Health Care Agency, Behavioral Health Service, AQIS CYBH Support

# QRTips

**January 2018**

**Assessments** – Initial Assessments including the completion of the Care Plan must be completed as soon as possible and no longer than 60 days from the first intake session. The Care Plan is valid for **365 days** as soon as the required signatures are obtained.

A Care Plan is considered **valid** when all the requirements are met, including the content and all required signatures. Each individual Plan Coordinator (PC) must determine what signatures are required. For example:

- An LPHA signature (An LPHA is a Licensed, Waivered, or Board Registered Psychologist, MSW, MFT, MD, or RN). If the provider completing the Care Plan is not an LPHA, then a co-signature by an LPHA must be obtained. This co-signature is not a requirement for the CP to become valid* but it still needs to be obtained as soon as possible.
- Client signature (or reason client refused) is required
- Signature of the responsible party (e.g., the parent or conservator) if client is determined unable to sign for themselves
- For Medicare, an MD signature is required

*County Staff only - There are a number of rules in the OC EHR system which will assist in determining if the Care Plan (CP) is valid or not. If the OC EHR system determines that the CP is not valid, it will not allow billable planned services to be entered. Once the required signatures have been obtained by the PC, the Care Plan will be valid for 365 days. If not an LPHA provider, then the OC EHR does require the co-signature to be obtained for a CP to become valid.

**Intake/Advisement Checklist** – This form must be reviewed by the therapist/provider and the consumer or legal guardian. Both the therapist/provider and consumer or legal guardian must sign the form and then provide a copy of the signed form to the consumer or legal guardian. As soon as a consumer turns 18 years old, a new Intake/Advisement Checklist must be reviewed, completed and signed by the now adult consumer along with providing a copy of the Advance Health Care Directives Information sheet.

**Documenting and billing for making referrals** – When making a referral to a Psychiatrist for an evaluation or to a Psychologist for Psych testing, document how the referral was made. Was this a face to face consultation? Was it over the phone or was the referral made by completing a referral form? Also, document what information was given to the MD or Psychologist at the time of the referral. Documenting and billing for "Made referral to the MD" or "Made referral to Psychologist for Psych testing" is not sufficient as a billable service. If all of the required information is contained in the progress note, then this referral can be billed as a case management or ICC service, even if both staff work at the same location.