

Questions & Answers from the Children's Documentation Trainings (11/17/03, 11/18/03, 11/21/03, 12/8/03, 12/9/03 and 12/10/03)

Assessment Client Plan (ACP) and Re-assessment & Re-authorization (R&R)

1. What do we bill for the ACP?
The Assessment Code, 93010, is used for completion of the ACP. The Plan Development Code, 98500, may be used for completion of the treatment plan.
2. Is there still a 30 day and 60 day differentiation between ACPs and R&Rs?
An ACP must be completed within 60 days of admission to a program, unless the case is being opened as a transfer. ACP transfers are completed within 30 days of admission. An R&R is completed to reauthorize continuation of services and is due 15 calendar days prior to the authorization expiration.
3. Do we document on the ACP/R&R that an interpreter was used?
Use of an interpreter may be documented in the presenting problem section or the psychosocial history section of the ACP/R&R. Interpreter use must be documented in the progress notes for every use, as well as efforts to arrange for interpreter services.
4. Is the ACP completed at each program change?
Yes, the receiving agency completes the ACP and the closing agency completes the Discharge Re-Assessment Summary.
5. If a client is discharged from a cost center and is opened to another cost center within the same agency, is an ACP completed at the new cost center or can the previous ACP be used.
An ACP must be completed at each cost center admission.
6. When a case is transferred in as a new case to the agency is an ACP or R&R due?
An ACP is completed at admission to an agency, including transfer and re-open cases. R&Rs are completed to authorize the continuation of services.
7. For cases that are closed in CATS but then require quick reopening, is this considered a new admission?
Yes
8. What about assessment if open to more than one cost center at an agency? Does more than one ACP packet need to be done?
It depends on the contribution of services authorized. The Client Data Sheet (CDS) must be completed for all cost centers in an agency. The most intensive service must have an original of all 3 forms of the packet (ACP, CDS, CHQ). The other less intensive service (in the same agency) must have a CDS but can obtain copies of the ACP and CHQ. The less intensive service should also have a supplemental goal sheet to accurately reflect the distinct services being provided from that cost center, otherwise documentation would reflect a duplication of treatment services.

9. Complete Assessment packet – if an agency has multiple cost centers open at the same time – can you make a copy of that plan or must one be done for each cost center?
See #8 above
10. Doesn't the ACP come before the MSO?
No, typically the MSO comes first with start and end dates of authorization. Only very few specifically identified exceptions exist. These exceptions are known to the Access Team and to the identified programs.
11. Program Admit Date – How can this be on an I1 before we get the MSO from Access?
Because an MSO is received prior to admission to most programs, the admit date will not be on the I-1 before the MSO is received from Access. There are some specific programs where the MSO comes after admission and the admit date exists prior to receipt of the MSO. Access is the responsible party for reconciliation of these differences.
12. Program Admit Date? When client comes to clinic and opened or MSO date?
Program Admit date is the date the client is opened in CATS.
13. Actual admit date usually precedes access approval date: How to reconcile? John walked in 12/1/03. Access sent us a referral on 12/10/03 approving services for 12/7/03. What is the acceptable program admit date? 12/1/03 or 12/7/03?
It depends on when John was opened to the program. If John was opened when he walked in on 12/1/03, then this would be the program admit date. However, if there was not an authorization until 12/7/03 then no services could be reimbursed between 12/1 and 12/6.
14. Program Admit Date for Stanford Home and the different programs that we have – what is the date we should use? Will it always be the MSO begin date? We may get an MSO for a WRAP client but they are not opened by the clinician for a few days. A residential client may come in and the Access MSO does not come back to us for a few days. (This is usually backdated to when the client 1st came in).
Each program will have its own program admit date. Program admit will not always coincide with the MSO authorization begin date.
15. On the ACP, is the date completed the date the ACP was started or the date it was signed?
Date Completed is the date the form was signed and completed by the clinician, not when the clinician began to complete the form. This may not be the same date as the date of client and caregiver signatures. If the date of the clinician signature precedes the date of the client and caregiver, there must be a corresponding progress note indicating how the plan was developed without the client's signature and why the client has not signed it (i.e. The development of the treatment plan was written based on today's session with the client. Client agreed to the following goals. Client will sign at the next session 12/30/03) as well as a progress note corresponding to the date the client did sign. If obtaining the signature is delayed, and such situations are expected to be limited, the progress notes should document continued efforts to obtain the signature.

