



BEHAVIORAL HEALTH PROVIDER HANDBOOK CODING MANUAL AND DOCUMENTATION GUIDELINES

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ORANGE COUNTY HEALTH CARE AGENCY | BEHAVIORAL HEALTH SERVICES
AUTHORITY & QUALITY IMPROVEMENT SERVICES (AQIS)
QUALITY ASSURANCE AND QUALITY IMPROVEMENT DIVISION

**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:

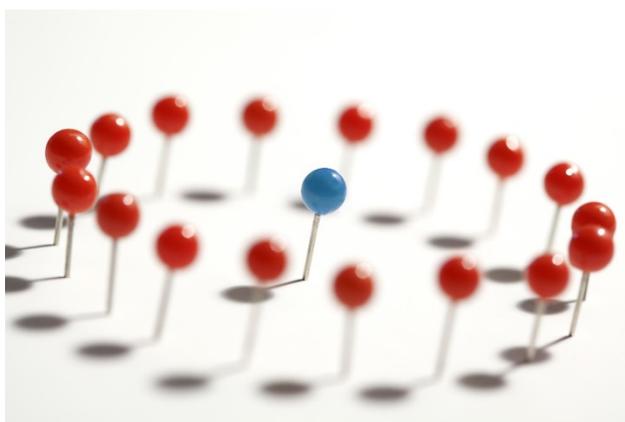
1. Rehabilitative Mental Health Services including:
 - a. Mental Health Services
 - b. Medication Support Services
 - c. Day Treatment Intensive
 - d. Day Rehabilitation
 - e. Crisis Intervention
 - f. Crisis Stabilization
 - g. Adult Residential Treatment Services
 - h. Crisis Residential Treatment 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 must meet criteria for [Medical Necessity](#) in order to bill for specialty mental health services.

Beneficiary/Client Centered Care:

The County of Orange behavioral health system is committed to providing quality beneficiary/client-centered care, which actively involves both the beneficiary/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 beneficiaries/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 beneficiaries/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 beneficiary/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 beneficiary/client and the staff's hope and belief that every beneficiary/client can develop meaningful roles and responsibilities in life. We

strive to have all interactions be positive with beneficiaries/clients and families, even in our language and tone. We hold a strengths-based perspective of moving beyond the symptoms and capitalizing on beneficiary/client's strengths. These strengths focus on areas such as strong community, family support, or natural supports, as well as acknowledging the beneficiary/client's best qualities, skill set, accomplishments and motivations. We identify beneficiary/client strengths throughout the treatment process to help overcome the barriers to reaching treatment goals.

In addition to the Recovery Model, we have integrated Trauma Informed Care, which recognizes the impact of different types of trauma in people's lives and value of providing compassionate and supportive services in a safe environment conducive to personal growth.

- **ACE Study** – The Adverse Childhood Experiences study brought attention to negative childhood experiences such as abuse and neglect and its impact on future health and functioning. The ACE screening tool may be useful for assessing and treatment planning of beneficiaries/clients who have experienced trauma
- **UCLA Child/Adolescent PTSD Reaction Index** – This is a self-report questionnaire to screen for exposure of traumatic events and assess for PTSD. It is a helpful tool to assist in ruling out or confirming the diagnosis of PTSD as the items directly links to the DSM-5
- **Real vs. Perceived Threats (safety)** – Assisting beneficiaries/clients to identify real vs perceived threats in treatment can help beneficiaries/clients reduce their level of fears, anxieties, worries and/or associated PTSD symptoms
- **Relaxation Skills** – A beneficiary/client who might be overwhelmed by a perceived threat can benefit from utilizing various forms of relaxation skills. These skills can be useful in reducing physical arousal, staying calm and resulting in better decision making.
- **Trauma Narrative** – Is a therapeutic technique to assist beneficiaries/clients to make sense of their traumatic experiences. It can aid in helping the beneficiaries/clients write their own positive story and gain control over their life
- **Reintegration** – A major component of trauma work is how a beneficiary/client can be reintegrated back into their community while managing their symptoms. This phase of treatment can assist the beneficiary/client in having a sense of normalcy



COMPLIANCE

Compliance is the responsibility of every corporation to ensure that it complies with the law. For healthcare, compliance ensures that the agency follows applicable federal/state laws and conducts business in an ethical manner. One of compliance's responsibilities is having a plan to ensure that claims submitted for payment are accurate and that all necessary documentation exists for the services provided. It is also the prevention, detection, and correction of billing improprieties.

The Health Care Agency (HCA) has an Office of Compliance, which includes a Chief Compliance Officer, Privacy Analysts, and various other staff to assist with compliance questions and concerns. Upon hire and each year thereafter, all HCA employees must complete the Annual Compliance Training, which covers agency guidance around compliance and privacy regulations. 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 mandates. 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 for which they are billing?
- 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. In addition to the New Provider Training (NPT), Annual Provider Training (APT) and Electronic Health Record (EHR) training, providers should check with their Service Chief for additional and ongoing trainings that occur within their individual clinics, supervision and staff meetings.
- 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 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 for which they are billing?

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 a billable progress note. You will not be expected to write billable progress notes for anyone else but yourself. Co-facilitated groups must now be written by each provider. The note must include: unique intervention (contribution) by each provider and also how much time they each spent intervening. If each provider is claiming the entire time, the note must indicate that the providers were intervening the whole time.

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

This manual is addressing the issue by going over the requirements and rules of documentation and service codes selected as well as addressing how to correct mistakes. You are attesting to the accuracy of the documents you completed when you sign your note or document. Every person involved in the documentation and billing of services is personally responsible for ensuring that such documentation and billings are accurate.

Can 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 it is decided that the billing code and/or the documentation need to be changed, it will be the responsibility of the clinician to change the billing code 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 the [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?

Yes, there are requirements for ongoing training of billing and review staff. Billers, coders, reviewers and certified Medi-Cal reviewers utilize DHCS audit guidelines, feedback from Triennial DHCS audits, APT annual revisions, undergo reliability reviews and attend regular training sessions.

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 - AQIS Main Line – (714) 834-5601 and to the Medical Billing Office Manager - (714) 834-6526. 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>.

In order to maintain a system that is consistent with legal and regulatory requirements, individuals should understand how the documentation and billing process occurs, as well as being informed of the 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 beneficiary/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.

1. The **HIPAA Security Rule** governs national standards for the security of electronic protected health information.
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.

HIPAA is the acronym for the Health Insurance Portability and Accountability Act passed by Congress in 1996 (federal law). The HIPAA Privacy regulations require health care providers and organizations, as well as business associates, to develop and follow procedures that ensure the confidentiality and security of protected health information (PHI) when it is transferred, received, handled, or shared. HIPAA compliance continues to be a problem 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 financial and legal penalties related to HIPAA violations. Remember that HIPAA violations don't just include inappropriate release or disclosure outside of our system; nor does HIPAA fines and penalties just relate to accessing or disclosing records. Denying **allowed access** to records is also a HIPAA violation. If a beneficiary/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 person whose PHI is breached, losing a small file or misdirection of a few faxes can rapidly escalate to significant financial and legal issues.

Note that **all aspects of beneficiary/client records** and privacy have legal implications and rules to viewing, accessing or disclosing records. If anything comes up about managing 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, there will be a greater opportunity to access information from other clinics in the electronic environment. While there will be a variety of technical safeguards in place, each staff person must understand that it is a violation of internal policies and procedures and a violation of state and federal privacy regulations to access PHI for any reason other than work-related assignments.

The following **BHS 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 PHI-General Rules](#)
- [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](#)



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

All staff must understand that when a potential problem arises in the privacy or security of records, there is usually some action required at a level beyond just the clinic's actions. 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, it is expected 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 are taken.

Privacy and EHR

On-line documentation in the EHR presents many opportunities to improve care to our beneficiaries/clients. This can include better coordination of services, easier tracking of clinical changes over time, or 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. Each staff person has access to more records in an EHR environment, including records from other clinics.

Notice of Privacy Practices and Acknowledgment of Receipt (COVID-19 FACT)

The Notice of Privacy Practices (NPP) may be verbally explained and documented and should be provided at the first opportunity. These links - http://ochealthinfo.com/bhs/about/medi_cal and [NPP Page](#) may also be provided.

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 beneficiary/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 documentation quality. **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 required under HIPAA. Be aware that a beneficiary/client has a right to revoke an Authorization to Use or Disclose Protected Health Information (a.k.a. release of information) for all or part of their patient record per [Administrative P&P-Compliance & HIPAA IV-7.04](#).

If the beneficiary/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 access the medical records about their minor child, as long as it is not **inconsistent with State or other laws**. 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 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 consent under the law, the **minor must authorize** the Authorization to Use or Disclose Protected Health Information (a.k.a. release of information) even to their parents or guardians.

FRAUD, WASTE, 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 beneficiary/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 Beneficiaries/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 Internet and/or in the P&P manual at your clinic.

Behavioral Health Services (BHS)

<https://www.ochealthinfo.com/bhs/pnp>

Adult and Older Adult Behavioral Health Service (AOABHS)

<https://www.ochealthinfo.com/bhs/pnp>

Children, Youth & Prevention Services (CYPBHS)

(Check with your Service Chief for copy)



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 Billing

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 \$23,331 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 Beneficiary/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 anonymously 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.

DOCUMENTATION REMINDER

Reminders about Abbreviations

As we focus on documentation in this manual, whether it be the assessment, care plan or progress notes, please remember that if you abbreviate words or use acronyms, you will need to ensure that the reader understands your abbreviations. We recommend that you either: 1) Spell the word out the first time you abbreviate the word (i.e., treatment -Tx); or 2) Attach an abbreviation list to your chart. Especially in an audit, record request from beneficiary/client or another provider, or if the chart is ever subpoenaed for court records, it is important that the reader understands your abbreviations.



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. In these cases, services will not be billed to Medi-Cal or Medicare. Additionally, some programs are designed to provide services to individuals who do not meet medical necessity. Other funding sources are used for these individuals 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 the California Code of Regulations: [Title IX, Article 2, Section 1830.205](#).

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

Medical Necessity is demonstrated by the following three elements:

1. An included ICD-10 diagnosis, determined by a licensed/waivered clinician or psychiatrist.
2. A significant impairment in an important area of life functioning as a result of the primary mental health diagnosis (dx).
3. An intervention that will significantly diminish the impairment and mental health problems 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 (beneficiary/client) must meet the criteria outlined above in order for the services provided to be reimbursed by a third-party payer.

Medical Necessity is determined by a complete and comprehensive assessment. ICD-10 Codes (Not DSM-5 Diagnoses Codes) are actually used on all claims for specialty mental health services. The County continues to recommend using the criteria from the DSM-5 to identify diagnostic criteria/ current symptomatology to select your ICD-10 codes. The DSM-5 descriptors are important to be included in the documentation.

Medical Necessity is NOT:

1. The clinician writing in the chart, “Beneficiary/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, cross walked to the ICD-10. However, there are five general categories that we do **not** treat or bill for as part of a specialty mental health program, when these diagnoses are the *only* reason for the beneficiary/client being seen. Five General Categories of Excluded Diagnoses for Outpatient Mental Health:

1. Substance Disorders (F10 – F19) (e.g., Other stimulant dependence, with stimulant-induced psychotic disorder with hallucinations)
2. Intellectual Disabilities (F70 – F79) (e.g., Mild)
3. Mental Disorders due to Physiological Condition (F01- F09) (e.g., Psychotic disorder with hallucinations due to known physiological condition)
4. Antisocial Personality Disorder (F60.2)
5. Z Codes (all Z-codes except for Z03.89) (e.g., Disruption of family by separation and divorce)

For a complete list of included diagnoses, please refer to the [Included Diagnosis List](#).

Please note that the only exception for billing for an excluded diagnosis is during the assessment period when we are determining if the beneficiary/client meets medical necessity. Once it has been determined that the beneficiary/client does not have an included diagnosis and therefore, does not meet medical necessity, the provider can bill for that final assessment session that the excluded diagnosis was determined. All subsequent billings with solely an excluded diagnosis must be non-billable. At that point, the provider is to give the beneficiary/client the NOABD and inform them of their right to a second opinion. If the beneficiary/client decides to obtain a second opinion, another provider doing the evaluation could bill for the assessment in determining if the diagnosis is correct, even if the diagnosis is confirmed to be an excluded diagnosis. Please note that these exceptions to billing an excluded diagnosis only pertain to assessment codes for the final session of establishing that the beneficiary/client has solely an excluded diagnosis or a second opinion confirmation of an excluded diagnosis by another provider. Treatment codes are never to be billed with solely an excluded diagnosis. Please note that in all cases, the excluded diagnosis must be established by a licensed or waived provider practicing within their scope of practice.

What If My Beneficiary/Client Has a Co-Occurring Disorder?

Your beneficiary/client may have a co-occurring disorder. For example, along with a mental health condition, your beneficiary/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. Interventions must also be addressing the mental health problem. Please note that when you plan to bill for services with a Co-Occurring disorder that is an excluded diagnosis, the included diagnosis needs to be in the primary position (listed first in the Diagnosis Treated Today widget). If you do not put the included diagnosis in the first position, the County EHR will assume you are billing for the excluded diagnosis, which will trigger an error correction report.

By History vs. Provisional vs. Rule-Out Diagnoses

“By history,” “Rule Out” and “Provisional” diagnoses are not included diagnoses and as such they do not meet medical necessity criteria. However, a beneficiary may have a “by history,” “rule out” or “provisional” diagnosis **as long as there is also at least one included diagnosis.**

A “By History” diagnosis means “I am giving this diagnosis based on history of previous evaluations and treatment by other professionals.”

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 the

DSM-5 descriptors for Unspecified Anxiety Disorder and entering the corresponding ICD-10 F41.9 Anxiety Disorder, Unspecified.

When you are able to determine a more specific diagnosis, the unspecified diagnosis should be updated with the more specific diagnosis.

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. Please be aware that the ICD-10 may offer more diagnoses that may match the clinical presentation in terms of specificity than the DSM-5. For example, the DSM-5 offers only Bipolar 1 disorder, current or most recent episode unspecified for presentations where the episodic presentation is mixed. DSM-5 gives you either manic or depressed choices; but if the episodic presentation was mixed, you would choose the unspecified diagnosis. Whereas, the ICD-10 offers you more specific diagnostic choices and allows you to select from 4 choices: F31.1, F31.2, F31.3 or F31.4 Bipolar disorder, current episode mixed, (mild, moderate or severe w/wo psychotic features) that might match the clinical presentation better.

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, have clinical experience, and he/she has demonstrated competency.



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 waived psychologist, a licensed clinical social worker, a registered clinical social worker, a licensed marriage and family therapist, a registered marriage and family therapist, a nurse practitioner, or a registered nurse.

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* after the 5 years have elapsed. Please note that if a psychologist is waived from another county and transfers to work in Orange County, he or she must apply for another

waiver for Orange County. The new waiver will only be valid for the remaining time left from the 5 year period from the start date of the initial waiver. 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 valid Medi-Cal waiver shall be recouped.

All registered/waivered employees, interns or volunteers are required to be receiving supervision while providing and billing for services. The county has chosen as evidence of supervision the **Clinical Supervision Reporting Form**. Clinical Supervision Reporting Forms for registered/waivered providers must be signed and on file with the Managed Care Supportive Services at the time services are provided to claim for billable services. Please note that this also affects any interns or trainees under the supervision of the registered/waivered provider, if the registered/waivered supervisor does not have their Clinical Supervision Reporting Form in place.

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.

Other Qualified Providers:

- 1. Mental Health Workers (MHW).** The State Plan permits the provision of services by “Other Qualified Providers,” defined as, “an individual at least 18 years of age with a high school diploma or equivalent degree determined to be qualified to provide the service by the county mental health department.” Mental Health Services (excluding Therapy), TCM [Targeted Case Management], Crisis Intervention, Crisis Stabilization services may be provided by any person **determined by the Mental Health Plan (MHP) to be qualified to provide the service**, consistent with state law. State law requires these “Other Qualified Providers” to provide services “under the direction of” a Licensed Mental Health Professional (LMHP) within their respective scope of practice.

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 of 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 (bullet point #1) 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 DHCS waiver.
- Unless waived and clinical supervision form on file, supervisor's co-signature is 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 (Master's 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 DHCS 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. **Associate Marriage and Family Therapists:**
- Have completed a Master’s 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 Master’s 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. **Associate Professional Clinical Counselors:**
- Have completed a Master’s 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 (LMFT):**
 - 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.

	MD, DO, NP	Licensed, Registered Psychologists and Psychology Interns ¹	LCSW/ ASW, LMFT/ AMFT and LPCC/ APCC	Social Work Student Interns and MFT / PCC Trainees	Rehabilitation Specialists (MHRS/MHS) / RN	Other Qualified Provider/ Mental Health Workers (OQP/MHW)
Assessment	Yes	Yes	Yes	Yes	No – for any clinical documents (MSE, CFE, Dx,, CP, Psychosocial) Yes ¹ – for gathering non-clinical assessment info.	*TBD ¹ – only for gathering non-clinical assessment info.
Medication	Yes	No	No	No	No *Exception: RNs may bill 90899-8 for injection or other medication services within their scope of practice.	No
Psych Testing	No	Yes	No	No	No	No
Psychotherapy (Individual, Family or Group)	Yes	Yes	Yes	Yes	No	No
Crisis Intervention	Yes	Yes	Yes	Yes	Yes ¹	*TBD ¹
Crisis Psychotherapy	Yes	Yes	Yes	Yes	No	No
Rehabilitation Services	Yes	Yes	Yes	Yes	Yes ¹	*TBD ¹
Intensive Home-Based Services	Yes	Yes	Yes	Yes	Yes ¹	*TBD ¹
Case Management	Yes	Yes	Yes	Yes	Yes ¹	*TBD ¹
Intensive Care Coordination	Yes	Yes	Yes	Yes	Yes ¹	*TBD ¹

¹ Licensed or waived supervisor’s co-signature is required for all Peers and MHWs (e.g., Youth Partner, Parent Partner, etc.). MHS/MHRS providers should speak with their direct supervisor regarding program-specific requirements such as co-signatures. *TBD - AQIS will determine if the Other Qualified Provider/Mental Health worker is appropriate to Bill. AQIS to review and determine what services should be provided and bill by OQP/MHW.

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.

TELEHEALTH

Beginning in April 2020, the MHP expanded the delivery of behavioral health services to include Telehealth to ensure that beneficiaries/clients can access all medically necessary specialty mental health services (SMHS) while minimizing the community spread of COVID-19. This section covers important information regarding Telehealth/Telephonic services.

