SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

January 2021

Presented by BHRS Quality Management

San Mateo Avatar
Mental Health Clinical Forms

V 1.26.21

1 poll

Form Name

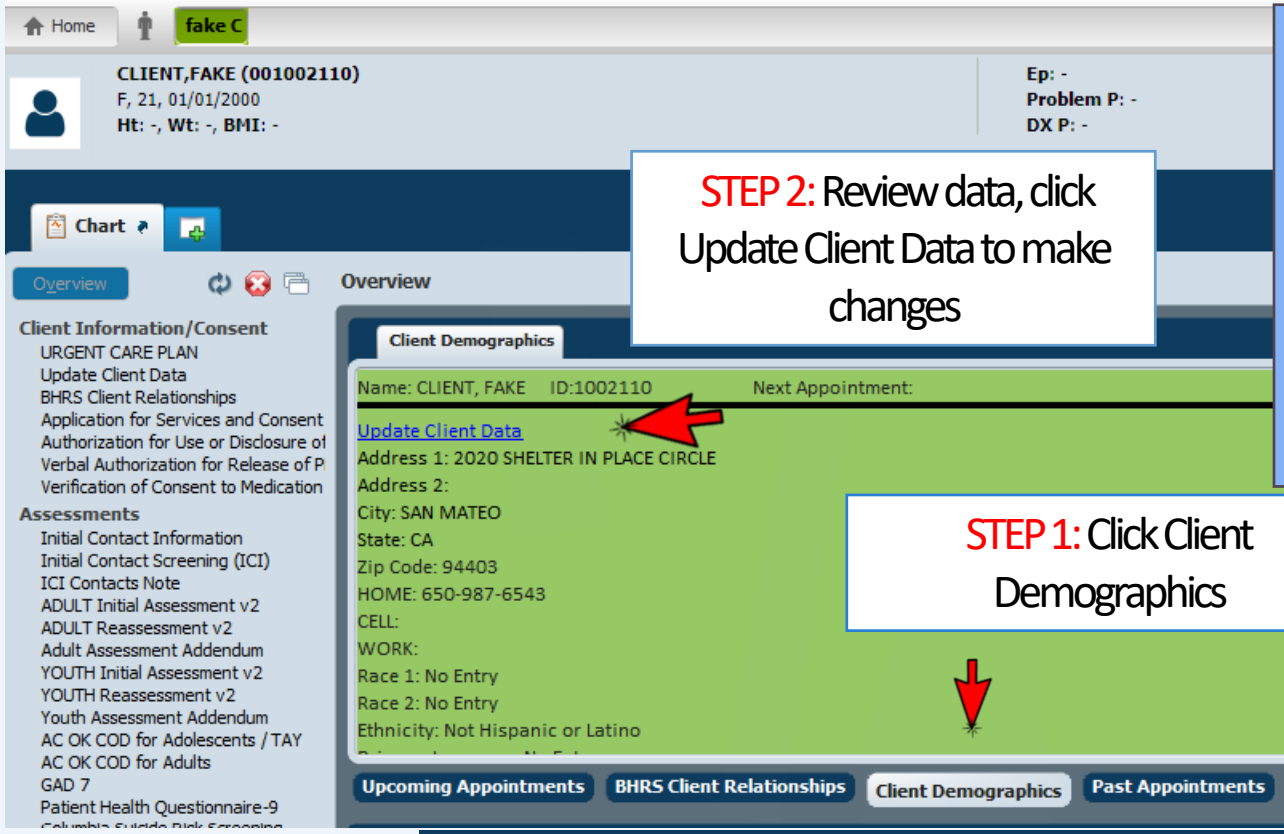
Update Client Data

FAQs:

Q: How do I update my client's phone number or address?
A: The "Update Client Data" Form.

Q: Am I required to ask my client for their email address?
A: Yes, add it to the "Update Client Data" Form.

Q: Am I required to document the physical location in every phone/video session?
A: Yes, document in the Progress Note.



STEP 2: Review data, click Update Client Data to make changes

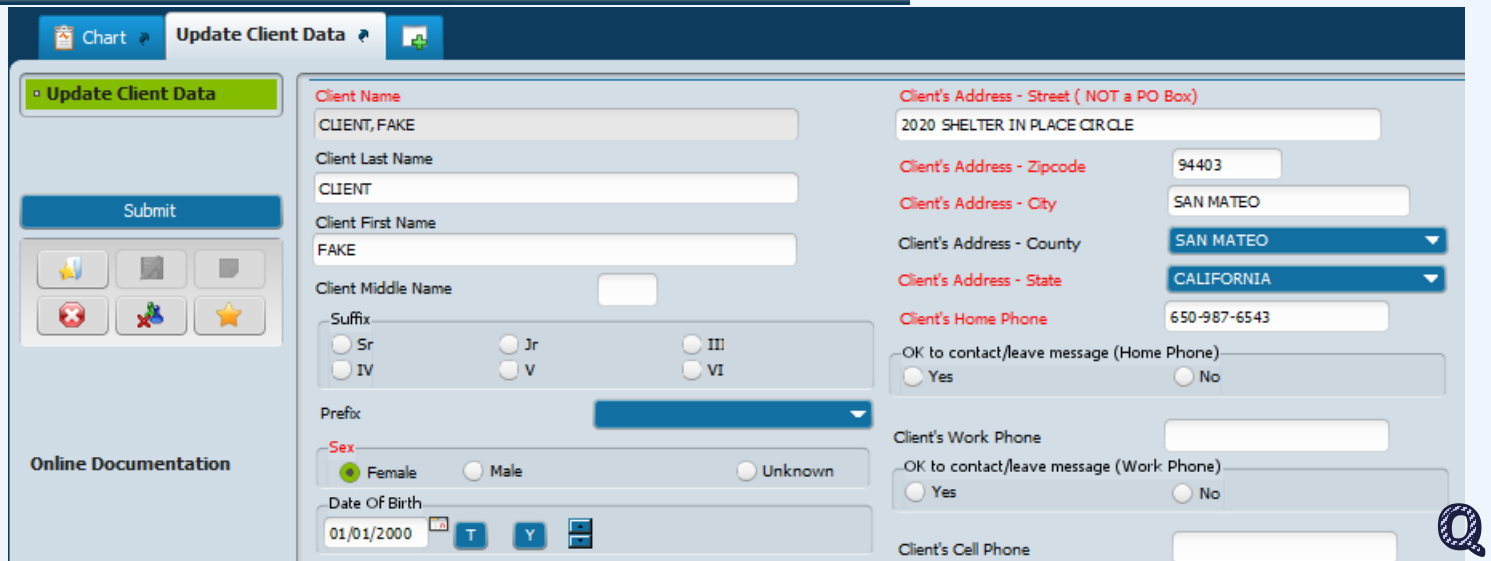
STEP 1: Click Client Demographics

Pro Tip

Check the client's phone number, address, and email address in every phone or video session.

Update it on the spot.

STEP 3: Update data, click Submit



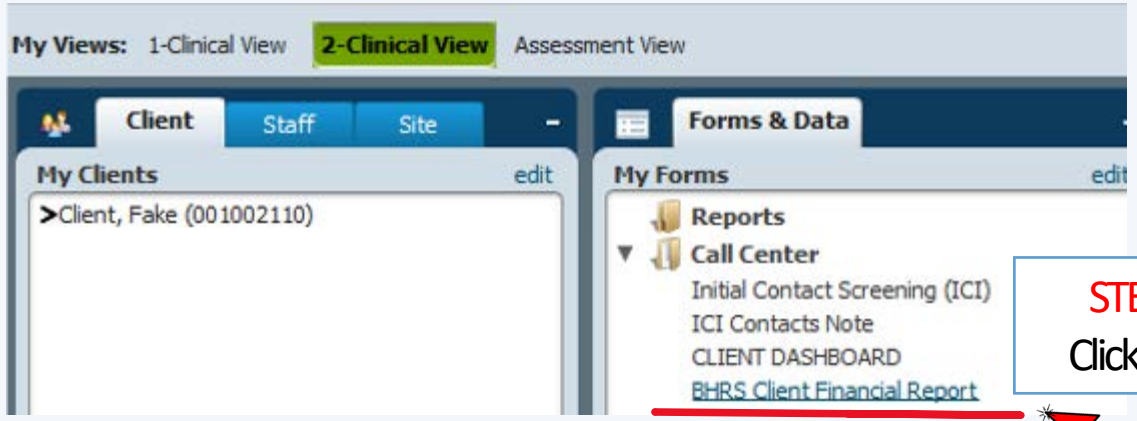
Form Name

BHRS Client Financial Report

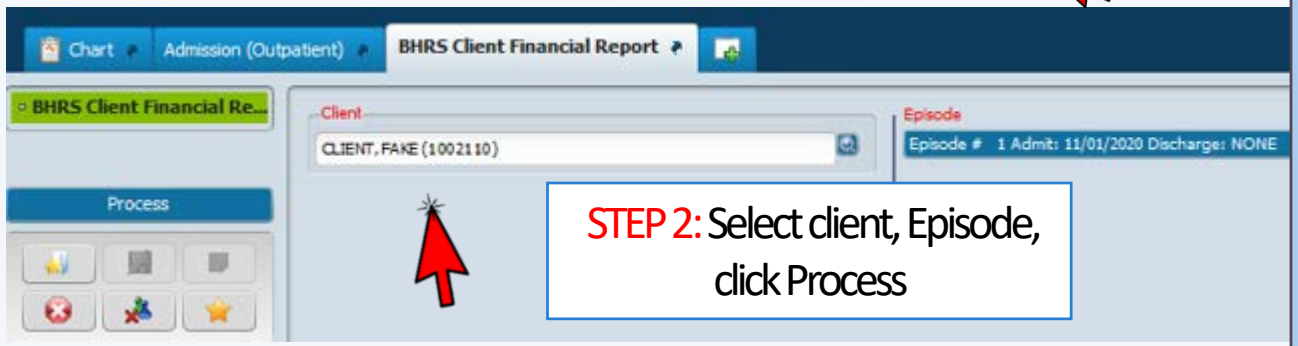
FAQs:

Q: How do I check the client's insurance?

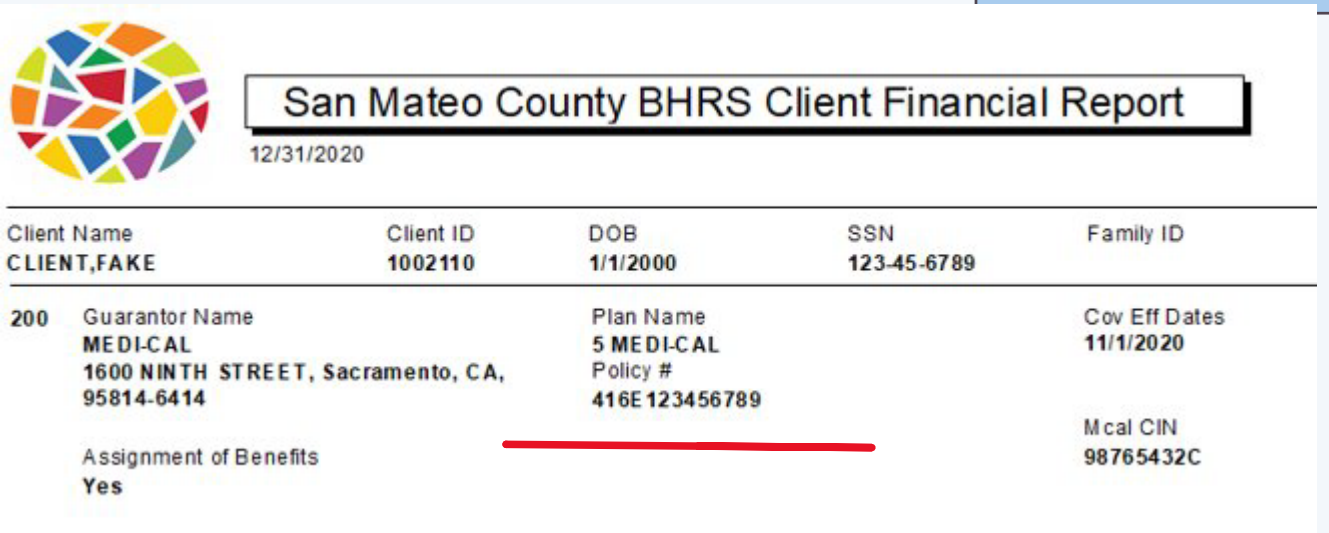
A: Ask your admin or check the BHRS Client Financial Report.



