual.

Non-Compliant Codes – Crisis Intervention

**90899-107 Crisis Intervention Non-Compliant Chart**

Crisis services that would otherwise be billable, except that the service is written after 14 days or longer from the date of service.
OTHER SERVICES

90899-19 [H2019] TBS (Therapeutic Behavioral Services)

One-to-one intensive behavioral intervention, provided up to 24-hours per day, seven days a week. Staff (usually unlicensed) who provide this service are required to have special training to do so and must work under the supervision of a licensed clinician. All documentation must be co-signed by the supervising clinician. To be eligible for this service, a client must have been previously admitted to a psychiatric hospital, be currently residing in a Group Home for the most disturbed youth (Level 12 or 14), or be in danger of being placed in such a home.

PATHWAYS TO WELL-BEING (KATIE A. SUBCLASS) SETTLEMENT

I. Why are we providing Pathways to Well-Being (PWB) services?

The Katie A. Lawsuit, Katie A. et al. v. Bonta et al., refers to a class action lawsuit filed in Federal District Court in 2002 concerning the availability of intensive mental health services to children/youth in California who are either in foster care or at imminent risk of coming into care. A settlement agreement was reached in the case in December 2011. Services associated with the Katie A. Subclass Settlement are now referred to as Pathways to Well-Being (PWB).

II. When did we start PWB services?

January 1, 2013 was the State’s targeted implementation date of PWB services. However, since there were delays by the State to finalize the guidance of these services until recently, CYPBHS implemented the services in July 2013.

III. Who meets the PWB criteria?

A. Minors (children/youth up to age 21)
   1. with an open child welfare services case
   2. with full scope Medi-Cal (Title XIX)
   3. who meet medical necessity for Specialty Mental Health Services
   4. have either of the following criteria(s):
      Currently in or being considered for:
      i) Wraparound, therapeutic foster care, specialized care due to behavioral health needs or other intensive EPSDT services (i.e. TBS, crisis stabilization/intervention).
      or
      ii) Group Home (RCL 10 or above), psychiatric hospitalization or 24 hr. mental health treatment facility; or has experienced his/her 3rd or more placements within 24 months due to behavioral health needs.

Eligibility Form

CYPBHS has created an Eligibility Form that will need to be completed to verify if the minor meets the criteria for PWB services. The form has been updated. Please click on the link to view the form.
IV. 2 New BHS-CYPBHS Billing Codes

A. PWB services currently only have 2 new primary billable codes, which are Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS). BHS-CYP will include the option to code for a No Fee (non-billable service) or a Non-compliant service as there maybe circumstances in which these two primary services may not be billed.

1. Intensive Care Coordination (ICC):
   a) 90899-151 Intensive Care Coordination
   b) 90899-152 Intensive Care Coordination No Fee
   c) 90899-153 Intensive Care Coordination Noncompliant

2. Intensive Home-Based Services (IHBS):
   a) 90899-154 Intensive Home-Based Services
   b) 90899-155 Intensive Home-Based Services No Fee
   c) 90899-156 Intensive Home-Based Services Noncompliant

B. ICC & IHBS services are guided by the Core Practice Model (CPM):
   CPM adheres to a set of family centered values and principles that are driven by a defined Child and Family Team (CFT) process, and would be utilized by all agencies or individuals who serve the PWB members and their families.

C. All of these new codes are already included in the current ED.

V. ICC services in detail

A. ICC Defined:
   A service that is responsible for facilitating assessment, care planning and coordination of services, including urgent services for children/youth who meet the PWB criteria.
   Note: All who meet the PWB criteria are required to receive ICC services. When a child becomes part of PWB use the ICC vs. Targeted Case Management codes. There is an Exception: ICC services cannot be billed for client’s placed in a psychiatric hospital unless it is 30 days prior to transition to home placement or discharge from psychiatric hospitalization for the purposes of coordinating care as part of the discharge planning. If the services do not relate to discharge planning that meet the criteria above, the services during a psychiatric hospitalization should then be billed as non-billable service codes per Medi-Cal guidelines.

B. ICC Services:
   Identify an ICC Coordinator which mirrors what a primary therapist is already doing when coordinating services for a youth in Foster Care. This is not a role change but simply a title that the State has asked us to use for these cases.

   1. The ICC Coordinator can be any CYPBHS mental health provider/representative that is part of the Child and Family Team (i.e., licensed clinician, rehab worker, etc.). Typically in CYPBHS the primary therapist would be the ICC Coordinator. The exception to this rule would be when a case is also opened in CCPU, then the CCPU therapist and the primary therapist will consult to determine who would become the ICC Coordinator. Once the ICC Coordinator is determined, this must be documented on the PWB 90-Day review tracking sheet.

   2. The ICC Coordinator’s duties may include but are not limited to:
a) Facilitating the planning and delivery of services cross-system/multi-agency (i.e., wraparound services, TBS, education, probation, etc.).
b) Assessing the need for urgent mental health services.
c) Coordination of care to address services on the Care Plan and the Individualized Plan of Care.

3. The ICC Coordinator is typically the point of access on the Child and Family Team (CFT):
A CFT is comprised of the youth, family members and all ancillary services with the goal of successfully transitioning the youth out of the child and welfare system by way of integrating a multidisciplinary approach, that may, but are not limited to services such as child welfare, mental health, education, probation, etc. It could be that you are already participating in these types of meetings but if not, direction will be provided in the future as to how these will be formed.

VI. IHBS services in detail

A. IHBS Defined:
Are intensive, individualized and strength-based, needs-driven intervention activities that support the engagement/participation of the minor and his/her significant others to help the minor develop skills and achieve the goals and objectives of the Care Plan.

When a child becomes part of the Pathways to Well-Being subclass, Rehab services will no longer be used and replaced with IHBS instead. This is similar to what we are currently doing when referring a case for Rehab services. The primary therapist determines the need and then makes the referral for Rehab services and will now do the same for IHBS. IHBS covers both individual and family services. If an individual is psychiatrically hospitalized the provider must utilize non-billable service codes.

B. IHBS Services:
1. Medically necessary skill-based interventions for remediation of behaviors or improvement of symptoms
2. Development of functional skills to improve self-care, self-regulation or other functional impairments
3. Improve and/or educate self-management of symptoms
4. Promote the development or maintenance of social supports
5. Address behaviors that interfere with the achievement of stable and permanent family life
6. Address behaviors that impede seeking or maintaining a job
7. Address behaviors that impede with educational objectives
8. Address behaviors that impede with transitional independent living (i.e. seeking or maintaining housing and living independently).

C. IHBS vs. Rehab Services:
The major difference is that IHBS is used for PWB members only vs. children/youth who have not been identified to meet the criteria for this subclass. Services listed above are essentially the same as Rehab services as we know it.

VII. How will we implement PWB services?

A. How this might look:
1. Provider will screen all present and in-coming foster youths for PWB using the Eligibility Form. It is not necessary to document in a progress note the completion of this form. If the clinician has determined PWB eligibility prior to completing the assessment, a progress note documenting the child/youth has met medical necessity should be completed and the dated entered onto the PWB Eligibility Assessment form.

Documentation Manual for Clinician and Billing Staff, V10, January 2018
2. Once the PWB member is identified, then immediately:
   a) Add ICC and/or IHBS to the existing Care Plan, or Interim Care Plan if appropriate.
      i. This may be done by writing in ICC next to Targeted Case Management and if
         necessary, writing in IHBS next to Rehab services.
      ii. The clinician needs to initial and date the Care Plan changes.
      iii. Signatures from the youth or guardian are not necessary for updating this existing
           Care Plan.
      iv. The clinician needs to write a corresponding progress note about the Care Plan
           update and bill it as ICC.
   b) Provider will need to update the documents for coordination of care for services provided
      in collaboration with SSA and/or other programs. **Reminder: As the Care Plan and
      other documents are updated, you must notify the other programs of this update as
      part of coordination of care (e.g., WRAP, etc.) so they can also start using these
      codes.**
   c) No less frequent than every 90 days, it is required that PWB services be reviewed (only a
      progress note is required for these reviews). (See page 8 for an example of the tracking
      sheet)
      i. This service re-assesses the client’s and family’s needs and progress in treatment. It
         is a review of the Child and Family Team (CFT) Plan which is completed at each
         CFT meeting and should be conducted, at a minimum, with input from the social
         worker and client/family.
      ii. The content of the 90-Day review progress note should be similar to what we
          currently write for a 6-Month Update progress note.
      iii. This is a billable ICC service (unless the client is currently residing in a group home).
   d) In order to know when the 90-Day reviews are due, think of these as quarterly reviews
      which would usually fall between the 6-Month Update and the Annual Update review. Also
      between the Annual Update review and the 6-Month Update review. (See pages 10 and 12 for examples)
   e) When a 90-Day review falls at the same time as the 6-Month or Annual Update review
      only one progress note is needed. No need to write two separate notes. The Care Plan
      continues to only be updated at the 6-Month and Annual Update review.

B. **For the PWB members only**, the 6-Month Update/quarterly review and Annual Update/quarterly
   review (known as the 90-Day review), should be billed as ICC and **not** as an assessment service.

VIII. **When do we stop providing PWB services?**

A. Once the PWB subclass member is no longer in the child-welfare system, or no longer meets any of
   the PWB subclass criteria, ICC/IHBS services can be discontinued.
   1. The ICC Coordinator needs to complete the PWB Eligibility Form only with the following
      information: clinic name, client’s name, DOB, MRN, check “NO” in item 6 regarding client does
      not meet PWB criteria, date and sign. Support staff will enter this information in IRIS.
      Termination date will be the date on which the form was signed.

B. However, if the minor continues to be eligible for Medi-Cal and meets medical necessity for specialty
   mental health services as determined by the clinician, the minor may continue to receive mental
   health services based on their needs.

IX. **PWB “Reminders”**
1. Use the Eligibility Form to assess if a youth meets the PWB criteria (not billable).
2. ICC Services are basically the same as Targeted Case Management services. ICC billing codes are only used for those clients who meet the PWB criteria. All members of the subclass must receive ICC.
3. IHBS Services are basically the same as Rehab services. The IHBS codes should only be used for those identified as PWB members and who meets medical necessity for specialty mental health services.
4. EXCEPTIONS: ICC services cannot be billed for client’s placed in a psychiatric hospital unless it is 30 days prior to transition to home placement or discharge from psychiatric hospitalization for the purposes of coordinating care as part of the discharge planning. IHBS services cannot be billed for client’s placed in a psychiatric hospital.
   - When a client is psychiatrically hospitalized, continue to use non-billable codes.
5. When the youth is no longer in the child welfare system, complete the PWB Eligibility Form to indicate that the youth is no longer a subclass member and stop billing ICC and IHBS services. Submit form to support staff who will then enter eligibility termination date into IRIS.
6. Continue to provide mental health services (i.e. individual therapy, collateral therapy, case management, psychiatric services, rehab services, etc.) if the minor is determined to have a need for specialty mental health services, has Medi-Cal and meets medical necessity.

X. Glossary

Child and Family Team (CFT) – A CFT is comprised of the youth and family and all of the ancillary individuals who are working with them toward their successful transition out of the child welfare system. The team is comprised of the child welfare worker, the youth and family, service providers and any other members as necessary and appropriate. No single individual, agency or service provider works independently but rather as part of the team for decision-making. Child welfare workers and mental health staff and service providers work within a team environment which engages youth and families as partners in that environment. Each individual team member has their unique role and responsibilities, but they are always working as part of the team.

Core Practice Model (CPM) – The Core Practice Model (CPM) is a set of concepts, values, principles, and standards of practice that outline an integrated approach to working with children/youth and families involved with child welfare who have or may have mental health needs. It provides a framework for all child welfare and mental health agencies, service providers and community/tribal partners working with youth and families.

Foster Care Placement – 24-hour substitute care for all children placed away from their parent(s) or guardian(s) and for whom the State agency has placement and care responsibility. (Section 1355.20 Code of Federal Regulations).

Intensive Care Coordination (ICC) – a service that is responsible for facilitating assessment, care planning and coordination of services, including urgent services (for children/youth who meet the Katie A. subclass criteria).

Intensive Home Based Services (IHBS) – are intensive, individualized and strength-based, needs-driven intervention activities that support the engagement and participation of the child/youth and his/her significant others and to help the child/youth develop skills and achieve the goals and objectives of the plan.