What is a Telephonic/Telehealth Service?

A telephonic or telehealth service is any medically-necessary behavioral health service rendered over the telephone or via telehealth to a beneficiary/client. Beneficiaries may receive services via telephone (audio only) or telehealth (audio-visual platform) in their home as deemed clinically appropriate and with verbal consent, and providers may deliver services via telephone/telehealth from anywhere in the community, outside a clinic or other provider site. The standard of care is the same whether the patient is seen in-person, by telephone, or through telehealth.

When and how do we use the General Informed Consent for Telehealth and Telephonic Services?

The General Informed Consent for Telehealth and Telephonic Services does not replace the original Informed Consent for Services. Any beneficiary/client (new or existing) who will be receiving telephone or telehealth services will need to be given the General Informed Consent for Telehealth and Telephonic Services. For those determined appropriate for and able to engage in telehealth services, the Email Acknowledgment Form will also need to be completed. A new beneficiary/client will need to be given the original General Informed Consent for Services and the General Informed Consent for Telehealth and Telephonic Services. If a beneficiary/client is unable to or chooses not to participate in telephone or telehealth services, then they would not need to be given the General Informed Consent for Telehealth and Telephonic Services or the Email Acknowledgment Form. Applicable consents/form will need to be reviewed with beneficiary/client and their verbal consent should be obtained and documented in the progress note.

Can we provide telehealth/telephonic services for beneficiaries/clients outside of California?

No, providers are not permitted to provide telehealth and/or telephonic services to beneficiaries/clients who are located outside of California. The following is the information from the Board of Behavioral

Sciences (BBS) and California Association of Marriage and Family Therapists (CAMFT) regarding beneficiaries/clients who are physically located out-of-state:

Per the Board of Behavioral Sciences, “California licensees or registrants who wish to engage in telehealth with a beneficiary/client located in another jurisdiction need to check with that jurisdiction to determine its laws related to telehealth, and if licensure in that jurisdiction is required.” (<https://bbs.ca.gov/licensees/hipaa.html>) For California, providers must be licensed or registered in California.

CAMFT advises that in addition to checking the laws in another state, the provider also needs to ensure their malpractice insurance provides coverage out of state.

What Specialty Mental Health Services (SMHS) can be provided via telephone/telehealth?

The following services may be rendered and billed over the telephone and/or via telehealth to a beneficiary/client currently enrolled or eligible to enroll in the Mental Health Plan (MHP):

- Assessment
- Plan Development
- Collateral
- Case management
- Crisis Intervention
- Individual therapy (Psychotherapy)
- Individual Rehabilitation Service
- Intensive Care Coordination (ICC)
- Medication Support Services (including Evaluation and Management Services)
- Medication requests: Medi-Cal allows prescribing and dispensing of 100-day supplies of medications and early refills are allowed, as long as 75% of the expectation duration has occurred
- Intensive Home-Based Services (IHBS)
- Therapeutic Behavioral Services (TBS) Assessment, TBS Plan Development and TBS Collateral



Please note: Certain services, such as day rehab, day treatment intensive, crisis residential treatment services, and adult residential treatment services, require a clearly established site for services in order to be claimed, however, not all components are required to be provided in-person. (e.g., services can be provided via telephone/telehealth for a beneficiary/client quarantined in their room in a residential facility due to illness).

Licensed providers and non-licensed staff may provide services via telephone and telehealth, as long as the service is within their scope of practice.

It is imperative that providers exercise caution when conducting telehealth and/or telephonic services to ensure beneficiary/client privacy is protected. Both the provider and the beneficiary/client should be aware of their surroundings during the telephonic service to minimize any potential Health Insurance Portability and Accountability Act (HIPAA) breaches or violations.

What Current Procedural Terminology (CPT) code(s) should I use to capture my telehealth/telephonic service?

Providers should continue to utilize the same CPT codes when providing telehealth/telephonic services. For example, if a provider conducted a 20 minute telephonic service for Case Management, the provider would still bill 90899-1.

IRIS considerations:

1. DHCS does not restrict the location of services via telehealth. Beneficiaries/clients may receive services via telehealth in their home, and providers may deliver services via telehealth from anywhere in the community, outside a clinic or other provider site.
2. Service codes: claim the appropriate CDM (CPT) service code based upon the service provided. If you provided an assessment service, bill the same assessment service code used previously.
3. In your Registration conversation, please select the following:
 - a. Encounter Type: select Site Visit
 - b. Place of Service: select Telehealth
 - c. Place of Service Address fields: these fields are currently required in IRIS – please enter your clinic address. We are working with IT to remove these fields, so if they one day disappear, do not be alarmed.

The screenshot shows the IRIS registration form with several fields highlighted in red boxes. The 'Encounter Type' dropdown is set to 'Site Visit'. The 'Place of Service' dropdown is set to 'Telehealth'. The 'Street Address of Service', 'City of Service', 'State of Service', and 'Zip Code of Service' fields are also highlighted. The 'State of Service' is set to 'CA'. The 'Primary Medical Condition' is set to 'Patient Denies Any Med...'. The 'Registration Date' is 03/25/2020 and the 'Registration Time' is 14:53.

4. Enter the service as you normally would in BCE.
 - a. Please select the modifier “GT” for any service that is performed with the beneficiary/client via telehealth. This will ensure successful and correct billing of telehealth services. Please note that the GT modifier does not apply to telephone (audio only) services.
5. Telehealth services with the beneficiary/client are considered face to face. Telehealth services without the beneficiary/client present are non-face to face.
6. Services provided via telephone – continue to select Encounter Type of Telephone and face to face time will be 0 minutes.

Can a provider conduct an initial mental health assessment via telephone and/or telehealth?

Yes, per the [Behavioral Health Information Notice 20-009](#), footnote 6: “DHCS received questions about intake/assessments; DHCS confirms that these service components may be appropriately provided to beneficiaries through telephone or telehealth.” During the COVID-19 pandemic, assessments for medical necessity of Specialty Mental Health Services may be completed and finalized via telephone and/or

telehealth. All other requirements must be adhered to including conducting financial screening, obtaining beneficiary/client identification and obtaining informed consent. Verbal informed consent should be obtained and documented. Verbal financial screening and beneficiary/client identification is acceptable at this time, but should be followed-up with in-person screening including the presentation of required documentation should that opportunity become available during the course of treatment. The progress note should state the beneficiary/client's agreement to receive the assessment via telephone and/or telehealth as well as that the service was provided via non-standard means due to the COVID-19 pandemic. Providers may verify the beneficiary/client's identity and address verbally and obtain proof of the beneficiary/client's identification when the beneficiary/client can be seen in-person.

A primary diagnosis must be provided at the point of finalizing the assessment based on the information that was gathered. As with any other case, the diagnosis is subject to revision in light of additional information being obtained.

Authorization to Use and Disclose PHI form(s)

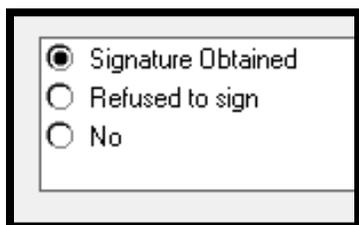
Sample statement from Office of Compliance for general justification for obtaining verbal authorization: *The COVID-19 Pandemic and CDC's guidance on social distancing make it impractical to obtain beneficiary/client's signature on an Authorization to Use and Disclose PHI form. The beneficiary/client has no alternative method to submit a signed document and I have explained the amount and kind of information that will disclosed. The beneficiary/client has understood and has provided me with a verbal consent to disclose on [enter date and time].*

Suspension of Notice of Privacy Practices (NPP) Obligations

Per the Office of Compliance: During this national emergency pandemic HCA's obligation to provide a Notice of Privacy Practices (NPP) and NPP acknowledgement of receipt form at the onset of care is suspended. However, the beneficiary/client should receive an NPP as soon as practicable as soon as national emergency is over.

What about the Care Plan and Care Plan signature/validation?

A provider may complete all elements of assessment (Psychosocial, Diagnosis, Community Functioning Evaluation, and Care Plan) via telephone and/or telehealth. If the provider is unable to obtain observational data such as certain elements of the Mental Status Exam (MSE) due to not laying eyes on the beneficiary/client, the provider should document this in the note: "This writer was unable to complete this section as this service was provided via telephone due to the COVID-19 pandemic." The missing information should be obtained upon the first in-person encounter with the beneficiary/client as appropriate.



The image shows a screenshot of a form with three radio button options. The first option, "Signature Obtained", is selected with a black dot. The second option is "Refused to sign" and the third is "No".

During the COVID-19 pandemic, a verbal agreement for Care Plan is permissible. When a verbal agreement is obtained from the beneficiary/client, conservator, or parent/guardian, please select "Signature Obtained" as shown below and document in the corresponding progress note that a verbal agreement(s) was obtained along with the reason for the missing signature(s).

Please remember that a Care Plan becomes valid with the provider's signature alone and is good for 365 days from the date of the provider's signature. However, if beneficiary/client, conservator, or

parent/guardian is not available to provide a verbal agreement at this time, then please continue to follow the existing workflow of selecting “Refused to sign” and documenting in the progress note the reason for the missing agreement/signature to validate the Care Plan.

Additional resources can be found here:

- [COVID-19 Fact Sheet – Guidance for County Operated MHP Programs](#)
- [IRIS & AQIS Support Teams Telehealth FAQ](#)
- [Office of Compliance Privacy Guidelines for Telecommuting Due to COVID-19](#)

Please consult with your supervisor about any program-specific telehealth guidelines.

THE FLOW

Evaluation

During the initial session with a beneficiary/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 beneficiary/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 Adverse Benefit Determination-Delivery System (NOABD). Notice of Action-A replaced with The NOABD -Delivery System 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 beneficiary/client shall be admitted following an established protocol. Documentation requirements are listed in other parts of this document at which point the beneficiary/client is considered a “long-term beneficiary/client.”

BHS’ Definition of a Long-Term Beneficiary/Client

A “long-term beneficiary/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 beneficiary/client and demonstrate strong clinical interventions that addresses the mental health problem with the beneficiary/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 beneficiary/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 beneficiary/client to determine how it is that they will know that the beneficiary/client is ready to discharge from treatment. Discharge criteria should be established from the outset so that the beneficiary/client knows what is expected for his/her course of treatment. This should be included in the objective section of the Care Plan and tied to the beneficiary/client’s desired goal or outcome.

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 beneficiary/client and it is clinically relevant.

Discharge Planning vs. Placement Services from a Psychiatric Hospital

Discharge Planning

- Beneficiary/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 beneficiary/client on an inpatient psychiatric unit is **not** billable.

However, it is permissible to bill for **placement services** while a beneficiary/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 beneficiary/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 beneficiary/client is not ready to be discharged. Any other type of discharge service, including follow-up care while the beneficiary/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 beneficiary/client starts services with any of our BHS outpatient clinics, including the Crisis Assessment Team (CAT) and Crisis Stabilization Unit (CSU). Please note that CAT, CEGU Probation and CSU are under the MHP EOC umbrella; however, CAT, CEGU Probation and CSU would not be opening an MHP EOC if they were the first providers for the beneficiary/client, since they are both short term programs. If the MHP EOC was already opened and was still current at the time CAT, CEGU Probation or CSU provided services, both programs would be considered within the MHP EOC. This MHP County Treatment EOC will follow the beneficiary/client throughout their journey in all our programs. This treatment episode should be closed when the beneficiary/client leaves services and is no longer open at any of our BHS outpatient facilities, CAT, CEGU Probation or CSU.

The purpose of the MHP County Treatment EOC is that it allows all county clinics or providers involved in the beneficiary/client’s care, to share a single medical record, assessment and care plan. The overarching

MHP EOC is a snapshot of the beneficiary/client's care and encourages coordination of care among all providers under this umbrella of treatment. All providers involved in the beneficiary/client's care has access to clinically relevant information to provide the most informed and coordinated care.

In the first 60 days of a MHP County Treatment EOC, all the initial assessment paperwork including a full Initial Assessment - (Psychosocial and Mental Status Exam (MSE), Community Functioning Evaluation (CFE), Diagnosis Form and valid Care Plan must be completed. Please note that with the upcoming revision of combining all forms into one assessment evaluation, all elements are still expected to be completed within the first 60 days of the MHP EOC.

The cycle dates or Care Plan due dates are no longer tied to the EOC date as Care Plans are good for 365 days from the day the plan became valid, which is when the LMHP or waived clinician signs the plan. Please note that annual updates and Care Plans can be renewed prior to 365 days. The renewal due date for the next plan is always 365 days from date the previous plan became valid. The only exception may be for short-term programs (e.g., YRC) where the beneficiary/client is referred to a program, for example, for 60 days. Although a program may set up short-term care plans, the program will need to manually track their timelines since the County EHR is always 365 days. So for example, if YRC completes goals and objectives for 60 days, but the court extends the stay another 30 days, they will need to do a new care plan or revise the old care plan for the last 30 days.

The most frequent errors with the MHP County Treatment EOC occur when programs forget to run 2 County EHR reports (Client History by MRN for AOABH and BHS EOC Summary reports for CYPBH) at admission and discharge. These reports prevent 4 types of errors from happening. First, when admitting a new beneficiary/client into your County EHR program, you will know if the beneficiary/client is opened currently in another program and whether or not there is a current valid assessment and care plan already in the EHR. If the MHP County Tx EOC is open and there is an existing assessment and care plan, you can review the assessment and care plan and decide if you agree with clinical formulation and plan. If so, you can coordinate with the other provider who will be the Plan Coordinator, and add your services, goals and objectives onto the existing care plan.

Second, if you discover that the MHP County Tx EOC was closed by the previous provider, or that the beneficiary/client has never been in treatment with another provider, then your front office staff must open the MHP County Tx EOC for you **before you provide and bill for any services**. Failure to do so will keep all billed charges stuck in IRIS and will not be submitted to the state. You must also create your own assessment (currently the Psychosocial, CFE and Diagnosis Forms) and care plan as well as complete all initial paperwork (consents, psychometric measures, etc.). Please note if you are attempting to use another clinic's assessment and care plan when the MHP County Tx EOC was closed or discharged, **the previous assessment and care plan has expired**. Unfortunately, the County EHR is not always accurate in letting you know that the plan has expired, when the episode of care was discharged. So it may still reflect that it is a valid care plan if the 365 days has not elapsed. You must therefore, check the report if the MHP County EOC is still open or not, before billing for services. If the MHP County Tx EOC was closed and you bill to the expired care plan, all claimed (billed) treatment services must be credited back to the state and changed to non-compliant service codes.

Third, when you are ready to discharge the beneficiary/client from you program, you will need to run those the same reports that you ran for admission, to know whether or not to close the MHP County Tx EOC. If you are the last program to provide services for this beneficiary/client and no other programs are currently open and you will not be transferring the beneficiary/client to another County EHR clinic, you

will close the MHP County Tx EOC when you discharge the beneficiary/client. If the report indicates that another program is open or you plan to transfer the beneficiary/client to another program, please do not close the MHP County Tx EOC. If you inadvertently close the MHP County Tx EOC while another County EHR program is providing services, you will have ended the episode of care and caused the assessment and care plan to be expired. We recommend that you contact the EHR Liaison to report the error, so they can reverse this accidental closure as soon as possible and thereby reactivate the current care plan.

Fourth, if you do not discharge the MHP County Tx EOC when it should be closed, it gives the appearance that the beneficiary/client is still under the care of the MHP, but has not been seen for over a long period of time. This gives the appearance of negligence and lack of clinical care. Therefore, running these 2 reports at admission and discharge are likely to prevent hardship and avoid costly errors for our providers.

Facility EOC

A facility EOC is the date on which the beneficiary/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 illustrated when there are two county clinics providing services to the beneficiary/client at the same time. This EOC should be closed when the beneficiary/client leaves your program. If the beneficiary/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)/ URGENT AUTHORIZATION OF SERVICES

In the event that the beneficiary/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 elapse or before the Initial Assessment and Care Plan can be completed; however, you must have enough information to, at least, document that medical necessity has been 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** to be completed for every case unless, of course, there is an urgent need and medical necessity has been established.

The ICP has only been allowed for use by the first clinic starting the timeline (opening of the MHP County Tx EOC). If a second provider opened within the first 60 days of the first clinic's date of admission, theoretically, they could also utilize the interim care plan for the remaining time left from the date of admission. As mentioned previously, you will need to know if you are past the first 60 days of the MHP County Tx EOC. If multiple programs are opened, you will need to run the IRIS report to determine the holder of the timeline. Please refer back to the MHP County Tx EOC section.

Based on DHCS guidelines and feedback from the December 2019 DHCS Triennial audit, the Interim Care Plan (ICP) is an authorization for urgent services and must contain all the elements of the regular care plan with the exception of being less comprehensive. Here is what documentation you must have to create an ICP:

- 1) Medical Necessity has already been established by a LMHP/waivered clinician (Included Diagnosis on the Diagnosis Form, Impairments as a result of the mental health problem – CFE)
- 2) SMART Goals & Objectives
- 3) Proposed Types of Interventions
- 4) Detailed description of the interventions and which goals/objectives they will address
- 5) Proposed frequency and duration of interventions
- 6) Progress note of collaboration and/or agreement with the Interim Care Plan
- 7) Signature of LMHP/waivered Provider which will validate the plan
- 8) Signature of the Beneficiary/Client



Current County EHR Interim Care Plan (ICP) Form

When you have the necessary information for all the required elements for the ICP, you are ready to fill out the ICP form. Please note that our current County EHR ICP form does not have all the form fields to prompt you for each of the 8 elements listed above. You will need to gather this information first and include them in the two free text field or the template check boxes. When you open the current county ICP, you will see two tabs – Interim Care Plan and Signatures. Start with the Interim Care Plan tab. In that section, you will see a question regarding the urgent situations the beneficiary/client needs to be treated before the full assessment and care plan are complete. Below the question are several boxes that you can check that are written for you that you can select if they apply. The last box says, “Other” which opens the free text field to write in your own words what the major reason for treating the beneficiary/client before the assessment was complete. We recommend that if you have more specific reasons than the one given by the template that you use the “Other” option. A good reason to use the “Other” option is to describe what impairment is causing you to treat the beneficiary/client immediately, and what would happen if you didn’t provide immediate treatment.

Below the “Urgent Situations” for treatment are the “Proposed Interventions” that are a list of checkboxes to select all the types of services that are needed to stabilize the situation. Once you select a type of service, another blank field opens up next to it, which asks for the frequency of service (e.g., one time a week). Since our old ICP does not have a place for the “Duration”, you will need to type that also in the field, for example, “One time a week for the next 60 days.” This would fulfill our frequency and duration requirement for proposed interventions.

