Four Points Counseling Center

Medicaid Requirements

In-Network

Health First CO Rocky Mountain Health Plans (RMHP) Colorado Access/CHP+ Colorado Community Health Alliance (CCHA)

Intake Assessments

Applies to all assessments, not just clients with Medicaid plans

The primary purpose of the assessment is threefold:

Demonstrate medical necessity Establish the focus of treatment Build rapport with the client

The focus of treatment will usually have a direct relationship to the diagnosis. The following are selected topics from the assessment template.These do not represent all topics (full template text available at the end of this document).

- **Chief Complaint/Presenting Problem**
  Reflects what will become the focus of treatment. Include some of the client's own words in quotes if possible.
- **PCP Coordination**
  CMS requires that all clients are asked about primary and dental care and if they will authorize sharing information with their PCP. If they consent, communication is required, which management handles for therapists (see therapist guide for more information).
- **Cultural/Spiritual Information**
  Listed separately as both are required. If client declines to answer or you were unable to assess, indicate this explicitly rather than writing N/A. (N/A implies culture/spiritual information is not relevant to the client which is not possible.)
- **Client Strengths**
  Skills, natural capabilities, personality characteristics, and resources the client may possess, utilize, or have available that may benefit their mental health and/or treatment goals.
- **Stated Goals**
  Include goals for treatment from the client's perspective and in the client's own words when possible.
- **Diagnosis**
  The full name of the condition should be written out with ICD-10 code in parentheses. The diagnostic rationale *must be provided* using DSM-5 criteria. Use actual DSM-5 language, modifying with client-specific details. (Using DSM language is the best course for several reasons, please ask if you'd like more information.)
  Client meets criteria for major depressive disorder, recurrent, moderate (F33.1) due to depressed mood most of the day nearly every day for a period of 3 months…
- **Recommendations/Plan**
  List services that would benefit the client based on the presenting concern/symptoms with brief explanation for the anticipated impact on the client's mental health/functioning/symptoms and describe the plan to implement services. Include the date of the next scheduled appointment if possible.
  Client is recommended to attend individual therapy weekly to address mood symptoms and develop coping skills for regulating mood. Client is recommended to engage concurrently in continued medication management with prescriber. Proceed with scheduling individual sessions at weekly intervals beginning with the session scheduled for Tuesday May 1, 2022. Clinician will collaborate with prescriber as authorized by client.
- **Services**
  The type, frequency and duration of services should be specified. A sentence is already written into the plan regarding phone calls as needed.
- **Goals**
  These should be concrete but broad enough to cover the range of services you plan to provide.
- **Discharge**
  Criteria for discharge must be listed. Include the client's own words if possible. For example, "I will no longer experience frequent panic attacks." Criteria can be changed with plan updates.
- **Signature**
  If the plan isn't signed because the client left treatment or is unreachable, document this in a progress note, quicknote

or on the treatment plan directly. It is preferable for the plan to be on file without a signature than to wait for an extended period to get a signature. The existing plan can be sent for signature later if the client returns.

❖ **Treatment Plan Copy**

A copy is required to be *offered* to the client. The electronic forms take care of this automatically. If you use a paper copy, document that a copy was given or that one was offered and declined. (You may simply note this by hand.)

Missed Content

Ideally, assessment topics are covered within one session. However, a fundamental goal of the assessment is building sufficient rapport that the client returns. If you run out of time, focus on gathering information related to symptoms/diagnosis, functional impairment, and risk status. Missed topics can be covered in the next session and documented with an addendum to the assessment.

Treatment Plans

Formal treatment plans are only needed for clients with Medicaid. The treatment plan form serves as a guide to ensure you meet all required topics, although you may complete the treatment plan by hand and scan/upload to the chart as well.

Medicaid Treatment Plan: Licensed/Candidate

Therapist completes treatment plan via Therapist Access and submits to client for signature. Candidate treatment plans are signed by supervisors before reaching clients.

- ❖ After the client signs, they will be prompted to download a copy.
- ❖ A copy is sent via email to the therapist and the therapist is requested to upload the plan to the chart.

Completion Timeline

Initial treatment plans must be completed in collaboration with the client by the end of the second session or within two weeks of the initial assessment.

