

Rum River COUNSELING

Orientation Guide

Welcome to Rum River Counseling

Rum River Counseling, Inc. (RRC) is a counseling group of therapists in private practice. We are dedicated professionals, firmly grounded in effective therapy practices, striving to provide our clients with the highest quality of care. Through a combination of compassion, knowledge, and respect, we work with children, teens, adults, couples and families to encourage personal growth and development.

RRC was founded on the principles of providing a comfortable, pleasant, and non-judgmental atmosphere for clients as well as the professionals providing mental health services.

This orientation guide is designed to provide you with an overview of the day to day operations of RRC. While this guide is not exhaustive, it includes most of the information you will need to feel comfortable getting started. Please feel free to ask questions, take notes, and continue to add information to add to the usefulness of this guide.

We are pleased to have you join us! We look forward to getting to know you. If you have any comments, concerns or questions, please do not hesitate to ask!

Sincerely,

A handwritten signature in cursive script that reads "Jenny".

Dr. Jenny Holdredge, PsyD MA LMFT
Owner/Clinic Director

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Important Phone Numbers

Intake/Main Number	763-482-9598
Drew's Cell <i>(time sensitive issues)</i>	612-382-0032 <i>drew@rumrivercounseling.com</i>
Jenny Holdredge (Owner) Cell	952-270-1073 <i>jenny@rumrivercounseling.com</i>
Julie Pearson (Admin Manager)	<i>Juliep@rumrivercounseling.com</i>
Barb Kloetzke (Admin Assistant)	<i>barb@rumrivercounseling.com</i>
Angie Krantz (Admin Assistant)	<i>angelak@rumrivercounseling.com</i>
Lindsey Solorzano (Scheduling Coordinator)	<i>lindseys@rumrivercounseling.com</i>
Kim Hansen (Credentialing only)	<i>khansen@rumrivercounseling.com</i>

**the "admin team" (italicized) – when emailing the admin team, be sure to include everyone.*

Local Crisis Phone Numbers

Anoka County RiverWind Crisis Services	763-755-3801
Ramsey County Crisis Services	651-266-7900
Hennepin County Crisis Services (child)	612-348-2233
Hennepin County Crisis Services (adult)	612-596-1223
Carver County Crisis Services	952-442-7601

For after-hours emergencies, or if client needs immediate assistance they need to call 911 or visit the local emergency room, medical group or their primary care physician.

Getting Started at RRC

Contract

The independent contract relationship that you have with RRC is outlined in the Independent Contract Agreement.

Tax Forms: W-9 & 1099

You will complete a W-9 at the beginning of your contract relationship with RRC. The W-9 is the tax form for an independent contractor. You will receive a 1099 tax form in January of each year for your taxes. Make sure Jenny has your W-9 before starting.

Paychecks

Payroll payment is directly deposited into your account - please complete the ADP Direct Deposit Enrollment form. The fee for this is \$2/paycheck.

Payroll

You will receive a “payroll” check on the 1st and 15th of each month. Payment from will be determined on a fee split, based on the accounts receivable (AR), less your half (2%) of the 4% billing fee. Payment will be based on the accounts receivable from the 19th to the 18th of the previous calendar month. Please see your contract for specific fee split information.

Website bio & photo

Our website is www.rumrivercounseling.com and it displays bios and photos of our staff . Biographies and photos are very important to get to us ASAP. Many clients look at our website and choose which therapist they’d like to see based on these. Photo requirements are: professional grade photo. We just need a digital copy to place it on the website.

Email account

RRC utilizes business email through a company Gmail account – yourname@rumrivercounseling.com is your email address.

The email account is encrypted for inter-office email, but NOT for emails outside of RRC.

Your email username is: _____ password is: _____ (this log in info is emailed to your personal email acct)

Valant (Scheduling, Documentation, Billing)

Our scheduling, documentation, & billing is electronic. See Valant guide for more info.

Phones & Voicemail

RRC has a main intake number: 763-482-9598. Your voicemail box # is _____ (You will get this in your Welcome email before your orientation) - All of your voicemails will be emailed to your RRC email account. If you want to have access to listening to your VM remotely you need to email drew and let him know, the system can only save a certain number of messages and once your box is full no more messages can be left, this is why by default messages are deleted from the system once they are emailed to you. To set up the voicemail you can call 763-482-9598 then dial your extension, then dial *, it will then ask for a password. Unless you have told me a different code you want to use your code will be 0000, you can change it at any time.

Alarm System

The following offices have alarm systems: Blaine and Ramsey. Please email Drew a 4 digit code that you want to use to arm and disarm the alarm.

Alarm instructions

If you are the last one out for the day, to arm the alarm type in your code you then have 1 minute to leave, locking the door too of course. Don't arm the alarm if you are planning on staying in the office as there are motion detectors. If you are the first one in or the alarm is beeping a constant tone you have 30 seconds to type in your code. IF the alarm is accidentally set off (you will know it) call Drew FIRST right away 612-382-0032 or Jenny second 952-270-1073 so we can tell the alarm people not to call the police.

Keys

You will receive a set of keys which, depending on the office, may include: a front door key, a suite key, and a file key (most offices have a file key in a lockbox to use). Please do not make copies of these keys unless authorized to do so. Keys must be returned upon termination of contract agreement. If keys are not returned, then you will be billed for the amount of replacing the locks. If you lose a key, please inform RRC immediately. There is also a file cabinet lock box code, you will want to ask Drew for the pin number.

Money box

Credit cards are processed in Valant.

Place all other client payments (cash/check) into the black money box or safe located in the staff work area.

If client pays with cash, post or clip a note to the cash indicating:

- client name
- date paid
- total amount paid

If client pays with a check:

- make sure that the client name is somewhere on the check so that we can cross-reference the payment
- be sure to scan in checks
- once a check is scanned write "Scanned" on the check and place it in the money box

Office Procedures and Care

Opening and Closing

While each office is set up differently, this should guide you in the opening and closing process:

Opening

1. If you are the first one to the office for the day, please turn on the waiting room/reception area lighting, turn on the music, and tidy up the beverage table (turn on any fountain, fireplace, etc. specific to each office).
2. Please turn on the overhead lights in all of the other offices and any sound machines.

Closing

1. **ALWAYS shut down your computer completely when YOU are finished for the day, even if someone else might be using your computer that day** – failure to do so may expose a security/confidentiality risk. (Additionally, do NOT check the box to remain logged in at all times or use the shortcut for saving any passwords)
2. When leaving and you are not the last one, **please turn off all of your office lamps and leave your overhead light turned on.** This provides the illusion that there are others in the office in case a therapist is the only one left at the end of the day/evening.
3. The last person at the end of the evening will turn off all overhead lights, lamps, and music.
4. Check that the file cabinets are locked. File cabinets should be locked at all times.
5. If you are leaving during the business day, and no one else is in the office, please lock the inside office doors.

Note: At St. Paul use the in/out board in the staff kitchen & turn off all overhead lights.

Housekeeping

Our waiting room is our client's first impression – do your part to ensure that their first impression is a good one!

It is especially important to keep checking the shared areas of the office throughout the day.

- Take out any trash, stock up & clean the beverage table, straighten chairs, and tend to anything else that you see. If you are too busy to do this, please alert another staff to take care of any housekeeping concerns you see.

- Take note of any items needed (cups, water, spoons, napkins, teas, etc.).
- Alert Jenny or Drew of any items in need of replacement, repair or cleaning/maintenance.

We have a professional cleaning service that cleans our offices each weekend. If you notice any areas that have been missed by the cleaning service, please let Jenny or Drew know.

Supplies

Each office has a designated Point Person who keeps track of supplies and sends a list to Drew weekly. If you notice that we are low or out of any supplies, please email the Point Person add items to the list provided in the staff work area. Low supplies = one package remaining of any necessary supplies.

Office Sharing

If you are sharing an office with another therapist, please be certain to discuss any schedule variations with Jenny. This will prevent any scheduling conflicts. In some instances, you may be expected to discuss office schedule variations with your office partner, after initially discussing it with Jenny. Please be sure to balance the shared space so that each person has space for books, etc. If any concerns arise, please connect with your office partner to resolve and loop in Jenny if assistance is needed to resolve any concerns.

Office Furniture

Please alert Jenny if the furnishings in your office are in need of cleaning/maintenance, repair/replacement. Should the need arise to replace furniture, you are welcome to purchase furniture yourself or provide feedback to Jenny regarding your style preferences.

Consult Meetings

Staff meetings take place on a monthly basis.

There are 4 staff meetings per month, in order to accommodate all staff attending 1 meeting per month. Lunch is provided for the onsite meetings. The staff meetings are primarily a time to consult on clients and to briefly discuss day to day operations of RRC. From time to time, staff meetings will involve trainings and/or other opportunities for staff development.

Please RSVP after the 15th and before the 1st of each month – the menu will be emailed out to you as your reminder. Your attendance is expected and greatly appreciated. If you cannot attend, please follow up with Jenny to get notes and other information that you missed.

A yearly list of the staff meeting dates is located on the J drive, Staff Resources website & is sent with your Welcome email.

General Procedure Information

Staff Resources Website

Important information is available here as is the link to the online Orientation Guide

J Network Drive on Office Computers

Important information can be located in the RRC Review folder – located on the J Network Drive in the STAFF FORMS Folder.

Please do not store confidential information on the actual office computer. Saved documents must be stored electronically on the J Network drive – a folder with your name is provided. If you use a form such as Letterhead, please save it as a new document right away as we don't want your document to overwrite the original.

CC Agreements and Emailed Statements

Please take a moment to review the Counseling Policy packet for each of your clients in CS. If your client completed a CC agreement and/or gave permission to receive statements via email, this will need to be entered into the Valant Card Manager.

Billing

Billing is to be completed at the end of each work day – with all documentation completed.

As part of practice management, it is important that you observe your billing via the View/Edit Charges tab for any potential claim issues. **Billing and payments must be entered on the same day as the service.**

Alert Jenny & Admin to any potential claim issues.

Always reply to “all” when there is a current email string discussing the claim (usually the original intake email) and also please respond back to an existing email string rather than create a new one. To alert Admin to issues as you can imagine, we have many strings of emails going on about problem claims and we do not want any new info to be missed.

Statements and Itemized Receipts

A client may request a statement for insurance/accounting purposes. These are to be requested when client's current balance is paid in full. Statements are not in place a way for client to get a “bill” —we do not let clients accrue balances and have them pay each time. Statements are sent via the Patient Portal, so your client must have an active Patient Portal.

