Network Provider
Care Plan Development
Guideline

September 21, 2015

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Introduction

We recently revised our Client Care Plan form and each new referral and authorization we send will include the new form. I previously sent the form to you by email as a fillable PDF document, which we encourage you to use to type your Care Plans on your computer. In the very near future, we will be scanning your Care Plans into our Electronic Health Record, so legibility will be even more of a concern.

As always, please feel free to contact us with questions or concerns:

Elaine Palacios, MRT, 781-1566, Authorization and Care Plans

Louise Mendez, 781-1559, Billing and Credentialing

Amanda Getten, LMFT, 781-4881 Clinical or programmatic questions

Medical Necessity:

MediCal reimburses us for services that meet "medical necessity." If the answer to each of the following questions is YES, then medical necessity is met.

1a) Does the client have an included primary diagnosis? Not every diagnosis in DSM is considered included by Medi-Cal. Medi-Cal targets specific diagnostic categories and excludes others. Nearly all mood, anxiety, psychotic, adjustment and disruptive behavior disorders are included. Some excluded primary diagnoses are substance abuse/dependence/intoxication, Mental Retardation and Learning Disorders, Delirium/Dementia, Disorders due to General Medical Conditions, Autistic Disorder and Antisocial Personality Disorder. A comprehensive list of included diagnoses can be found in your Network Provider handbook.

1b) Do the presenting symptoms support the primary diagnosis? The Client Care Plan contains a list of symptoms for you to rate. While it may seem overly picky to rate each symptom a client experiences, chart auditors always look at what is written explicitly, not assumed or implied. Attention to this level of detail can make the difference between billable services and those which are disallowed.

2) Does the client have at least one moderate to severe impairment in any of the four areas of Life Role Function due to mental illness? (A client may also qualify if lack of treatment is likely to result in a significant deterioration in functioning or, for kids, a likely failure to develop normally.) Both parts of this question are crucial.

First, it is not enough to have a diagnosis – a client also must have a significant impairment to qualify for services.

Second, the impairment must be because of the mental illness – we do not treat addictions or medical conditions. For example, a client who is disabled due to a severe back injury might have a very severe occupational functioning impairment, but it is due to his medical condition. However, if the back injury results in depressed mood and symptoms of withdrawal/loss of interest or energy which make it difficult for him to seek work, then his depression could result in some level of occupational impairment. Well-written care plans make a direct connection between the symptom and the resulting impairment.

3) Is the proposed intervention likely to diminish the impairment or reduce the frequency/intensity of presenting symptoms? We answer this question based on the interventions you select to utilize in treatment. We want to see a connection between what you are trying to do and the problems presented by the client. We are looking for evidence based practices and active interventions designed to help a client cope and manage their illness more effectively.

4) Would the condition not respond to physical healthcare-based treatment alone? Specialty mental health services, whether provided at a Mental Health clinic or in a Network Provider's office, are reserved for conditions which would not respond to a visit to a primary care physician for medication only. For conditions which respond well to medication, a well written Client Care Plan documents how therapy can help a client in ways medications alone cannot.

As we review the Client Care Plans you submit, we are looking to see that you've clearly answered each question. Your careful completion of the Client Care Plan provides the documentation we need to bill MediCal for your services and to pay you for the services you provide.

Step by Step Client Care Plan Directions

(1) Total of sessions to date equals the number of times you've seen the client for therapy so far; case management units can be left out of the total.

(2) Current DSM 5 Diagnosis: .

1. Please use the DSM taxonomy number and name (common abbreviations are fine, i.e., ADHD, PTSD, etc.).
2. Include DSM qualifiers as needed (i.e., Bipolar Disorder, Mixed, Moderate or Major Depression, Recurrent, Severe w/psychotic features).
3. You can change a diagnosis, but be sure the symptoms you rate support it fully!

(3) Current Symptoms: Rate the symptoms your client experiences. As mentioned, be sure you've endorsed symptoms which support your primary diagnosis. If some symptoms are well controlled by medication, you can still list the symptom and say "controlled by meds." For example, if you are treating a client with the diagnosis ADHD, Combined Type, whose medication helps control the symptoms fairly well, the grid might look like this (I used green type to improve readability, but you do not need to do so!):