On the right of the “Proposed Interventions” is the additional narrative free text window to add more information. We recommend that you identify the diagnosis or problem that you are treating in this window first. Then it is clear to all providers on the treatment team what diagnosis for which they should be treating immediately and billing. If you’ve already listed your impairment(s) in the “Urgent Situations” sections like we mentioned previously, you can then turn your focus towards the other required elements, mainly your goal and objective. Given that this is a short term treatment plan for the first 60 days, you can list minimally one goal and objective. This is similar to the regular care plan only less comprehensive. So this goal and objective should address the immediate reason this beneficiary/client needs treatment.

You will then need to list the descriptions for each interventions and how they will address the goal and objectives.

Finally, in this same window, you have the option to include the statement of collaborating with the beneficiary/client in developing the plan and obtaining the beneficiary/client's agreement with the service as well as having offered a copy of the ICP to the beneficiary/client or you can write a progress note with these elemental statements (See example at the end of this section). **We recommend putting these statements here in this ICP window**, as there is a tendency to either forget to write those statements in the progress note, or you forget to reference the note on the ICP, so the reviewer will miss it. These are all the requirements that we need to add to our old ICP, which we could remedy here in this additional narrative window.

Please note that a beneficiary/client signature is required, but not to activate the plan. The provider's signature, similar to the regular care plan, will activate the plan. Since our current ICP cannot capture a signature for the form, we recommend that the LMHP or waived provider sign the form to activate the plan. Then, you will need to print out a text version of the plan and get an external signature, and scan the document back into the Interim Care Plan folder.

Please note that the Interim Care Plan can be good for up to 60 days from the date that the MHP EOC was established. Please remember check to determine that the beneficiary/client has not been opened in another County EHR clinic site. Otherwise, the ICP would not work as either there is already an existing assessment and care plan supersedes the ICP, or the initial 60 days may have expired and no treatment services can be billed until the full assessment and care plan is completed.

Please see the example of a filled out ICP below with all the new elements. Revisions to the new version of the EHR ICP are scheduled to come in the near future along with some training to use the new document. But until that time, please follow these changes in the current ICP to be in compliance with state requirements. Please note in the example (next page) the six revisions to the current ICP are marked with the red arrows. The "CAP" is the acronym for "Corrective Action Plan," which was implemented as a result of the feedback from DHCS Triennial audit.

The following is an example of a progress note that would meet the requirement in the case where the provider did not write the beneficiary/client participation and agreement statements on the ICP. This would also apply to the regular Care Plan if the provider did not document beneficiary participation on the plan:

“Beneficiary/client participated in interim care (or care) planning meetings on (date) and (date). The beneficiary/client participated in developing their interim care (or care) plan goals and interventions; in particular, the goals for (state goal or goals that the beneficiary gave specific input for). The beneficiary/client was satisfied with the beneficiary/client plan and stated verbal agreement at the meeting held on (date).”

INITIAL ASSESSMENT

The purpose of an assessment is to evaluate whether the beneficiary/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 beneficiary/client is a new beneficiary/client, a returning beneficiary/client or an existing beneficiary/client, which can guide the provider to establish the appropriate timelines when developing the Care Plan.

Intake Assessment Paperwork

This refers to the Initial Assessment including the Care Plan. The Initial Assessment in the County Electronic Health Record includes a Psychosocial History, Community Functioning Assessment (CFE), Diagnosis Form and Mental Status Exam (MSE) as part of the Psychosocial Form. The Initial Assessment and Care Plan should be completed within 60 days of opening the case. The initial assessment of the beneficiary/client must address all 11 assessments items: presenting problem, relevant conditions and psychosocial factors, history of trauma or exposure to trauma, mental health history, medical history, medications, substance exposure/substance use, beneficiary/client strengths, risks, mental status examination, ICD-10 included diagnosis(es). The assessment must be completed by the LMHP - signature, date, license or degree and NPI #. MHS/MHRS/MHW will no longer complete clinical sections of the assessment (e.g. the mental status exam, making a diagnosis or writing the clinical summary that may include conceptualization of the case based on clinical symptoms and behaviors, and discussing treatment planning. Certain elements of assessment and care planning may continue to be gathered by MHS/MHRS/MHW.

In the event that the initial assessment documents cannot be completed within 60 days, the reason(s) should be documented in the progress notes. All services other than assessment crisis service are to be billed as a non-compliant chart code.

A Brand New Admit:

A provider has 60 days to complete an Initial Assessment (and Care Plan) for any new beneficiary/client entering our County mental health system. In our system, the new episode of care is called the Mental Health Plan Episode of Care (MHP EOC). Once the Care Plan becomes valid, it is good for 365 days from the date the clinician signs or until a new CP becomes valid, whichever comes first.

The relevant “timeline” now revolves around the completion of the assessment and Care Plan (CP), not the admission date. A Care Plan will be **valid for 365 days** from the date of the clinician’s signature. Beneficiary/client signature is still required on the CP but is not necessary to validate or begin the timeline for services. A Care Plan is considered **valid when** all the requirements are met, including the content and all required signatures (provider and co-signature if applicable). Each individual Plan Coordinator (PC) must determine what signatures are required. For example, a psychologist student trainee would need a licensed clinician’s co-signature.

Re-Admission after Discharge:

If a beneficiary/client is discharged, the MHP EOC is discharged and the beneficiary/client 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 beneficiary/client will start a new Episode of Care. Irrespective of whether a beneficiary/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. The process remains the same regarding signatures.

CARE PLANS/AUTHORIZATION OF SERVICES

Care Plan (CP)

Care Plan is the term for what was formally known as the Beneficiary/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.

The CP is valid from the date the LMHP/Waivered Provider developed, signed with provider's license or degree and NPI number. A co-signature on the CP by a LMHP/Waivered Provider is required for unlicensed, non-waivered providers, as well as Licensed vocation Nurses, Licensed Psychiatric Technicians, Physicians Assistants, Pharmacists and Occupational Therapist.

In the event that a beneficiary/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 beneficiary/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 beneficiary/client when updating the Care Plan. In addition, it is expected that all necessary signatures are obtained. If a beneficiary/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 beneficiary/client at subsequent visits and at least at every update of the Care Plan. If the beneficiary/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 beneficiary/client to sign the plan at every face-to-face visit no longer applies.

Care Plan Expectations

A Care Plan is developed and 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 beneficiary/client and should be completed within the documented time frames. Treatment objectives should address 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 diagnosis. Specialty Mental health Outpatient Services ICD-10 Covered Diagnoses Table - [Included Diagnosis List](#). The most recent version is effective October 1, 2019 until the next version is released by DHCS.

Proposed interventions should be documented in the “Intervention Grid” tab to: 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. The interventions should be tied to the objectives.

Orange County EHR clinics will require that additional assessments be completed in conjunction with each new Care Plan and include a Mental Status Exam (MSE), Community Functioning Evaluation (CFE), and Diagnosis form. For the initial assessment evaluation, a Psychosocial Evaluation is required. At each yearly update, a new Psychosocial is required to update any of the 11 elements required by DHCS for annual assessments. Both AOABH and CYPBH Care Plans are due annually. When completing the annual updates, please do not leave any sections blank as the state will interpret that you did not assess for that section and may result in your assessment being out of compliance.

Use of Reference Paperwork

A problem could arise when a clinic/program uses another clinic’s Initial Assessment, but creates its own Care Plan with its own timelines. That assessment may already be expiring and creating a new Care Plan without an updated re-evaluation can appear as if the requirement of a plan being based on a thorough and current 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 if the findings are the same. 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 assessments should be scanned into 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 of re-writing the same information as long as the information is current and accurate.

When any clinic is creating the first Care Plan in the OC EHR for a beneficiary/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 beneficiary/client is opened at any other clinic. At the time of intake, the opening clinic will need to run a BHS EOC Information Report called the 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 beneficiary/client. In the event that more than one clinic is providing care, it is extremely important for the OC EHR clinic to coordinate care to determine who is the plan coordinator and who is providing what services to avoid any duplication of services.

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 beneficiary/client or responsible party, the collaboration with the beneficiary/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.

LMHP Signature on the Care Plan

It is an expectation that the Care Plan will be signed by a Licensed Mental Health Professional (LMHP) as soon as the plan is developed. The care plan is effective once the provider signs. The beneficiary or caregiver/conservator signatures are expected to be obtained to be in compliance with the beneficiary participation requirement. The 365 day timeline starts as soon as the provider’s (and if applicable, the



licensed/waivered/registered provider’s) signature is obtained. Please note that providers must sign their signatures with their NPI numbers. Billable services can occur once the clinician completes all of the assessment paperwork and signs the CP as long as it complies with medical necessity and all of the timeline expectations.

Language Appropriateness of the Care Plans

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

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 beneficiary/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 (diagnoses).

A “diagnosis treated today” is the “problem” (diagnosis) that the provider wishes to associate with the service being documented and treated on that day. This means that a “diagnosis treated today” should already be listed as an established diagnosis in the BH Diagnosis PowerForm. If the diagnosis you wish to choose for the service is not listed in the “problem” section, then a team discussion should occur to appropriately update the BH Diagnosis PowerForm. 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.

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 beneficiary/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 beneficiary/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 beneficiary/client. Progress notes reflect the beneficiary/client's progress and are not meant to be process recordings of the interaction.

3. *Be relevant to the service provided that day* – Use the 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 beneficiary/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 the main substance of your intervention provided. Also, the documented 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, spelling, grammar, correct word usage of the note, but also that of the provider's signature, title and/or licensure.

Progress Notes Should Answer “5 Questions”:

1. *Who did you see today?* (Diagnosis widget and beneficiary/client information already pre-printed) – e.g., Beneficiary/client is a 26-year old single Chilean female diagnosed with Schizophrenia, Paranoid Type (F20.0).
2. *Why did you see the beneficiary/client today?* (Purpose of Visit) – e.g., Beneficiary/client came in for a scheduled appointment to continue learning ways to manage her auditory hallucinations.
3. *What did you do?* (Intervention PN) – e.g., Clinician worked with the beneficiary/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 beneficiary/client minimize the voices by discussing ways to reduce the intrusiveness of the voices.
4. *What was the beneficiary/client's response?* (Response to Intervention PN)– e.g., Beneficiary/client reported that she could try reality testing with her mom as she trusts her mom. Beneficiary/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?* (MHS Ind PN Plan) – e.g., The Clinician will meet with beneficiary/client again next week and will assess how the techniques discussed today have worked for the beneficiary/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.” Please note that certain notes and codes may require additional or specific content (i.e., Medication Notes E&M codes require the MD to document 50% of time spent counseling and/or coordinating care) to justify the code billed. MHS and other qualified providers will write behaviors instead of symptoms because this is a scope of practice issue.

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 beneficiary/clients’ feelings about having been recently diagnosed with Schizophrenia. Clinician helped Beneficiaries/clients accept the diagnosis and discussed common feelings such as anger, confusion, and denial.” For CYPBH, a general statement about today’s group may be an anger management group and discuss signs or triggers to anger and how to practice defusing their anger once they have been triggered.

Although it is OK to have a general statement about what the group was about, each group note needs to be **individualized** to the beneficiary/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.” Or “Jane identified that being talked to by her teacher triggers her in class, and she is not able to recover once she is triggered.”

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 beneficiary/clients who participated in the group, using the total number of beneficiaries/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.

The formula for billing group is the total number of minutes of the group divided by the number of beneficiaries/clients regardless of their funding source. Then you add the documentation time for the group progress note. For example, if you have a group of 10 kids (8 Medi-Cal & 2 Self Pay) and you ran the group for 90 minutes, you would calculate $(90 \text{ min.} \div 10 + 10 \text{ min. documentation time for the progress note}) = 19 \text{ minutes billed for this group member.}$ So the formula would always result in 9 minutes service time plus your documentation time for each progress note.”

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 beneficiaries/clients, each note would have “6” minutes entered in the travel time field in the billable tab of the progress note. The clinician should document the total number of participants even though they might not have the same health plan (e.g., 3 participants with Medi-Cal and 6 participants with Medicare, then the total number of beneficiaries/client entered would be 9).

Each facilitator must write their own note for each beneficiary/client participating in the group, if the group is co-facilitated. We can no longer write one note documenting for two providers as the state system cannot accommodate billing for both providers on one claim.

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 his or her own unique intervention, which is aimed at reducing the mental health impairment. In order for the co-facilitator to bill the entire time of the group, he or she must have been intervening and participating simultaneously the entire time. Otherwise, each facilitator could only claim for his or her time spent intervening.

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.

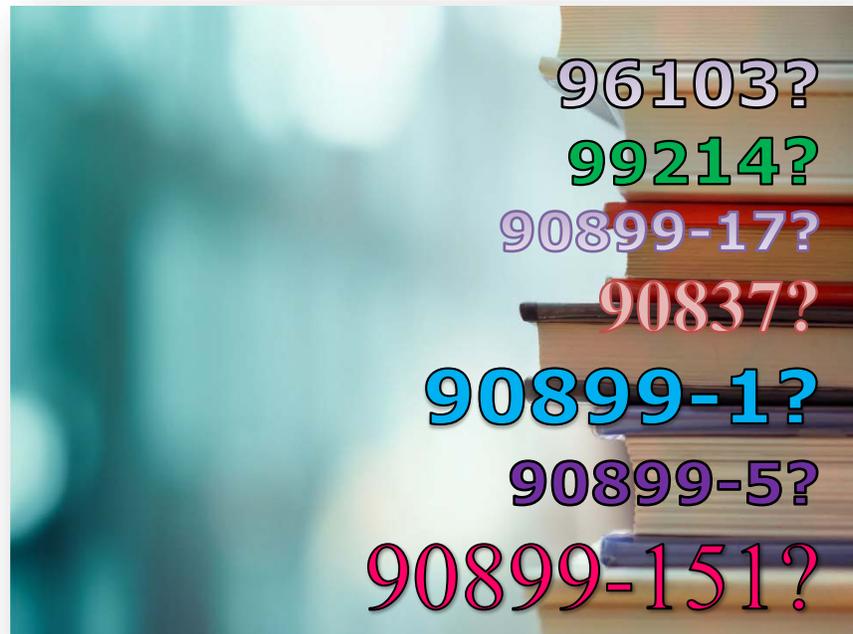


CODES

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 the AQIS Support Team.



TARGETED CASE MANAGEMENT SERVICES (CMS)

Targeted Case Management (TCM) services help beneficiary/client to access needed medical, educational, social, pre-vocational, vocational, rehabilitative or other community services. There should be documentation as to why the beneficiary/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 (case consultation) between interagency providers (from different clinics/programs), monitor service delivery and linkage access to community services.

The criteria for billing case consultation between two providers requires the following:

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

In addition for two provider intra-agency (from the same clinic):

- The provider needs to document what information was shared or gathered in the case consultation, and
- The provider if applicable, will document how he/she will change the approach/intervention in dealing with a specific problem discussed in this consultation,
- The documentation clearly indicates how the beneficiary/client is likely to benefit from the case consultation and includes any clinical decisions based on the consultation

For additional documentation guidance regarding specific case management activities, please review the following scenarios:

1. Case Consultations between two service providers (intra-agency) – If two providers from the same clinic decide to do a case consultation for a particular beneficiary/client, there is other information that should be included in your documentation, in addition to the criteria listed above, to claim for services. Here are some of the questions to consider for both providers in their progress notes:

- Are both providers part of the treatment team for the beneficiary/client, or in the process of referring the beneficiary/client to the other provider (e.g., clinician consulting with psychiatrist that may result in a medication evaluation; or therapist seeking psychological testing from psychologist)? In other words, do both providers have clinical business consulting and coordinating care as part of the treatment team or adding the provider to the treatment team? If so, then both providers should indicate their relationship to the beneficiary and could both claim for services. If not, then, the service is non-billable.
- Is this meeting activity between two providers a routine (e.g., weekly) occurrence that would be seen as clinical or administrative supervision? If so, the service activity should not be billed to

Medi-Cal. If not, does the documentation support the medical necessity for ongoing (e.g., weekly) consultation? If so, the service activity could be billed to Medi-Cal. Please note that there should be a proportionate amount of direct (treatment) services along with indirect case management services. We have received feedback in the past from DHCS that overutilization of case management service, while underutilizing direct treatment services is an audit concern. The exception being indirect services for the purpose of attempting to reengage the beneficiary/client back into treatment.

- Finally, have both providers documented in their progress notes their role and involvement in the service? Do both providers support the time claimed in their documentation by describing in detail what information was shared and how it can/will be used in planning for the beneficiary/client care or services to the beneficiary/client (i.e., how the information discussed will impact the beneficiary/client plan)? If all of the above conditions and criteria have been addressed, you have a billable consultation between two providers of the same clinic.

2. Case Consultations in Case Conference or Treatment Team Meetings (Intra-Agency Team) - The term “case conference” is not specifically defined in the State Plan, MHP contract or regulations; however, it may refer to a discussion between direct service providers and other significant support persons or entities involved in the care of the beneficiary. Please note that the service activity of the case conference or team meeting must be consistent with the service code claimed. For example, if the case conference or team meeting’s activities consist of coordinating care between providers, monitoring of beneficiary/client’s progress, clinical decision making, adjusting of treatment and linking to any other mental health services needed, then the case conference should be claimed as case management. Similarly, if the documented case conference or team meeting’s discussion among multiple providers consisted of establishing medical necessity, clarifying diagnosis or determining appropriate treatment, the service code claimed would better fit the assessment code. The only exception might be for Pathways to Well Being (PWB) cases where these Child, Family Team meetings would code certain assessment activities (e.g., re-assessing strengths and needs at least every 90 days) to Intensive Care Coordination (ICC).

Individual participants claiming for their participation in these types of services (e.g., case consultation (TCM), or even assessment) must describe their role and involvement in the service. Any participation time claimed, which may include active listening time, must be supported by documentation showing what information was shared and how it can or will be used in planning for beneficiary/client care or services to the beneficiary/client (i.e., how the information discussed will impact the care plan). Please note that providers claiming for case consultation for case conference or treatment team meeting must be part of the treatment team for the beneficiary.