Statement requests must be in by Thursday of each week. Any statement requests received each week will be reviewed the following Monday to send out on Wednesday.

To assist in ensuring that requests are not missed, please carefully complete your request as follows:

In the SUBJECT line write: Statement

(Whether it is a receipt or a statement, please only write the word Statement and nothing else. We need to be able to quickly search for & locate requests.

In the BODY of the email please give us:

First initial & last name

Office location(s)

ie: J.Smith -Andover

Any other info, such as “statement for all of 2016” or “itemized receipt for payments made on 4/22 and 5/30”

Email to Julie & Jenny.

It is important that any cost estimated payments or other payments collected or charged are as close to the actual amount as possible. When overages occur, it can result in a delay in providing a receipt, as itemized receipts (for client flex or spending account reimbursement) need to show that the full payment is applied to services rendered. If you need assistance in knowing how much you should be charging or collecting, please ask.

Collecting Balances

Our policy is to collect payments immediately when due. We do not send out statements to clients to collect balances. If a client has a deductible or insurance is not verified, the Estimated Payment amount. See the Cost Estimated Payment chart for more info.

All clients with no sessions scheduled will need to be CLOSED and closed clients with a \$0 account balance will need to be de-activated in Valant.

Please collect all patient balances in full at next session. See section on Estimated Payments for more info. The chances of payment decrease after a client discontinues counseling. Collecting payment at the time of session not only prevents the mounting of high & intimidating balances, it ensures that you are paid for your work.

Balances not collected will need to be charged to the client’s credit card on file. If not paid within 30 days of the balance posting, the CC on file should be charged.

Feel free to follow up with a reminder to clients to pay their balance, ***but do not wait beyond 30 days to charge the CC on file***. Please ensure that the CC on file is current and if it expires, instruct your client to complete a new CC Auth located under Current Clients tab on RRC website.

Collections

If a client is closed and is not responding to statements and/or the credit card on file is declined/expired, then these are accounts we will want to consider for collections. Please try to make a concerted effort to contact your client directly about payment before giving us his/her name for collections. Note: we have not had to utilize a collection agency in YEARS, so please be diligent in following up on balances so we can continue this trend!

Documentation Guidelines

Please take a moment to ensure that your client charts are in line with the standards & expectations that we must follow in order to bill insurance.

- Counseling Policies reviewed and signed.
- Credit card on file is required except for those with MA/PMAP.
- DA/Eval written using the Intake Note in Valant.
- DA/RE-eval yearly or major change – 90791. If you make a major change in diagnosis, be sure to do a new DA and bill a 90791. Create a new Tx Plan also.
- ROI e-faxed to Primary Care Provider (PCP) or refusal noted (even if no meds) – required for Maj Dep dx and ADHD.
- If your client has a **Major Depression** diagnosis, you MUST document a discussion about a medication evaluation in your chart. If the client is on meds, you must also document coordination of care OR client's refusal to allow coordination of care.
- Progress note for each session.
- Tx Plan signed by client, therapist, & supervisor (if applicable) on or before 4th session
- Tx Plan Reviewed every 180 days
- D/C Summary to PCP
- D/C Letter to client if unplanned termination

Master File Location

Client files are the property of RRC. If you leave RRC, you must leave your original file with us. This is primarily for audit purposes, as we are required by insurance companies to keep all files for a minimum of 10 years. As an independent contractor with RRC, you are contracted under RRC for insurance purposes. With Jenny's written permission and a Release of Information, you may copy a file for your records in the event that a client follows you.

Record Copies

On the J Drive there is a folder called RECORD COPIES. In it, you will find a Records Statement, a Record Copies Worksheet, & an Invoice for Record Copies-nonsocial security. Please take a moment to review these 3 items. When you get a request for records, please complete the Records Statement and fax it the

appropriate phone number. (For how to fax see page ____). The Record Copy Worksheet is intended to be a guide for assisting you with things to consider when getting record copies. The Invoice for Record Copies an invoice to send to whoever is requesting the records. Social Security has its own invoice. This info is also available on the Staff Resources website.

Insurance Procedures

Insurance information is entered and verified by Admin. Once verified admin will reply to the original intake email with some information about the coverage but the therapist must review the Notes/Images tab on the Patient tab in Valant to determine exact coverage and billing restrictions. The copay is also listed on the Demographics tab of the Patient tab in Valant.

Secondary Insurance or HRA's

Do not collect until processed – it is very complicated – Jenny will let you know or you can ask.

If you have a client with secondary insurance and are wondering about if the secondary has processed, please email Jenny to check. If a client has an HRA, he/she must be aware of how it works. HRA payment info is provided to the HRA by the primary insurance company after they process the claim.

Providers are not directly contracted with HRA's, so clients must communicate with the HRA directly.

MA Pmaps

Pmaps for BC, HP, and UBH are identified in Valant in order for us to denote whether the insurance is regular or thru MA. We re-verify straight MA and Pmaps each month, in the case the clients switch plans. If we find your client loses or changes coverage at the beginning of the month when we re-verify you will receive an email letting you know. If you client loses coverage please call them and let them know they cannot be seen until coverage is back in place. If the coverage changed to a different type of PMAP you do not need to do anything.

For clients with Pmap's - Please be diligent in asking your clients about any insurance changes on a very regular basis - especially those on Cobra, MA Pmaps , or those going thru major changes (employment, divorce, etc.). Please refrain from scheduling a client with MA or a MA Pmap the first few business days of the month, giving us time to re-verify coverage.

EAP's

Make sure to carefully read the instructions on the Notes/Image tab regarding how to bill the EAP and/or knowing which paperwork to complete.

Coordination of Benefits (COB)

This is necessary for insurances to know in order to pay claims properly. What your clients need to know:

1. **COB** = Is informing your health insurance if you have other insurance besides the policy with them.

2. If **COB** information is updated with your insurance, claims will process correctly.
3. If **COB** information is **NOT** updated with your insurance, claims will be denied until the update is received.
4. Insurances require a **COB** update at least 1 time per year, some require more.
5. When receiving new insurance coverage (even through the same insurance company) a **COB** update is **mandatory** with your new insurance policy. Be sure they are updating **COB** with the **new** insurance policy and not the termed policy if having prior coverage with that insurance. (This is the **COB** update.)
6. If you had, or currently have, more than one insurance at a time, each insurance needs a **COB** update. You **NEED** to call each insurance and tell each of them about the other policy and provide that policy information to them. (This is the **COB** update.)

Insurance Chart Audit Criteria

If we keep all files up to these standards, we will have less to worry about in the event of an audit. The info below has been provided by one of the insurance companies that we work with.

<p><u>Diagnostic Assessment Report:</u> 90791 needs a DA report, not just a regular PN To be completed prior to the third session DA must include the following elements:</p> <ul style="list-style-type: none"> • Presenting problems/ justification of DSM diagnosis • Family history • Chemical health history • Medical and psychiatric history • Appropriate psychiatric referral (adherence to DHS guidelines for psychiatric referral) • Acknowledgment of other practitioners • Note if client declined or consented for PCP collaboration • Relevant social conditions • Mental status • Risk assessment (i.e. suicidality, homicidality, self-injurious behavior, substance abuse/dependence, physical/sexual abuse, child/elder neglect or eating disorder) • Patient's strengths and limitations • DSM 5 codes 	<p><u>Treatment Plan:</u></p> <ul style="list-style-type: none"> • To be completed prior to the fourth session • Must address the following: • Diagnosis • Measurable goals (Includes baseline data and desired outcome. Goals are stated with frequencies, percentages, or a Likert scale that can objectively indicate progress.) • Estimated time frames for treatment goals • Discharge planning • Special status situations (if any risks are identified in the diagnostic assessment, they need to be addressed in the treatment plan.) <p>Must include: Signatures (Includes patient's signature once a year, provider's signature on each treatment plan and review, and supervisor's signature when applicable.)</p> <p>Document in the individualized treatment plan (ITP) the specific interventions with measurable goals and objectives (including start and stop time) describing how the mental health professional will use psychotherapy to treat the member's mental illness.</p> <p>Reviewed and updated every 180 days or if major diagnosis change.</p>
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<ul style="list-style-type: none"> • Clinical plan • Explained informed consent <p>Medical necessity Document the medical necessity for psychotherapy in the diagnostic assessment.</p>	
<p><u>Progress Notes:</u> Present & signed for each date of service billed Each progress note must include:</p> <ul style="list-style-type: none"> • Type of service • Date of service • Session start and stop times • Scope of service (nature of interventions or contacts including treatment modalities, phone contacts, etc.) • Client's progress (or lack of) to overall treatment plan goals and objectives • Treatment or intervention activity & Client's response or reaction to treatment intervention(s) • Client provided information (verbal and non-verbal information the client provided) • Formal or informal assessment of the member's mental health status (current functioning and issues) • Name and title of person who gave the service • Date documentation was made in the member's record • Action plan • Type of service rendered (CPT code or name and duration of service) • Date and responsible clinician's name (present on all entries) • Required clinical supervision (when applicable, supervision is documented) <p>Other elements that may be included:</p> <ul style="list-style-type: none"> • Current risk factors the member may be experiencing • Emergency interventions • Consultations with or referrals to other professionals 	<p><u>Discharge Documentation</u> Describes the termination and/or transition of services. It provides closure for a service episode and referrals, as appropriate. There are two (2) types of clinical discharge documentation:</p> <ul style="list-style-type: none"> • Discharge Note: A brief Progress Note to indicate that the case is closed, per the Minimum Requirements below. (This is considered an administrative activity and is not billable unless it is part of a final billable service with the client present.) • Discharge Summary: A comprehensive document that is clinically necessary in order to provide continuity of care for the next service provider, per the Minimum Requirements below. <p>Timeliness of Discharge Summary & Discharge Note Cases/episodes must be closed within 90 days (3 months) after the client's last service, unless the rationale for maintaining an open case is written in the clinical record.</p> <p>A quarterly written rationale must be provided if the case will be kept open during continued noncontact. Discharge documentation must be entered into the clinical record within one (1) working day of the discharge decision, but prior to closing the episode, and must be clearly labeled as either "Discharge Summary" or "Discharge Note".</p> <p>Minimum Requirements Discharge Note: A Progress Note that includes brief documentation of the following:</p> <ol style="list-style-type: none"> a. Reason for discharge/transfer. b. Date of discharge/transfer. c. Referrals made, if applicable. d. Follow-up care plan. <p>Discharge Summary: A document that must meet the requirements of a Discharge Note plus a summary of the following:</p> <ol style="list-style-type: none"> a. Treatment provided. b. Overall efficacy of interventions

