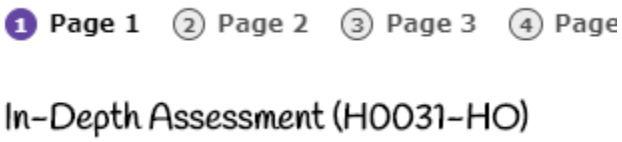
DOCUMENTATION: THERAPY INTAKE ASSESSMENT

Enter the basic information:

- Client ID
- Client's Name (make sure it's not misspelled = must match EHR)
- Session Date
- Start Time
- End Time
- Age
- The duration and number of units will auto-calculate
- Where the session took place
- Who participated in the session (client, parent? Someone else was there too?)

Note – The service code at the top of the page will change to the appropriate code once you select the setting and the client's age.



Complete the checklist of presenting problems.

Then use narrative to put in detail what exactly the problems are. Include client/parent quotes.

How does the client perceive his/her problems?

- In a simple sentence, tell us if the client is aware of the problem, doesn't care, etc.

Based on the age of the client, you will then need to complete the sections that populated.

- Please be as specific as you can.
- If nothing applies, be professional and write out "Not applicable to this client".
- Make sure the sections have enough content to be acceptable.
    - For example, for family functioning, explain how the family interacts with each other, problems ,etc.
    - For educational history, tell us what school the client is in, what grade, what kind of grades he gets, discipline issues, learning problems, etc.

Complete the mental status exam.

Summary of Findings.

- This is a narrative summary of all the sections above.
- Write 5 or 6 sentences summarizing the problem and identifying important information about the case.

Summary of Findings *

What does the client or parent want from our services?

- Ask the client/parent… what do you want out of counseling?

Desired Services or Outcomes from the client's point of view:

Indicate what the Primary Diagnosis is. Write the ICD-10 code + the name. --- "F90.1 – ADHD - xxxx"

- If you are not licensed, that's OKAY, this would be a "provisional" diagnosis until the licensed person completes the LE form, and later you complete the Master Treatment Plan.

Enter a secondary diagnosis if necessary.

- Here you can enter diagnosis from history, meaning ones that were previously given.

Primary Diagnosis

Secondary Diagnosis (if any)

Justification for Diagnosis

Complete The Justification for Diagnosis

- TIP – Have a word file with all the DSM-5 criteria for the most common diagnoses.
- So, for ADHD, for example, you would just copy/paste the ADHD criteria here, and then adjust accordingly to what the client is showing as far as symptoms.

Select the plan – Individual therapy? TBOS? PSR?

Complete your name, credentials (e.g. LMHC), Sign your name, and date it.

Click NEXT

Complete the CFARS/FARS.

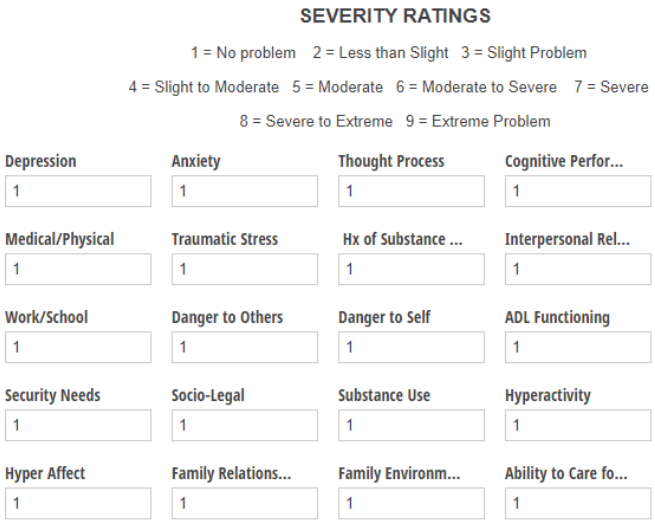
Enter the basic information:

- Start Time
- End Time
- Where the session took place
- Leave it as INITIAL

* Note – The CFARS is the same form as the FARS. If something doesn't apply to your client, enter 0, or 1 for checklist.

For example…

in-home behavior does not apply to adults, so put 1 for that one if you are doing an adult intake.



Complete the severity ratings for each area:

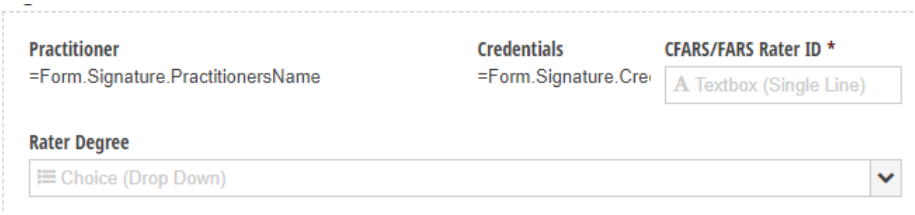
- You will want to stick to between 4 and 7.
- Anything below 3 is not worth having therapy.
- Anything over 8, then the client should probably be hospitalized to a residential setting.

Enter the number of school days available in the past 30 days (usually 22), and the days attended.

Was the client admitted to DJJ? Press Yes or No.

Total number of days spent in the community in the past 30? Usually 30 unless client was in residential setting.

Enter your CFARS/FARS ID and select your Rater Degree.



Sign your name.

If you are not licensed, you will SUBMIT the intake assessment.
Then you will contact the licensed person assigned to that case, and you'll let them know to complete the LE.

If you are not licensed,
You will now SUBMIT the "Assessment NL"
(and remember to save a copy of the file – instructions later on)

If you are licensed,
Click NEXT

You will now complete the Master Treatment Plan.

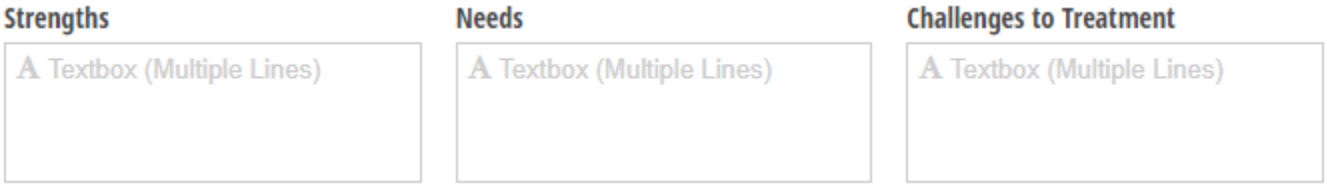
If you are not licensed, you must complete the separate file called "Master Treatment Plan" on the website.

- You must do this AFTER the LE is completed, and the licensed person either confirmed your diagnosis, or gave you a new one for the Master Treatment Plan.