3. **Review of Records and Claiming for Chart Review– Effective as of September 30, 2020**, Record review is reimbursable when performed as part of the following services and service activities:
 - Mental Health Services (assessment & care plan development, collateral & individual therapy, rehabilitation)
 - Targeted Case Management
 - Medication Support Services, and
 - Crisis Intervention

What seems allowable for record or chart review is when a provider reviews a progress note or two in preparation for the treatment session. The provider could then indicate in the same progress note what documents were reviewed and what issues will be addressed based on the review. These two elements documented in the progress note establishes the purpose and medical necessity for reviewing documents. Also what is important is the time claimed in the record review. It should be within community standards of 5 to 10 minutes of reviewing 1 or 2 progress notes. It should also make clinical sense of why those documents were reviewed. If the review of records or chart is outside of the usual community standard, then, the documentation must substantiate the time claimed for such a review. For example, “The evaluator reviewed the 4 progress notes of the assessment sessions, the psychological testing report from the MMPI 2, the inpatient hospital records just prior to the beneficiary/client’s outpatient admission here and the psychiatrist evaluation note. These documents were reviewed for the purpose of completing the assessment evaluation and care plan.” This lengthier description is necessary to justify billing for 45 minutes of record review to write up the assessment and care plan.

What happens if the provider does the lengthier record review on a different day? What service code should the provider select?

Unfortunately, there is not a “one size fits all” answer that satisfies every situation. It requires paying attention to the code definition and rules and also County and EHR policies and procedures. Some service codes or CPT codes will require face to face interaction, so those codes could not be used on a different day. Both our county and EHR policies require that providers make separate claims for service activities that happen on different days, and does not allow for rolling time into one claim. Certain codes, like assessment for write up may allow to make a separate claim, while therapy codes cannot be used. Therefore, for those situations, case management or ICC codes may be appropriate for claiming for record review when the beneficiary/client was not seen on the same day. Please note that the documentation needs to support the code selected.

What happens if the provider reviews the beneficiary’s chart, in preparation for a session with the beneficiary, and the beneficiary no shows? Is the time for the chart review still claimable?

The answer from the state is “Yes” as long as the provider documents the circumstances of the beneficiary’s no show, the time spent to review the chart in preparation for the beneficiary’s appointment is reimbursable. Can the provider submit a subsequent claim for chart review in preparation for the beneficiary’s next appointment? The answer from the state is: “Yes” as long as the time claimed is reasonable and in preparation for the beneficiary’s appointment. Please note that the criteria discussed in the previous 2 paragraphs still apply here. You need to document what document was reviewed and for what purpose. The documentation needs to support the time claim.

Since in this situation, the beneficiary no-showed for the appointment, you could not bill a treatment session unless you followed up the same day with a call and checked in with the beneficiary/client over the phone or through telehealth platform. The code you would select would depend on what activity you performed during the call. If you were checking in and monitoring how the beneficiary was doing and why he or she no-showed, then you might select a case management code and include your chart review time. If the service activity involved some therapy or rehab intervention, then you might select a treatment code. Whichever code you select, it must be supported by your documented intervention.

4. Child, Elder, Dependent Adult Abuse Reporting

At this time, we have not heard anything different from the state regarding Child, Elder, Dependent Adult Abuse Reporting. For the time being, the filing of abuse reports, **both verbal and written**, shall all be coded as **non-billable until further notice**.

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 beneficiary/client to coordinate outpatient mental health services; a Plan Coordinator goes to Juvenile Hall for a session with an incarcerated beneficiary/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 beneficiaries/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 beneficiary/client that “no showed” for a scheduled appointment.

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 30 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 (Refer to Psychological Testing codes). In BHS, we typically do this type of service during the first 60 days as well as when we do our annual updates and Care Plans.

Assessment activities are usually face-to-face or by telephone with or without the beneficiary/client or significant support persons and may be provided in the office or in the community. An assessment may also include **gathering information** from other professionals that will contribute towards the completion of the assessment formulation (i.e., determining diagnosis, course of treatment, etc.). As a reminder, this code is not used if clinician's is consulting or coordinating care.

Examples of assessment activities in order to gather, collect, clarify diagnosis, etc. include the following:

- Interviewing the beneficiary/client and/or significant support persons to obtain information to assist in determining appropriate treatment.
- Administering and scoring outcome measures such as PSC, CANS, MORS, etc.
- Observing/gathering information about the beneficiary/client in a setting such as milieu, school, etc. may be indicated for clinical purposes.

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 beneficiary/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. Sessions should not be billed just because the 60 days have not elapsed. This is the state feedback from the past two Triennial audits. The issue is whether or not treatment could have and should have been started earlier. Only if the case has the complexity requiring additional assessment, should the full 60 days be utilized.

This code 90899-6 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 for a new assessment and care plan.

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 beneficiary/client the progress and problems during the preceding months.
- Assessing the beneficiary/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 or a disability assessment or conducting a second opinion assessment if the beneficiary/client appealed the original assessment findings and was seeking a second opinion regarding medical necessity.

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 30 days or longer from the date of service; or the service is non-compliant because the 60 days assessment period has past.

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. Please note that Psychological Testing codes have changed since January 1, 2019. Whereas psychological testing, administration, scoring and interpretation used to be covered by a single code 96101 by a psychologist or physician, the change in codes in 2019 now use up to four codes: two codes for Psychological Evaluation Services (96130 and 96131) and two codes for Test Administration and Scoring (96136 and 96137). Presently in the County EHR, we have available 2 of the 4 codes 96130 and 96136. The other 2 codes will be added later (likely Jan. 1, 2022)

when the state transitions to CPT codes and requires 96131 and 96137 for each additional of psychological evaluation or testing administration/scoring. For now, IRIS will handle in the background the billing of additional time if the amount of time goes beyond the time range for 96130 and 96136. The provider will only need to track the total time of the service activity (until the state transitions to CPT codes and requires multiple CPT codes). When testing and results are automated by computer or electronic platform, the code 96146 is used for the entire time. A neurobehavioral status exam is billed using 96116. Let's look at the codes' definition closely.

Billable Codes – Psychological Testing

96130 [H2015] Psychological Testing Evaluation Services by Physician or Other Qualified Health Care Professional

Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed. The County EHR will not use extended codes until January 1, 2022. Until then, this code will cover the entire time. When the state starts processing CPT codes, then this code will be limited to the first hour of testing and evaluation, and require the extended code 96131 for each additional hour.

96136 [H2015] Psychological or Neuropsychological Test Administration and Scoring by Physician or Other Qualified Health Care Professional

Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method. As mentioned above, the County EHR will not use extended codes until January 1, 2022. Therefore, the same rules will apply to the code covering the entire time. When the state begins using CPT code, the time limit for this code is for the first 30 minutes. Additional time will be coded for each 30 minute increment using code 96137.

96146 (H2015) Automated Testing and Result

Psychological or neuropsychological test administration, with single automated instrument via electronic platform, with automated result only.

Tests that fall under these codes may include WAIS-IV, Rorschach, MMPI-2, Connor's Continuous Performance Test 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

96116 [H2015] Neurobehavioral Status Exam with Interpretation and Report

Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgement, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report. The County EHR will use this code for the entire time until January 1, 2022. At that time, the code will be limited to the first hour, and the code 96121 will be utilized for each additional hour.

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. Psychological Testing that is administered to meet internship or graduate school requirements and do not establish medical necessity for such service activities are to be coded as non-billable. Psychological Testing that does not result in a summary of results or written report with interpretation are also considered non-billable services.

When psychological testing services are non-billable to most insurers, including Medi-Cal, 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 and Psychological Testing services that would otherwise be billable, except that the progress note was written after 30 days or longer from the date of service will be code and non-compliant mental health assessment code.

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 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, 2020).

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 beneficiary/client and/or with family members, however, part of the session must include interaction with the beneficiary/client for at least part of the time. Interventions documented should focus on the beneficiary/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 beneficiary/client and/or family, with at least part of the service face-to-face with the beneficiary/client.

90834 [H2015] Psychotherapy 38-52 minutes

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

90837 [H2015] Psychotherapy 53 + minutes

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

Examples:

- Treating an excluded diagnosis: Discovered that beneficiary/client continues to use marijuana three times per day, despite the fact that he is attending NA meeting once a week. Confronted his ongoing marijuana abuse, and recommended to increase his attendance at NA meetings. Also, he probably needs to seek for a sponsor.
- Not addressing the mental health problem: Beneficiary/client was happy and denied any problems to discuss. Beneficiary/client shared music she likes.

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 30 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.

Current code for collateral:	It will change to on 1/1/2022:
90899-157 Collateral Services (for Family Rehab Service)	*H2015 Comp Comm Supp Svc (Group Rehab for family or non-family)
90899-157 Collateral Services	*90846 Family Therapy without Patient
90899-157 Collateral Services	*90847 Family Therapy with Patient

90899-149 Collateral No Fee	TBD or stay the same
90899-163 Non-Billable Collateral Travel Time	TBD or stay the same
90899-162 Collateral Non-Compliant Chart	TBD or stay the same

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 (beneficiary/client present), worked with beneficiary/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 (beneficiary/client not present), assist the significant support person improve awareness of their aggressive communication patterns that trigger the beneficiary/client’s angry escalation. Identified alternative styles of communication that beneficiary/client receives well and practiced those in role plays in order to help the beneficiary/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 beneficiary/client present. The service may have been provided while the beneficiary/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. For example, if the focus of the session treated the caregiver’s problem rather than the beneficiary/client’s.

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 30 days starting from day 1 as 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 beneficiaries/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 beneficiary/client and one or more additional beneficiaries/clients are treated at the same time. The identified intervention(s) are consistent with the beneficiary/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.

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 beneficiaries/clients who are being treated. Beneficiaries/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 beneficiaries/clients' functioning improves. The focus must not be solely on

the family members' problems. The therapist would drop an Encounter Document for each beneficiary/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 (i.e., addressing an excluded diagnosis) would also be non-billable. For example, a substance or alcohol group that did not focus on the mental health problem would be a non-billable group therapy code.

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 30 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 resulting from a mental health condition. Rehabilitation Services must restore, maintain, and/or teach the beneficiary/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-solved, 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).

Reminder: it is important to distinguish between “rehabilitation” and “personal care activities.” Personal care activities are not reimbursable activities.

Rehabilitation services are subject to medical necessity. The beneficiary/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 service documentation should not talk about therapy or therapeutic processes as this would be practicing out of scope for the MHS/MHRS.

INDIVIDUAL REHABILITATION

Billable Codes – Individual Rehabilitation

90899-17 [H2017] Individual Rehabilitation Services

Individual Rehabilitation services are provided to an individual beneficiary/client with the focus on developing the above named skills. Services can be provided either face-to-face, telehealth 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 beneficiary/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. Services that are more for personal service care than rehab should be non-billable.

This may be a helpful 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. Assessment from other clinic expired; care plan expired; Rehabilitation Services not on care plan; no assessment paperwork; ICP expired would also be reasons a non-compliant code would be used besides not documenting within 30 days from the date of service.

Individual Rehab services that would otherwise be billable, except that the service is written after 30 days or longer from the date of service should be a non-compliant service code.

COLLATERAL REHABILITATION

Billable Codes – Collateral Rehabilitation Services

90899-157 [H2015] Collateral Rehabilitation

Collateral rehabilitation services are provided to a beneficiary/client's significant support person(s) to benefit the beneficiary/client with the focus on developing the above named skills. Services can be provided either face-to-face, over the phone or via telehealth. Think of this services as providing simple counseling which is different from checking in or linking and coordinating care.

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

Example of Collateral Rehabilitation note:

- CSP goal # 1, indicates that the beneficiary/client frequently uses manipulation to get his mother to give him money so he has a lower motivation to seek permanent employment. The PP has been working with the beneficiary/client's mother to develop a list of the things that the beneficiary/client should work toward being more responsible. In this process, we have discovered that part of the problem is that the beneficiary/client's mother is not very effective at setting limits, and easily gives in to the beneficiary/client's demands. The beneficiary/client's mother complains that it is "difficult" for her to set a limit with the beneficiary/client because she fears that if she says no to the beneficiary/client, he will choose to go live someplace else. PP has been working to teach the mother how to set a limit, what to expect as a potential reaction to the limit, and how to maintain consistency.

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 beneficiary/client present. The service may have been provided while the beneficiary/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. For example, helping the parents obtain stable housing so that the beneficiary/client would not be as stressed, may sound like helping the beneficiary/client, but the note is addressing the parents' lack of skills to obtain or maintain housing for the family.

Non-Billable Reminders: providing services that are out of scope of practice (making dietary recommendations or using psychological techniques), conducting job searches for the parent, listening to the parent vent without addressing how the parent can work with beneficiary/client to ameliorate the problem.

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 30 days starting with day 1 as the date of service.

GROUP REHABILITATION

Billable Codes – Group Rehabilitation

99078 [H2015] Group Educational/Rehabilitation

Psycho-educational services rendered to beneficiaries/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 beneficiaries/clients who have been identified as needing assistance with medication management. Beneficiaries/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 beneficiaries/clients to teach him/her ways to better organize his/her thoughts so that medication compliance can be improved.

Reminder: Group Rehabilitation and Group Therapy cannot occur at the same time. Should there be a need for 2 providers. Group providers must have similar scope of practice credentialing.

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 (i.e. substance abuse groups).

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 was not on the ICP or Care Plan; or was provided before the ICP or Care Plan was established.

Group services that would otherwise be billable, except that the service is written after 30 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 form is signed by the beneficiary agreeing to the administration of each prescribed psychiatric medication. 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 beneficiary/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 medication 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 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 beneficiary/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 beneficiary/client and/or family or coordinating care, the “level” of service can be selected based on total face-to-face time spent with the beneficiary/client and family.

Counseling, as it relates to Evaluation and Management (E&M) codes, is defined as a discussion with a beneficiary/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
- ✚ Beneficiary/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 beneficiary/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.

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.

OUTPATIENT E&M CODES

Billable Codes – Medication Services

99212 – [H2010] PF/PF/SF/10

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

Unless the chart note documents that greater than 50% of an E&M visit is spent counseling the beneficiary/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 beneficiary/client visit typically 15 minutes.

Unless the chart note documents that greater than 50% of an E&M visit is spent counseling the beneficiary/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 straight forward 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 straight forward 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.

99214 – [H2010] Det/Det/Mod/25

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

Unless the chart note documents that greater than 50% of an E&M visit is spent counseling the beneficiary/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.

99215 – [H2010] Com/Com/High/40

Comprehensive, face-to-face, office based beneficiary/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 beneficiary/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 beneficiary/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 beneficiary/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 systems: 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 beneficiary/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 beneficiary/client).

- ✚ Established beneficiary/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 beneficiary/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 beneficiary/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 the beneficiary/client present)

Medication Services, beneficiary/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 beneficiary/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 beneficiary/client is not present), for services such as giving an injection, administering medication, and discussing side effects, risks, benefits of psychotropic medication.

Non-Billable Codes – Medication Services

90899-18 Comp Med Service Non-Billable

Non-billable medication codes are used for any medication service activities while the client/beneficiary is in a psychiatric hospitalization, jail or any other facilities determined to be ineligible for Federal Financial Participation or ineligible for Medi-Cal. This non-billable code would also be used for services 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 30 days or longer from the date of service.

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 beneficiary/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, 2020)

This code is typically used when the beneficiary/client is seen for a crisis evaluation and the clinician is able to de-escalate the beneficiary/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 beneficiary/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).

Sample Crisis Psychotherapy-Billable Progress Note

CONFIDENTIAL PATIENT INFORMATION See California W & I Code (Section 5328) Fed. Regs 42 CFR Part 2		COUNTY OF ORANGE, CALIFORNIA HEALTH CARE AGENCY BEHAVIORAL HEALTH SERVICES MHP ENCOUNTER DOCUMENT											
Clinic Name Clinic Address		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Client's Name:									
Check only one encounter type <input type="checkbox"/> Clinic <input type="checkbox"/> Telephone <input type="checkbox"/> Field <input type="checkbox"/> Home <input checked="" type="checkbox"/> Site Visit Indicate Location <input type="checkbox"/> Adult Group Home <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> Board & Care <input type="checkbox"/> Child/Youth Group Home <input type="checkbox"/> Private Residence <input type="checkbox"/> Psych Res Tx Ctr		Include address where service was provided if Field or Site Visit was selected as the encounter <input type="checkbox"/> Age Specific Comm Ctr <input type="checkbox"/> Client's job site <input type="checkbox"/> Community Court <input type="checkbox"/> Correctional: <input type="checkbox"/> Community Location: <input type="checkbox"/> CYS Touchstones <input type="checkbox"/> Drug/Alcohol Residential		<input checked="" type="checkbox"/> ER <input type="checkbox"/> Faith Based <input type="checkbox"/> Homeless Shelter <input type="checkbox"/> Host Clinic: <input type="checkbox"/> Independent Clinic <input type="checkbox"/> Phoenix House		DOB: MRN #: FIN #:							
Face to Face <input type="checkbox"/> Y <input type="checkbox"/> N		Trauma <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown		Substance Abuse Diagnosis <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown		General Medical Condition Codes							
ICD Dx Treated Today (Primary First)		Date of Service		Service Minutes		Date of Documentation		Documentation Minutes		Travel Minutes		Face to Face Minutes	
F32.1		8/31/2020				124		18		24		124	
				Do not include "doc" time		Clinician Credit Reason		Date:		Initials:			
						<input type="checkbox"/> MD Sig <input type="checkbox"/> Clt Sig <input type="checkbox"/> No Care Plan <input type="checkbox"/> Dup Svc <input type="checkbox"/> Other							
		Date ED Entered		OT Initials		Repeat Service Corrections Only		Date ED Corrected		OT Initials			
						<input type="checkbox"/> 77 Repeat Svc Diff Provider <input type="checkbox"/> 76 Repeat Svc Same Provider							
Language in which client received services, if other than English:						Interpreter utilized? <input type="checkbox"/> (Describe in Progress Note)							
INDICATE ONLY ONE CPT CODE FROM THE LIST BELOW													
DESCRIPTION		CPT CODE		HCPCS		CPT MODIFIERS							
BH CRISIS SERVICE													
Crisis Psychotherapy		<input checked="" type="checkbox"/> 90839 SF 70		H2011-HE		EVIDENCE BASED PRACTICES (EBP)							
Crisis Intervention		<input type="checkbox"/> 90899 SF 70				SERVICE STRATEGIES (SS)							
Med Escort		<input type="checkbox"/> 90899-10 SF 72		H2011-HE		The following Non Billable Activities were provided: <input type="checkbox"/> Addressing a non-included dx <input type="checkbox"/> Faxing <input type="checkbox"/> Addressing health care <input type="checkbox"/> Leaving Messages <input type="checkbox"/> APS Report <input type="checkbox"/> Looking for a client <input type="checkbox"/> CAR Report <input type="checkbox"/> Med Escort <input type="checkbox"/> Chart Review or Record review <input type="checkbox"/> Scheduling an Appointment <input type="checkbox"/> Consultation and/or collaboration <input type="checkbox"/> Translation <input type="checkbox"/> Copying <input type="checkbox"/> Waiting <input type="checkbox"/> Other:							
Crisis Intervention - Non-Fee		<input type="checkbox"/> 90899-14 SF 72											
Non-Bill Crisis Intervention Travel Time		<input type="checkbox"/> 90899-116 SF 72											
Crisis Intervention Noncompliant		<input type="checkbox"/> 90899-116 SF 73		Min:									
Non-Bill Indiv Therapy/Counsel Travel Time		<input type="checkbox"/> 90899-160											
Therapy/Counseling Noncompliant		<input type="checkbox"/> 90899-161											
I authorize HCA to bill for services indicated on this fee sheet. I certify that the services shown on this sheet were furnished by me personally, that the services were medically necessary.													
Jane Green, LMFT										8/31/2020			
Print Provider Name and License						Provider Signature				Date			

Sample Crisis Psychotherapy-Billable Progress Note

COUNTY OF ORANGE, CALIFORNIA HEALTH CARE AGENCY
BEHAVIORAL HEALTH SERVICES
HOSPITAL ASSESSMENT PROGRESS NOTE

Client Name: _____

MRN: _____ - _____ - _____

Was the Evaluation completed? Yes No (If No, complete Reason and Presenting Problem fields only)

Reason: AMA Referred to AOABH CAT (CYBH Only) Taken into Custody
 AWOL Not Medically Cleared Other: _____

Presenting Problem:

16 year old mixed descendent (African and Hispanic) male brought into the ER by his mother due client having persistent feeling of loss of interest. Client has been sleeping a lot, isolating from his friends and family, not eating well, gets frustrated easily when asked and today he told his mother that he wanted to end his life, but was not willing to share his plans or means. Mother is very worried about her son's well-being and fears that he might kill himself. This clinician went to the hospital to assess client for possible danger to self, danger to others or gravely disabled and determine if client needs to be placed on 5585 hold.