<ul style="list-style-type: none"> • Summary of effectiveness of treatment, prognosis, discharge planning, etc. • Test results and medications • Symptoms 	c. Progress made toward the mental health goals/objectives. d. Clinical decisions/interventions: <ul style="list-style-type: none"> • Treatment planning recommendations for future services relevant to the final Client Plan; and • Referral(s) for aftercare services/community support services.
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Interactive Complexity

Use the Interactive Complexity add-on code (90785) to designate a service with interactive complexity. Report interactive complexity for services when any of the following exist during the visit:

- Communication difficulties among participants that complicate care delivery, related to issues such as:
 - High anxiety
 - High reactivity
 - Repeated questions
 - Disagreement
- Caregiver emotions or behaviors that interfere with implementing the treatment plan
- Discovery or discussion of evidence relating to an event that must be reported to a third party. This may include events such as abuse or neglect that require a mandatory report to the state agency
- The mental health provider overcomes communication barriers:
 - By using any of the following methods:
 - Play equipment
 - Physical devices
 - An interpreter
 - A translator
 - For members who:
 - Are not fluent in the same language as the mental health provider
 - Have not developed or have lost the skills needed to use or understand typical language

Estimated Payments

For clients with a deductible, we collect an estimated payment amount at the time of service. Cost estimation tools provided by insurance company allow the collection of coinsurance and deductible amounts up front at the time of service, rather than waiting until after the claim is processed. This collected payment is based on an estimate of out-of-pocket costs for services provided. Actual coverage and member liability amounts are determined once the claim is processed and the client receives an explanation of benefits (EOB). Any overpayments will be applied to ongoing balances or refunded within 30 days of

claim processing. Any underpayments must be paid by mail, online at our website, or at the next scheduled appointment (if scheduled appointment occurs within 1 week of receiving the EOB). You will receive an updated cost estimated chart along with your Welcome email.

Scheduling/Intake Process

Scheduling Process

The Admin team does the intake scheduling.

Always call Drew's cell at 612-382-0032 for scheduling emergencies (even if you contact Admin) - emailing is not sufficient.

Your Schedule

If you need to make changes to your schedule or are wanting to add additional clients, please inform Jenny. Jenny will coordinate this with you and with Admin.

Open Intake:

As long as you are accepting new clients, please mark your openings as "Open Intake" or "Open Intake TELETHERAPY." Even if you feel your schedule is full we suggest putting up openings a month or two out as many people will wait that long to see you!

Open Therapy:

Appointment times reserved for your current clients only. If you are not accepting new clients, it is still very important to enter your open times as "open therapy" so that we are aware of your scheduling and can assist your current clients with any immediate scheduling needs. Please keep your schedule updated a minimum of 2-3 weeks out at all times, regardless if you are taking new clients (4-5 weeks if taking new clients).

Vacations and Time off

For noting vacations or time off on your schedule – reserve this in only ONE slot at the top of your schedule. If you literally reserve all of the times on the full day, then it makes the master schedule difficult to read.

Intake "No-Shows"

We currently provide all new intakes with "reminder" emails. Admin is responsible for de-activating no show intakes – however they only know if there was a no-show intake if you let them know. So, if they do not hear anything from you, they will continue scheduling them, even if they keep no-showing – that is why it is important to let her know of no show intakes.

We make it a priority to inform new clients of our "No-Show" Policy: If a client "No Shows" for their first appointment we are unable to provide them with future services.

****Remember to reply ALL to the intake email if a client “No-Shows” to an intake and what the plan is with this client.**

No Show/Late Cancells MA/PMAPs

It the intake, review our counseling policies as is. If they no show or late cancel, you don't say anything about the charge - enter and invoice and add a Billing Note for me to write it off. And, let them know immediately that they will be subject to same day appointments or discontinuation of services. Same day means that they cannot schedule out with you anymore and that they would need to contact you the day before or the day of to be seen.

Other Intake Info:

- The Counseling Policies include the ability for clients to upload a copy of their ID and Insurance card. At the intake session – we are required to have a copy of the client’s ID/Driver’s License and BOTH sides of the client’s insurance card.
- Intake email: Every time a new client is scheduled with you, Admin will email you the date & time as well any issues (for new clients) that they are wanting to discuss. We ask that once you receive a “Intake” email that you reply with a simple "got it" or “thank you” so we know you are aware of the appointment.
- We provide reminder emails/texts/calls for appointments.
- All intake appointments that need to be canceled or scheduled by the client can be taken care of by our office, but any ongoing appointment reschedules or cancels are handled by you, the therapist.
- Be sure and provide your clients with your ext # and maybe your email address too. We do inform new clients that we are unable to provide future services if they No Show for the first appointment. We emphasize the importance of letting us know!

Minors with unmarried parents are required to have both parents’ (with legal custody) signatures into us PRIOR to scheduling. Alternatively, if unable to obtain both parents’ signatures, we will accept a note from an MD verifying the medical necessity of us seeing the client. If only one parent has sole legal custody, we need proof via custody paperwork or will accept a completed Minor Consent form, as this is a legal document for consent purposes.

RRC does not send statements to clients for balances. You will collect any copays or other payments per Payee info or Patient Balance listed in Billing in CS.

Please contact Jenny or Jenny if you are uncertain as to what you will need to collect. Please review our Counseling Policies regarding this and be sure to review carefully with clients at intake.

The only additional forms you may need are extra Releases of Information. These are also located on our website.

Intake Process

Scheduling workflow	
New Intake:	Returning/Transfer/Direct Referral:
Client calls or completes an online appt request form	Client calls or completes an online appt request form
Client is emailed link to complete Counseling Policies Minors with Divorced Parents Counseling Policies from both parents are required Non-IP's for Family Therapy Non-IP version of Counseling Policies required	Client is emailed link to complete Counseling Policies Minors with Divorced Parents Counseling Policies from both parents are required Non-IP's for Family Therapy Non-IP version of Counseling Policies required
Once signed Counseling Policies are received, contact client via phone or email to schedule	Once signed Counseling Policies are received, contact client via phone or email to schedule
Create a new client and add registration info (if returning client, we update registration info)	Create a new client and add registration info (if returning client, we update registration info)
Schedule client if New Client in Purple Open Intake	Send Intake Email to therapist, supervisor (if applicable) and the rest of the admin team
Set appt reminder(s)	Set appt reminder(s)
Set up portal	Set up portal
Send out measures	Send out measures
Send Intake Email to therapist, supervisor (if applicable) and the rest of the admin team	Admin team completes any additional verification, gets authorizations if needed & let therapist & team know OK to schedule
Admin team completes any additional verification, gets authorizations if needed & let therapist & team know	Therapist schedules and updates all via the Intake Email
Therapist workflow	
New intake:	Current client:
Receive Intake Email & reply ALL	Receive Intake Email & reply ALL
Observe appt on schedule & send Google Meets invite	Review balances in CS and/or Valant & have client pay prior to returning
Initiate outbound message to client via Client Portal	Schedule appt on Valant schedule, send Google Meets invite and reply to Intake Email
Review insurance info (to know what the pat resp due is (copay, co-ins, ded)	Send one time measures, if needed (History and/or Screening Form)
Review the Signed Counseling Policies in Patient Chart Documents	Appt reminders, if not done already?
Enter CC info in Card Manager for non MA/Pmap clients	Initiate outbound message to client via Client Portal

Review history and screening forms in Uninitialed Documents in Documents tab	Review insurance info (to know what the pat resp due is (copay, co-ins, ded)
Click on the appointment to add billing code (click on Patient tab to see if ins name is in lower or UPPER case)	Review the Signed Counseling Policies in Patient Chart Documents
Document session using Mobile Notes - use Intake Note that matches the History form	Enter CC info in Card Manager for non MA/Pmap clients
Accept Payment or Accept Prepayment and Record appointment or Record appointment if no payment charged	If sent, review history and screening forms in Uninitialed Documents in Documents tab
Schedule followup session(s)	Click on the appointment to add billing code (click on Patient tab to see if ins name is in lower or UPPER case)
Appt reminders - edit if needed	Document session using Mobile Notes - If billing Intake and/or History measure sent, use Intake Note that matches the History form
Set up ongoing measures	Accept Payment or Accept Prepayment and Record appointment or Record appointment if no payment charged
Treatment plan - by end of 3rd visit	Schedule followup session(s)
	Appt reminders - edit if needed
	Set up ongoing measures
	Complete/update treatment plan

SCHEDULING PROCESS FOR DIRECT REFERRAL, RETURNING AND/OR CURRENT CLIENTS (rev. 11/1/2020)

DIRECT REFERRAL CLIENTS: A potential new client who contacts the therapist directly (as a direct referral or other means).

RETURNING "CLOSED" CLIENTS: Returning client who is officially closed or has had a break in therapy over 3 months & should be closed & contacts the therapist directly to resume counseling.

