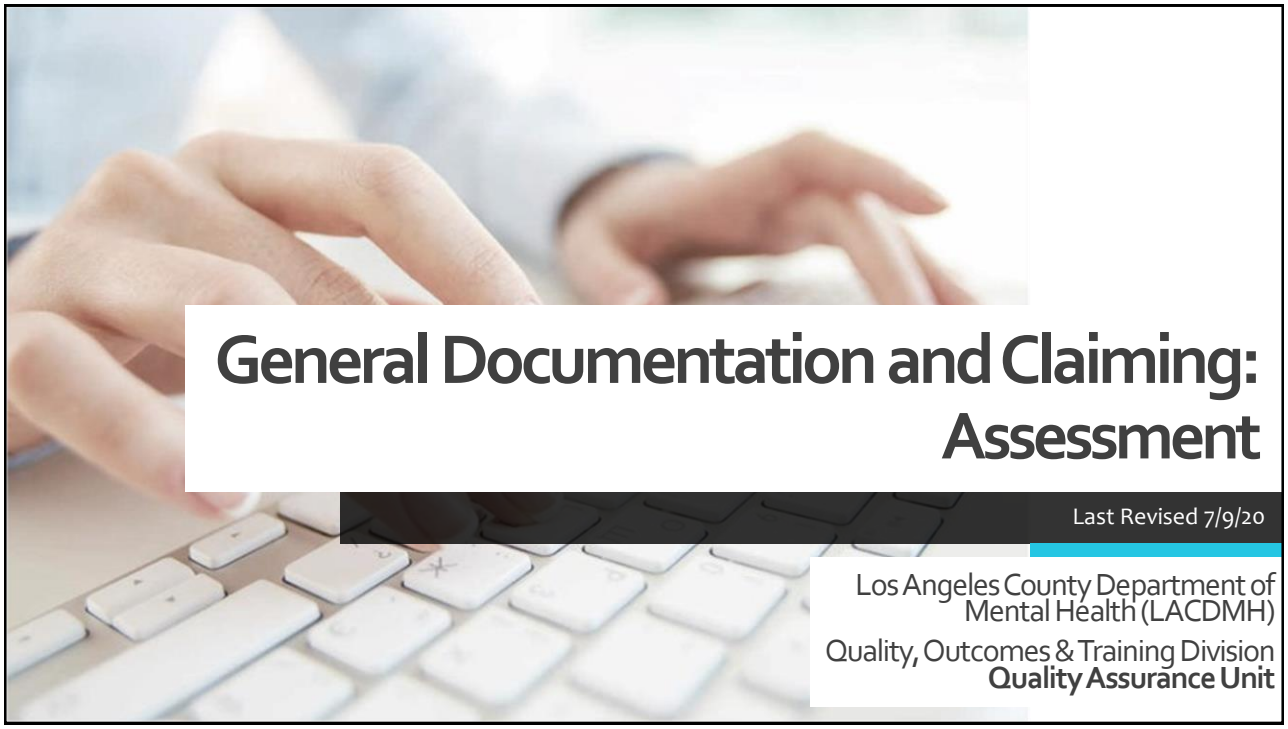

General Documentation and Claiming: Assessment

Last Revised 7/9/20

Los Angeles County Department of Mental Health (LACDMH)
Quality, Outcomes & Training Division
Quality Assurance Unit

About this Presentation

Disclaimer

- This video series presentation highlights the basic minimum documentation and claiming standards for the provision of Medi-Cal Specialty Mental Health Services in Los Angeles County and incorporates interim guidance to assist practitioners in meeting the mental health needs of the County while minimizing the community spread of COVID-19.
- For a comprehensive list of documentation and claiming rules please refer to the Organizational Provider's Manual, the A Guide to Procedure Codes, and LACDMH Policy 401.03, which can all be accessed through the DMH website ***at*** https://dmh.lacounty.gov/ and for the latest COVID-19 related QA information, click on the COVID-19 link from the Quality Assurance page.
- For contract staff, please check with your agencies regarding higher standards than the ones discussed in this presentation that may have been set and how your agency is setting standards around COVID-19.

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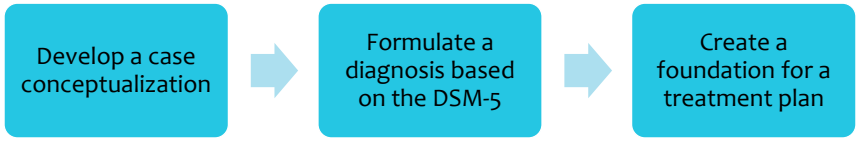
Purpose of a Clinical Assessment

- Gather and document salient information about the client's current presentation and biopsychosocial history in order to:



- Determine if client meets Medical Necessity

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Assessment: Documenting Medical Necessity

Included Diagnosis

- The primary diagnosis for treatment **MUST BE** an included diagnosis
  - Exceptions:
    - Initial contacts during **Assessment**
    - **Crisis intervention**
  - Secondary or tertiary diagnosis can be an "**allowable**," "**non-included**" diagnosis (e.g. Abuse of Other Non-Psychoactive Substances)

