



Four Points Counseling Center

Therapist Guide

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Please download the guide to use the hyperlinks. Content is added regularly and information may change over time, so please check for new versions occasionally. The title of the guide as indicated on the Clinician Drive will always include the date the guide was last revised.

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I. Office Information

Main: (970) 682-1337 **Fax:** (855) 461-3393 **Website:** fourpointscs.com **General Email:** info@fourpointscs.com

Mailing Address (both locations)

1221 E Elizabeth St, Ste 3
Fort Collins, CO 80524-4066

Site Contacts See [Emergency Phone Tree](#) for contact info and alternate contacts

Elizabeth St: Ashley Shaw
Garfield Ave: Emily O'Rourke-Mills

Internet

Employee Network: Four Points **Guest Network:** Four Points Guest **Password:** therapy55

Internal password cannot be shared (no clients, visitors, friends, etc.)

Consult Groups

Elizabeth St: Every other Thursday @ 12pm Garfield: TBD

Parking

Elizabeth St: Please don't park directly in front of the office (or any other business) so clients may park closeby.
Garfield: Please use street parking. The parking lot is shared with clients of the chiropractic clinic.

Noise

Please be mindful of noise during office hours, generally 8am to 6pm. It's ideal to hang pictures after hours.

II. Daily Operations

Admin Requests

Therapists can request many administrative functions through a form available on the website. Examples: Close caseload, request new clients, discharge clients, request billing/insurance support, request client outreach, etc.

Intake Process

Clients make contact via phone or email. After setting a tentative intake appointment, they're emailed the New Client Information form. *We ask them to send it back plus put a credit card on file within 48 hours to hold their appointment.* (Cards are stored on file by registering for the portal.)

Welcome Email

When the above items are complete, the client is emailed important information that highlights the cancellation policy and check in process. An attachment contains more details and helpful information.

Paperwork

Most clients complete paperwork and e-sign within the portal. Paperwork is sent by the admin team after the intake is scheduled and automatically uploaded to the chart. It's available to review under the Docs & Forms tab.

Intake forms:

- ❖ Disclosure and Consent to Treatment *Therapist signature not needed*
- ❖ Notice of Privacy Practices/HIPAA Acknowledgment
- ❖ Telehealth Disclosure and Consent
- ❖ Financial Policy and Charge Authorization
- ❖ Preliminary History
- ❖ Clients Under 12: Direction for Treatment of Minors
- ❖ Clients with Medicaid: Health First Rights and Responsibilities

Releases of information are not included automatically in intake paperwork. Please complete these as appropriate. [ROIs](#) are covered later in this guide.

Pre-Intake Checks

The following are monitored ahead of the intake appointment.

1. **Portal registration:** Has the portal been activated?



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2. **Intake paperwork:** Is it complete?
3. **Electronic communication:** Did the client consent? A memo is made in TA indicating if the client consented or declined.
4. **COC letter:** If the client consents to a coordination of care letter for their PCP, the letter is created on the therapist's behalf using information from the assessment once it's complete.
5. **Feedback requests:** Did the client consent?

Incomplete Paperwork

Clients who don't complete paperwork (or the portal hasn't been activated) within 2 days of intake are nudged to complete it. If it's still not complete, a note is entered in the memo section of the chart so the therapist is aware. It is the therapist's responsibility to check the document section of the chart before intakes to review paperwork, if present, or to be aware that paperwork needs to be completed during intake. **Paperwork will be the therapist's responsibility to complete.**

Completing paperwork at the time of the appointment:

1. Paperwork tablet: Tap the bookmark on the homescreen of the tablet for the FPCC website. Go to the [online forms](#) tab and open the *abbreviated* intake form. Give the tablet to the client to complete. (This is faster and simpler than logging into Therapist Access from the paperwork tablet.)
2. Hard copies: Client completes, then scan and upload to the chart after session (in person clients only).

Benefit Verification

Benefits are verified before intakes. A portal message is sent to clients with coverage and payment info. The exception is for those with an appointment scheduled with little lead time (3 days or fewer until the appointment). These clients are informed they may not have payment/benefit info before the intake, but they will have this info in their portal at the time their card is charged. They're encouraged to contact their insurance company if they'd like to know payment information upfront.