Open Child Welfare Services Case – means any of the following: a) child is in foster care; b) child has a voluntary family maintenance case (pre or post, returning home, in foster or relative placement), including both court ordered and by voluntary agreement. It does not include cases in which only emergency response referrals are made.
Parent Partners/Advocates – Parent Partners/Advocates are key individuals who work with children/youth and families within the public child welfare, juvenile probation or mental health systems. Parent Partners/Advocates are past consumers and can convey information on how systems and programs can instill the family-centered and family driven philosophy and principles necessary to engage children/youth and families.

Rehabilitation – Per SPA #10-016, rehabilitation means a recovery or resiliency focused service activity identified to address a mental health need in the client plan. This service activity provides assistance in restoring, improving, and/or preserving a beneficiary’s functional, social, communication, or daily living skills to enhance self-sufficiency or self-regulation in multiple life domains relevant to the developmental age and needs of the beneficiary. Rehabilitation also includes support resources, and/or medication education. Rehabilitation may be provided to a beneficiary or a group of beneficiaries.

Specialty Mental Health Services – Per Title 9, Chapter 11, Section 1810.247, means:
(a) Rehabilitative Mental Health Services, including:
   (1) Mental health services
   (2) Medication support services
   (3) Day treatment intensive
   (4) Day rehabilitation
   (5) Crisis intervention
   (6) Crisis stabilization
   (7) Adult residential treatment services
   (8) Crisis residential treatment services
   (9) Psychiatric health facility services
(b) Psychiatric Inpatient Hospital Services
(c) Targeted Case Management
(d) Psychiatrist Services
(e) Psychologist Services
(f) EPSDT Supplemental Specialty Mental Health Services
(g) Psychiatric Nursing Facility Services

Therapeutic Foster Care (TFC) – TFC will be added to this manual at a later date. Further guidance and training from the State is being planned.

Wraparound – Wraparound is an intensive, individualized care planning and management process. The Wraparound process aims to achieve positive outcomes by providing a structured, creative and individualized team planning process that results in plans and services that are effective and relevant to the child and family.

XI. Informational Link:
Core Practice Model Guide for Katie A. subclass members:
# Examples of the 90-Day PWB Member Tracking Sheet

**Pathways to Well-Being Member Tracking Sheet Blank Form**

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<td>Child meets PWB criteria:</td>
<td>Child meets PWB criteria:</td>
</tr>
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</tbody>
</table>

**Pathways to Well-Being Member Tracking Sheet**

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Documentation Manual for Clinician and Billing Staff, V10, January 2018
How to implement the 90-Day Reviews

Example A:
A. This is a new case and identified to meet the criteria for the Katie A. subclass during the assessment period.
B. The case is opened May 1, 2013.
   1. The clinician will complete the Initial Assessment within the 60-Day period by June 29, 2013.
      a) During the 60-Day assessment period, the Pathways to Well-Being subclass Member Tracking Sheet shall be completed as well when the youth has been identified to meet the subclass criteria. If the client meets criteria to receive ICC and or IHBS then the CARE PLAN will include TCM/ICC and or Rehab services/IHBS.
   2. The 1st 90-Day review is due at the 6-Month Update, October 31, 2013, even though in this case it is greater than the 90-Day review period. The purpose for this 1st 90-Day review exception is to align the 90-Day review with the 6-Month Updates and Annual Updates going forward.
      a) The 90-Day review is documented in the appropriate quarterly box on the PWB Member Tracking Sheet and in a corresponding progress note to reflect progress towards the Core Practice Model objectives. This is billed as ICC.
      b) This is a 90-Day review/6-Month Update, only one note is required and this is billed as ICC.
      c) As usual procedure for a 6-Month Update; the MTP and the CARE PLAN will need to be updated.
   3. The next 90-Day review will be due 3 months following the 6-Month Update review and is due by January 31, 2014.
      a) Update the appropriate quarterly box on the Pathways to Well-Being Member Tracking Sheet and document in a corresponding progress note the progress and/or barriers during this period. This is billed as ICC.
   4. The next 90-Day review will be at the actual Annual Update review and due by April 30, 2014.
      a) The 90-Day review is documented in the appropriate quarterly box on the Pathways to Well-Being Member Tracking Sheet and in a corresponding progress note to reflect progress towards the Core Practice Model objectives. This is billed as ICC.
      b) This is a 90-Day/Annual Update, only one note is required and this is billed as ICC.
      c) As usual procedure for an Annual Update review; the MTP and CARE PLAN will need to be updated.
### Pathways to Well-Being (PWB) Member Tracking Sheet

**ICC Coordinator (Name & Title):** Candy Parker, LCSW  
**Date:** 05/01/13  
**Example A**  
**Case Opened:** 05/01/13

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<td>2nd Quarter / 6 Month Review</td>
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<td>01/31/14 for update of case</td>
</tr>
<tr>
<td>90-Day Review</td>
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<td>04/30/14 for update of case</td>
</tr>
<tr>
<td>90-Day Review</td>
<td>4th Quarter / Annual Review</td>
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Pathways to Well-Being Member Tracking Sheet
Intensive Services

DHCS put out an Information Notice (16-004) on February 5, 2016 that MHP’s are obligated to provide Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) services to beneficiaries under age 21 who are eligible for full scope Medi-Cal services and meet the medical necessity criteria for Specialty Mental Health Services. The notice clarifies that neither membership in the Pathways to Well-Being (formerly Katie A.) class or subclass is a prerequisite to consideration for receipt of ICC and IHBS, and therefore a child does not need to have an open child welfare services case to receive these services.

How Do We Determine When to Provide Intensive Services?

- All children receiving specialty mental health services are to be screened to see if they may benefit from intensive services (ICC/IHBS)
- A new eligibility form for both the Pathways to Well-Being Subclass and Intensive Services has been created which includes suggested criteria for Intensive Services
- These “criteria” are not requirements but are intended to be used as guidance when trying to determine need for ICC/IHBS services

How Do We Determine When to Provide Intensive Services?

- All children receiving specialty mental health services are to be screened to see if they may benefit from intensive services (ICC/IHBS)
- A new eligibility form for both the Pathways to Well-Being Subclass and Intensive Services has been created which includes suggested criteria for Intensive Services
- These “criteria” are not requirements but are intended to be used as guidance when trying to determine need for ICC/IHBS services

Conditions to Consider When Determining Eligibility

When determining eligibility for Intensive Services, screening the minor for the type of services or placements he/she is currently receiving or being considered is important. Below is a list of services or placements to consider.

- Wraparound/Full Service Partnership (FSP) Wraparound
- Specialized Care Rate (Therapeutic Foster Care)
- Intensive SMHS (TBS, Crisis Stabilization, In-Home Crisis)
- RCL 10+ or Foster Family Agency/Short Term Residential Therapeutic Program
- Psychiatric Hospitalization and/or discharged within 90 days
- Two or more psychiatric hospitalizations within 12 months
• Two or more placement changes for behavior within 24 months

**Child and Family Teams (CFT)**

- Since ICC, IHBS and CFTs are now available to all Medi-Cal beneficiaries, CFTs will also occur with youth who do not have open SSA cases, this includes Probation youth
- When working with a Probation youth in a CFT, the Probation officer will take the role the Social Worker normally takes (i.e. Facilitator)
- When your client does not have an open SSA or Probation case, the therapist takes on the role of the Facilitator and ICC Coordinator. The Therapist schedules/arranges the initial meetings
- The therapist will use the Client Service Plan/Care Plan in lieu of the CFT Plan

**Billing for ICC and IHBS**

- Same service function codes used for the Pathways to Well-Being subclass will be used for Intensive Services (ICC/IHBS) to the general Medi-Cal population
- Lockouts and limitations will remain in place (i.e. cannot bill while child/youth is in a 24-hour psychiatric facility)
- CFT modifier will be made available to track services provided during a CFT meeting
- IHBS can only be billed with ICC services
- IHBS services cannot be provided during the same time of day that TBS services are being provided

**CFT Facilitator**

- If there is no SSA or Probation involvement, the role of CFT Facilitator will typically be assigned to the primary therapist; however, anyone on the CFT can be designated as the Facilitator if the team deems it appropriate and consistent with the child and family’s needs and preferences.
- Most therapists engage in practice behaviors that mirror the CFT Facilitator already. For complex cases, therapists usually increase their level of engagement with the child and family, as well as other individuals or service providers who are involved with the family
Examples of Therapist as Facilitator

- The therapist meets with the child/youth and family to discuss changes in the child’s services plan due to a crisis event or intensification of symptoms. Therapist facilitates the process by which services are planned and linkages to ancillary services are made.
- The therapist collaborates with child/youth and family, as well as other services providers such as Wraparound, TBS coach, rehab worker, school teacher, etc. during a face-to-face meeting.
- Therapist tries to engage informal support person(s) and/or systems that play an important role in the life of the child/youth and family by inviting them to a meeting with the child/youth and family. Therapist directs and structures this gathering of individuals.

ICC Coordinator

- The role of the ICC Coordinator for the CFT is no different than it is for the Pathways to Well-Being subclass
- The therapist will continue to ensure that all services to the child/family are documented and coordinated with other services providers when applicable
- Activities related to service planning and coordination of services can occur inside or outside of a CFT meeting

Examples of Therapist as ICC Coordinator

- The therapist reviews progress of child/youth in treatment and makes adjustments to the Client Service Plan/Care Plan with input from child/youth and family and other service providers and support persons. (Note: Review of Client Service Plan/Care Plan should occur no less frequent than every 90 days).
- The therapist ensures that services from other providers/organizations/support persons are integrated into the Client Service Plan/Care Plan and reviewed with the CFT
- Therapist initiates troubleshooting process when access or delays to services emerge for the child/youth and family. Therapist works with service providers to address the problem.

ICC Services

Intensive Care Coordination (ICC): a service that involves facilitating assessment, care planning and coordination of services, including urgent services and carried out through the CFT process.

Service Components:
1. Comprehensive Initial and Ongoing Assessment/Reassessment
2. Development and Adaptation of the Client Service Plan/Care Plan
3. Referral, Monitoring and Follow-up Activities
4. Transition

What Do ICC Services Look Like? An ICC Coordinator serves as the single point of accountability to:

- Ensure that medically necessary services are accessed, coordinated and delivered in a strength-based, individualized, family/youth driven and culturally and linguistically relevant manner and that services and supports are guided by the needs of the child or youth.
- Facilitate a collaborative relationship among the child or youth, his/her family and involved child-serving systems
- Support the parent/caregiver in meeting their child or youth’s needs
- Help establish the Child and Family Team (CFT) and provide ongoing support
- Organize and match care across providers and child serving systems to allow the child or youth to be served in his/her home community.

IHBS Services

Intensive Home Based Services: are intensive, individualized and strength-based, needs-driven intervention activities that support the engagement and participation of the child or youth and his/her
significant others and to help the child or youth develop skills and achieve the goals and objectives of the Service Plan.

Service Components:
1. Development of positive behaviors and functional skills
2. Education of child/youth and caregivers/family
3. Developing connections with community and social networks
4. Increase behaviors that promote healthy transition towards independence

What Do IHBS Services Look Like?
- Medically necessary skill-based interventions for the remediation of behaviors or improvement of symptoms
- Development of functional skills to improve self-care, self-regulation, or other functional impairments
- Development of skills or replacement behaviors that allow the child or youth to fully participate in the CFT and service plans
- Improvement of self-management of symptoms, including self-administration of medications as appropriate;
- Education of the child or youth and/or their family or caregiver(s) about, and how to manage the child or youth’s mental health disorder or symptoms
- Support of the development, maintenance and use of social networks including the use of natural and community resources

Presumptive Transfer

To provide children and youth in foster care who are placed outside their counties of original jurisdiction, in California, access to Specialty Mental Health Services (SMHS) in a timely manner, Assembly Bill 1299 (Ridley -Thomas, Chapter 603, Statutes 2016 ) was enacted to establish presumptive transfer. Presumptive transfer means a prompt transfer of the responsibility for the provision of, or arranging and payment for SMHS from the county of original jurisdiction to the county in which the foster child resides.