Impairment

- A significant impairment in an important area of life functioning (e.g. home, work, school, social, family, etc.) **as a result of** the client's mental health symptoms
  - Example: Difficulty keeping a job due to their depressed mood, lack of energy, and difficulties concentrating, which are significantly interfering with their work performance

- ***NOTE:*** *EPSDT Medical Necessity criteria does not require explicit impairment*

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Assessment Requirements

- **Completed BY** – practitioners within scope of practice and in accord with Guide to Procedure Codes
- **Completed FOR –**
  - **New** Clients (require creation of clinical record)
  - **Returning** Clients (existing clinical record and returning for services)
  - **Continuous** clients (existing clients receiving services for 3 continuous years)
  - When **additional information** that may impact treatment is gathered
    - Use Assessment Addendum form when clinically appropriate or the Community Functioning Evaluation form when documenting additional ancillary needs
    - Significant changes impacting treatment may include: new symptoms, behaviors, & impairments (which may or may not result in a new Diagnosis); being discharged from an inpatient facility; major transitions in one's life such as changing to a new environment (e.g. home or school) or experiencing a major loss (e.g. becoming homeless, death/loss of a loved one, loss of employment, or loss of health); etc.

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Assessment: General Rules and Documentation

- Assessments for new clients must be completed within 60 days of the initiation of services related to assessment or emergent treatment.
- Any program accepting a client is responsible for ensuring there is a current, accurate and complete assessment (with all required elements).
- Most recent assessment in the client's record sets the 3 year time limit based on the start date of the assessment. (e.g. current assessment start date = 8/26/17, triennial re-assessment due by 8/26/20)
- If the assessment is not completed in one contact, a progress note must be written that documents which sections were completed during that, and any subsequent contact.
- An assessment must be completed prior to completing the Client Treatment Plan.

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Assessment: Required Data Elements for New Clients

Required Data Elements	Examples
Assessor Information	Name, discipline
Identifying Information & Special Needs	Name of client, date of birth, gender, ethnicity, preferred language
For Children – Biological Parents, Caregivers, & Contact information	Names, contact information (phone/address), other relevant information
Presenting Problem	Precipitating event/Reason for referral, current symptoms and behaviors (intensity, duration, onset, and frequency), and impairments in functioning; Client's chief complaint; history of presenting problems; & current level of functioning
Mental Health History	Previous treatment, including providers, therapeutic modality and response, and inpatient admissions
Client Strengths	Client strengths to assist in achieving their treatment goals
Risks	Situations that present a risk to the beneficiary and/or others, including past or current trauma.
Medical History	Relevant physical health conditions reported by the client or significant support person. For children/youth – include prenatal and perinatal events and relevant/significant developmental history.

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Assessment: Required Data Elements for New Clients Continued

Required Data Elements	Examples
Medication	Information about medications client has received or is receiving to treat mental health and medical conditions, including the duration of treatment.
Substance Exposure/Substance Use	Past and present use of tobacco, alcohol, caffeine, complimentary & alternative medicine (CAM), & over the counter and illicit drugs
Relevant conditions and psychological factors affecting the client's physical and mental health	Living situation, daily activities, social support, cultural and linguistic factors, history of trauma or exposure to trauma, education, employment, legal, etc.
Mental Status Examination	Mental Status Examination – current clinical presentation
Clinical Formulation	Case conceptualization consistent with information gathered from assessment
Diagnostic Descriptor	A diagnosis consistent with information in clinical formulation and current Diagnostic and Statistical Manual of Mental Disorders or DSM
ICD-10-CM Diagnosis Code	A code from the most current ICD-10 code set consistent with the diagnostic descriptor
Signature of staff person allowed to perform a Psychiatric Assessment	Name, signature, discipline/title, identification # (if applicable), & Date

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Assessment: Process and Documentation Considerations

The Clinical Formulation and the Diagnosis need to be consistent with the clinical information documented in the assessment

- DSM-5 criteria must be used to make diagnostic determinations. Once the DSM-5 diagnosis is determined, it must be cross-walked to the corresponding ICD-10 code to determine if it's an Included Diagnosis, one of the required elements to meet Medical Necessity (See Org. Manual for Included Diagnosis List)
- Significant functional impairments in an important life area as a result of the included primary diagnosis need to be clearly identified/documented to meet another required element of Medical Necessity (Impairments)
- The Clinical Formulation should be an analysis/integration of the case rather than a restatement of facts from previous sections of the assessment
  - The Clinical Formulation highlights the symptoms, behaviors, and impairments that will be prioritized and addressed in the Client Treatment Plan (Interventions)

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Process and Documentation Considerations for the Clinical Formulation

Information to consider in formulation	Examples
Present client's identifying information	Client is a 34 year old Mexican-American male who is unemployed, living with his wife and their 4 year old son.
Presenting Problem(s)	Client reported that in the past 2 months he has been increasingly depressed, with a loss of energy, irritability, feelings of worthlessness, and loss of interest and pleasure in almost all activities. Per Client, due to his depressive symptoms, he has not been seeking employment and has been unable to do housework or take care of his child.
Precipitating factor(s)	Client informed his depressive symptoms increased significantly soon after losing his job, reinforcing his belief there is something wrong with him.
Predisposing factor(s)	Per Client, he was bullied for years beginning in the 1st grade because he was not able to keep up with academic standards and because he was small in stature most of his youth due to developmental delays of being a preemie.
Perpetuating (or maintaining) factor(s)	Client reported, to this day, he remembers the taunts and despite having made a lot of progress. Client stated he internally believes something is wrong with him and he is always behind. "I'm always trying to catch up. I don't feel as if I am good at anything or that I am good enough and that is why people do not like me."

