Assessing and Diagnosing

- ✓ Purpose
- ✓ Medical Necessity
- ✓ Assessment Requirements
- ✓ Completing the Assessment
- ✓ Claiming for the Service
- ✓ Using IBHIS

Standard Course of Action

1. **Assessing**
   - Complete a mental health assessment and establish medical necessity;
   - Complete an initial medication evaluation (if needed)
2. **Planning**
   - Develop a client treatment plan (and if applicable, obtain medication consent) with the client; then
3. **Treating**
   - Provide treatment services to address the identified mental health condition and assist the client in reaching his/her objectives.

Why do we assess clients?

Purpose of the Assessment

- Learn the client's story by evaluating his/her current status and history of mental, emotional, and behavioral health
- Develop a conceptualization, formulate a diagnosis, and determine if the client meets **medical necessity**
- Determine what the client's needs are and what services that best address those needs

Medical Necessity:
Determines who is covered and who is eligible

Clients must meet the following criteria to be eligible for Specialty Mental Health Services:

- An outpatient **Included primary diagnosis**
- **Impairment(s)** as a result of the included diagnosis
- DMH's **proposed Interventions** can address the mental health condition and are expected to:
  - ✓ Significantly diminish the impairment OR
  - ✓ Prevent significant deterioration in an important area of life functioning OR
  - ✓ Allow the child to progress developmentally as individually appropriate

Note: If the client is under the age of 21 with the Medi-Cal benefit **Early and Periodic Screening, Diagnosis, & Treatment (EPSDT)** and does not meet criteria for impairment or intervention above, medical necessity can be met if SMHS are needed to correct or ameliorate a defect, mental illness, or condition

For more information, refer to the Organizational Providers Manual

Categories of Medi-Cal Included Diagnoses for Outpatient Services

- Schizophrenia Spectrum and Other Psychotic Disorders
- Bipolar and Related Disorders
- Depressive Disorders
- Anxiety Disorders
- Obsessive Compulsive and Related Disorders
- Trauma and Stressor Related Disorders
- Dissociative Disorders
- Somatic Symptom and Related Disorders
- Feeding and Eating Disorders
- Gender Dysphoria
- Disruptive, Impulse-Control, and Conduct Disorders
- Personality Disorders, *except Antisocial Personality Disorder*
- Paraphilic Disorders
- Attention-Deficit/Hyperactivity Disorder
- Autism Spectrum Disorders, *except Autistic Disorder*

Refer to the Organizational Providers Manual for the complete list of included diagnoses

Pause the video if you want to review this list

What if the client does not meet medical necessity?

- Client is not eligible to receive Specialty Mental Health Services
- Next steps:
  - ✓Issue a **Notice of Action-A (NOA-A)** to the client
  - ✓Determine if:
    - ✓ Client meets and is appropriate for other program funding sources (e.g. CalWorks or MHSA PEI Expansion)
    - ✓ Client should be referred back to his/her health plan or other appropriate provider

For more information regarding NOA-A's, refer to QA Bulletin 17-18 Notice of Action (NOA) Letters A & E

Assessment Requirements

What information must be gathered?

1. Presenting problem(s): Chief complaint, history of presenting problem(s), **current level of functioning**, relevant family history and current family history

2. Relevant conditions and psychosocial factors affecting the client's physical and mental health

3. Mental Health History: previous treatment, including providers, therapeutic modality and response, inpatient admissions

4. Medical History: Relevant physical health conditions, for children – developmental history

5. Medications: medications received/receiving, duration, allergies or adverse reactions

6. Substance Exposure/Substance Use: past and present use of tobacco, alcohol, caffeine, complementary and alternative medications, and over the count and illicit drugs

7. Client Strengths: strengths in achieving client plan goals

8. Risks

9. Mental Status Exam

10. Diagnosis

Pause the video if you want to review this list

For more information, refer to the Organizational Providers Manual

Who can complete an assessment?

- Assessing and diagnosing are to be completed by practitioners who are within scope of practice and in accord with Guide to Procedure Codes
  - Refer to "Allowable Discipline(s)" column within the Guide
  - This includes completing/finalizing any of assessment forms for
    - ✓ New Clients
    - ✓ Returning Clients
    - ✓ Continuous Clients

For more information, refer to the Guide to Procedure Codes for Specialty Mental Health Services

When does an assessment have to be completed by?