The placing agency shall notify the Mental Health Plan (MHP) where the child resides through their posted single point of contact within 3-business days of the presumptive transfer decision and ensure that the foster child's residence address is updated in the Medi-Cal Eligibility Data System (MEDS) within 2-business days of making the determination. This notification shall include the following information:

a. Identifying information about the child: name, date of birth, and address
b. Name, location, and contact information of the referring placing agency
c. Name and contact information of who can sign releases of information
d. Name and contact information of who can sign consents
e. (See ACL 17-77 page 7)
f. (See ACL 17-77 page 7)

To notify the MHP in Orange County of a presumptive transfer case, please call CYPBHS Administration at (714) 834-5015

Additional Information All County Letter 17-77

- All County Letter 17-17
- Presumptive Transfer P & P 10-18-2017
GENERAL ADD-ON CODES

These codes identify an additional part of the treatment; something beyond the principal service. Add-on codes are reported in conjunction with a main/principal service and should never be reported alone.

+90785 Interactive Complexity

Interactive complexity involves factors that complicate the service delivery of a mental health procedure. This includes:

- Psychotherapy with the use of an interpreter.
- Psychotherapy which includes the use of play therapy to engage verbally underdeveloped children.

This add-on code can only be selected in conjunction with the following CPT codes as the principal service:

- 90832 Individual Psychotherapy 16-37
- 90834 Individual Psychotherapy 38-52
- 90837 Individual Psychotherapy 53 +
- 90853 Group Psychotherapy

+90840 Psychotherapy for Crisis

This add-on code is used in conjunction only with the Crisis Psychotherapy code and is used when the visit for crisis psychotherapy exceeds 74 minutes. Each additional unit, which is to be specified by the provider, allows for 30 extra minutes of crisis psychotherapy. Examples of how this add-on would be used are indicated below:

- 75-104 minutes of Crisis psychotherapy, report both 90839 as the main CPT and +90840 x 1 unit (which is equal to 30 extra minutes)
- 105-134 minutes of Crisis psychotherapy, report both 90839 as the main CPT and +90840 x 2 units (which is equal to 60 extra minutes)

**Add-On codes to be used in conjunction with medication services can be found in the medication service section.

NON-BILLABLE and NON-COMPLIANT SERVICES

As mental health providers, the scope of our services can have a wide range. On occasion, we might determine that our clients need our help, but that need is not linked to their mental illness or tied to their mental health impairments. It is ok to provide these services; it is just not ok to bill a third-party payer for providing these services. Therefore, it is important to understand what services are not billable. It is also necessary to understand when a chart is out of compliance, thereby not allowing us to charge an outside payer source for that service (such as Medi-Cal/Medicare). It is important for all services to be coded appropriately.
NON-BILLABLE SERVICES:

Non-Billable services are defined as services that an outside third-party payer would NEVER reimburse.

Non-Billable services can include but are not limited to the following:

1. Review of records (of any kind).
2. Waiting time.
3. Translating/Interpreting.
4. Clerical Services:
   a. Faxing
   b. Scheduling appointments
   c. Photocopying
5. Searching for a missing client.
6. Checking messages.
7. Leaving messages.
8. Providing transportation.
9. Supervision with a supervisor/service chief.
10. Completion of bus pass application.
11. Completion of immigration form.
12. Completion of the monthly Shelter Plus Care visit form.
13. A home visit for the sole purpose of doing a Shelter Plus Care inspection.
14. Most letter writing is not billable.
15. Services for the sole purposes of addressing anything other than the mental illness/mental health impairment. This can include solely dealing with:
   a. Substance abuse/other excluded diagnoses
   b. Health care
16. Any service while the client is in Psychiatric Hospitalization, or an Institute for Mental Disease (IMD).
   a. Exceptions to this rule:
      1. Day of admission
      2. Placement services provided during the 30 calendar days immediately prior to the day of discharge for a maximum of 3 non-consecutive periods of 30 days. These notes should be clearly labeled “Placement Services.”

Rule of thumb: If the service you’re providing cannot be linked to the mental illness or impairments caused by the mental illness, it’s probably non-billable.

NON-COMPLIANT SERVICES

Non-Compliant services are defined as services that would normally be reimbursable but because something is wrong with the chart (e.g., a failed Care Plan, late documentation, etc.) we are not authorized to submit the services for billing. Additionally, services would be deemed non-compliant if written after 14 days or longer from the date of service.

A chart can be deemed out-of-compliance for several reasons. Different payer sources require that different forms be in place in order to submit a billing to them for reimbursement. Most commonly, charts are out of compliance due to a failed Care Plan. Care Plans usually fail for the following reasons:

1. Not signed by the client/conservator/legal guardian
(Exception: If the client refuses to sign due to symptoms of their mental illness, such as paranoia or if a physical disability prevents them from signing, the plan will still pass if documented appropriately. However, mere refusal to sign because they don’t agree with the plan will still result in a failed Care Plan).

2. Does not document medical necessity or show impairment related to the mental illness.
BILLING

After a service has been documented on a progress note, it is the duty of the writer to complete the proper billing for the service provided. Clinics operating with an Electronic Health Record will encounter different methods in which the billing is submitted than with the traditional paper clinic. Although clinics are undergoing the transition between a paper world and an electronic world, the format may change but the billing requirements remain the same.

OC EHR Clinic

If you are operating in a clinic that is using the Orange County Electronic Health Record (OC EHR), the billing requirements are located within the progress note. All of the progress notes within the OC EHR contain separate billing tabs labeled as billable, non-billable, and non-compliant. It is the requirement of the note writer (you) to complete this section before exiting the progress note. Completing this required section is much like filling out an ED. Many of the questions remain the same.

Paper Clinic

If you are operating in a traditional paper clinic, no new changes are being introduced. The progress note is written on one side of a document, while the other side includes the billing information known as the “Encounter Document.” This document is often referred to as a PNED for Progress Note/Encounter Document.

The purpose of the Encounter Document (ED) portion of the PNED is to accurately code a service to obtain appropriate third-party reimbursement. Coding the ED is the process of providing complete healthcare information for each client encounter in terms that a third-party payer understands.

Other Required Information For The ED

On the ED, select the CPT code that best describes the service provided. The entire ED captures all allowable revenues associated with a visit. It is the “tool” that should guide providers to select the appropriate level of service and/or procedure and therefore includes:

Client Name, Date of Birth, MRN, FIN

Clinic Name and Address

Encounter Type (i.e., Clinic, Telephone, Home, Site, Field, etc.)

  o If Home or Site is selected then the appropriate sub-location must be selected as well.

  o Site is defined as a location with a physical address.

    ▪ Host Clinic is a place of service for site and is used when:

      • The staff person and client are both registered to the same clinic, but the service is provided at a different Short Doyle Medi-Cal clinic.

      • A service is provided at a Short Doyle Medi-Cal clinic (County or Contract) by a staff person who travelled to see the client at the client’s
assigned location (which is different from the location of the staff providing the service). A real life example would be if a clinician from the psychological testing unit conducts a psychological assessment with a client at the Santa Ana clinic.

- Field is defined as a location **with no** physical address (e.g., a street intersection).

- **Face-to-Face**: Select yes when all or part of the service was spent with client and/or family. Face-to-Face minutes should include time spent with client and/or family, when at least part of the service was face-to-face with the client.
- **Trauma**: Select whether trauma is present or not or unknown, as reported by the client.
- **Substance Abuse Diagnosis**: Select “Yes,” “No,” or “Unknown.”
- **Custody**: Select whether the client is “In” custody or “Released” from Juvenile Hall. This applies to Children, Youth and Prevention Services only.
- **Healthy Families (HF)**: Select the appropriate Healthy Families services provided. This applies to Children, Youth and Prevention Services only.
- **Diagnoses**: Two columns exist on the ED for the diagnoses. The first column should list those diagnoses that are being treated during the service “Today.” The other diagnoses that are not being treated may be listed on the second column.
- **General Medical Condition**: This should reflect the appropriate numeric code(s) for General Medical Condition.
- **For Group Use Only**: When providing service to a group of clients, document the number of clients present, the number of staff providing the service, and the name of the co-therapist. This is essential for accurate billing.
- **Date of Service**: The date on which the service was provided.
- **Service Minutes**: The time spent providing a service.
- **Document Minutes**: The time spent documenting the service.
- **Date of Documentation**: The date on which the service was documented. The OC EHR automatically captures this information and it does not have to be entered anywhere. On paper, the clinician must enter the date of documentation. An “S” can be used to indicate that a service was documented the “same day” the service was provided. Services that are documented more than 14 days after the service was provided are considered non-compliant and shall not be billed.
- **Travel Minutes**: See section entitled “Documenting Travel Time.”
- **CPT Code**: Select the appropriate code for the service rendered. The option to write in a CPT code that is not listed on the ED may be done on the space provided where “Other CPT code” is indicated on the ED. Additional CPT codes are found in the “Current Procedural Terminology” Standard Edition from the American Medical Association.
- **CPT Modifiers**: Select these codes to communicate to the payer that service or procedure has been altered by some specific circumstance, but not fundamentally changed in its definition or code.
- **Service Strategies “SS” – Modifier I**: Select the applicable service strategies provided during the service.
- **Evidence Based Practices “EBP” – Modifier II**: A recognized EBP such as Eye Movement Desensitization and Reprocessing (EMDR) or Parent Child Interaction Therapy (PCIT) should be documented in this section if the provider is utilizing such practice.
- **Add-On Codes – Modifier III**: These codes identify an additional part of the treatment; something beyond the principal service and are reported in conjunction with the main/principal service.
- **Clinician Name, License, Job Class**: This identifies specifically who provided the service.
- **Signature**: The provider’s signature is necessary to bill for the service provided.
DOCUMENTING TRAVEL TIME

Documentation of travel time is complex. The most important distinctions to be made are to define travel time versus transportation time and to understand the differences between billable travel time and non-billable travel time. In very simple and general terms, travel time is when the provider is in the car without a client and transportation is when the client is in the car with the provider and there is no service being provided.

CLINICIAN IN THE CAR WITHOUT A CLIENT:

It is considered “travel time” when a provider is in the car without a client traveling from one location to another to provide a service at that particular location. If the service that the clinician is providing is billable, then the travel time is also billable (unless the provider is traveling from one Medi-Cal certified site to another Medi-Cal certified site). If the service that the provider is providing is not billable, then their travel time is also not billable.

Travel time must be split between all billable notes for the services provided at the same location.

1. BILLABLE TRAVEL TIME: When providing a billable service a clinician can charge for travel time (exceptions listed below).

2. NON-BILLABLE TRAVEL TIME:
   a. When traveling between two certified Medi-Cal sites.
   b. When billable services are not provided.
   c. When picking up a client to bring them back to the clinic for an appointment.
      i. If a clinician picks a client up from somewhere and brings them back to the clinic for a doctor’s appointment, this should be coded as non-billable travel time. If a clinician provides a billable service to the client while in the car, then this is considered SERVICE time.

CLINICIAN WITH CLIENT IN THE CAR:

When a client is in the car with the clinician the following scenarios could occur:

1. BILLABLE SERVICE TIME: If a clinician is providing a billable service while in the car with the client (such as case management or therapy) then this time should not be considered “travel” but instead be billed as SERVICE time.

   Example # 1: [One code would be checked in this scenario]

   • A clinician went from the clinic to the client’s home in the car without a client (5 minutes – Travel time).
• Picked up the client and took them to the grocery store. During the ride the clinician spoke to the client about how to manage the client’s stress while at the grocery store (7 minutes – Service time).

• While at the grocery store the clinician assisted the client in learning how to utilize coping skills while being in crowded areas, how to communicate with store clerks, and how to continue to manage the client’s stress (30 minutes – Service Time).

• Then the clinician took the client back in the car to the client’s home and processed with the client about their experience, reinforcing the utilization of positive coping skills (8 minutes – Service time).

• The clinician then traveled back to his/her office without a client in the car (5 minutes - Travel time).

• The service was documented on the same day (13 minutes – Documentation time).