STEP 1: Click Here



STEP 2: Select client, Episode, click Process



San Mateo County BHRS Client Financial Report

12/31/2020

Client Name	Client ID	DOB	SSN	Family ID
CLIENT,FAKE	1002110	1/1/2000	123-45-6789	

200 Guarantor Name
MEDI-CAL
1600 NINTH STREET, Sacramento, CA, 95814-6414

Assignment of Benefits
Yes

Plan Name
5 MEDI-CAL
Policy #
416E123456789

Cov Eff Dates
11/1/2020

Mcal CIN
98765432C

Pro Tip

Program specialists and supervisors ALWAYS check the client's insurance before assigning staff to the client and before issuing a NOABD (only MediCal clients get NOABDs).

Medicare clients –we only get reimbursed for MD, prescribing NP, and LCSW.

Form Name

Progress Notes with Face to Face

FAQs:

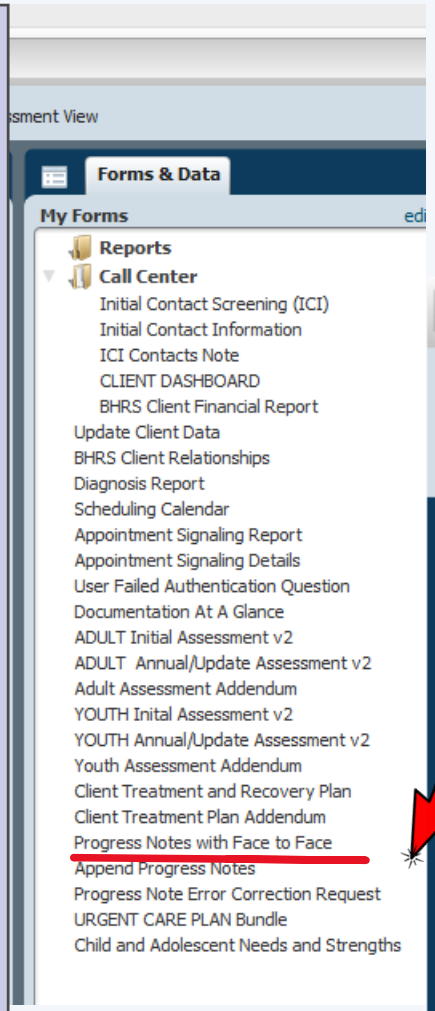
Q: What progress note form do staff use?

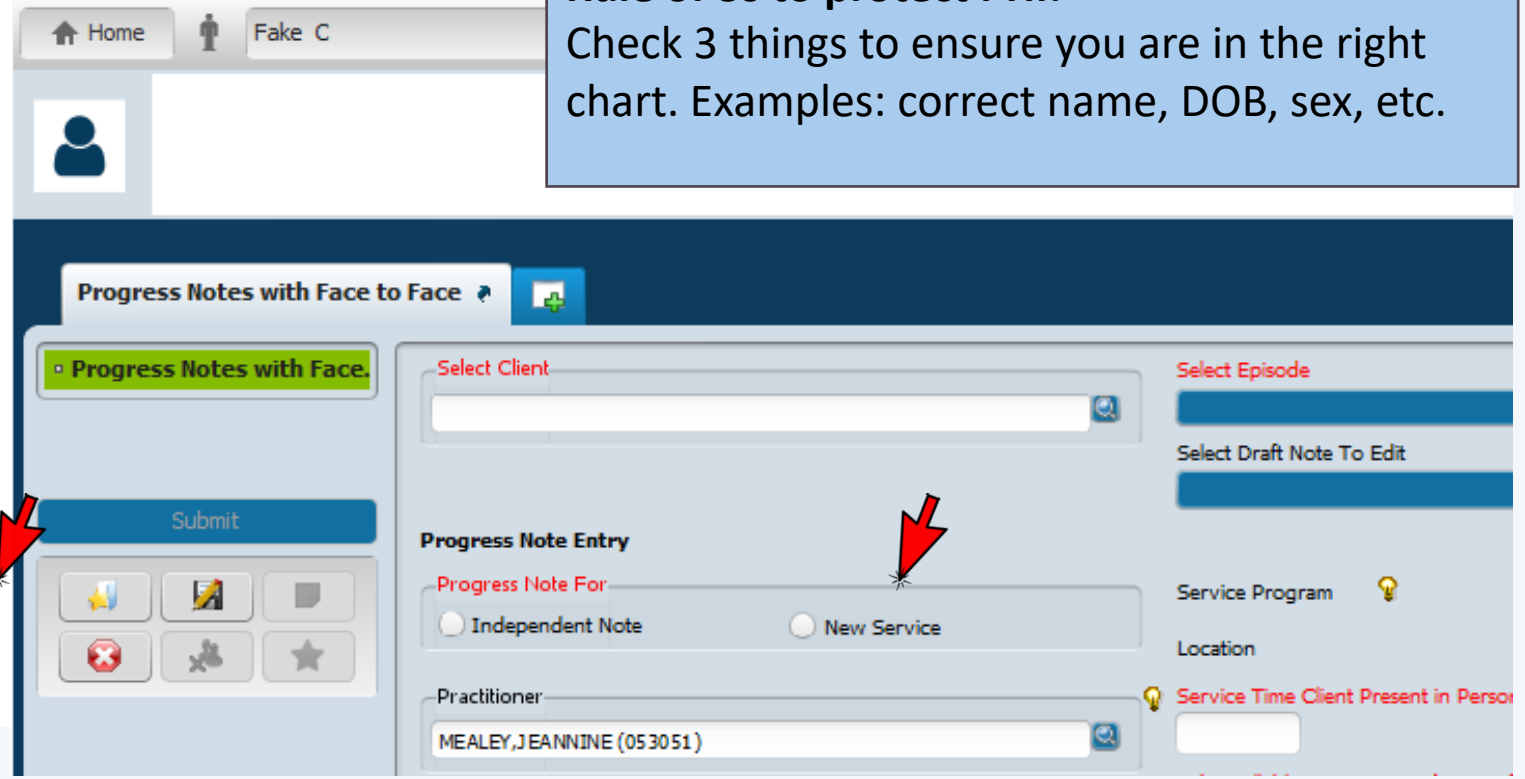
A: "Progress Notes with Face to Face"

Medical Staff also use the *"Medication Administration Record"* progress note for injections.

***Q:* Do staff use the ICI Contact Note?**

A: No, only the Call Center uses ICI Contact Note.





Pro Tip

Protect PHI:

Always check to make sure that you are the selected practitioner and correct program.

Rule of 3s to protect PHI:

Check 3 things to ensure you are in the right chart. Examples: correct name, DOB, sex, etc.

"New Service" - use for open clients and select client

" Independent Note" - use for closed clients

Form Name

Progress Notes with Face to Face Location

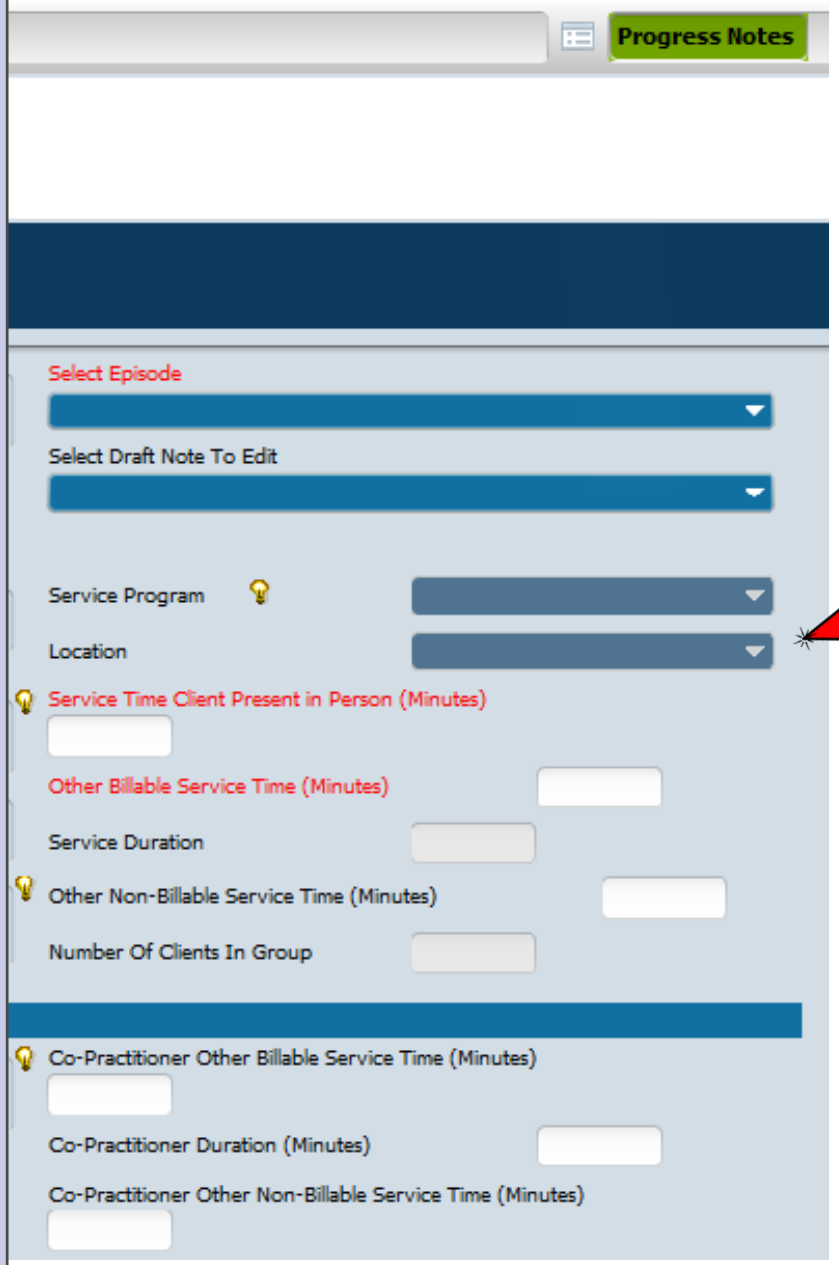
FAQs:

Q: What determines if a service will be billed?