The Standard

Assessments are to be completed and finalized prior to providing any treatment services.

In rare cases…

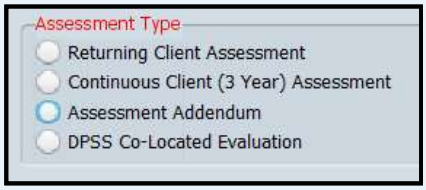
If a client meets medical necessity and needs an emergent service, then this can be provided prior to the completion of the assessment.

- **Emergent service** – a service needed to address an urgent condition which is "a situation experienced by a client that, without timely intervention, is highly likely to result in an immediate emergency psychiatric condition"

For more information regarding Emergent Services, refer to QA Bulletin 17-09 Services Prior to the Completion of an Assessment & Client Treatment Plan

Types of Assessments

Type of Client	Form in IBHIS
New clients	• Adult Full Assessment • Child/Adolescent Full Assessment • Age 0 to 5 ICARE Full Assessment • Immediate/Same Day Assessment • Crisis Evaluation Progress Note
Returning clients (e.g. clients with an existing clinical record in IBHIS and returning for services at a DMH DO program)	• Adult Assessment Addendum • Child/Adolescent Assessment Addendum
Existing clients who have been continuously receiving services for **3 years**	
Existing clients who present with new **additional information** that may impact treatment	



Other Required Elements – Completing the CANS and PSC

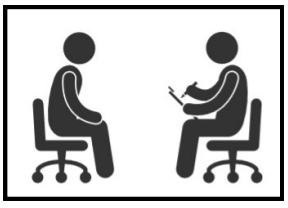
Children & Adolescent Needs and Strengths (CANS)	Pediatric Symptom Checklist (PSC-35)
• Purpose – Identify the child and family's needs and strengths	• Purpose – Identify and assess for emotional and behavioral problems in children
• Required for - newly active clients ages 6 through 20	• Required for - newly active clients ages 3 through 18

• Frequency –
  • At the initial assessment
  • Every 6 months throughout treatment
  • At the end of treatment.
	• Frequency –
	  • At the initial assessment
	  • Every 6 months throughout treatment,
	  • At the end of treatment

• Completed by - a practitioner certified by the PRAED Foundation	• Completed by – the caregiver

For more information regarding the CANS and PSC, refer to Clinical Forms Bulletin 19-03

Completing the Assessment



Assessment Process

Before the assessment session with a client…

- Client (or someone on behalf of the client) requests services
- An appointment for the assessment is scheduled in a practitioner's **Scheduling Calendar**
- Client consents to services, participates in a financial screening process, and understands how confidentiality/HIPAA work

Tip: Prior to the assessment appointment, practitioners may want to review the following in IBHIS:

- Treatment Console (Client Episodes, IBHIS Services Summary, Legacy Episode History)
- Notes Console (past progress notes, COS/MAA specific to the client)
- Clinical Console
- Chart View (past assessments, treatment plans, progress notes)

During the assessment session with a client…

- An **LE00019 Episode** is created when the client presents for the assessment appointment
- Practitioner and client meet/speak to each other
- Practitioner documents information on the assessment form (if done collaboratively)

Assessment Process

After the assessment session with a client…

- Practitioner may fine tune the assessment.
- Practitioner claims for the assessment service via **Individual Service Progress Note**

If applicable, practitioners may need to gather additional information from significant support persons

- Practitioner documents any additional information on the assessment form
- Practitioner claims for any additional assessment service(s) via the **Individual Service Progress Note**

Once all the relevant information is gathered, the assessment is finalized, and a diagnosis is provided via the **Diagnosis Form**.