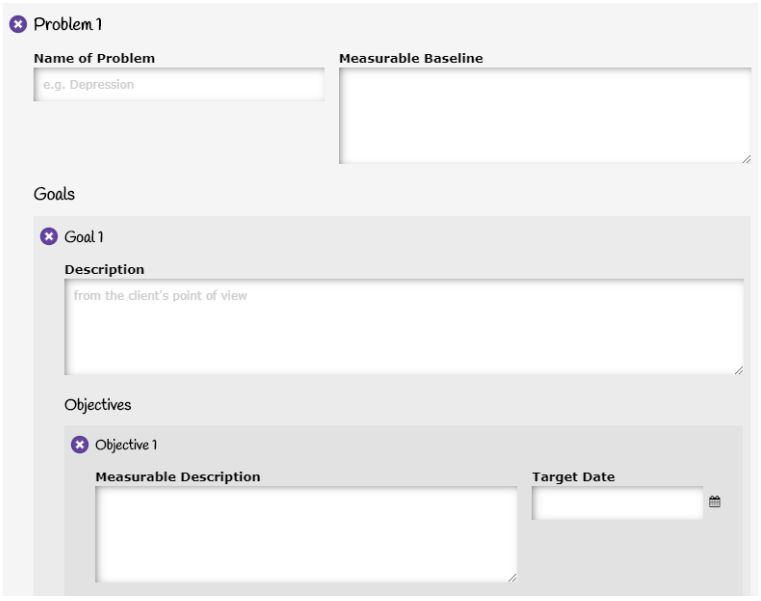
Enter the basic information:

- Session Date
- Start Time
- End Time
- Where the session took place
- Enter the diagnoses if not already populated.

Complete the following 3 text boxes with the appropriate response:



Problems – Goals – Objectives



Each client should have <u>at least 1 Problem</u>, to a max of 3, maybe 4.

Each Problem should have <u>at least 1 Goal</u>.

Each Goal should have <u>at least 3 Objectives</u>.

Name of the Problem

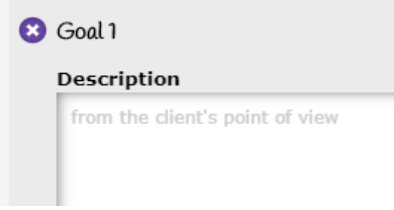
- Use the Bio-Psychosocial Checklist
- Examples – "Defiance". "Depression". "Anxiety". Those are the problems.

Measurable Baseline

- For Defiance, for example, how many times a week is the client experiencing this problem.
- *"Client curses, talks back, and shows disrespectful behaviors at least 15 times a week, as reported by the parent and by the teachers".*
    - *Client curses, talks back, and shows disrespectful behaviors* ← *it describes what kind of defiance*
    - *at least 15 times a week* ← *it quantifies the number of instances and the frequency*
    - *as reported by the parent and by the teachers* ← *it tells you WHO thinks this*

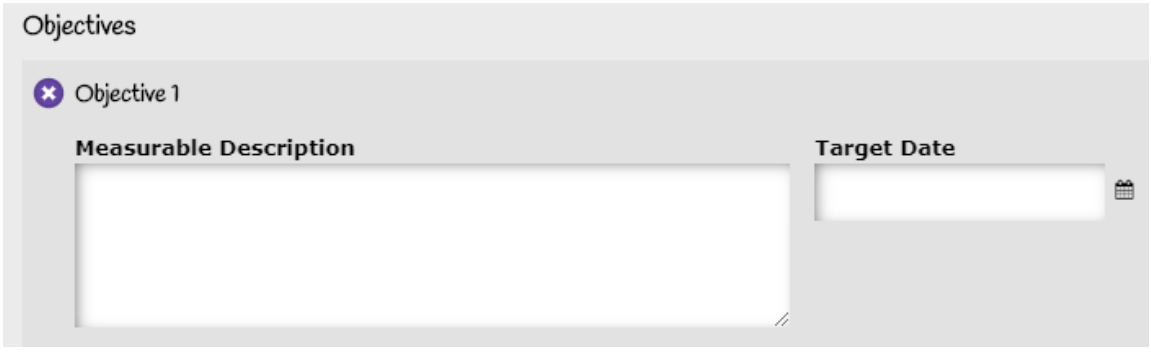
The Goal

- Always from the client's point of view, even with quotations.
- Example: "*I want Johnny to learn how to behave around others and stop all disrespect – Mother stated"*
- Goal should be generalized (later, the objectives will be measurable).



The Objectives

- Objectives are specific. They are measurable & need to follow this 3-part format (to make Medicaid happy).
- You should have at least 3 objectives per goal.



- The target date for each objective should be 6 months from the date of the plan.
    - e.g. Treatment Plan date = 01.01.20, then target dates should be 07.01.20

- Example

"Johnny will learn at least 4 anger management techniques per week, over the next 6 months, as reported by the parent or self-reported by the client himself".

- *Learn at least 4 anger management techniques* ← *it QUANTIFIES it and says WHAT they need to do*
- *per week, over the next 6 months* ← *shows frequency and duration*
- *as reported by the parent or self-reported by the client himself* ← *it tells you how you would know*

- More Examples (for additional examples… see Cheat Sheet…. But never use the same objectives over and over and over and over for all the clients!!! – Always tweak them somewhat)

  Client will reduce depressed mood down to 0 x per week over a period of 6 months, as reported by client, guardian, or observed by the clinician.

  Client will learn and role-play 4 ways to feel happier about her life, over the next 6 months, as reported by the client during sessions with the clinician.

  Client will explore and verbalize at least 5 triggers of depressed mood in the next 5 months, as evidenced by discussions with clinicians and as reported by client.

The Discharge Criteria should be a small narrative about "what needs to happen for the client to be discharged".

Complete the Service Grid

- Individual Therapy You should put **4** units per week

- TBOS You should put **8** units per week
  - Even if TBOS is requested, you can leave IT with 4 units
  - Because if we don't get "insurance authorized" for TBOS, then at least we have IT to use.
  - You can also start off with IT, and then utilize TBOS.
  - Important TIP
    - You should NEVER go back and forth using IT and TBOS.
    - For example, you should never bill IT one week, and then TBOS for a while, and then go back to IT, then TBOS again.

- If you are recommending PSR or Group, then enter 4 units for Group, and 12 for PSR.
- You are authorizing all of the services "clinically".
- If the insurance company requires an authorization for these, then we'll need to authorize them too.

TBOS or PSR Certifications

- If you selected TBOS, or PSR in the grid, you need to "justify" why.
- Complete the select certifications as needed.
- Pay attention to make sure you are checking-off what's needed.