A: The service code, location code, type of service minutes and the client's insurance.

Q: Do I use the client's location, or my location?

A: *If the client is in a lockout location, USE THE LOCKOUT- Client's Location, not your location. If the client is NOT in a lockout: Use the appropriate location code.*



Pro Tip

MH Lockout Locations: Jail or Jail-like setting; IMD-like Napa SH; Psychiatric Hospital & PES Skilled Nursing Facility-Psych; Redwood House/Serenity House—Lockout; Redwood House/Serenity House—(MedSup/CM)

Location Codes: Common Non-Lockout Location Codes

OFFICE: Providing a service from your home office and/or work site (not on phone, not video, client is not in lockout)

PHONE: Phone service with client or another person (on phone or video) unless client is in a lockout location

TELEHEALTH: is VIDEO CONFERENCING with client unless client is in a lockout location.

MISSED VISIT: Use "missed visit" location code

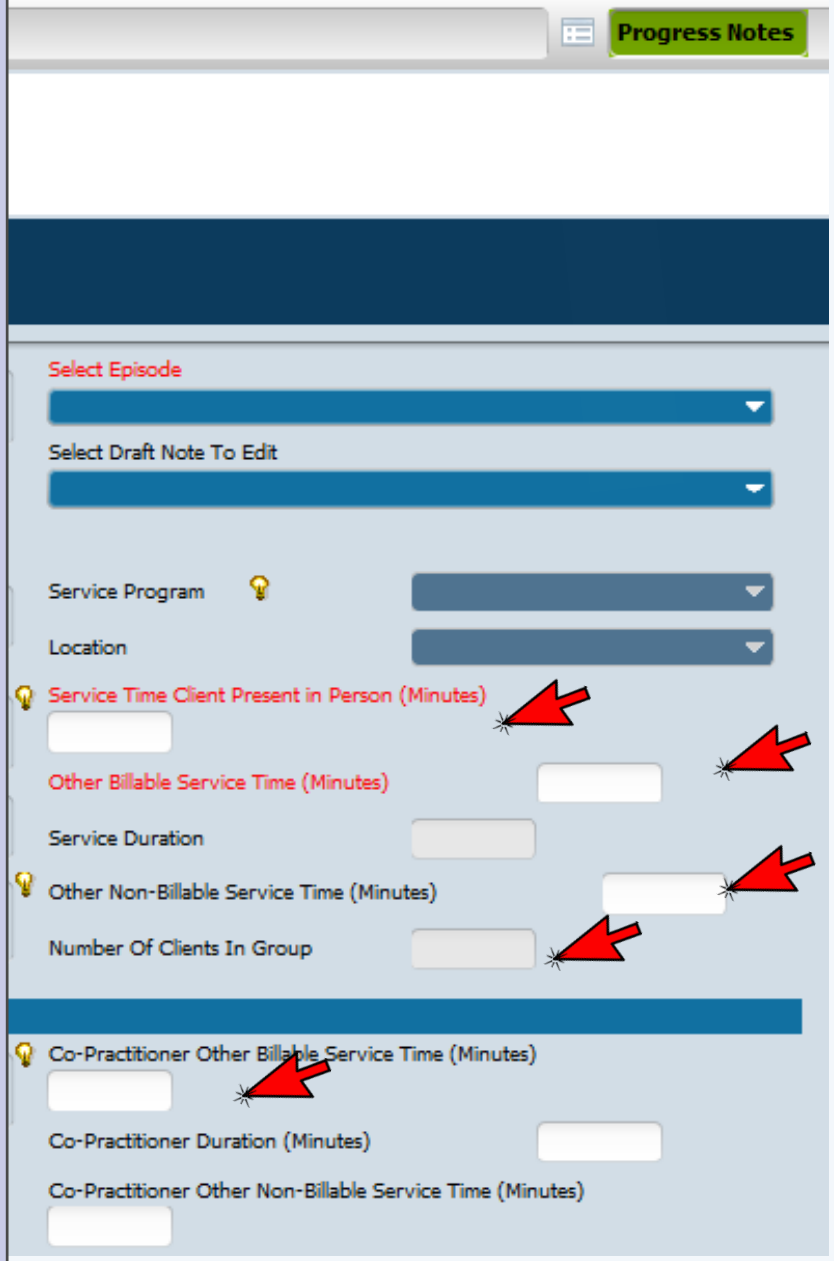
VOICE MAIL/FAX/EMAIL: When documenting voice mail/fax/email/text –these are non-billable services

There are several other location codes that are billable

Form Name
Progress Notes with Face to Face Service Minutes

FAQs:
Q: What time is included in Service Time Client Present in Person?

A: This is only the time that client is physically present in person or by video



Pro Tip

For **group services** Avatar divides the service duration by the number of clients, you don't do that. The total number of minutes to write all progress notes is entered, e.g. 40 minutes for 4 notes, not 10 minutes

Service Time Client Present in Person: This is only the time that client is physically present in person or by video.

Other Billable Service Time: Charting billable progress note, travel, phone contact with client, collateral contacts, other services where the client is NOT present by video/nor in person.

Other Non-Billable Service Time: If the service is a billable service, you may include non-billable time and do not need to write a separate progress note: e.g. CPS reporting, group prep, listening to voicemail. If the entire service is 55, leave blank.

Number of Clients in Groups: Only for groups; this is the number of open clients represented. Family members of an open client are counted as one (1 client even if there are many family members present).

Co-Practitioner: Time is only billed for group services with more than one provider.

Form Name

Progress Notes with Face to Face- Notes Field

FAQs:

Q: Must a treatment plan goal always be selected for each progress note?

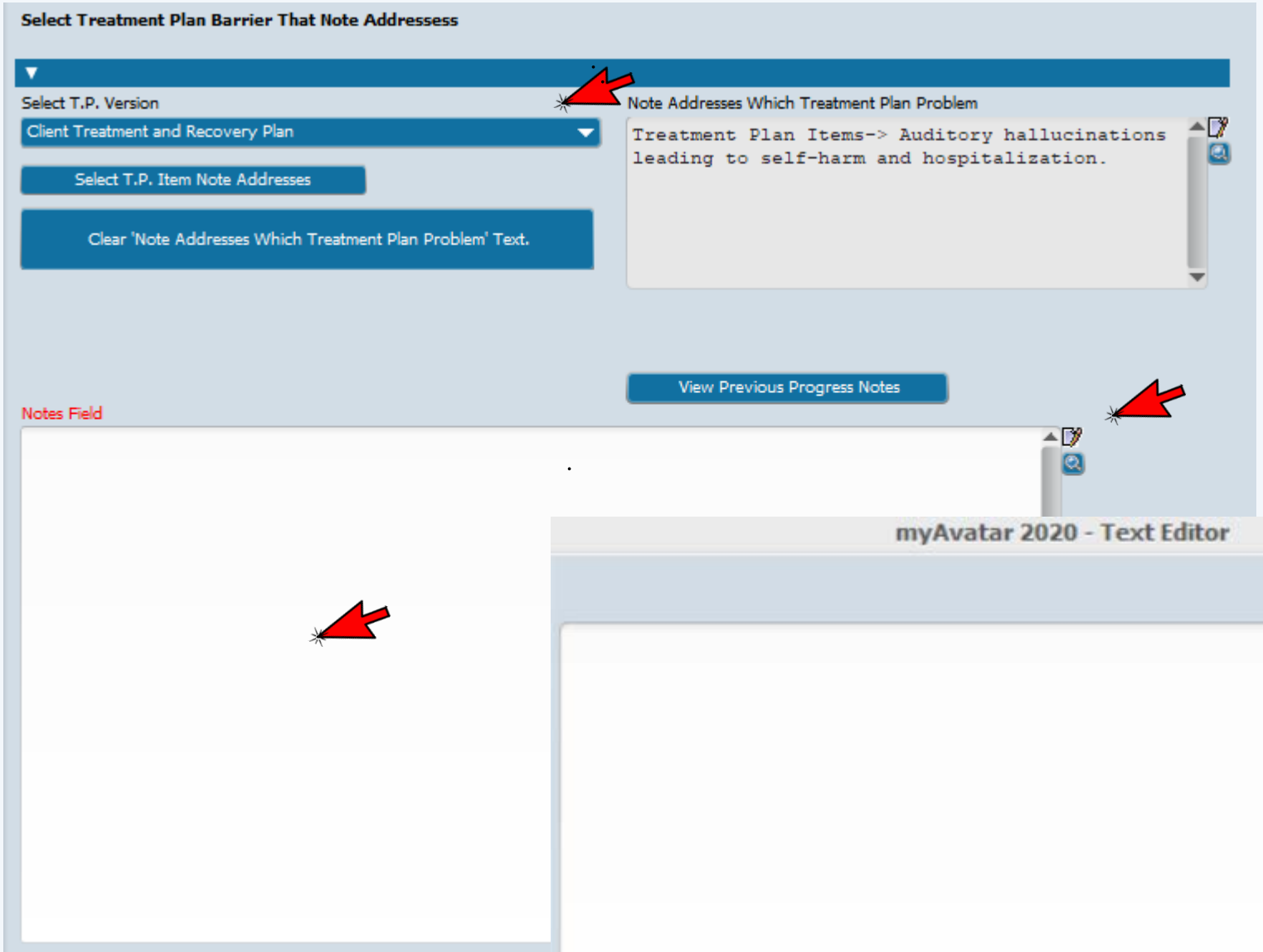
A: No, it is not required but it is recommended.

Q: I hear there are templates in Avatar to help me complete important sections of the progress note. Where can I find these?

A: Right click in the Notes Field or click on the pad and pencil.