Uploading Paperwork

Paperwork completed outside of TA at any point during a client's treatment, whether hard copy or electronic, should be **uploaded to the chart within 5 calendar days.**

- ❖ Paperwork is saved under the "Docs & Forms" tab.
- ❖ Please do not check "clinical content" or the admin team won't be able to access documents.

DOCUMENTS ON FILE

[Upload New Document](#)

Tablet Check In

Clients are prompted to check in on the tablet and enter a contact number. An email is sent to the therapist to alert them of their client's arrival. We ask that you not rely too heavily on the tablet to know when clients arrive and periodically check the waiting area if you don't receive an email.

Mistaken Appointment Times

If you see a client has shown up when they don't have an appointment, please contact them right away (this is why we ask them to enter their phone number at check-in). If you're unable to reach them, please contact your supervisor or Lauren Stanley to contact the client for you.

TA Troubleshooting

Glitches in TA, such as frequent sign outs, blocked login attempts, and repeated crashing, can usually be fixed with one these solutions:

- ❖ Ensure there is only one TA window open. Even a window open in another browser type can cause issues.
- ❖ Close out all browsers and browser windows and log back in.
- ❖ Clear the browser cache and cookies.



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Client Portal

Client Messages

There will be a blue icon next to “Messages” in TA. Click the Messages button to get to the inbox where you can read messages and reply to your client.



My Client Can't Find The Portal

We know, but we have a solution. Clients can go to fourpointsc.com and click the “Client Resources” tab, then “Client Portal.”

Records Requests

Please refer clients or third parties (employers, other therapists, etc) to submit requests via fax (855-461-3393) or via email (info@fourpointsc.com).

III. Payment Information

Methods of Payment

We technically accept cards and cash and checks for clients seen in person. Clients seen exclusively via telehealth can only pay by credit card. Credit cards are highly preferred as they minimize uncollectibles, significantly benefiting therapist income. If a client strongly prefers cash/check, we can accommodate this. Please follow the steps below.

Paying by Cash / Check

Make sure to [stop the auto-charge](#) when you complete the progress note and follow the instructions below for collection. Please also complete the admin request form to alert management. (Cash/check payment is very infrequent!)

Collection Process:

- ❖ Place cash/checks in the safe at the end of each day.
- ❖ Payments for the same day should be in the same sealed envelope. Write the following on the envelope:
 - Date of service
 - Client name, payment amount, payment method (do this for each client)
Ex: Brad Stanley check for \$51.00 or Brad Stanley \$51 cash
- ❖ **We can't make change!** If a client gives you \$20 but has a \$15 copay, they can only get a credit that will be applied to future payments.

Credit Cards

Cards are required unless a client has Medicaid, even as secondary.

- ❖ **Auto-charging:** Charts have charge amounts entered according to the client's copay, coinsurance, deductible, or self-pay amount. Completing a progress note triggers This amount gets pulled through to assessment/progress notes to enable charging when notes are completed and locked.
 - If claims reveal a payment amount should change, the amount is adjusted and the client is refunded if they've made an overpayment.
 - A charge is run after the “Finalize and Lock” button is clicked. (Filling out the note and hitting “Continue” will not cause a charge to be run.)
- ❖ **To stop the auto-charge, uncheck the box next to the charge amount.** The card won't be charged, but you can still complete the note and submit a claim to insurance. (It's not possible to change the charge amount from this screen.)

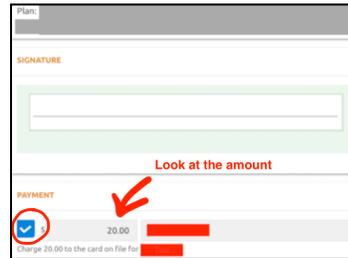


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Why you might stop an auto-charge:

- Client asks for you to wait to charge them until their next paycheck
- Client would like to pay with a different card (they can do this in the client portal)



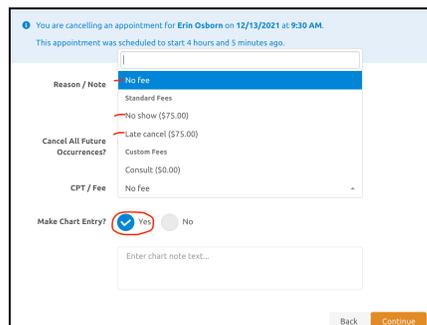
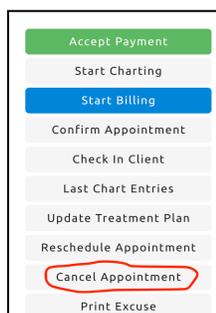
- ❖ **Charge the non-default card:** More than one card can be stored in a client's portal. The card set as the default is the one processed when notes are locked. If a client asks for a card other than the default card to be charged, please ask which card they'd like charged and complete the admin request form on the website.
 - FYI: Clients sign a "financial policy and charge authorization" that states they must inform their therapist at the time of session if they want to switch the card charged for that day. We include this so that clients are responsible for informing you in time to stop an auto-charge. We also can easily refund charges, so it's no big deal if a charge runs that we need to reverse.