Complete your name, credentials (e.g. LMHC), Sign your name, and date it.

Upload any files if necessary (e.g. drawings, client reports, etc.).

DON'T FORGET TO MAKE SURE THE CLIENT, AND THE PARENT, SIGN AND DATE THE TREATMENT PLAN SIGNATURE PAGE (WHICH WAS INCLUDED IN THE NEW CLIENT INTAKE PACKET)!!!

SUBMIT the Intake Assessment (or Master Treatment Plan if unlicensed).
(if you are doing an intake for someone else, save the file – instructions later on in this PDF)

Can I do an individual session with the intake?

YES!

You can do an individual session, and bill a note for H2019-HR,
after you are done with your Medicaid intake.

DO make sure, in the progress note, that you address the problems or concerns related to your case's treatment plan, even if not yet fully developed.

DOCUMENTATION: LEs

This section applies to those licensed counselors who do Les for others.

The purpose of the LE (licensed evaluation) is to verify the diagnosis given by the non-licensed counselor during the intake, to verify the presenting problems, making sure the client is a real person, etc. It is a simply 8–10-minute (1 unit) call. We recommend you text and/or call the client and let them know you need to schedule this short meeting to approve the services for the counselor who is on the case.

You must complete the LE within 14 days.

Enter the basic information:

- Client ID
- Client's Name (make sure it's not misspelled = must match EHR)
- Session Date

- Start Time
- End Time
- The duration and number of units will auto-calculate
- Where the session took place
- Who participated in the session (client, parent? Someone else was there too?)

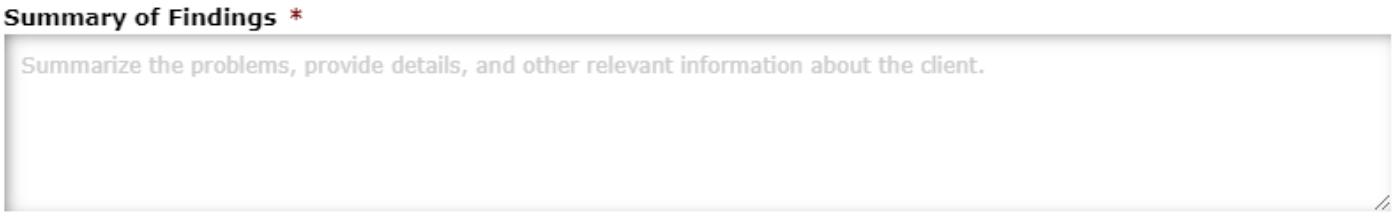
Address which presenting problems the client talked about.

- You CAN indicate many problems here, but the MAIN problems will become part of the treatment plan.
- Consult with the Bio-Psychosocial done by the intake clinician.

Complete the Suicidal Risk check.

Summary of Findings.

- Here is where you will use a narrative form to summarize the problem(s).
- Be specific as possible.
- Include anything relevant that the client/family discloses, even if not directly related to the problem.
    - e.g. Client attends school and is in 6th grade; client's parents are divorce, etc.



Complete the Mental Health Status

Indicate what the Primary Diagnosis is. Write the ICD-10 code + the name. --- "F90.1 – ADHD - xxxx"

Enter a secondary diagnosis if necessary.

- Here you can enter diagnosis from history, meaning ones that were previously given.

Select the Plan (Outpatient Services).

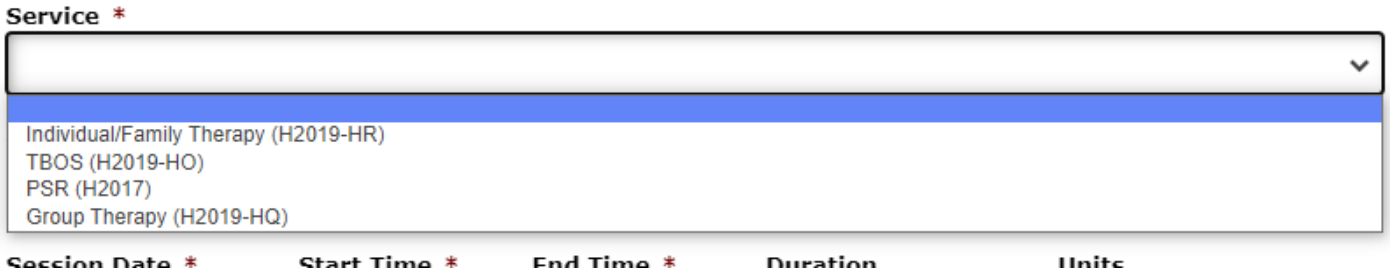
Complete your name, credentials (e.g. LMHC), Sign your name, and date it.

Upload any files if necessary (e.g. drawings, client reports, etc.). >>>>>> Press Submit Note.

Let your colleague (the intake clinician), know that it's been completed, and what the diagnosis is, so that he/she can proceed to complete the treatment plan for the client. Please do this right-away so you do not forget.

DOCUMENTATION: THERAPY PROGRESS NOTES

When you select Progress Notes, it will prompt you to select the correct type that you want to use:



Based on your selection, the template changes to show the required items for that note.

Enter the basic information:

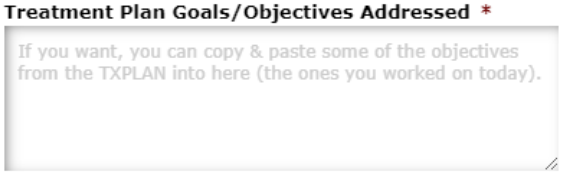
- Client ID
- Client's Name (make sure it's not misspelled = must match what we have on file)
- Session Date
- Start Time
- End Time
- The duration and number of units will auto-calculate
- Where the session took place
- Who participated in the session (client, parent? Someone else was there too?)
- If it was a group therapy or multiple-client PSR session, indicate the number of people in the group.

Check the appropriate problem(s) that was discussed TODAY.

- This should something from the client's treatment plan.
- Example, if the client's problems for the treatment plan are: Defiance, Depression, and Social Skills, then at least one of these must be checked off when you write a note. You would NOT want to select Eating Disorder, for example.
- If PSR… then you have to check the PSR activity done today.

Treatment Plan Goals/Objectives Addressed

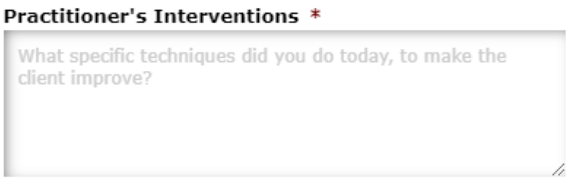
- An easy way to do this is to copy & paste some of the objectives from the TXPLAN into here (the ones you worked on today). For this, you'll need the client's treatment plan opened in another window. You should save a copy of the treatment plan so you can have it on your computer.
- Otherwise, you should write-in the specific objectives that you worked on.