16. Suggestion: Access authorization area on ACP/R&R – gray makes it blend in too much, take the gray out.
The gray background was added to enhance the area and make it stand out. At this time it will not be changed but it will be considered in future revisions.
17. Parent and Caregiver need clarification and if not the same, both should be consistently used on all forms.
“Parent” and “Caregiver” are not necessarily the same person in a child/youth’s life, however both have roles and responsibilities relating to daily care of the child/youth. When a form (i.e. CHQ) prompts you for a name of the “Parent/Caregiver”, it is asking for the person responsible for the daily care of the child and will also prompt you for the relationship that person has to the child/youth. “Parent” refers to the biological or adoptive parent. “Caregiver” refers to the person responsible for the day to day care of the child/youth and may or may not be the parent.
18. In cases of Group Homes, is caregiver the agency?
For Group Home clients, please identify a person within the agency responsible for the day to day care of the youth. This could be the therapist, social worker, house manager, lead staff, etc. The relationship of this person to the client would be identified as it relates to the group home (i.e. Group Home Therapist, Group Home House Manager, etc.)
19. RCL 12-14, Day treatment services – who is the “caregiver”?
See #18 above
20. Focus client in Group Homes – who would be the caregiver? Group Home name?
Same as #18 above.
21. In a residential program, who is considered “caregiver”? Each resident has an LHPA therapist, MHRS for day rehab. Each house has a residential administrator. So who signs under caregiver?
Same as #18 above.
22. Process for updating Legal Guardian if client’s county legal guardian changes. Can you state CPS Dept. or SW name? (on ACP)
The name of the person responsible is used and not just CPS Dept.
23. “Term legal guardian is often the person court appointed and is not necessarily the parent.” Please clarify.
If the legal guardian is not the parent, then indicate the name of the legal guardian or “dependent of the court” or “ward of the court”. If the child is a dependent of the court, then write the CPS worker’s name and contact information next to “dependent of the court”. If a child is a ward of the court, then write in the probation officer’s name and contact information next to “ward of the court”. Not all kids identified with CPS or Probation are dependents or wards of the court.
24. Do agencies fill in #18 on “Language spoken in the home”
Yes, if a language is spoken in the home that is not listed.

25. Could the psycho-stressors on page 2 be numbered to correlate with Axis V on page 6? In that way all check boxes can be inclusive in the ACP.
This suggested change will not be made to the current forms but will be considered upon future revisions.
26. Problem Areas – Potential Risk – Subjective? Client’s perspective?
The process of assessing problem areas and potential risk are grounded in gathering clinical information including the client’s perspective, however the documentation in the Problem Area section is based on the Clinician’s assessment and clinical judgment.
27. If I check boxes in the problem areas section, do I need to write a presenting problem as well?
Yes, both are required.
28. If you check “no” to a problem do you also need to check “none” on severity of problem and potential risk?
Please check one box in all three categories (history, severity of problem and potential risk) for all 22 problem areas.
29. Potential Risk section: What is the clinician's liability by marking or not marking a particular check box? What if they put no/low risk and something happens? What about anchors for the levels of severity of risk?
Assessments are completed at one point in time with information available at that time. The clinician is responsible for the assessment and for the identification and documentation of risk concerns at the time of assessment. It is recognized that changes may occur rapidly in a client’s life, resulting in significant changes to risk. Liability is a concern when action is not taken appropriate to the risk identified.
30. Can you differentiate between current risk and potential risk?
Current risk (severity) is defined as “within the past 2 months”. Potential risk is futuristic and defined by “up to 60 days”.
31. Define anchors for “insignificant, mild, moderate, severe” in the Glossary.
Insignificant, mild, moderate and severe are descriptors that are defined as relating to the child/youth’s functioning at the point in time of the assessment. Clinical judgment is to be used much like in choosing a GAF score. The suggestion to add anchors to the Glossary will be considered during future revisions.
32. On Page 3 of the ACP, when do you mark “transfer”?
Mark “transfer” in answering the question “Previous Outpatient Mental Health Services?” when you have received this case as a transfer from another outpatient mental health service provider.
33. No unknown options under client MH section, what do we do for clients when information is not known?
Write “unknown” and any plans to gather the information in the narrative section for this section. Subsequent progress notes should indicate efforts made to obtain the information if applicable.