During the Assessment Session

- Focus on what is **relevant** to start treatment, address any immediate needs, and determine an initial diagnosis

- Remember that additional assessment information can always be gathered later
  - ✓ Diagnosis can be refined at a later time
- If you are not able to gather certain information, document why

- Consider asking information from other significant supports (especially for children), then document where the assessment information is coming from

- If any assessment information was obtained via telehealth or telephone, document this information

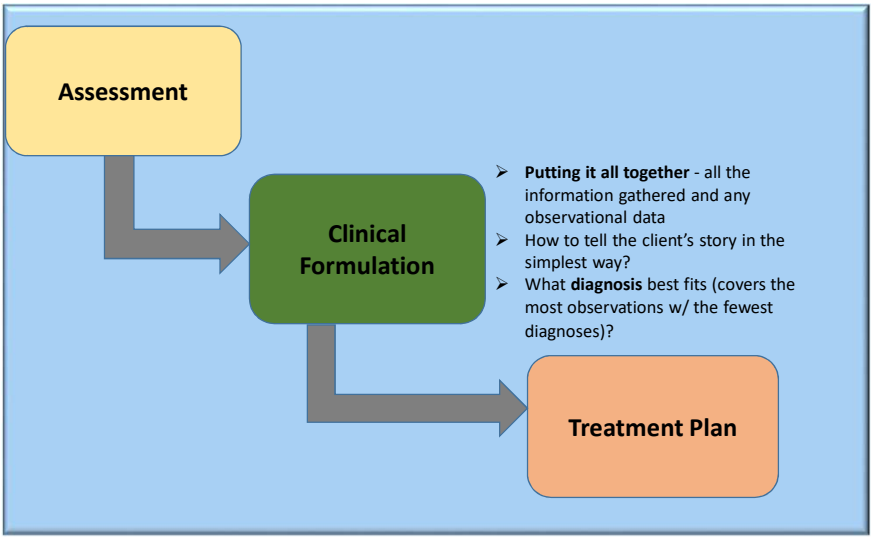
Making the Assessment Session a Collaborative Process

- Create an environment where the client/family knows their feedback is encouraged and respected
  - ✓ It's the client's story – make sure we get it right

    "OK, so let's sum up what we've discussed today…"

  - ✓ Help clients understand why we diagnose:
    - "We want to understand your symptoms so that we can give you the best treatment.
    - "Based on the symptoms that you're telling me…"

Clinical Formulation



- **Putting it all together** - all the information gathered and any observational data
- How to tell the client's story in the simplest way?
- What **diagnosis** best fits (covers the most observations w/ the fewest diagnoses)?

Clinical Formulation – Information to Consider

1. **Presenting Problem**
   - ✓ Why is the client here, and what is he/she hoping to achieve?
   - ✓ Does the client meet medical necessity?
2. **Pre-disposing factors**
   - ✓ What factors contributed to the development of the problem?
3. **Precipitating factors**
   - ✓ How did the client get to his/her current situation?
   - ✓ Why does the client want help now?
4. **Perpetuating factors**
   - ✓ Are there any risk factors that need to be considered?
5. **Previous treatment and responses**
   - ✓ Has client been responsive to services in the past?
6. **Protective factors**
   - ✓ What are the client's strengths that can help him/her in treatment?
7. **Proposed services**
   - ✓ What services might help the client?

Pause the video if you want to review this

Clinical Formulation Example – Adult Client

Pause the video if you want to review this example

Client is a 39-year-old biracial African-American/Honduran single female who is seeking mental health services due to feeling extremely depressed for at least 6 months. Client reports symptoms indicative of Major Depressive Disorder. These symptoms were exacerbated after losing her job and ending a relationship with a long-term boyfriend. Client's ongoing depression has negatively impacted her ability to maintain her hygiene, concentrate on school work, finish college, maintain employment, and form relationships with peers.

Client reported experiencing similar symptoms of depression throughout her teenage years as well as in her early 20's. Client has a history of poor self-esteem and experiencing feelings of worthlessness which has likely been worsened by having a negative relationship with both of her parents, and feeling overly criticized by her father who is no longer in her life.

Client appears motivated to participate in treatment and make positive changes in her life including moving into her own place and getting a stable job. Since client responded positively to outpatient therapy in the past, individual therapy, specifically CBT, may be a good fit for client's treatment. Client would also benefit from an initial medication evaluation to determine if psychotropic medications can assist with her symptoms.

