DOCUMENTATION
BRAND-NEW STAFF TRAINING
DEVELOPED JULY 26, 2022

Lisa Nosal, LMFT
Utilization Review Manager
Sonoma County Behavioral Health

OVERVIEW

- Quick Overview of Specialty Mental Health Services
- Providing Services & Procedure Codes
- Progress Note Format (PIRPL) & Content
- Plan Development for Targeted Case Management
- Claiming for Services – Miscellaneous Rules
- Other Assessments
- Respectful Language & Cultural Considerations

WHAT ARE SPECIALTY MENTAL HEALTH SERVICES?

Access Criteria
Documenting Criteria
Medical Necessity

WHAT ARE SPECIALTY MENTAL HEALTH SERVICES?

California's Department of Health Care Services (DHCS) has two levels of mental healthcare for Medi-Cal beneficiaries:

Clients with "Mild to Moderate" needs

- Mental healthcare through the health centers, Kaiser, or other agencies (i.e., wherever they normally receive physical healthcare) or through community private therapists
- Part of the Managed Care Plan through Medi-Cal

Clients with "Severe" needs

- Mental healthcare through the Mental Health Plan (MHP) – that's us!
- In California, each county contracts with DHCS to provide this level of care, called Specialty Mental Health Services

WHO QUALIFIES FOR SMHS AS OF 2022?

Adults (21 years old and above)

- The client has a significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities, or is likely to develop one.

AND

- The impairment is due to a diagnosed or suspected mental health disorder, according to the criteria of the current DSM.

Children & Youth (20 years old and below)

- The client has a high risk of a mental health disorder due to specific trauma

OR the client meets both criteria below:

- The client has a significant impairment in life functioning, is likely to develop one, or is likely not to progress developmentally as appropriate, or needs mental health services the managed care plan is not required to provide.

AND

- The client's impairment or condition is due to a diagnosed or suspected mental health disorder, according to the criteria of the current DSM, or due to significant trauma placing the beneficiary at risk of a future mental health condition.

WHERE DO YOU DOCUMENT IF THE CLIENT MEETS ACCESS CRITERIA?

For meeting access criteria for Specialty Mental Health Services overall, documented in the assessment (initial, then CANS/ANSA reassessments)

- Belongs in the "Level of Care" section
- If the diagnosis isn't yet finalized, explain the symptoms or conditions that lead you and the treatment team to believe that the client qualifies for accessing services.
- Examples:

Rebekah has a diagnosis of Major Depressive Disorder, Recurrent, Severe, with severe symptoms of depression and suicidality. **DSM DIAGNOSIS**

These symptoms are causing significant impairments in her family functioning, residential stability, and employment. **FUNCTIONAL IMPAIRMENTS CAUSED BY SYMPTOMS**

She therefore meets access criteria for specialty mental-health services. **THEREFORE: SHE MEETS CRITERIA**

OR

Rebecca has significant impairments in her family functioning, residential stability, and employment. **FUNCTIONAL IMPAIRMENTS CAUSED BY SYMPTOMS**

These impairments seem to be caused by symptoms of depression and suicidality. **SUSPECTED DSM DIAGNOSIS**

She therefore meets access criteria for specialty mental-health services. **THEREFORE: SHE MEETS CRITERIA**

WHERE IS MEDICAL NECESSITY DOCUMENTED?

Even once the client meets access criteria for Specialty Mental Health Services, each individual intervention provided must be medically necessary for that particular client.

Services must be medically necessary and clinically appropriate to address the client's presenting condition. Those services are documented in progress notes. While progress notes don't have to document every single impairment or diagnosis for the client, they should be clear about what **condition** (e.g., homelessness) or **symptom** (e.g., anxiety) the intervention was addressing.