CURRENT CLIENTS: Active clients who have had a break of less than 3 months & who contact the therapist directly to continue counseling OR current clients who have insurance or other registration updates

	NEW INTAKE	DIRECT REFERRAL	RETURNING CLIENTS	CURRENT CLIENTS
Refer Client to Registration		Therapist directs potential client to main ph# or to website Online Scheduling Form (for NEW client registration).	Therapist directs the potential client to website Update Registration Form or main ph# 763-482-9598, Option 2.	
Alert Admin Team		Therapist emails Admin via <i>registration@rumrivercounseling.com</i> to give the heads up that the direct referral client will be registering to see them.	Therapist emails Admin via <i>registration@rumrivercounseling.com</i> to give the heads up that current/returning client will be updating registration/insurance information If possible, try to use the original email string from the first intake, as we try to keep track of changes by using the same string when possible. Otherwise, be sure that the subject line of the email	

			includes the clients first, last name and office location if you work at more than one office.
Client contacts Registration	Client calls or completes an online Appointment Request form	Client calls or completes an online Appointment Request form & therapist is notified.	Client calls or completes an online Registration Update or Appointment Request form & therapist is notified.
Counseling Policies required prior to scheduling	Admin emails client link to electronically complete Counseling Policies Minors with Divorced Parents Counseling Policies from both parents are required Non-IP's for Family Therapy Non-IP version of Counseling Policies required	Admin emails client link to electronically complete Counseling Policies Minors with Divorced Parents Counseling Policies from both parents are required Non-IP's for Family Therapy Non-IP version of Counseling Policies required	If client does not have current Counseling Policies, including Telemedicine Policy & Consent, then Admin emails client link to electronically complete Counseling Policies Minors with Divorced Parents Counseling Policies from both parents are required Non-IP's for Family Therapy Non-IP version of Counseling Policies required
Counseling Policies received	Admin schedules client in Purple Open Intake & sends out Intake Email Patient Type is "Needs Verification New Intake" until verification complete.	Admin sends email notifying therapist Counseling Policies have been received and that verification is in process Patient Type is "Needs Verification New Intake" until verification complete.	Admin sends email notifying therapist Counseling Policies have been received and that reverification is in process Patient Type is "Needs Verification Transfer/Return/Update" until verification complete.
Appt reminders & Portal invite	Admin sets up appt reminders & portal invite sent	Admin sets up appt reminders & portal invite sent	Admin sets up appt reminders & portal invite sent (if not done previously)
Measures	Admin sends out the Intake Measures	Admin sends out the Intake Measures	Therapist sends out One-time Measures, if needed.
Verification	Admin verifies coverage within 5 business days of the registration. Patient Type is changed to Verified..."	Admin verifies coverage within 5 business days of the registration. Patient Type is changed to Verified..."	Admin re-verifies coverage within 5 business days of the registration update. Patient Type is changed to Verified..."
Permission to Schedule		Once verified, Admin emails back "ok" for therapist to schedule	Once verified, Admin emails back "ok" for the therapist to schedule

Scheduling	Occurs immediately after Counseling Policies received	If no availability on schedule, therapist schedules direct referral Evaluation (Intake).	Therapist can schedule returning client for Evaluation (Intake).	Therapist can schedule the current client for regular appointment.
Google Meet Invite	Therapist sends client invite to teletherapy session via Google Meet	Therapist sends client invite to teletherapy session via Google Meet	Therapist sends client invite to teletherapy session via Google Meet	Therapist sends client invite to teletherapy session via Google Meet
Appointment Notification		Therapist informs Admin of the intake date by replying to intake email.	Therapist informs Admin of the intake date by replying to intake email.	Therapist does not need to inform Admin of the appt date by replying to intake email.

Intake Email Example

Client Name-

Office-

Therapist-

Date & Time-

Insurance-

Reason for visit-

Additional info-

Paperwork- emailed portal invite to [email address(es)]

- Policies have been received & will soon be uploaded in the Patient Chart under Documents (cc auth is included, if non-MA).
- Portal invite has been sent & Measures have been sent to the client Portal.
- Measures (Clinical History, diagnostic screening forms), once complete, are located in Uninitialed Documents until AFTER the Mobile Note is started. (Before the Mobile Note is started, Measures can be viewed, but NOT initialed, or will not populate into the Mobile Note. Once the Mobile Note is started, the Measures move to the Patient Chart under Documents.)

Once verified:

- Insurance is active - In Patients, look for insurance info in Notes/Image. Copays will be shown on the Demographics page.
- Policies have been received & are uploaded in the Patient Chart under Documents (cc auth is included, if non-MA).
- Portal invite has been sent & Measures have been sent to the client Portal.
- Measures (Clinical History, diagnostic screening forms), once complete, are located in Uninitialed Documents until AFTER the Mobile Note is started. (Before the Mobile Note is started, Measures can be viewed, but NOT initialed, or will not populate into the Mobile Note. Once the Mobile Note is started, the Measures move to the Patient Chart under Documents.)
- Please be sure to select the billing code for the insurance written in UPPERCASE or lowercase

Overview of Electronic Documents in Valant

We used to have paper Policies and Personal History forms that were sent out to clients when we saw them in person. The admin team sent out the forms to clients and it was the responsibility of the client to complete and the therapist to check to ensure that everything was completed fully (then, it was scanned & uploaded into CS). If clients did not complete a personal history, we required that they complete this in the waiting room during the appointment time.

At the New Year, we switched to electronic intake forms, and the system we used to manage our electronic forms only had admin access, so therapists relied on the admin team to upload the electronic intake forms. We began requiring forms to be completed 3 days prior to the intake or we rescheduled/cancelled the intake in order to provide time for us to manage the incoming forms.

Now that we have electronic forms integrated within our EMR, therapists are able to manage the receipt of the paperwork. Therapists are also able to schedule measures to be completed on a recurring basis between appointments and to send one time measures to the portal to screen clients for changes in diagnosis, reviewing treatment, assessing progress, etc.

The **Patient Chart** in Valant is virtually the manilla file folder we used for the client's paper chart.

- ✓ The "Overview" is similar to a Service Record or face sheet. There, you can find the current diagnosis, previous/upcoming appointments, as well as copies of your Notes.
- ✓ The Diagnosis tab is where you can edit or add a Diagnosis.
- ✓ The Measures tab is where you would set up a one time measure or a recurring measure to be sent out between appointments.
- ✓ The Documents tab is where you would find the completed "Counseling Policies" and the Measures AFTER you complete the Mobile Notes.

Counseling Policies

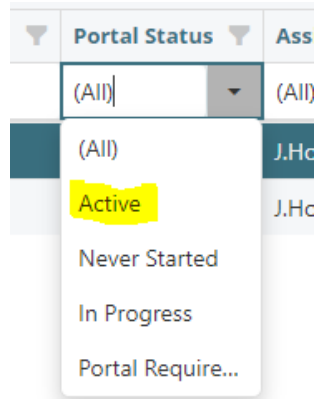
You can find the completed & signed Counseling Policies in the Documents section of the Patient Chart. The credit card authorization is included in this document for non MA/Pmap clients) and is where you will locate the credit card authorization information for adding a credit card on file in the Card Manager.

Once we receive the completed & signed Counseling Policies (including a CC authorization for non-MA clients) the new intake is scheduled and we send the Portal Invite out to the client.

Client Portal

The Measures are sent to the Portal immediately and can be completed once the portal is activated. Once the Portal is Active, an email will automatically be sent from Valant to the client to notify them of the Measures and a reminder email notification will be sent to the client from Valant 2 days prior to the scheduled appt. Registration sends the Portal Invite once Counseling Policies are received & Registration is completed (New Intake/Direct Referral) or updated (Returning/Transfer client).

Returning/Transfer client: Therapists can schedule the appointment once the Counseling Policies are received. It is important to monitor that the Portal is "Active" so that the client has enough time to complete the Measures. Under Patients, therapists can see when the Portal status is "Active."



Intake Measures

The next most important documents would be the Intake Measures (History Form, Symptom Screener, etc.). The Measures, once completed by the client, are temporarily "stored" or held in the Uninitialed Documents tab on the main menu (or on the Dashboard). Essentially, these documents are stored/held here until you begin your Mobile Note. Completed Measures in Uninitialed Documents can be viewed prior to the intake (***do NOT "initial" the measures or they will not populate into the Mobile Notes***).

Once the Mobile Note is started, then the Measures are automatically transferred to the Documents section of the Patient Chart. (This is how it works for all Measures, whether they are intake measures or they are measures you send as one time or recurring measures.)

If you have an intake and do not see that the Measures are in the Uninitialed Documents folder, then you can send your client a secure Message via the portal to remind them to complete them.

Electronic Forms Q&A

Q. What to do if your client completes the Counseling Policies, but fails to complete the Measures at all or does not complete them fully?

A. You can still see the client, but bill that first visit as a regular appointment (90834, 90832, 90837, 90847) and let them know that the Measures **MUST** be completed fully prior to the next appointment. Once the completed Measures are received, you would bill that subsequent appointment as the 90791 as it will have the info necessary for you to complete the DA. Since we cannot really have them go and sit in the waiting room to complete, this is the alternative. Let them know how important it is to have the History and Screening forms completed. If they fail to complete those by the next session, consequently, I would recommend spending the session reviewing the info in the Worksheets of the Intake Note (click the options on the Worksheet so that it generates the narrative). If your client completes the Measures, but not fully, you can go to the Patient Chart – Measures and send a one time measure of the measure that was not completed fully.

Q. What if the CC info provided does not work?

A. Direct clients to our website – Current Clients tab – where they can complete the Credit Card Updates link, as this is required for all non-MA insured clients, even if a ded or MOOP has been met. This needs to be completed prior to scheduling follow up sessions.

Intake Measures sent to the Client Portal:

Adults:

- ✓ Adult Symptom Screener
- ✓ Clinical History Form
- ✓ DSM Cross Cutting Measures
- ✓ (and, if MA client, send CAGE-Aid and WHODAS)

Couples (each person, including the Non IP)

- ✓ MFT Clinical History Form
- ✓ Clinical History Form
- ✓ DSM Cross Cutting Measures
- ✓ (and, if MA client, send CAGE-Aid and WHODAS)

Children:

- ✓ Child Symptom Screener
- ✓ Comprehensive Child History

History Forms

Clinical History Form (CHF)

- The CHF contains 16 of the sections of the Intake Note
- Designed to be assigned pre-intake to the patient (via Patient Portal) if you will be using either the Intake Note or the Child Intake Note
- Can be assigned as a one-time measure on the Measures tab in EMR
- After the patient submits it, start your Intake Note or Child Intake Note, and the data will pre-populate the appropriate sections
- If for any reason you don't want these data to be pulled into your Intake Note or Child Intake Note, simply "ignore" the CHF on the "Template Details" page when starting your note
- The 16 sections are: Stressors; Substance History: Substances used, Treatment History, and Consequences of Substance Abuse; Past Psychiatric History: Inpatient, Outpatient, Suicide/Self Harm, and Violence; Past Medical History; Psychiatric Medicine History; Patient Allergies; Family Psychiatric History; Social History: Developmental & Educational, General, and Menstruation & Pregnancy; and Review of Systems

MFT History Form (MFT CHF)

- Designed in partnership with and endorsed by the American Association for Marriage and Family Therapy (AAMFT)
- The MFT CHF contains 18 of the sections of the Marriage and Family Therapy Intake Note
- Designed to be assigned pre-intake to the patient (via Patient Portal) if you will be using the Marriage and Family Therapy Intake Note
- Can be assigned as a one-time measure on the Measures tab in EMR
- After the patient submits it, start your Marriage and Family Therapy Intake Note, and the data will pre-populate the appropriate sections
- If for any reason you don't want these data to be pulled into your Marriage and Family Therapy Intake Note, simply "ignore" the MFT CHF on the "Template Details" page when starting your note
- The 18 sections are: Referral; Relationship Information; Presenting Problem - Intake; Family of Origin History; Substance Abuse Hx; Substance Treatment Hx; Substance Use Consequences; Inpatient Hx; Outpatient Hx; Suicide/Self-Harm Hx; Violence Hx; Past Medical Hx; Psychiatric Med Hx; Developmental and Educational Hx; General Social Hx; Menstruation and Pregnancy Hx; Family Background; External Systems