Clinical Formulation Example – Child/Adolescent Client

Pause the video if you want to review this example

Client is a 15-year-old Hispanic male who was brought into services by his mother due to symptoms related to depression and anxiety. Client was also hospitalized 3 months ago due to experiencing suicidal thoughts. Client reported that he has not experienced suicidal ideation in the last 30 days, however continues to have a depressed mood and is anxious at school nearly every day. Client's current symptoms/behaviors impair his functioning at home (client isolates himself from family members and gets into arguments with his siblings) and at school (client reportedly has no friends and is displaying poor academic performance). Client meets criteria for Major Depressive Disorder, recurrent episode with anxious distress.

Throughout middle school and high school, client displayed a history of isolating himself and having poor relationships with peers. Client and mother hope client can learn more adaptive skills in treatment. Both client and mother appear open and engaged to start services. Client's mother is especially motivated to assist client in any way she can. This will be client's first time receiving any mental health services.

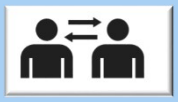
Given client's symptoms, he would benefit from individual therapy, dyadic therapy (client and mother), and possibly a referral for an initial medication evaluation.

Claiming for the Assessment Service

Progress Note

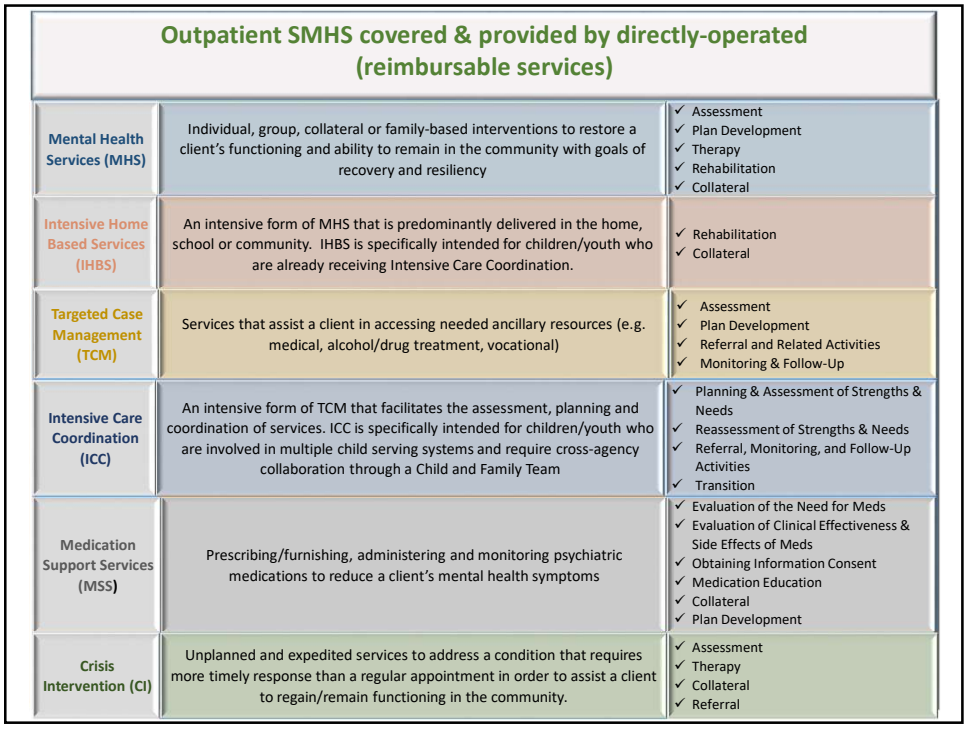
- Services provided to clients are documented using a progress note **(Individual Service Progress Note)**

- Within the progress note:
  - ✓Select the procedure code based on the service provided
  - ✓Enter the duration of the service
    - ✓**Face to Face Time** = time spent seeing the client