Pro Tip

Use "System Templates" and ~~Speel~~ Spell Check



Form Name

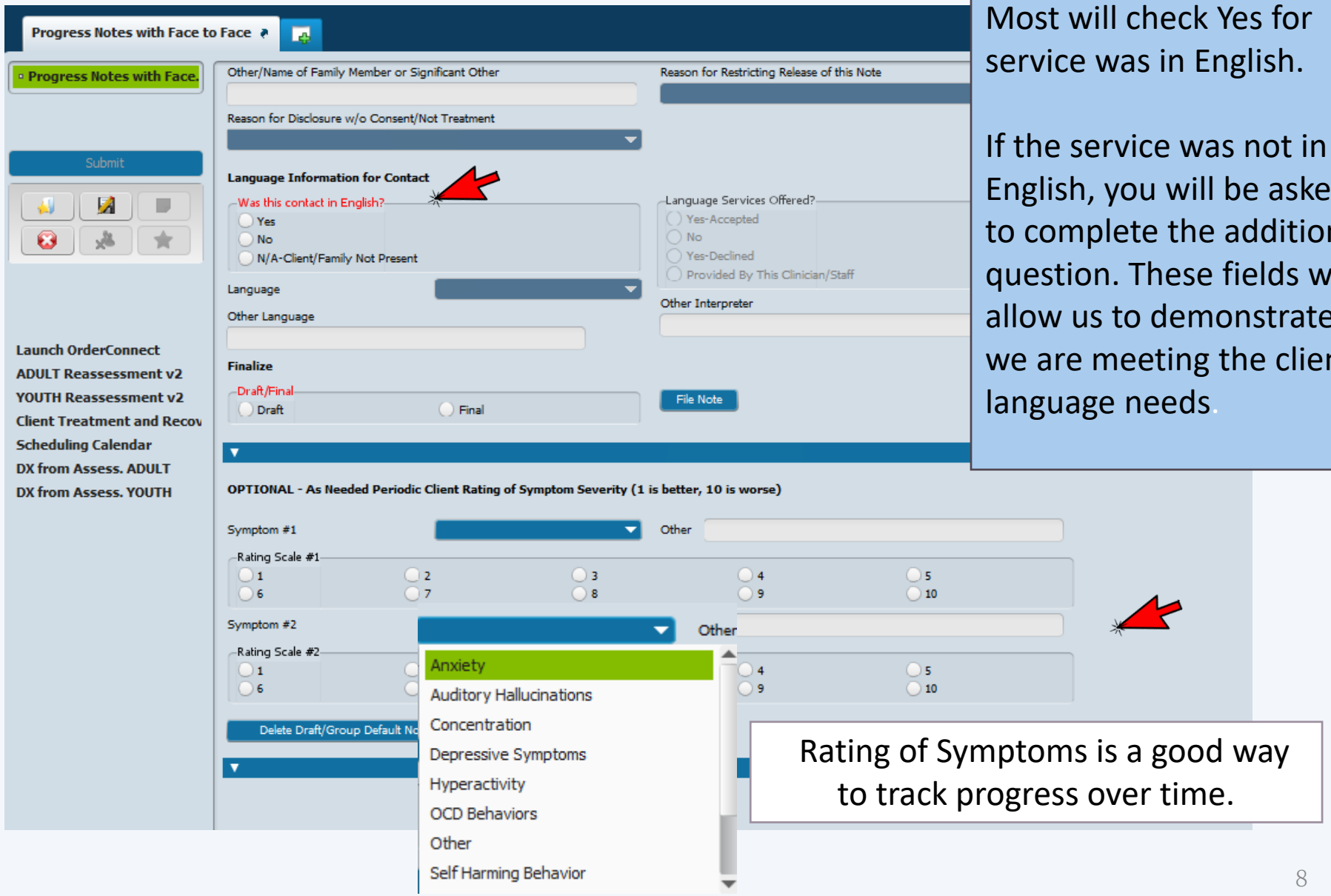
Progress Notes with Face to Face

Other Items

FAQs:

Q: Are we required to document the language the services were provided in in every progress note?

A: Yes, Language is required, this is a Medi-Cal requirement.



Pro Tip

Most will check Yes for service was in English.

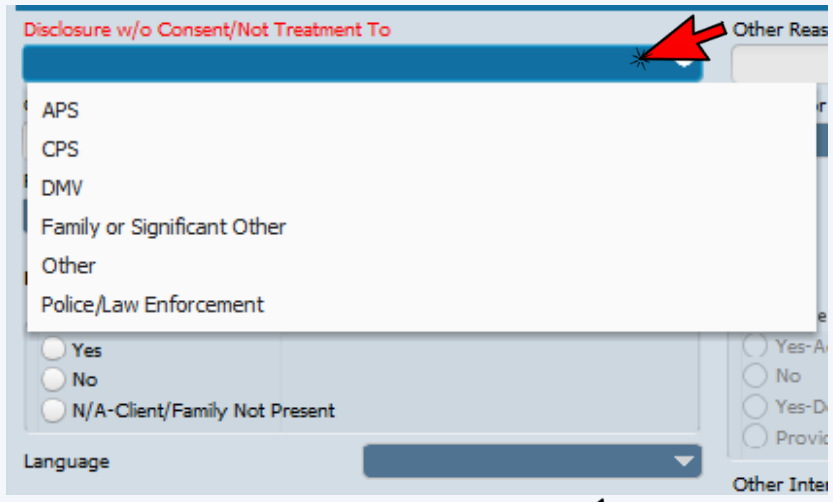
If the service was not in English, you will be asked to complete the additional question. These fields will allow us to demonstrate we are meeting the client's language needs.

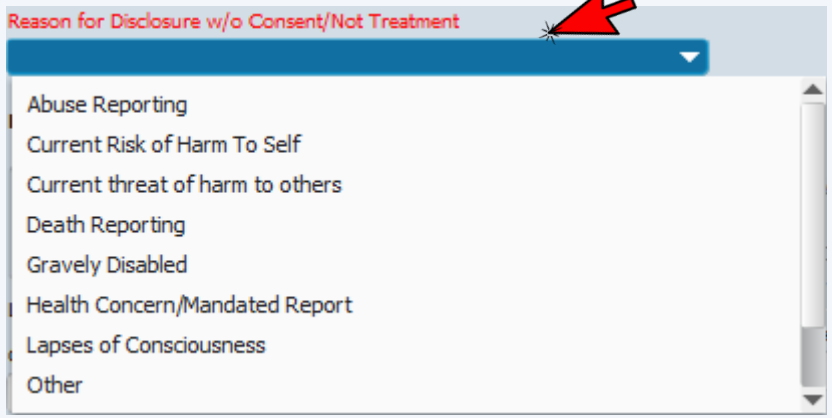
Rating of Symptoms is a good way to track progress over time.

Form Name
Progress Notes with Face to Face-
Disclosure Note Type

FAQs:
Q: I had to make a mandated report and did not have client consent, what do I do?

A: Use progress "Note Type", "Disclosure W/O Consent."





Pro Tip

A disclosure without consent is when you share a client's PHIis when you share a client's PHI without client consent, for a reason other than current treatment, payment, or operations.

Disclosure w/o Consent/Not Treatment To

- CPS
- APS
- Police/law enforcement
- DMV
- Family or significant other
- Other
- For other and Family Member State Name of Person

Reason for Disclosure w/o Consent/Not Treatment

- Abuse reporting
- Current risk of harm to self
- Current threat of harm to others/duty to warn/protect
- Death reporting
- Gravely Disabled
- Health Concern/Mandated Report
- Lapses of Consciousness
- Urgent safety/crisis situation
- Welfare check
- Other
- For other reason

Form Name

Progress Notes with Face to Face- Restricted Note Type

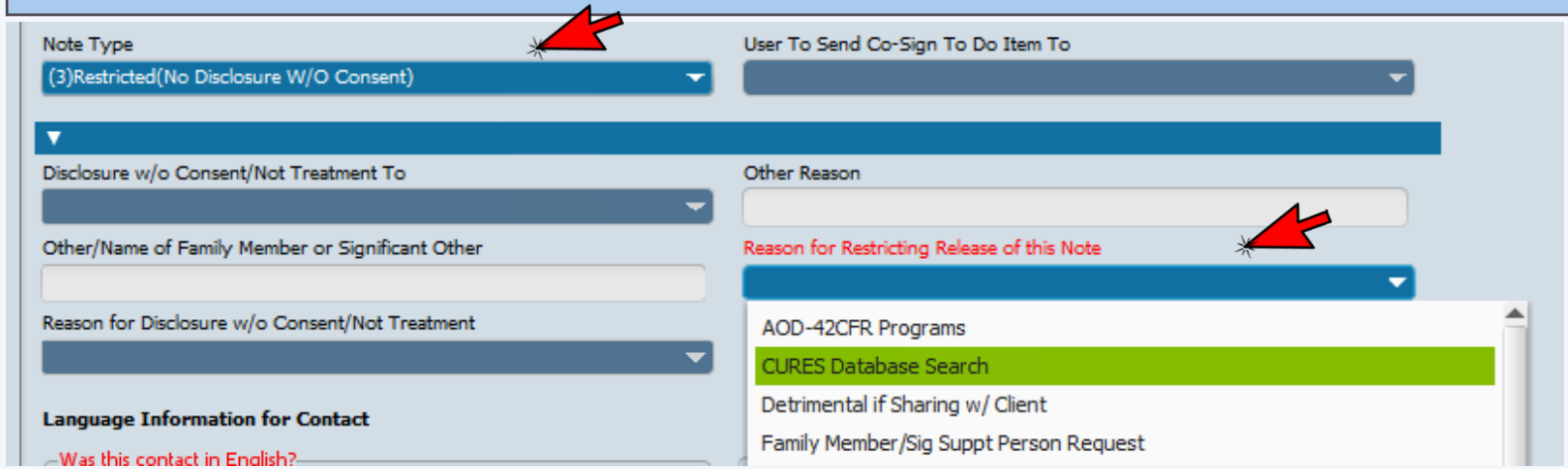
FAQs:

Q: How do I make sure a progress note does not get released with sensitive information in it?
A: Use restricted progress note type

Q: What happens when I restrict a progress note in Avatar?
A: It puts a flag on the note.

Pro Tip

Restricting the note does not block access. Anyone with Mental Health Avatar access can see the note. The restriction is a "flag" or reminder to review the note for appropriateness prior to releasing the chart in case it contains info that should not be released.



Reason for Restricting Release of this Note

- **Family member/significant support person/others shared confidential information but requested not to share with client. These notes cannot be shared with the client.**
- Sharing with client would be detrimental/might result in serious risk of harm to client or others.
- HIV status
- Information shared by an AOD Provider – 42 CFR Program
- Youth client's request to restrict-sexual history (not abuse) or AOD use/treatment or private/personal information

Form Name
Urgent Care Plan Bundle

FAQs:

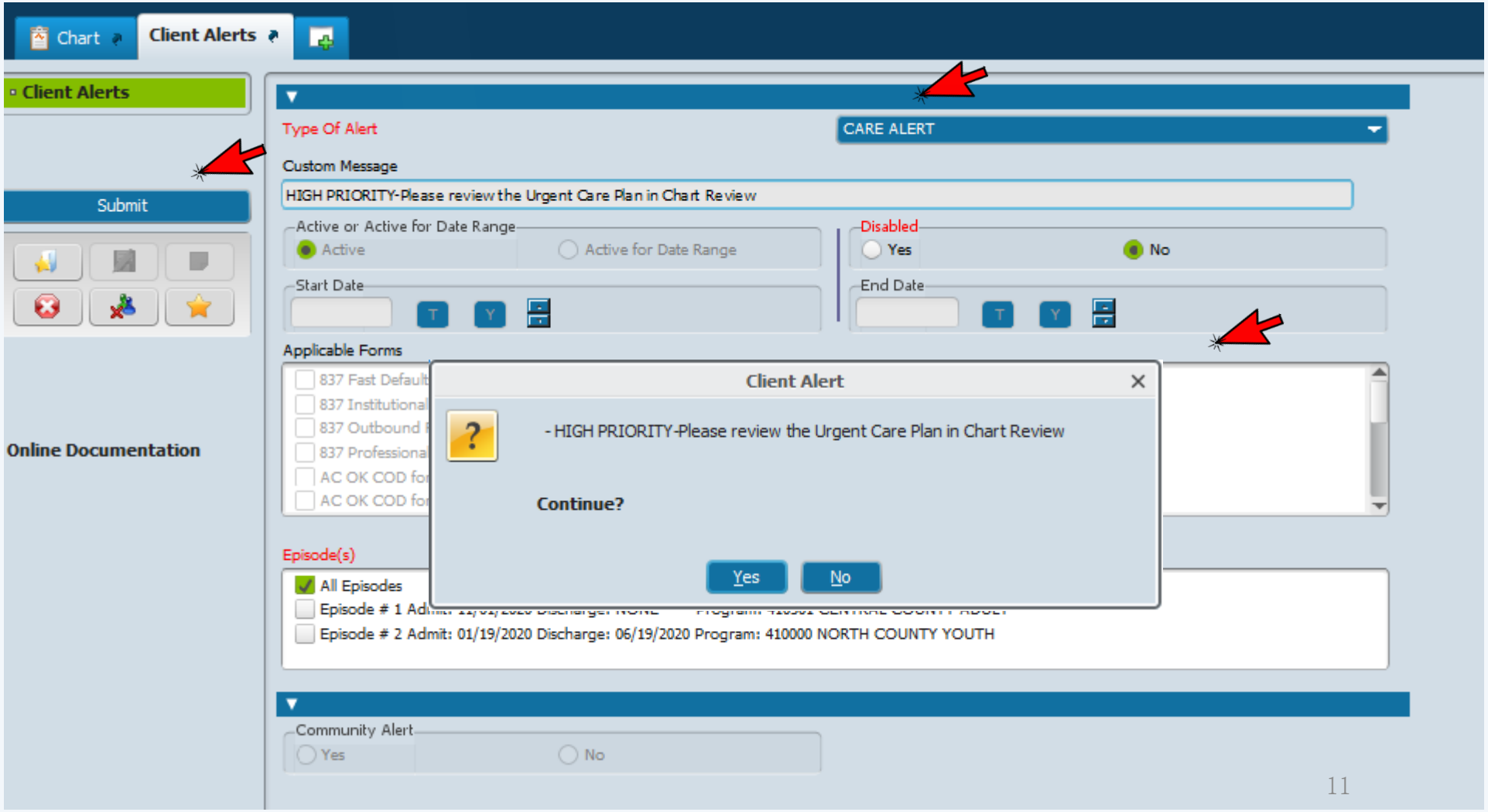
Q: What "Custom Message" do I select?

