SHASTA COUNTY MENTAL HEALTH PLAN
INTERVENTION DESCRIPTIONS, SERVICE CODES, AND DOCUMENTATION REQUIREMENTS

Link to the most current version of "Service Code Descriptions" on the HHSA Compliance page: http://intranet/hhsa/Compliance.aspx

Description	Service Code	Definition	Documentation
Assessment	**10**	A service activity designed to evaluate the current status of an individual's mental, emotional, or behavioral health.	Initial and ongoing Assessments are created using the appropriate assessment form. The assessment includes but is not limited to: presenting problem, relevant conditions and psychosocial factors, mental health history, medical history, mental status exam, analysis of the individual's clinical history, analysis of relevant cultural issues and history, and diagnosis. Assessment activities may include communication with family and/or other sources and review of outside documentation. Progress note must include: brief narrative describing the assessment activity which also includes a brief summary of information gathered and from where/whom. Include beneficiary's response and participation if present, and the plan for client moving forward (referrals, recommendations, what client/staff will do next, alternate approaches for future interventions, etc.). Documentation Format: Assessment and Progress Note using the MPP model when client is present (in person or by phone).
Plan Development	**13**	A service activity that consists of development of an individual's Client Plan, approval of Client Plan, and/or monitoring of an individual's progress.	Progress note must include: description of service to be provided with narrative of what was attempted and/or accomplished by the service staff in the planning process; documentation of participation of the individual and support persons in the planning process, description of changes in individual's service needs, and plan for service updates when there is a change, and the plan for client moving forward (referrals, recommendations, what client/staff will do next, alternate approaches for future interventions, etc.). Documentation Format: Client Treatment Plan and Progress Note using the MPP model when client is present (in person or via phone).
Case Management/ Brokerage	**50**	Services that assist an individual to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure individual's access to service and the service delivery system; monitoring of the individual's progress; placement services; and plan development. May be either face to face or by phone with either the individual or significant support persons and may be provided anywhere in the community.	Must include: description of service provided describing what was attempted and/or accomplished by individual and/or service staff, description of changes in individual's service necessity, beneficiary response if present, and the plan for client moving forward (referrals, recommendations, what client/staff will do next, alternate approaches for future interventions, etc.). Documentation Format: Progress Note using the MPP model when client is present (in person or via phone).

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Intensive Care Coordination (ICC)	**53**	**Intensive Care Coordination** A more intensive form of Targeted Case Management that facilitates assessment of, care planning for, and coordination of services for children and youth, ICC includes urgent services for beneficiaries with intensive needs.	Must include: brief narrative describing what was attempted and/or accomplished toward the personal milestone, by the individual and service staff, description of changes in individual's service necessity, individual's response to interventions, and the plan for client moving forward (referrals, recommendations, what client/staff will do next, alternate approaches for future interventions, etc.). Documentation Format: Progress Note in MPP format
Collateral - Without Client Present	**33**	Service activity to a significant support person in an individual's life for the purpose of meeting the needs of the individual in terms of achieving the goals of the individual's client plan. Collateral may include, but is not limited to, consultation and training of the significant support person(s) to assist in better utilization of specialty mental health services by the individual, consultation and training of the significant support person(s) to assist in better understanding of the individual's mental illness, and family counseling with the significant support person(s). Contacts with significant support persons must be directed exclusively to the mental health needs of the beneficiary.	Must include: treatment plan goals being addressed, support persons present, description of service provided describing how the service relates to the individual's goals and the support person's response, and the plan for client moving forward (referrals, recommendations, what client/staff will do next, alternate approaches for future interventions, etc.) Documentation Format: Progress Note using the MPP model.
Collateral - With Client Present	**33**	Service activity to a significant support person in an individual's life for the purpose of meeting the needs of the individual in terms of achieving the goals of the individual's client plan. Collateral may include, but is not limited to, consultation and training of the significant support person(s) to assist in better utilization of specialty mental health services by the individual, consultation and training of the significant support person(s) to assist in better understanding of the individual's mental illness, and family counseling with the significant support person(s). Contacts with significant support persons must be directed exclusively to the mental health needs of the beneficiary.	Must include: treatment plan goals being addressed, support persons present, description of service provided describing how the service relates to the individual's goals and the response of the beneficiary and the support person, and the plan for client moving forward (referrals, recommendations, what client/staff will do next, alternate approaches for future interventions, etc.). Documentation Format: Progress Note using the MPP model.
Family Therapy (Client Must Be Present)	**32**	**Family Therapy** A service activity that is a therapeutic intervention that focuses on symptom reduction as a means to improve functional impairments, which includes one or more family members and the client. Must be focused on reducing the client's functional impairments, or to prevent deterioration, and to assist the client in meeting the goals of their treatment plan. **Client must be present for family therapy.**	Must include: description of service provided describing therapeutic interventions consistent with the individual's goals/desired results/personal milestones which focus primarily on symptom reduction as a means to improve functional impairments; client's response to interventions, and the plan for client moving forward (referrals, recommendations, what client/staff will do next, alternate approaches for future interventions, etc.). Documentation Format: Progress Note in MPP format