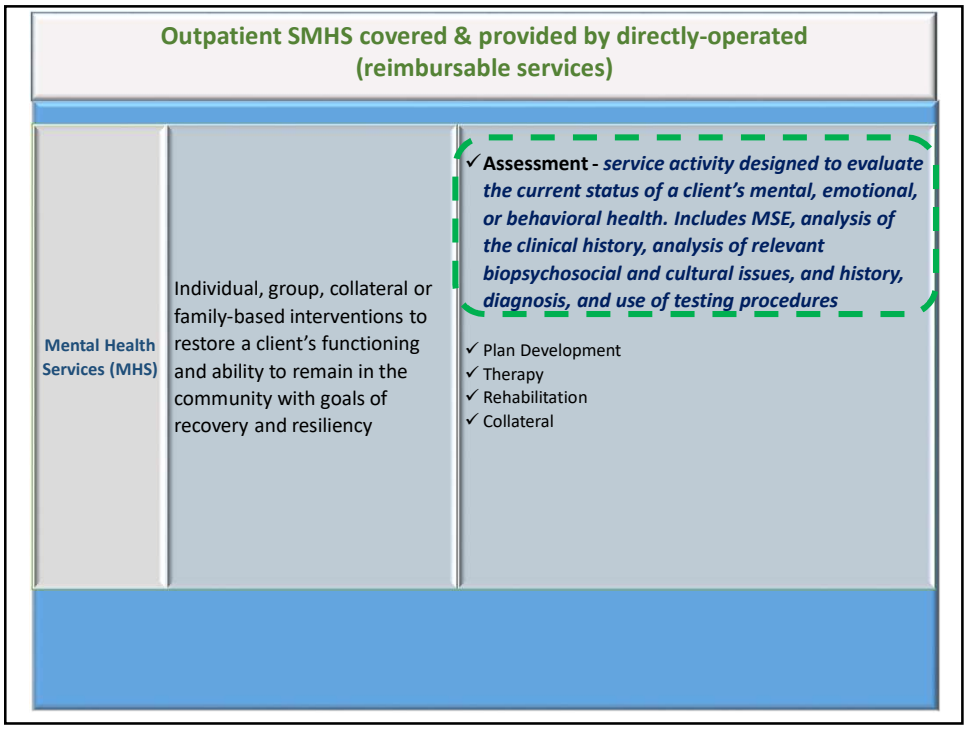
    - ✓**Other Time** =
      - time spent providing a service to a significant support person
      - time spent writing the progress note and completing other applicable forms (e.g. completing the assessment form)

      - travel time, if this applies



Outpatient SMHS covered & provided by directly-operated (reimbursable services)

Mental Health Services (MHS)	Individual, group, collateral or family-based interventions to restore a client's functioning and ability to remain in the community with goals of recovery and resiliency	✓ Assessment ✓ Plan Development ✓ Therapy ✓ Rehabilitation ✓ Collateral
Intensive Home Based Services (IHBS)	An intensive form of MHS that is predominantly delivered in the home, school or community. IHBS is specifically intended for children/youth who are already receiving Intensive Care Coordination.	✓ Rehabilitation ✓ Collateral
Targeted Case Management (TCM)	Services that assist a client in accessing needed ancillary resources (e.g. medical, alcohol/drug treatment, vocational)	✓ Assessment ✓ Plan Development ✓ Referral and Related Activities ✓ Monitoring & Follow-Up
Intensive Care Coordination (ICC)	An intensive form of TCM that facilitates the assessment, planning and coordination of services. ICC is specifically intended for children/youth who are involved in multiple child serving systems and require cross-agency collaboration through a Child and Family Team	✓ Planning & Assessment of Strengths & Needs ✓ Reassessment of Strengths & Needs ✓ Referral, Monitoring, and Follow-Up Activities ✓ Transition
Medication Support Services (MSS)	Prescribing/furnishing, administering and monitoring psychiatric medications to reduce a client's mental health symptoms	✓ Evaluation of the Need for Meds ✓ Evaluation of Clinical Effectiveness & Side Effects of Meds ✓ Obtaining Information Consent ✓ Medication Education ✓ Collateral ✓ Plan Development
Crisis Intervention (CI)	Unplanned and expedited services to address a condition that requires more timely response than a regular appointment in order to assist a client to regain/remain functioning in the community.	✓ Assessment ✓ Therapy ✓ Collateral ✓ Referral



Outpatient SMHS covered & provided by directly-operated (reimbursable services)

Mental Health Services (MHS)	Individual, group, collateral or family-based interventions to restore a client's functioning and ability to remain in the community with goals of recovery and resiliency	✓ **Assessment** - ***service activity designed to evaluate the current status of a client's mental, emotional, or behavioral health. Includes MSE, analysis of the clinical history, analysis of relevant biopsychosocial and cultural issues, and history, diagnosis, and use of testing procedures*** ✓ Plan Development ✓ Therapy ✓ Rehabilitation ✓ Collateral