34. Was there an AOD tool used to formulate the AOD questions on ACP or other forms?
Yes
35. Substance abuse (True/False) - Do you not mark a box if it's unknown?
The True/False questions in the Substance Abuse section are to be asked of the client and are to be marked from the client's perspective. There should not be an "unknown" answer because you are asking the client.
36. Prenatal exposure – do you need a PN if unknown?
No
37. Do we include prescribed (i.e. Ritalin) meds in "Type of Substance" section?
No, Type of Substance section refers to medication or drugs abused by clients, not those taken as prescribed.
38. Do AA & NA count as an alcohol & drug service"?
Yes
39. Is a goal for AOD still mandatory?
If a client has dual diagnosis issues and is ready to work on them, a goal is required to address that need.
40. Thank you for addressing HIPAA/substance Use and client plans – other providers may have this question/concern.
To reiterate: If a client has revealed a substance abuse issue to a clinician in confidence, the assessment and progress notes should note that confidence related to disclosure and honor it. It is expected that a clinician would work with a client to develop a treatment plan or goal to allow for treatment to proceed with caregivers involved while honoring the confidence, if at all possible. If not possible, other treatment goals would be developed as part of the client plan.
41. If there is a substance abuse goal, does it have to be written on the treatment plan or can it just be documented in the substance abuse section?
If a client has a substance abuse goal that will be addressed during the current authorization period by your agency, then a goal related to substance abuse is expected on the treatment plan. The only exception is #40 above.
42. Do we refer out for substance abuse if we do not treat that?
Contracted providers are expected to provide a range of mental health services addressing a variety of mental health and dual diagnosis issues including but not limited to substance abuse issues. Services shall be provided in accordance with the Sacramento County Mental Health Plan contract. Please discuss with your County Program Coordinator.

43. If there are no risks and no substance abuse issues, do we need to write “no risk/no substance abuse” in the summary section?
No, however, the lack of risk (from 22 problem areas) may also suggest a lack of need for service and this should be examined closely.
44. Clonidine (not an anxiolytic) and strattera (not a stimulant) - - - Check drug category for accuracy.
Information noted and will be changed in the next revisions.
45. On psychiatric medication section on 4 of 8, suggest adding date or month/year of prescription and suggest adding columns boxes.
Suggestion noted and will be considered in future revisions of the forms.
46. One of changes being made on diagnosis is multiple secondary diagnoses.
This change was included to accommodate the multiple secondary diagnoses presented in our system.
47. What if diagnosis is changed more than 1x during an authorization period? Put in an additional page 6?
If a diagnosis changes more than once in an authorization period, you must complete a new client data sheet with the updated diagnosis and indicate an asterisk (*) in the Updated Diagnosis section with a corresponding asterisk in the summary section and write “Diagnosis Change, see progress note dated...” In the progress note referencing the “Diagnosis Change,” support the change with clinical rationale.
48. Suggested change to form – “see progress note” for multiple changes in Updated Diagnosis section.
See #47 above.
49. Updated Diagnosis: Do you want us to write Name and Licensure under check box? (on ACP & R&R)
No, document the name and license of the person updating the diagnosis in the supporting progress note indicated.
50. New R&R for change in Diagnosis?
You do not need to complete a new R&R when there is a change in diagnosis. You may complete the updated diagnosis section of the R&R and update the CDS and enter the new information into CATS. A corresponding progress note also needs to document the change.
51. If substance abuse is a Primary Diagnosis, do we put it in both boxes provided?
A substance abuse diagnosis should not be a primary diagnosis for youth served in our system of care relative to medical necessity. However, dual diagnosed clients exist in our system. To diagnose substance abuse issues, please use the Substance Abuse box (labeled Secondary Axis I in the diagnosis area of the form).