No Shows and Late Cancels

The cancellation policy requires 24 hours notice to avoid a fee. The fee for a missed appointment or late cancellation is \$75 (except for clients with Medicaid who cannot be charged, which is a contractual stipulation of CMS). If you'd like to waive the fee, that is up to you. In general, we discourage repeatedly waiving fees for the same client, especially within a short period. Keep in mind waived fees will impact therapist income and continually waiving fees can contribute to attendance issues.

Please follow the steps below to complete notes for missed appointments and assign or waive fees.

- ❖ Click on the appointment from your calendar or dashboard, then click "cancel appointment." Indicate whether it should be a no show, late cancel, or "no fee".
- ❖ **Waiving fees:** When marking an appointment as a cancellation or no show, the default option is "no fee." So to waive a fee, just leave this option selected. Then select "Yes" next to "Make Chart Entry?" It's important to make a chart entry so that you can document that there was a missed appointment/late cancel and that there's a record of waiving the fee. If you'd like to charge the fee, select the appropriate option.



- ❖ For cancellations with at least 24 hours notice, follow the same steps above and choose "no fee." You don't need to make a chart entry unless you want to. **TA will always show an appointment was canceled, but it's ideal to have a notation of some sort about the reason so it will become part of the client record, which is important if the client has attendance difficulties.**
 - If you choose not to make a chart entry and instead enter the notation at the top under "Reason," it will show up only under the appointments tab in the chart, but not as part of the client record.
 - So instead of selecting no, you can enter the text on the same screen by clicking "yes" next to "Make Chart Entry" and enter the reason for the cancellation in the box.



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10:00 - 11:00 AM

Cancelled: 01/21/2022 10:06 AM
6 minutes after appt. start.

By: Lauren Stanley

Reason: sick

Chart Entry - 01/21/2022 - Locked

Client called in to say she wasn't feeling well and asked to reschedule for next week. Booked an appointment for next Wednesday.

Redact Add Addendum

- The note will become part of the record, which is helpful for several reasons including in case of a Medicaid audit.

III. Billing, Coding and Benefits

Client Insurance Changes

Unless it's January when benefits are checked anew, therapists are often the first to learn of client policy changes. If a client tells you about a change, please **complete the admin request form ASAP**. This ensures claims are managed appropriately and helps prevent your income from being impacted.

Clues a Policy May Change:

Sometimes these topics come up during the course of a typical session, which may give insight into an upcoming insurance change.

- ❖ Beginning a position at a new company
- ❖ Leaving a job, losing a job, seeking unemployment benefits
- ❖ Obtaining employment after being unemployed
- ❖ Securing disability benefits or losing disability benefits
- ❖ Reaching a "milestone insurance age" (Lauren made this up)
 - Medicare eligibility age (65 years)
 - Young adults aging out of eligibility for parent coverage (26 years)

Diagnosis Alerts

Diagnosis impacts treatment. If you have questions about this, please consult with the Clinical Director.

- ❖ NOS/other specified disorders
- ❖ Impulse control disorders (gambling, kleptomania, pyromania, IED, trichotillomania), PDs, adjustment disorders*
- ❖ Conduct disorders, ODD

Adjustment disorder: Although insurance may state it's not covered, it usually will be approved.