TIP – you can enlarge the text boxes by clicking on the bottom-right drag-icon.

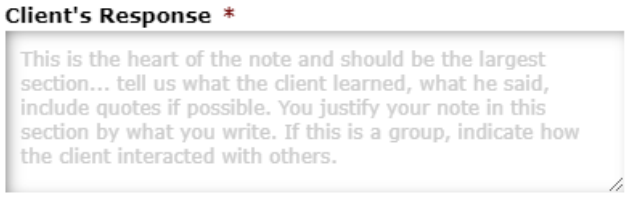
Practitioner's interventions

- What specific techniques did you do today, to make the client improve?
- Medicaid wants to know what you did. Cognitive behavioral therapy? Role playing? Be as specific as you can be in this section.
- In a group setting, what you write here should ideally be the same for all clients in the group.



Client's Response

- This is the most important part of the note, so it should be the section with the most content.
- Tell us what the client learned, what he said, include quotes if possible.
- You justify your note in this section by what you write.
- If this is a group, indicate how the client interacted with others.



Pr nt is improving (or not) towards his goals.

Complete the Suicidal Risk Check and indicate if the client had Homework.

The Plan for next time, should be something like "Continue therapy as scheduled, sessions scheduled for next week"

Complete your name, credentials (e.g. LMHC), Sign your name, and date it.

Verification of Services

- Remember to have the client sign the Verification Form on our website (in their computers, on your phone, tablets, etc.) – They can access it from anywhere.

Upload any files if necessary (e.g. drawings, client reports, etc.). >>>>> Press Submit Note.

DOCUMENTATION: TREATMENT PLAN REVIEWS/ADDENDUMS

A Treatment Plan Review (TPR) is billable.

A Treatment Plan Addendum (Addendum) is not billable, but it is used to update something in between TPRs.

At the very top, you can select a TPR or Addendum, and the boxes change depending on your selection.

The Addendum is supposed to be to change/add services in the grid, add a new clinician. Everything else you should do a TPR.

Enter the basic information:

- Client ID
- Client's Name (make sure it's not misspelled = must match EHR)
- Where the session took place
- Session Date
- Start Time
- End Time
- DOB
- Age
- Who participated in the session (client, parent? Someone else was there too?)

The Review Period

- Is always FROM the date of the last TPR (or Master TP)….
- TO today's date (the date when the TPR is done).

Indicate what the Primary Diagnosis is. Write the ICD-10 code + the name. --- "F90.1 – ADHD - xxxx"

Enter a secondary diagnosis if necessary, and whether they have changed.

IF they have changed from the last TPR (or Master TP), then enter the Justification for the diagnosis.

- TIP – Have a word file with all the DSM-5 criteria for the most common diagnoses.

- So, for ADHD, for example, you would just copy/paste the ADHD criteria here, and then adjust accordingly to what the client is showing as far as symptoms.

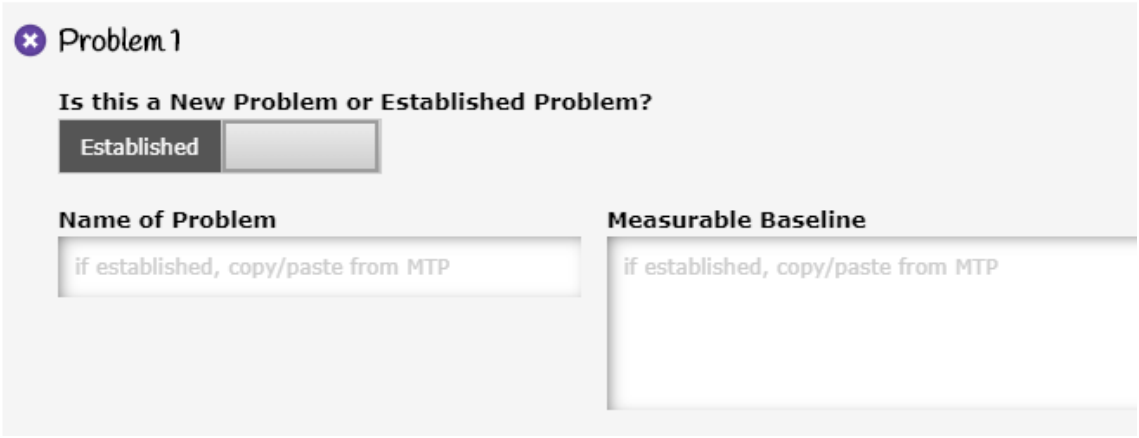
Complete the Findings of Current Symptoms

- Focus on the behaviors and symptoms that the client is going through on the past 5-6 months
- It's OK to write other information, but don't leave the past 5-6 months out.

Complete the Strengths, Needs, and Challenges to Treatment since the last TPR or Master TP was written.

Next you will go over the status of each problem/goal/objective.

For each problem, indicate if it's an existing problem, or a new one.
Established = it was in the previous TPR or Master TP already.