Completion of ED according to Example #1:
<table>
<thead>
<tr>
<th>ENCOUNTER LOCATION (If not clinic or PT's home):</th>
<th>123 Main Street Santa Ana, CA 92701</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Service:</td>
<td>01/01/2012</td>
</tr>
<tr>
<td>Service mins:</td>
<td>45</td>
</tr>
<tr>
<td># of Clients:</td>
<td>(5)</td>
</tr>
<tr>
<td>Face to Face mins:</td>
<td>13</td>
</tr>
<tr>
<td>Face to Face mins:</td>
<td>10</td>
</tr>
<tr>
<td>Non-bill Trav:</td>
<td>0</td>
</tr>
</tbody>
</table>

**AXIS I & II**
- Treated today: 295.30
- Treated today: n/a

**BILLABLE CPT**
- 90834 (H2015-HE) Psychotherapy 30-52 min

**NON-BILLABLE CPT / NON-COMPLIANT CPT**
- n/a

**AXIS III**
- Axis VIAGF: 12
- 45

**OTHER CPT CODE**
- None

**CPT MODIFIER I** (Service Strategies)
- MS3 Supportive Education

**CPT MODIFIER II** (Evidence Based Practices)
- 01 Assert. Comm Tx

**CPT MODIFIER III** (Unusual Procedures)
- None
2. **NON-BILLABLE TRAVEL TIME:** If a clinician provides a billable service to a client and during that same visit the clinician took the client somewhere, but did not provide a service while in the car, this time is considered NON-BILLABLE TRAVEL time.

Example #2: [2 codes would be used in this scenario – a billable service code and the non-billable travel time code associated with the type of service]

- A clinician went from the clinic to the client’s home in the car without a client (5 minutes – travel time).
- Picked up the client and took him/her to the grocery store. During the ride the clinician and client only listened to the radio (7 minutes – non-billable travel time).
- While at the grocery store the clinician assisted the client in learning how to utilize coping skills while being in crowded areas, how to communicate with store clerks, and how to continue to manage his/her stress (30 minutes – service time).
- Then the clinician took the client back in the car to the client’s home. During the ride back, the clinician and the client only listened to the radio. (8 minutes – non-billable travel time).
- The clinician then traveled back to his/her office without a client (5 minutes - travel time).
- The service was documented on the same day (13 minutes – documentation time).
Completion of ED according to Example #2:

<table>
<thead>
<tr>
<th>CLINIC NAME</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Santa Ana Clinic</td>
<td>1200 N. Main Street</td>
<td>Santa Ana, CA 92701</td>
</tr>
</tbody>
</table>

**Client Identification**

Doe, Jane

**Encounter Type**

- Site Visit
- Other Comm Loc

**Face to Face**

Yes 30

**Date of Service**

01/01/2012

**Service Mins**

30

**Date of Doc**

10

**Trav Time**

15

**Non-billable**


**Axis I & II (Treated today)**

| 295.30 | |

**Axis I & II Not Treated Today**

| 90832 (H2015-HE) Psychotherapy 16-37 min | |

**Non-billable CPT**

| No Entry | |

**Axis III**

| 12 | 45 |

| 90899-113 Comp w/ MSH - Non-billable travel | |

**CPT MODIFIER I (Service Strategies)**

MS3 Supportive Education

**Additional SERVICE STRATEGIES**

**CPT MODIFIER II (Evidence Based Practices)**

01 Assert. Comm Tx

**CPT MODIFIER III (Unusual Procedures)**

None
3. **NON-BILLABLE SERVICE TIME:** The case in which a clinician would use NON-BILLABLE SERVICE time to document the transporting of a client, would be when the clinician did not provide any billable service at all with the client - solely transporting the client from one location to another. The clinician’s time to and from the location while the clinician was alone would be non-billable travel time, and the time with the client in the car would be non-billable service time (since transporting is the service that that was provided).

Example #3: [1 code would be used in this scenario]

- A clinician went from the clinic to the client’s home in the car without a client (5 minutes – non-billable travel time).

- The clinician picked up the client and took the client to the doctor. During the ride the clinician and client only listened to the radio (7 minutes – non-billable service time).

- While at the doctor’s office, the clinician waited for the client in the waiting room (30 minutes – non-billable service time).

- Then the clinician took the client back in the car to the client’s home. During the ride back, the clinician and the client only listened to the radio. (8 minutes – non-billable service time).

- The clinician then traveled back to his/her office without a client (5 minutes – non-billable travel time).

- The service was documented on the same day (13 minutes – non-billable documentation time).

**Because all the services provided were not billed, a non-billable service code would be selected. Therefore, it is unnecessary to also use a non-billable travel code.**

Completion of ED according to Example #3:
The overall rule of thumb for how to document travel time is to first figure out if you provided a billable service and then determine if the time the client was in the car was billable or not. If you are hung up on documenting travel time and your question is not answered in a scenario listed above, the best option is to consult with a knowledgeable source. This might be your supervisor or a documentation specialist such as someone in the department of Authority and Quality Improvement Services (AQIS).
DOCUMENTATION EXAMPLES

There are many different formats and strategies that can be used to write progress notes, but the essential information that needs to be contained within the note remains the same. It doesn’t matter if you are writing a PIP, SOAP or SIROP note; you need to answer the following five questions:

Who:  Who are you seeing?
Client demographic info

32 year-old SWF dx with 296.30 MDD Recurrent Unspecified.

Why:  Why are they being seen?
Add why client is here today and how that links to the Mental Health Impairment

Seen today to address client’s depressive symptoms and how they interfere with her being active in the community: socializing, working, shopping, etc.

What:  What did you do today?
Specify your interventions using as many descriptive action words as applicable

Writer processed with client about ways to cope with her feelings of sadness, hopelessness and fatigue which recently caused her to lose her job. Role played situations in which client triumphs over her feelings of hopelessness and encouraged visualization of negative feelings as small monsters that she can easily defeat. Encouraged her to continue to defeat these monsters by staying awake for at least 10 hours each day, instead of sleeping for 16-18 hours.

Response:  How did the client respond?
List the client's response to the interventions of the clinician

Client was able to process about possible coping skills with some prompting. As the session progressed she became more animated and involved. She seemed to enjoy the role play and stated that she really likes feeling victorious over her feelings. Client stated that when she envisions her negative feelings as small monsters that are afraid of her she feels powerful and strong. Her appearance was somewhat disheveled, however this was a slight improvement from past visits where client also appeared malodorous. Today, client appeared to have been showered but clothes were wrinkled and her hair appeared unkempt.

Plan:  What’s the plan?
Discuss plan of client and PC

Client will continue to think of her feelings of sadness and hopelessness as small, weak monsters and will remind herself daily that she can defeat them. She will demonstrate this by getting out of bed by 8:30am each day and staying awake until at least 8:00pm each night. PC will meet with client again in 2 weeks to measure her progress and continue to work on improving her coping skills in this area.
As shown above, the answers to the questions do not have to be overly wordy to be effective. It is best to answer in sentences that are succinct and to the point as much as possible. However, you do need to give enough information to demonstrate medical necessity and show that you provided billable interventions.

These tips really helped!!
Wow, now I can write my notes so easily!

Here are some examples of several types of notes you may encounter in a typical chart.

**Assessment**

1. **Who:** Client is a 28 year-old, Asian, Female with a dx of Bipolar Disorder, MRE Manic, Moderate.

2. **Why:** Client came in today for her initial appointment to determine if she qualifies for services.

3. **What:** Met with client and processed about the difficulties she has had over the past 6 months. Explained the Informed Consent, Notice of Privacy Practices, Advanced Directives, MHP guide to mental health services, MHP Provider list and the MHP Intake Advisement Checklist and client verbalized understanding and agreement. Explored client’s need for services and explained what services are offered. Completed the ICP with client due to her immediate need for housing and MD services. Client is currently homeless. Her symptoms of insomnia, racing thoughts and excess energy have caused her to stay up all night singing and watching TV really loudly resulting in her eviction on 4/1. She feels that she can’t control her actions and wants to resume medication to help with this (she was on medication in the past and found it helpful).

4. **Response:** Client was cooperative and somewhat hypervocal throughout the session. She was disorganized and had to be prompted to remain on topic. She did verbalize understanding and agreement with program information and feels that services will be very helpful to her. She explained that she is currently homeless after receiving multiple warnings due to her loud behavior at night. She states that she would like to get back on medication to stabilize her mood and that she needs help finding a new place to live. She is unable to do this independently due to her disorganization and racing thoughts.

5. **Plan:** Client will return to see the MD on mm/dd/year and PC on mm/dd/year. Client will collect rental applications from three places she would like to live before next appointment. PC will assist client with maintaining her focus to complete the applications in the next session as well as documenting client’s functioning with the Initial Assessment.

**Individual Rehab Service**

1. **Who:** Client is a 35 year-old, Caucasian, Male with dx of Schizoaffective D/O - Bipolar Type
2. **Why:** Drove to client's B&C for scheduled visit to address showering which he has not been doing regularly due to distracted thoughts as he often is RTIS.

3. **What:** Met with client. Spoke to client about his objective of showering more often and discussed how he often forgets to shower because he is distracted by the voices. Writer worked with client on developing some techniques that he can use to remind himself to shower (e.g., putting sticky notes on his dresser that asks if he showered today) regardless of the distractions made by the voices he hears.

4. **Response:** Client sat a few feet apart from writer and appeared disengaged. At times, he would respond to writer but often was observed mumbling to himself. When asked about that, he reported he wasn't talking to anyone. Client did agree to try to take showers more often and said he would use the note idea.

5. **Plan:** Client has planned to go from only taking 1 shower a week currently with prompting, to at least 1 without prompting during this next week. Writer will follow up with client in 2 weeks to see if he has achieved his goal and will continue to address this need.

**Psychotherapy**

1. **Who:** Client is a 23 y/o, SWF with diagnosis of Unspecified Anxiety Disorder.

2. **Why:** Met with client to address anxiety which impairs client’s ability to communicate with others.

3. **What:** Met with client at her B&C to talk about ways to decrease her anxiety. Client seemed sad today and reported to writer that she has been feeling "bad" about an incident with her roommate. She stated that she left her hairbrush on her roommate’s bed and the roommate got mad at her. Client reported being worried that the roommate was still mad with her and that she might get kicked out of the B&C for causing friction in the house.

4. **Writer provided client with relaxation techniques such as deep breathing and counting to 10 and encouraged her to use these techniques when she is feeling that way in the future. For this matter, writer provided reality testing with her to determine whether or not anyone was truly mad or if it was her anxiety that was causing her to feel this way. Also discussed communication techniques that client can use if she is worried that others are angry with her. Introduced concept of journaling with client as an outlet for her anxiety.**

5. **Response:** Client appeared able to process the reality testing and reported to writer that no one was saying anything bad to her and began to realize that others probably weren't mad at her. Client was very alert and articulate, but still reported feeling somewhat uneasy even though she knew they were no longer mad.

6. **Plan:** In combination with the deep breathing and counting to 10, client will start to use a journal from today forward each time she feels anxiety. Client agrees to document how she is feeling, why, and write some ways that she might be able to change her feelings. Writer will check-in with client within the next two weeks to follow up on her use of journaling as well as deep breathing and counting.

**Case Management Service**

1. **Who:** Client is a 35 year-old, SAM with dx of Schizoaffective D/O - Bipolar Type
2. Why: Met with B&C Operator following visit with client in an effort to coordinate services.

3. What: Talked with B&C operator about client’s showering and passed along his goal of trying to take 1 shower in upcoming week without any prompting from B&C operator. Also inquired about his distracted thoughts and RTIS. B&C operator reported that client typically sits on couch and "talks to himself" while others are in the room. Encouraged B&C operator to not remind him of showering this week and report back to writer if client was able to take shower without prompting. If unable to take shower on own, by 8/22, then B&C operator will prompt client and report to writer.

4. Response: Client not present for this discussion.

5. Plan: B&C op to monitor client and not prompt with showers this week to see if client can remember on his own.

**Crisis**

1. Who: Client is a 49 year-old, MAAM with dx Unspecified Anxiety Disorder

2. Why: Suicide/Risk Assessment after client revealed being suicidal in therapy session today.

3. What: During today's session with client, he revealed to writer that he was feeling suicidal. Inquired more about these thoughts (plan, intent, and means). Writer provided a thorough suicide and risk assessment. Client indicated that he was just feeling like he didn't care about anything and was "tired of being anxious about everything" and said that he felt like a burden on his family. Writer provided empathy and attempted to get client to understand that this feeling would pass and that it's normal to feel like nothing is going to get better. Client continued to express that he didn't care and at times was visibly upset, crying. Client did have a plan to get a gun and "just end things," but reported that he did not currently own a gun or have means to a gun.