Mental Health History – Including Collateral Information Provided by Family / Other / 3rd Party (If no, explain):

Client reported suffering from depression since he was 12 year old when his parents' divorce "and my dad doesn't want anything to do with me). Client reported that his depression intensified over the year, where he described school to be difficult, and he also lost interest in sports. He reported that over the past two weeks, he has had low energy, not wanting to get out of bed, not having appetite and not interacting with friends. He stated that his girlfriend broke up with him yesterday, and he felt like life was not worth living. Client has not received outpatient services, but is interest in seeing a therapist.

Drug / Alcohol History & Current Signs/Symptoms of Intoxication:

None reported

Medical Problems / Medical Consults:

None reported

Current Medications:

None reported

Sample Crisis Psychotherapy-Billable Progress Note

COUNTY OF ORANGE, CALIFORNIA /HEALTH CARE AGENCY
 BEHAVIORAL HEALTH SERVICES
 HOSPITAL ASSESSMENT PROGRESS NOTE

Client Name: _____

MRN: _____ - _____ - _____

Suicide Risk Indicators

<input type="checkbox"/> Current / previous S/I, S/A	<input type="checkbox"/> Command hallucination	<input type="checkbox"/> Chronic physical illness
<input checked="" type="checkbox"/> Hopelessness / helplessness	<input type="checkbox"/> History of drug / alcohol use / abuse	<input type="checkbox"/> Perceives self as burden to others
<input type="checkbox"/> Suicide Plans	<input type="checkbox"/> Currently under the influence	<input type="checkbox"/> Sees no other option
<input type="checkbox"/> Means or access to means	<input type="checkbox"/> Prescription drug abuse	<input type="checkbox"/> History of impulsivity
<input type="checkbox"/> Intent to commit suicide	<input type="checkbox"/> Recent loss (death, divorce, job)	<input type="checkbox"/> Major psychiatric diagnosis
<input type="checkbox"/> Possession of a firearm	<input type="checkbox"/> History of psychiatric hospitalization	<input type="checkbox"/> Preparations (will, give aways, goodbye)
<input type="checkbox"/> Access to a firearm	<input checked="" type="checkbox"/> Significant life events / stressors	<input type="checkbox"/> Family history of suicide
<input type="checkbox"/> Prior use of violent methods	<input type="checkbox"/> Chronic pain	

Narrative:

Suicide Protective Factors / Consumer Strengths

<input checked="" type="checkbox"/> Hope and optimism about future	<input type="checkbox"/> Agrees to take psychiatric meds	<input checked="" type="checkbox"/> Able to follow thru w/ safety planning
<input type="checkbox"/> Future plans / goals	<input type="checkbox"/> Will see psychiatrist in 24 – 48 hrs	<input checked="" type="checkbox"/> Agrees to 24 hour monitoring
<input checked="" type="checkbox"/> Immediate, reliable support	<input type="checkbox"/> Suicide not supported by current belief / values	<input type="checkbox"/> Agrees not to consume drugs / alcohol
<input checked="" type="checkbox"/> Purpose / meaning in life	<input type="checkbox"/> Religiously / spiritually invdved	<input type="checkbox"/> Other: _____
<input checked="" type="checkbox"/> Positive connection with family	<input type="checkbox"/> Resilient towards life stressors	
<input type="checkbox"/> Seeing a therapist	<input type="checkbox"/> Agrees to elimination of means	

Narrative: client does want to live and want to be able to go back to school. He desires to complete his high school education. Client reported that his mother is a supportive factor and he does not "want to see her sad."

Danger to Others Risk Indicators

<input type="checkbox"/> History of violence	<input type="checkbox"/> History of impulsivity	<input type="checkbox"/> Preoccupation with violent fantasy
<input type="checkbox"/> Plans to harm or kill another	<input type="checkbox"/> Paranoid delusions about others	<input type="checkbox"/> Command hallucinations involving violence
<input type="checkbox"/> Possession to a firearm	<input type="checkbox"/> Agitated easily	<input type="checkbox"/> Persecutory delusions
<input type="checkbox"/> Access to a firearm	<input type="checkbox"/> Prescription drug abuse	<input type="checkbox"/> Major psychiatric diagnosis
<input type="checkbox"/> Other means	<input type="checkbox"/> Obsessing about violence	<input type="checkbox"/> Sees no other option
<input type="checkbox"/> Intent to harm or kill another	<input type="checkbox"/> History of psychiatric hospitalization	<input type="checkbox"/> Identifiable / intended victim(s)
<input type="checkbox"/> History of incarceration	<input type="checkbox"/> Currently under the influence	<input type="checkbox"/> Significant life events / stressors
<input type="checkbox"/> Anger / rage / frustration	<input type="checkbox"/> History of drug / alcohol use / abuse	

Narrative: None reported

Danger to Others Protective Factors / Consumer Strengths

<input type="checkbox"/> Hope and optimism about future	<input type="checkbox"/> Agrees to take psychiatric meds	<input type="checkbox"/> Able to follow thru w/ safety planning
<input type="checkbox"/> Future plans / goals	<input type="checkbox"/> Will see psychiatrist in 24 – 48 hrs	<input type="checkbox"/> Agrees to 24 hour monitoring
<input type="checkbox"/> Immediate, reliable support	<input type="checkbox"/> Violence not supported by current belief / values	<input type="checkbox"/> Agrees not to consume drugs / alcohol
<input type="checkbox"/> Purpose / meaning in life	<input type="checkbox"/> Religiously / spiritually invdved	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Positive connection with family	<input type="checkbox"/> Resilient towards life stressors	
<input type="checkbox"/> Seeing a therapist	<input type="checkbox"/> Agrees to elimination of means	

Narrative: N/A

Sample Crisis Psychotherapy-Billable Progress Note

COUNTY OF ORANGE, CALIFORNIA /HEALTH CARE AGENCY
 BEHAVIORAL HEALTH SERVICES
 HOSPITAL ASSESSMENT PROGRESS NOTE

Client Name: _____

MRN: _____ - _____ - _____

Grave Disability / Self Neglect Risk Indicators

<input type="checkbox"/> Previous history of grave disability	<input type="checkbox"/> Poor hygiene	<input type="checkbox"/> Lack of positive social support
<input type="checkbox"/> Refusing or failing to eat	<input type="checkbox"/> Paranoia related to food or shelter	<input type="checkbox"/> Major psychiatric diagnosis
<input type="checkbox"/> Disoriented / confused	<input type="checkbox"/> Eviction / recent homelessness	<input type="checkbox"/> No plans for filling basic needs (food, etc)
<input type="checkbox"/> Refusing to take medications	<input type="checkbox"/> Wandering aimlessly	<input type="checkbox"/> Insufficient clothing

Narrative: None reported

Other Risk Indicators (time not included in billable time) None reported

Suspected Child Abuse Report filed Suspected Elder Abuse Report filed Suspected Dependent Adult Abuse Report filed

Was the client interviewed? Yes No (If Yes, complete following field)

What's the best outcome that could occur as a result of your evaluation today?

This clinician met with client, empathized, provided psychoeducation on depression, assessed for suicidality and reviewed safety plan. Discussed about coping strategies (i.e., Breathing techniques, journaling, taking a walk with his mother). Also discussed him seeing a therapist for ongoing support. Client expressed not wanting to kill himself. He reported that he desires to live and wants to get help for his depression. Minor was able to discuss about coping factors that works.

Was the client's Family or Significant Other interviewed? Yes No (If Yes, complete following field)

What's the best outcome that could occur as a result of your evaluation today?

This clinician met with mother and reviewed safety plans. Encouraged the mother to lock up all sharp objects and meds. Also encouraged mother to monitor client, and should any crisis occurs to contact CAT. Also provided mother with a referral for outpatient services. Mother was willing to follow through with safety plan and will contact the clinic in the morning

Risk Summary:

Level of Risk Considered to be: None Low Medium High

As evidenced by:

Client has no means or plans to harm himself. He stated that he had a desire to live and do better in school.

If Level of Risk Considered to be Low, Medium, or High, complete Acuity of Risk section

Acuity of Risk Considered to be: Acute Chronic

As evidenced by: History (Hx) of depression

Sample Crisis Psychotherapy-Billable Progress Note

COUNTY OF ORANGE, CALIFORNIA HEALTH CARE AGENCY
 BEHAVIORAL HEALTH SERVICES
 HOSPITAL ASSESSMENT PROGRESS NOTE

Client Name: _____

MRN: _____ - _____ - _____

Interventions (What did I do today?)

This clinician met with mother and obtained psychosocial history, medical, mental health history, family history, history of substance abuse, family history and hx. of abuse. Met with client and conducted MSE, assessed for suicidality, provided psychoeducation on depressive symptoms. Reviewed safety plan.

Plan of Care:

Minor is not a danger to self and has no means, plans or intent to harm himself. Therefore, minor will not be placed on a 72 hour hold. Minor has been referred for outpatient services. Reviewed safety plan with mother and minor. Mother and minor were in agreement with the safety plan

Disposition:	<input type="checkbox"/> Hospitalized 5150 / 5585	<input type="checkbox"/> Hospitalized - Voluntary	<input checked="" type="checkbox"/> Diverted
Tarasoff:	<input type="checkbox"/> Yes (NB)	<input checked="" type="checkbox"/> No	
Weapons:	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	
Weapons Type:			
Confiscated by:			

Jane Green

8/31/2020

Print Provider Name & License

Provider Signature

Date

Additional Client Information Requirements

Unk.	Referred to CYBH	Referred to CYBH	Referred to CYBH
Client's Highest Education	Assigned Clinician	Assigned Care Manager	Assigned Psychiatrist

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 such as treating/evaluating an excluded diagnosis. 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 beneficiary/client is placed on a 5150 hold and staff accompanies and remains with the beneficiary/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 30 days or longer from the date of service.

OTHER SERVICES

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

Short-term one-to-one intensive behavioral intervention provided as often as needed to children, adolescents, and transitional-aged youth throughout the week. “TBS Coaches” (usually unlicensed staff) who provide this service are required to have special training to do so, and have all documentation co-signed by a licensed clinician if their direct supervisor is unlicensed.

The only documentation required for County Providers regarding TBS is documenting coordinating care on the Services tab of the Care Plan. This tells the auditor that since TBS is not a stand-alone service, you are providing the therapy and other specialty mental health services, and that the TBS provider is coordinating care with you. There should also be a progress note written for each consultation and coordination of care every time the TBS coach consults with you regarding the beneficiary/client’s

progress. This is a requirement at least once a month for TBS providers, and it is a billable Case Management or ICC service if the beneficiary/client is PWB/IS.

PATHWAYS TO WELL-BEING

I. Who meets the PWB criteria?

- Children/youth under the age of 21 years.
 - i) When the PWB beneficiary turns 21 years old, they are no longer eligible to receive ICC or IHBS services and therefore cannot bill for these services. However, if the beneficiary continues to require specialty mental health services and meets medical necessity, they may continue to receive other similar mental health services such as Case Management and Rehab, and bill for those services so long as they are authorized on the Care Plan.
- Children/youth with an open child welfare case.
- Children/youth with full scope Medi-Cal.
- Children/youth who meet medical necessity for Specialty Mental Health Services.
 - i) This would include at least one assessment session that established an included mental health diagnosis by a licensed or waived clinician practicing within his or her scope of practice, at least one impairment as a result of the included diagnosis and how ICC and/or IHBS services could ameliorate the impairment(s).
 - ii) You will need to create or revise an Interim Care Plan (ICP) or Care Plan and put ICC and IHBS along with descriptions of these interventions of how you would implement these services to meet the beneficiary/client's goal and objectives.
- CYPBH has created an Eligibility Assessment Form (Pathways to Well-Being/Intensive Services) that you will need to be completed for every child/youth to assess and verify if the child/youth meets the criteria for PWB services. Please complete the form in the EHR as this is required for every child.

BILLING CODES

In providing PWB/IS, there are two general categories of services that are provided. These categories are:

- 1) Intensive Care Coordination (ICC)
- 2) Intensive Home-Based Services (IHBS)

It is important 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 CYBH AQIS Support Team.

Billable Code –Intensive Care Coordination

90899-151- Intensive Care Coordination

Intensive Care Coordination (ICC) is an intensive form of Targeted Case Management (TCM) that facilitates assessment of, care planning for, and coordination of services for children and youth. ICC includes urgent

services for beneficiaries with intensive needs. Although ICC services are similar to traditional TCM, these services are intended for children and youth who:

- Are involved in multiple child-serving systems;
- Have more intensive needs; and/or
- Whose treatment requires cross-agency collaboration

A **CFT Modifier** was added to IRIS to track the clinician's attendance at a Child Family Team (CFT) meeting. The new modifier is titled MCFT and must be used to track all CFT meetings attended. Please select the MCFT modifier in the charge details window.

Reminder: ICC services cannot be billed for beneficiary/clients placed Juvenile Hall; neither can ICC be billed 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 placement planning.

Non-Billable Codes-Intensive Care Coordination

90899-152 Intensive Care Coordination No Fee

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.

Contacting parties to organize or to schedule meetings or to discuss/review logistics for ICC or IHBS services are considered clerical tasks and cannot be billed as ICC. The provider should use the ICC Non-billable service codes for these services.

Non-Compliant Codes-ICC

90899-153 Intensive Care Coordination – Non-Compliant

ICC 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 ICC service is provided would result in the service being deemed non-compliant.

ICC services that would otherwise be billable, except that the service is written after 30 days or longer from the date of service.

Billable Codes – Intensive Home Based Services

90899-154 Intensive Home-Based Services

IHBS services are essentially the same services as Rehab services. The difference between IHBS and more traditional Mental Health Services is that IHBS is expected to be of significant intensity to address the mental health needs of the child/youth consistent with the child's/youth's beneficiary/client plan, and will predominantly be delivered outside an office setting, and in the home, school or community.

If an individual is psychiatrically hospitalized the provider must utilize non-billable service codes.

IHBS Services: (Include but are not limited to):

- Medically necessary skill-based interventions for remediation of behaviors or improvement of symptoms including, but not limited to, the implementation of a positive behavioral plan;
- Development of functional skills to improve self-care, self-regulation or other functional impairments;
- Improve and/or educate self-management of symptoms;
- Promote the development or maintenance of social supports;
- Address behaviors that interfere with the achievement of stable and permanent family life;
- Address behaviors that impede seeking or maintaining a job;
- Address behaviors that impede with educational objectives;
- Address behaviors that impede with transitional independent living (i.e. seeking or maintaining housing and living independently).

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

Non-Billable Codes-Intensive Home Base Services

90899-155 Intensive Home-Based Services - Non-Billable

Non-billable rehab services provided to individuals. The service may have been provided while the beneficiary/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.

IHBS services cannot be billed for beneficiary/client's placed in a psychiatric hospital.

The travel time associated with a billable 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 90899-154 code. For more examples, please refer to the [Travel Time section](#) within this manual.

Non-Compliant Codes – Intensive Home Based Services

90899-156 Intensive Home-Based Services Non-Compliant

IHBS 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.

IHBS services that would otherwise be billable, except that the service is written after 30 days or longer from the date of service.

Child and Family Team (CFT) Meetings

PWB cases must have CFT meetings no less frequently than every 90 days.

At a minimum, the child/family, social worker and mental health provider must be present at the CFT meeting. Ideally, the 90 day review should be to address the effectiveness of the treatment and provides the clinician with the opportunity to monitor and make any necessary adaptations to the treatment plan.

Your documentation should reflect your unique contribution to the team meeting per your specialized discipline and your intervention should address the children/youth's goals and objectives as outlined on the Care Plan. Your progress note and intervention should not be only a summary of details of the meeting but you must integrate and detail in your progress note intervention section what you uniquely contributed to the meeting that addresses the child's/youth's mental health goals and objectives.

The suggested practice on ensuring that CFT meetings occur no less frequently than every 90 days is by using the PWB 90 day tracking form. The form identifies who the ICC Coordinator is and provides a quick visual that CFT meetings are in compliance. Log the CFT meeting date on the form that corresponds to the CFT progress note.

If you choose not to use the PWB 90 day tracking form, make your 90 day reassessment progress note easy to find by referencing it at the beginning of the note, since the state auditors will be looking for evidence that this was completed periodically.