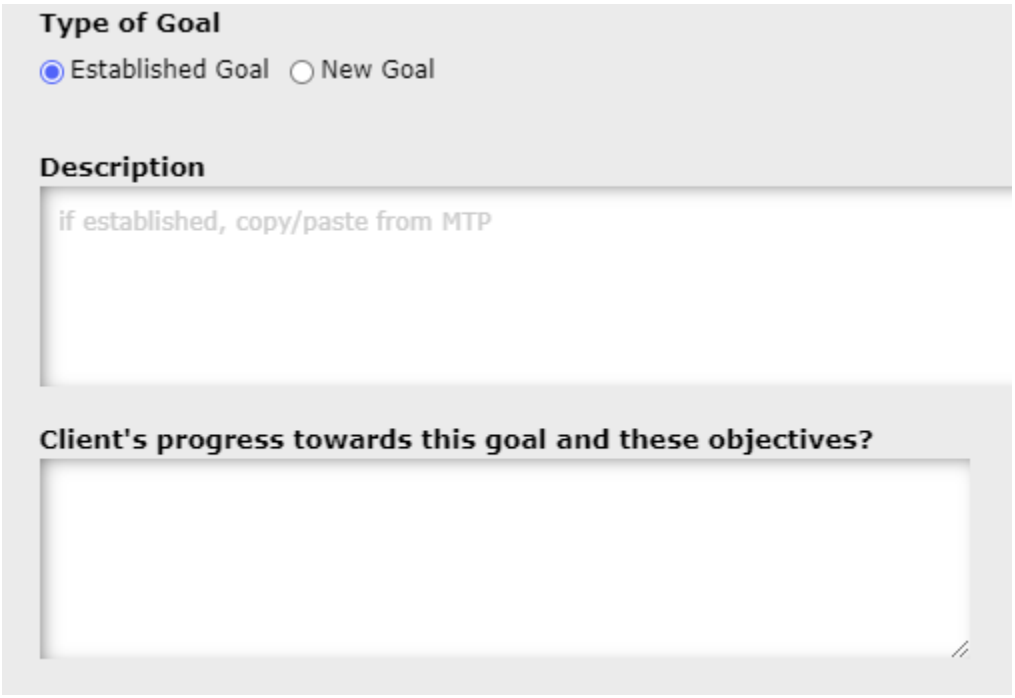


Type-in the Name of the problem and the measurable baseline

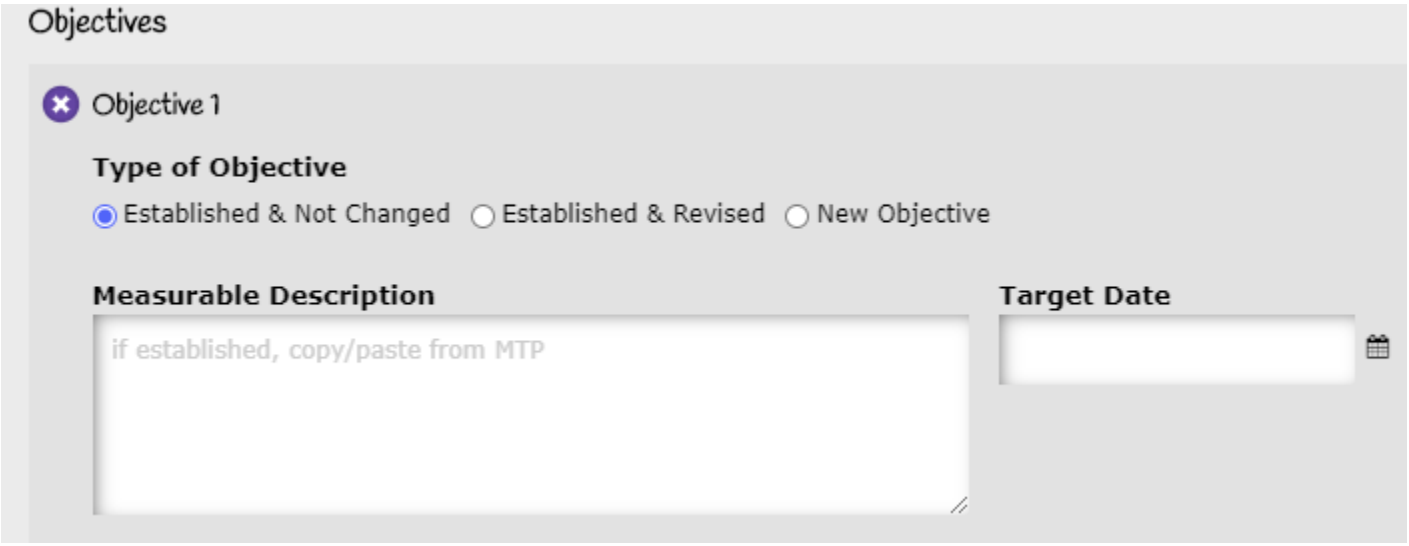
- if established problem, copy/paste the info from the Master Treatment Plan

Goals

- Is the goal established last time, or a new one? Enter it in the Description Box.
- If established, you will see an extra box, to enter the PROGRESS towards that goal and those objectives to follow.
    - How is the client progressing or not progressing in this goal?
    - Be specific.



Objectives



- Established & Not Changed = you had these objectives before and you're not changing them.
- Established & Revised = you had these objectives before, and you ARE adjusting them somewhat.
- New Objective = you are adding a new objecting under the goal.

- It is recommended that you always adjust AT LEAST SOME of the objectives somewhat.
  - e.g. "…..15 times a week…." to " ….10 times a week…"

Remember how to write the objectives in Medicaid-compliant fashion:

"Johnny will learn at least 4 anger management techniques per week, over the next 6 months, as reported by the parent or self-reported by the client himself".

- *Learn at least 4 anger management techniques* ← *it QUANTIFIES it and says WHAT they need to do*
- *per week, over the next 6 months* ← *shows frequency and duration*
- *as reported by the parent or self-reported by the client himself* ← *it tells you how you would know*

Target Date = 6 months from today's TPR date.

ALWAYS KEEP CONSISTENCY!

GOAL # 1 IN TPR	SHOULD =	GOAL # 1 IN MASTER TREATMENT PLAN
OBJECTIVE # 2 IN TPR	SHOULD =	OBJECTIVE # 2 IN YOUR LAST TPR

- The point is…. Don't go around changing the goal/objective numbers.
- If you need to add a new objective, you should click on "Add Objective". Same with Goals.

Complete Recommendation box.

The Discharge Criteria should be copied from Master Treatment Plan, or adjusted if needed to be.

Complete Progress Towards Discharge.

Complete the Service Grid

- Individual Therapy You should put **4** units per week

- TBOS You should put **8** units per week
  - Even if TBOS is requested, you can leave IT with 4 units
  - Because if we don't get "insurance authorized" for TBOS, then at least we have IT to use.
  - You can also start off with IT, and then utilize TBOS.
  - Important TIP
    - You should NEVER go back and forth using IT and TBOS.
    - For example, you should never bill IT one week, and then TBOS for a while, and then go back to IT, then TBOS again.

- If you are recommending PSR or Group, then enter 4 units for Group, and 12 for PSR.
- You are authorizing all of the services "clinically".
- If the insurance company requires an authorization for these, then we'll need to authorize them too.

TBOS or PSR Certifications

- If you selected TBOS, or PSR in the grid, you need to "justify" why.
- Complete the select certifications as needed.
- Pay attention to make sure you are checking-off what's needed.

Complete your name, credentials (e.g. LMHC), Sign your name, and date it.

DON'T FORGET TO MAKE SURE THE CLIENT, AND THE PARENT, SIGN AND DATE THE TREATMENT PLAN SIGNATURE PAGE. THIS MUST BE UPLOADED TO THE TX PLAN REVIEW – ASK MIRIAM TO GIVE YOU A PDF COPY OF THE CLIENT'S SIGNATURE (PSYCHIATRY@LUKASCOUNSELING.ORG)

SUBMIT the Review/Addendum

DOCUMENTATION: TCM

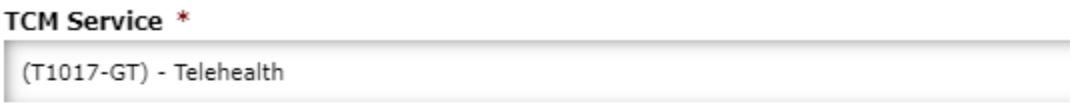
This applies to Case Managers only.