Outpatient SMHS covered & provided by directly-operated (reimbursable services)

Mental Health Services (MHS)	Individual, group, collateral or family-based interventions to restore a client's functioning and ability to remain in the community with goals of recovery and resiliency	✓ **Assessment** • **90791** - assessment activities conducted by practitioner w/in scope • **90792** - assessment activities w/an in-depth evaluation of medical issues conducted by practitioner w/in scope • **90885** - reviewing records for the purpose of informing the assessment/diagnostic formulation • **T1001** - when an NP/CNS/RN gathers assessment information about medical issues/needs to inform the mental health assessment • **H2000** - when staff (who is not w/in scope to dx) gathers information (not related to diagnosing, MSE, or medical issues) to inform the mental health assessment ✓ Plan Development ✓ Therapy ✓ Rehabilitation ✓ Collateral

Procedure Code Modifiers
- ✓ **SC** – for services provided over the telephone
- ✓ **GT** – for services provided via telehealth

Assessment Scenarios

Social worker meets w/ client to complete an Adult Full Assessment.	**90791**
Psychologist meets w/ client in order to re-assess client after client has been in treatment for 3 years. Psychologist completes the Continuous Client Assessment.	**90791**
MFT reviews DCFS, Court, and school records for the purpose of informing a client's assessment. MFT documents information on the assessment.	**90885**
Social worker and client's father speak over the phone so that the social worker can gather information about the client's developmental history. This information is documented in the client's assessment.	**90791SC**

Progress Note Example 1 – Assessment Service

Practitioner met with the client and foster mother for the purpose of conducting an assessment for Specialty Mental Health Services. **Reimbursement**

Practitioner completed the following sections: Reason for Referral/Chief Complaint, Psychiatric History, and Current Risk and Safety Concerns. Refer to the Child/Adolescent Full Assessment dated 5/1/20. Practitioner plans to contact client's CSW on 5/3/20 to gather remaining information regarding Psychosocial Information and Developmental History.

Both client and foster mother were cooperative during the assessment process. **Clinical**

Time not billed: Reviewing Consent for Services and discussing HIPAA, confidentiality, and mandated reporting. **Legal**

Face to Face: 61 minutes

Other Time: 68 minutes (*includes writing the progress note and documenting on the assessment form*)

Procedure Code: 90791 (*assessment occurred in person*)

Pause the video if you want to review this note

Progress Note Example 2 – Assessment Service

Practitioner met with the client for the purpose of conducting an assessment. Refer to the Adult Full Assessment 5/3/20. **Reimbursement**

Client was open to services and forthcoming with sharing information about himself. **Clinical**

At the next session, practitioner and client plan on developing the treatment plan.

Time not billed: Reviewing consent for services, HIPAA, and confidentiality. Client signed all necessary forms. **Legal**

Face to Face: 66 minutes

Other Time: 58 minutes (*includes writing the progress note and documenting on the assessment form*)

Procedure Code: 90791 (*assessment occurred in person*)

Pause the video if you want to review this note

Forms in IBHIS

Assessment Forms in IBHIS

Adult

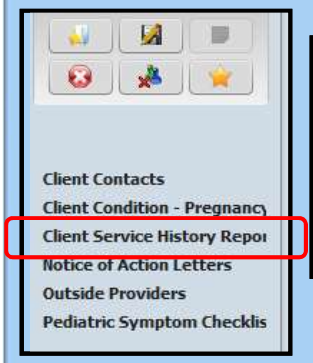
- Adult Full Assessment
- Adult Assessment Addendum Form
  - Returning Client Assessment
  - Continuous Client (3 Year) Assessment
  - Assessment Addendum
  - DPSS Co-Located Evaluation
- Immediate/Same Day Assessment
- (Crisis Evaluation Progress Note)