__ Bullies others (3) __ Fighting __ Cruel to animals __ Cruel to people __ Criminal behavior __ Fire setting __ Property destruction __ Burglary __ Runs away __ Truancy __ Other	__ Easily annoyed __ Annoys others __ Holds grudges __ Argues with adults __ Often angry __ Defiant __ Spiteful __ Loses temper __ Other __ Other	_2_ Poor attention to details _2_ Poor attention _1_ Does not seem to listen _2_ Poor follow through _1_ Poor organization _1_ Avoids tasks requiring sustained mental effort __ Loses things _2_ Easily distracted *Symptoms are partially controlled by meds*	__ Forgetful _1_ Fidgets _2_ Leaves seat __ Runs / climbs inappropriately _1_ Can't play quietly _2_ On the go __ Talks excessively _2_ Blurts out answers __ Interrupts _2_ Problems waiting turn __ Other	__ Tense __ Restless keyed up __ Irritable __ Excessive worry __ Unable to control worry __ Panic attacks __Agoraphobia __ Obsessive thoughts __ Compulsive behaviors __ Nightmares __ Other

Life Role/Functional Assessment: We recently made some changes to this section of the Client Care Plan, which we hope will make it clearer. If you use Clindox, your page one will not change, but the information and examples below may still be useful to you.

(4) If a functional impairment is present in this category, check the box indicating whether the impairment is primarily due to mental illness, substance abuse or medical conditions. Please select only one. If no impairment exists in this category, leave the boxes blank.

(5) Check the box indicating the level of impairment in this category. The descriptors of impairment are examples only, and are not intended to be an exhaustive list. We've included them to help improve inter-rater reliability.

(6) Describe the impairment and the way the symptom results in the impairment. You can do this in a number of different ways. If a sample descriptor matches you client's impairment, you may circle or underline the part that applies, and/or cross off the part that doesn't. Write a brief description of the symptom and the resulting impairment. Below are samples.

LIFE ROLE FUNCTION ASSESSMENT:

a) Occupational/educational impairment primarily due to? ■ Mental illness □ Substance use □ medical conditions (4)

□ None (5) Successfully employed; + school attendance/grades	□ Low impairment Some conflicts at school/work	□ Moderate Misses work/school 2-3 times monthly	■ Severe Misses ~~work~~ /school 2/3 times a week. ~~Lost many jobs~~	□ Very severe Disabled/Unable to work; expelled from school
Describe: (6) Fear of recurring panic attacks results in frequent absences from school and failing grades.				

a) Occupational/educational impairment primarily due to? □ Mental illness □ substance use ■ medical conditions (4)

□ None (5) Successfully employed; + school attendance/grades	□ Low impairment Some conflicts at school/work	☐ Moderate Misses work/school 2-3 times monthly	□ Severe Misses work/school 2/3 times a week. Lost many jobs	■ Very severe Disabled/Unable to work; ~~expelled from school~~
Describe: (6) Unable to hold a job due to severe back injury.				

a) Occupational/educational impairment primarily due to? □ Mental illness □ substance use □ medical conditions (4)

■ None (5) Successfully employed; + school attendance/grades	□ Low impairment Some conflicts at school/work	☐ Moderate Misses work/school 2-3 times monthly	□ Severe Misses work/school 2/3 times a week. Lost many jobs	□ Very severe Disabled/Unable to work; expelled from school
Describe: (6)				

(7) Progress toward treatment objectives: Write a brief summary of progress in therapy so far. We realize you will be completing this section very early in the client's treatment. You may choose to comment on rapport or motivation at this early stage.

(8) Client Strengths: Work with your client to identify strengths and resources to achieve treatment goals. Examples could include internal resources (intrinsic motivation, insight, verbal skills, problem solving strengths, sobriety etc.) or external supports (supportive family or friends, an AA sponsor, etc.).

(9) Current Medications: List the MD name and any medications client takes, if known.

(10) Treatment Interventions: **Interventions are what you will do to help your client**. Write the strategies you will use to help your client here. Skills you plan to teach your client work very well, for example: "Teach client to … (use thought stopping, deep breathing, use a mood log, express needs assertively using "I" statements, use problem solve, etc.)." Other appropriate interventions include empathic listening, confrontation, role play, exposure/response prevention interventions, CBT strategies to reduce negative thinking, etc. This is not an exhaustive list. Evidenced based and active interventions are strongly preferred.

(11) Current Treatment Objectives: **Objectives are the tasks your client will accomplish during the authorization period.** Objectives must be observable or measurable. At Mental Health, we've drawn heavily from the Berkeley Training Associates model by Stan Taubman, DSW. He describes six levels of objectives, ranging from acknowledging the problem to achieving a reduction in functional impairment. Selection of an appropriate goal depends on a number of factors, including your client's level of engagement and motivation for change. Listed below are the six levels of objectives along with samples from each level for a client

named Sarah, who is experiencing depressed mood.