Coding Guidelines

Assessment

90791: Assessment code

- ❖ Booked for 60 min but not a time-based code
- ❖ Frequency of billing will flag insurance;
- ❖ If not completed in the first session, the next appointment should be billed under a different code, such as 90837

Time-Based Therapy

Start and end times indicated in progress note must equal the required time period of code used

90837: Individual, 53+ minutes

90834: Individual, 38-52 minutes

90832: Individual, 16-37 minutes

90847: Family/couples with client present, at least 26 minutes

90846: Family/couples without client present, at least 26 minutes

Crisis Sessions

90839: Crisis code, 30-74 minutes

- ❖ **High distress clients:** Complex and/or life-threatening circumstances that demand immediate attention; may display suicidal intent, disabling anxiety, or other overwhelming psychological symptoms



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- ❖ **90840 add-on:** Code used for each additional 30 minutes, cannot be used as standalone code
- ❖ **Documentation:** Include assessment of risk and mental status, substance use if applicable, referrals if given, safety planning if client demonstrates SI, and outcome of session
- ❖ **Billing:** Cannot be billed in conjunction with interactive complexity or any codes above including 90791 or 90837 (Can be used in place of 90791 if clients attends intake and is too escalated to complete assessment, in this case include a preliminary diagnosis to allow for billing)
- ❖ **Reimbursement:** Not guaranteed, especially with add-on code. More likely to be reimbursed without 90840 add-on.

Medicaid is more commonly billed for crisis sessions. Some commercial plans will reimburse for 90839 and some will not. If a commercial plan doesn't reimburse, the client can be billed for the amount at the insurance rate rather than the self-pay rate. This code should be used infrequently.

Interactive Complexity

90785: Add-on code for complex communication factors

- ❖ Can be used when at least one of the following is present:
 - Maladaptive communication that complicates delivery of care
 - Caregiver emotions or behaviors interfere with treatment
 - Evidence or disclosure of a sentinel event (e.g. abuse or neglect) and mandated report with initiation of discussion of the event and/or report with patient and other participants
 - Use of play equipment, physical devices, or interpreters/translators
- ❖ Cannot be used with crisis codes (90839, 90840) or family therapy codes (90846, 90847)
- ❖ Can be used with group therapy code 90853 but not family group therapy code 90849

Medical necessity

Documentation: Indicating long-term stability or a consistently high level of functioning in progress notes could be seen as an indication that sessions are needed less frequently.

Frequency: Holding sessions more frequently than once weekly creates the risk of being flagged for overutilization. This risk is increased when billing 90837 consistently and/or using add-on codes. [Alert Clinical Director to clients seen 2x/wk.](#)

Add-on codes: In general, add-on codes can flag insurance for over-utilization and trigger an audit. It's critical that add-on codes are used appropriately and with abundant justification in the session note.

Modifiers

Medicaid

Medicaid claims must have the HE modifier to indicate behavioral health services. You'll see this already added to notes for clients with Medicaid; please do not remove this. If another modifier is needed, place it in the second position. You won't ever need to add HE.

POS Codes

All claims must have a Place of Service code.

POS 11: In office

POS 10: Telehealth- client is at home

POS 02: Telehealth- client is not at home

- ❖ Sessions booked as teletherapy will need to have the correct tele POS code selected. For some insurance panels, such as Aetna, coding a claim with POS 10 or 02 and leaving off the GT modifier will always result in a denied claim.
- ❖ **Claims corrections:** If you left off a modifier and locked the note, please complete the admin request form. This also applies to coding sessions incorrectly, for example if you mistakenly coded a session as 90837, you can request that it be changed to 90834.



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Teletherapy Modifiers

All plans except Traditional Medicare: GT modifier

Traditional Medicare: No modifier, do not use GT

EAP Modifiers and Codes We no longer accept EAPs but just in case you special request a client...

- ❖ **United EAP:** HJ modifier
- ❖ **Cigna EAP:** CPT code 99404, no modifier
- ❖ **Aetna EAP:** Claims submitted outside of TA. Code sessions as you would for any other sessions.
- ❖ **BCBS EAP:** Not accepted (Compsych)

Adding modifiers

While on the screen for the session note, you'll see four modifier spaces under the box for the CPT code.

The example below is a client with Medicaid, so the HE modifier is added by default. If your note is for teletherapy, just add GT in the second blank. (The modifiers should not switch positions- GT cannot come first.)

CPT Code / Units (90834) Psychotherapy 45 min 1

Hide Modifiers

Service Modifiers HE GT

Multiple Modifiers

- ❖ The only modifiers you'll need to actively think about are United EAP (HJ) and teletherapy (GT) since HE is already added for you.
- ❖ If an EAP modifier or the HE modifier is needed, GT will always come second.
- ❖ We'll always help you know exactly what to do, but if you're curious, the reason for this is the modifier with the biggest impact on reimbursement has to be in the first position.