52. Limiting of diagnoses to primary and secondary may easily result in no substance abuse diagnosis.
There is a specifically identified box/space to enter a substance abuse diagnosis in the diagnosis section of the ACP/R&R.
53. If a particular program is focusing on an Axis 1 diagnosis what happens w/diagnosis consistency among service coordinators?
Diagnostic consistency is expected throughout a child's treatment. Clinical justification should support cases in situations where more than one diagnosis is the focus of treatment. The diagnosis should not conflict in such cases and progress notes should document efforts toward diagnostic reconciliation and rationale for variability.
54. What if Primary diagnosis is different for agencies that are focusing on a particular diagnosis?
See #53 above. The record should document discussion and coordination between providers regarding any differences in diagnosis and treatment focus. The record should document efforts made to reconcile any differences that may impact the coordination of care between agencies, which in turn may impact the quality of care.
55. Can you go through a hypothetical treatment plan? Clarify measurable and frequency on page 7, show examples.
This is covered in the Documentation Trainings. Remember that each treatment plan is individualized.
56. Is day treatment still requiring 3 goals?
Day Treatment youth are usually receiving more intensive services than outpatient, and so may be working on 3 simultaneous goals. There is no requirement for the number of goals, however service need generally dictates goals sufficient in number to lower the level of service need.
57. Who does "support person" refer to on the plan?
The support person is the person identified by the client as someone who will be instrumental in the implementation of the treatment plan along with the client. This may be a parent, teacher, uncle, mentor etc. Collateral is billed for service activities to a significant support person for the purpose of meeting the client's mental health needs as identified in the treatment plan.
58. Is there a limit on the resolution date?
Goals are individualized and client specific and, therefore, may take a range of time to address and resolve. The expectation is that treatment planning include time frames and resolution dates. Remember, the resolution date for goals must stay within the current authorization period.

59. Does there have to be a date in the tentative discharge section?
No, but the section should include more that “the client will be discharged when goals are accomplished.” The Tentative Discharge Plan should include progress expectations focused on improvement of symptoms and control or mastery of behavior that will allow the client to function beyond the support of mental health services.
60. Is coordination of care only for outside agencies (not within your agency)?
The coordination of care section is to be used for coordination of services with other programs, generally outside your agency. Coordination does not mean one caseworker talking with another team member regarding each session or encounter with a client. If your agency is providing another service, however, coordination will occur between programs in your agency.
61. If the coordination meeting happens after the fact, do we go back and write it in on the ACP/R&R?
The expected date of the coordination plan should be written on the ACP/R&R. If an unexpected coordination meeting happens later, then you must document such a meeting in the progress notes. You may also add an addendum to the ACP or R&R on page 8 in the coordination of care section referencing such a progress note. All addendums must be dated and initialed.
62. Do coordination meetings after the ACP date need to be added in after it's done?
Same as # 61 above.
63. In the Coordination Meeting box on pg. 8 should meetings after the ACP is done be filled in as well as progress noted?
See #61 above.
64. CCMS doesn't give out the Member Handbook etc. and always gets McFlooded even though they have a Yellow sheet of paper explaining why they didn't give it. What can they do so they don't get McFlooded?
County UR has a wide variety of reviewers who may not be familiar with specific program procedures. QM is working to develop a UR Tool specific to CCMS to address issues such as this one. CCMS's functions start with 26.5 evaluations and the mental health service provider is responsible for informing and giving the client the handbook. Until a UR tool specific to CCMS is developed, you may note the error on the returned McFlood.
65. For CCMS: We do not hand out member handbooks. Could we just put in NO in section with typing in client is 26.5 client?
No, please check “NO” and document in the progress note section that since the client is 26.5 the primary provider will be giving the member handbook.
66. What are all the providers' signatures for on page 8?
Signature lines inform the client and family of other providers coordinating to provide services. There may be several providers coordinating to provide an array of services for one client and signatures of involved parties on the treatment plan documents the collaborative efforts.

