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OFFICIAL MEMORANDUM

DATE: September 3, 2015
TO: Community Psychiatric Rehabilitation Programs
FROM: Nora K. Bock, Director of Adult Community Treatment *NB*
Connie Cahalan, Children's Director *CC*
RE: Assessment and Treatment Planning Process Changes – **REVISED**

Effective July 1, 2015, The Division of Behavioral Health established a *new* assessment and treatment planning process within Adult and Children/Youth Community Psychiatric Rehabilitation (CPR) programs, with an expected date for full implementation of October 1, 2015. The accompanying Community Treatment Bulletin includes two revisions to include: 1) within 3.5.2 and 5.8.9 that a licensed psychologist may approve the treatment plan only in instances when the person is currently receiving no prescribed medications and the clinical recommendations do not include a need for prescribed medications; and 2) within 5.8.8 the 90-day timeframe for physician/APN signature requirements only applies to initial treatment plans and not annual treatment plans.

As a reminder, the purpose of the change in the assessment and treatment planning process is to revise and update the screening, initial/ongoing assessment, and treatment planning process as well as the content requirements. The goal of these changes is to modernize and streamline the assessment process in order to improve access to care.

This new process allows for quicker access to services by removing the physician from the admission process and allowing eligibility to be determined by other personnel qualified to render diagnoses. The physician signature on the treatment plan, now required at a later point in time for initial treatment plans, will still certify that treatment is needed and services are appropriate and medically necessary, as described in the treatment plan. Additional notable differences in this process include changes in timelines, as well as billing and documentation requirements. Please note that the initial assessment is more comprehensive than ever before, while the subsequent annual assessments address only areas of change for individuals served.

The attached bulletin and workflow documents provide details of the new process and requirements. Please contact Susan Blume with any questions you may have. Thank you.

NB:ldn

Attachments

cc: Laurie Epple
Susan Blume
Natalie Fornelli
Brent McGinty
Rhonda Turner
Tim Rudder
Donna Siebeneck
Regional Executive Officers
Chiefs of Children's Community Operations
Chiefs of Adult Community Operations

Missouri Division of Behavioral Health

Bulletin Number: FY 16—033	COMMUNITY TREATMENT BULLETIN	Effective Date: July 1, 2015
Revised September 3, 2015	Subject: New Assessment and Treatment Planning Process in the Community Psychiatric Rehabilitation Program	Number of Pages: 9

1. Programs Affected

- 1.1 Community Psychiatric Rehabilitation (CPR) Programs and Adult and Youth Community Services.

2. Background and Purpose

- 2.1 This bulletin provides clarification on the **new** assessment and treatment planning process within CPR programs.
- 2.2 Revise and update the screening, initial/ongoing assessment and treatment planning process and content requirements with the goal of an updated, streamlined assessment process that improves access to care.

3. Policies and Procedures

- 3.1 Effective July 1, 2015, all CPR programs will be required to implement processes as outlined in this bulletin and supporting documents.
- 3.2 Eligibility determination requires confirmation of an eligible diagnosis as evidenced by a signature from a licensed diagnostician or a physician/APN prior to delivering CPR services.
 - 3.2.1 Signatures can be obtained by **either** a face-to-face meeting with a licensed diagnostician **OR** a face-to-face meeting with an unlicensed QMHP followed by a sign off by a licensed diagnostician or a physician/APN.
****Note: The licensed diagnostician is accountable for the stated diagnoses.***
- 3.3 Psychosocial assessment must be completed within 30 days of date of completion of eligibility determination.
- 3.4 Treatment plan must be completed within 45 days of date of completion of eligibility determination.
- 3.5 The physician/APN signature on the initial treatment plan must be obtained within 90 days of completion of eligibility determination, after a face-to-face meeting, consultation, or case review.

- 3.5.1 The physician/APN signature certifies that treatment is needed and services are appropriate, as described in the treatment plan and does not recertify the diagnosis.
- 3.5.2. A licensed psychologist may approve the treatment plan only in instances when the person is currently receiving no prescribed medications and the clinical recommendations do not include a need for prescribed medications.