You're unlikely to ever need more than two modifiers. If you have a situation in which 3 or more modifiers are needed, please talk to Lauren Stanley.

Authorizations and Visit Limits

Sometimes a policy or specific benefit within a policy will have an authorization for a number of sessions or a limit on the allowed number of visits that are important to track. Some examples include:

- ❖ **EAP benefits:** Can be as few as 3 sessions or as many as 12 or more, but they usually expire, most often at the end of the calendar year.
- ❖ **Policy benefit:** A payer may construct benefits in such a way that a set number of sessions are "free." For example, 6 sessions before copay applies.

Therapist's Role in Authorizations and Visit Limits

When an authorization or visit limit applies, we will determine this for you and set a countdown to run in TA. In some cases, there's nothing needed from you beyond adding a modifier to your notes, such as United's HJ modifier for EAP clients.

For some authorizations, however, paperwork may be necessary which is clinical in nature. In this case, we'll get you the paperwork, help you fill it out and submit it for you. We'll communicate with the payer, watch for the approval, and manage renewing the authorization in TA.

Visit Countdown

There is a countdown available in TA. From the client's main profile screen, scroll down until you get to benefit confirmations. To the right of this section is Pre-Authorizations which has the countdown.

Pre-Authorizations +

2 of 10 visits

| Dates | Therapist(s) | Authorization # | Authorization Date |
|-------------------|-----------------------|-----------------|--------------------|
| 1/5/22 - 12/31/22 | All Lauren Stanley | JJVVXXX-01 | 1/5/22 |

Notes



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Teletherapy Reimbursement

The majority of insurance companies reimburse telehealth and in person sessions at the same rates. There are a couple of companies that pay them out differently, such as CCHA and Medicare. See the Contracted Rates spreadsheet available on the website for more information.

Benefit Verifications

Client benefits are verified prior to intake but benefits may change throughout a plan year and after plan renewal/change. We utilize the portal and/or email clients to communicate benefits and payment information during a client's treatment.

- ❖ **Portal messaging:** When messages are sent in the portal, clients are notified via email.
- ❖ **Initial verification:** Prior to intake, a client's benefits are verified and the information is sent to them in the portal, along with some other information.

Hi _____, just letting you know it looks like you have a \$10 copay for each session. If you have any questions, feel free to reply to this message or call the office at 970-682-1337.

In general, we use this portal to communicate any changes regarding your insurance or payments that we want to let you know about. You can also use the portal to send a message to our team if you ever have questions about your insurance or charges, or of course you can call the office anytime.

*Take care!
(Staff member)*

- ❖ **January verifications:** Many clients have calendar year plans with a deductible that resets in January. Benefits are verified at this time.
- ❖ **Medicaid verifications:** We check monthly that all Medicaid plans are still active and whether anyone's RAE (regional accountable entity) has changed. We find there are hardly ever any changes.
- ❖ **If you know your client will be getting a new policy under a different payer, it is very important that management is alerted well ahead of the switch so it can be determined if you are in network or not. Please submit the admin request form as soon as you become aware of an insurance change.**

IV. Therapist Income, Benefits and Related Topics

Payroll Logistics

Therapists receive direct deposits every other Friday, unless federal holidays interfere with paydays, in which case you'd be given advance notice. The payroll schedule is on the Clinician drive in the Admin folder.

Payroll Deadline for Notes

The payroll deadline for notes submission is the Saturday night before Friday pay day at 11:59pm.

Why Do Notes Have a Payroll Deadline?

The documentation policy is to complete notes within 5 working days of the date of service (except for clients in crisis or instances of mandated reporting- those should be submitted within 24 hours- see the policy for more info). Submitting notes is relevant to your income and to payroll for two reasons.

1. Notes are directly tied to claims submissions. Notes completion is the trigger for claims to go out. When notes are not completed, it extends the time for reimbursement to come in. When this happens chronically or en masse, it will impact your income significantly.
2. Notes prompt credit cards to run. Credit cards on file are charged when notes are locked. This is the item most relevant to payroll, because credit card funds are received immediately. Thus, you may be well within the documentation timeline, but if you want your paycheck to include certain client credit card charges, you'll need to make sure their notes are completed by the payroll deadline. Otherwise, those funds will make it onto the next payroll.



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Again, the deadline is Saturday night before Friday pay day at 11:59pm.