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Process and Documentation Considerations for the Clinical Formulation

Information to consider in formulation	Examples
Previous treatment and responses	Client had similar current symptoms about 2 years ago after his wife had temporarily separated from him due to marital discourse. He was treated at Edelman MHC with Zoloft 25mg and participated in weekly individual CBT therapy and symptoms reduced within 6 months.
Protective and positive qualities	Client attends church weekly and stated he prays daily for guidance and support. Client shared he has wanted to die x1 in the past year and read the bible to uplift his mood enough to not harm himself.
Present Mental Status Examination	Client presents as slightly disheveled. He is cooperative with the interviewer and is judged to be an adequate historian. Recent and remote memory are good. His flow of thought is coherent and thought content reveals he has feelings of worthlessness and guilt. Client denies SI/HI at this time. In the past year he has had suicidal ideation with no plans/attempt x1. Client is oriented x4. Fund of knowledge adequate. Some insight to his mental health condition. Judgment is moderately impaired evidenced by history of rash decision making when markedly stressed. His mood and affect are congruent to diagnosis of Major Depressive Disorder, Recurrent, Moderate.
Proposed treatment plan	Recommended treatment is medication support and individual CBT therapy.

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Completing the Required CANS and PSC-35

Children & Adolescent Needs and Strengths (CANS-IP)

- **Purpose**: Identify the child and family's needs and strengths to develop a shared vision to address client's needs and inform level of care determination, planning, decision making and monitoring outcomes.
- **Use in Treatment Services**: The CANS-IP was developed to facilitate the linkage between the assessment process and individualized treatment planning.
- **Required for**: Newly active clients ages 6 through 20.
- **Frequency**:
  - At the initial assessment
  - Every 6 months throughout treatment
  - At the end of treatment
- **Completed by**: A practitioner certified by the PRAED Foundation

Pediatric Symptom Checklist (PSC-35)

- **Purpose**: Identify and assess for emotional and behavioral problems in children to assist in earlier detection and treatment of psychosocial problems leading to better outcomes for children.
- **Use in Treatment Services**: The PSC-35 is useful in assessing whether a client's behaviors are improving or worsening throughout treatment.
- **Required for**: Newly active clients ages 3 through 18.
- **Frequency**:
  - At the initial assessment
  - Every 6 months throughout treatment
  - At the end of treatment
- **Completed by**: The client's caregiver

For more information regarding the CANS-IP and PSC-35, refer to Clinical Forms Bulletin 19-03

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Clinical Assessment during COVID-19 Public Health Crisis

- The choice of assessment forms to use during this time is up to the provider and practitioner.
  - However, if the Immediate/Same Day Assessment form is chosen, the Full Assessment should be completed if and when the client presents for in-person services.
- A diagnosis must be established at the point of finalizing the assessment based on the information that has been gathered. As with any other case, the diagnosis is subject to revision in light of additional information being obtained.
  - During the COVID-19 crisis, assessments can be finalized without face to face contact
- When certain information cannot be obtained during a telephone contact (e.g. some observational data included in the mental status exam), it should be obtained upon the first in-person encounter with the client.

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Some Examples of Delivering SMHS

What you did	Type of Service	Service Component(s)	Procedure Code	If delivered by telephone	If delivered by telehealth	Allowable Discipline(s)
Clinician gathered mental health assessment information from client and/or the client's significant support person(s) (e.g. family, teacher, DCFS worker, etc.)	MHS	Assessment	90791	90791SC	90791GT	▪ MD/DO ▪ PA ▪ PhD/PsyD (Licensed or Waivered) ▪ SW (Licensed, Registered or Waivered) ▪ MFT (Licensed, Registered or Waivered) ▪ NP or CNS (Certified) ▪ PCC (Licensed or Registered) ▪ Student professionals in these disciplines with co-signature

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Some Examples of Delivering SMHS

What you did	Type of Service	Service Component(s)	Procedure Code	If delivered by telephone	If delivered by telehealth	Allowable Discipline(s)
RN collected information related to medical and medication history as part of mental health assessment	MHS	Assessment	T1001	T1001SC	T1001GT	▪ NP or CNS (Certified) ▪ RN ▪ LVN
Practitioners not within scope of claiming 90791/90792/T1001 collecting information (e.g. family hx, substance abuse hx) as part of mental health assessment	MHS	Assessment	H2000	H2000SC	H2000GT	▪ All Disciplines
Reviewed court records for the purpose of completing the client's mental health assessment	MHS	Assessment	90885	NA	NA	▪ All Disciplines

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