Client agreed to be hospitalized voluntarily. Writer phoned client's mother while client was sitting with writer. Explained situation. She indicated that she was just outside in the parking lot waiting for client and agreed to take him to the hospital. Client's mother came in while writer was still talking with client and writer gave her the options of hospitals that will take his insurance.

4. Response: Client appeared sad and frustrated about his anxiety. At times, client was crying. At other times, client just sat with his head down. Client always answered questions when prompted and was agreeable to short-term psychiatric hospitalization.

5. Plan: Client planned to leave this meeting today and check into the hospital in Santa Ana. Writer will follow up with client after he is admitted and formulate follow up plan.

**RN Injection**

1. Who: Client is a 50 year-old, single, Iranian, Female diagnosed with Paranoid Schizophrenia.

2. Why: Client came in today for her ongoing injection.
3. What: Injection given for Haldol Decanoate 100mg. Injection site is the left gluteal and there were no signs/symptoms of redness, abscess or pain at the site. Educated client on medication compliance. Questioned client about side effects, SI/HI, delusions, AH/VH.

4. Response: Client was pleasant and cooperative, oriented x3, denies alcohol/drug use, has appropriate affect and no abnormal movements. Client denied any side effects and has no questions, she understands indications. Client denies any SI/HI, delusions or AH/VH.

5. Plan: Client will take all meds as prescribed and return for her next injection on \textit{mm/dd/year}.

**MD Service**

1. Who: Client is a 23 year-old S/V/M diagnosed with Schizophrenia.

2. Why: Client came in for ongoing medication monitoring.

3. What: Assessed med adherence, treatment compliance and side effects. Evaluated thought processes, content and response to internal stimuli. Educated client on risks, benefits and alternatives to medication. Encouraged client to avoid ETOH/MJ/Drugs to remain safe from interactions, encouraged substance abuse meetings, Wellness Center, NAMI, Healthy Diet, Exercise, MTP compliance and made sure that client knows he can call 911/CAT/Go to nearest ER if he has an emergency. Prescribed Abilify 15mg 1po qd and Vistaril 50mg 1po qhs. More than 50% of the visit included counseling and/or coordination of care.

4. Response: Client states that he is taking meds as prescribed and is tolerating Abilify well, denies any SE. Client is well dressed, cooperative and his thought process is more organized today. He denies any AH/VH or delusions, affect is bright, speech is clear and spontaneous with a normal rate. Client has no psychomotor agitation, fair insight and fair judgment. Client verbalized understanding of risks/benefits and alternatives to medication and denied any ETOH/MJ/Drug use. Overall, client states that he feels “much clearer” but is still not attending any classes due to disorganized thoughts. Client also states that he does not feel able to attend any support groups at this time because he lacks the ability to plan out his attendance. This is something that client will work on with PC. Client verbalized understanding of the importance of a healthy diet, exercise and MTP compliance as well as the procedure to contact CAT, go to the ER or call 911 in an emergency.

5. Plan: Client will take all medication as prescribed and will return to see MD on \textit{mm/dd/yyyy}. 
### Action words commonly used in MHS notes:

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<td>Prioritize</td>
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<td>Resolved</td>
<td>Responded</td>
<td>Reviewed</td>
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<tr>
<td>Role Played</td>
<td>Set Limits</td>
<td>Structured</td>
<td>Summarized</td>
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### Action words commonly used in CMS notes:

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<td>Explained</td>
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<tr>
<td>Followed Up</td>
<td>Gathered</td>
<td>Helped Plan</td>
<td>Informed</td>
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<td>Inquired</td>
<td>Instructed</td>
<td>Linked</td>
<td>Referred</td>
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<tr>
<td>Simplified</td>
<td>Talked About</td>
<td>Taught</td>
<td>Trained</td>
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FORMS

There have been many questions about how to document and bill for a variety of forms that our clinical staff often complete. It is necessary to keep in mind that what is actually done and how that is documented will impact whether or not the activity is billable and what code should be selected.

Remember that under regulations (TITLE IX), Targeted Case Management (TCM) services include:

“Services that assist a beneficiary to access 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.”

Not all services qualify as case management, nor will all forms that the provider completes meet the definition above. Therefore, the completion of a form will not always be billable.

If the clinician is billing for the completion of a form, a copy of the form completed should be filed in the chart. In the event that the service was completed in the field, or if some other circumstance prevents the clinician from putting a copy of the completed form in the chart, the progress note should detail the content(s) of the form and indicate the reason why a copy could not be placed into the chart.

FORM COMPLETION:

Typically, the completion of a form can be billed if the following requirements are met:

- Clinical expertise is required in relation to the client’s mental illness.
- The note meets all the requirements for notes.
- The form is completed.

REFERRALS:

Referrals to services are covered under Targeted Case Management (TCM) if:

- The Care Plan clearly shows impairment in the area in which the referral is being provided.
- The note meets all documentation requirements.
- The referral form is completed.
CONSENTS

INFORMED CONSENTS

In general, it is an expectation that the client or his/her legal representative will sign an informed consent before any services are provided. An exception may be in the case of crisis services in which the clinician may not be able to obtain an informed consent. If the client refuses to sign the informed consent the reason for the refusal should be clearly documented.

CYPBHS: Therapists are expected to obtain a new informed consent signed by the client soon after the consumer turns 18 years old.

MEDICATION CONSENTS

Psychiatric services that involve the prescription of psychotropic medication require the client or his/her legal representative to sign an additional consent for medication. Consents for medication should list the specific medications to be prescribed and their corresponding dosage ranges.

To manage psychiatric conditions, dependents of the court will require the authorization/consent of the judge prior to the administration of any psychotropic medication. Medication consents will remain valid if the client transfers to another clinic within the same legal entity.

CONSENTS FOR RETURNING CLIENTS

If a client discharges and returns for services at any point in time, a new informed consent and new medication consents shall be completed.

LANGUAGE APPROPRIATENESS OF CONSENTS

Treatment consents must be in the client’s primary language or have a clear statement as to the fact that it was translated to the client, with the date on which it was translated and the name of the person who did the translation for the client.

AUDIT CONSIDERATIONS

In an internal audit of Medi-Cal reimbursable services, should the informed consent or medication consents be missing from the chart, services would not fail. Clinicians are expected to obtain the consents, but services rendered will still be billed.

In the case of a disaster and scanned consents are unable to be viewed, services provided will not be recouped. Our goal is to provide services as needed.
LANGUAGE LINE

Policy

So often one hears how language can be a barrier for people seeking services and oftentimes the individual making the call or seeking services is doing so for the first time. Taking this step can be scary and the person may be feeling vulnerable, this is why we need to take the necessary steps to assess the individual’s needs, even when they may speak a language other than English.

For this reason, all our staff members have access to the Language Line, through Language Line Services Inc., at 1 (844) 898-7557 to help assess the individual’s needs. Remember that when helping the individual, it is your responsibility to make a risk assessment to ensure the person is not in imminent danger.

Procedure

Over-the-telephone Interpretation Services – For County AND Contract Clinics

Use when a client that has been identified to communicate in a language that you do not speak, and you have exhausted all internal office resources:

- Dial 1 (844) 898-7557 (Language Line Services Inc.)
- Indicate: language needed
- Input: 4 digit unit number
  - To obtain your 4 digit unit number
    - Contact your Service Chief or Supervisor
  - Retain the 4 digit unit number for future use
- Provide: caller’s name, telephone number (please do not provide personal number)

- Interpreter’s name and ID # should be documented in the client’s record
- Brief the interpreter and give any special instructions
- Keep a separate log which includes:
  - User Name
  - Date of Call
  - Time of Call
  - Approximate Call Duration

On-site (in-person) requests – For County Clinics ONLY

- Complete the Onsite Interpreter Request form (can be obtained from Service Chief or Supervisor)
- Email to: onsiterequests@FluentLS.com

*Contract clinics should utilize their individual vendors for on-site interpretation services.
Important information

Working with an interpreter – At the beginning of the call, briefly tell the interpreter the nature of the call. Speak directly to the limited English proficient individual, not to the interpreter, and pause at the end of a complete thought. Please note, to ensure accuracy, your interpreter may sometimes ask for clarification or repetition.

3-way call – Use the conference feature on your phone, and follow the instructions above to connect to an interpreter. If you are initiating the call, get the interpreter on the line first, then call the limited English proficient individual. If you are receiving a call, ask the caller to “Please Hold,” and then conference in the interpreter.
ADJUNCT SERVICES

CHILD ABUSE SERVICES TEAM (CAST)

CAST is a county public-private partnership of Orange County’s Social Services Agency, the Health Care Agency, the District Attorney’s Office, and the non-profit Orange County Child Abuse prevention center. It was formed to decrease the trauma for abused children and their families by offering a coordinated child-friendly approach to child abuse investigations. CAST conducts forensic interviews and forensic medical examinations, provides expert legal testimony, and supports victims and non-offending family members with mental health crisis intervention services and voluntary child advocacy services.

The Health Care Agency, Behavioral Health, Children and Prevention Services has two therapists out-stationed at the CAST facility. CAST therapists are there to provide mental health services to the children and families who are served at CAST.

What do the CAST therapists do?

The overarching goal of the therapists at CAST is to assure that children begin the healing process. Specific responsibilities of the therapists are as follows:

- To provide mental health crisis intervention services to children and non-offending caregivers.
- To assess the mental health needs of CAST clients and provide treatment services or refer children and families to appropriate services in the community.
- To maintain current lists of qualified treatment professionals throughout the local community and facilitate collaborative relationships with those providers in order to maintain a sufficient referral base to meet the needs of all CAST clients.
- To be available to the rest of the CAST team for consultation and feedback regarding how to best respect the emotional needs of children during the forensic investigation process.
- To conduct trainings for other CAST team members on the effects of abuse on children and the mental health needs of child abuse victims.
- To conduct trainings and presentations for other practitioners and community agencies on the effects of abuse on children and the mental health needs of child abuse victims.
- To collaborate with other CAST team members to deliver presentations on the CAST program and host tours of the CAST facility.

CONTINUING CARE PLACEMENT UNIT (CCPU)

The CCPU is unit of clinicians who are co-located with the Social Services Agency Children and Family Services division, working with children and youth in the foster care system. Four CCPU clinicians provide intensive case management and consultation services and seven clinicians provide mental health treatment services in the Multidimensional Treatment Foster Care (MTFC) program.
What do CCPU case managers do?

The first thing they do is to consult with the SSA case carrying Social Worker to develop a plan based on the individual child's needs. The CCPU Clinical Staff will maintain contact with the Social Worker throughout the implementation of the plan. The plan might include any of the following:

- Participate in team meetings (and TDMS) in order to help coordinate all components of a child’s care.
- Work on improving continuity of care when children change placements and/or service providers by making sure that essential information about mental health treatment needs are communicated to the new providers.
- Assist in clarifying a child’s mental health diagnosis and determining treatment needs.
- Link the child and caregivers to mental health services, both in and out of county, as needed.
- Assess substance abuse problems and provide linkage to services as needed.
- Consultation and assistance regarding children psychiatrically hospitalized, both in and out of county.
- Meet with a child and caregiver in order to assist the caregiver to respond more effectively to the child’s mental health needs, sometimes assisting in developing a behavior management plan.
- Meet with a child periodically to encourage cooperation with caregivers and treatment providers.
- Review psychological testing reports, clarify what they mean and advise regarding any further assessment that may be needed.

Link an emancipating youth to the mental health services they will need after emancipation (this includes the ability to keep the case open for a brief period after dependency is terminated in order to make sure the youth is successfully linked to the needed services).

What is Multidimensional Treatment Foster Care (MTFC)?

Multidimensional Treatment Foster Care is an evidence-based community treatment model that is an alternative to more costly group home or other residential treatment settings for youth who are dependents of the Orange County Juvenile Court. Orange County implemented MTFC in 2004 as a joint project of the Social Services Agency (SSA) and the Orange County Health Care Agency Behavioral Health, Children, Youth and Prevention Services. Seven clinicians in the CCPU program provide the mental health treatment services that are an integral part of this model.

The Multidimensional Treatment Foster Care model was developed by the Oregon Social Learning Center in Eugene, Oregon in 1983. The model is based on over 20 years of longitudinal research on the development of antisocial behavior and the manner in which a child's living environment influences behavior, attitudes and emotions, the developers of MTFC came up with a model that involves surrounding a child with an environment that prevents the development of antisocial behavior and promotes the development of positive skills and behaviors that help the child to be successful at home, at school and in the community.
The ultimate goal of Multidimensional Treatment Foster Care is stabilization and reunification with a parent, relative or other permanent caregiver. This is accomplished by providing:

- Close supervision
- Fair and consistent limits and predictable consequences for rule breaking
- A supportive relationship with at least one mentoring adult

The intervention is multifaceted and occurs in multiple settings. The intervention components include:

- Behavioral parent training for MTFC treatment foster parents
- Skills training for the youth
- Family therapy for the biological (or reunification) family
- Individual therapy for the youth
- School-based behavioral interventions and academic support
- Psychiatric consultation and medication management when needed

**THERAPEUTIC BEHAVIORAL SERVICES (TBS)**

**What is TBS?**

- Intensive one-to one, short term treatment intervention for children and youth with serious emotional problems or mental illness:
  
  ✓ Who are experiencing a stressful transition or life crisis **AND** are currently placed in a Level 12 (or higher) placement; **OR**
  
  ✓ Who may be placed in a Level 12 (or higher) group home **AND** who need additional short-term support **EITHER** to prevent placement in a Level 12 – 14 group home, or in a locked mental health facility, or to facilitate a transition to a lower level of residential care including return to a home

*Note: Consideration of placement into a Level 12 (or higher) group home may be only one possibility among many for the child’s placement.*

**What does TBS do?**

- Helps create specific coping skills (squeezing stress balls, taking space, sports, wrapping in a blanket, creating safety area, writing in journal, listening to music, exercising, drawing, reading)

- Teaches relaxation exercises (deep breathing, progressive relaxation, meditation)
• Assists the client and/or caregiver in praising/reinforcing for the absence of behaviors and/or progress
• Promotes positive communication skills
• Increases client knowledge and use of community resources
• Teaches clients how to set and organize priorities
• Develops token economies to reward for behavioral changes and use of coping skills
• Teaches client/caregiver to recognize trigger events that promote problem behaviors and how to intervene early to prevent problem behaviors.
• Teaches client and caregiver to recognize client’s strengths
• Teaches client and caregiver to maintain consistency and follow through
• Especially for TAY (Transition-Aged Youth, ages 18-21): teaches clients how to assess their own needs and access resources to increase their independence such as vocational training and job placement
• Assists clients to access positive social environments: clubs, NAMI, churches, YMCA, etc.

Who is eligible for TBS?

• Under 21 years of age
• Have Full Scope Medi-Cal or be eligible for these benefits
• Meets medical necessity for EPSDT services
• Be a member of the class that is eligible for this benefit:
  ✓ Hospitalized for psychiatric reasons within the past 24 months, or currently residing in a Level 12 or 14 group home, or
  ✓ In danger of being placed in a Level 12 or 14 group home, or
  ✓ Has previously received TBS while they met at least one of the three conditions mentioned above
• Must not be currently residing in a psychiatric hospital, Juvenile Hall or comparable facilities.

How are TBS services requested?

• To apply for TBS, the mental health coordinator for the case (i.e., therapist or case manager) makes a referral for TBS. SSA Social Workers can also apply for TBS
• For County programs and contractors without a TBS program, referrals are made to the TBS Oversight Office
• Referrals for TBS to the TBS Oversight office can be submitted via mail, fax or PHI-protected email. Referrals are then outsourced to our TBS provider agencies

• For contract programs with TBS, the primary therapist at the agency makes the referral through the agency’s TBS coordinator

**What are the requirements for overview and clinical consultation in regards to TBS?**

• The primary therapist on the case provides regular and active clinical direction to the TBS coach. Weekly face-to-face meetings are preferred.

• TBS is not a stand-alone service; so there must be other services being provided (i.e., individual therapy, medication or case management)

• No TBS case can be opened unless a county or contract clinic has an open case for the client

**Special note:** The following situation requires TBS Oversight Office consultation and approval: when the coach is providing more than 20 hours of TBS per week and/or cases that are expected to exceed 4 months duration.

**Billing reminder:** Billings for TBS assessment, plan development and mental health services with family or other is billed under TBS Service Function Code 58. Case Management and Consultations continue to be billed to Service Function Code 01.

**Other reminders:** Contractors bear full responsibility for determining TBS class membership, service need and documentation of medical necessity.

**WELLNESS RECOVERY ACTION PLAN (WRAP)**

Wellness Recovery Action Plan (WRAP) is described as a structured system that helps individuals track uncomfortable feelings and behaviors and develop planned responses to reduce, modify or eliminate these feelings and behaviors. WRAP was developed by a group of individuals who were trying to find their own ways of effectively dealing with their mental health issues. A WRAP also acts as a plan that can tell others what an individual needs when the individual feels so badly that they cannot make decisions for themselves and need support to stay safe. WRAP is used all over the world to support people with struggling with challenges including (but not limited to) trauma, depression, anxiety, substance abuse, post-traumatic stress disorder as well as physical health concerns such as diabetes. WRAP supports individuals with maintaining their wellness and taking control over their lives. WRAP is based on empowerment and personal responsibility and it takes a holistic approach to recovery which encourages a focus on wellness and strengths rather than on what is not going well.

**Documentation Requirements:** The requirements are the same as for other outpatient programs. An Initial Assessment and Care Plan must establish medical necessity before any services can be billed for. Timelines are the same unless individual programs have specific requirements. WRAP programs may develop their own assessments and Care Plans; or they may request the assessment from the consumer’s primary therapist and develop their Care Plan. Please contact your service chief or program director for specific requirements.
SPECIALTY PROGRAMS

Crisis Stabilization Unit (CSU)

Crisis Stabilization Unit (CSU) provides emergency psychiatric evaluation and crisis stabilization to adults ages 18 and older on a 24-hour, 7-day per week basis. Crisis stabilization includes crisis intervention, medication administration, consultation with significant others and outpatient providers, and linkage and/or referral to follow-up care and community resources. CSU provides telephonic psychiatric consultation for community emergency rooms and other county operated and contracted program staff requesting access to CSU or inpatient psychiatric services in the community. The goal of this service is to refer clients to the most appropriate non-hospital setting when indicated, and to authorize individuals to psychiatric inpatient units when the need for this level of care is present.

Due to the nature of the services at CSU the documentation is quite different than in the clinics. The following guidelines demonstrate the documentation requirements at CSU:

1. The arrival and discharge dates and/or times on the IRIS input sheet should match the arrival and discharge dates and/or times on the progress notes and Discharge Summary.
2. The length of stay must be accurate and match on the progress notes, the IRIS form and the Discharge Summary.
3. The maximum length of stay is 20 hours. If the stay is more than 20 hours then the excess time is non-billable. If the length of stay includes a fraction of an hour you will round down for 29 minutes or less and round up for 30 minutes or more.
4. The date of service should match the arrival date.
5. All forms should be signed by the relevant staff and dated.
6. Progress notes are written in a continuous format, beginning with the date and time and ending with a signature and title. The initial entry or the MD note should show medical necessity and note why the person was admitted (DTS, DTO, and GD).
7. If progress notes indicate that restraints were used then a restraint log should be present and entries should be made every 15 minutes until the restraint is completed.
8. If the client is voluntary there should be an informed consent. If the client is involuntary there should be a completed 5150 form in the chart.
9. The client should sign a med consent for any medication that they receive unless it is in a crisis situation. In this case, the progress note should justify the need for the medication.
10. Clients are required to have an included diagnosis which should be documented consistently in the progress notes; IRIS input form, MSE and Discharge Summary.
THINGS TO REMEMBER

As you may have noticed from reading this documentation manual, chart documentation can be very complex and is sometimes a confusing subject. There are many nuances and several regulations and guidelines to follow. Below is a list of things that may or may not have been mentioned in other areas but are worthy of reiteration.

1. All services should be billed based on the actual number of minutes provided.

2. All services coded and documented should be provided within the provider’s scope of licensure or practice.

3. When correcting errors or amending the document, please remember:

   **Paper Chart:**
   a. **White-out should not be used** on any document in the chart.
   b. Place one single line through the item you wish to remove/correct.
   c. Write “error” and/or “addendum.”
   d. Initial the correction.
   e. Date the correction.

   **Electronic Health Record:**
   Modifying a progress note
   1. On the BH Outpatient Summary page of the client’s chart
   2. In the Clinical Documents widget, select the desired progress note to modify; click to open the Text Rendition of note
   3. Right click on the document; Select the Modify from the menu for progress note form to appear
   4. Make necessary changes and re-sign the form
      • In Form Browser the changes made will change the Status of the document from “Auth/Verified” to “Modified.” The Text rendition of the document will show “Document Has Been Updated” in **red** text
      • The text rendition of a Modified form may display in a different order than it was originally created
      • Changes made will cause a redaction of the previous display on the Text Rendition; showing the original documentation redacted and the new documentation and date changed.
      • Performed on: This date should NOT be modified by the user on the progress note:

         ![Image of the text rendition of a Modified form](image)

         • Documentation (only) changes do not cause a Credit/Debit of the service of the progress note as seen in Charge Viewer.

         ![Image of charged service](image)
• Changing the CPT Code, minutes or if the service changes billing on either the Billable or Non-Billable Tabs or the Non-Compliant tab will cause an automatic Credit and Re Debit of the service in Charge Viewer.

Modifying a Saved (In Progress) progress note or PowerForm Document
1. On the BH Outpatient Summary page of the client’s chart

2. Select Form Browser from the Table of Contents
   a. In the Sort by: dropdown menu, select ‘Status’ to sort by status types

3. ‘In Progress’ sorts to the top (Saved)

4. Select the document to be Modified that was previously “Saved”

5. Right-click the selected form and choose Modify to open the form; document opens

6. Performed on: date does not change and should NOT be modified by the user

7. Make necessary changes and Sign or re-save the form:
   a. Signing (clicking on green Checkmark) changes the Status of the document from In Progress to Auth/Verified

4. Once an item is placed in the chart (EHR) it is considered part of a legal document. Any change made to the document should be made according to the practices indicated above.

5. Signatures
   a. Sign with your license. Non-licensed staff should sign with their title.
   b. Your signature and license/title will need to be legible.

6. 14-Day Policy
   a. Within BHS, it is expected that services rendered are documented and entered within 72 hours. However, there will be times in which the documentation exceeds the 72 hour expectation. While BHS will allow for different day documentation (DDD), **no content changes can be made to a progress note after 14 days from the date the service was provided.**

   - If your note was **written after 14 days from the date of service, it should be coded as non-compliant** (date of service is counted as day 1).
   - If a change requires that one remember what service was provided and it is after 14 days from the date of service, those changes cannot be made.
   - If a change can be made without reliance on memory, e.g., corrections to a code, corrections when signature or license type are left off, etc., these changes can be made after the 14-day mark (unless otherwise prohibited in the OC EHR).

   b. Please refer to BHS’ P&P 05.01.05 for additional guidance in regards to corrections and amendments for clinicians who have separated from BHS.

7. Initials
   a. Each page of a multi-page document should be initialed unless that page is signed in full.
8. Page Numbering
   a. Each page of a multi-page document should be numbered.
   b. The omission of initials and page numbers on multi-page documents will not constitute a failure in our own internal reviews.

9. Dating and Initialing Documents
   a. When you complete a document such as the Initial Assessment or the Care Plan, you must initial and date each page.

10. Internal Audit Recoupment
    a. Once a service has been entered into IRIS for billing purposes and more than 14 days have passed since the date of service, the content of the progress note can no longer be modified. For instance during a chart audit by AQIS a progress note does not demonstrate medical necessity. AQIS directs the provider to credit back the service and to re-enter it as a non-billable service. Given that this service was already entered into IRIS the provider may not alter the content of the progress note to avoid crediting the service.

**MAJOR CHANGES**

This section of our documentation manual is where you will find major changes made to this version of the documentation manual and will be updated as versions change. The items indicated here can also be found in other areas of the document, as applicable.