67. Suggest the verbiage on the “signatures” line be highlighted or enlarged so it doesn’t just blend in. Maybe take out some of the signature lines.
The number of signature line may be reduced in future revisions to accommodate this suggestion. See #66 above.
68. Why are we giving plans to clients?
The treatment plan (pages 7 and 8 of ACP) is given to the client and not the entire ACP, unless a specific request for records is received and authorized. Providing clients with a copy of their treatment plan is required by the Department of Mental Health. More importantly, giving clients a copy of the plan demonstrates creating a collaborative partnership with the client/family, recognized as a core value of the Sacramento Mental Health Plan.
69. Ways goals are numbered on the supplemental goal sheet is #1, 2, and 3 just like the ACP/R&R. How do we differentiate among resolved goals?
Please re-number the supplemental goal sheet appropriately. This will be corrected during future revisions.
70. On Supplemental Goal sheets, the goal # should be 3, 4, 5 not 1, 2, 3.
See #69 above.
71. Where is supplemental goal sheet filed? After page 7 or 8?
After page 8 of the ACP or R&R.
72. On supplemental goal sheet...if there is only 1 supplemental goal, can it be done on the 2nd page where the signatures are?
Yes, but be sure to number the supplemental goal appropriately.
73. Can we use the Children’s ACP for 0-5 children?
No, the 0-5 ACP should be used for children ages 0-5 and is also used for re-authorization instead of the R&R.
74. Re-Authorizations: Do all 3 (CHQ, R&R AND CDS) all have to be done on the every 90 day authorizations to begin with? excessive?
No, the CHQ and the CDS are required annually at minimum. See CHQ P&P and CDS P&P. The R&R is required to request a reauthorization. Please complete a CHQ or CHQ Update annually at minimum or whenever important new health information is obtained after the initial CHQ is completed.
75. Do we have an electronic version of this ACP and R&R without lines in areas where we have to type answers to questions? If not can we delete the lines? (i.e. in “client plan” section)
The electronic version of the ACP/R&R does not have lines in narrative areas. There are, however, lines in the client plan section that cannot be deleted. The electronic versions are templates.

Client Data Sheet (CDS)

1. On the new CDS do we still write CATS codes?
Yes, until CATS is no longer used because the data entry person will need to enter the information into CATS.
2. If the info on the CDS hasn't changed, do we do another one at R&R?
Yes, because there will always be at least one or two pieces of information that has changed from year to year (i.e. age, grade in school, today's date). Electronic versions of the CDS are encouraged to be used for this purpose. Note: The CDS is considered part of the assessment process and accurate completion is the responsibility of the clinical and not clerical staff.
3. With 3 month authorizations, do we do the CDS and CHQ update?
No, the CDS and CHQ are to be completed annually at minimum. See CDS P&P and CHQ P&P.
4. Updated Diagnosis box on new CDS, when is this completed?
The 'Word' version of the CDS has an updated diagnosis box that can be used to update a diagnosis without completing a new CDS, given all other information on the CDS is still current and accurate.
5. What new questions are asked on the CDS that requires that a clinician enter it rather than clerical staff?
The clinician is expected to complete all fields of the CDS as part of the initial assessment. Clerical staff may enter the CDS date into CATS.

Child/Youth Health Questionnaire (CHQ) and CHQ Update

1. Upon transfer can we do the CHQ update?
Yes, a CHQ Update must be completed in conjunction with any transfer. See CHQ P&P.
2. Is CHQ done with the R&R at 6 months or annually ok?
The CHQ update is done with an R&R or annually at minimum. See CHQ P&P. When R&Rs are due less than annually, you may wait to do the CHQ update until the annual renewal.
3. CHQ: Pg 2 delete the word "ever" for broken bones and bruising, as we only want since the last R & R;
This particular section starts with the phrase "Since the Last CHQ". This change will be considered in future revisions.
4. If medication is added after the CHQ is completed, where do we add it?
You may always addendum a CHQ as long as you initial and date the addendum. There must also be a corresponding progress note to explain the rationale for the addendum.

5. Information on medications is requested on both CHQ and ACP – does this need to be on both?
Yes, the CHQ and ACP are not always completed simultaneously. The CHQ is often completed prior to any psychiatrist appointment, at which point the medication information may change. The CHQ asks for both past and present medications to assist the doctor's assessment. The ACP asks for current medication only (unless there are no current meds, then it asks for a list of historical medication) as part of the psychosocial assessment.
6. If we choose to use the Adult Health Questionnaire for an older or transition age youth, do we still update it annually?
Yes, an annual Health Questionnaire is now required for all EPSDT services.
7. Will CHQ be translated into Spanish?
It may be in the future, however due to the current limited resources, this project has not been completed along with other assessment documents. This translation effort would apply to all threshold languages.