TCM must complete Assessment and Service Plan within **30 days**

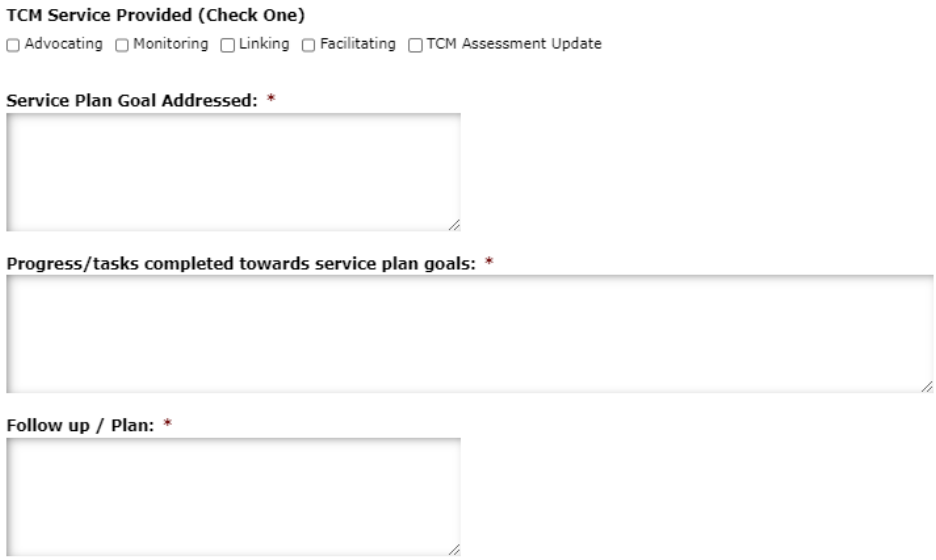
The Service Plan **MUST** be completed within **7 Days** of the Assessment.

Unless you are doing a non-billable note or discharge note, then the main 3 tabs you will work with are these:

- Select the correct bill code.
- Enter the Client ID and Name (look at your spreadsheet to make sure you get the right Client ID).
- DOS, Times (duration & units auto-calculate).
- Location.
- Persons Present.

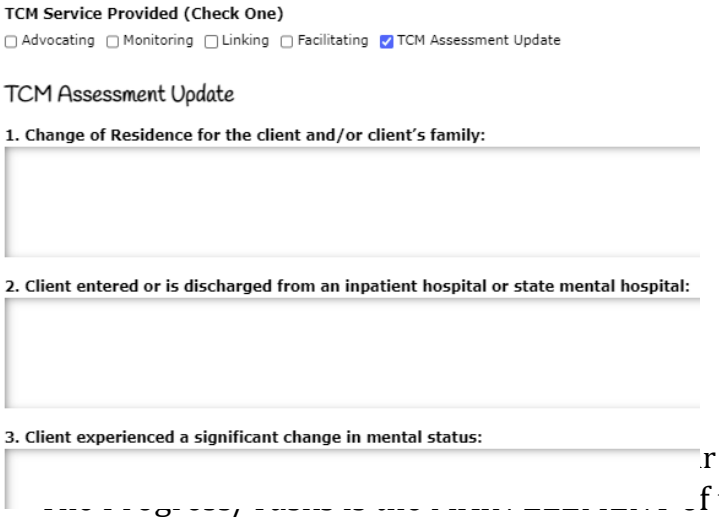


Then there's the body of the note:



Note

If you select "TCM Assessment Update" (the one you do annually), then a new set of DIFFERENT options/fields will open up to complete the assessment update.



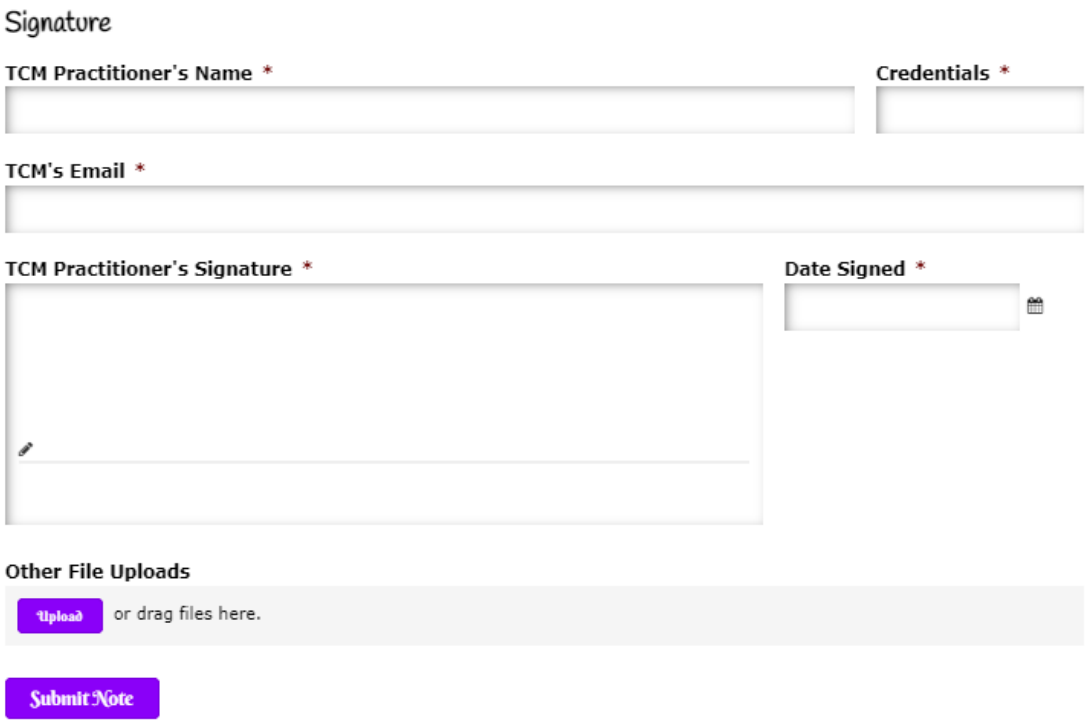
r SP – which you should keep a Word copy of it).

f the note.