4. Qualified Personnel

4.1 The following **mental health professionals are approved to render diagnoses** in accordance with the current version of the Diagnostic and Statistical Manual of Mental Disorders:

- Physicians (includes psychiatrists)
- Psychologists (licensed or provisionally licensed)
- Advanced Practice Nurse
- Professional Counselors (licensed or provisionally licensed)
- Marital and Family Therapists (licensed or provisionally licensed)
- Licensed Clinical Social Worker
- Licensed Master Social Worker who is under registered supervision with the Missouri Division of Professional Registration for licensure as a Clinical Social Worker. (LMSWs not under registered supervision for their LCSW credential cannot render a diagnosis.)

These professions are categorically approved as licensed diagnosticians as long as the diagnostic activities performed fall within the scopes of practice for each. However, individuals possessing these credentials should practice in the areas in which they are adequately trained and should not practice beyond their individual levels of competence.

5. Billing and Documentation

5.1 Screening

- 5.1.1 Billed to the community services category as initial referral – T1023 (15 minute units).
- 5.1.2 Consists of obtaining initial demographic description and/or referral to an appropriate service prior to determining eligibility for CPR program.
- 5.1.3 May be provided over the telephone.
- 5.1.4 Can be provided by clerical staff with specialized training.
- 5.1.5 Written report must be included in the client record.

- 5.1.6 Time must be documented in progress note.
- 5.1.7 Progress note must be signed by the service provider.

5.2 Eligibility Determination

- 5.2.1 CPR program services may be billed when eligibility determination is complete and signed off by a licensed diagnostician or a physician/APN.
- 5.2.2 Time is not billable by any staff **when the individual is assigned to the rehabilitation level of care** (the time is included in the assessment bundle rate).
- 5.2.3 All QMHP time is billed as Behavioral Health Assessment - H0002 (15 minute units) **when the individual is assigned to the maintenance level of care.**
- 5.2.4 Physician/APN time (which is optional) is billed as Physician Consultation - 99241xx (15 minute units).

5.3 Documentation of eligibility determination to include, at a minimum:

- 5.3.1 **Presenting problem and referral source;**
- 5.3.2 **Brief history of previous psychiatric/addiction treatment including type of admission;**
- 5.3.3 **Current medications;**
- 5.3.4 **Current mental health symptoms** (must support diagnosis);
- 5.3.5 **Current substance use;**
- 5.3.6 **Current medical conditions;**
- 5.3.7 **Diagnoses, including mental disorders, medical conditions and notation for psychosocial and contextual factors;**
- 5.3.8 **Functional assessment using Department approved instrument;**
- 5.3.9 **Identification of urgent needs** (suicide, personal safety, risk to others);
- 5.3.10 **Initial treatment recommendations;**
- 5.3.11 **Initial treatment goals to meet immediate needs within the first 45 days of service; and**
- 5.3.12 **Signature and title of all service providers is required.**