- ❖ If there is a delay in completing the plan, such as client crisis or administrative delay due to technical issues, this must be documented briefly in the progress note or using a quicknote:

  Client presented in crisis and session was utilized for support and stabilization. Treatment plan was not completed due to client's crisis state. Treatment plan will be revisited and completed in next session.

  Client collaborated on plan goals and objectives. Client was sent the treatment plan for signature but due to technical issues, client has been unable to sign the plan as of the date of this note. Client confirmed on [date] their understanding and agreement with the content of the plan. Clinician will follow up with client during the next session and will be prepared to ask client to sign a paper copy if needed.

Multiple Services

❖ **Multiple Internal Services**

If a client sees two or more providers at FPCC, only one plan is needed if at least one goal is stated for each service.

A client receives individual therapy and family therapy. The client may have one treatment plan if the plan contains a goal for individual therapy and a goal for family therapy with objectives, etc. for each. Therapists should collaborate on completion of the plan.

❖ **Internal and External Services**

If a client receives services from FPCC as well as another agency/provider, the policy is for the client to have a treatment plan at FPCC.

Treatment Plan Updates

- ❖ CCHA and CO Access: Annual
- ❖ RMHP: 6 months
- ❖ Therapists are responsible for tracking due dates
- ❖ Updates needed: Change in diagnosis, addition to services (ex: adding couples therapy), or change in level of care (ex: hospitalization and return to outpatient services)
- ❖ Upload documents: Completed plans must be uploaded to TA.

Four Points Counseling Center

Medicaid Requirements

TA Treatment Plan

The goals and objectives from the plan must be added under the Records tab in TA so they will be pulled into progress notes. Copy/paste the following text into the *Treatment Plan* section. Enter the date the next plan is due, which will alert you when the review date is nearing.

When the charting screen is open for a progress note, check the box to include the treatment plan as part of the note. This only needs to be done once per client and the setting will be saved.

Goal #1:
Objective:
Objective:

Progress Notes

Use the Medicaid templates in TA for progress notes.

- **Goals/Objectives:** Client goals and objectives will auto-populate if you completed the steps above for the TA treatment plan. Make sure the content of your notes in some way ties to the goals/objectives, because the goals/objectives are directly linked to the client's presenting problem in the assessment.
- **Risk assessment:** Every session requires documenting risk status.
- **Prevention/Maintenance:** If you include any recovery-focused or prevention-oriented interventions, please document this in the note. This could include relapse prevention or lifestyle changes to promote overall health and wellness. (This is not a requirement, just a bonus and Medicaid will give you a high five.)

Late Cancellations and No-Shows

Medicaid policy prohibits charging late cancellation and no-show fees. If you notice a client with Medicaid (even as a secondary policy) has a credit card on file, please click the delete button or let leadership know.

Please discuss the cancellation policy during the first session. Going forward, the attendance policy can be discussed as needed, with barriers to regular attendance being explored as a clinical issue and/or problem-solved collaboratively.

Discharge

Reason for Discharge: Lack of Attendance

To discharge a client for inconsistent attendance, conversations with the client should be documented, as well as any related concerns that were addressed, and the client's response. For example, you might tell a client after the first no-show (depending on the circumstances and the client's response to the no show):

> *I understand complications can arise that impact your ability to attend sessions or to let me know that you won't be attending. Because I have a very booked schedule and absences impact me as well, I'd like to take this opportunity to let you know a couple of things about my policy for missed appointments. For clients with ongoing difficulty attending sessions, it can impact my ability to continue scheduling with them. My hope is you and I won't encounter that, as I'm looking forward to continuing to work with you. In general, three no-shows or late cancellations can be the reason for discharge. What are your thoughts about this?*

Before proceeding with discharge, the client must be explicitly informed that further missed appointments within a specific and reasonable timeframe will result in discharge. Judgment and discretion can be used regarding what *reasonable* means. One year is not reasonable, and an "extended period of time" is not specific.

Reason for Discharge: Lack of Engagement

Clinicians should outreach clients who unexpectedly miss a session (no show) within 24 hours of the missed appointment, and ideally outreach should occur at the time the session is missed, for example 10-15 minutes into the appointment window. The outreach should occur sooner if the client's risk level is high. All attempts to contact the client should be documented in the chart with a quicknote.