- Be Specific
- Be Descriptive
- Someone looking at your note needs to 100% figure out what you did based on this data

- Follow-Up/Plan

Signature, Email, and Credentials

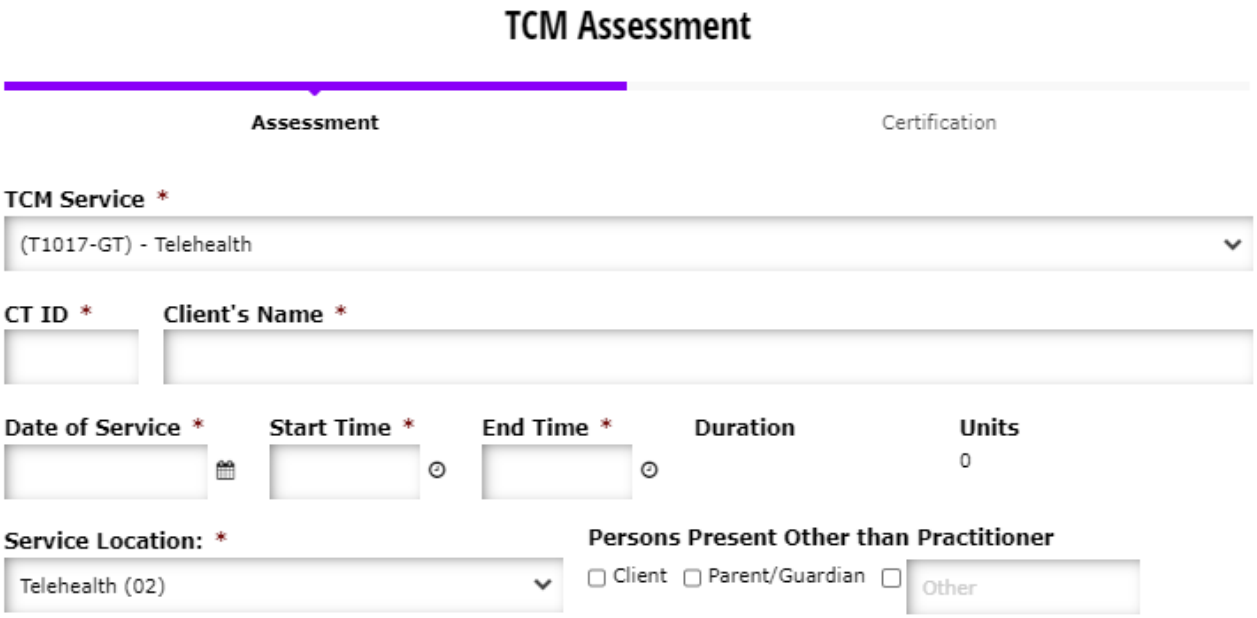


When you are done, press SUBMIT NOTE.
You will receive a confirmation page – (if you don't get one, it means your note didn't go through!)

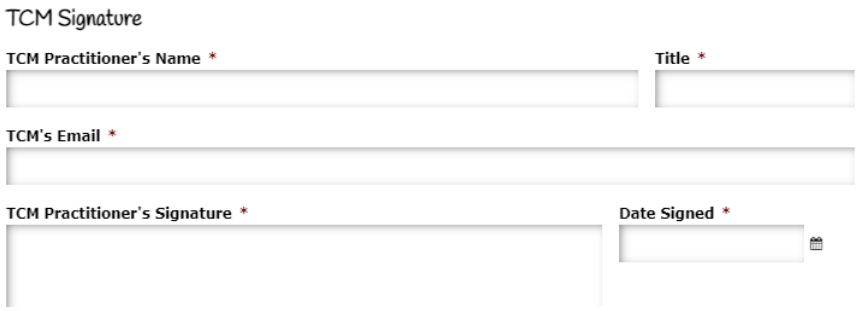
ALWAYS MAKE SURE YOU ARE ON WIFI BEFORE YOU SUBMIT A NOTE!
THIS WILL PREVENT YOU FROM HAVING TO REPEAT YOUR WORK!

TCM ASSESSMENT & SERVICE PLANS

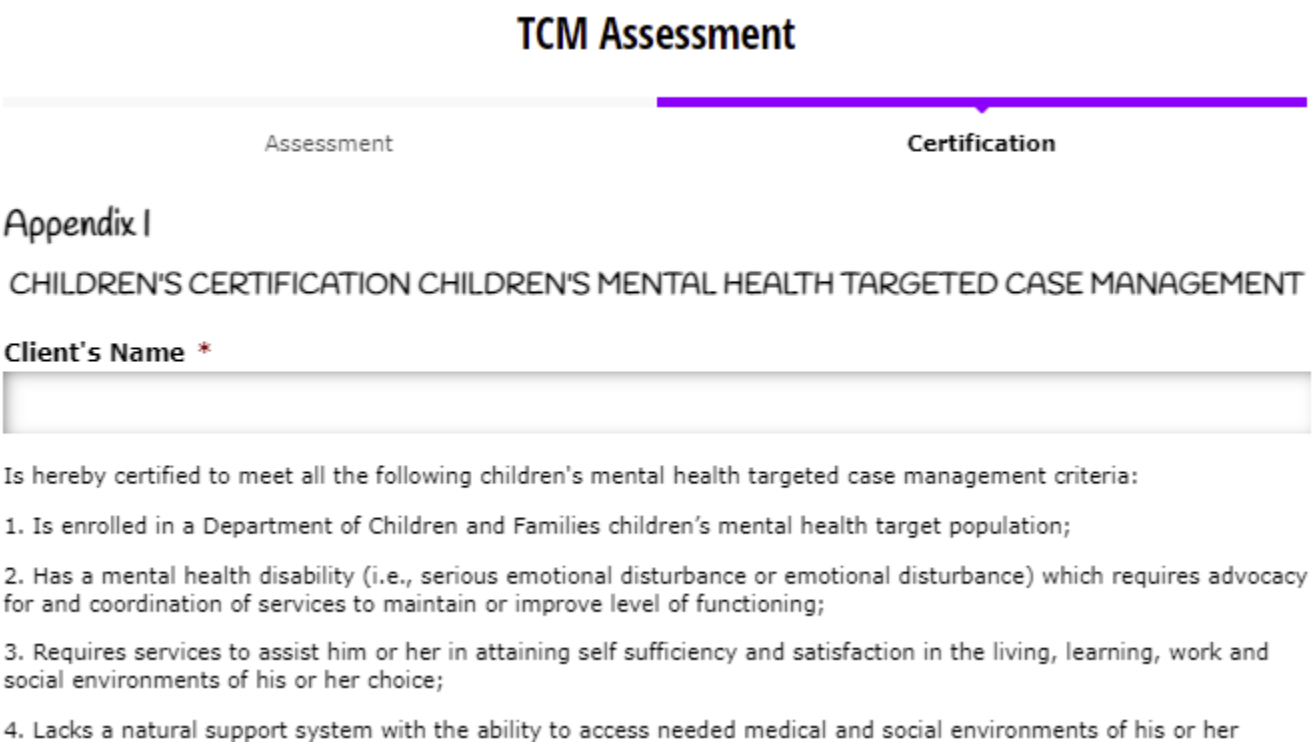
- The initial assessment has 2 sections (assessment and certification)