Benefits

Please see the employee handbook for current information about PTO, sick leave and other benefits.

Income Reports

One of the greatest features of TA is the ability to see in real time what your income looks like. You can see the claims and client payments that have come in whenever you'd like to run a report.

How to Run Income Reports

Under the Therapy heading on the left side menu, select "Reports"

- ❖ **Date Range:** Choose the date range you'd like
- ❖ **POS Code:** Leave this with the default of "Any"
- ❖ **Locations:** This should default to the location where you work
- ❖ **Run:** To run the report, click "Filter"

Interpreting Your Income Report

- ❖ **Net charges:** This is the total billed amount that goes *out* to insurance companies, it is not what we expect to receive back. Billed amounts will always be significantly higher than contracted amounts.
 - We set billed amounts to be higher than the highest paying contract. Plus, billed amounts are based on doctoral rates because we are only able to set one "class" of charges. So there will be a large discrepancy between billed amounts and amounts received- this is to be expected.
- ❖ **Insurance payments:** Reimbursement amounts received directly from insurance companies or other third party payers.
- ❖ **Client payments:** Payments made directly from clients for their share of contracted insurance rates, such as copay, coinsurance, or deductible amounts. This also includes self-pay amounts and payments for no show and late cancel fees.
- ❖ **Income:** The insurance and client payment amounts added together. (Net charges really has nothing to do with anything here- it would be a more useful category for a "cash pay only" practice where charged amounts were directly proportional to anticipated income.)
- ❖ **Therapist income:** To determine what your gross income looks like, which is your income before taxes, etc. are taken out, multiply the number in the "income" field by your percentage.

| | | | | | | | |
|-------------|----------|--------------------|----------|-----------------|----------|--------|----------|
| \$ | 8,671.53 | \$ | 2,697.02 | \$ | 1,335.75 | \$ | 4,032.77 |
| Net Charges | | Insurance Payments | | Client Payments | | Income | |

Detailed Results

Some of the terminology in the detailed results underneath the income information is specific to the insurance industry. You aren't expected to know any of this information, but in case you want to know what the income report means more fully, here is an explanation of some of the more confusing terms.

- ❖ **Discounts:** These are limits that an insurance company places on the amounts a provider can charge. For example, our billed amount for 90837 is \$160, but the insurance company may only allow \$106, so they communicate an error (or discount) that speaks to this limit. They don't deny the claim, they just say, "We won't pay you that much," which leads to the next item, which is an adjustment.
- ❖ **Adjustments:** Amounts paid differently than billed. This is a numerical explanation for the difference between the billed/charged amount and the amount paid by the insurance company. ("Charged" refers to the insurance company, NOT the client.)
- ❖ **Insurance refunds:** Amounts can show up here for a couple of reasons. A client's plan could terminate after the plan paid for a session, so the company took money back. Or a claim may have been submitted twice, but the



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company didn't realize this until paying out the claim a second time, so they nullified the second payment (essentially paying \$0 - it's not really a refund but it's classified that way). In any of these cases, we tend to anything needed.

- ❖ **Client refunds- Insurance responsibility:** These refunds occur mostly for the reasons you'd expect- A client makes a payment they don't need to make and are given the money back. Usually this is because the client meets their deductible (or out of pocket maximum) and there is inevitably a delay between the deductible being met and the time we receive the ERA/EOB that alerts us it has been met. In the meantime, the client has continued to pay their deductible when attending sessions, and those payments have to be given back to the client. This is the nature of working with insurance clients, and we minimize this type of refund by engaging in a number of verification and monitoring methods.
 - **How refunds impact therapists:** Therapists still receive payment for the services they provided. In the case of a deductible that's been met, the client paid for those services out of pocket, and what will happen is the insurance company is ALSO going to send payment for the same services. You won't get paid twice for those sessions, though. Instead, the insurance payment refunds the client for the payment they didn't actually need to make.
 - The insurance payment will show up in your income report as a client refund because it is money for a service(s) that has already been paid to you, which needs to go to the client. If the client is sent a message in the portal about the refund, you will usually be copied on this message so you're aware of what the refund is for.
 - **What if the client had an outstanding balance?** If the balance was because the client hadn't been paying their deductible (albeit unnecessarily), you wouldn't have already been paid for the service(s), so you would be paid from the insurance reimbursement and no refund to the client would be necessary.
- ❖ **Other client refunds:** If other refunds occur, for example because a client disputes a no show fee, you would have been alerted to this ahead of time to discuss it before the refund was approved, so this would not come as a surprise. And in the case of a client dispute, if the admin team talks to the client directly, the client will be reminded of the cancellation policy but will most likely then be referred to discuss the matter with the therapist, rather than intervening as a first step. If needed, management can step in to assist with making a call regarding waiving a fee or letting a fee stand, but it's not ideal for that to be the first course of action.
- ❖ **Write-offs:** Write-offs usually occur because an amount is determined to be uncollectible. This could be because a client has discharged, has been invoiced and contacted multiple times, and has still not sent payment. These are essentially "bad debts." Requiring credit cards on file is our primary defense against bad debts.