5.4 Assessment and Treatment Planning

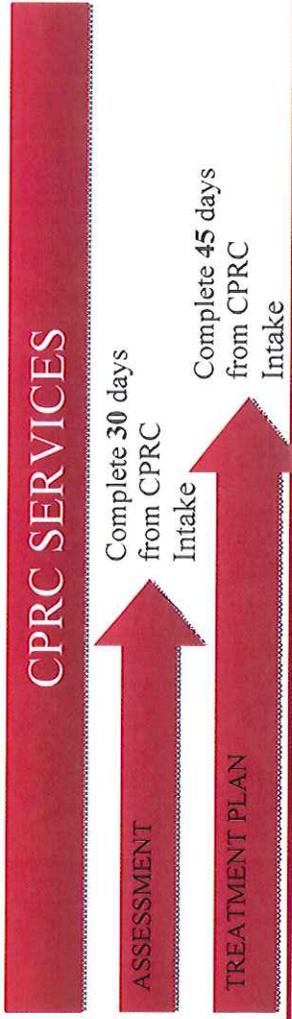
- 5.4.1 Staff time for development of assessment or treatment plan **for individuals assigned to the rehabilitation level of care** is not billable by any staff (it is included in the bundled rate).
 - 5.4.2 Authorization for submitting the billing claim in CIMOR for the bundled assessment **in the rehabilitation level of care** (H0031/H003152) occurs when the assessment and treatment plan are complete and signed by all required parties, not including physician/APN signature for initial treatment plans. The physician/APN has up to 90 days to sign the initial treatment plan.
 - 5.4.3 All QMHP time, for individuals determined to **not qualify** for the CPR program is billed to the community service category as Initial Screening – H0002xx (15 minute units). Signature and title of service provider is required.
 - 5.4.4 All QMHP time for assessment activities **for individuals assigned to the maintenance level of care** is billed as Behavioral Health Assessment - H0002 (15 minute units).
 - 5.4.5 All QMHP time for treatment planning activities **for individuals assigned to the maintenance level of care** is billed as Treatment Planning - H0032 (15 minute units).
 - 5.4.6 Physician/APN time **for individuals in the maintenance level of care** is billed as Physician Consultation - 99241xx (15 minute units).
- 5.5 An initial assessment for individuals **assigned to the rehabilitation level of care** includes, at a minimum:
- 5.5.1 **Basic information** (demographics and including age, language spoken);
 - 5.5.2 **Presenting concerns** (from perspective of the person, reason for referral/referral source, what occurred to cause the person to seek services now);
 - 5.5.3 **Risk assessment** (suicide, safety, risk to others);
 - 5.5.4 **Trauma history** (experienced, witnessed, including abuse, neglect, violence, sexual assault);
 - 5.5.5 **Mental health treatment history;**
 - 5.5.6 **Mental status;**

- 5.5.7 **Substance use treatment history & current use** (including alcohol, tobacco and/or other drugs. For children/youth also prenatal exposure to alcohol, tobacco or other substances);
- 5.5.8 **Medication information** (current medications, medication allergies/adverse reactions, efficacy of current or previously used meds);
- 5.5.9 **Physical Health summary** (health screen, current primary care, vision and dentist, date of last exams, current medical concerns, BMI, tobacco use status, exercise level. For children/youth, also note immunization record and any medical concerns of any family member that may impact the child/youth);
- 5.5.10 **Assessed Needs – Functional Domains** (challenges, problems in daily living, barriers, and obstacles - based on use of DLA20);
- 5.5.11 **Risk taking behaviors/child/youth risk behaviors;**
- 5.5.12 **Living Situation** (where living, who living with, financial situation, guardianship and including need for assistive technology. For children/youth, parental/guardian custodial status);
- 5.5.13 **Family** (including cultural identity, what was it like growing up, what is your family like now. For children/youth, family functioning/dynamics, relationships and any current issues/concerns impacting the child/youth at this time);
- 5.5.14 **Developmental information** (for adults and children/youth - evaluating current areas of functioning such as motor development, sensory, speech problems, hearing and language problems, emotional, behavioral and intellectual functioning, ability for self-care);
- 5.5.15 **Spiritual beliefs/religious orientation;**
- 5.5.16 **Sexuality** (is person sexually active, practice safe sex, sexual orientation);
- 5.5.17 **Need for and availability of social, community and natural supports/resources** (friends, pets, meaningful activities, leisure/recreation interests, self-help groups, resources from other agencies. For children/youth also interaction with peers, respond in terms of the child and the family as a whole);
- 5.5.18 **Legal Involvement History;**
- 5.5.19 **Legal Status** (guardianship, payee ship, conservatorship, probation/parole etc.);
- 5.5.20 **Education** (including intellectual functioning, literacy level, learning impairments, attendance, achievement);

