Service Code Grid - Specialty Mental Health Plan

Provider Type: LPHA – Adult Services (NOT FQ provider)

ASSESSMENT		
Avatar Code / Description	**Info re: TIME**	**Description**
M90791 (M90791N) Psychiatric Diagnostic Evaluation	**Minimum: 31 min.** **Max: None**	**LPHA** assessment activities, including: collecting and gathering current info & history info with the client to determine appropriate level of care / treatment needs & recommendations / diagnosis. Identifying current impairments in functioning / trauma / medical info / psychosocial info / strengths / risk factors. Completion of MSE. Completion of PSC-35 & CANS / ANSA with client. Review of records done to support gather information to inform the assessment. **LPHA** meeting with caregiver/significant support person to gather information to inform an assessment/re-assessment.
		Sample Note Language: Met with client to gather information to inform assessment and establish preliminary diagnosis of Major Depressive Disorder. Client reports current symptoms of depression with suicidal ideation without intent. No current SUD reported. Clinician plans to meet with client identified collateral source, their mother, to gather additional assessment information.
		Sample Note Language: Met with parent / caregiver / significant other to gather information to inform assessment. Support person reported symptoms of severe depression and a history of suicidal ideation with past attempts and two hospitalizations. Collateral information will be included in assessment. Plan is to complete last interview with client to finalize treatment recommendations.
M90885 (M90885N) Psych Eval of Med Records & Tests	**Minimum: 31 min.** **Max: None**	**LPHA** activity: review of records to inform assessment, medical necessity (initial & ongoing), and/or for diagnostic purposes when there is *no direct patient contact*. This may occur at different times during treatment, not *just* when conducting initial assessment, if an LPHA is reviewing records to inform a change in treatment or to update a diagnosis, etc.
		Sample Note Language: Review of pertinent inpatient records and records received from prior treatment provider to inform assessment. Clinician plans to meet with client again to go over current symptoms of depression & risk factors to finalize assessment and make treatment recommendations.

M96127 **Brief Emotional/ Behavioral Assessment**	**Minimum: 31 Min.** **Max: None**	**Provider types:** MD/DO, NP/CNS, PA, PhD/PsyD, Licensed/Waivered LCSW/ASW, LMFT/AMFT, LPCC/ APCC, RN, MA • Standalone completion of standardized screening/assessment tools (e.g., ANSA, depression inventory, etc.) • Scoring and documentation with the standardized instrument may be included. • Client/significant support person not required to be present during scoring/documentation; scoring & documentation included as 'direct time'. • Can be used for additional time beyond the initial screening tool administration with the client.
		Sample Note Language: After completion of ANSA assessment with client, documented the ANSA and evaluated the Take Home Report for significant changes. Report indicated client has improved in strengths and reduced needs. Writer will meet with client to explore findings at next regularly scheduled session and will share ANSA results with client care team next week.
MH0031 **MH Assessment by Non-Physician**	**Minimum: 8 Min.** **Max: None**	**All provider types** doing assessment activities (see M90791 above). *LPHA would typically choose M90791.* **All provider types:** Meeting with caregiver/significant support person to gather information to inform an assessment/re-assessment.

MH2000
Comprehensive Multidisciplinary Evaluation
	Minimum: 8 Min.
	
	Max: None
		All provider types:
		• Review of a holistic perspective of the client, including psychiatric, physical, psychosocial, family, recreation and occupational areas.
		• Assessing and Coordinating Care with other Providers and Agencies
		• Client/Support Person does not have to be present
		• Multiple staff can bill for participation in a case consultation meeting
		• Not meant for brief check-in, rather intended for use under the following circumstances:
		  ○ The consultation produces actionable item(s) on behalf of the client and/or a change to the client's treatment.
		  ○ Each claiming provider has made a unique contribution to the consultation.

		Sample Note Language: Provider attended multidisciplinary case consultation with coordinator, doctor, and peer support specialist. Provider reported on client's progress including increasing social activities to twice per week. Along with improvements noted by other providers, determination made to update ANSA with client to evaluate current needs and update plan of care.