1. Client will acknowledge the problem.
   Sarah will acknowledge feelings of depression using feeling words by (date).
2. Client will describe the problem accurately.
   Sarah will identify three triggers for depressed periods by (date).
   Sarah will learn to rate her moods on a 0-10 scale.
3. Client will identify strengths, resources and/or strategies to resolve the problem.
   Sarah will identify three positive coping strategies she's used in the past to feel better.
   Sarah will identify three activities she enjoys doing by (date).
4. Client will act on identified strengths, resources and/or strategies to resolve the problem.
   Sarah will keep a daily mood log to rate her mood and challenge negative thinking.
   Sarah will use her crisis management plan each day she rates her mood at "6" or worse.
5. Client will achieve symptom reduction.
   Sarah will sleep at least 8 hours nightly for one week.
   Sarah will report fewer untriggered crying spells by (date).
   Sarah will report an absence of suicidal thoughts by (date).
6. Client will achieve a functioning improvement goal.
   Sarah will report improved school attendance by (date).
   Sarah will report satisfaction with her improved ability to call friends to initiate interactions by (date).

Adapted from Treatment Plan Documentation Guide, Stan Taubman, DSW, LCSW

Whenever possible, help your client identify reachable objectives and actively participate in treatment. Particularly in a brief therapy model, we want them to be actively solving problems!

Each Client Care Plan must identify at least three current objectives.

(12) Expected Outcomes: What do you and your client hope to achieve as a result of your work together? Briefly describe longer term goals for client. Please note that symptom reduction and functional improvement goals described above fit nicely here, as would a quote from a client regarding what they would like to accomplish. Some therapists use Solution Focused strategies like the "miracle question" (some variation on the question, "If you woke up tomorrow and your depression no longer bothered you, what would be different about your life?") to prompt clients to talk about what they'd like to accomplish. Regardless of your style, we are looking for information about where you and your client are headed in treatment. Termination planning can go in this section – if you think the client will be ready to end soon, feel free to add a line here to tell us so.

(13) Case Management activities: Briefly describe the contacts (if any) you plan to have with agency workers or significant others. Remember that Case Management units are 10 minutes in length – we encourage you to briefly summarize treatment and concerns in phone calls to social workers, teachers or Mental Health lead coordinators rather than attending long Team Decision Making Meetings or IEPs.

(14) Services Requested: Itemize your request for sessions, based on your client's needs and the interventions you will use. Case Management sessions (up to 10) are automatically authorized. You may request a maximum of 15 sessions. If you need to adjust your request after we've authorized services, just provide the type of session clinically indicated and bill for they type of service you provided. We will make corrections to the authorization as needed.

(15) Client Signature: Please obtain client signature and date signed if aged 12 or older. Often younger kids want to sign their own plan, so please ask them their preference. All clients should clearly understand what they are working on, so be sure to work with them to develop objectives and explain the plan in a way they can understand. If a minor client refuses to sign, write in why they refused and the date.

(16) Parent/Guardian/Conservator signature: If your client is in a Department of Social Services foster care placement, we will obtain the social workers signature for you. Foster parents are not able to authorize mental health treatment for dependents in their care. For minors living with parents or other legal guardians, please involve the parent in the treatment as appropriate, but at least involve them in the plan development.

(17) Network Provider Signature and Discipline: Please legibly sign your name and add your discipline (LMFT, LCSW, etc.) and date of signature.

Please mail or fax your completed Client Care Plan to:

San Luis Obispo County Mental Health
Attention: Managed Care/Elaine Jordison, MRT
2178 Johnson Avenue
San Luis Obispo, CA 93401

FAX: (805) 781-4176

Authorization Process

1. Your request for additional sessions becomes effective when we receive your plan by fax or mail.

2. We meet weekly (currently Wednesday afternoon) to review plans and authorize services.

3. We need to receive the Client Care Plan by Monday at 12:00 p.m. to have it ready for Wednesday's meeting.

4. If your plan is complete and clinically sound, we generally approve it as requested. If we have questions about the plan, we will contact your for clarification. We generally will authorize some of the sessions you've requested while we wait for further information from you, to prevent a disruption in treatment.

5. We try to give you feedback regarding your plan. This could be a simple statement, such as, "Thanks for your good work with this client."

6. Occasionally a client will become ineligible for MediCal during treatment, and we will notify you so you can wrap up with the client. Clients must have San Luis Obispo MediCal or be Healthy Families SED to qualify for this program.

7. We will notify you in writing when your sessions are approved or denied.