*A: **For a message with no end date:***

- ***"Care Alert" -** this notice will appear on the chart "HIGH PRIORITY-Please review the Urgent Care Plan in Chart Review."*
- ***"Care Message" -** to set an end date."*

Pro Tip

Complete the "Urgent Care Plan" with contact information and or instructions for other providers.



Form Name

Urgent Care Plan Bundle

FAQs:

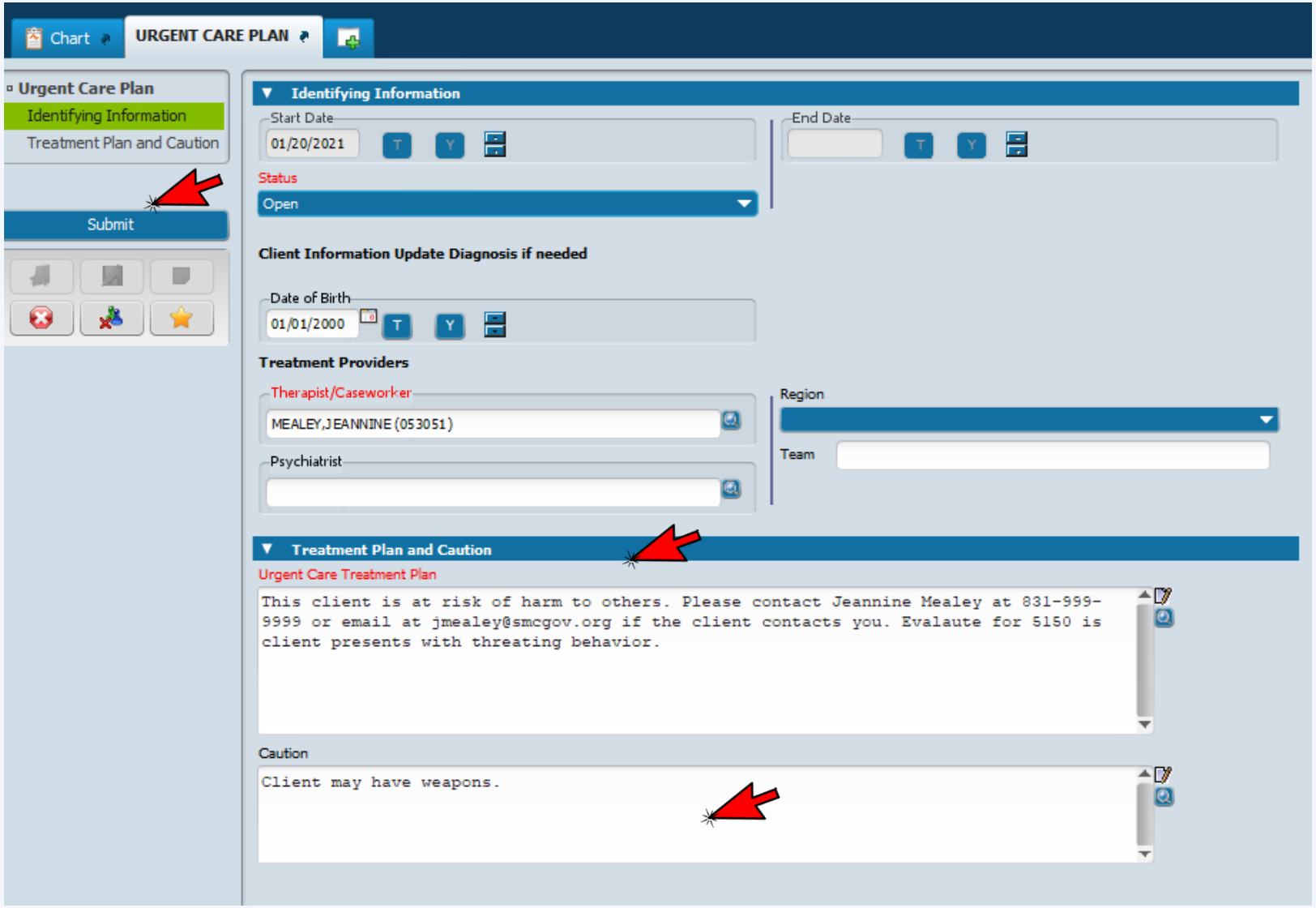
Q: What is the Urgent Care Plan used for?

A: To provide information about the client's current situation, such as current risk, safety issues, your contact information or other instructions.

More information about urgent care alerts is located here: https://www.smchealth.org/sites/main/files/file-attachments/bhrsavatarurgentcarealert.pdf?1503077336

Pro Tip

Disable the "Care Alert" when it is no longer needed.



Progress Notes with Face to Face- *"Oops, I made a mistake"*

FAQs:

Q: I realized I made an error on a progress note I submitted. How do I correct this?

A:
1. Use the "Append Progress Note" or
2. "Progress Note Error Correction Request" or
3. Write a new progress note.

Q: Can you delete a finalized progress note?
A: No

Progress Note Error Correction Request is for correcting billing information, such as:

- Date of Service
- Service Duration
- Service Charge Code/Type of Service
- # of Clients in Group
- Location Code
- Duplicate Entry
- Wrong Co- Practitioner, Wrong Episode, Wrong Client.

Any clinician/supervisor can correct a progress note, even if they did not write the original note.

Append Progress Note is for adding information to a completed progress note.
Appended information that is added is attached to the original note.

- Any clinician/supervisor can append a progress note, even if they did not write the original note.
- If information needs to be added or corrected to the content of a finalized note that required a co-signature, a new note must be written to address mistakes or additions of the original note's content.

Pro Tip

Always correct progress note billing errors.

Email ASK QM if you are unsure if a correction is needed.

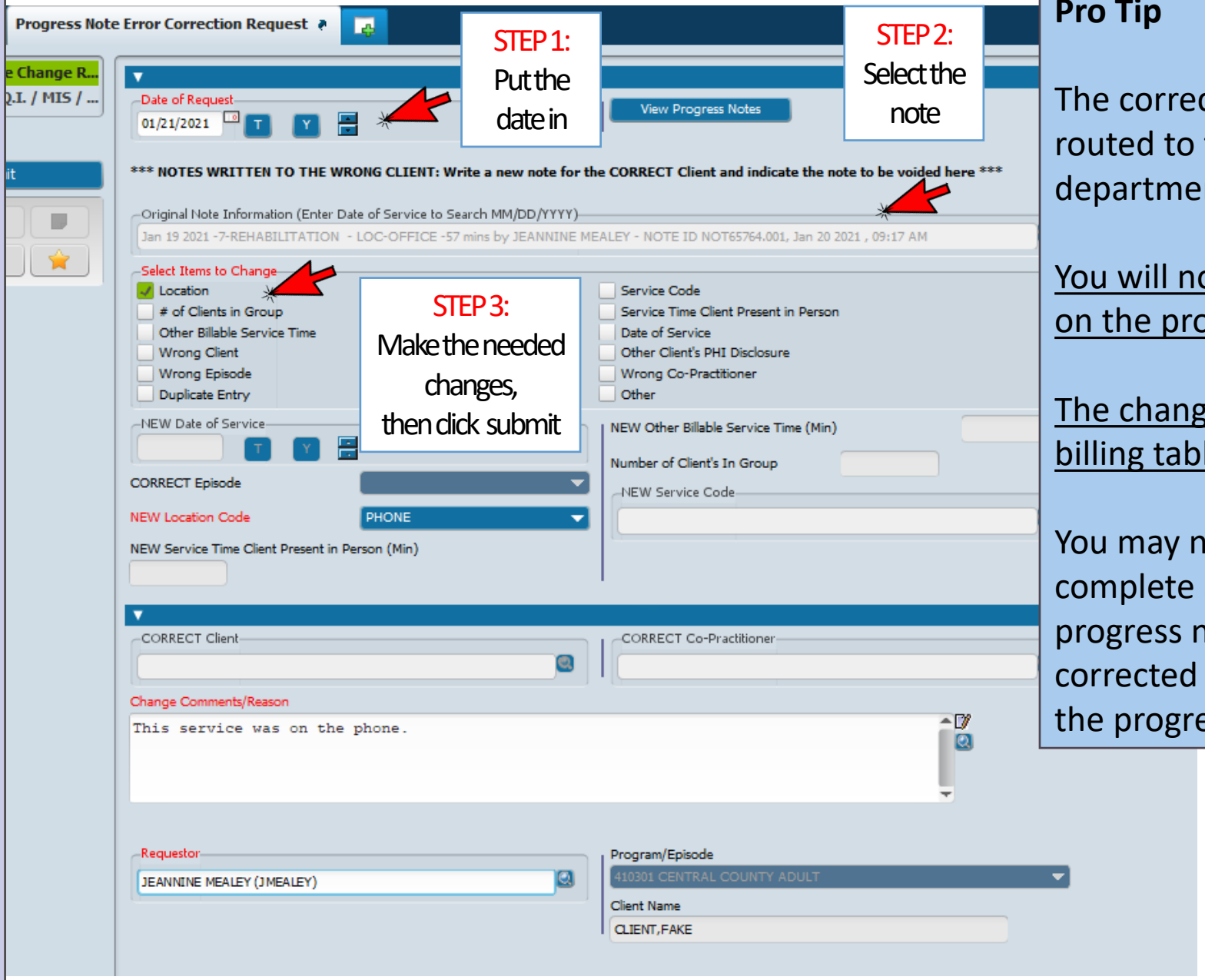
Form Name

Progress Note Error Correction Request

FAQs:

Q: If I wrote a progress note in the wrong client's chart, after I complete the error correction request to remove this note from the incorrect client's chart, do I need to then re-enter it into the correct client's chart, or can Avatar do this for me?