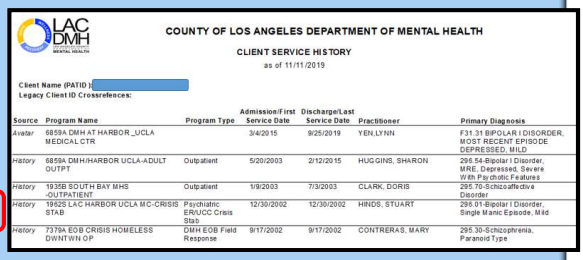
Child & Adolescent

- Child/Adolescent Full Assessment
- Child/Adolescent Assessment Addendum Form
  - Returning Client Assessment
  - Continuous Client (3 Year) Assessment
  - Assessment Addendum
- Age 0 to 5 ICARE Full Assessment
- Immediate/Same Day Assessment
- (Crisis Evaluation Progress Note)

Within the Assessment Forms in IBHIS…

- Links to other relevant forms/reports on the left-hand side of the form:





COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

CLIENT SERVICE HISTORY

as of 11/11/2019

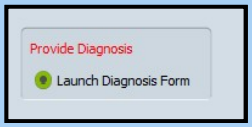
Client Name (PATID):
Legacy Client ID Crossrefences:

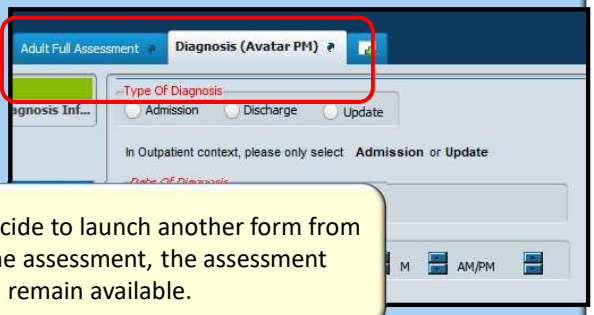
Source	Program Name	Program Type	Admission/First Service Date	Discharge/Last Service Date	Practitioner	Primary Diagnosis
Avatar	6859A DMH AT HARBOR _UCLA MEDICAL CTR		3/4/2015	9/25/2019	YEN,LYNN	F31.31 BIPOLAR I DISORDER, MOST RECENT EPISODE DEPRESSED, MILD
History	6859A DMH/HARBOR UCLA-ADULT OUTPT	Outpatient	5/20/2003	2/12/2015	HUGGINS, SHARON	296.54-Bipolar I Disorder, MRE, Depressed, Severe With Psychotic Features
History	1935B SOUTH BAY MHS -OUTPATIENT	Outpatient	1/9/2003	7/3/2003	CLARK, DORIS	295.70-Schizoaffective Disorder
History	1952S LAC HARBOR UCLA MC-CRISIS STAB	Psychiatric ER/UCC Crisis Stab	12/30/2002	12/30/2002	HINDS, STUART	296.01-Bipolar I Disorder, Single Manic Episode, Mild
History	7379A EOB CRISIS HOMELESS DWNTWN OP	DMH EOB Field Response	9/17/2002	9/17/2002	CONTRERAS, MARY	295.30-Schizophrenia, Paranoid Type

Tip: Copy and paste information from this report and enter it in the Mental Health History Section of the assessment

Within the Assessment Forms in IBHIS…

- Launch into and complete other forms within the assessment:
  - ✓PHQ-9, PHQ-A, PCL-5, GAD-7
  - ✓Diagnosis Form
  - ✓CANS

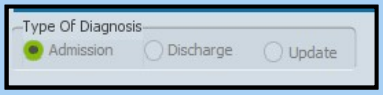




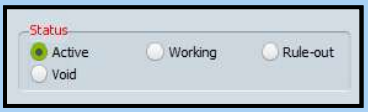
If you decide to launch another form from within the assessment, the assessment form will remain available.