Examples of the 90-Day PWB Member Tracking Sheet

Pathways to Well-Being Member Tracking Sheet Blank Form

Clinic Name and address

**Pathways to Well-Being
(PWB) Member Tracking Sheet**

Label

ICC Coordinator (Name & Title): _____

Date: _____

90-Day Review: 1st Quarter	90-Day Review: 2nd Quarter	90-Day Review: 3rd Quarter	90-Day Review: 4th Quarter / Annual Review
Child meets PWB criteria: ___ Yes ___ No			
See progress note dated: _____ for update of case.	See progress note dated: _____ for update of case.	See progress note dated: _____ for update of case.	See progress note dated: _____ for update of case.
Initials: _____	Initials: _____	Initials: _____	Initials: _____
90-Day Review: 1st Quarter	90-Day Review: 2nd Quarter	90-Day Review: 3rd Quarter	90-Day Review: 4th Quarter / Annual Review
Child meets PWB criteria: ___ Yes ___ No	Child meets PWB criteria: ___ Yes ___ No	Child meets PWB criteria: ___ Yes ___ No	Child meet PWB criteria: ___ Yes ___ No
See progress note dated: _____ for update of case.	See progress note dated: _____ for update of case.	See progress note dated: _____ for update of case.	See progress note dated: _____ for update of case.
Initials: _____	Initials: _____	Initials: _____	Initials: _____
90-Day Review: 1st Quarter	90-Day Review: 2nd Quarter	90-Day Review: 3rd Quarter	90-Day Review: 4th Quarter / Annual Review
Child meets PWB criteria: ___ Yes ___ No			
See progress note dated: _____ for update of case.	See progress note dated: _____ for update of case.	See progress note dated: _____ for update of case.	See progress note dated: _____ for update of case.
Initials: _____	Initials: _____	Initials: _____	Initials: _____
90-Day Review: 1st Quarter	90-Day Review: 2nd Quarter	90-Day Review: 3rd Quarter	90-Day Review: 4th Quarter / Annual Review
Child meets PWB criteria: ___ Yes ___ No			
See progress note dated: _____ for update of case.	See progress note dated: _____ for update of case.	See progress note dated: _____ for update of case.	See progress note dated: _____ for update of case.
Initials: _____	Initials: _____	Initials: _____	Initials: _____
90-Day Review: 1st Quarter	90-Day Review: 2nd Quarter	90-Day Review: 3rd Quarter	90-Day Review: 4th Quarter / Annual Review
Child meets PWB criteria: ___ Yes ___ No			
See progress note dated: _____ for update of case.	See progress note dated: _____ for update of case.	See progress note dated: _____ for update of case.	See progress note dated: _____ for update of case.
Initials: _____	Initials: _____	Initials: _____	Initials: _____

Pathways to Well-Being Member Tracking Sheet

When do we stop providing PWB services?

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. PWB subclass members no longer qualify for ICC and IHBS when they turn 21 years old. Once the individual is 21 years old, providers should no longer bill ICC or IHBS. Providers should update the Care Plan by removing ICC and IHBS services and adding Targeted Case Management (TCM) and Rehab services if medically necessary.

- A. The ICC Coordinator needs to complete the PWB Eligibility Assessment Form only with the following information: clinic name, beneficiary/client's name, DOB, MRN, check "NO" in item 6 regarding beneficiary/client does not meet PWB criteria, date and sign. Have a support staff enter the End Date into the PWB/KTA Cohort 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.

Please note that the PWB subclass members' status are subject to change depending on whether or not they return to the family and then may reenter the foster care system again. If this happens, then it is appropriate to re-assess their eligibility status and complete the form again.

Informational Links:

- [Core Practice Model Guide for Katie A Subclass Members](#)
- [Medi-Cal Manual for Intensive Care Coordination \(ICC\), Intensive Home Based Services \(IHBS\) & Therapeutic Foster Care \(TFC\) for Medi-Cal Beneficiaries](#)
- [Integrated Core Practice Model](#)

Presumptive Transfer

To provide children, youth, and non-minors in foster care who are placed outside their counties of original jurisdiction access to Specialty Mental Health Services (SMHS) in a timely manner in compliance with Presumptive Transfer (Assembly Bill 1299, Ridley-Thomas, Chapter 603, and Statutes 2016). 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. Presumptive Transfer does not apply to children or youth with Kinship Guardianship Assistance Payment (Kin-GAP) or Adoption Assistance Program (AAP) if they are not in foster care.

Within 3-business days of the presumptive transfer decision, the placing agency (either Child Family Services or Probation) notifies the Orange County Mental Health Plan (MHP) single point-of-contact, posted publically at the Orange County Health Care Agency website, where the child, youth, or non-minor resides. The placing agency has 2-business days of making the determination to ensure that the foster youth's residence address has been updated in the Medi-Cal Eligibility Data System (MEDS).

The placing agency requests SMHS with a Notification of Presumptive Transfer form, which 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)

After the Notification of Presumptive Transfer has been received by Children Youth and Behavioral Health (CYBH) Administration, CYBH determines if the child, youth, or non-minor has already been linked with SMHS County or County Contracted provider in Orange County. If the child, youth, or non-minor has not been connected to SMHS, then CYBH Administration will facilitate linkage to a SMHS County or County Contracted provider by contacting the provider and giving them the necessary information to contact the placing agency and caregiver to generate the referral for SMHS.

There are two types of Presumptive Transfer Referrals:

- 1) EXPEDITED Presumptive Transfer Referral – A County or County Contracted clinic is assigned a Presumptive Transfer case within 48 hours or by the next available working day. The clinic will assign a therapist and an intake appointment within two (2) working days. The clinic will submit the AB1299 Presumptive Transfer Fax Cover Sheet within two (2) working days to CYBH Administration with the assignment and appointment.
- 2) NOT EXPEDITED Presumptive Transfer Referral - A County or County Contracted clinic is assigned within two (2) working days (excluding weekends or holidays). The clinic will assign a therapist and an intake appointment within five (5) working days. The clinic will submit the AB1299 Presumptive Transfer Fax Cover Sheet within five (5) working days to CYBH Administration with the assignment and appointment.

CYBH Administration will inform the placing agency of the County or County Contracted provider's contact information so the placing agency may send the required mental health documentation. CYBH is required to accept an assessment, if one exists, of needed SMHS for the foster child, youth, or non-minor from the MHP in the county of original jurisdiction. Nothing should preclude CYBH from updating the assessment or conducting a new assessment if clinically indicated, but these updates or new assessments may not delay the timely provision of SMHS to the child, youth, or non-minor.

If a foster child, youth, or non-minor dependent has Medi-Cal and is referred from an outside county placing agency, foster care agency, or a caregiver, and the Presumptive Transfer referral **does not** come from CYBH Administration, please submit a completed AB1299 Presumptive Transfer Fax Cover Sheet for Programs with the assigned therapist and scheduled initial intake appointment. The AB1299 Presumptive Transfer Fax Cover Sheet should be sent to CYBH Administration either by secure email or by fax.

If an intake appointment **cannot** be made for any reason, please follow your clinic's internal close-out procedure for referrals and send the AB1299 Presumptive Transfer Fax Cover Sheet to notify CYBH Administration that the referral is being closed. Please include the reason the referral is being closed and the date your clinic closed the referral.

Services provided are to be consistent with the child, youth, or non-minor's treatment needs and goals as documented in the mental health beneficiary/client plan and as determined by the child, youth, or non-minor's Child and Family Team. The placing agency contact person should be kept up-to-date with the status of the case and should be notified if the case is discharged.

For questions regarding Presumptive Transfer, please secure email OCPresumptiveTransfer@ochca.com or call CYBH Administration at (714) 834-5015.

Additional Information:

- **All County Letter No. 17-77**
- **All County Letter No. 18-60**
- **All County Letter No. 19-94**
- **Presumptive Transfer P & P 01-13-2020**

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 beneficiaries/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. Waiting time.
2. Translating/Interpreting.
3. Clerical Services:
 - a. Faxing
 - b. Scheduling appointments
 - c. Photocopying
4. Searching for a missing beneficiary/client.
5. Checking messages.
6. Leaving messages.
7. Providing transportation.
8. Supervision with a supervisor/service chief.
9. Completion of bus pass application.
10. Completion of immigration form.
11. Completion of the monthly Shelter Plus Care visit form.

12. A home visit for the sole purpose of doing a Shelter Plus Care inspection.
13. Most letter writing is not billable.
14. 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
15. Any service while the beneficiary/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 missing/expired/failed Care Plan, missing type of service on the Care Plan, etc.) we are not authorized to submit the services for billing. Additionally, services would be deemed non-compliant if progress notes were written after 30 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. **“A failed Care Plan may result in recouping 12 months of claims.”** Care Plans usually fail for the following reason: Does not document medical necessity or show impairment related to the mental illness.

REMINDER:

Clinicians can include modifiers to their progress notes if the service provided meets criteria identified in the [Guide for Use of Modifiers on Progress Notes](#).

The guide provides descriptions on the types of services that will qualify as a modifier with the associated codes. A grid of all of the available modifiers to be listed on a progress note is provided in the guide. Some commonly used modifiers include: Telehealth, CFT Meetings, Ethnic Specific, Evidence Base Practices, etc. Staff should consult with their supervisor for further guidance as to the order of priority when selecting modifiers.



BILLING

Along with documenting a provided service on a progress note, it is also the duty of the writer to complete the proper billing for the service provided. 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 Services. 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 Encounter Document (ED). The purpose of this portion of the progress note is to accurately code a service to obtain appropriate third-party reimbursement. It is the process of providing complete healthcare information for each beneficiary/client encounter in terms that a third-party payer understands.

The screenshot displays the OC EHR billing interface. On the left is a vertical menu with the following items: **✓ Mental Health Service**, MSE Appearance/Speech, MSE Emotional State, MSE Thoughts/Content/F, MSE Sensorium/Intellectu, MSE Areas of Immediate C, Risk/Protective Factors, **✓ Billable Services** (highlighted in green), **✓ Non-Billable Services** (highlighted in yellow), Non-Compliant Services, and MORS - PN. The main area on the right contains a form for entering service details. At the top, there is a 'Service:' field with the text 'Psychotherapy 38-52 min (90834)'. Below this are two columns: 'Service Minutes' and 'Doc Minute'. The 'Service Minutes' column has four input fields, with the first containing '50' and the others containing 'minute(s)'. The 'Doc Minute' column has one input field containing '11'. At the bottom, there is a 'Face to Face Minutes' section with an input field containing '50' and 'minute(s)'.

Billable Services

Service:

Service Minutes	Doc Minutes	Travel Minutes	Total Minutes
<input type="text" value="50"/> minute(s)	<input type="text" value="11"/> minute(s)	<input type="text" value="14"/> minute(s)	<input type="text" value="75"/> minute(s)
<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>
<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>

Face to Face Minutes
 minute(s)

If the Client's primary language is not English:

Services were provided in

<input type="radio"/> Spanish	<input type="radio"/> Mandarin
<input type="radio"/> Vietnamese	<input type="radio"/> Other
<input type="radio"/> Farsi	
<input type="radio"/> Korean	
<input type="radio"/> Arabic	

Specify Other Language

Was an Interpreter used other than provider?

Yes
 No

If Yes, indicate Interpreter Type

Language Line
 Staff other than clinician
 Other.

Was there any billable non-face to face time?
 Yes No

Please explain billable non-face to face time

Please go to the Charge Details icon above to validate the Diagnoses and add any Billing Modifiers, Service Strategies (SS), or Evidence Based Practice (EBP) Codes in the Charge Details window. If all Diagnoses are correct, add Modifiers as necessary then click OK. Clicking OK in the Charge Details window is required to appropriately link your Diagnosis, modifiers, SSs, or EBPs to the service. If the Diagnoses are not correct, please go back to the Diagnoses and Problems widget to correct and resubmit your service. Diagnosis cannot be corrected within the Charge Details window.

Please click Yes or No to verify you opened the Charge Details window.

Yes
 No

Required Information for the Billing Tab(s)

- CPT code (“Service”): Select from the dropdown menu the appropriate CPT code for the service provided.
- Service Minutes: The time spent providing a service.
- Doc Minutes: The time spent documenting the service.
- Travel Minutes: See section entitled “Documenting Travel Time.”
- Face to Face Minutes: The time spent with beneficiary/client and/or family, when at least part of the service was face-to-face.
- Billable Non Face to Face Time: Select “Yes” or “No.” If “Yes” is selected, then please provide a brief explanation of the Non Face to Face billable service activity that occurred.
- Beneficiary/client’s primary language (complete ONLY IF beneficiary/client’s primary language is not English): Select in which language the service was provided.
- Interpreter: Select “Yes” or “No.” If “Yes” is selected, then indicate Interpreter Type.

- Charge Details: Open the Charge Details window to attach the diagnoses to the progress note and to select any applicable modifiers for the service provided. Select “Yes” or “No” to verify you opened the Charge Details window. See the [Guide for Use of Modifiers on Progress Notes](#).



- Signature: Click a green check mark  at the top left hand corner to electronically sign the progress note.

Other Required Information for the Encounter Tab in IRIS

There are additional items required to ensure the documentation captures all allowable revenues associated with a visit. These items can be captured in the BHS Pre-Reg Conversation. Please refer to the Quick Guides available on the [BHS EHR Blog](#) for more details on how to use the Encounter tab. It is a “tool” that should guide providers to select the appropriate level of service and/or procedure and therefore includes the following additional elements:

- Encounter Type (i.e., Clinic, Telephone, Home, Site, Field, etc.)
 - If Home or Site is selected then the appropriate sub-location must be selected as well.
 - 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 beneficiary/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 traveled to see the beneficiary/client at the beneficiary/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 beneficiary/client at the Santa Ana clinic.
 - For Telehealth services, choose Site as the encounter type and then a field named Place of Service will become available. Choose Telehealth from the Place of Service.
 - Field is defined as a location **with no** physical address (e.g., a street intersection).
- Trauma: Select whether trauma is present or not or unknown, as reported by the beneficiary/client. Please note that if “Yes” is selected, there must be further documentation of assessment of trauma history in the chart (typically in the assessment documents).
- Substance Abuse Diagnosis: Select “Yes,” “No,” or “Unknown.”

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 beneficiary/client** and transportation is when the **beneficiary/client is in the car with the provider and there is no service being provided.**

CLINICIAN IN THE CAR WITHOUT A BENEFICIARY/CLIENT:

It is considered “travel time” when a provider is in the car without a 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 beneficiary/client to bring them back to the clinic for an appointment.
 - d. If a clinician picks a beneficiary/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
 - e. If a clinician provides a billable service to the beneficiary/client while in the car, then this is considered SERVICE time.

CLINICIAN WITH BENEFICIARY/CLIENT IN THE CAR:

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

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

It is billable Service Time only if the beneficiary/client’s riding in the car is part of the impairment from a mental health disorder and the intervention addresses impairment and objective on the Care Plan.

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

- A clinician went from the clinic to the beneficiary/client’s home in the car without a beneficiary/client (5 minutes – Travel time).
- Picked up the beneficiary/client and took them to the grocery store. During the ride the clinician spoke to the beneficiary/client about how to manage the beneficiary/client’s stress while riding to grocery store, which has prevented beneficiary/client from leaving the house to buy food for himself (7 minutes – Service time).
- While at the grocery store the clinician assisted the beneficiary/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 beneficiary/client's stress (30 minutes – Service Time).

- Then the clinician took the beneficiary/client back in the car to the beneficiary/client's home and processed and debriefed the beneficiary/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 the beneficiary/client in the car (5 minutes - Travel time).
- The service was documented on the same day (13 minutes – Documentation time).

Billing of above example in Progress Note

CONFIDENTIAL PATIENT INFORMATION
CA W&I Code, Section 5328,
42 CFR Part 2, 45 CFR Parts 160 & 164

County of Orange Health Care Agency
Behavioral Health Services
1200 N. Main St, Ste 200, Santa Ana, CA 92701



Patient: Zzztest, Client A
DOB/Age/Gender: 07/12/1984 36 years Female

MRN: 1000-64-xxxx

Progress Notes

Document Name: BH MHS Individual PC/CM PN -Text
Service Date/Time: 08/28/2020 16:41 PM
Document Status: Auth. (Verified)
Created by: Smith, John (08/28/2030 4:41 PM)
Signed by: Smith, John, Psy.D., NPI#108xxxxxxx
(08/28/2020 16:41 PM)

BH MHS Individual PC/CM PN Entered On: 8/28/2020 4:41 PM
Performed On: 8/28/2020 2:53 PM by Smith, John

Mental Health Services Individual

Diagnosis Treated Today: Diagnosis Treated Today

1. Schizoaffective Disorder, Depressive Type (F25.1)

Purpose of Visit: Consumer is having more isolation and depressive symptoms as a result of her Schizoaffective Disorder and has left the house in the past 5 days. Consumer's isolation and refusal to leave the house puts her at risk for not having food in the home as she needs to go to the grocery store. Consumer reports significant stress when riding in traffic and not wanting to engage with people including the cashier at the store. 10 minutes travel time billed only for going to consumer's house and returning to clinic.

Intervention PN: Picked up consumer and took her to the grocery store. During the ride, the clinician spoke to the consumer about how to manage her stress while riding to grocery store, which has prevented her from leaving the house to buy food for herself. While at the grocery store the clinician assisted the consumer 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. Then the clinician took the client back in the car to the consumer's home and processed and debriefed her about their experience, reinforcing the utilization of positive coping skills

Response to Intervention PN: The consumer was reticent at first, but was able to work through her discomfort. Her depressive symptoms seemed to lift some as she was able to go through the store and gather all her needs for the week. She still feels uncomfortable, but able to tolerate the discomfort better. She admitted feeling more relieved once she got back home and noted that she is still not ready to take a trip to the store on her own.

MHS Individual PN Plan: Will continue to work on coping skills of relaxation and role play conversations with store clerks. Also will help consumer evaluate negative expectations and assumptions and explore evidence for and against her assumptions to give a more balanced expectation and assumptions. Will see consumer in 3 days for home session.

Smith, John - 8/28/2020 2:53PM

Billable Services

MH Individual Billable Services: Psychotherapy 37 + min (90834)

Service Minutes 90837: 45 minute(s)

Document Minutes 90837: 13 minute(s)

Travel Minutes 90834: 10 minute(s)

Total Minutes 90837: 68 minute(s)

Face to Face Minutes Billable: 45 minute(s)

Modifier Required? : Yes

Smith, John - 8/28/2020 2:53PM

Modifiers List- Images currently included in the form version of this document have not been included in the text rendition version of the form.