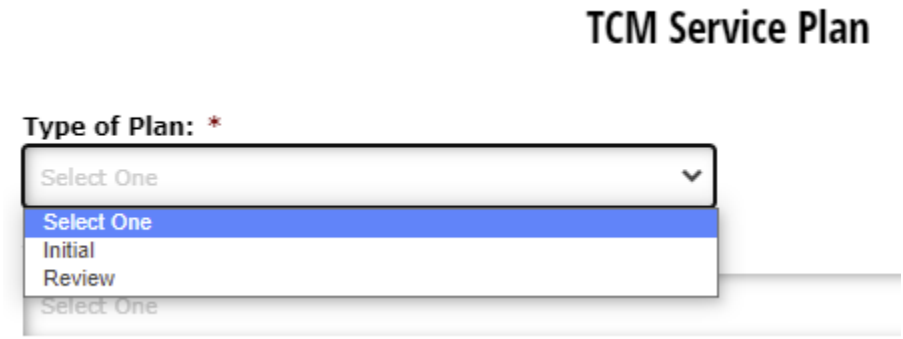
- **YOU DO NOT NEED TO CREATE A SEPARATE PROGRESS NOTE WHEN BILLING THE ASSESSMENT OR THE SERVICE PLAN (OR SERVICE PLAN REVIEWS).** BY CREATING THE DOCUMENT, IT AUTOMATICALLY BILLS IT FOR YOU AS LONG AS THE FIELDS ABOVE ARE COMPLETED.
- Complete all fields as always.
- Signature, Date, Your Title (Case Manager) etc.



- Page 2 is Medicaid's Certification. Depending on the age of the client, it will auto-populate the appropriate one.

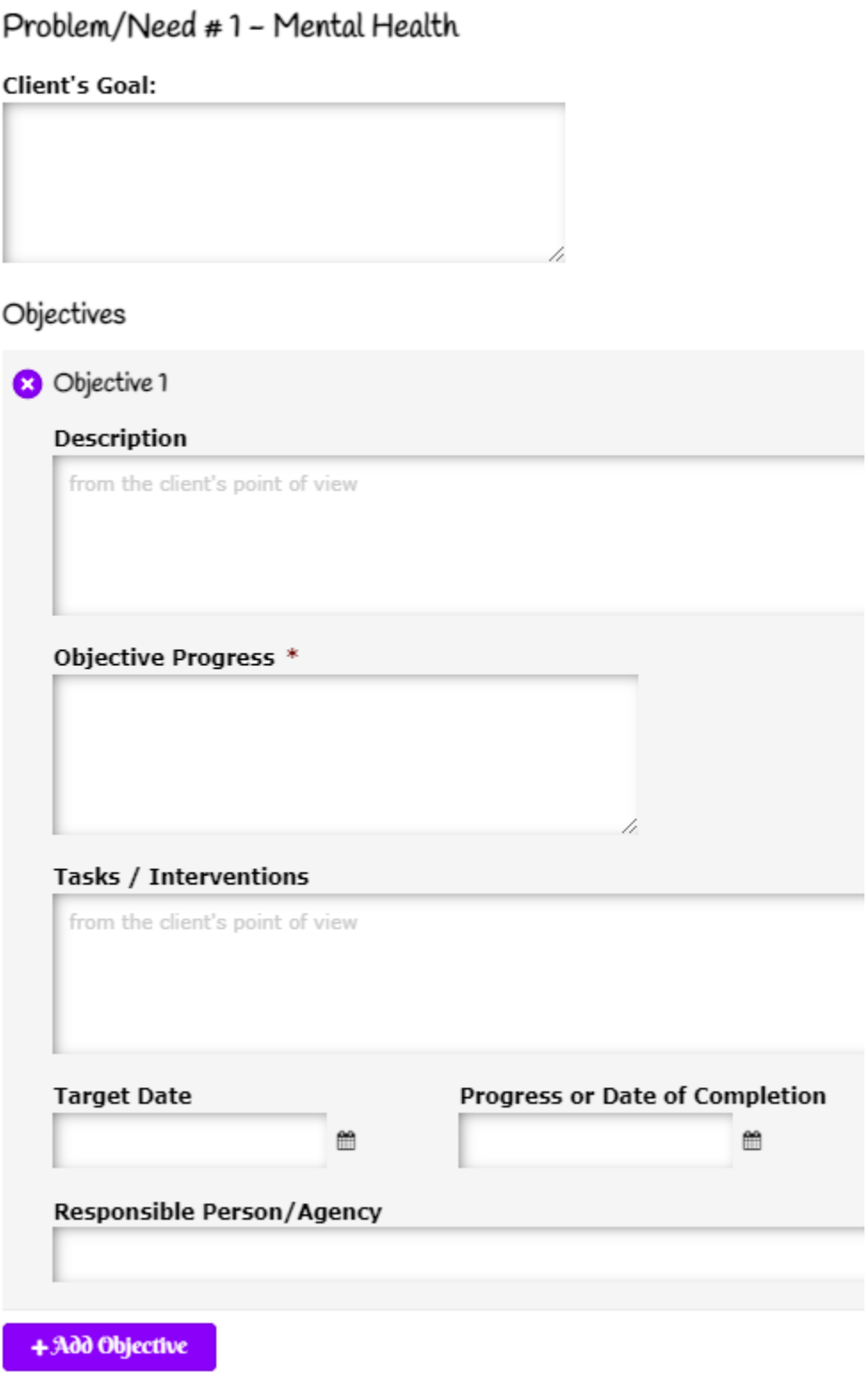


- When you do the service plan, it will as you whether it is the initial or the review. And based on that, different fields will auto-populate.



- Complete the required fields:

For each of the 9 needs – you can add objectives by pressing the purple boxes:



- Again, put your name, sign, date, etc. at the end of the service plan.
- **Both the ASST and SP will automatically go to THE TCM SUPERVISOR for review.**

For service plan reviews –
DON'T FORGET TO MAKE SURE THE CLIENT, AND THE PARENT, SIGN AND DATE THE SERVICE PLAN SIGNATURE PAGE. THIS MUST BE UPLOADED TO THE SP PLAN REVIEW – ASK MIRIAM TO GIVE YOU A PDF COPY OF THE CLIENT'S SIGNATURE (PSYCHIATRY@LUKASCOUNSELING.ORG)