PROVIDING SERVICES

Procedure Code Definitions

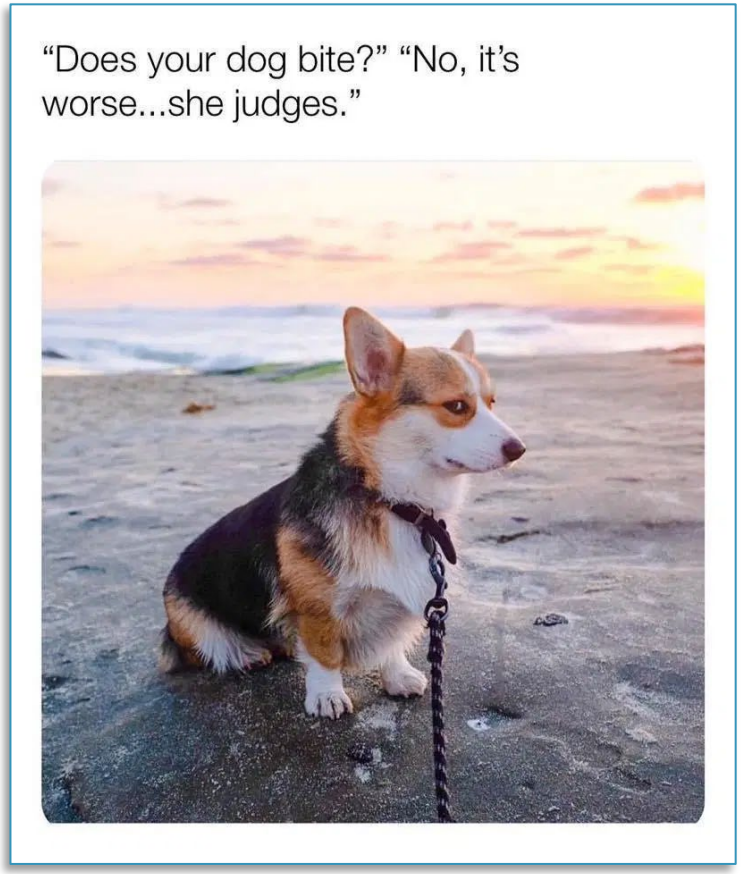
IMPORTANCE OF UNDERSTANDING PROCEDURE CODES

Procedure codes correspond to the services DHCS contracts with us to provide

They define what “Specialty Mental Health Services” are

They are the basis for understanding what types of services we should be providing for clients

331/431 – ASSESSMENT



Assessing

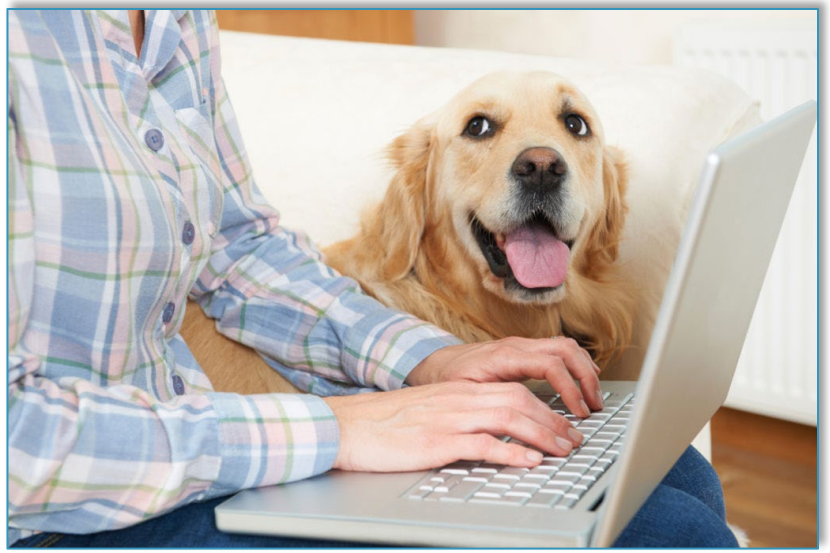
Evaluating

Determining needs

"A service activity designed to evaluate the current status of a client's mental, emotional, or behavioral health. Assessment includes but is not limited to one or more of the following: mental status determination, analysis of the client's clinical history, analysis of relevant cultural issues and history, and diagnosis."

SCSS cannot perform MSE, diagnose, gather medication history, or analyze psychosocial factors (e.g., analyze for diagnosing).