A: Yes, you must re-enter the progress note into the correct chart in Avatar. Avatar will not do this for you.



Pro Tip

The correction request is routed to the billing department.

<u>You will not see the change on the progress note</u>.

<u>The change is made in the billing table.</u>

You may need to also complete an append progress note to add the corrected information to the progress note.

Form Name
Append Progress Note

FAQs:
Q: I already submitted a progress note, but realized I forgot to add some information to it. Is there a way to add information to a progress note that has already been finalized?

A: Append the progress note to add the needed information.

STEP 1: Select note type, and note

STEP 2: Make the needed changes, then click submit

Pro Tip

"Append Note" CANNOT be used if a note originally required a co-signature.

To add a comment or correct the content of a co-signed note:

- Write another progress note
- Use the same service date as original note
- Reference the original progress note
- Code it 55

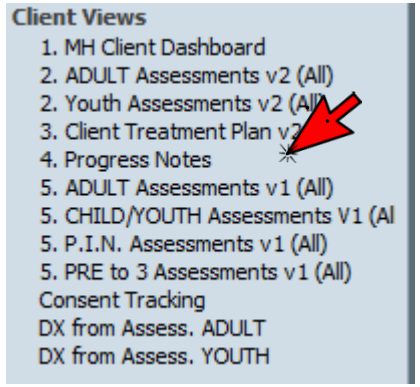
Form Name

Append Progress Note

FAQs:

Q: I appended a progress note but I can't find the appended information, what happened?

A: The append information is added to the formal report.



SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Progress Notes Report

Displays All Progress Notes on File (grouped by program

CLIENT,FAKE **(1002110) D.O.B.** 1/1/2000

Service Information

Prog. Note For: New Service
Note Type: (5) Disclosure W/O Consent
Disclosure w/o Consent/Not Treatment: Family or Significant Other
Other/Name of Family Member or Significant Other: Father John
Reason for Disclosure w/o Consent/Not Treatment: Current threat of harm to others
Date of Service: 1/20/2021
Service Program: 410301 CENTRAL COUNTY ADULT (1)
Location: OFFICE
Service Charge Code: **(55) UNCLAIMABLE SERVICE**

Practitioner: MEALEY,JEANNINE
Service Time Client Present in Person (Min): 15
Other Billable Service Time (Min): 5
Service Duration (Min): 20
Other Non-Billable Service Time (Min): N/A

Progress Note

A disclosure is when you share a client's PHI without client's consent, for a reason other than current treatment, payment, or operations.

Was this contact in English? Yes

Electronically Signed By:

JEANNINE MEALEY MFT (MARRIAGE FAMILY THERAPIST), on 1/20/2021

Unique Note ID: NOT65764.002 1/20/2021 09:32 AM

Note Appended on: 1/21/2021

I'm adding missing information to this progress note.

Electronically Signed by:

JEANNINE MEALEY MFT (MARRIAGE FAMILY THERAPIST), on 1/21/2021

Pro Tip

To view appended information on progress note: <u>print the progress note report</u>

Form Name

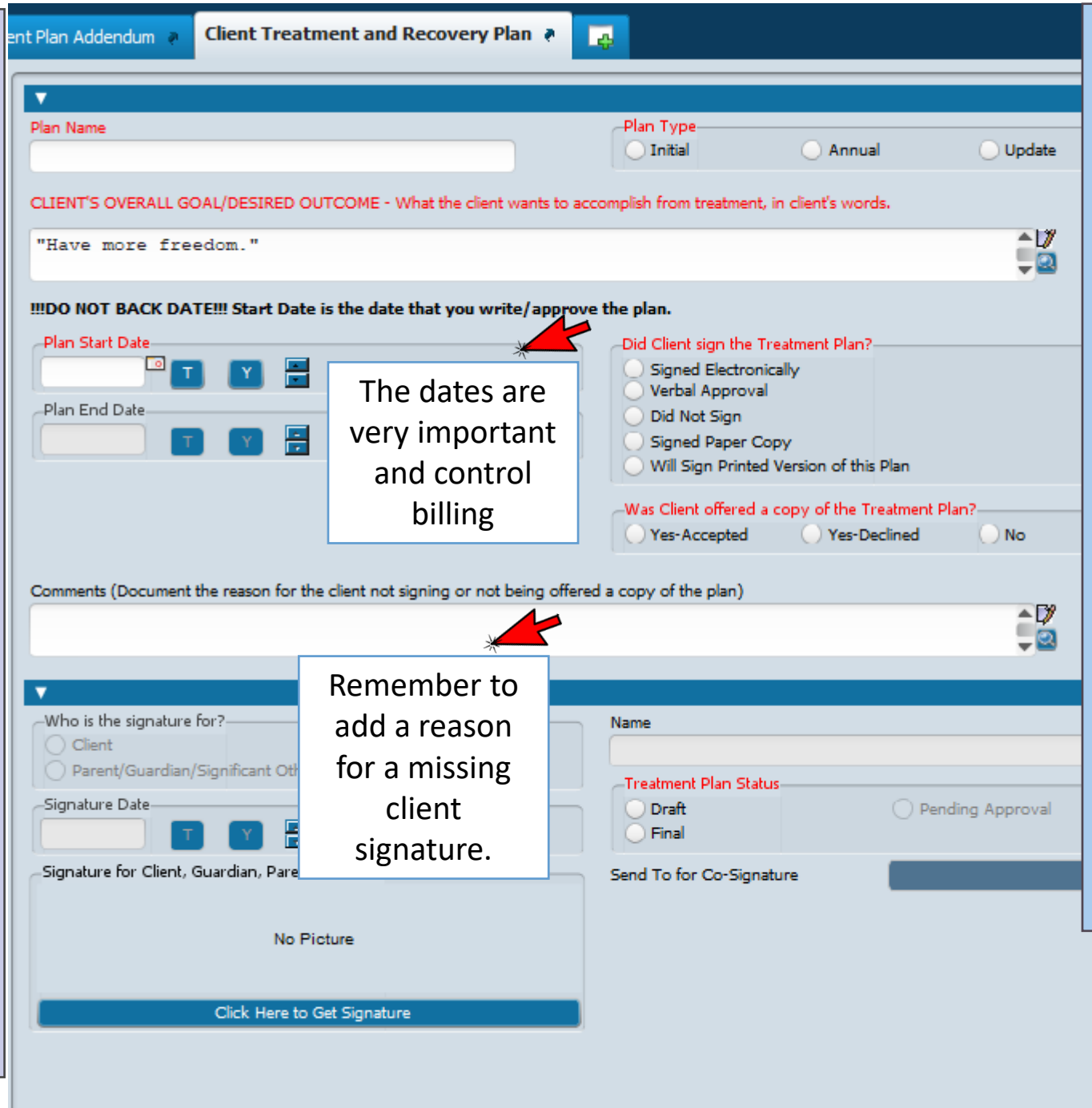
Client Treatment Plan

FAQs:

Q: In the overall goal section, do you write down word for word what the client says?
A: That is best.

Q: Can the start and end date be changed *once inputted?*
A: No, try to make the date in the future if you are starting early. Try to finalize by the start date.

Q: I accidentally started a new treatment plan when I already had one in draft. Can I delete one of the drafts?
A: Yes, you can delete a draft.



The dates are very important and control billing

Remember to add a reason for a missing client signature.

Pro Tip

If you are completing the treatment plan late, <u>don't back date the start date.</u>

The plan is considered completed once the <u>LPHA signs</u>.

If you can't get the client to sign and it is due, document why the client did not sign in the comments box and finalize the plan. Be sure to also write a <u>progress note</u> (and adding the date of the corresponding note on treatment plan).

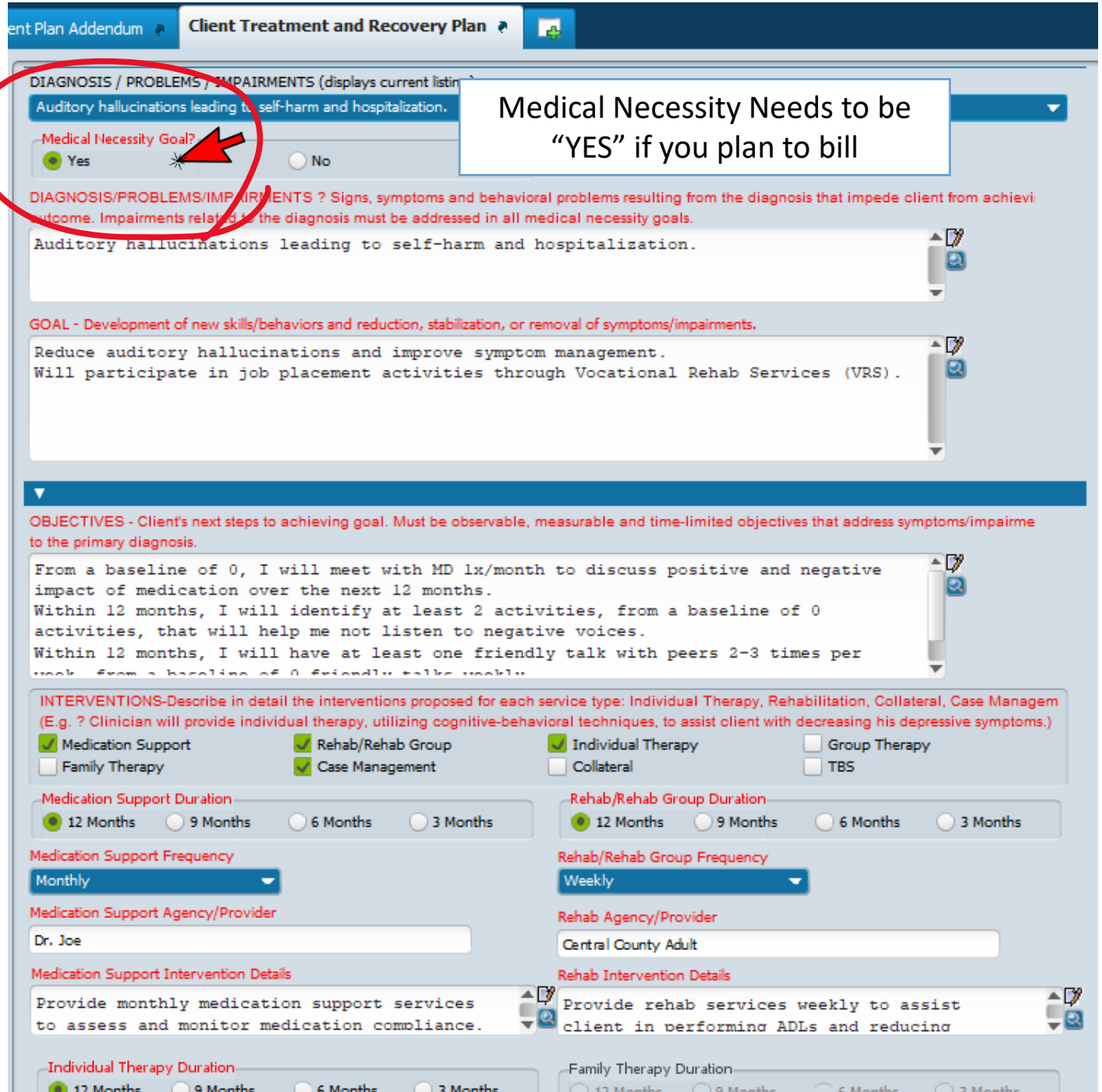
Form Name
Client Treatment Plan

FAQs:

Q: Do all of the goals need to be medical necessity goals?
A: No, but only medical necessity goals can be billed to Medi-Cal.