- 5.5.21 **Employment** (currently working, work history, interested in working, work skills);
- 5.5.22 **Military services history;**
- 5.5.23 **Clinical Formulation** – interpretive summary (includes identifying co-occurring or co-morbid disorders, psychological/social adjustment to disabilities and/or disorders);
- 5.5.24 **Diagnosis;**
- 5.5.25 **Individual’s Expression of Service Preferences;**
- 5.5.26 **Assessed Needs/Treatment Recommendations** – consider life goals, strengths, preferences, abilities and barriers; and
- 5.5.27 **Signature of individual completing assessment is required.**
- 5.6 **Brief assessment requirements for individuals assigned to the maintenance level of care** are satisfied through documentation of eligibility determination.
- 5.7 **The annual assessment for individuals assigned to the rehabilitation level of care** includes, at a minimum:
 - 5.7.1 **Identification of Clinical Assessment Sections for update** (such as check boxes for sections of the assessment being updating. Be sure to include information in the narrative for each section being updated);
 - 5.7.2 **Update narrative** (list each assessment section being updated with a narrative explanation – only for sections identified as needing update);
 - 5.7.3 **Clinical Formulation** – interpretive summary;
 - 5.7.4 **Diagnosis change/update;**
 - 5.7.5 **Individual’s Expression of Service Preferences;**
 - 5.7.6 **Assessed Needs/Treatment Recommendations;** and
 - 5.7.7 **Signature of individual completing assessment, Community Support Supervisor (if different than individual completing assessment), and licensed diagnostician or physician/APN is required.**
- 5.8 **The treatment plan for individuals assigned to the rehabilitation or maintenance level of care** includes, at a minimum:
 - 5.8.1 **Identifying information;**

- 5.8.2 **Goals** (expressed by the person/family, individualized/measurable/achievable/time specific, start date, strengths and skills and how they will be used to meet this goal, supports and resources to meet this goal, things that could get in the way of meeting this goal, linked to assessed need);
- 5.8.3 **Specific treatment objectives** (start date, understandable to the person, sufficiently specific to assess progress, responsive to disability/concern, reflective of age/development/culture/ethnicity);
- 5.8.4 **Specific interventions** (action steps/modalities/service to be used including duration, frequency of interventions and who is responsible for the intervention, also includes action steps of person/their natural supports/family);
- 5.8.5 **Identification of other agencies/community supports** (includes others working with the person, plans for coordinating with other agencies, services needed beyond the scope of the program that are addressed by referral/services at another community organization);
- 5.8.6 **Estimated discharge/transition plan** (criteria for service conclusion - how will you/parent or guardian/clinician know that we are done with treatment/transition is warranted?);
- 5.8.7 **Initial Treatment Plan** requires signatures of individual completing the initial treatment plan, Community Support Supervisor (if different from individual completing initial treatment plan), client or parent/legal guardian receiving services. The physician/APN signature is obtained within 90 days of eligibility determination;
- 5.8.8 **Annual Treatment Plan** requires signatures of Qualified Mental Health Professional, Community Support Specialist, client or parent/legal guardian receiving services and physician/APN. The 90 day timeframe for physician/APN signature requirements does not apply to the annual treatment plan;
- 5.8.9 A licensed psychologist may approve the treatment plan only in instances when the person is currently receiving no prescribed medications and the clinical recommendations do not include a need for prescribed medications; and
- 5.8.10 **If the physician/APN or licensed psychologist (if no medications are prescribed) fails to sign the initial or annual treatment plan it will result in disallowance of the bundled rate and services billed.**

ADULT AND CHILD CPR PROGRAM WORKFLOW



CPRC Eligibility Determination

• Brief Questions to do service referral
 – Get person to the right place & which program.
 • QMHP is not required.

• Eligibility Determination for CPRC requires confirmation of eligible diagnosis.
 • Requires a signature from a licensed diagnostician, or a physician/APN prior to delivering CPR services.
 • Signature can be obtained in one of two ways:

OPTION 1
 Face-to-face with licensed diagnostician (licensed psychologist, LPC, LCSW) **OR** a physician/APN.

OPTION 2
 Face-to-face with unlicensed QMHP with sign off by a licensed diagnostician (licensed psychologist, LPC, LCSW) **OR** a physician/APN.

• CPRC Services can be billed when Eligibility Determination is complete and signed off by a licensed diagnostician (licensed psychologist, LPC, Marriage/Family Counselor, LCSW, licensed Master Social Worker under registered supervision) **OR** a physician/APN.

Signature Requirements

Initial ASSESSMENT
 (1) Individual completing the assessment

Initial TREATMENT PLAN
 (1) Qualified Mental Health Professional;
 (2) Community Support Specialist, if different from QMHP;
 (3) Individual or parent/legal guardian receiving services; and
 (4) Physician/APN*

Annual ASSESSMENT
 (1) Individual completing the assessment; (2) Community Support Supervisor, if different from individual completing the assessment; and *(3) Licensed diagnostician or physician/APN

Annual TREATMENT PLAN
 (1) Community Support Supervisor;
 (2) Community Support Specialist;
 (3) Individual or parent/legal guardian receiving services; and
 (4) Physician/APN*

Physician/APN Signature*
Recommendation: The physician/APN signature on the initial treatment plan is obtained within 90 days from completion of Eligibility Determination after a face-to-face meeting, consultation, or case review. The 90 day timeframe for physician signature does not apply to annual treatment plans. The physician/APN signature also may certify that treatment is needed and services are appropriate, as described in the treatment plan – the physician/APN signature does not certify the diagnosis. A licensed psychologist may approve the treatment plan when the person is currently receiving no prescribed medications and the clinical recommendations do not include a need for prescribed medications.

ADULT AND CHILD CPR PROGRAM WORKFLOW Billing and Documentation

SCREEN

CPRC Eligibility Determination

CPRC SERVICES

ASSESSMENT

Complete 30 days
from CPRC
Intake

TREATMENT PLAN

Complete 45 days
from CPRC
Intake

- Billed to the department as 15 minute units of initial referral – T1023
- Consists of obtaining initial demographic descriptions and/or referral to an appropriate service prior to determining eligibility for CPRC. May be provided over the telephone.
- Can be provided by clerical staff with specialized training
- The written report must be included in the individual's file
- Time must be documented in a progress note

- Rehabilitation level of care –
- Time not billable by any staff (it is included in the bundled rate)
 - The eligibility determination content areas must be documented in the record
 - The DLA-20 is completed, documented, and billed according to policy
- Maintenance level of care –
All QMHP time is billed as 15 minute units of Behavioral Health Assessment – H0002
- Physician/APN time (which is optional) is billed as 15 minute units of Consultation – 99241xx
 - Time and activity must be documented in a progress note
- Not CPRC eligible –
- H0002 HO (Intake Screening) is billed

- Rehabilitation level of care –
- Staff time for development of assessment or treatment plan is not billable by any staff (it is included in the bundle rate)
 - Authorization for submitting the billing claim in CIMOR for the bundled assessment in the rehabilitation level of care (H0031/H003152) occurs when the assessment and treatment plan are complete and signed by all required parties, not including physician/APN signature for initial treatment plans. The physician/APN has up to 90 days to sign the initial treatment plan. The 90 day timeframe for physician/APN signature does not apply to annual treatment plans. A licensed psychologist may approve the treatment plan only in instances when the person is currently receiving no prescribed medications and the clinical recommendations do not include a need for prescribed medications.
 - If the physician/APN or licensed psychologist (when medications are not clinically recommended) fails to sign the treatment plan, it will result in a disallowance of the bundled rate and could result in disallowances of services billed.
- Maintenance level of care –
- All QMHP time for assessment activities is billed as 15 minute units of Behavioral Health Assessment – H0002
 - All QMHP time for treatment planning activities is billed as 15 minute units of Treatment Planning – H0032
 - Physician/APN time is billed as 15 minute units of Consultation – 99241xx
 - Time and activity for all services must be documented in a progress note
 - If the physician/APN fails to sign the treatment plan, it could result in disallowance of services billed. A licensed psychologist may approve the treatment plan only in instances when the person is currently receiving no prescribed medications and the clinical recommendations do not include a need for prescribed medications.