2. **NON-BILLABLE TRAVEL TIME:** If a clinician provides a billable service to a beneficiary/client and during that same visit the clinician took the beneficiary/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 beneficiary/client’s home in the car without a beneficiary/client (5 minutes – travel time).
- Picked up the beneficiary/client and took him/her to the grocery store. During the ride the clinician and beneficiary/client only listened to the radio (7 minutes – non-billable travel time).
- While at the grocery store the clinician assisted the beneficiary/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 beneficiary/client back in the car to the beneficiary/client’s home. During the ride back, the clinician and the beneficiary/client only listened to the radio. (8 minutes – non-billable travel time).
- The clinician then traveled back to his/her office without a beneficiary/client (5 minutes - travel time).
- The service was documented on the same day (13 minutes – documentation time).

Completion of ED according to Example #2:

CLINIC NAME Santa Ana Clinic 1200 N. Main Street Santa Ana, CA 92701		<input checked="" type="checkbox"/> Santa Ana PACT <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Client Identification Doe, Jane	
Encounter Type Site Visit	Home locations Select one	Site Locations Other Comm Loc	Face to Face Yes	F to F min 30	(Date ED entered _____ OT Initials _____)
Trauma Yes	Substance Abuse No	Language used English	Interpreter Utilized ? <input type="checkbox"/>		(Date ED Corrected _____ OT Initials _____)
Date of Service 01/01/2012	Service Mins 30	Date of Doc (S)	Doc Mins 13	Trav Time 10	Non-bill Trav 15
AXIS I & II (Treated today) 295.30	AXIS I & II Not Treated Today	GROUP TREATMENT			ENCOUNTER LOCATION (If not clinic or PT's home) Enter address Ralph's 123 Main Street Santa Ana, CA 92701
		# of Clients	# of Therapists	Co-Therapist Name	
		BILLABLE CPT			CPT MODIFIER I (Service Strategies) M53 Supportive Education
		90832 (H2015-HE) Psychotherapy 16-37 min			Additional SERVICE STRATEGIES
		NON-BILLABLE CPT /NON-COMPLIANT CPT			CPT MODIFIER II (Evidence Based Practices) 01 Assert. Comm Tx
		No Entry			CPT MODIFIER III (Unusual Procedures) None
AXIS III 12	AXIS V/GAF 45	NON-BILLABLE TRAVEL CPT 90899-113 Comp com Svc MH - Non-billable travel			
		OTHER CPT CODE			

3. **NON-BILLABLE SERVICE TIME:** The case in which a clinician would use NON-BILLABLE SERVICE time to document the transporting of a beneficiary/client, would be when the clinician did not provide any billable service at all with the beneficiary/client - solely transporting the beneficiary/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 beneficiary/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 beneficiary/client's home in the car without a beneficiary/client (5 minutes – non-billable travel time).
- The clinician picked up the beneficiary/client and took the beneficiary/client to the doctor. During the ride the clinician and beneficiary/client only listened to the radio (7 minutes – non-billable service time).
- While at the doctor's office, the clinician waited for the beneficiary/client in the waiting room (30 minutes – non-billable service time).
- Then the clinician took the beneficiary/client back in the car to the beneficiary/client's home. During the ride back, the clinician and the beneficiary/client only listened to the radio. (8 minutes – non-billable service time).
- The clinician then traveled back to his/her office without a beneficiary/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:

CONFIDENTIAL PATIENT INFORMATION
See California W & I Code (Section 5328)
Fed. Reg. 42 CFR Part 2

COUNTY OF ORANGE, CALIFORNIA, HEALTH CARE AGENCY
BEHAVIORAL HEALTH SERVICES MHP ENCOUNTER DOCUMENT

CLINIC NAME Santa Ana Clinic 1200 N. Main Street Santa Ana, CA 92701		<input checked="" type="checkbox"/> Santa Ana PACT <input type="checkbox"/> <input type="checkbox"/>		Client Identification Doe, Jane	
Encounter Type Site Visit	Home locations Select one	Site Locations Other Comm Loc	Face to Face Yes	F to F min 15	(Date ED entered _____ OT Initials _____)
Trauma Yes	Substance Abuse No	Language used English	Interpreter Utilized ? <input type="checkbox"/>		(Date ED Corrected _____ OT Initials _____)
Date of Service 01/01/2012	Service Mins 45	Date of Doc (S)	Doc Mins 13	Trav Time 10	Non-bill Trav 0
AXIS I & II (Treated today) 295.30		GROUP TREATMENT		ENCOUNTER LOCATION (If not clinic or PT's home) Enter address Mr. Doctor's office 123 Main Street Santa Ana, CA 92701	
AXIS III 12		AXIS V/GAF 45		CPT MODIFIER I (Service Strategies) M55 Delivered in Partnership w/Health Care	
		BILLABLE CPT No Entry		Additional SERVICE STRATEGIES	
		NON-BILLABLE CPT /NON-COMPLIANT CPT 90899-5 Case Mgt - Non-billable		CPT MODIFIER II (Evidence Based Practices) 01 Assert. Comm Tx	
		NON-BILLABLE TRAVEL CPT No Entry		CPT MODIFIER III (Unusual Procedures) None	
		OTHER CPT CODE No Entry		<input type="checkbox"/> 76 Repeat Svc Same Prov. <input type="checkbox"/> 77 Repeat Svc Diff Prov.	
REPEAT SERVICES CORRECTIONS					
Date Corrected		OT Initials			

Clinician Credit Reason # _____ Date _____ Init _____
Credit reasons 1)MD sig (2) Ctr. Sig (3) No MTP/CSP (4) Dup Svc (5) Other

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 beneficiary/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. County EHR is designed to help providers answer the following five questions:

1. Who did I see?
2. Why am I seeing them today? (Purpose of today's visit)
3. What did I do today? (Interventions)
4. How did the beneficiary/client react? (Response to Interventions)
5. What will we do next? (Plan)

County EHR automatically pulls basic demographic information of beneficiary/client into every note, so all you need to do is copy and paste Diagnosis Treated Today into the note to answer question 1 in full. It is your responsibility to address questions 2 through 5 in a clear and concise manner by following the prompts in the EHR.



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

Assessment

1. Who: Beneficiary/client is a 26 year-old Chilean single female presenting with symptoms of anxiety and depression (decreased need for sleep, frequent tearfulness, difficulty concentrating).
2. Why (Purpose of visit): Beneficiary/client was seen for the initial assessment for Specialty Mental Health Services (SMHS).
3. What (Interventions): Assessed current problems and conditions, gathered mental health, medical and substance use history, and explored beneficiary/client's risks and strengths.
4. Beneficiary/client Response (Response to intervention): Beneficiary/client was cooperative and engaged throughout the session. Beneficiary/client acknowledged an interest in receiving SMHS. Beneficiary/client denied any current SI/HI.
5. Plan (What will we do next?): Will continue collaborating with beneficiary/client on completing assessment and developing Care Plan.

*Important reminder: Assessment services are being reviewed for medical necessity and accurate billing. Every assessment note must justify that new information was gathered and/or new assessment activity was done.

CYPBH Assessment Sample:

Purpose of today's visit (Why am I seeing Beneficiary/Client): Beneficiary/client is a 7-year-old Caucasian male referred to CYPBH by the school psychologist due to beneficiary/client having difficulty staying on task, easily distracted, and unable to complete his schoolwork. Beneficiary/client has an IEP in place due to failing all his courses and being disruptive in classroom. Beneficiary/client's mother also has observed beneficiary/client to be impulsive and hyperactive. He needs constant redirections to complete a task.

Interventions (What did I do today): Clinician met with mother and beneficiary/client in order to conduct a mental health assessment. Clinician presented and discussed informed consent form, MC Mental Health Services and provider list. NPP and NPP acknowledgement of Receipt. Clinician provided car safety information and offered Voter registration to beneficiary/client's mother. Clinician obtained the following information from mother: presenting problem, psychosocial, history of trauma, medical history, mental health history, medication, substance exposure. In addition, clinician gathered from mother as to beneficiary/client's strengths and risks. Met with beneficiary/client and conducted Mental Status Exam, gathered information as his strength and risks from beneficiary/client's point of view. Towards the end of this session, clinician met with beneficiary/client and his mother. Highlighted beneficiary/client's cooperative behavior during this session with beneficiary/client alone and how he was easily redirected.

Response to Intervention (How did the beneficiary/client react): beneficiary/client and mother participated in discussion and completion of intake forms. Beneficiary/client's mother signed informed consent form and receipt of NPP. Beneficiary/client's mother reported that beneficiary/client's school psychologist recommended for beneficiary/client to get mental health evaluation. Mother reports that beneficiary/client has been having difficulty staying on task, gets easily agitated and he constantly has to redirect him at home. At school his teacher has observed beneficiary/client to constantly get out of his seat, is disruptive in the classroom to a point the teacher sends beneficiary/client to the school psychologist's office. Beneficiary/client is failing in his school. Beneficiary/client reported having difficulty staying on task and gets frustrated easily because "my brain is running a 100 miles per hour and I can't stop it." Beneficiary/client wants to do better in school and does want to get help to cope with hyperactivity and impulsivity. Beneficiary/client was easily distracted in session but was easily redirected.

Plan (What will we do next): Clinician plans to complete the assessment summary and develop Care Plan.

Individual Rehab Service Sample:

1. Who: Beneficiary/client is a 35 year-old, Caucasian, Male with dx of Schizoaffective D/O - Bipolar Type
2. Why (Purpose of visit): Drove to beneficiary/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 (Interventions): Met with beneficiary/client. Spoke to beneficiary/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 beneficiary/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. Beneficiary/Client Response (Response to intervention): Beneficiary/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. Beneficiary/client did agree to try to take showers more often and said he would use the note idea.
5. Plan (What will we do next?): Beneficiary/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 beneficiary/client in 2 weeks to see if he has achieved his goal and will continue to address this need.

CYPBH Individual Rehabilitation Service Sample:

CPT: 90899-17

Service: 98 minutes

Doc: 15 minutes

Dx: F34.1 Persistent Depressive Disorder

B) The beneficiary/client is a 17 year-old male with a diagnosis of F34.1. The beneficiary/client reports feeling constantly sad and unmotivated. He complains of poor sleep and irregular appetite. He denies any suicidal or homicidal ideation, intent or plans. His self-esteem is low, and he has a history of substance abuse in the past. He does not do well in school, and is pessimistic about his future. The purpose of this session was to encourage the beneficiary/client to be more active in the community as well as to explore getting a job.

I) Rehabilitation Worker (RW) engaged the beneficiary/client in conversation to build rapport. Suggested to the beneficiary/client that participating in volunteer work or getting a job could result in him feeling better about himself. RW assisted the beneficiary/client in implementing alternative ways to set boundaries with other people. **The beneficiary/client requested to go shopping for clothes. While shopping we continued the conversation about getting a job as a way to learn independent living skills.**

R) The beneficiary/client shared that he feels bored and wants to explore new activities to do. He says that he wants to look for a job and RW assisted him.

OP) The beneficiary/client was open with RW, and communicated his needs.

Psychotherapy Sample:

1. Who: Beneficiary/client is a 23 y/o, SWF with diagnosis of Anxiety Disorder, Unspecified.
2. Why (Purpose of visit): Met with beneficiary/client to address anxiety which impairs beneficiary/client's ability to communicate with others.

3. **What (Interventions):** Met with beneficiary/client at her B&C to talk about ways to decrease her anxiety. Beneficiary/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. Beneficiary/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.

Writer provided beneficiary/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 beneficiary/client can use if she is worried that others are angry with her. Introduced concept of journaling with beneficiary/client as an outlet for her anxiety.

4. **Beneficiary/Client Response (Response to intervention):** Beneficiary/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. Beneficiary/client was very alert and articulate, but still reported feeling somewhat uneasy even though she knew they were no longer mad.
5. **Plan (What will we do next?):** In combination with the deep breathing and counting to 10, beneficiary/client will start to use a journal from today forward each time she feels anxiety. Beneficiary/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 beneficiary/client within the next two weeks to follow up on her use of journaling as well as deep breathing and counting.

Case Management Sample

1. **Who:** Beneficiary/client is a 35 year-old, SAM with dx of Schizoaffective D/O - Bipolar Type
2. **Why (Purpose of visit):** Met with B&C Operator following visit with beneficiary/client in an effort to coordinate services.
3. **What (Interventions):** Talked with B&C operator about beneficiary/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 beneficiary/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 beneficiary/client was able to take shower without prompting. If unable to take shower on own, by 8/22, then B&C operator will prompt beneficiary/client and report to writer.
4. **Beneficiary/Client Response (Response to intervention):** Beneficiary/client not present for this discussion.
5. **Plan (What will we do next?):** B&C operator to monitor beneficiary/client and not prompt with showers this week to see if beneficiary/client can remember on his own.

Action words commonly used in **Assessment** notes:

Assessed	Developed	Formulated	Redirected
Clarified	Discussed	Gathered	Rendered
Collaborated	Elicited	Inquired	Reviewed
Completed	Explored	Observed	Summarized
Conducted	Evaluated	Obtained	Synthesized

Action words commonly used in **Rehab** notes:

Assisted	Encouraged	Identified	Rehearsed
Clarified	Engaged	Modeled	Reminded
Coached	Explained	Practiced	Role Played
Demonstrated	Facilitated	Problem Solved	Set Limits
Educated	Focused On	Provided	Summarize

Action words commonly used in **Psychotherapy** notes:

Acknowledged	Encouraged	Normalized	Recommended
Advised	Engaged	Observed	Reminded
Assisted	Explained	Offered	Resolved
Assured	Explored	Planned	Responded
Clarified	Facilitated	Praised	Reviewed
Confronted	Focused On	Prioritized	Set Limits
Counseled	Identified	Problem Solved	Structured
Demonstrated	Monitored	Processed	Summarized
Elicited	Negotiated	Reassured	

Action words commonly used in **Case Management** notes:

Addressed	Developed	Gathered	Referred
Answered	Directed	Helped Plan	Simplified
Arranged	Discussed	Informed	Talked About
Attempted	Documented	Inquired	Taught
Consulted	Explained	Instructed	
Contacted	Facilitated	Linked	
Coordinated	Followed Up	Monitored	

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** needed medical, educational, social, prevocational, vocational rehabilitative, or other community service that are impacted by their identified mental health problems. 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 (i.e., form letter of attendance for probation records) 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 beneficiary/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 beneficiary/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 beneficiary/client is unable to sign the informed consent and provides a verbal consent, it should be clearly documented. If the beneficiary/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 beneficiary/client soon after the beneficiary/client turns 18 years old.

Informed Consents for Telehealth and Telephonic Services

Beneficiary/client who will be receiving telephone or telehealth services will need to be given the General Informed Consent for Telehealth and Telephonic Services. For those determined appropriate for and able to engage in telehealth services, the Email Acknowledgement Form will also need to be completed. Both forms will need to be reviewed with beneficiary/client. If the beneficiary/client is unable to sign the informed consent and provides a verbal consent, it should be clearly documented.

Medication Consents

Psychiatric services that involve the prescription of psychotropic medication require the beneficiary/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.

Medication consents must cover all of the following: 1) Reason for taking the medication; 2) Reasonable alternatives were discussed with beneficiary/client; 3) Frequency range; 4) Duration; and 5) Possible side effects if medication taken longer than 3 months. These areas cannot be left blank or crossed out. The consent also must include the psychiatrist's signature, degree/job title and license number.

Please note that the duration cannot be left unspecified (i.e., TBD). Per DHCS, a specific end date must be provided.

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 beneficiary/client transfers to another clinic within the same legal entity. Application Regarding Psychotropic Medication (JV220) for dependents or wards of the court needs to have the lists of the side effects beyond 3 months prescription in question #17 for JV220A or question #13 for JV220B. Please scan into the EHR any attachments of side effects. Also, the route of administration needs to be included on the consent for question #19 for JV220A or question #16 for JV220B

Consents for Returning Beneficiaries/Clients

If a beneficiary/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 beneficiary/client's primary language or have a clear statement as to the fact that it was translated to the beneficiary/client, with the date on which it was translated and the name of the person who did the translation for the beneficiary/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

Use when a beneficiary/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 beneficiary/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

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.

ASL- American Sign Language Interpretation

Procedure

American Sign Language Interpretation Services – For County

Use when a beneficiary/client that has been identified to communicate in American Sign Language that you do not sign, and you have exhausted all internal office resources:

- Requests must be made **at least three business days** (72 hours) before the service. (Accurate Communication)
 - Complete Request Service form available on County Intranet page under Behavioral Health Services Forms – Language Services [ASL- Interpretation Services](#)
 - Submit the request form via email or fax to:
 - Email: ASLCA@accuratecommunication.net
 - Fax: (310) 868-1464
 - There is a **minimum** charge of **two hours** per request. Subsequent charges shall be in **15 minutes** increments.
 - Cancellations must be made **one full business day** prior to service to avoid paying in full for the service requested.
 - Designated ASL Coordinator: (310) 401-3998
- **Interpreter’s name and ID #** should be documented in the beneficiary/client’s record

- Brief the interpreter and give any special instructions

Reminder: If a service was provided in another language other than English please include language provided located in the Billing Tab section and identify if an interpreter was involved or not. Beneficiaries/Client Plans must also be provided in preferred language and noted on the CP.

SPECIALIZED (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 Youth Prevention Services has 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 beneficiary/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 beneficiaries/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.

CAST Example Documentation

MHS Assessment

Diagnosis Treated Today: Adjustment Disorder, Unspecified (F43.20); Child Sexual Abuse, suspected, Sequela (T76.22XS)

Purpose of the Visit: Eight year old female was interviewed by the CAST team due to allegedly being sexually abused by her 21 y/o male cousin. The 8 y/o was referred for a mental health evaluation to assess for post-traumatic stress symptoms and to determine if the child is struggling with the aftermath of the traumatic experience.

Intervention: Clinician met with assigned Detective, Social Worker and parents to collect information regarding the alleged abuse and assess if further mental health services is needed for the child. Clinician gathered information from the parents on their observation of their daughter's behavior in the home and school. Clinician assessed the parents' knowledge and ability to help the youth cope and adjust with the alleged abuse. The cousin had been living with the family for a couple of years, but left the country. The parents verbalized their feelings of anger that they were unaware that their nephew was allegedly abusing their daughter. The parents reported that daughter is more clingy/needy of mother's reassurance and attention since reporting of the alleged abuse. Parents have been very sensitive and supportive to her and are interested in other ways that they can support her during this difficult time.

Based on the evaluation information gathered today, child was referred to Child Guidance Center for outpatient mental health treatment.

Continuing Care Placement Unit (CCPU)

CCPU is a unit of clinicians who are co-located with the Social Services Agency Children and Family Services division, working with children and youth in foster care. CCPU is split into two teams: one team provides intensive care coordination services and one team under Treatment Foster Care Oregon (TFCO) provides intensive mental health treatment services.