**Intake Assessment Paperwork**

This refers to the Initial Assessment including the Care Plan. While the paper forms are not exactly the same as the e-forms, the content is essentially the same. The Initial Assessment includes a Psychosocial Assessment, Community Functioning Evaluation, and Mental Status Exam (MSE). The Initial Assessment and CP should be completed within 60 days of opening the case. In the event that the intake documents cannot be completed within 60 days, the reason(s) should be documented in the progress notes and services other than assessment and crisis cannot be billed.

**Use of Reference Paperwork**

A problem arises when a clinic/program uses another clinic’s Initial Assessment but creates its own CP with its own timeline. That Assessment may already be quite old. Creating a new CP can appear as if the requirement that a Care Plan be based on a thorough Assessment is not met. To accommodate this, it is acceptable to get a copy of the previous program’s full Initial Assessment and then create a new Assessment document referencing that original Assessment. The new Assessment should clearly update all changed information and confirm which parts of the previous information are still accurate. A copy of the old Assessment must be in the chart if it is referenced on the new Assessment document. If a program chooses to reference the previous Assessment (and places a copy in the chart), the program could simply write in
the appropriate sections something like, “See section 2b from Assessment dated….” instead or re-writing the same information and as long as the information is current and accurate.

When any clinic is creating the first CP in the OC EHR for a client, the full Initial Assessment must again be done in the OC EHR. This means completing a full OC EHR Psychosocial Assessment, even if an Initial Assessment was recently done on paper. This is because in the OC EHR environment uses that information entered into the OC EHR form for a number of purposes that cannot be met simply by scanning in a paper document. This does not stop the Plan Coordinator from obtaining the paper Initial Assessment and using it to fill in much of the e-forms. When this is done, the paper forms should be referenced on the e-form and the paper form scanned into the OC EHR.

Use of the Interim Care Plan (ICP), Formerly Known as the ITP or Mini CSP

The ICP has historically only been allowed for use by the first clinic starting the timeline. This will continue to be the practice whenever there is more than one clinic involved and one of those clinics is an OC EHR clinic. The only exception to this will be when two paper clinics have opened the case, during the Initial treatment episode, and both are completing their own set of intake documents, beginning with the Initial Assessment. In this situation, each clinic may use the ICP within the assessment period (the first 60 days) if services other than assessment and crisis intervention are needed.

It should be remembered what that ICP is for. It is not a routine document. It is to be used when there is a strong clinical need to provide services quickly, before the full Initial Assessment and CP are done, but after you have enough information to, at least provisionally, document that medical necessity is met. Ideally, the CP will be created before services are provided in which case an ICP would not be needed, however that is not always possible.

Contract Clinics

If a contract legal entity (LE) has multiple clinics/programs and wishes to utilize a single CP to cover all programs, this is permissible. The LE and each program must have this clearly documented in their P&Ps and the process must be implemented across all clients (i.e., it is not a client by client choice as to whether to use a single CP or for each program to have its own CP).

Revising Care Plans

CPs that require changes may be revised rather than completely re-done. It is expected that if a CP is modified with significant changes (such as a new objective, or adding a treatment intervention) the discussion of that modification with the client/responsible party should be documented in a progress note. All revised CPs maintain the same end date as when the original CP became valid.

Conversion Care Plan (CCP)

This exists only in the OC EHR. It is a “place holder” plan that is filled in by the Conversion Team that is at the clinic for the month prior to “go live.” The Conversion Team looks at the paper Care Plan that is on the chart and from that enters into this Conversion Care Plan (CCP) the types of services that have been approved on that paper plan and the date that paper plan is set to expire (a.k.a. end date).

The end date on the CCP is the “natural end date” of that particular plan OR six (6) months from the start of the go-live date at that clinic location, whichever comes first. The “natural end date” will vary depending
on what type of plan it is (regular Care Plan vs. Interim Care Plan), the program for which it was created and when it was created. Here are some examples:
### FOR THIS GRID, PLEASE USE THE FOLLOWING EXAMPLE

**Clinic Go-Live 11/17/14**  
**6 months after Clinic Go-Live 5/17/15**

<table>
<thead>
<tr>
<th>Type of plan</th>
<th>Date plan became valid</th>
<th>Natural End Date</th>
<th>CCP End Date</th>
<th>Reasoning</th>
</tr>
</thead>
<tbody>
<tr>
<td>ITP/ICP</td>
<td>3/1/14</td>
<td>4/29/14</td>
<td>4/30/14</td>
<td>Since the ICP is valid for a short period (a full Assessment is due on day 60) the CCP end date will be the same as the natural end date, plus one day.</td>
</tr>
<tr>
<td></td>
<td>(EOC start 3/1/2014)</td>
<td>(59 days from start of EOC)</td>
<td>(60 days from start of EOC)</td>
<td></td>
</tr>
</tbody>
</table>
| Annual Care Plan (aka MTP) | 4/15/14 | AOABHS: 10/31/14  
CYPBHS: 4/30/14 | AOABHS: 11/1/14  
CYPBHS: 5/1/15 | AOABHS plan would expire naturally on 10/31/14. This is before the 6 months of the go-live of the clinic (5/17/15). Therefore, the end date of the CCP is the same as the natural end date of the plan (but one day later so that the last day of the plan 10/31/14 can be billed).  
CYPBHS plan would expire naturally on 4/30/15. This is before the 6 months after the go-live of the clinic (5/17/15). Therefore, the end date of the CCP is the same as the natural end date of the plan (but one day later so that the last day of the plan 4/30/15 can be billed). |
|              | **May/November Cycle** |                  |              |          |
| Annual Care Plan (aka MTP) | 8/13/2014 | 8/12/15 | 5/17/2015 | The CCP will end date before the natural expiration date of the plan because 6 months after the go-live of this clinic (5/17/15) is BEFORE the natural expiration date of this plan (8/12/15). |
|              |                       | Due to all the EOC cycles ceasing starting 6/2014, this plan is good for one year if interventions are authorized as such. |              |          |
The need for this Conversion Care Plan is that it allows the OC EHR to immediately begin to run the system rules which will only allow services approved on the plan to be entered as billable by the clinician. Given the nature of the conversion and the confusion around the determination of the end dates, we expect and understand that there may be end dates calculated in error. If errors are found, the clinic Service Chief can amend the conversion Care Plan and make the necessary corrections.

WRAP and TBS Providers

These adjunct service providers must continue to coordinate with the referring program, obtain a copy of the Initial Assessment paperwork from the referring program, obtain information as to what is the reason for the referral (via a phone call or a rehab order). These contract providers would do their own updated WRAP Assessment or TBS Assessment in order to develop their own Care Plan. These Care Plans will now be good for 365 days once these become valid. However, because these adjunct services are based on the Initial Assessment paperwork of the referring program, coordination of care becomes extremely important. WRAP and TBS providers must ensure that the referring program does have the case opened and their required documentation in place. If the referring program is out of compliance with their paperwork, then the adjunct provider will also be out of compliance.

TBS providers: Even though the Care Plan will now be good for 365 days, authorization from the referring program must be in place for services to be provided.

If feasible, some WRAP and TBS providers could write their own Initial Assessment paperwork in addition to their own Care Plan (good for 365 days) if signed by an LPHA. This would reduce the risk of being out of compliance if the referring program is out of compliance.

Coordination of Care

Throughout this process, it will be very important to know if the client is opened at any other clinic. At the time of intake, the opening Children’s clinic will need to run a BHS EOC Information Report, previously known as a Coordination of Care Report. Adult clinics will continue to run a Client History by MRN.

In addition to the time of intake, clinics that are on the OC EHR and creating their CP for the first time will need to run the BHS EOC Information Report. The OC EHR clinic will need to know who all are involved with providing services to the same client. In the event that more than one clinic is providing care, it is extremely important for the OC EHR clinic to coordinate the care.
**TRANSITIONING BETWEEN OC EHR AND PAPER CLINICS**

**VARIATIONS of PAPER and OC EHR CLINICS**

**The following scenarios only apply to County-Operated Clinics.**

**KEY:**

= Paper Clinic  
OC EHR Clinic

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**Scenario #1: PAPER CLINIC BECOMES AN OC EHR CLINIC**

Prior to the Paper Clinic going live in the OC EHR, all existing clients will have a Conversion Care Plan (CCP) created by the OC EHR Conversion Team. The Initial Assessment will also have been scanned into the OC EHR by the Conversion Team.

The CCP will expire either 6 months after that clinic goes live or on the natural expiration date of the paper plan, whichever comes first.

Once the CCP expires, the Plan Coordinator (PC) will need to create a new, full Initial Assessment and Care Plan (CP) within the OC EHR. Once done, the new CP is good for 365 days from the date it becomes valid.
Scenario #2: OC EHR CLINIC TRANSFERS TO PAPER CLINIC

**OC EHR Plan**
- good for 365 Days

**Transfers to paper clinic.**
- Paper clinic uses OC EHR clinic’s existing plan.

**Transfers at Day 261**

**OC EHR Plan good from Day 261 - 365**

If a client is at an OC EHR clinic and transfers to a paper clinic, the paper clinic can use the existing Initial Assessment and CP from the OC EHR clinic.

- The OC EHR clinic will print out a copy of the Initial Assessment and CP for the paper clinic’s Chart.
- The OC EHR clinic needs to handwrite on the CP the expiration date of the CP.
- If the paper clinic uses the CP of the OC EHR clinic, the expiration of the CP remains the same as when the plan was originally established.

**Client transfers before COUNTY OC EHR CP expires. Paper clinic chooses to complete new Initial Assessment and CP.**

- Up to 365 Days
- New Intake & CP done.
- 65 Days

Alternatively, the Paper Clinic may choose to redo the Initial Assessment and CP all together.
- However, while the new Initial Assessment and CP are being completed, the paper clinic will have to use the CP of the OC EHR clinic already in existence.
- The Paper Clinic may not use an ICP during this period of time. Services not on the OC EHR Clinic’s CP may be added if needed during this period.
- Once the new Initial Assessment and CP are completed by the Paper Clinic, the new CP will be good for 365 days from the date that it becomes valid.
Scenario #3: AN OC EHR CLINIC LATER JOINED BY A PAPER CLINIC

The conversion process as described in scenario #1 will have already occurred to move the first clinic to an OC EHR clinic.

The OC EHR clinic will function as the PC.

When a Children’s paper clinic commences services, it must coordinate care by running a BHS EOC Information Report, formerly the Coordination of Care Report. Adult clinics will run a Client History by MRN. Upon realizing that the client is also open at an OC EHR clinic, the paper clinic must coordinate care and ask to be added onto the OC EHR Clinic’s CP.

The PC will add the services of the paper clinic onto the CP of the OC EHR clinic.

The OC EHR clinic will print and give the paper clinic a copy of the Initial Assessment and CP for the paper clinic’s charts.

The CP is good for 365 days from the date it becomes valid. When services for the paper clinic are added to the CP of the OC EHR clinic, the original expiration date of the CP remains the same.

Whenever there is a change to the CP, it is the responsibility of PC to coordinate care.

The OC EHR Clinic’s PC must ensure that all services provided by paper clinic are contained within the CP.

