



General Documentation and Claiming: Assessment

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

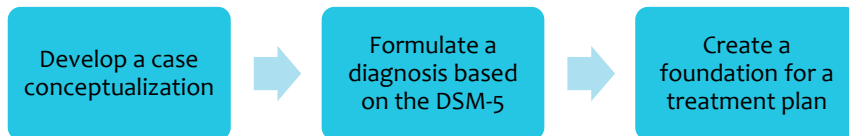
About this Presentation

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.

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 the Assessment Addendum form
 - 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 LACDMH QA Website Manuals for the Included Diagnosis List)
- Significant functional impairments in an important life area as a result of the included primary diagnosis need to be clearly identified/documentated 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 1 st 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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Targeted Case Management Needs Evaluation Requirement

A needs evaluation must be completed:

- Upon determination of medical necessity (at initial assessment)
- Annually for clients receiving Targeted Case Management (TCM)
- When new ancillary needs arise

Required forms to use:

- For adult clients (age 21 and over) – **Needs Evaluation Tool** (effective 10/1/20)
 - Replaces the Community Functioning Evaluation
- For children (age 6 through-20) – the **CANS-IP** can be used as a needs evaluation
- For children (age 0-5) – **CANS-IP** or **CANS 0-5**

For more details and guidance please see:

- [QA Bulletin 20-06 TCM Needs Evaluation](#)
- [Clinical Forms Bulletin 20-04](#) (Provides details regarding use of the NET form)
- [TCM Needs Evaluation Training](#) (PowerPoint in PDF format)

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Intensive Care Coordination (ICC) Services

Intensive Care Coordination (ICC) is an intensive form of Targeted Case Management (TCM). ICC Services must be available to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) clients who meet medical necessity for SMHS and have the need for cross-agency collaboration and teaming.

Policy

All providers who currently provide TCM will be expected to be able to provide ICC to all EPSDT clients for whom it is appropriate and medically necessary

Forms to Use

ICC Eligibility Form

- Complete prior to a Client Treatment Plan (CTP) & any time the CTP is being considered for updates based on significant changes in the client's condition or status

Training

ICC Video and PowerPoint posted here:
<https://dmh.lacounty.gov/qa/qa-training/>

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Supplemental Assessments for Services Requiring Pre-Authorization

- **Services Requiring Pre-Authorization (before providing/claiming)**
 - Intensive Home Based Services (**IHBS**)
 - Therapeutic Behavioral Services (**TBS**)
 - Therapeutic Foster Care Services (**TFC**)
- IHBS, TBS and TFC each have their own **supplemental assessments** that must be submitted along with other documents when requesting pre-authorization
- For details on the **pre-authorization process** for IHBS, TBS and TFC:
 - See **QA Bulletin 20-05R** and **FAQs** on the QA Bulletin webpage: <https://dmh.lacounty.gov/qa/qabul/>
 - See recorded **Webinars** on the QA Webinars webpage: <https://dmh.lacounty.gov/qa/qaw/icc-ihbs-tbs/>

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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 | <ul style="list-style-type: none"> ▪ 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 | <ul style="list-style-type: none"> ▪ 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 | <ul style="list-style-type: none"> ▪ All Disciplines |
| Reviewed court records for the purpose of completing the client's mental health assessment | MHS | Assessment | 90885 | NA | NA | <ul style="list-style-type: none"> ▪ All Disciplines |

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Thank You for Watching!

To find out how to receive a confirmation of completion for this video training please stay tuned!

To locate Provider Manuals and other QA resources related to documentation and claiming, please go to:

<https://dmh.lacounty.gov/>

QA questions can be sent to the QA Mailbox:

QualityAssurance@dmh.lacounty.gov

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Please complete the survey to receive a Confirmation of Completion!

iPhone or iPad:

1. Open up the camera app on your iPhone or iPad
2. Hold the device's camera up to the QR Code
3. No need to hit the shutter button, your iOS device will automatically recognize the QR code
4. Click the pop up window that appears and complete the survey
5. Make sure you have mobile signal or you're connected to Wi-Fi



Android:

For Android devices you will need to have a QR code reader app installed on your phone.

You can also type in the link below in your browser and complete the survey.

Or use this link by typing it in a browser: <https://tinyurl.com/Assessment-Module-Quiz>

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