Q: Do all of the interventions I plan to use need to be on the treatment plan?
A: Yes

Q: Do I need to add med support if I am not a medical staff but our MD will provide med support for this client?
A: Yes



Pro Tip

There are "System Templates" for goals and objectives.

Fill in the intervention sections completely, adding as much detail as you can.

You are adding all of the interventions for your team/program, not just the ones that you provide.

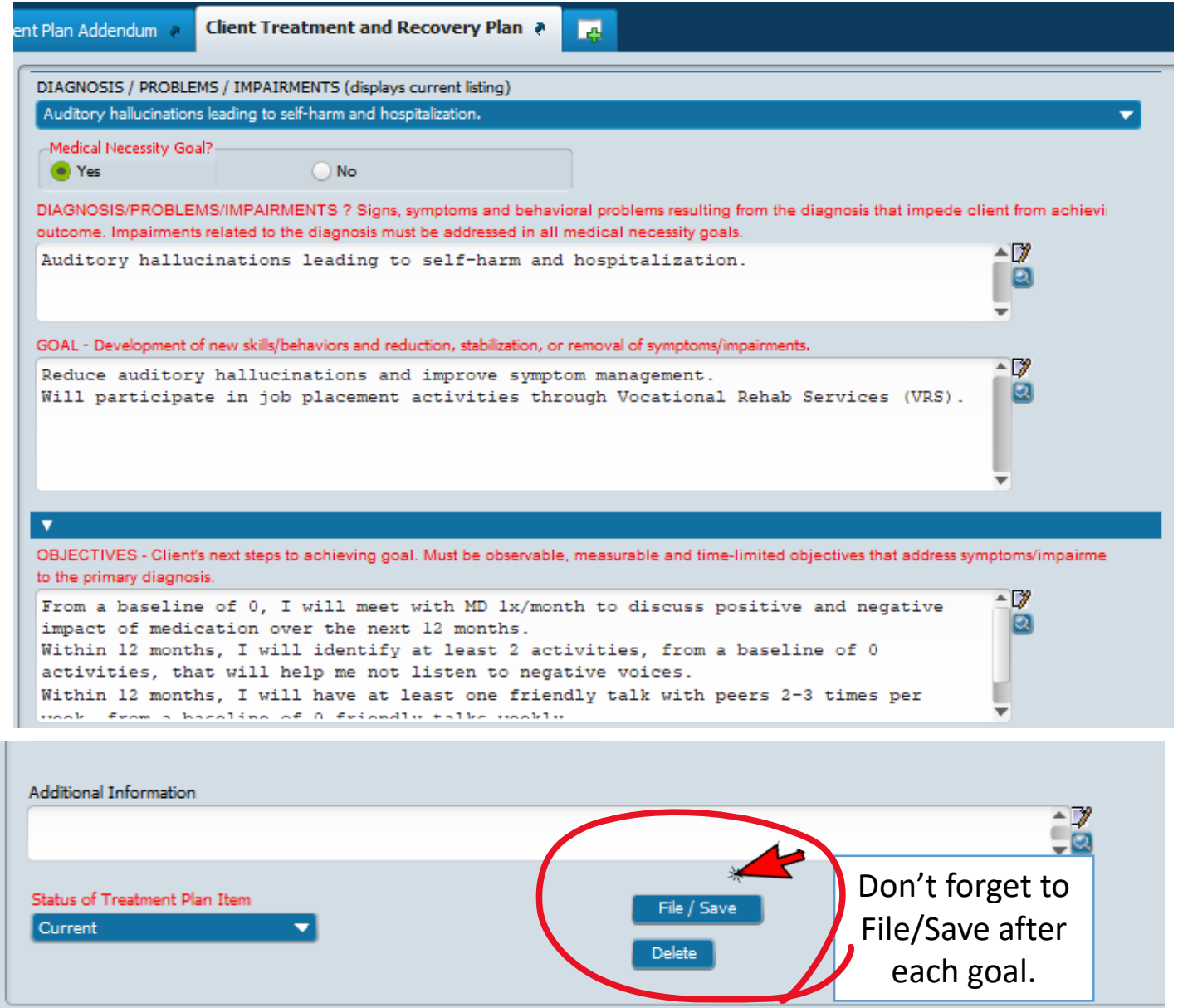
Form Name

Client Treatment Plan

FAQs:

Q: I entered the goal and other information, but it did not save. What happened?

A: This is a common problem. Make sure that you File/Save each Diagnosis Goal set, one at a time, or you will lose your work.



Pro Tip

Don't just copy and paste the last plan. You must update the goal, objectives, and interventions.

Form Name

Client Treatment Plan

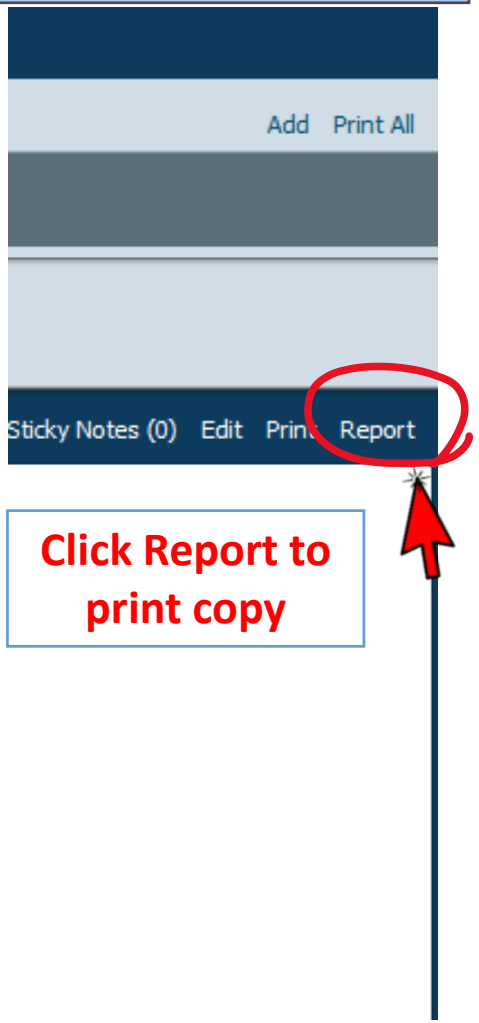
FAQs:

Q: How do I print a copy of the treatment plan for the client to sign?

A: From Chart --> Client Treatment and Recovery Plan --> Report

Pro Tip

Limit printing and/or completing paper PHI from home and off-site. Do this only when necessary. Only use hard copies and print documents if no other method is available to perform your work. **Keep printed/paper PHI-safe**. Lock it up. Take it to the office as soon as reasonably possible.



Form Name

Treatment Plan Addendum

FAQs:

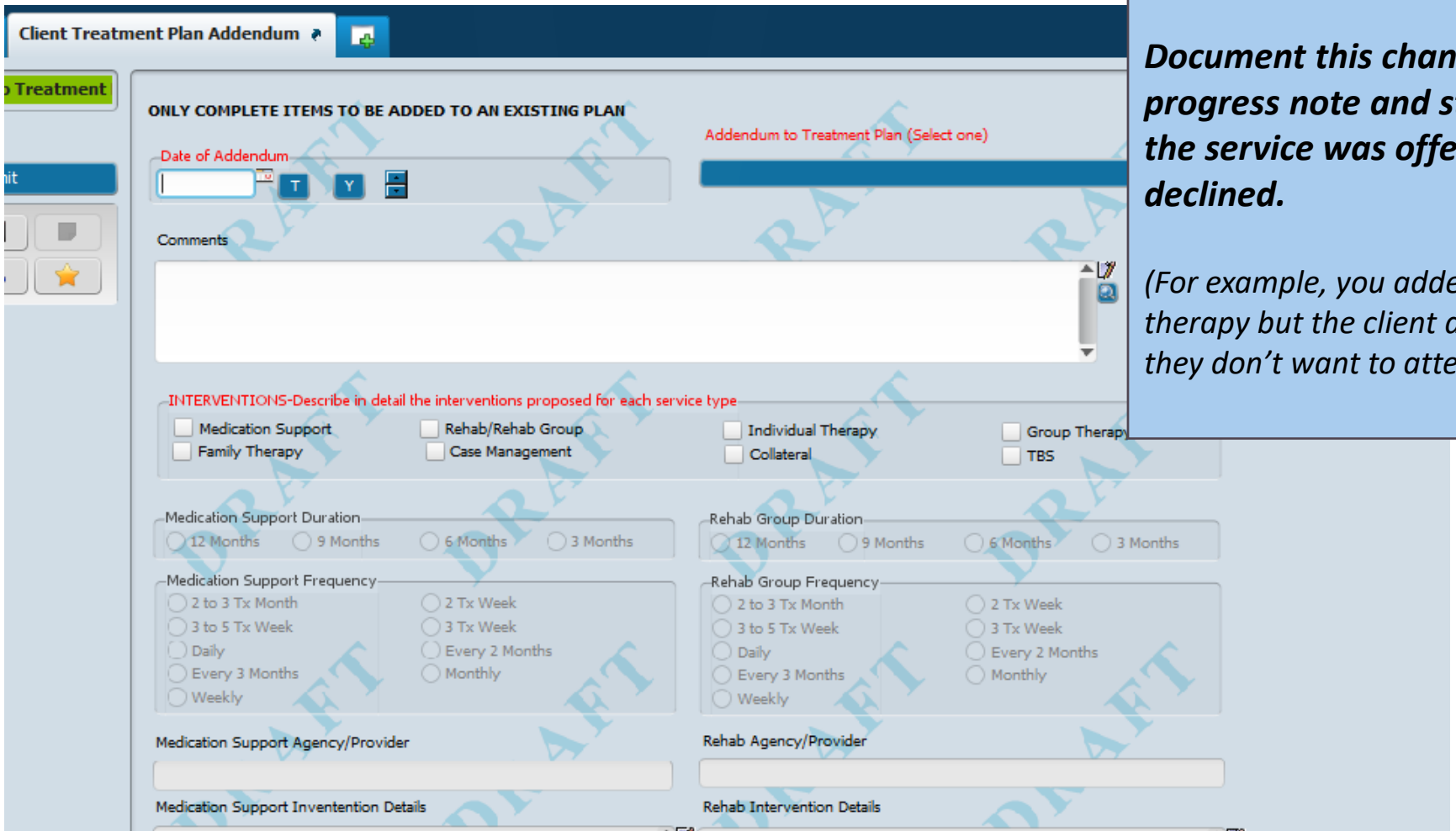
Q: Does the addendum expire when the treatment plan it is attached to expires?
A: Yes, the Addendum will expire when the Treatment Plan it is attached to expires.

Q: Is there a limit to the number of addendums that can be done for a treatment plan?
A: NO

Q: Does the client need to sign or at least verbally agree to the addendum?
A: The same rules apply as the main treatment plan.

Treatment plan addendums

- May be used at any time.
- Use to collect a signature
- Use to add/modify a goal, objective or intervention.
- Use to add Planned Service being provided that is not on the Treatment Plan, as **soon as possible**



Pro Tip

If a service is added to the treatment plan or addendum but not provided:

Document this change in a progress note and state that the service was offered and declined.