Discharge Re-Assessment Summary

1. If you open a client and only see them once (no ACP done), do we complete the Discharge Re-Assessment Summary form?
Yes, complete the Discharge Re-Assessment Summary, which now serves as the final progress note.
2. What is discharge date?
The discharge date is the date the client's case is closed out of CATS from a particular cost center. The closing cost center cannot bill after the discharge date.
3. Are the codes on the Discharge Re-Assessment Summary the same as the CATS codes?
No
4. Is the ICD9 required/needed on the CATS discharge form?
No, the ICD9 code required for the primary focus of treatment is only required on the CDS, ACP, R&R and AMSP.
5. How long do we have to complete the Discharge Summary?
The Discharge and Re-Assessment Summary acts as the final progress note, so guidelines around timeliness of progress notes should be followed.
6. Do you still have 30 days after discharge date to close out in CATS?
The discharge date is the date the case is closed out in CATS. The data entry process for this must abide by the current standard (within 30 days).

Child and Family Access Team and Authorizations

1. Will admit date = date on MSO? Clarify.
No, not necessarily. Admit date is the date the client is admitted to the program/cost center in CATS. The start date on the MSO authorization is determined by Access and may not be the same as the Program admission date.
2. For two month assessments, is the ACP sufficient when requesting an extension of authorization from ACCESS?
Yes
3. Are MSO authorization dates remaining the same i.e. Day rehab is 6 months if there are other programs attached, they are also 6 months. Stay the same?
Yes, if a client is open to Day Rehab, the authorization cycles for other programs will correspond to the authorization cycle for Day Rehab (6 months cycles by State regulation)
4. When there are multiple providers, how are authorizations handled? Will R&R's be due at the same time?
There are some instances in which there may be more than one provider serving a youth in our system. In order to ensure services are not being duplicated, R&Rs must be submitted on the same authorization cycles.
5. What if a client is not opened right away, will the authorization be based on the admit date?
No, the authorization will be provided by Access and will not exceed one year. If a child is authorized from January 14th to December 31st but not opened until March 17th, then the agency will only have a 10 month authorization and the R&R will be due 15 calendar days prior to the end of the authorization (December 16th).

Performance Outcomes

1. How to bill Performance Outcomes. (all under assessment)?
Because performance outcomes are now integrated into the ACP and R&R, there is no need to break out the billing for performance outcomes under the Evaluation Code of 96010. The assessment includes outcomes and can be billed under Assessment Code of 93010. The Evaluation billing code is NO longer used for completion of the Discharge Re-Assessment Summary.
2. Do we bill performance outcome billing at page 4 Community?
No, because performance outcomes are now integrated into the ACP and R&R (see response #1 above).
3. What agencies/ "intensive providers" are to do CAFAS training? Provide a list.
All WRAP, FOCUS and TAP providers.
4. What programs are considered intensive – WRAP, FOCUS & Day Rehab?
WRAP, FOCUS, TAP

5. Intensive programs = WRAP, FOCUS; what about DTI/DR?
Same as #4 above.

6. Why no CAFAS or PECFAS except in intensive?
The CAFAS and PECFAS were developed for use with Seriously Emotionally Disturbed children and youth. The more intensive programs are more likely to serve that population of children/youth. Functional outcome information is incorporated into the new ACP for the majority of EPSDT clients.

7. Does 0-5 still use the PECFAS?
No, a child must be at least 4 years old to complete the PECFAS and the 0-5 ACP will be revised to include appropriate outcomes for that population.

8. The Sacramento Assessment Center evaluates Probation Dept. Wards who need out of home placement and provides fairly limited treatment. Therefore outcomes regarding effectiveness of treatment is difficult to measure on performance outcomes. Could SAC be exempted from performance outcomes?
No, the outcome information is integrated into the ACP and the entire ACP must be completed by all providers within the Sacramento Mental Health Plan.

9. The new forms have lots of check boxes, is this in part to aggregate the info? How will this aggregated info be used?
Aggregate information will be used to evaluate individual programs and countywide trends.

General Questions/Comments

1. Color of the paper affects the photocopies and faxing (blue hard to read (most people end up having to copy it in order to fax it to ACCESS); Can we change the color of the paper?
Forms are color coded in our system and there is no plan to change it at this time.