You can discharge a client for lack of engagement after **three attempts** to contact the client. Initial outreach attempts can be by phone, text, or email. Please ensure the electronic communication consent has been signed if using text or email.

Clients with Medicaid plans are required to have a final outreach attempt in writing, commonly referred to as a discharge letter. Request that they make contact by a specific date, after which they will be discharged from services, however they

are welcome to contact FPCC to explore returning for services at a future date if they desire. The discharge letter can be mailed or delivered via email. If the letter is sent by mail, the date by which they need to make contact should be approximately 10 days from the date it's mailed. For email, one week is sufficient.

Documenting Discharge

Conversations about discharge and/or reducing session frequency should be documented as they occur. There is a discharge summary template on the drive, as well as a note template which can be used if a termination session is held with a client. The note session allows a progress note as well as a discharge summary to be completed at once.

Planned Discharge

This is almost always navigated within the context of a therapy session, thus the dialog around this can be documented accordingly and a discharge summary can be included within the final session note (link to template below).

Unplanned Discharge

Clients may terminate treatment for a variety of reasons without prior planning. If the discharge occurs outside the course of treatment and the discharge summary cannot be copied into a session note, copy and paste the template into a quick note.

Timeline

FPCC policy is for clients to be discharged within two weeks of the final date of service or the final outreach attempt.

Acute clients should be formally discharged as soon as possible (within 48 hours) due to the increased liability to the therapist and the practice.

Discharge Summary

Coordination of Care

Collaboration and consultation with other treating providers should be documented in the chart. PCP care coordination letters are managed for therapists using information contained in the intake assessment. If a client does not have a PCP or dental care provider but would like one, please submit an admin request and referral information will be sent to the client via email.

Care Coordination Letter

CCHA Crisis Plan

CCHA requires a crisis plan for its members which has requirements similar to a relapse prevention plan. If you have a client with CCHA, please make a copy of the template, save it to your own drive, and upload it to the chart when complete. It's intended to be created collaboratively with your client. Please give a copy to your client as well.

A copy has also been saved to the crisis folder with Medicaid language removed for use with any client.

CCHA Crisis Plan

See below for intake template full text

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Intake Template

There are multiple variations of the template- minors, adults and one with and without a preliminary history (comprehensive and abbreviated versions, respectively).

CLINICAL ASSESSMENT

Chief complaint/history of presenting problem:

History of mental health concerns and treatment, include provider/agency names if available:

Outcomes of previous MH treatment:

History of suicidal/homicidal ideation:

Current suicidal/homicidal ideation: (If yes, risk assessment with protective/supportive factors must be included.)

Previous or current self-harm:

History of involuntary treatment:

Are other providers currently treating you for a mental health need? (If yes, include provider/agency name.)

Are you currently being treated for a medical condition? (If yes, include condition and provider/agency name.)

Past and/or current substance use/substance use concerns: (Include substances, amount and frequency.)

History of substance use treatment? (If yes, include provider if possible and describe outcome.)

Biopsychosocial history:

How does client describe their gender identity and sexual orientation?

Is client's reason for seeking therapy related to needs around gender identity or sexual orientation?

Trauma history:

Food/exercise concerns:

Legal issues:

Cultural needs of client/considerations for treatment:

Spiritual background/considerations for treatment:

Client strengths:

BRIEF MENTAL STATUS EXAM

Appearance: *Neat Well-groomed Disheveled Inappropriate Other*

Mood: *Euthymic Anxious Depressed Euphoric Dysphoric Irritable Other*

Affect: *Congruent with mood Incongruent with mood / Full Expansive Restricted Blunted Flat Labile Fixed*

Speech*: Normal rate/tone/volume Pressured Tangential Other*

Concentration*: Intact Distractible/Inattentive Other:*

Insight*: Good Fair Poor*

Judgment*: Good Fair Poor*

Orientation*: Person, place and time? (Yes/No)*

Attitude*: Calm Cooperative Guarded Withdrawn Aggressive Other*

Behavior*: Normal Agitated Delayed Other*

DIAGNOSIS AND RECOMMENDATIONS

DSM 5 diagnosis with justification:

Client's stated goals for treatment:

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Medicaid Requirements

Recommendations/plan for treatment in relationship to diagnosis: