FRESNO COUNTY MENTAL HEALTH PLAN
Documentation Standards for Consumer Records & Crisis Intervention Services Program Documentation and Billing Guidelines

The Fresno County Mental Health Plan (MHP) requires that all outpatient specialty mental health services provided by vendor, regardless of the payer source for the consumer, must adhere to the current standards set forth by the California Department of Mental Health and the Department of Health Care Services applicable to Short-Doyle/Medi-Cal billing. Any documentation requirements specific to other payer sources shall also be met by vendor as additional standards to those cited below.

Such documentation shall be on the standardized forms of the MHP if applicable. All other forms must address all of the documentation standards described below and must be approved in advance of usage by the MHP. The documentation standards are described below under key topics related to consumer care.

A. Assessments

1. The following areas shall be included as appropriate as a part of a comprehensive consumer record:

    a. Relevant physical health conditions reported by the consumer shall be prominently identified and updated as appropriate.

    b. Presenting problems and relevant conditions affecting the consumer's physical health and mental health status shall be documented, for example: living situation, daily activities, and social support.

    c. Documentation shall describe consumer strengths in achieving consumer plan goals.

    d. Special status situations that present a risk to consumer or others shall be prominently documented and updated as appropriate.

    e. Documentation shall include medications that have been prescribed by mental health plan physicians, dosages of each medication, dates of initial prescriptions and refills, and documentation of informed consent for medications.

    f. Consumer self report of allergies and adverse reactions to medications, or lack of known allergies/sensitivities shall be clearly documented.

g. A mental health history shall be documented, including: previous treatment dates, providers, therapeutic interventions and responses, sources of clinical data, relevant family information and relevant results of relevant lab tests and consultation reports.

h. For children and adolescents, pre-natal and perinatal events and complete developmental history shall be documented.

i. Documentation shall include past and present use of tobacco, alcohol, and caffeine, as well as illicit, prescribed and over-the-counter drugs.

j. A relevant mental status examination shall be documented.

k. A five axis diagnosis from the most current DSM, or a diagnosis from the most current ICD, shall be documented, consistent with the presenting problems, history, mental status evaluation and/or other assessment data.

2. Timeliness/Frequency Standard for Assessment

The MHP shall establish standards for timeliness and frequency for the above mentioned elements.

B. Progress Notes

1. Items that shall be contained in the consumer record related to the consumer's progress in treatment include:

a. The consumer record shall provide timely documentation of relevant aspects of the consumer care

b. Mental health staff/practitioners shall use consumer records to document consumer encounters, including relevant clinical decisions and interventions

a. All entries in the consumer record shall include the signature of the person providing the service (or electronic equivalent); the person's professional degree, licensure or job title; and the relevant identification number, if applicable

b. All entries shall include the date services were provided

c. The record shall be legible

d. The consumer record shall document referrals to community resources and other agencies, when appropriate

e. The consumer record shall document follow-up care, or as appropriate, a discharge summary

2. Timeliness/Frequency of Progress Notes

Progress notes shall be documented at the frequency by type of service indicated below:

a. Every Service Contact

i. Mental Health Services

ii. Medical Support Services

iii. Crisis Intervention

b. Other

i. As determined by the MHP for other services

DEPARTMENT OF BEHAVIORAL HEALTH
Crisis Intervention Services Program
Documentation and Billing Guidelines

Billing Code	Description	Service examples
031	Other	
032	Phone	• Calls to hospitals, other M/H programs, etc. • Crisis Intervention on phone. Best to pick service type but if it doesn't fit and done on phone
033	Case Management	All CIS staff except for MHW's: • Linking to a program or agency • Time spent monitoring the level of the client's symptoms (i.e., "Client's symptoms have not decreased and will need to transfer for inpatient care) • Discussion with family regarding client's mental health issues • Time spent giving discharge instructions, tie them specifically to symptoms that make up the crisis • Accompanying client to speak with M.D. • One-to-one intervention with the client to address symptoms not included in the assessment (i.e., "I am responding to the client's mental health crisis by ……" • Any time that staff notice and address changes in the client's symptoms that are outside of the assessment and/or will be passing the information on to appropriate staff
034	Assessment	**Licensed Staff Only** • Initial or re-assessment connected to disposition
035	Therapy	• **Clinician's only –** focus on symptom reduction, state specific interventions
036	Med. Mgmt.	**M.D. code only.**
037	Med. Support	**RN, LVN, LPT only** • Time spent discussing medications with client, family/significant others, Medical Director as well as discharge instructions
956	Note to Chart	**Mental Health Worker services only**