2. Do we encourage cut and paste? **No, cut and paste is not encouraged or advised for clinical documentation. A thorough assessment or re-assessment is based on a current evaluation of need for mental health services, justification for medical necessity, etc., and should be reflected in documentation. All documentation should include the client's current mental, emotional, and behavioral condition. Progress notes should be individualized, and vary from session to session based on the client's current condition.**

3. How much time do we have to complete paperwork for a transfer?
30 days which is the same amount of time as is currently allowed for a transfer.

4. Having only 30 days on a transfer is not very much time since all paperwork must be completed again.

You are currently required to do an ACP and CDS in 30 days. The only addition will be the 3 pages of the Updated CHQ.

5. Are the forms available on the W drive?

The W drive is only available inside the County. It is not accessible to contract providers. Forms are available by contacting Rosario Baluyut with Quality Management, 875-7928.

Addendum Questions

3-15-04

Q: Since county operated programs are concurrently authorized with CAPS, does the case manager at CAPS need to do an ACP within 30 days to signify taking over as the case manager (as is required for "transfers" per P&P) when a county operated program ends services and requests that the client becomes meds only thru CAPS?

A: A progress note indicating the step down to meds-only is sufficient and an R&R would be done on the regular cycle because it is not a true transfer as described in the ACP P&P, since CAPS was already concurrently open.

6-22-04

Q: If Day Rehab hours are from 3:30pm-6:30pm, can a child attend for more than 50% and then attend a separate billable collateral meeting at 5:30pm?

A: Mental Health services (except TBS) cannot be reimbursed during the hours of Day Rehab or Day Treatment. If a Day Rehab provider is being reimbursed for the full hours of Day Rehab, they cannot bill a separate service during those same hours. This represents double billing and is Compliance issue. According to DMH Notice 02-06, "Beneficiaries are expected to be present for all scheduled hours of operation for each day". DMH Notice 02-06 does address "unavoidable" absences.

6-22-04

Q: If a WRAP provider attends Day Rehab with a client to assist/support a client during those hours, can WRAP bill for that time?

A: As stated above, mental health services (except for TBS) cannot be reimbursed during the hours of Day Rehab or Day Treatment. WRAP services would not be MediCal reimbursable during those hours of Day Rehab or Day Treatment.

9-20-04

Q: Up to what age is a CAFAS done?

A: 17

9-28-04

Q: Do CPS reports go into client's chart?

A: CPS reports can be filed in a chart. They should be maintained in a confidential section of the chart and should **not** be forwarded with a request for records. They should also be listed on the HIPAA accounting of disclosures list.

11-4-04

Q. "Can a PSC be billed as co-staff for sharing resources with a clinician". *example: PSC found resources and is telling the clinician what she found and how to use the resources with the client*

A. This type of inter-agency collaboration would be billed as case management brokerage by the PSC. It would not be co-billed. Documentation should clearly explain how the sharing of resources benefits the client according the client plan. In this case the receiving/listening person is not providing a service and thus would not bill or co-bill.

11-4-04

Q. If the PSC is reporting to the clinician something she did with the client. Who bills? Can they co-bill?

A. Merely reporting on an event that occurred with a client, such as providing daily progress updates, is not a billable service. If the PSC is discussing a service provided to the client, the client's response, and plans for next steps to further implement the client plan, this is considered an inter-agency consultation and would be billable as case management brokerage. The PSC would bill. A co-staff billing must clearly justify each worker's role as necessary, unique and unduplicated in the service being provided.

11-4-04

Q: What is a situation where a PSC could be billed as co-staff?

A: Any co-staff billing must clearly justify each worker's role as necessary, unique and unduplicated in the service being provided. Ask the question "could this service be provided by just one person?", if yes, then it most likely not a service to be co-billed.

Co-billing is limited to consultations which are billed under case management brokerage.

11-24-04

Q: Can you document in the progress note that you did a report and is it billable?

A: You should document in the chart that the mandated report was completed and CPS was contacted within 36 hours as required by law. In order for this to be billable as a Case Management Service, the documentation must reflect the entire service provided i.e. risk assessment, completion of mandated reporting, follow-up reaction or support plan. Completing the report without documentation supporting a case management service is considered a non-billable administrative mandate.