What is the role of CCPU case managers?

CCPU works very closely with the Social worker.

The plan might include any of the following:

- Participate in team meetings (and CFT - Child Family Team) 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 as needed.
- Assess substance abuse problems and provide linkage to services as needed.

- Consultation and assistance regarding children psychiatrically hospitalized,
- 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 Treatment Foster Care Oregon (TFCO)?

MTFC is now Treatment Foster Care Oregon 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 TFCO in 2004 as a joint project of the Social Services Agency (SSA) and the Orange County Health Care Agency Behavioral Health (HCA), Children, and Youth Prevention Services. Seven clinicians in the CCPU program provide the mental health treatment services that are an integral part of this model.

The Treatment Foster Care Oregon 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 TFCO 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 Treatment Foster Care Oregon is the 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 TFCO 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

CCPU Intensive Care Coordination Documentation Example:

Purpose of visit: 10 y/o female with symptom history including sad and anxious moods, restlessness and irritability, verbal and physical aggression, oppositional defiance, bullying of peers, and periodic elopement behaviors that place the youth at continued risk for disruption from current placement and/or needing higher level of care. For purposes of consultation and care coordination, CCPU participated in the beneficiary/client’s CFT.

Intervention: CCPU participated in beneficiary/client’s CFT today with ssw, beneficiary/client, foster parents, therapist and WRAP team. Discussed the youth’s progress and strengths and areas of continued concern for this beneficiary/client and foster family. Foster mother reports that youth has improved her behaviors and has responded well to the rewards systems and structure put into place after the last CFT meeting. Praised foster mother for doing a great job rewarding the youth’s improved behaviors while ignoring bad behaviors, which has helped reduce the stress and chaos in the home. Pointed out that medications are a support, but unlikely the reason for the increased compliance (given this changed immediately after foster mother sat down with youth and explained she would have to return to STRTP if she doesn’t change her behavior). SSW reported family was able to get a refill of the meds so that youth will not run out and shared that she is med compliant.

Plan: CCPU will continue to provide consultation and supportive case management services to SSW and the foster family and will continue to consult TBS Coach and update the WRAP team as needed.

CCPU Treatment Foster Care Oregon Individual Therapy Documentation Example:

14 year old Asian male who exhibits symptoms of ADHD and PTSD which include distractibility, inattention, impulsivity, avoidance of stimuli that remind him of past traumatic experiences, recurrent memories of traumatic events, sleep disturbances and anxiety. These symptoms impair his school, home and community functioning and periodically place his residential placement in jeopardy. Since entering the TFCO program the beneficiary/client has impulsively run away a few times and insinuates he will do so again. He also experienced disruptiveness at school and in the foster home due to defiance, impulsivity, anxiety, stealing, and distractibility.

Clinician assisted him in the acquisition, maintenance and enhancement of skills that would improve his emotional and behavioral stability in his foster home and during visits with adult sister so that he could progress toward reunification with sister. Clinician attempted to engage the beneficiary/client despite evasiveness and avoidance. Clinician attempted to gather information regarding functioning in the foster home, performance in school and connecting with aftercare family. Clinician repeatedly redirected him to conversation as he was often distracted, unfocused, tangential.

Affirmed his efforts to engage in behaviors that earn points on his school card and daily point sheet. Coached and encourage his engagement in prosocial activities, exercise and effective management of impulsivity and anxiety. Reinforced his helpfulness in the foster home. Encourage him to contact and stay in touch with his sister throughout the week. Reinforced his management of his impulsivity and anxiety particularly by practicing stopping and thinking before he acts and calmly expressing his thoughts and feelings. Coached the beneficiary/client on communicating clearly and coherently.

Coached him on improving his thoughtfulness and impulse control as he engages with caregivers in foster home.

The beneficiary/client was very distracted, unfocused and sometimes disengaged from session. Initially, he struggled to speak coherently providing single words utterances, incoherent expressions, and mumbling. He was fairly receptive to trying to express and clarify himself. He complained that he was bored and disoriented with his circumstances. As the session progressed with feedback about his struggle and suggestions for stopping and thinking through his thought before communicating he gradually became more calm, coherent and engaged. The beneficiary/client was receptive to reinforcement and positive feedback about his prosocial functioning. He was considerate of strategies he could enact to cope with his boredom and disorientation. He was non-committal about how he might improve his ability to regulate his anxiety, distractibility and impulsiveness. He was also receptive to affirmation for his prosocial endeavors, respectful engagement with adults, and managing his impulsivity, inattention, distractibility.

This clinician provided intensive care coordination with various providers on this case to effectively coordinate care for the beneficiary/client. Clinician will continue to provide individual therapy on a weekly basis to target improvement in his management of anxiety, impulsivity, distractibility, and inattention to assist in his progress toward graduating from TFCO and reunifying with his sister.

SPECIALTY PROGRAM

Crisis Stabilization Unit (CSU)

The County Crisis Stabilization Unit (CSU) provides emergency crisis stabilization services to adults ages 18 and older who cannot wait for a regularly scheduled appointment on a 24-hour, 7-day per week basis. Crisis stabilization services includes crisis intervention, therapy, psychiatric assessment and medication administration, nursing assessment, consultation with significant others and outpatient providers, peer mentor services, referral, linkage and follow-up services. CSU medical professionals provide telephonic psychiatric consultation for community emergency departments; county operated and contracted programs requesting access to CSU and to inpatient psychiatric services in the community. The goal of this service is to refer beneficiaries/clients to the most appropriate non-hospital setting when indicated, and authorize individuals to psychiatric inpatient units when the need for this level of care is present. Crisis stabilization services are also designed to minimize distress for the beneficiary/client or family resulting from lengthy waits in emergency departments, reduce the wait time for law enforcement presenting beneficiaries/clients for emergency behavioral health treatment and treating the beneficiary/client in the least restrictive setting as appropriate.

Due to the fact that the CSU is not in the enhanced Electronic Health Record as the rest of the outpatient system of care, the documentation is still completed in a hard copy chart. 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. Crisis stabilization is a blended service, therefore progress notes from all disciplines note date and time of service for continuity care and treatment timeline. The initial entry or the MD note should show medical necessity for crisis stabilization 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 beneficiary/client is voluntary there should be an informed consent. If the beneficiary/client is involuntary there should be a completed 5150 form in the chart.
9. The beneficiary/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. Beneficiaries/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:

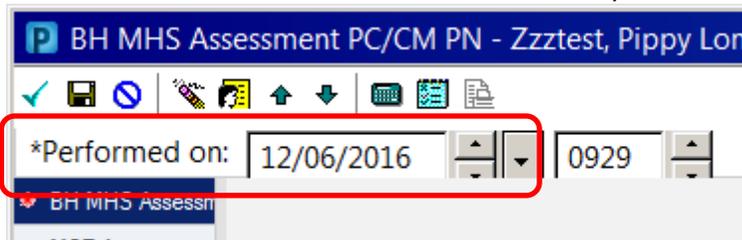
- a. **White-out should not be used** on any document in the chart.
- b. Place one single line through the item you wish to remove/correct.
- c. Write "error" and/or "addendum."
- d. Initial the correction.
- e. Date the correction.



Electronic Health Record:

Modifying a progress note

1. On the BH Outpatient Summary page of the beneficiary/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:



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

- 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 beneficiary/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 (for forms scanned into the EHR)
 - 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. 30 Day Policy
 - a. Within BHS, it is expected that services rendered are documented as soon as possible. However, there are times in which the documentation of service will occur on a different day from the date of service. While BHS will allow for different day documentation (DDD), **no content changes can be made to a progress note after 30 days from the date the service was provided.**
 - If your note was **written after 30 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 30 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 30 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/providers who have separated from BHS.
 7. Initials (for paper charts or paper documents scanned into the EHR)
 - a. Each page of a multi-page document should be initialed unless that page is signed in full.
 8. Page Numbering (for paper documents scanned into the EHR)
 - 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 (for paper documents scanned into the EHR)
 - 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 30 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 and the Care Plan (CP). The Initial Assessment includes a Psychosocial Assessment with a Mental Status Exam, Community Functioning Evaluation, and the Diagnosis Form. Please note that upcoming changes to the County EHR may include combining these assessment forms into one form. As of February 2020, only licensed or waived clinicians are completing these forms in the County EHR. The Initial Assessment and CP should be completed within 60 days of opening the case. In the event that the Initial Assessment and CP 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.

Please note that DHCS has given feedback on extending number of assessment sessions without medical necessity. Although the provider has up to 60 days to complete their assessment and care plan, did the provider need to wait the full 60 days to start treatment? The state's feedback on several reviewed cases indicated that the providers were not gathering any new information during the assessment as evidenced in their progress notes. Therefore, they concluded that there was no medical necessity to continue billing for assessment; and the beneficiary/client should already be in treatment. Please be mindful that extended assessment sessions must demonstrate medical necessity and the complexity of the beneficiary/client to justify continuing to bill for assessment. This needs to be documented in your assessment progress notes.

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 of 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 beneficiary/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.

Initial Assessment Paperwork

This refers to the Initial Assessment and the Care Plan (CP). The Initial Assessment includes a Psychosocial Assessment with a Mental Status Exam, Community Functioning Evaluation, and the Diagnosis Form. Please note that upcoming changes to the County EHR may include combining these assessment forms into one form. All 11 sections of the Psychosocial must be assessed and documented in the initial assessment as well as all annual updates. Blank sections are seen by DHCS as line items that were not assessed. For example, because the EHR has not required the medical history to be completed, we have been out of compliance with this line item. Please note that the **Medical History and the linkage to a Primary Care Physician (in the Coordination of Care tab) are required elements in our assessments.**

The required elements of an assessment are:

1. Presenting Problem
2. Relevant conditions and psychosocial factors affecting the beneficiary's physical health and Mental health
3. History of trauma or exposure to trauma
4. Mental Health History
5. Medical History
6. Medications
7. Substance Exposure/Use
8. Beneficiary/Client Strengths
9. Risks
10. Mental Status Exam (MSE)
11. ICD-10 Diagnosis



These forms (Psychosocial with the Mental Status Exam, Community Functioning Evaluation and Diagnosis Form) and Care Plan must be completed by a licensed or waived clinician. The Initial Assessment and CP should be completed within 60 days of opening the case. In the event that that the Initial Assessment

and CP 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.

Please note that DHCS has given feedback on extending number of assessment sessions without medical necessity. Although the provider has up to 60 days to complete their assessment and care plan, did the provider need to wait the full 60 days to start treatment? The state's feedback on several reviewed cases indicated that the providers were not gathering any new information during the assessment as evidenced in their progress notes. Therefore, they concluded that there was no medical necessity to continue billing for assessment; and the beneficiary/client should already be in treatment. Please be mindful that extended assessment sessions must demonstrate medical necessity and the complexity of the beneficiary/client to justify continuing to bill for assessment. This needs to be documented in your assessment progress notes.

Assessment and Annual Re-evaluation Timelines and Frequency

The Care Plan (CP) timeline becomes valid once the clinician or waived clinician completes all the assessment documents and Care Plan. All documents must be completed prior to the completion of the Care Plan. The Clinician's signature and date on the completed Care Plan begins the timeline. The beneficiary/client's collaboration in the CP and signature is still required.

The OC EHR system used to assist in determining if a CP was valid once the beneficiary/client's signature was obtained. Now that CP becomes validated when the completing clinician's signature is obtained, it is important that clinicians track the 365 day timeline until further notified.

There should no longer be gaps in timelines since Care Plans become valid once the clinician completes the annual assessment and CP. Please remember for the County EHR that the annual assessment includes the Psychosocial Document with MSE, which contains all 11 elements of assessments. The Community Functioning Evaluation and the Diagnosis form are expected to be updated as well. Care Plans still need to demonstrate that beneficiaries/clients were involved in the collaboration of goals and objectives. Beneficiary/client signatures are still required to show agreement with the plan; and the beneficiary/client or caregiver was offered a copy of the CP.

Use of the Interim Care Plan (ICP)

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 are more than one clinic involved in the beneficiary/client's care that share the OC EHR. The ICP is valid for the first 60 days from the date of admission.

The ICP 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 can be completed, but after you have enough information to, at least establish medical necessity. That is, at least one included ICD-10 mental health diagnosis has been established as well as an impairment as a result of that diagnosis.

The ICP must be developed and completed by a LMHP or waived clinician, who will also determine goals and objectives to be met to stabilize the urgent situation. The ICP is signed by the LMHP/waivered provider and includes his/her licensure or degree, NPI # and date. Beneficiary/client's signature is also obtained to demonstrate the beneficiary/client's agreement with the ICP, and a copy should be offered and documented on the plan. A progress note is also expected regarding the beneficiary's participation with the plan. As is the same with the regular care plan, the provider's signature is the activation date. Please

see section on ICP for an example. The County EHR will be revising the ICP to highlight all these requirements and make it easier for the provider to complete.

Medication Consents

Medication consents must demonstrate that beneficiaries/clients were informed of the following information:

1. Reason for taking the medication
2. Reasonable alternatives were discussed with beneficiary/client
3. Frequency range
4. Duration – must have a specific end date (i.e., cannot be “TBD” or “Ongoing”)
5. Possible side effects if medication taken longer than 3 months.

These areas cannot be left blank or crossed out. The consent must include the psychiatrist’s signature, degree/job title and license number.

Scope of Practice

Waivered or registered mental health professional may only direct services under the supervision of a Licensed Mental Health Professional (LMHP). Mental Health Rehabilitation Specialists (MHRS), under the direction of a LMHP may provide mental health services including contributing to Assessment and rehabilitative services, but cannot provide therapy.

They can also provide Targeted Case Management, Crisis Intervention and Rehabilitation Services. Other Qualified Providers refer to individuals at least 18 years of age with a high school diploma or equivalent degree and determined to be qualified to provide the service by the county mental health plan. Other Qualified Providers could provide mental health services (excluding therapy), Targeted Case Management and/or Crisis Intervention depending on the scope of practice the county mental health plan has determined, based on the provider’s level of education, training and experience.

Services that are rendered out of the scope of practice of the provider are non-reimbursable services.

GLOSSARY

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

Clinical appropriateness Defines the natural “link” that exists between the beneficiary/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 beneficiary/client.
- Focus on what is **clinically appropriate** for the beneficiary/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 beneficiary/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. BHS P & P is Corrections/Amendments to ED when provider no longer a County Employee

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 beneficiary/client and/or family, with at least part of the service face-to-face with the beneficiary/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 beneficiary/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 beneficiary/client. It does not include a bilingual therapist working with a monolingual non-English speaking beneficiary/client without an interpreter.

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

LMHP “Licensed Mental Health Professional” The following are considered LMHP’s: Physicians, licensed/waivered psychologists, licensed/waivered clinical social workers, licensed/waivered marriage & family therapists, and licensed psychiatric nurse practitioners

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 beneficiaries/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.

Scope of Practice describes the procedures, actions, and processes that a healthcare practitioners is permitted to undertake in keeping with the terms of their professional license,. The scope of practice is limited to that which the law allows for specific education and experience, and specific demonstrated experience. For example diagnosing is not a function within the MHS job classification and therefore is not within the scope of practice for the MHS

Telehealth If you spoke with the beneficiary/client over the telephone and were able to see them through an audio visual platform (similar to Face Time, Zoom , etc.), that would be a Telehealth service. If you can see the person while providing the service – Telehealth; if it’s just a telephone call - Telephone

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 beneficiary/client. 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.



CHANGES AHEAD – January 1, 2022

At the time of writing this documentation manual, AQIS was aware of some upcoming changes from the Department of Health Care Services (DHCS) that would affect our billing and documentation. Specifically, the state plans to transition to billing CPT codes, estimated roll out time probably around or after January of 2022. Although you are already familiar with CPT codes, the state will be formalizing a standardized list of CPT codes along with specific rules that we will need to be adhered to in using these codes. Some of our home-grown codes may be replaced by the CPT standard set of codes. Other codes such as the E&M codes, psychological testing codes and psychotherapy codes will remain the same; however, additional rules and codes may be required depending on face to face time or test administration time. Currently, our billing system in IRIS is not able to utilize a second and third CPT code with the same claim. Since the state has been accepting HCPC codes, our billing system has managed the conversion of CPT codes and any time rulings to HCPC codes, so providers could be reimbursed for services.

When the state transitions to CPT codes, the provider will be required to adhere to the rules of the CPT code and insure that their documentation supports the code. There will be rules regarding face to face time, second and third codes if the time spent is beyond a specific range for certain codes, and documentation supporting the medical necessity for using the extended sessions. There will be add-on codes for specific procedures utilized during a regular assessment, therapy or medication sessions along with additional documentation requirements for use of the add-on codes. The reasons for add-on codes and increase documentation requirements is that different procedures may be reimbursed at different rates. What we will present in this section is some of the changes and codes we expect to see in January of 2022. You will not be able to use these codes until DHCS has indicated that they are ready to receive them, and our billing system has built these codes into our system. So here is some general information that are in the works for the upcoming transition to CPT codes.

GENERAL ADD-ON CODES*

These general add-on codes will become effective no earlier than January 2022. These general add-on 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 refers to specific communication factors that complicate the delivery of a psychiatric procedure. Common factors include more difficult communication with discordant or emotional family members and engagement of young and verbally undeveloped or impaired patients. Typical patients are those who have third parties, such as parents, guardians, other family members, interpreters, language translators, agencies, court officers, or schools involved in their psychiatric care. (2020 CPT book)

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 (most frequently selected by Orange County Mental Health clinicians) as the principal service:

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



*Please note that the +90785 Interactive Complexity code will be locked out and denied for Outpatient Mental Health services when the 90839 Crisis Psychotherapy is utilized by the same provider on the same day.

+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)

***New rule:** When the state transitions to CPT codes in January 2022, the crisis psychotherapy code 90839 will lock out all other therapy codes. Clinicians, who provided one of the other psychotherapy codes earlier in the day, will not be able to claim for that service on the same day that they claimed for Crisis Psychotherapy. Another possible scenario may occur when CAT uses the crisis psychotherapy code and any other clinician trying to bill for other psychotherapy code on the same day will be locked out from billing 90832, 90834 or 90837.

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.

Total Duration of Prolonged Service (these are minutes in addition to the “typical” minutes associated with the E&M code)	Codes to Report
Less than 30 minutes	Not reported separately
30-74 minutes	*99354 once
75-104 minutes	*99354 once and *99355 once
105 minutes or more	*99354 once and *99355 twice or more for each additional 30 minutes

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

99214 – [H2010] Det/Det/Mod/25

- ✚ 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**

As mentioned earlier, 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.

