Assessment

The California code of regulations notes the following items that must be included in an assessment:

- PRESENTING PROBLEM is related to Primary Included Diagnosis,
- MENTAL HEALTH HISTORY supports the Primary Diagnosis as per DSM IV Criteria,
- PSYCHOSOCIAL ASSESSMENT includes the following (Give details if "Yes"; how does it IMPACT the mental health issues):
- CULTURE/SPIRITUALITY
- LEGAL
- MEDICAL (INCLUDES ALLERGIES)
- TRAUMA
- SUBSTANCE USE/ABUSE
- RISK FACTORS (HISTORY AND CURRENT)
- WORK/SCHOOL
- FAMILY/SOCIAL
- DEVELOPMENTAL (CHILDREN/ADOLESCENT)
- STRENGTHS
- CLINICAL SUMMARY
- UPDATED ANNUALLY

ASSESSMENT SUMMARY: The Summary: Moves from "what" (data) to "what does this mean and how do we use it?"

Sets the stage for prioritizing needs and goals. Basically: Family or client's story + Your clinical assessment = hypothesis or clinical summary.

See Chapter 2 in the clinical documentation guide for more information

Diagnosis

Must be updated annually.

A change in diagnosis must have documentation to support a change.

The Primary Diagnosis must be an "included" diagnosis.

The following list contains diagnoses that CANNOT be the primary focus of clinical treatment:

*Mental Retardation
*Learning Disorders
*Motor Skills Disorder
*Communication Disorders
*Autistic Disorder, other Pervasive Developmental Disorders are included
*Tic Disorders
*Delirium, Dementia & Amnestic & Other Cognitive Disorders
*Mental Disorders due to a General Medical Condition
*Substance-related Disorders
*Sexual Dysfunctions
*Sleep Disorders
*Antisocial Personality Disorder
*Other conditions that may be a focus of Clinical Attention, except Medication Induced

Clients can have these diagnosis but they CANNOT be the primary treatment diagnosis

See Chapter 2 section 2 in the clinical documentation guide for more information

Establish Medical Necessity

To be eligible for Medi-Cal reimbursement a service must meet all 3 criteria for medical necessity (diagnostic, impairment, & intervention):

❶ **Diagnostic:** Has an included diagnosis and as a result of the included diagnosis has at least one of the following impairments:

❷ **Impairment:**

- A significant impairment in an important area of life functioning (Social, Work, School, ADL's, etc.)
- A probability of significant deterioration in an important area of life functioning
- Children also qualify if there is a probability the child will not progress developmentally as individually appropriate. Children covered under EPSDT qualify if they have a mental disorder that can be corrected or ameliorated.

❸ **Intervention:** Intervention Related Criteria: Must have all 3:

1. The focus of the proposed intervention is to address the condition identified in impairment criteria above, and **2.** It is expected the proposed intervention will benefit the consumer by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning; and/or for children it is probable the child will be enabled to progress developmentally as individually appropriate (or if covered by EPSDT, the identified condition can be corrected or ameliorated), and **3.** The condition would not be responsive to physical healthcare based treatment.

Treatment Plan

Client must have one "Finalized" treatment plan per year.

- To edit the treatment plan create a draft.
- Treatment plans must be written in client centered language.

MUST HAVE THE FOLLOWING:

- CHALLENGES/BARRIERS (PROBLEMS) -Should be BEHAVIORAL, not just a list of symptoms related to the client diagnosis.
- HOPES (GOALS)-Should be what the client wants has agreed to work on.
- ACTIONS (OBJECTIVES)-Should be actions the client will take to achieve his or her goals and should be strength oriented; Must also be: Measurable & Observable
- SUPPORTS (INTERVENTIONS)-Should be SPECIFIC how the mental health practitioner will support client achieving his/her goals.
- The case coordinator is responsible for coordinating all services through the treatment plan.
- There should be themes gathered together in the treatment plan
- Consider adding new interventions to the barrier as opposed to a new set of barriers.

See Chapter 3 in the clinical documentation guide for more info.

Services/Progress Notes

- **Every progress note must stand alone and meet medical necessity.**
- **Every billed service should be medically necessary.**
- All progress notes should be written in FIRP format.
  - **F:** Functioning- who, what, where, why.
  - **I:** Intervention- what clinical intervention was provided. This is essential to document.
  - **R:** Response- what was the client's response to the intervention provided.
  - **P:** Plan- what is the plan for services. How did this service drive potential next steps.
- Even case management needs to identify: function of the service (F), intervention provided (I), and plan for continued services (P).
- Progress notes should be tied to a treatment plan, which demonstrates how the service is tied to a plan.

See Chapter 5 in the clinical documentation guide for more information

Medical Necessity Required This Point Forward

Onset of Services Documents Required

- ☐ Admission
- ☐ Psychosocial Assessment
- ☐ Mental Status Assessment
- ☐ CANS/ANSA
- ☐ **Admission Part Two Bundle Which Includes**
  - ☐ CSI Admission
  - ☐ Diagnosis (select admission type)
  - ☐ Client Relationships
  - ☐ Client Case Coordinator
  - ☐ Onset of Services
  - ☐ Authorization to use exchange or disclose confidential BH Info
  - ☐ *Within* Authorization to use exchange or disclose confidential BH Info
- ☐ Treatment Plan
- ☐ Treatment Plan Participation Consent
- ☐ UMDAP

Continuing Client– Annual Renewal Required

- ☐ Update Psychosocial Assessment with relevant changes including assessment summary that evaluates potential for discharge plan.
- ☐ Mental Status Assessment
- ☐ CANS/ANSA
- ☐ Update Diagnosis
- ☐ Treatment Plan
- ☐ Treatment Plan Participation Consent
- ☐ UMDAP

Discharge— Required Documentation

- ☐ Complete a Discharge Note (potentially not billable depending on what you did)
- ☐ Enter Discharge Diagnosis
- ☐ Complete Discharge Form
- ☐ Add and end date to the case coordinator. If known, add name of "new" coordinator.

Top 10 QI

10. Please don't copy and paste, it becomes very obvious when you are reading the same thing back to back or in multiple charts, it starts to look like fraud, it starts to look like fraud.

9. Please use limited acronyms and short hand. Things git hard 2 undRstNd w 2 mNE acronyms. The chart should be user friendly for all, including clients who have a right to access their own records

8. Felling confused about all of our compliance messages? Run the 316 report to quickly see all of the details (*hint; it has been called apple-like because it is so user friendly)*

7. Informed consent is not a form. It is the process of a clinician engaging with clients/their family to understand the risks and benefits of treatment so they can make informed choices about treatment.

6. The Goldilocks rule applies to documentation; keep it just right—longer is often not better and too short and lacking detail does not support medical necessity.

5.The chart must show we have involved clients (and when appropriate their families and support system) in the development of a treatment plan.

4. It is the privilege and responsibility of the care coordinator to oversee that all services are medically necessary including the services from additional providers (both county and contracted). The case coordinator is like air traffic control for services– so the services do not get confusing and chaotic for the client.

3. There needs to be a clear link between the assessment, diagnosis, treatment plan and services (they should all relate the same thing)

2. Medical necessity is a concept not a form– the concept of medical necessity should be demonstrated in all components of the chart.

1. Every service must be medically necessary, demonstrating a clinical intervention. We are behavioral health, the services need to demonstrate how we are using clinical skills to address the client's identified needs. Think: why should the government pay you for this service? The government pays us for clinical skill not completing forms. Always demonstrate your use of clinical skill (or it is non-billable).