Billing codes:	Select the appropriate crisis intervention code: 032, 033, 034, 035, 036, 037.
Time billed:	Direct services + documentation time
Time limits for billing:	Can only bill up to 8 hours of time within a 24-hour period. A new 8 hours starts every 24 hours.
Staff able to bill:	Licensed, waivered, registered MD, Ph.D., LCSW, LMFT, RN, LVN, LPT, CMHS
Other staff:	MSW's bill code 956 – note to chart
Current Billing rate:	$3.75/per minute

Do not bill:

1. Observation only (i.e., client sleeping)
2. Time spent solely performing clerical tasks (i.e., faxing, photocopying, filing, etc.)
3. POV codes 040 and 042 as they require that a Plan of Care be in place within 60 days of the crisis service, which may or may not occur.

Documentation recommendations:

1. Always document how services are connected to the mental health crisis
2. Always identify the specific intervention that you are doing for a specific client
3. Do not use the term "stabilization" as the focus is on crisis intervention
4. Justify the service minutes billed
5. Use a separate progress notes when the chart is not in their possession. Clerical staff will need to gather all documents into the single medical record for this crisis visit
6. State the client and family's response to your intervention
7. Indicate discussions with other mental health professionals (this is critical when scope of practice issues necessitate consultation and referral)
8. Document outcome and follow-up plan

Crisis – Therapy (individual)

After initial assessment is done.

Focus on symptoms that are connected to why they came in. Focus on recording what, where, when these symptoms occur and make interventions that will help consumer reduce the occurrence of those symptoms.

If you tell a consumer what they can do if confronted by these symptoms again, it can be billed as Crisis Therapy.

Crisis – Therapy (family)

Talking to family after initial crisis assessment has been done and billed. Focus on the consumer's symptoms connected to their crisis and how the family members can assist

the consumer by using interventions prescribed by you, role playing interactions, things to watch for, coaching positive responses to consumer's behaviors. Similar to Collateral but there is no code for Collateral. If you would coach the spouse of your consumer on appropriate response or interventions to help the consumer cope or deal with reason they were in the crisis.

Crisis – Assessment

Assessment in connection with Discharge: Use POV 034. Assessing the initial symptoms/ behaviors/situation that created the mental health crisis in the first place written on a progress notes form or Re-assessment form. If you add instructions for self care or specific mental health interventions or referrals to outside agencies it can be included in the code 034. If you don't assess anything but just give them referrals make sure you make an intervention focused on the reason for the crisis and code it as Case Management, 033. Just handing them a discharge referral list is not billable.

Make sure you write exactly what you did and the interventions that you made plus how the consumer or family member responded. Add to the note if the consumer agrees to follow through or refuses and why.

General Notes

Always include in your notes, what makes it a Mental Health Crisis. Concentrate on what they did or do, and how you responded as a mental health professional AND what you did or do and how they responded and identify all persons involved in the crisis.

Hints for wording on Crisis Notes:

SI or SA related to . . . (circumstances, symptoms, relationships)
I . . . (exactly what you did in response to the crisis)
This writer . . .
Consumer was or did . . .
Identify mental health symptoms that consumer is having

Crisis – Phone

If the service you are providing doesn't fit into any category, ie. Case management, Therapy, Assessment, Medications, and if the services were provided over the telephone, use POV 032. This may be a service connected to a consumer's mental health crisis, for example the initial time you spend with the family member, talking directly to the consumer who may be calling for help, talking to any person connected to the crisis, making additional phone calls to police while the caller is on the phone or the second person who makes the call to police or ambulance.