CYBH Documentation Guidelines for Assessment Measures *(for EHR clinics)*

General Guidelines

- In your PNs documenting assessment activity, use the terms "scoring" and "interpretation."
  - e.g., “The clinician administered, scored, and interpreted the Outcome Questionnaire.”
  - This is because you enter the information into the EHR in order to score and interpret the results so what you are doing is not simply data entry. Data entry would be an incomplete reflection of what you are doing, so please avoid using this term.

- To reduce potential audit issues, be sure the billable assessment note contains a brief description of the resulting interpretation. Refer to the Quickguides for sample phrasing and be sure to customize the summary before citing specific items and ratings.

- If the administration, entry and scoring/interpretation ***all take place on the same day***, only one billable assessment note is required.

- If the assessment tool(s) are ***entered into the EHR on a date different from the date of actual administration***, please document as follows:
  - In the EHR psychometric Powerform, change the 'performed on date' to match the date of actual administration and attach the Powerform to the MHP County Tx EOC.
  - In addition, separate notes are required:
    - The first note would be for the administration of the OQ. This note is billable for the ‘performed on date’ documenting that the measure(s) were administered and any follow up that took place. This note is attached to the FIN from the actual date of service (administration).
    - The second note would document scoring and interpretation and **would be a different FIN.** This note is billable documenting the scoring and interpretation activities dated with the date the measures were entered into the EHR (***not*** the performed on date).

Special Considerations

Intensive Services Clients:

- During the Intake, the IC will bill assessment for use of measures and the intake interview.
- During the 30-60 day assessment period, the clinician will bill assessment for all activity.
- Once the Care Plan is signed and/or whenever the assessment measures are administered/interpreted, the clinician will bill assessment *only for the time spent on the instruments*. The remaining time will be coded as it would normally be (i.e., non-billable CM, Individual Tx, Crisis Psychotherapy/HAPN, Crisis Intervention/HAPN, etc.).

Pathways to Well-Being (PWB) Clients:

- During the Intake and Assessment Period, all activity is billed as assessment.
- Once the client has been determined to meet PWB eligibility (which includes determination of medical necessity), all outcomes assessment time is billed as ICC.
- If PWB clients and placed in GH, assessments billed as assessment and not as ICC.