ASSESSMENT (Psychologist only (PhD/PsyD, including Associates)		
Avatar Code / Description	**Info re: TIME**	**Description**
M96130 & M96131 Psych Testing Evaluation	**Minimum: 31min.** **Max: None**	Psychological testing done by a Psychologist or Psychological Associate, including testing, integration of client data, interpretation of tests, clinical decision making and interactive feedback to the client and family members.
		Sample Note Language: Completed a battery of tests with client including Thematic Apperception Test (TAT), and MMPI. Time includes preparing client for testing and debriefing with client and family. Plan to complete additional tests next week, review tests to document assessment and then make informed clinical recommendations.

PLAN DEVELOPMENT		
Avatar Code / Description	**Info re: TIME**	**Description**
MH0032 MH Svc Plan by Non-Physician	**Minimum: 8 min.** **Max: None**	**All provider types:** development of client Problem List and/or Care Plans, updating client plans, approval of client plans and/or monitoring of a client's progress. **All provider types:** Meeting with caregiver/significant support person to develop a care plan/client plan.
		Sample Note Language (TCM Care Plan creation – template in avatar): **BE SURE TO CHOOSE **NOTE TYPE** MHP TCM CARE PLAN** **EXAMPLE 1:** Writer met with client to provide case management related to their goal to **[**find affordable housing; specifically subsidized community housing when adult residential treatment is completed**]**. Writer will continue to support client through case management services to address their needs identified in the assessment, including coordinating with community resources, until **[**client transitions to stable housing**]**. Client agrees with this plan.
		Sample Note Language (Problem List Update – template in avatar): **BE SURE TO CHOOSE **NOTE TYPE** PROBLEM LIST UPDATE / REVIEW** Writer met with **[**client**]** to review, add, or remove problems from the problem list that are current and relevant to the client's behavioral health treatment. Problem(s) identified that need to be added are depression and unemployment / wanting to find a part-time job**,** identified on this date, 4/24/2024.

TARGETED CASE MANAGEMENT (TCM – MT1017 requires Care Plan)

Avatar Code / Description	Info re: TIME	Description
MT1017 Targeted Case Management	**Minimum: 8 min.** **Max: None**	**All provider types:** Assisting client to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. Examples: communication, coordination, and referral; monitoring service delivery to ensure access to service and the service delivery system; monitoring of individual progress. Meeting with caregiver/significant support person for the purpose of connecting them with resources/community supports to address the client's needs.
		Sample Note Language (TCM Care Plan already documented in previous note): Writer contacted Food Bank to gather information about how client can access free food, as currently they do not have financial resources for monthly food needs. Learned how to refer client to receive free food. Plan to support client in obtaining food on a weekly basis from Food bank.
		Sample Note Language (TCM Care Plan already documented in previous note): Client unable to manage emotions due to anxiety and agreed to attend group focusing on anxiety and depression. Writer contacted Group Intervention Center and gathered info about their groups. Initiated referral process as group seems to be a good match for client. Plan to discuss group with client and assist client in next steps to attend group.
MH2021 Community Wrap-Around	**Minimum: 8 min.** **Max: None**	**All provider types:** coordination of care between **Specialty Mental Health System** and providers who are **outside** Specialty Mental Health. Examples: Specialty Mental Health refers to the Managed Care System or to Substance Use Disorder treatment (DMC-ODS).
		Sample Note Language: Client's Alcohol Use may qualify client to receive Outpatient SUD treatment in addition to the current mental health services. Contacted Janus intake team to refer and link to SUD treatment. Janus staff provided walk-in hours for intake; plan to support client in attending an intake session.

THERAPY		
Avatar Code/ Description	**Info re: TIME**	**Description**
M90832S (M90832NS) Psychotherapy	**Minimum: 16min.** **Max: None**	**LPHA** meeting with the client to provide therapeutic interventions that focus primarily on symptom reduction and restoration of functioning to improve coping and adaptation and reduce functional impairments. Therapeutic intervention includes the application of cognitive, affective, verbal or nonverbal strategies based on the principles of development, wellness, adjustment to impairment, recovery and resiliency to assist a beneficiary in acquiring greater personal, interpersonal and community functioning or to modify feelings, thought processes, conditions, attitudes or behaviors which are emotionally, intellectually, or socially ineffective.
		Sample Note Language: Checked in with client using scaling question to determine current level of anxiety. Explored what would make client anxiety rating a point higher and a point lower. Writer asked exception-seeking questions to explore times in which client has experienced lower ratings of anxiety and explored what was different about those situations. Discussed how they would know if their anxiety was completely gone and what would be different. Clinician plans to continue to meet with client weekly to work toward achieving therapy goals which include x, y, z.
M90853 (M90853N) Group Psychotherapy	**Minimum: 23min.** **Max: None**	**LPHA** meeting with a group of clients to provide therapeutic interventions as described above.
		Sample Note Language: Client participated in DBT group. Client was engaged during the group and shared thoughtful comments & feedback to peers. Group provided mindfulness meditation exercises and psychoeducation about mindfulness and meditation practices to increase coping skills & stress management ability. Next DBT group meets on 5/3/2024
M90847 (M90847N) Family Psychotherapy	**Minimum: 26min.** **Max: None**	**LPHA** providing conjoint psychotherapy with client and their family present.
		Sample Note Language: At client's request provided family therapy with client, Mom & Dad present. Client identified that symptoms of anxiety and depression have increased due to the stress of recent divorce and client wanted to talk this through with parents so they can support anxiety reduction. Supported client to share symptoms and triggers with parents and provided education to family regarding how to support client.