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Individual Therapy	**30**	Individual therapy uses psychotherapeutic interventions to improve symptoms and functional impairments; activities may be aimed at the development of insight or affective understanding, behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination of the above to provide therapeutic change. Individual Therapy is provided to the client, therefore, the **client must be present.**	Must include: description of service provided describing therapeutic interventions consistent with the Individual's goals/desired results/personal milestones which focus primarily on symptom reduction as a means to improve functional impairments; individual's response to interventions, and the plan for client moving forward (referrals, recommendations, what client/staff will do next, alternate approaches for future interventions, etc.). Documentation Format: Progress Note using the MPP model.
Individual Rehab	**34**	Service activity that includes, but is not limited to, assistance in improving, maintaining, or restoring an individual's functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources and/or medication education.	Must include: brief narrative describing what was attempted and/or accomplished toward the personal milestone, by the individual and service staff, description of changes in individual's service necessity, individual's response to interventions, and the plan for client moving forward (referrals, recommendations, what client/staff will do next, alternate approaches for future interventions, etc.). Documentation Format: Progress Note using the MPP model.
Intensive Home Based Services (IHBS)	**37**	**Intensive Home Based Services** Individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a child/youth's functioning, aimed at building skills necessary for successful functioning in the home and community, and improving the family's ability to help the child successfully function in the home and community.	Must include: brief narrative describing what was attempted and/or accomplished toward the personal milestone, by the individual and service staff, description of changes in individual's service necessity, individual's response to interventions, and the plan for client moving forward (referrals, recommendations, what client/staff will do next, alternate approaches for future interventions, etc.). Documentation Format: Progress Note using MPP format
Group Psychotherapy	**31**	**Face To Face** Psychotherapy provided to a group of individuals. Examples of therapy groups are: Dialectical Behavior Therapy (DBT), Cognitive Behavior Therapy (CBT), and Anger Management.	Must include: number of participants in the group, co-leader if applicable, description of service provided describing therapeutic interventions consistent with the Individual's goals/desired results/personal milestones which focus primarily on symptom reduction as a means to improve functional impairments, client's response to interventions provided, and the plan for client moving forward (referrals, recommendations, what client/staff will do next, alternate approaches for future interventions, etc.). ***See the *Group Service Documentation Tip Sheet* for additional documentation requirements.** Documentation Format: Group Progress Note

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Group Rehab	**35**	**Face To Face** Assistance in improving, maintaining, or restoring a group of individuals' functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources and/or medication education.	Must include: number of participants, co-leader if applicable, brief narrative describing what was attempted and/or accomplished toward the personal milestones, by the individual and service staff, description of changes in individual's service necessity, and the plan for client moving forward (referrals, recommendations, what client/staff will do next, alternate approaches for future interventions, etc.) ***See the *Group Service Documentation Tip Sheet* for additional documentation requirements.** Documentation Format: Group Progress Note
Crisis Intervention	**70**	A service activity that consists of an immediate therapeutic response to or on behalf of an individual exhibiting acute psychiatric symptoms to alleviate problems which, if untreated, present an imminent threat to the patient or others. Service activities include but are not limited to one or more of the following: assessment, collateral and therapy. The maximum claimable amount for crisis intervention in a 24-hour period is 8 hours.	Must include: acuity of individual or situation which jeopardizes individual's ability to maintain community residence, brief narrative describing what was attempted and/or accomplished by service staff, beneficiary's response, and the plan for client moving forward (referrals, recommendations, what client/staff will do next, alternate approaches for future interventions, etc.). Documentation Format: Progress Note using the MPP model.
Medication Phone/ Signature	**24**	**Non Face To Face** Telephone call, preparation, medication refills	**Non Face to Face** for coordinating medical management with other health care professionals, simple or brief. Must include: description of the service, medical necessity for the services, and the plan for client moving forward (referrals, recommendations, what client/staff will do next, alternate approaches for future interventions, etc.). Documentation Format: Progress Note
Med Injection	**202**	**Face to Face (MDs, NPs, RNs, PAs)** Therapeutic, prophylactic, or diagnostic injection; subcutaneous or intramuscular.	Service includes delivery of medication injection, as prescribed by an MD; intended to assist client with symptom stabilization and improve acquisition of mental health treatment goals. Must include: description of the service, medical necessity for the services, client's response to the service, and the plan for client moving forward. Documentation Format: Progress Note
Medication Brief-Est Client (Established Clt) ---------- **Medication Brief-New Client**	**22** ---------- **20**	Brief office visit for a lesser level of drug monitoring, such as changing the dosage of prescriptions that are used in the treatment of mental, psychoneurotic and personality disorders.	Requires pharmacological regimen oversight. Services include evaluation of safety and effectiveness and/or simple dosage adjustment to long-term medication. Must include: description of the service, medical necessity for the services, client's response to the service, and the plan for client moving forward. Documentation Format: Progress Note ***NOTE: If you are writing a treatment plan for a new client, you will need to include both New and Established Medication Brief in your interventions.***