Client Billing Screen

We pride ourselves on managing claims and claims issues on behalf of therapists. However, it's convenient as well as comforting to be able to access client financials, whether out of curiosity or because those financials are directly tied to your income. To get to a client's billing screen, go to the client's profile and click the "Billing" tab.

V. Clinical Work

Documentation Policy

The policy requires notes to be completed within 5 calendar days of the date the session was held (the date of service or "DOS"). Clients in crisis, with active suicidality/homicidality or when mandated reporting is initiated due to the disclosure of reportable information, documentation must be completed within 24 hours.

Release of Information

Use online forms via the website (Therapist Access) or hard copies. These are not available in TA. Please upload to the chart when complete.

Discharge Summary

[Options for Discharge Summaries](#)

[Fillable Discharge Summary Template](#)



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Routine Discharge

Ensure discharge summaries are completed for all clients. Discharge summaries should be completed within 30 days of a client's discharge from services, and sooner when possible. The discharge summary template in TA should be used for this purpose. Discharge summaries do not need to be completed for clients who were scheduled to see you but were never seen.

High Acuity Clients

High acuity clients should have a discharge summary completed as soon as possible due to the increased need to indicate the client is no longer under your care.

60 Days of Inactivity

Clients who have been inactive for 60 days for any reason should be contacted and, depending on the outcome, considered for discharge.

Clients who want to "take a break" from services, or those prone to participating intermittently in therapy should have a discussion with the therapist about the point at which the therapist will follow up. **After 60 days**, if there is no contact from the client, the therapist should attempt to clarify if the client would like to return for services. If the client would like to continue the break, has moved on to another provider, or cannot be reached, this should be noted in the chart and the client should be discharged.

The client (if reachable) may be informed they are welcome to return for services if they desire. Additional information can be left directing them to contact the main line or the therapist directly depending on preference to continue working with the client in the future or not. Connect with your supervisor to discuss in more detail.

This is not about shutting out the client, but rather about liability. Until the client is discharged, they remain under your care and you (as well as FPCC) could be held liable for some aspects of their well being.

Incident Report

Incident reports are required in the following circumstances. The form must be complete and sent to a director within 5 calendar days.

- ❖ **Mandated Reporting:** Fill out an incident report any time you have to make a mandated report.
- ❖ **Client/Staff/Other Injury Onsite:** If an employee of FPCC or a client is injured while on FPCC property, let management know right away and follow up with an incident report. Complete a report even if the person says they are just fine and no significant action has to be taken.
- ❖ **M1 Hold:** Complete a report if crisis response or the police are called to take a client to be stabilized.
- ❖ **Other Unusual Events:** Complete a report for other significant and out of the ordinary events involving clients or others, for example a hostile and aggressive client results in the police being called.
- ❖ **Client Death:** For a natural cause of death or death unrelated to mental health, the therapist completes an incident report and a discharge summary. If there are no concerns related to the client's treatment, there is nothing further needed. If concerns exist, a review of the chart should be conducted by the Clinical Director who will also connect with the therapist.
 - In the event a client dies by suicide, homicide or overdose, the following will take place: Contact will be made to express condolences with the family if appropriate.
 - Therapist and Clinical Director will work together to determine how this should be managed.
 - Clinical Director will make notification to regulatory agencies.
 - Clinical Director will conduct a post mortem review of the chart.

Templates

Several templates are available for needs not yet mentioned. If the template says MAKE COPY in the title, please make sure you do this, otherwise it will interfere with other's ability to use the template in the future. It is incumbent upon us all to engage in thoughtful consideration about the appropriateness of writing letters or granting other requests as well as our comfort level in accommodating requests. We encourage asking yourself the following:

- ❖ **In your opinion, is the request one that is warranted?**

Ex 1: Client wants to apply for disability benefits, regardless of whether you're the right person to provide documentation supporting a request, does it seem that there is a case to be made for disability application?