Comprehensive Child Clinical History Form (CC CHF)

- The CC CHF contains 21 of the sections of the Child Intake Note - Comprehensive
- Designed to be assigned pre-intake to the patient (via Patient Portal) if you will be using the Child Intake Note - Comprehensive
- Can be assigned as a one-time measure on the Measures tab in EMR
- After the patient submits it, start your Child Intake Note - Comprehensive, and the data will pre-populate the appropriate sections
- If for any reason you don't want these data to be pulled into your Child Intake Note - Comprehensive, simply "ignore" the CC CHF on the "Template Details" page when starting your note
- The 20 sections are: Introductory Information; Chief Complaint; Current Behavior; Review of Systems; Mental Health Treatment/Evaluation History; Psychiatric Medication History; Medical History; Social History - Menstruation & Pregnancy; Family Mental Health/Social History; Family Medical History; Prenatal Development and Birth History; Developmental History; Current Living Situation; Family Relationships; Educational History; Social History; Lifestyle Health; Legal History; Trauma/Stressors; Spiritual Orientation; Caregiver Comments

Measures

In most cases, third-party payers require diagnostic screening as part of the Diagnostic Evaluation. Another treatment standard involves clients with Depression or AD/HD to complete a standardized screening questionnaire (such as the PHQ) at the first session to guide treatment. RRC requires all clients to complete screening forms to assist with providing the highest standard of care.

Once the patient has submitted the Measure, you may preview it on the uninitialed documents tab in Valant. Do not initial it or it won't later be pulled into your Intake Note. If you want to fill it out in session, you can click Edit Measure on the Intake Note and edit the measure. Be sure to save when finished.

Based on your Intake Measure results, you may assign follow-up measures. Then, when you open your Note for follow-up appointments, the completed follow-up measures will be pulled into your Mobile Note.

Most Mobile Notes Measures in Valant generate a numerical score that can be tracked over time in the Measurements tab in the patient's clinical chart. These scores will automatically populate from the Measure to the Measurements tab.

Rum River Counseling Inc

Jennifer Holdredge, Dr. / MA PsyD, LMFT

Sam Practice Client (PRASAM)

Measurements: Sam Practice Client (PRASAM)

+ New Options EasyNav

OVERVIEW
DIAGNOSES
DOCUMENTS
MEDICATIONS
ALLERGIES
LAB REQUESTS
PATIENT TASKS
MEASUREMENTS
LAB PANELS
MEASURES
HISTORY
DASHBOARD
HELP
REFRESH

Measurement
Date Range

MEASUREMENT

DATE

VALUE

PCLS - Weekly - Arousal Subscale	09/21/2020	0
PCLS - Weekly - Avoidance Subscale	09/21/2020	4
PCLS - Weekly - Cognitions Mood Subscale	09/21/2020	8
PCLS - Weekly - Intrusion Subscale	09/21/2020	9
PCLS - Weekly - Total Score	09/21/2020	21

Below is a list of all Mobile Notes Measures indicating which will import scores to the Measurements tab in the patient chart.

Measure	Imports to Measurements?
Adult Symptom Screener - Adult Symptom Screener	No
Agoraphobia Subscale - Agoraphobia Subscale	Yes
*AIMS - Abnormal Involuntary Movement Scale	Yes
ASRS-v1.1 - Adult ADHD Self-Report Scale Symptom Checklist	Yes
AUDIT - Alcohol Use Disorders Identification Test	Yes
BAM- Brief Addiction Monitor	Yes
CAGE-AID - CAGE Questionnaire Adapted to Include Drugs	Yes
CES-DC - Center for Epidemiological Studies Depression Scale for Children	Yes
Child Symptom Screener - Child Symptom Screener	No

*COWS - Clinical Opiate Withdrawal Scale	Yes
EDE-Q - Eating Disorder Examination Questionnaire	Yes
HDCL-C - Johns Hopkins Depression Checklist for Children	Yes
IPDS - Iowa Personality Disorder Screen	Yes
GAD-7 - Generalized Anxiety Disorder - 7-item	Yes
GDS-15 - Geriatric Depression Scale - 15-item Short Form	Yes
GDS-30 - Geriatric Depression Scale - 30-item version	Yes
ICG - Inventory of Complicated Grief	Yes
MDQ - Mood Disorder Questionnaire	Yes
MEQ - Morningness-Eveningness Questionnaire	Yes
NIDA-Modified ASSIST - NIDA-Modified Alcohol, Smoking, and Substance Involvement Screening Test	Yes
PCL-C - PTSD Checklist - Civilian Version	Yes
PCL-S - PTSD Checklist - Specific	Yes
PDSS - Panic Disorder Severity Scale	Yes
PHQ-9 - Patient Health Questionnaire-9	Yes
PSC - Pediatric Symptom Checklist	Yes
SCARED-Child - Screen for Child Anxiety Related Disorders - Child Version	Yes
SCARED-Parent - Screen for Child Anxiety Related Disorders - Parent Version	Yes
SCARED-Parent Panic Disorder Subscale	Yes
SCARED-Parent GAD Subscale	Yes
SCARED-Parent Separation Anxiety Subscale	Yes
SCARED-Parent Social Anxiety Subscale	Yes
SCARED-Parent Significant School Avoidance Subscale	Yes
SEEK-PSQ - SEEK Parent Screening Questionnaire	No
SPIN - Social Phobia Inventory	Yes
Suicide Ideation Intensity Subscale - Suicide Ideation Intensity Subscale	No
Trauma Questionnaire - Trauma Questionnaire	No
Vanderbilt-Parent - NICHQ Vanderbilt Assessment Scale - Parent Informant	Yes
Vanderbilt-Parent ADHD Subscale	Yes
Vanderbilt-Parent ODD Subscale	Yes
Vanderbilt-Parent Conduct Disorder Subscale	Yes
Vanderbilt-Teacher - NICHQ Vanderbilt Assessment Scale - Teacher Informant	Yes
WHODAS 2.0 - World Health Organization Disability Assessment Schedule 2.0	Yes
*YMRS - Young Mania Rating Scale	Yes
Y-PSC - Pediatric Symptom Checklist - Youth Report	Yes

Screening Instruments

Adult Symptom Screener

A 51-item measure that screens for the following DSM-IV diagnoses: Depression; Generalized Anxiety Disorder; Panic Disorder; Social Anxiety Disorder; Obsessive-Compulsive Disorder; PTSD; Bipolar Disorder; Eating Disorder; Alcoholism; Drug Abuse; ADHD; Personality Disorder; and Schizophrenia/Psychosis.

Designed to be assigned pre-intake to the patient in the Patient Portal, and be pulled into your Intake Note.

Recommended Follow-Up Measures

- Depression = PHQ-9
- Generalized Anxiety Disorder = GAD-7
- Panic Disorder = PDSS
- Social Anxiety Disorder = SPIN
- PTSD = PCL-C
- Bipolar Disorder = MDQ
- Eating Disorder = EDE-Q
- Alcoholism = AUDIT
- Drug Abuse = NIDA-Modified ASSIST
- ADHD = ASRS
- Personality Disorder = IPDS

Child Symptom Screener

A 146-item screener for the following DSM-IV diagnoses in children: ADHD (Inattentive Subtype, Hyperactive/Impulsive subtype, and combined); Oppositional Defiant Disorder; Conduct Disorder; Depression; Anxiety disorders (Anxiety Disorder, Panic Disorder or Significant Somatic Symptoms, Generalized Anxiety Disorder, Separation Anxiety, Social Anxiety Disorder, and Significant School Avoidance); OCD; History of Trauma; Psychosis; Alcohol abuse; Drug abuse; Developmental disorders; Autism Spectrum Disorders; Enuresis; and Encopresis.

Incorporates the entire Vanderbilt parent version, entire SCARED parent version, entire HDCL-C, and other screening questions.

Designed to be assigned as a pre-intake to the patient in the Patient Portal, and be pulled into your Child Intake Note.

Recommended Follow-Up Measures

- ADHD (Inattentive Subtype) = Vanderbilt-parent
- ADHD (Hyperactive/Impulsive Subtype) = Vanderbilt-parent

- ADHD (Combined Inattention/Hyperactivity) = Vanderbilt-parent
- Oppositional Defiant Disorder = Vanderbilt-parent
- Conduct Disorder= Vanderbilt-parent
- Depression = HDCL-C
- Anxiety disorder = SCARED-parent
- Panic Disorder or Significant Somatic Symptoms = SCARED-parent
- Generalized Anxiety Disorder = SCARED-parent
- Separation Anxiety = SCARED-parent
- Social Anxiety Disorder = SCARED-parent
- Significant School Avoidance = SCARED-parent
- History of Trauma = Clinician follow-up
- Psychosis = Clinician follow-up
- Alcohol abuse = AUDIT
- Drug abuse = NIDA-modified ASSIST (beta)
- Developmental disorders = Clinician follow-up
- Autism Spectrum Disorders = Clinician follow-up
- Enuresis = Clinician follow-up
- Encopresis = Clinician follow-up

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure – Adult

A 23-item measure that screens for the following DSM-5 domains: Depression; Anger, Mania, Anxiety, Somatic Symptoms, Suicidal Ideation, Psychosis, Sleep Problems, Memory, Repetitive Thoughts and Behaviors, Dissociation, Personality Functioning, and Substance Use.

Scores Produced

The measure produces a domain score for each of the following domains. The domain score represents the highest score on any item within the domain.