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Medication In-Depth - Est Client (Established Clt) ---------- **Medication In-Depth - New Client**	**23** ---------- **21**	This Code should be used in conjunction with in-depth management of psychopharmacologic agents, which are potent medications with frequent serious side effects and should represent a very skilled aspect of patient care. There should be a review of the medication and its side effects, or any drug-drug interactions, as well as a problem focused history and a mental status exam to assess the patient's response to treatment. A portion of this billing includes the writing or renewing of a prescription.	In-depth assessment and management of psychopharmacologic agents. Any psychotherapy supplied is minimal and not required. Must include: description of the service, medical necessity for the services, client's response to the service, and the plan for client moving forward (referrals, recommendations, what client/staff will do next, alternate approaches for future interventions, etc.). Documentation Format: Progress Note ***NOTE: If you are writing a treatment plan for a new client, you will need to include both New and Established Medication Brief in your interventions.***
Individual w/E&M (Evaluation & Management)	**29**	**Provided by MDs, NPs, PAs** Individual psychotherapy, insight oriented, behavior modifying and/or supportive with medical evaluation and management services (monitoring), in outpatient facility with the patient. Individual w/E&M is provided to the client, therefore, the **client must be present.**	Must include: date of service, service function, location of service, duration of service, description of service provided describing therapeutic interventions consistent with the Individual's goals/desired results/personal milestones which focus primarily on symptom reduction as a means to improve functional impairments, individual's response to interventions, and the plan for client moving forward (referrals, recommendations, what client/staff will do next, alternate approaches for future interventions, etc.). Documentation Format: Progress Note using the MPP model.
Psychiatric Diag (ME) (Formerly IME/AME)	**11**	**Provided by MDs, NPs, PAs** Initial and Ongoing Medication Evaluation	In-depth assessment and management of psychopharmacologic agents. Any psychotherapy supplied is minimal and not required. Must include: description of the service, medical necessity for the services, client's response to the service, and the plan for client moving forward (referrals, recommendations, what client/staff will do next, alternate approaches for future interventions, etc.). Documentation Format: Progress Note
Medication Education Group	**25**	**Face to Face (NPs, RNs, PAs)** A service activity provided to a group of individuals consisting of education and training for patient self-management by a qualified nonphysical health care professional using a standardized curriculum. The purpose of the educational and training services is to teach the individuals (may include caregivers) how to effectively self-manage their illnesses/diseases or delay disease comorbidity in conjunction with their professional healthcare teams. Education and training related to subsequent reinforcement or due to changes in the individuals' condition or treatment plan are reported in the same manner as the original education and training.	Must include: number of participants, co-leader if applicable, brief narrative describing what was attempted and/or accomplished toward the personal milestones, by the individual and service staff, client's response to the service, and the plan for client moving forward (referrals, recommendations, what client/staff will do next, alternate approaches for future interventions, etc.). ***See the Group Service Documentation Tip Sheet for additional documentation requirements.** Documentation Format: Group Progress Note

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Screening/ Evaluation	**5**	**LPS Conservatorship Evaluations**	This code is used specifically for LPS evaluation which is not a billable service.
Psych Testing Evaluation	**12**	**Psychological Testing Evaluation** Includes integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s).	Must include: identifying information, reason for referral, date of assessment, brief history, clinical observations and decision making, test results, diagnostic impression, treatment recommendations, summary, and signature. Progress note must include: brief narrative describing the actions taken by provider, client's/family's response and plan/follow up care. Documentation Format: Progress Note and/or Long or Short Psycho diagnostic Testing Evaluation *This is billed by Licensed/Registered/Waiered Psychologists and Registered Psychological Assistants only.*
Psych Test Admin & Scoring	**18**	**Psychological Test Administration and Scoring** Psychological test administration and scoring.	Note: for health care insurance billing other than Medi-Cal, must include AT LEAST TWO tests and can be administered with any method. Progress note must include: brief narrative describing the actions taken by provider, client's/family's response and plan/follow up care. Documentation Format: Progress Note and/or Long or Short Psycho diagnostic Testing Evaluation. *This is billed by Licensed/Registered/Waivered Psychologists and Registered Psychological Assistants only.*