		Discussed family communication patterns with goal to decrease client involvement in parental disagreements. Plan is to follow up with family at client's request.
M90849 (M90849N) Multiple-Family Group Psychotherapy	**Minimum: 43min.** **Max: None**	Allows for documentation of groups that include multiple clients and their families.

REHABILITATION		
Avatar Code/ Description	**Info re: TIME**	**Description**
MH2017 Psychosocial Rehabilitation	**Minimum: 8min.** **Max: None**	**All provider types:** Skill building to help client restore, improve, or preserve functioning socially, in their communication, or in their daily living skills. Improves self-sufficiency and/or self-regulation. Providing assistance to address a beneficiary's mental health needs. **All provider types:** Meeting with caregiver/significant support person for the purpose of coaching, skill development as a means to support the client with managing behavioral health needs.
		Sample Note Language: This writer facilitated mindfulness-based breathing exercise to assist client with strengthening stress management skills, which directly impacts their experience of depression symptoms. This writer supported client to continue building self-awareness and manage physical symptoms of sadness. To assist with managing sadness, writer facilitated behavioral activation (outdoors) activity to build consistency and routine. Writer encouraged client to continue practicing skills to manage symptoms of depression that include sadness until the next rehabilitation session. Plan to continue psychosocial rehab weekly to continuing strengthening stress management skills.
MH2017G Group Psychosocial Rehabilitation	**Minimum: 8min.** **Max: None**	**All provider types:** Skill building as above in a group setting. **Sample Note Language:** Taught motivational interviewing group focusing on education around the stages of change to group participants to help increase their self-awareness around behavioral changes related to their mental health. Participants completed worksheets identifying action steps they could take towards their own mental health goals. Follow up plan: participants will practice these action steps over the next week and share their experiences with the group at the next group session.

CRISIS INTERVENTION		
Avatar Code / Description	**Info re: TIME**	**Description**
M90839 **Psychotherapy for Crisis Intervention**	**Minimum: 30min.** **MAX time: 8 hours of crisis intervention in a day across all providers**	**LPHA:** An unplanned, expedited service to address a condition that requires more timely response than a regularly scheduled visit. Supporting a client to cope with a crisis and regain functioning with the goal to stabilize an immediate crisis situation and maintain the client in the community if possible. Includes MSE and disposition. Treatment includes therapy, mobilizing resources and implementation of interventions to address the crisis. Use this code when there is a psychotherapy element in your interventions.
	NOTE: 90839 cannot be done via telehealth or telephone **Code = MH2011 if service provided via phone / telehealth**	**Sample Note Language:** During a visit to client at board and care, staff reported that client had been down / depressed for a couple days and now was refusing to leave their room and reporting suicidal ideation. Staff at B & C requested writer provide support and determine if 5150 / CSP admission was indicated. Talked with client to assess presentation and symptoms of depression. Conducted MSE. Client reported having no hunger and being unable to sleep and unable to stop thinking about talking their own life. Client reported a plan to overdose with inability to stop thinking about this plan and was unable to talk with writer about their safety and insisted that things would not get better. Writer placed client on 5150 hold and arranged for transportation to CSP. Plan is to ensure client receives treatment at CSP.
MH2011 Crisis Intervention	**Minimum: 8min.** **MAX time: 8 hours of crisis intervention in a day across all providers**	**All provider types** doing crisis activities (see M90839 above). LPHA would typically choose M90839.