The Diagnosis Form in IBHIS…

- **Type of Diagnosis**
  - ✓ Admission = first diagnosis entered for the LE00019 Episode
  - ✓ Update = any diagnoses entered after the Admission Diagnosis



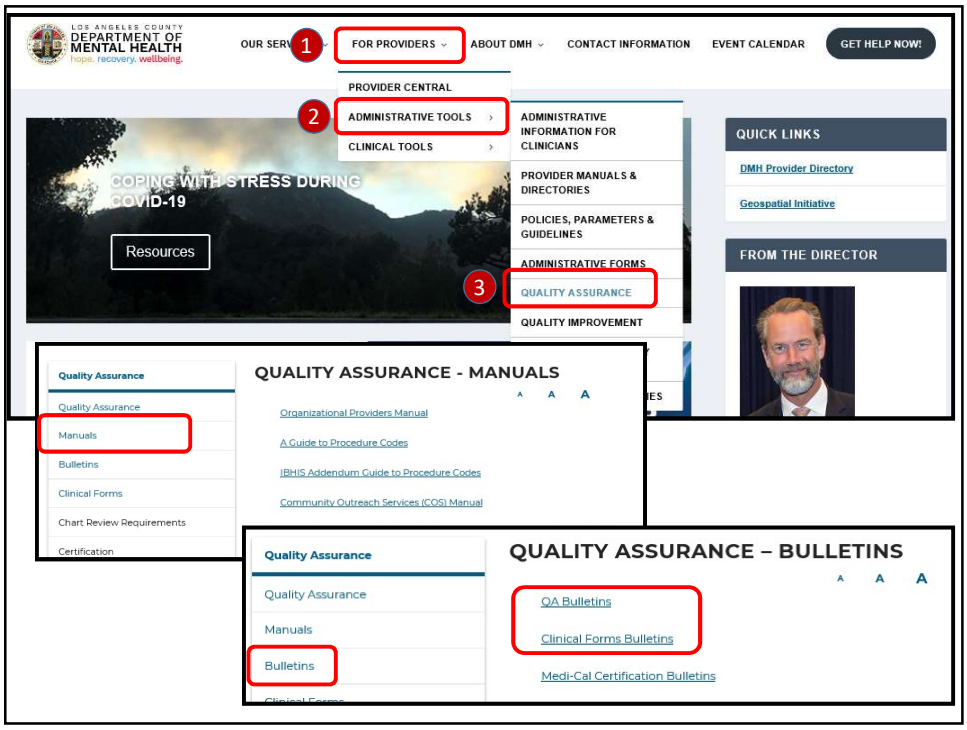
- **Status**
  - ✓ Active = diagnosis that is the focus of treatment
  - ✓ Working = diagnosis that is being considered
  - ✓ Rule Out = diagnosis to be considered after more information is obtained
  - ✓ Void = diagnosis entered in error



Let's go into IBHIS…

- Full Assessment Form
- Assessment Addendum Form
- CANS
- PSC-35
- Diagnosis Form
- Problem List
- Scheduling Calendar
- Individual Service Progress Note

Assessment Resources



Assessment – Resources

- Organizational Providers Manual
  - ✓ What it is: Provides information about the Short-Doyle/Medi-Cal claiming and documentation system
  - ✓ Where to go: DMH Website > For Providers > Administrative Tools > Quality Assurance > Manuals
- Guide to Procedure Codes for Specialty Mental Health Services
  - ✓ What it is: Provides a comprehensive list of the procedure codes used for claiming SMHS
  - ✓ Where to go: DMH Website > For Providers > Administrative Tools > Quality Assurance > Manuals
- LACDMH Policy 401.03 - Clinical Documentation for All Payer Sources
  - ✓ What it is: Provides policy and procedures for clinical record documentation related to the delivery of SMHS within DMH
  - ✓ Where to go: DMH Website > For Providers > Administrative Tools > Policies
- QA Bulletin 17-18 Notice of Action (NOA) Letters A & E
  - ✓ What it is: Provides information regarding what Notice of Action Letters are and when these would be provided to beneficiaries
  - ✓ Where to go: DMH Website > For Providers > Administrative Tools > Quality Assurance > Bulletins
- QA Bulletin 17-09 Services Prior to the Completion of an Assessment & Client Treatment Plan
  - ✓ What it is: Provides information regarding emergent services
  - ✓ Where to go: DMH Website > For Providers > Administrative Tools > Quality Assurance > Bulletins
- Clinical Forms Bulletin 19-03
  - ✓ What it is: Provides information about the CANS and PSC as well as requirement and timeframes for completion
  - ✓ Where to go: DMH Website > For Providers > Administrative Tools > Quality Assurance > Bulletins