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Ex 2: Client requests an excuse letter from work due to mental health concerns. Is it your opinion based on knowledge of the client, the client's symptoms and current functioning that the client's mental health is preventing the client from working? This can be tricky and may be best managed in consultation with leadership for assistance navigating the language used if a letter is written.

- ❖ **Is this within the scope of my practice?**
- ❖ **Should I seek consultation prior to granting this request?**
If you're concerned about liability, you should always consult with the clinical director. If you are a candidate, it's required to consult with your clinical supervisor before writing a letter or granting other requests.
- ❖ **How comfortable do I feel fulfilling this request?**
- ❖ **What are the implications for precedent setting with this client?**

Excuse Letter

[Excuse letter template](#)

This letter is available to use and modify as needed for a variety of purposes, but in general the intent is for uses in which very minimal information is shared and the purpose is to excuse a client from school or work for a limited period of time. A [release of information](#) must be obtained.

Coordination of Care Letter

This is also referred to as a PCP letter and is sent on the therapist's behalf to the client's PCP if consent is given as part of the intake paperwork. Information shared is brief and includes the presenting problem, diagnosis, and treatment goals and serves as a notification that the client is in therapy. Therapists may use the COC letter template at other times to communicate/notify other providers about a client's care.

Walk/Talk Session Waiver

This [waiver](#) is to be used prior to engaging in any walking sessions with clients. Discuss the content of the waiver with your client or their parent/guardian prior to giving it to them to sign. It's important that this is signed ahead of going on a walking session due to liability.

VIII. Crisis and Reporting

Crisis Protocol

[Crisis Response Protocol](#)

Use the linked document as a guide for crisis situations. Do not wait until you are in a crisis situation to learn this protocol.

The M1 Hold and M-2 Rights of Patients documents are available in the Crisis folder. The protocol referenced above should be followed in the event a therapist considers writing a hold or calling crisis response/911, which should be rare. Again, this protocol should already be familiar when it is needed.

Mandated Reporting

Please see [Mandated Reporting](#) for comprehensive information including contacts.

Minors

Reports for minors must be filed "immediately" but the law is not clear on what immediately means. FPCC's internal policy is to file as soon as reasonably possible, which we interpret to mean the end of the day unless the disclosure occurs late in the day, in which case the report should be filed by noon the next day. If there is a chance you will not get the report filed within 24 hours, you **must** let leadership know so the report can be filed on your behalf.

Elders and At-Risk Adults

File within 24 hours.



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IX. Quick Reference Timelines

This section is a work in progress

Discharge

- ❖ **Discharge Inactive Clients:** After 60 days of inactivity, contact client and discharge, including completing discharge summary- discharge isn't official until it is documented (depending on outcome of contact attempt)
- ❖ **Discharge Acute Clients:** Complete discharge ASAP
- ❖ **Routine Discharge:** Within 30 days of termination

Documentation

- ❖ **Notes:** 5 calendar days
Expedited Timeline: In the event of crisis, active suicidality/homicidality or mandated reporting, notes must be completed within 24 hours
- ❖ **Uploads:** Within 5 calendar days

Mandated & Incident Reports

- ❖ **Minors:** File as soon as possible- by the end of the day unless disclosure occurs late in the day. If disclosure occurs late in the day, file by noon the next day. See [reporting section](#) for more info.
- ❖ **Elders/At-Risk Adults:** File within 24 hours.
- ❖ **Incident Reports:** Complete report and sent to a director within 5 calendar days.

Miscellaneous

- ❖ **Code Corrections:** ASAP - Claims are submitted in less than 24 hours from the time the note is locked. Please submit a correction even if it's over this time period though so we can note the correction when the claim bounces back.
- ❖ **PCP Letters:** Sent by admin team within 2 weeks of the date of intake.
- ❖ **Payroll Deadline:** For charges/payments to make it on payroll, make sure notes are complete by midnight on the Saturday before payday.
- ❖ **Request to Send Records:** Up to 30 days for records to be sent to a third party (client, clinic, etc).
- ❖ **Dual relationships:** Alert management within 48 hours if you become aware of a dual relationship with a client