(For example, you added group therapy but the client decides that they don't want to attend).

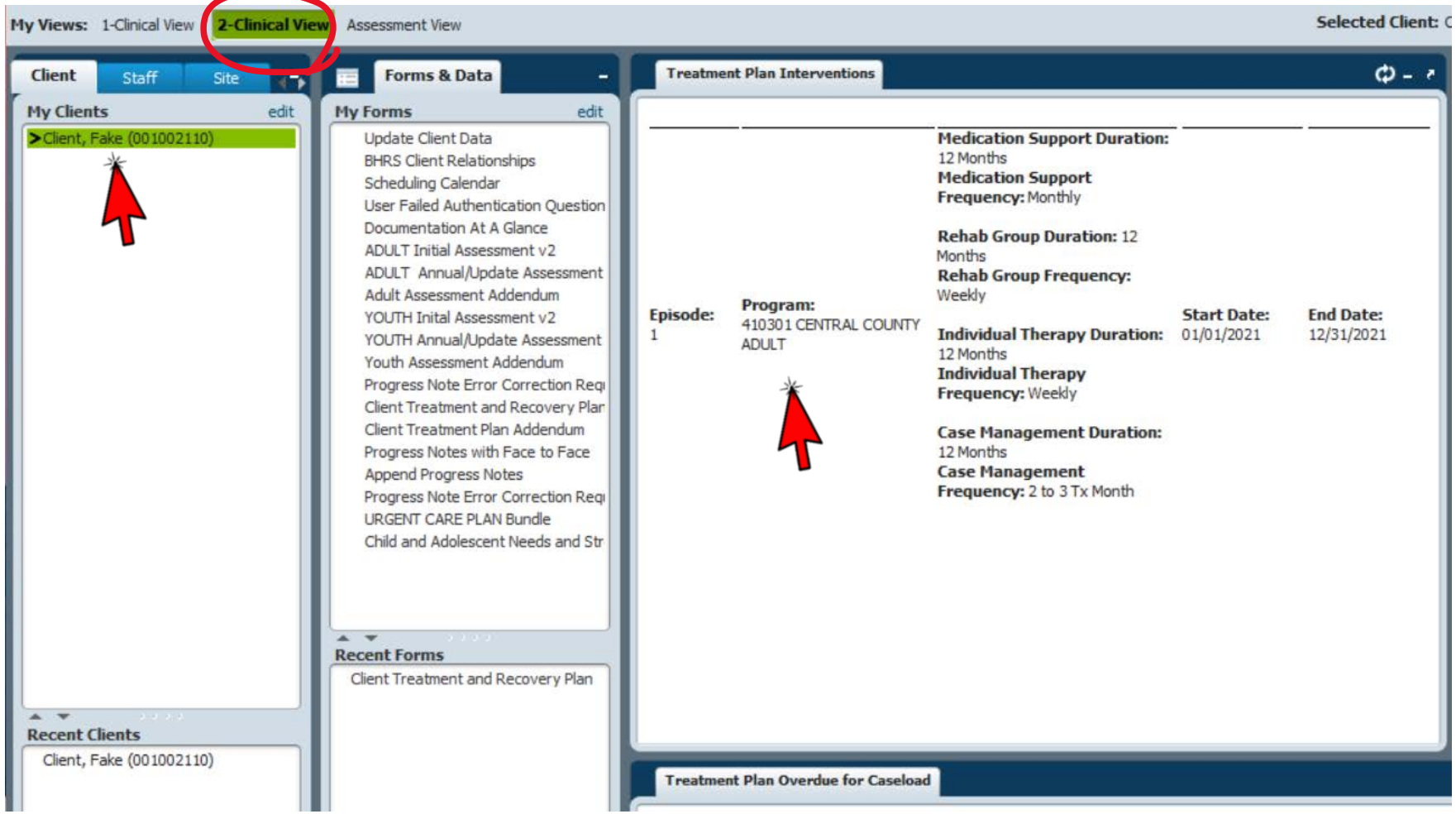
My Views

FAQs:
Q: Is there an easy way to see what planned services are approved on the treatment plan?

A: Yes, look at "My Views"

More information about Avatar "My Views" is located here https://www.smchealth.org/sites/main/files/file-attachments/avatarmyviewsfeature.pdf?1611172229

Pro Tip If you are billing under someone else's treatment plan you are required to review the treatment plan. Notify the clinician if your service type is missing and decide who will add the additional service type.



Diagnosis

Primary DX
No Dx on File

FAQs:

Q: The widget on the first page of the chart, shows in red "no diagnosis on file". However, we did completed the assessment and diagnosis.

A: You have selected a diagnosis without a DSM-5 diagnosis, which is needed.

Billable Diagnosis: https://www.smchealth.org/sites/main/files/file-attachments/billabledx-enclosures_2_in_18-053_icd-10.pdf?1597249807

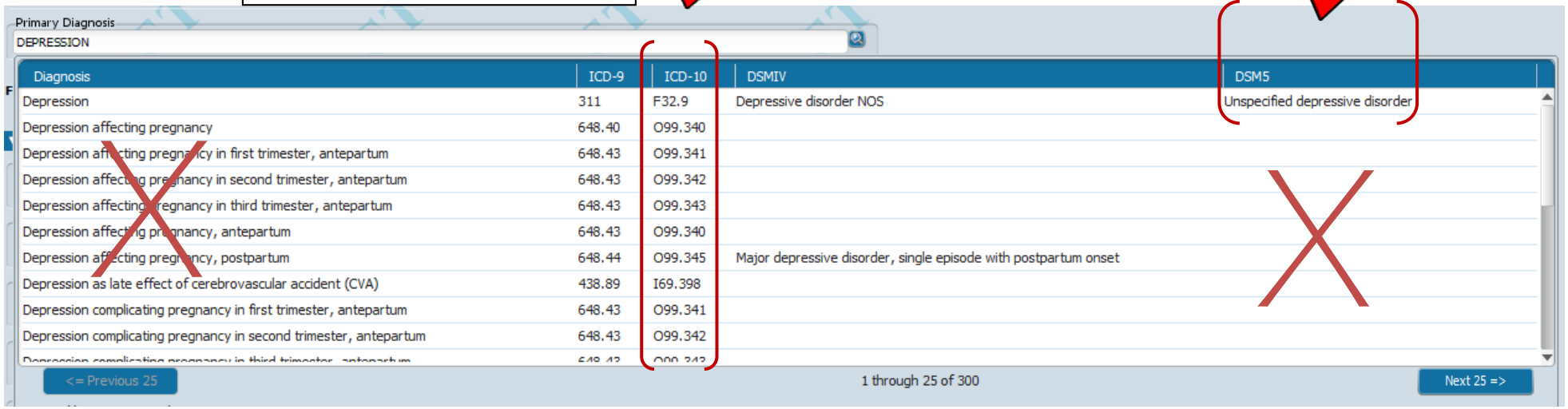
Pro Tip

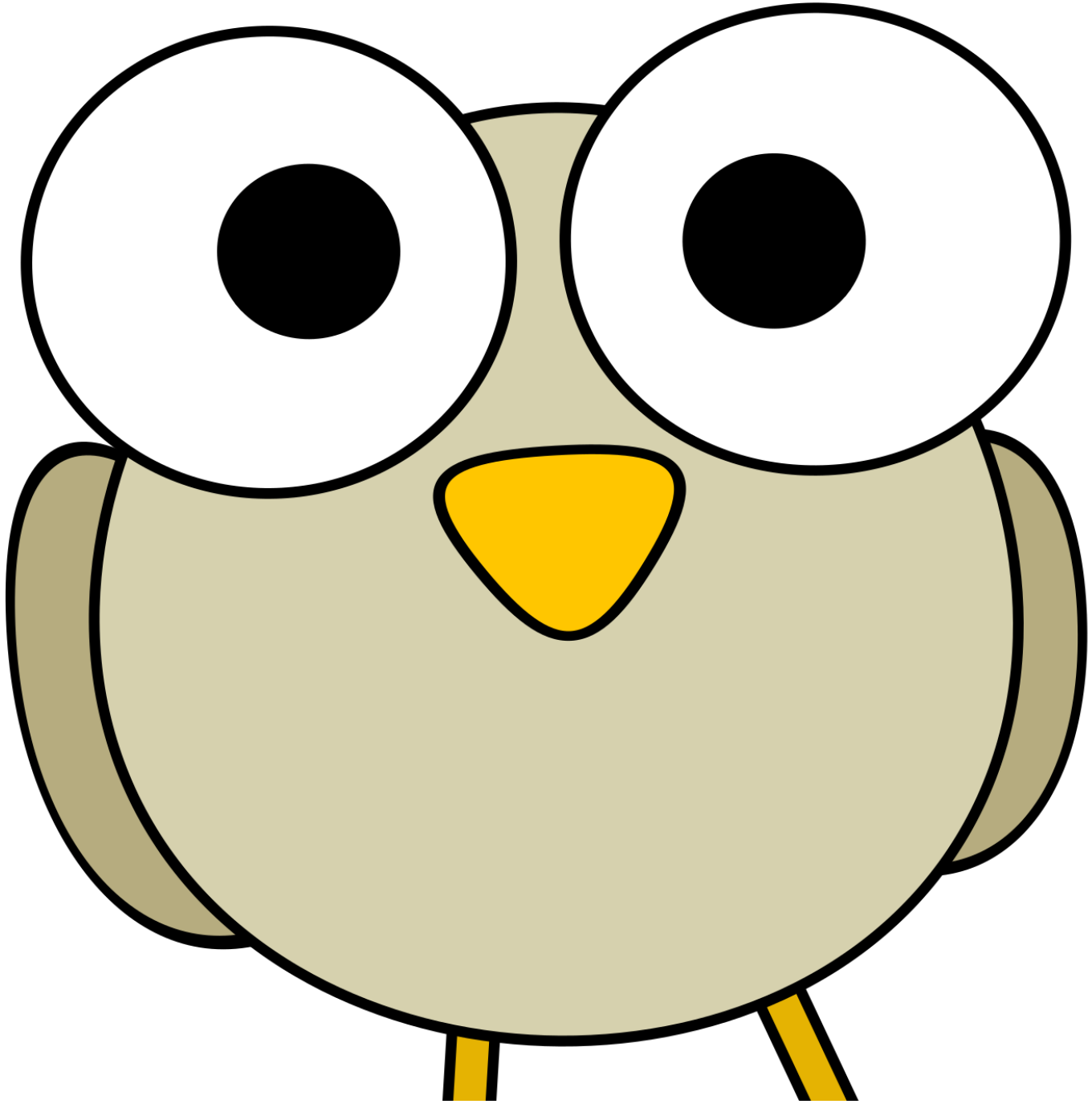
To correct a diagnosis, complete the **Reassessment**, check **Update**, and fill in the diagnosis AND include symptoms that meet criteria for diagnosis.

- Unspecified Mental Disorder F99 is not billable - DO NOT USE
- SELECT ONLY Diagnoses that have a DSM-5 diagnosis descriptor
- Check the ICD10 codes if you are not sure if it is billable, see attachment.
- Notify HS_BHRS_ASK_QM@smcgov.org if there is no billable diagnosis

Look at this column for ICD-10

Look at this column for DSM5





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