301/401 – TARGETED CASE MANAGEMENT (TCM)



Linking to

Referring to

Coordinating with other service providers

Advocating with other service providers

"Assists a client to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure client access to service and the service delivery system; monitoring of the client's progress; placement services"

If coordinating with non -service-provider, use 311/411 Collateral

303/403 – INTENSIVE CARE COORDINATION (ICC)

Linking…

Referring…

Coordinating…

- But! Only when the client
  - Is under 21 years old, and
  - Has a Child and Family Team (CFT) in place, and
  - The ICC intervention was generated through the CFT.

391/491 – PLAN DEVELOPMENT

Discussing the client's goals

Discussing what interventions might help the client achieve their goals

Discussing client's progress on goals and adjustments needed in interventions

Used primarily for Targeted Case Management Plan Development

Multidisciplinary Team Meetings often fall under Plan Development if with internal staff (use 301/401 Targeted Case Management if with another agency)

311/411 – COLLATERAL

Gathering information

Educating family members & others

Teaching/coaching skills to client and supports, or just to supports

Focus must be on supporting the *client*, not the support person

"A service activity to a significant support person in a client's life for the purpose of meeting the needs of the client in terms of achieving the goals of the client's Client Plan. Collateral may include but is not limited to consultation and training of the significant support person(s) to assist in better utilization of specialty mental health services by the client, 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 client may or may not be present for this service activity."

If coordinating with professional -level service provider, use 301/401 TCM

THERAPY

Emotional processing

Building insight

Examining behavioral and emotional patterns

Focusing on symptom reduction as way of reducing functional impairments

316/416 Family Therapy: Client *must b*e present (if not, it's Collateral)

341/441 Individual Therapy: Therapy with one client

351/451 Group Therapy: Therapy with two or more unrelated clients

Cannot be billed (or performed!) by SCSS

REHABILITATION

Skill-building

Teaching, coaching, role modeling

Trouble -shooting use of skills

"A service activity that includes, but is not limited to, assistance in improving, maintaining, or restoring a beneficiary's functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources."

511/415 – Rehabilitation Individual

514/414 – Rehabilitation Group (more than one client)

If coaching a family, use 311 Collateral

361 – MEDICATION SUPPORT SERVICES

Prescribing

Monitoring side effects

Refilling prescriptions

Discussing risks and benefits of medications

Cannot be billed (or performed by!) clinicians or SCSS. Please refer your clients to the nurse or prescriber.

371/471 – CRISIS INTERVENTION

Evaluating for a 5150 involuntary psychiatric hold

Responding immediately due to concern about escalating self-harm

Completing Suicide Risk Assessment for client currently at risk

Gathering information from family member who reported threat

De-escalating situation with potential for violence

“A service, lasting less than 24 hours, to or on behalf of a client for a condition that requires more timely response than a regularly scheduled visit. Service activities include but are not limited to assessment, collateral, and therapy.”

“Crisis” is based on provider’s clinical judgment of whether a quick intervention was clinically indicated

NON-REIMBURSABLE SERVICES

NPC (No Procedure Code)

- Academic/educational services
- Clerical/payee-related tasks
- Emailing and texting
- Personal care services
- Recreation
- Socialization without intervention
- Transportation
- Vocational services
- Supervision
- Translation/interpreting
- Mandatory reporting

299 Cancelled Appointment

300 No Show Appointment

FSP Full Service Partnership (see handout)

PROGRESS NOTES

Format & Content

PROGRESS NOTE FORMAT

P - Purpose

I - Intervention

R - Response

PL - Plan

ALL THE PARTS OF THE NOTE SHOULD FLOW TOGETHER:

Purpose: Here's the **clinical reason** I did what I did

Intervention: Here's what I did

Response: Here's how the client responded to what I did

Plan: Here's what we'll do next

EXAMPLE NOTE: INDIVIDUAL REHAB

P - (Purpose): Individual rehab to help Gareth learn emotional regulation skills.

I – (Intervention): I worked with Gareth on DBT skills for emotional regulation. We discussed whether he had been able to try out last week's new skills during the week. We did some troubleshooting in areas he reported having difficulties in. We agreed on homework for the upcoming week.

R – (Response): Gareth said that he was able to use mindfulness skills and Opposite Action to keep his anger "at a 3, rather than a 9" several times last week. He had the most trouble when talking to his father. He agreed that he should focus on times this week when the skills are easiest to use, so that he builds up confidence.

PL – (Plan): Next session in one week. I'll continue working with Gareth on emotional regulation, since he seems to be finding it useful.

EXAMPLE NOTE: TARGETED CASE MANAGEMENT

P - (Purpose): Targeted case management to help link Angelica to family therapy.

I – (Intervention): Contacted Lifeworks therapist to inquire if family therapy could be added to Angelica's individual therapy. Explained that Angelica's been reporting more conflict with her family. Described some of the recent events with the Lifeworks therapist.

R – (Response): Lifeworks therapist Diana said that she would need to double-check with her supervisor but thinks that recommending family therapy would be appropriate.

PL – (Plan): PSC will call family back tomorrow to let them know the progress of the referral. If Lifeworks cannot provide family therapy, PSC will check with Program Manager about other options.

EXAMPLE NOTE: ASSESSMENT

P - (Purpose): CANS reassessment for Wylder.

I – (Intervention): Conducted six-month CANS reassessment for Wylder.

R – (Response): No major changes since previous assessment.

PL – (Plan): Treatment team will continue providing mental health services, case management, and medication support services.

GROUP NOTES

If more than one group facilitator, one facilitator may write and sign each note

Notes for services with multiple providers must “clearly document the specific involvement and the specific amount of time of involvement of each provider of the group activity, including documentation time”

List of participants required (must be maintained separately from clients’ charts)

EXAMPLE NOTE: GROUP REHAB

P - (Purpose): Group rehab to help Gareth learn emotional regulation skills.

I – (Intervention): Session 6 of 8. I taught the entire group the new DBT skill of "Opposition Action." Co-facilitator checked with each participant on whether they had been able to try out last week's new skills during the week. Both facilitators did some troubleshooting in areas that all participants reported having difficulties in. I went over the homework for the upcoming week.

R – (Response): Gareth said that he was able to use mindfulness skills to keep his anger "at a 3, rather than a 9" several times last week. He had the most trouble when talking to his father. He agreed that he should focus on times this week when the skills are easiest to use, so that he builds up confidence. He provided insightful feedback to another participant dealing with similar issues.

PL – (Plan): Next session in one week. We'll continue working on emotional regulation skills.

BE BRIEF! KEEP NOTES CONCISE & TO THE POINT

Notes are not a transcript of the encounter, just a summary.

Include overall themes of the encounter (e.g., “family relationships,” “anxiety management,” “housing”)

- What was the main thing(s) I did?
- What are the main things the client is taking away?

Think about how does the interaction relates to what you’ve been working on.

Document any crisis behaviors, concerns, or risks (and any follow-up performed or needed).

Progress notes do not need to be written in “clinical-ese.” Use natural and conversational language. The important part is describing what you did and the clinical reasoning behind it.

PROGRESS NOTE TIMELINESS

Due within 3 business days for all non -crisis services

Due within 24 hours for crisis services

If you are late, please write the note anyway! It's important to document services, and we can submit billing late.

PLAN DEVELOPMENT FOR TCM

Plan Development Requirements
Examples

PLAN DEVELOPMENT REQUIREMENTS FOR TCM

Due to federal Medicaid regulations, Targeted Case Management (TCM) requires a plan.

The plan must be written up in a progress note, and should contain

- The client's medical, social, educational, and/or other needs being addressed with this plan
- Documentation that the client actively participated in identifying the goals
- A course of action (the plan!) to respond to the client's needs and goals
- A transition plan when a client has achieved their goals

Clients do not need to (and should not) sign the note. You just need to describe how the client was involved.

The note should use the 391/491 Plan Development procedure code.

PLAN DEVELOPMENT OUTLINE

P - (Purpose): Identify condition, symptom and/or need you're addressing with this plan.

I - (Intervention): Explain how you worked with the client (and client's support people) to develop the goal(s).

R - (Response): State the client's goal(s).

PL - (Plan): Describe the plan for what **TCM services** you think are needed to work with the client on their goal(s).

SAMPLE PLAN DEVELOPMENT NOTE 1

P - (Purpose): Treatment plan for TCM services related to Janet's residential stability.

I - (Intervention): Traveled to Janet's house. Discussed Janet's goals for housing, and what case management help she would need. Returned to CMHC Petaluma.

R - (Response): Janet said, "I want to stay consistently the same. Same routine, same medications, same home. I don't want to change anything."

PL - (Plan): Case manager will work with Janet to find an IHSS worker to help with vacuuming, dusting, and other household tasks. SCBH will coordinate with her landlord, IHSS, and other housing services to help Janet achieve her goal.

SAMPLE PLAN DEVELOPMENT NOTE 2

P- (Purpose): Treatment plan for TCM services related to Ash's goals for social, educational, residential, and family issues.

I - (Intervention): Talked to Ash about their goals and ways in which treatment team could help through case management.

R - (Response): Ash stated goals of, "I want to find places where I can make friends," "I really need to get my GED," and "I'm so tired of arguing with my family. I want to move out, or find ways to stop fighting so much." Ash said they will likely also need support in finding classes on daily living skills like cooking. They agreed that they'd like help working on these items.

PL - (Plan): SCBH to provide targeted case management to identify and link Ash to social environments (e.g., church, AA), educational resources for completing their GED, and family counseling. If Ash does decide to move out, SCBH to provide support in finding, applying for, and following up with residential options. SCBH to also work with Ash in finding and applying for classes in daily-living skills.

HOW OFTEN DO I NEED TO DEVELOP A PLAN?

Plan Development notes can cover multiple needs and goals (e.g., housing AND social functioning AND medical care)

There's no "expiration" on plans – if you and the client are still working on a goal, the plan is still in effect

New plans do need to be written up if there are new goals, or if the plan for interventions substantially changes

If you add a problem to the Problem List, that's a great time to think about whether you need a TCM plan!

Remember these are plans **only for Targeted Case Management interventions.** If the action plan for a client's goal is to provide rehab, therapy, medication support, residential care, or anything other than TCM, you do **not** need to write a Plan Development note.

If a client is not receiving any TCM services, they don't need a TCM Plan

CLAIMING FOR SERVICES

Miscellaneous Rules

CLAIMING FOR SERVICES

For services claimed by the minute, bill the exact number of minutes a service took, including documentation and allowable travel

Divide documentation for services provided on separate days into separate notes

All services provided after the death of a client are non-reimbursable (document any services – like linking the family to grief resources, etc. – with NPC code)

TELEHEALTH/TELEPHONE & WORKING FROM HOME

Telehealth: Two-way real-time audio and visual connection

- Use "Telehealth" versions of the procedure codes (e.g., 401)
- Use "Telehealth" as location (regardless of where you or the client are)

Telephone: Two-way real-time audio only connection

- Use regular versions of the procedure codes (e.g., 301)
- Use "phone" as location (regardless of where you or the client are)

Working from Home

- Use "telehealth" or "phone" location for all client contact that involves telehealth or phones
- Use "field" location for work at home that does not involve telehealth or phones (e.g., writing up an assessment interview)

CLINICAL VOICEMAILS – BILLABLE?

Leaving or listening to clinical voicemails may be billable if:

The person leaving or listening to the voicemail is a clinical staff person (SCSS, clinician/clinician intern, etc.)

The voicemail itself is a clinical task, like:

- Trading phone messages with a hospital social worker about a client's discharge placement
- Gathering collateral information left by a client's family member as a voicemail

Emails and texts (writing, receiving) are never billable. Use NPC.

ALLOWABLE TRAVEL TIME

You may claim for travel time from a Medi-Cal certified site to a non-Medi-Cal certified site and between non-Medi-Cal certified sites (except for commuting between your home and your work site). Examples:

Provider's home		Non-Medi-Cal certified site
Provider's home		Client's home
Medi-Cal certified site		Non-Medi-Cal certified site

DISALLOWED TRAVEL TIME

You may NOT claim for travel time between…

Starting Location		**Ending Location**
Provider's home	⟷	Medi-Cal certified site
Medi-Cal certified site		Medi-Cal certified site

SIGNATURES

Your professional "official" signature must always include your name as well as your professional degree, licensure, or job title

- Lisa Nosal, LMFT
- Jaqueline Rodriguez, MHRS

Your signature must be legible and/or include a typed version of your name and degree/licensure/job title

Abbreviations for degrees, licensures, and job titles are fine (i.e., "ASW" rather than "Associate Social Worker")

Electronic signatures that include all the required information are acceptable

OTHER ASSESSMENTS

Suicide Risk Assessment
Violence Risk Assessment
Post-Hospital Visit

OTHER REQUIRED ASSESSMENTS

Post-Psychiatric Hospitalization Visit (MHS 120)

- Complete within 10 days of a client's release from psychiatric hospitalization

Suicide Risk Assessment (MHS 126/Adult and MHS 808/Youth)

- Suicide Safety Plan
- Suicide Safety Support Plan
- Completed after psychiatric hospitalization for suicidality, when there's a 2 or 3 in danger to self, or when other clinical need arises

Violence Risk Assessment (MHS 620– Adult only)

- Completed when there's a 2 or 3 in danger to others or when clinical need arises
- Does not replace Tarasoff Warning

PSC-35 (Youth only)

- Completed with Initial Assessments and CANS 50 reassessment for youth

RESPECTFUL LANGUAGE & CULTURAL CONSIDERATIONS

Recovery-Oriented Language
LGBTQIA+ Considerations
Culturally Responsive Care

RECOVERY-ORIENTED AND RESPECTFUL LANGUAGE

Our job is to help people learn skills and develop supports to get better, not to judge them

Remember that unconditional positive regard is a vital element of mental healthcare

Clients are people, not diagnoses (e.g., “She’s a borderline” vs. “She has a diagnosis of Borderline Personality Disorder”)

Overly clinical and jargon-y language impedes communication

What does “high-functioning” or “decompensating” actually mean?

How will your reader know?

EXAMPLE LANGUAGE

FROM *RECOVERY ORIENTED LANGUAGE GUIDE 2ND ED.*, MENTAL HEALTH COORDINATING COUNCIL 2018

Language of Acceptance, Hope, Respect & Uniqueness	Worn-out words
• Kylie is having a rough time • Kylie is having difficulty with her recommended medication • Kylie's medication is not helping her • Kylie is experiencing unwanted effects of her medication • Kylie disagrees with her diagnosis • Kylie is experiencing …	• Kylie is decompensating • Kylie is treatment resistant • Kylie is uncooperative • Kylie doesn't accept she is mentally ill • Kylie has no insight

EXAMPLE LANGUAGE

FROM *RECOVERY ORIENTED LANGUAGE GUIDE 2ND ED.*, MENTAL HEALTH COORDINATING COUNCIL 2018

Language of Acceptance, Hope, Respect & Uniqueness	Worn-out words
• Sam is trying really hard to self-advocate • Sam may need to work on more effective ways of getting his needs met	• Sam is manipulative, irritable • Sam is demanding and unreasonable • Sam has challenging or complex behaviors • Sam is dependent
• Ash is choosing not to… • Ash would rather look for other options	• Ash is non-compliant • Ash has a history of non-compliance • Ash lacks insight

PARTICULAR DOCUMENTATION CONCERNS FOR LGBTQIA+ CLIENTS

Name in “Admission (Outpatient)” form must match Medi-Cal card

BUT!

Use the name, gender, and pronouns the client uses in your written documentation.

Be careful making assumptions about a client’s gender, pronouns, sexual orientation (or any other qualities!). “Samantha was previously married to a man” does not mean “Samantha is straight.”

CULTURALLY RESPONSIVE CARE

Be aware of your own social position and how that may be shaping your response to clients

Clinical language and models of "health" often pathologize historically marginalized populations and healing practices

Mainstream white American culture often emphasizes independence at the expense of family, results at the expense of relationships, "being nice" at the expense of discussing problems

Stay aware of your own social position, especially on axes where you hold more power and remember that simply by being a "provider," you hold power over clients

If your client holds more power than you on certain axes, please don't feel you are required to suffer abuse. Talk to your manager/supervisor.

HAVE QUESTIONS? WHAT'S NEXT?

You can email documentation questions to BHQA@sonoma-county.org

We conduct regular Pre-Billing Audits on randomly selected services, so you may get emails requesting information or corrections through that process.

New Employee documentation "spot check" about a month or so after this training.