- Depression (0-4)
- Anger (0-4)
- Mania (0-4)
- Anxiety (0-4)
- Somatic Symptoms (0-4)
- Suicidal Ideation (0-4)
- Psychosis (0-4)
- Sleep Problems (0-4)
- Memory (0-4)
- Repetitive Thoughts and Behaviors (0-4)
- Dissociation (0-4)
- Personality Functioning (0-4)

- Substance Use (0-4)

List of ALL Valant Mobile Notes Measures

http://help.valant.com/80948-documentation-tools/pps-and-io-list-of-mobile-notes-measures?from_search=54546597

[Adult Symptom Screener](#)

[Adverse Childhood Experience \(ACE\)](#)

[Agoraphobia Subscale](#)

[AIMS - Abnormal Involuntary Movement Scale](#)

[American Society of Addiction Medicine \(ASAM\) Criteria](#)

[ASRS v1.1 - Adult ADHD Self-Report Scale Symptom Checklist](#)

[AUDIT - Alcohol Use Disorders Identification Test](#)

[Behavioral Activation for Depression - Short Form \(BADS-SF\)](#)

[BAM - Brief Addiction Monitor](#)

[Brief Psychiatric Rating Scale 18-Item](#)

[CAGE-AID - CAGE Questionnaire Adapted to Include Drugs. V2](#)

[CES-DC - Center for Epidemiological Studies Depression Scale for Children](#)

[Child Symptom Screener](#)

[COWS - Clinical Opiate Withdrawal Scale](#)

[C-SSRS - Columbia-Suicide Severity Rating Scale - Full Scale, Clinician-administered, Lifetime-Recent](#)

[C-SSRS - Columbia-Suicide Severity Rating Scale - Full Scale, Clinician-administered, Since Last Contact](#)

[C-SSRS - Columbia-Suicide Severity Rating Scale - Screener, Self](#)

[DASS-21 - Depression Anxiety Stress Scale-21](#)

[DASS-42 - Depression Anxiety Stress Scales-42](#)

[DERS- Difficulties in Emotion Regulation Scale](#)

[DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure - Adult](#)

[EPDS-Edinburgh Perinatal/Postnatal Depression Scale](#)

[GAD-7 - Generalized Anxiety Disorder - 7-item](#)

[GDS-15 - Geriatric Depression Scale - 15-item Short Form](#)

[GDS-30 - Geriatric Depression Scale - 30-item](#)

[HERO Wellness Scale](#)

[HDCL-C - Johns Hopkins Depression Checklist for Children](#)

[ICG - Inventory of Complicated Grief](#)

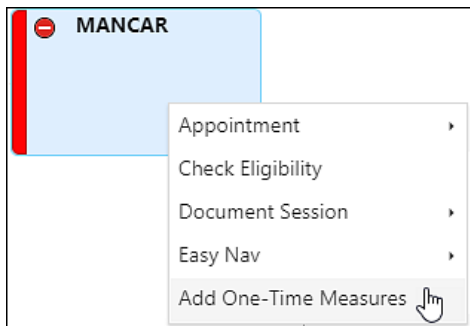
[IPDS - Iowa Personality Disorder Screen](#)
[Life Events Checklist for DSM-5 \(LEC-5\)](#)
[MDQ - Mood Disorder Questionnaire](#)
[MEQ - Morningness-Eveningness Questionnaire](#)
[NIDA-Modified ASSIST - NIDA-Modified Alcohol, Smoking, and Substance Involvement Screening Test](#)
[PR_TAJd - Patient Reported Treatment Adjustment Questionnaire](#)
[PCL-5 - PTSD Checklist for DSM-5 & PCL-5 Weekly - PTSD Checklist for DSM-5 Weekly](#)
[PCL-C - PTSD Checklist - Civilian Version](#)
[PCL-S - PTSD Checklist - Specific](#)
[PDSS - Panic Disorder Severity Scale](#)
[PHQ-9 - Patient Health Questionnaire-9](#)
[PSC - Pediatric Symptom Checklist](#)
[RAS-R - Recovery Assessment Scale 24-Item](#)
[SCARED-Child - Screen for Child Anxiety Related Disorders - Child Version](#)
[SCARED-Parent - GAD Subscale](#)
[SCARED-Parent - Panic Disorder Subscale](#)
[SCARED-Parent - Screen for Child Anxiety Related Disorders - Parent Version](#)
[SCARED-Parent - Separation Anxiety Subscale](#)
[SCARED-Parent - Significant School Avoidance Subscale](#)
[SCARED-Parent - Social Anxiety Subscale](#)
[SEEK-PSQ - SEEK Parent Screening Questionnaire](#)
[SPIN - Social Phobia Inventory](#)
[Suicide Ideation Intensity Subscale](#)
[Trauma Questionnaire](#)
[Vanderbilt-Parent - ADHD Subscale](#)
[Vanderbilt-Parent - Conduct Disorder Subscale](#)
[Vanderbilt-Parent - NICHQ Vanderbilt Assessment Scale - Parent Informant](#)
[Vanderbilt-Parent - ODD Subscale](#)
[Vanderbilt-Teacher - NICHQ Vanderbilt Assessment Scale - Teacher Informant](#)
[WHO-Five Well-being Index \(WHO-5\)](#)
[WHODAS 2.0 - World Health Organization Disability Assessment Schedule 2.0](#)
[YMRS - Young Mania Rating Scale](#)
[Y-PSC - Youth Report Pediatric Symptom Checklist](#)

Sending Measures to the Client Portal

Valant allows measures to be assigned and completed by patients with a patient portal account. This allows patients to fill out measures before an appointment. There are two different measurement: Scheduled Measures and One-Time Measures. Scheduled Measures are sent on a recurring basis to the portal two days before a patient has an appointment. One-Time Measures are assigned once. One-Time Measures can be assigned from the Scheduler or from the Patients Chart. In order to assign a one-time measure follow either of the following steps:

From the scheduler:

1. Right click on the Appointment
2. Click **“Add One-Time Measures”**



From the Patient Chart:

1. Click **Measures** from the navigation menu of the chart
2. Click the **One-Time Measures** subtab
3. Click the **Add One-Time Measure** button

Better Behavioral Health

George Michael Hall, pc

Measures: Jim James (JAMJIM)

Options

EasyNav

Scheduled Measures

One Time Measures

Measures marked with an asterisk (*) are not sent to Patient Portal.

Add One-Time Measure

ASSIGNED AT	CREATOR	START DATE	END DATE	MEASURES ASSIGNED	PROVIDER ID	CREATED?
No data						

After you select “Add One-Time Measure” on either option a dialog box will open to assign the measure. To assign the measure:

1. Assign the Provider who will be authoring the note with the **Provider** drop-down
2. Enter a start and end date
3. Click the **Measure**
4. Move the Measure to the column on the right side by clicking the greater than (>) button
5. Click **OK**

Add One-Time Measures

×

One-time measures assigned from here will be created on the start date. If an end date is set, the measures will be removed from portal at the end of the day.
Also, after one-time measures are created they may be included in new Mobile Notes documents.

Provider

EMP: Emily Phillips

Start Date

1/29/2020

End Date

2/29/2020

ASRS-V1.1
AUDIT
BADSF
BDD-YBOCS
CAGE-AID
CAGE-DC

>
»
<
«

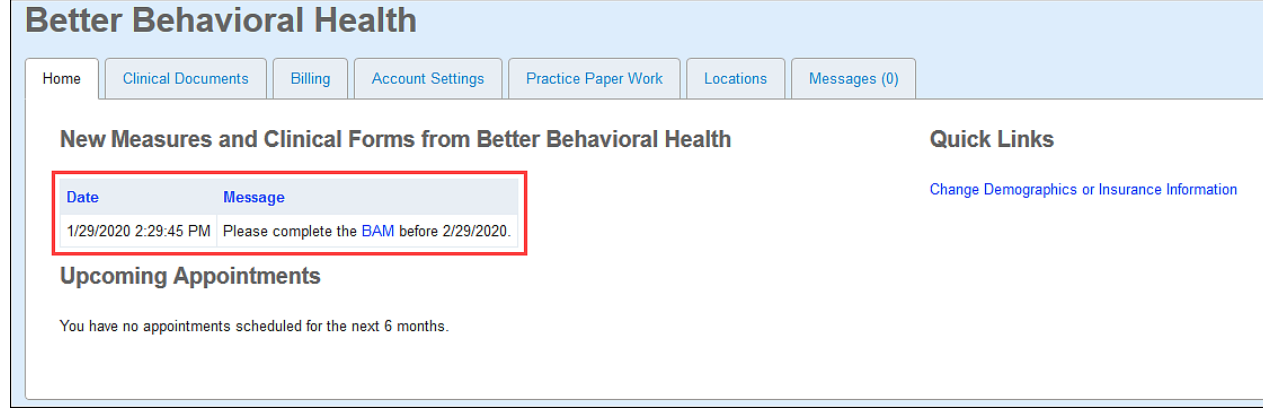
BAM

Measures marked with an asterisk (*) are not sent to Patient Portal.

OK

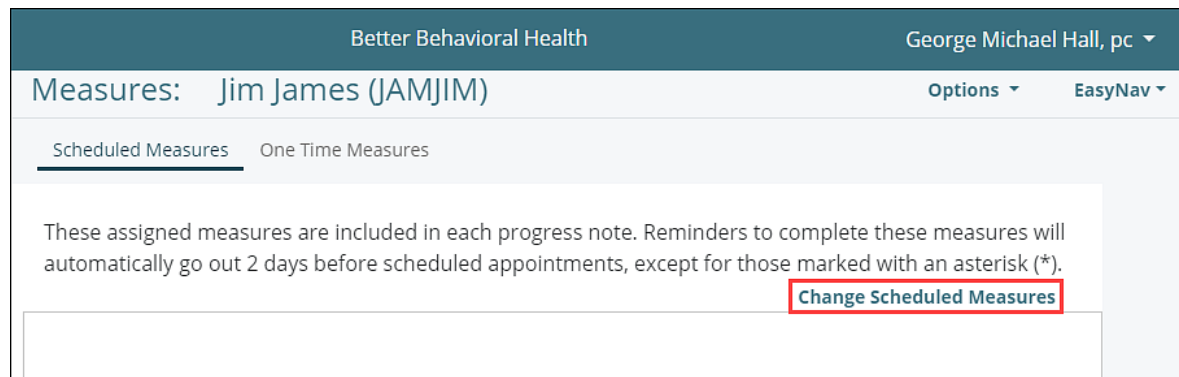
Cancel

Once a measure is assigned it will be immediately sent to the patient portal account to be completed. An email will be sent to the patient the following day to notify them of the measure. The email from the patient's perspective will look like the following:



Scheduled Measures can only be assigned from the Patients Chart. From the patient chart:

1. Click on the **Measures** tab
2. Click on the **Scheduled Measures** subtab
3. Click on the **Change Scheduled Measures** button on the bottom center of the page



After selecting Change Scheduled Measures a box will appear to add and remove scheduled measures.