If the paper clinic fails to be added onto the OC EHR clinic’s CP and does not have a copy of the CP in its charts, it must mark all services as non-billable (with the exception of assessment and crisis services).
Scenario #4: TWO PAPER CLINICS

- Paper Clinic #1 will have its own paperwork, including CP. If the CP was completed before June 2, 2014, it will expire in accordance with its existing timeframe. If the CP is completed on or after June 2, 2014, it will be good for 365 days.
- During the 1st 60 days of the case opening, Paper Clinic #1 may use an ICP if services other than assessment and crisis need to be rendered.
- Paper Clinic #2, if providing services at the same time as Clinic #1, will also have its own paperwork, including CP. If the CP was completed before June 2, 2014, it will expire in accordance with its existing timeframe. If the CP is completed on or after June 2, 2014, it will be good for 365 days.
- During the 1st 60 days of the case opening, Paper Clinic #2 may use an ICP if services other than assessment and crisis need to be rendered.
- Each paper clinic will maintain its own timelines for the completion of the paperwork.
- The paper clinic that goes live with the OC EHR first will become the Plan Coordinator.
- All steps to move the paper clinic to the OC EHR will have occurred prior to the OC EHR clinic going live. For example, the CCP and a scanned copy of the Initial Assessment will already be in the OC EHR.
- The CCP will expire either 6 months after that clinic goes live or on the natural expiration date of the paper plan, whichever comes first.
- Prior to writing the new CP, the PC at the OC EHR clinic must coordinate care by running a BHS EOC Information Report and ensure that all other clinics providing services are added to the CP. This must be a standard practice every time a Plan Coordinator is writing the first electronic Care Plan.
- The PC at the OC EHR clinic will create a new, full Initial Assessment and CP. The CP will incorporate the services of the paper clinic.
- Until the OC EHR clinic completes the CP in the OC EHR, the paper clinic will continue to bill off its own existing CP.
- Once the OC EHR clinic completes its CP in the OC EHR, both the OC EHR and paper clinic will work off the OC EHR CP. The paper CP will become invalid.
- Steps for Scenario #3, as detailed above, will then occur.
Scenario #5: OC EHR CLINIC JOINED BY ANOTHER OC EHR CLINIC

- The first OC EHR clinic will have a CP good for 365 days.
- If a second OC EHR clinic opens, it must run a BHS EOC Information Report (Coordination of Care Report) or Client History by MRN.
- The two OC EHR clinics will need to decide who will be the PC.
- If the PC switches to the other clinic, the role change will need to be reflected by the Service Chief (SC) in the OC EHR.
- The OC EHR clinic that is the PC will need to add the services of the 2nd Clinic onto the CP.

Diagnosis in the OC EHR

In the County Electronic Health Record there are two terms associated with diagnoses: Problem and Diagnosis Treated Today. A “problem” is the diagnosis associated with the client and should be identified as such via the diagnosis/problems widget or the BH Diagnosis PowerForm. The OC EHR does not allow for a “problem” to be prioritized or selected as primary. In cases where there are multiple “problems,” the OC EHR will alphabetize the problems (a.k.a. diagnoses).

A “diagnosis treated today” is the “problem” (a.k.a. diagnosis) that the provider wishes to associate with the service being documented and treated on that day. The “diagnosis treated today” does allow for prioritization and it is expected that the provider will include all of the client’s diagnoses with the session’s primary diagnosis being listed as the #1 priority.

Records Review

A review of any type of records is no longer billable to Medi-Cal at any time effective May 1, 2015.

Please see examples of the activities below which are now considered to be non-billable per DHCSs directive.

- **The client was transferred to a new clinician.** The new clinician reviews the chart prior to meeting with the client as part of an assessment activity

- **The client was transferred to a new MD.** The new MD thoroughly reviews the chart to determine all the previous medications the client has been prescribed, goes through the client’s past labs to determine their reactions to the different medications and possibly reviews other significant records such as hospitalizations

- The MD or clinician reviews the last progress note just prior to a therapy session
• The clinician reviews the chart in preparation for completing an Assessment, a 6-month update or an update on the Care Plan

• The MD reviews labs and the progress notes of the clinician before meeting with the client.

• Reviewing records from the client’s hospitalization

• Reviewing IEP reports from the school as part of an assessment activity or ongoing treatment activity

• The treating clinician reviewing a psychological evaluation conducted by a psychologist

• The treating clinician reviewing a report from Social Services

Please note that the scenarios listed above are not necessarily comprehensive of all the non-billable record review activities occurring in the clinics. As such, if there are questions regarding an activity not listed, please contact AQIS or consult with your Service Chief.

Katie A. Subclass

Changes were made to the Eligibility Form and Reminders section. Please refer to the Katie A. Subclass section above for more detail.
GLOSSARY

Care Plan (CP) This is a new term for what was known as the Client Service Plan or the Master Treatment Plan.

Clinical appropriateness Defines the natural “link” that exists between the client’s chief complaint or presenting problem and the service provided during an encounter.

- Avoid “over documentation” in order to justify a higher level of service.
- For Evaluation & Management (E&M) codes, select the E&M code based on the key elements of history, exam and medical decision-making and not on the acuity of the client.
- Focus on what is clinically appropriate for the client’s problem.

The Centers for Medicare and Medicaid Services (CMS) The federal agency responsible for oversight of Medicare. Prior to June 14, 2001, it was known as the Health Care Financing Agency (HCFA).

Co-Occurring Disorder Formerly known as dual diagnosis or dual disorder, co-occurring disorders describe the presence of two or more disorders at the same time. For example, a person may suffer substance abuse as well as bipolar disorder.

Co-Therapist (or Co-Leader) vs. Primary Therapist (or Primary Leader) You are probably accustomed to using the term “co-leader” to refer to all the people leading the group. It is necessary to have one of the leaders designated as the “primary leader” and all others as “co-leader.” If one of the leaders is a M.D., a licensed Ph.D., or an LCSW, that person shall be designated as the primary leader.

Compliance Describes the goal that corporations or public agencies aspire to in their efforts to ensure that personnel are aware of and take steps to comply with relevant laws and regulations. For health care agencies compliance is the detection, correction and prevention of billing improprieties. This includes having a plan to ensure claims submitted for payment are accurate and that documentation exists for the services provided. Compliance is not optional. It is an ongoing commitment from an organization to “do the right thing.”

CPT Modifiers Under certain circumstances, modifiers are appended to CPT codes to communicate to a payer that a service or procedure has been altered by some specific circumstance, but not fundamentally changed in its definition or code.

Current Procedural Terminology (CPT) is a listing of descriptive terms for medical (including psychiatric/psychological/counseling) procedures. Each procedure has a number associated with it. This coding system is prepared and updated by the American Medical Association. It is the national standard used for billing.

Diagnostic and Statistical Manual of Mental Disorders–5 This is a manual of diagnostic nomenclature for mental disorders. It describes diagnoses of mental disorders. Each mental disorder has a number associated with it. This manual is prepared and updated by the American Psychiatric Association. It is widely used nationally for diagnostic reference.

Orange County Electronic Health Record (OC EHR) This is an extension of our current IRIS billing system which incorporates the medical record of a client and allows users to chart progress notes, Care Plans, assessment information, etc.
**Encounter Document (ED)** On this form you will document the codes for whatever service you provided, as well as a variety of other data. Every item on the Encounter Document **must be fully** completed in order for the form to be processed. No one other than the person who provided the service may complete or change the Encounter Document. (There are some exceptions to this, Reference BHS P&P 05.01.05). Changes to the ED or alternate versions of the ED must be approved by BHS administrative staff in conjunction with the Office of Compliance.

**Excluded Diagnoses** Diagnoses that are not billable to Medi-Cal.

**Face-to-Face** This refers to the time spent in actual contact with the person(s) being seen. Some billing codes (especially individual therapy) must be selected based on the face-to-face time, even if other interventions that were not face-to-face are being included in the same note. Face-to-Face time is counted as the time the provider is face-to-face with client and/or family, with at least part of the service face-to-face with the client.

**Healthcare Common Procedure Coding System (HCPCS)** These are also known as level II codes (CPT Codes are level I) and are a subset of CPT codes. These codes are alphanumeric and were “created to report services and supplies not contained in the Level I listing” (an example would be injection codes). Medi-Cal has used them extensively in the past. Medi-Cal utilized their own coding system, known as Service Function Codes (SFC). They changed over to HCPCS codes in October 2003. Service Function Codes are, however, still being used for some state reporting requirements although not for billing purposes.

**Health Insurance Portability and Accountability Act (HIPAA)** Federal legislation which mandates certain standards for any program receiving federal dollars (including Medicare, Medicaid, or Medi-Cal in CA). This addresses issues of confidentiality, electronic management of records, and other items. HIPAA mandates that all agencies use CPT codes for identifying services rendered and ICD codes for diagnosis.

**Hospital vs. Emergency Room** “Hospital” and “Emergency Room” are not interchangeable terms.

**International Classification of Disease – 10TH Edition – Clinical Modification (ICD-10-CM)-ICD CODES** The ICD-10-CM is a nationally accepted standard for diagnosis coding.

**Interactive** Psychotherapy provided by the use of physical aids and non-verbal communication to overcome barriers to therapeutic interaction between the clinician and client who has lost or not yet developed expressive language communication skills or receptive communication skills. This service is typically provided to children. Interactive includes the use of an interpreter for a monolingual non-English speaking client. It does not include a bilingual therapist working with a monolingual non-English speaking client without an interpreter.

**Integrated Records Information System (IRIS)** The computer system that captures service and billing information and bills most services.

**Medical Necessity** Medical necessity refers to the condition, symptoms, etc. that justify the need for an office visit, diagnostic procedure, therapeutic service, laboratory testing or any other service that is provided. The following are methods that will help clearly communicate the presence of medical necessity.

- Document so that no doubt is left as to why something was ordered or performed. (Documentation requirements are discussed elsewhere.)

- Provide a diagnosis that clearly validates or supports the need for performing a diagnostic, therapeutic or laboratory service.
Use “personal history of” and “family history of” diagnoses to support psychological or medical testing. Otherwise the testing may be viewed as screening in nature. Screening tests are generally not billable to Medicare and other 3rd party payers.

**Medicare** is a national social insurance program, administered by the U.S. federal government that guarantees access to health insurance for Americans ages 65 and older and younger people with disabilities.

**Medicare Abuse** Medicare abuse is legally defined as, “Abuse may, directly or indirectly, result in unnecessary costs to the Medicare or Medicaid program, improper payment for services which fail to meet professionally recognized standards of care, or that are medically unnecessary.”

**Medicare Fraud** Medicare fraud is legally defined as, “Knowingly and willfully executing, or attempting to execute a scheme or artifice to defraud any health care benefit program or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.”

**National Provider Identifier (NPI)** An identification number that is assigned to an individual (commonly referred to as Type I NPI) or to an organization (commonly referred to as Type II NPI). Under HIPAA, the NPI is the official identifier for all healthcare related electronic interactions, including billing. Every clinician who submits services into IRIS must have an NPI. The NPI is the individual provider’s, not BHS’. It is the responsibility of every provider to keep their NPI information updated with the “enumerator,” the organization contracted with the federal government to manage NPIs.

**Office of the Inspector General (OIG)** Health and Human Service (HHS) OIG is the largest inspector general's office in the Federal Government tasked with investigating fraud, waste and abuse and to improving the efficiency of HHS programs.

**Plan Coordinator (PC)** The Plan Coordinator is currently known as the Plan Coordinator or Primary Clinician. In County OC EHR clinics, the Plan Coordinator will be responsible for the Care Plan and is the coordinator of the overarching treatment episode. All clients being seen in County OC EHR clinics will have a Plan Coordinator.

**Provider Transaction Access Number (PTAN)** This is a number assigned by the Medicare Administrative Carrier (MAC) to any licensed MD, Ph.D., or LCSW who intends to bill Medicare. A single PTAN covers a provider for all Behavioral Health Services treatment locations that have been registered with Medicare. If a person does not submit any bills under their PTAN for over a year, Medicare may deactivate the number.

**Provider** Many of us are accustomed to thinking of a “provider” as a group, or a contracted agency. In this manual, provider refers to any individual who is providing direct services.

**Third-Party Payer** Typically any insurance, including Medi-Cal and Medicare, is considered a third-party payer. The first two “parties” are the provider of services and the consumer. In BHS, third-party payer usually refers to insurance coverage other than Medi-Cal or Medicare while these two payers are usually discussed by name.

**Unlisted Psychiatric Service or Procedure (90899)** A CPT code that should be used when a service or procedure is provided that does not fall into any other available code category for Evaluation and Management (E&M) or mental health services. It may also be used when unusual or special services are provided that require justification or explanation. It is something like an “other” category.

- Before using the unlisted procedure code, make certain that the service provided is not better represented by another CPT code. If you are uncertain, consult your Service Chief.
On our Encounter Document you will see 90899 with an additional number attached to it in several places. These represent several procedures that do not have a specific CPT code or are not Medicare reimbursable and so the 90899 is used. The additional number that we attach is used to help us break down the broad “other” category into smaller groupings that are required primarily for accurate billing to Medi-Cal, but also to track service times. These additional 90899-x codes are sometimes referred to as “home-grown” codes. They are internal to our billing system and not recognized or sent outside of our billing system. When billed to Medi-Cal, they are “cross-walked” by the system to the appropriate HCPCS code which is required by Medi-Cal.