1. Select the **Measure(s)** to be assigned.
2. Move the Measure to the column on the right side by clicking the greater than button
3. Select **OK**

Change Assigned Measures

One-time measures assigned from here will be created on the start date. If an end date is set, the measures will be removed from portal at the end of the day.

Also, after one-time measures are created they may be included in new Mobile Notes documents.

BDD-YBOCS

*C-SSRS - Full Scale, Clinician-administered, Lifetime-Recent

*C-SSRS - Full Scale, Clinician-administered, Since Last Contact

C-SSRS - Screener, Self-Report,

BAM

Measures marked with an asterisk (*) are not sent to Patient Portal.

OK

Cancel

A reminder e-mail notification will be sent to the patient two days before the scheduled appointment.

Diagnostic Issues and Treatment Planning

Adjustment Disorders

Adjustment disorders are defined as a maladaptive reaction to an identifiable stressful life event(s) / stressor(s). (e.g., divorce, family crises, etc.) Symptoms must occur within three months of the event(s)/stressor(s) and are expected to disappear within 6 months after the stressors have been removed, thus if the symptoms last for more than 6 months and the stressors continually affect the person mentally, this may now termed as Chronic Adjustment Disorder (rarely) or another Axis 1 disorder may be present (more likely).

Adjustment Disorder is a short-term diagnosis- under 12 sessions

Adjustment Disorder is NOT diagnosed when the criteria is for another diagnosis is met.

Depressive Disorders

Depressive Disorders (**296.xx**) have specifiers (the 5th digit) that include resolution or being in "remission".

Do NOT "reduce" a mood disorder such as Major Depression down to an NOS diagnosis due to reduction of symptoms.

Depressive Disorder Specifiers:

- **.x5** In Partial Remission. For example: use this code for clients who formerly met full criteria for Major Depressive Episode and now either (1) have fewer than five symptoms or (2) have had no symptoms for less than two months.
- **.x6** In Full Remission. For example: the client has had no material evidence of Major Depressive Episode during the past 2 months.
- Just an FYI: No diagnosis of Major Depressive Episode can be given if it was superimposed onto a Dysthymic Disorder and the full criteria are no longer present. Then, only diagnose Dysthymic Disorder.
- For all other disorders without numerical specifiers for remission, you can write "In Full Remission" or "In Partial Remission" next to the treating disorder on the Discharge Summary. Or, if the client left before treatment was complete, you would simply leave the treating diagnosis as it is

Credit Card System

How To: Process CC Payments

Efaxing

Rum River Counseling Inc. Fax Number: 612-235-6447

Receiving an Efax

All faxes will come directly to your email as an attachment. To receive a fax, the sender will fax as normal to 612-235-6447, and the fax will be forwarded to your email. To read the fax, just open the attachment and read it or print it as you would a normal attachment.

Sending an Efax

1. Compose an email
2. Type in the "faxnumber@rcfax.com" where you would normally type in the email address you are sending to.
Example - 6122356447@rcfax.com
3. Attach the document you want to fax to the email (be sure to erase anything in the body of the email, like your signature, if you don't want it to show up on the cover sheet). Anything in the body of the email will show up on the cover sheet.

4. Send it as you would send an email (You can send PDF or Word files).
5. An email confirmation that the fax was either Sent or Failed will be sent to your mailbox. If it fails you must fax it again.

If you do not get a confirmation at all within an hour or less, contact Drew or Jenny!

EAP's

Make sure to carefully read the instructions on the Payee page regarding how to bill the EAP and/or knowing which paperwork to complete.

If unsure about anything (forms, etc.), ask Jenny right away!

The first insurance session **after** the EAP is a 90791. EAP's are "assistance" sessions and do not require a Diagnostic eval report - thorough progress notes are sufficient. The first insurance session needs to be a thorough DA report for which your subsequent treatment/therapy is based.

Important: Let Jenny know when the last EAP session is used so we can de-activate the EAP and activate the Insurance.

****Supervisees/Supervisors:** After completing any EAP forms required (including getting client signatures and your signature as the treating clinician), please scan and email the forms to your supervisor. The supervisor will sign off as the supervisor and fax the forms into the appropriate EAP company and will fax the forms to 612-235-6447 so that they are also uploaded onto the CS patient page. The completed & signed EAP forms will need to be scanned in and emailed to Jenny and Admin. ******

Private Pay

Please use the Private Pay CPT code (55555) from the drop down when entering the visit and NOT insurance codes. It is important to charge everyone the same rate and charge the correct amount for the service. You may discount the rate, but the invoice must show the full rate, the discounted rate, and the write off (which is the amount you discounted the rate) See How to Enter a Private Pay or Client Fee in CS.

How to Enter a Private Pay or Client Fee in CS - When you enter a private pay or client fee (no show/late cancel) invoice in Billing, here are the instructions:

1. (in Visits, enter the correct CPT code - pvt pay visit as a 55555, no show as 00001, late cancels as 00002, 1 unit and 0 min)
2. when invoicing it in Billing, select "patient" as Responsible
3. for private pay, enter \$150 as the unit/rate and "apply to invoice" (or \$200 if an intake) and \$85 for no show or \$50 for late cancel
4. click on the "edit" and leave the rate & charge the same but change the W/O and the Pat Resp listed. For example, if a pvt pay amount is \$100, enter \$50 for the w/o, enter \$100 as the pat resp, and click "save" on that line. (adjust accordingly for an intake, or if you are waiving or reducing the n/s or l/c fee)
5. DO NOT SUBMIT TO EDI - save it at the top also (the little disk icon)

No Show Procedure for Active Clients (NOT INTAKES)

1. Open the appointment slot on the schedule and select CANCELLATION from the drop down menu for Attendance Status. In the box below Attendance Status, write "no show."
2. From the open appointment box, enter a visit. For the CPT Code, select "00001 No Show" and select the blank line from the selections under Pri Diag Code. Enter 1 unit and 0 minutes.
3. For any cancellations, we need to select "cancellation" from the attendance status drop down menu on the window that pops up from the schedule in cs. then, in the box below the attendance, write "no show" or "late cancel" or any other note explaining the cancellation.
4. Enter a progress note for the action that you took in response to the no show. The options are to call the client or to write a letter or both. See example letter.
5. For billing, enter a new invoice. Select PATIENT as Responsible. Enter the fee into the Rate/Unit box. Check the box in front of the treatment line and select Apply to Invoice.

No shows – for clients with MA (straight MA or Pmaps): subject to same day scheduling instead

- Enter visit and invoice all no show fees even if not charging.
- Place call to all "active client" no shows – no exceptions!
- No show intakes do not require call – MUST inform the Admin team via the Intake email that day!
- Write progress note follow up for ALL no shows.

To add to Orientation Manual

review our counseling policies as is. If they no show or late cancel, you don't say anything about the charge - enter and invoice it but write it off. And, let them know immediately that they will be subject to same day appointments or discontinuation of services. Same day means that they cannot schedule out with you anymore and that they would need to contact you the day before or the day of to be seen.

Missed appointment client letter template:

Dear Client,

I missed seeing you at your scheduled appointment on Tuesday, August 10, 2009 at 10am.

(here are two options for scheduling)I do not have scheduled for future appointments at this time. Therefore, if I do not hear from you by August 20, 2009, I will close your file.

I have us scheduled for our next appointment on Tuesday, August 17, 2009 at 10am. Please contact us at 763-482-9598 to confirm this appointment. If you haven't confirmed this appointment by Friday, August 13th, 2009, I open that time up for another client. (if more appts are scheduled) Any future appointments that we have scheduled will be opened up for other clients, unless I hear from you otherwise.

If you would like to speak with me directly, you may leave a voicemail for me at 763-754-0903 x333 or email me at name@rumrivercounseling.com.

I know that coming to counseling can be difficult. If you would like to re-schedule with me or with another one of our counselors, please feel free to call our scheduling number at 763-482-9598. I wish you all the best.

Warm regards,
Therapist's Name, credentials

Late Cancel Procedure

Enter a visit and select late cancel. You can enter a note saying specifying why the client cancelled late as well as when they are rescheduled. Make sure to use the correct CPT code in Clinic Source (00002: Late Cancel). Add a billing invoice change the responsible party to patient and then enter \$50 in the rate unit box (what we charge for late cancels). Then enter the payment.

Cancellation with Notice

If it's more than 24-hour notice then just hit cancel on the schedule and nothing else.

How to enter a private pay or client fee in CS

When you enter a private pay or client fee (no show/late cancel) invoice in Billing, here are the instructions:

1. (in Visits, enter the correct CPT code - pvt pay visit as a 55555, no show as 00001, late cancels as 00002, 1 unit and 0 min)
2. when invoicing it in Billing, select "patient" as Responsible
3. for pvt pay, enter \$150 as the unit/rate and "apply to invoice" (or \$200 if an intake) and \$85 for no show or \$50 for late cancel
4. click on the "edit" and leave the rate & charge the same but change the W/O and the Pat Resp listed. For example, if a pvt pay amount is \$100, enter \$50 for the w/o, enter \$100 as the pat resp, and click "save" on that line. (adjust accordingly for an intake, or if you are waiving or reducing the n/s or l/c fee)
5. DO NOT SUBMIT TO EDI - save it at the top also (the little disk icon)

Treatment Plans

1. Choose goals from the goal library and then edit them to be more specific to your client. **NOTE:** just because it is in the goal library does not make it a good goal
2. What does make a good goal?
 - a. It relates back to your diagnosis—Ex: “Client will explore triggers to depression in session I order to work towards being able to recognize these triggers outside of session at least 75% of the time for two months consecutively.
 - b. The goal is measureable (see above goal)
 - c. If a client has a major mental health disorder such as GAD, MDD, etc. utilize a goal that will measure their symptom improvement. Ex: Client will decrease score on PHQ-9 but 5 points and maintain that score for two months consecutively.

How to Copy a Treatment Plan (Plan of Care) in CS

If you make a change to a client's diagnosis and the change is minor enough that it would make sense to continue with the current treatment plan, you can actually "copy" the current treatment plan so that it attaches under the new Eval page with the new/updated diagnosis. You will still need to print off the treatment plan so that the client can sign it (and scan it in and rename it so we can upload it in CS). We will soon have the option to allow clients to electronically sign the treatment plan, and will let you know how this will work once it is set!

CPT/Billing Codes

Reminders for 90837s:

One of the following criteria **MUST** be met in order to bill 90837:(Please include the language below that applies to your notes for each 90837 session)

1. Client is experiencing an acute crisis, is not at imminent risk of harm to self or others, crisis session is appropriate for providing rapid and time-limited assessment and stabilization.
2. Extended session is needed to address new symptoms or the re-emergence of old symptoms with a rapid, time-limited assessment and stabilization response. (Without this session, the new or re-emerging symptoms are likely to worsen or require a more intensive level of care.)
3. Diagnosis of PTSD, and using EMDR or traumatic incident reduction (TIR)
4. Diagnosis of PTSD, OCD or panic disorder, and using prolonged exposure therapy
5. Client is a child and needing 3 family therapy visits to re-stabilize the family (not synonymous with marital or family therapy).

Important information regarding interactive complexity codes:

- Add-on codes should be reported in conjunction with specified primary procedure codes; add-on codes may not be reported alone.
- The interactive complexity add-on code (90785) can only be used with 90791, 90832, 90834 & 90837 and ***cannot be used with family psychotherapy codes (90846/90847)***.
- When performed with psychotherapy, interactive complexity relates only to the increased intensity of the psychotherapy service; it does not change the time of the psychotherapy service.
- Documentation of interactive complexity should include:
 - ✓ A record of base service delivery code(s), all coding requirements and the interactive complexity code in the same note.
 - ✓ Evidence within the multicode service note indicating the specific category of complexity present during the intervention.
- Examples of appropriate uses of interactive complexity add-on code 90785:
 - ✓ Maladaptive communication among participants that complicates the delivery of care
 - ✓ Caregiver emotions or behaviors that interfere with the treatment plan
 - ✓ Evidence or disclosure of a sentinel event or mandated report to a third party and initiation of discussion of the event or report with patient and other participants
 - ✓ Use of play equipment, physical devices, interpreter or translator to overcome barriers to interaction with a patient who is not fluent in the same language —or who has not developed or has lost language skills

What does this mean for me?

- You should ensure that the interactive complexity add-on code is used appropriately as it relates to difficulties encountered during the psychiatric procedure.
- You should bill this code when it meets the specific criteria for interactive complexity.
- Please note that excessive use of this code could result in additional medical record review and potentially lead to recoupment of payment if the medical record does not support use of the code.

CPT Code Details

Definition

A new concept in 2013, interactive complexity refers to 4 specific communication factors during a visit that complicate delivery of the primary psychiatric procedure.

Code Type

Add-on codes are identified by a "+" prefix and may be reported in conjunction with other, specified codes, "primary procedures." Add-on codes may never be reported alone.

Replaces

Codes for interactive diagnostic interview examination, interactive individual psychotherapy, and interactive group psychotherapy are deleted.

Use in Conjunction With

- Psychiatric diagnostic evaluation, 90791, 90792
- Psychotherapy, 90832, 90834, 90837
- Psychotherapy add-on codes, +90833, +90836, +90838, when reported with E/M
- Group psychotherapy, 90853

When performed with psychotherapy, the interactive complexity component (+90785) relates only to the increased work intensity of the psychotherapy service, and does not change the time for the psychotherapy service.

May Not Report With

- Psychotherapy for crisis (90839, +90840)
- E/M services NOT reported in conjunction with a psychotherapy add-on service
- Family psychotherapy (90846, 990847, 90849)

Typical Patients

- Have other individuals legally responsible for their care, such as minors or adults with guardians, or
- Request others to be involved in their care during the visit, such as adults accompanied by one or more participating family members or interpreter or language translator, or
- Require the involvement of other third parties, such as child welfare agencies, parole or probation officers, or schools.

Interactive complexity is commonly present during visits by children and adolescents, but may apply to visits by adults, as well.

Report with CPT add-on code +90785

When at least one of the following communication factors is present:

1. The need to manage maladaptive communication (related to, e.g., high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicates delivery of care.

2. Caregiver emotions/behavior that interfere with implementation of the treatment plan.
3. Evidence/disclosure of a sentinel event and mandated report to a third party (e.g., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.
4. Use of play equipment, physical devices, interpreter or translator to overcome barriers to diagnostic or therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language.

CPT Code

On the Heading of the Note, please make sure that the Start & End times reflect the time ranges of the CPT Code you will be using.

When you go to enter the visit, a normal 45-50 min appt will look like the picture below. The 90834 CPT code should be used for a regular 45-50 min session and would be considered the former 90806. Please note that the 90834 can be used for any appt lasting between 38-52 minutes of face to face time.

Interactive Psychotherapy Codes

There is an ADD ON code for indicating that a client session is more complex than normal or when other people need to be involved. It is expected that this code will most frequently be used with the treatment of MINORS. However, if an adult client does not have coverage for Family Psychotherapy and you can CLEARLY document rationale for billing the presence of the additional person in the session, then you can use this add on code accordingly.

Documentation: Each progress note will need to clearly indicate EXACTLY what the complexity was. You will also need to add these to your treatment plan. This code can only be used with the new Intake CPT Code 90791 or with any of the Individual Psychotherapy (90832, 90834, 90837) or Group Psychotherapy (90853) codes. This can NOT be used along with Family Psychotherapy (90847, 90846) codes.

If you see a client in crisis any for amount of time up to 60 minutes, then you can use the 90839 code. Please reserve this for suicidal clients or clients who need an urgent appt due to symptom severity. As long as your documentation clearly dictates the use of a crisis appt, then please use this CPT code accordingly. If you end up going beyond the 60 min with the client in crisis, then select the 30 min add on code. ONLY use the 30 min add on code for crisis appts (90839) and do NOT add it to any other CPT code.

Telemedicine Billing

Rev 05/13/20

Insurance*	Location	Modifier**
Aetna	02/Teletherapy	95
PrefOne	02/Teletherapy	95
Medica	02/Teletherapy	none

United	02/Teletherapy	none
HealthPartners	02/Teletherapy	none
UCARE	11/Office	95
CIGNA	11/Office	95
BCBS	11/Office	95
MHCP Straight MA	11/Office	95
ALL OTHERS	11/Office	95

*Insurance names in ALL CAPS use Location 11/Office – the default on the schedule. Insurance names in Regular Case use Location 02/Teletherapy – needs to be selected on the schedule. All insurance companies that begin with the name listed in the chart use the same Location code (for example, Medica, Medica Secondary & Medica IFB are all Medica).

****Modifier Notes**

The way that CS is currently set up:

- When you select 11/Office, the 95 Modifier will AUTOMATICALLY populate.
- For PrefOne, when you select 02/Teletherapy, the 95 Modifier will automatically populate.
- For Medica/United/HealthPartners, when you select 02 or 11, no Modifier will populate.
- For any In Person visits, you would select the In Person Procedure (CPT) Codes and no modifier will populate. The In Person codes are at the bottom of the drop down menu so that they take more effort to select since we are rarely, if at all, seeing clients in person at this time.

Discharge Summary & Closing

Closed/Deactivated Clients

All clients who are not actively scheduled for therapy will need to be CLOSED right away - closing a client releases your liability from being the "active" therapist on record. Closing a client is not the same as being "deactivated" in CS. Deactivated clients are just "hidden" in CS as a way to reducing clutter. The goal is to deactivate any closed clients with a \$0 account balance in CS as long as they are not open with another therapist. Deactivating clients can take up a lot of time for me to do, so it doesn't end up on the top of my priority list, however, that should never impact whether you close a client or not, as those one is a liability issue and the other is a "clutter" issue.

- If an active client is closed or de-activated: We need to re-verify insurance - we ask that you give us a week to verify in case there are issues we discover re-verifying insurance.

Closing Procedure:

Please note, that if you did not complete the "New Eval" page in CS under Documentation prior to entering the Eval visit (1st visit) from the schedule, then the session count may not be showing as accurate on the Discharge Summary. You would simply write a note that clarifies the correct # of sessions attended.

Once the Discharge Summary is complete, you would go to the Visit tab and enter a Visit, selecting the CPT code of "CLOSED" and that is all you need to do electronically. As for the paper file, Please put it in the "closed" drawer of the file cabinet with a sticky note that says "closed".

Protocol for De-activated/Re-activated Clients in CS

If a client is closed or taking a break from therapy, the therapist will close the file and let Jenny know. Jenny will de-activate them in CS (if a balance is due, they will remain activated and statements will still go out for the balance. Clients will remain active if assigned to another therapist as an active client).

If a client calls to reschedule with that therapist or another therapist at RRC, Julie/Admin will:

- Re-activate the client account
- Review Patient & Payee info for any updates
- Schedule the client accordingly
- Send out new paperwork accordingly (at minimum, new policies, screening forms SDQ/PHQ) & welcome letter)
- Inform the therapist of the appointment
- Email Drew so he can check to see if a previous balance is due and will call the client to discuss payment
- Put NEEDS VERIF for the ID #

Next, Julie & Barb will re-verify accordingly & pass along any concerns/updates.

Then the therapist will:

1. Inform Julie/Admin if additional paperwork is needed (new personal history, release of info, etc.)
2. Review Patient & Payee info for any updates
3. Determine if a new eval is needed – if not, then change the scheduled appt to

How to complete Records Requests & Invoices

CS Records Statement

Scan in and email to Jenny

Client Name:		Date of Birth:	
Therapist:		Office Location:	
	Item	Charges	
	Retrieving/copying records	\$17.96	
	____ # of Pages Copied x \$1.35		
	Total Charge:		

Instructions

Therapist:

- ☐ Save a Copy of Records as a PDF from Documentation tab in CS
- ☐ Complete INVOICE, if needed (for Social Security, enter amount on the invoice on the coversheet) Note: we cannot charge for Soc Security APPEALS.
- ☐ Scan the CS Record Statement and email it to Jenny
- ☐ EFAX the records to the requestor

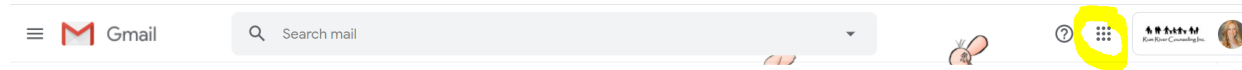
Jenny:

- ☐ Enter in CS
 - Visit Tab
 - Enter new visit
 - Select "REC COPY / CHARGE FOR RECORDS COPIES" from CPT list
 - Enter 1 unit, 0 min
 - Billing Tab
 - Create new invoice
 - Select PATIENT as Responsible
 - Enter Total Charge amount (from above) into Rate/Unit box
 - Click on box to apply visit to the invoice
 - Save

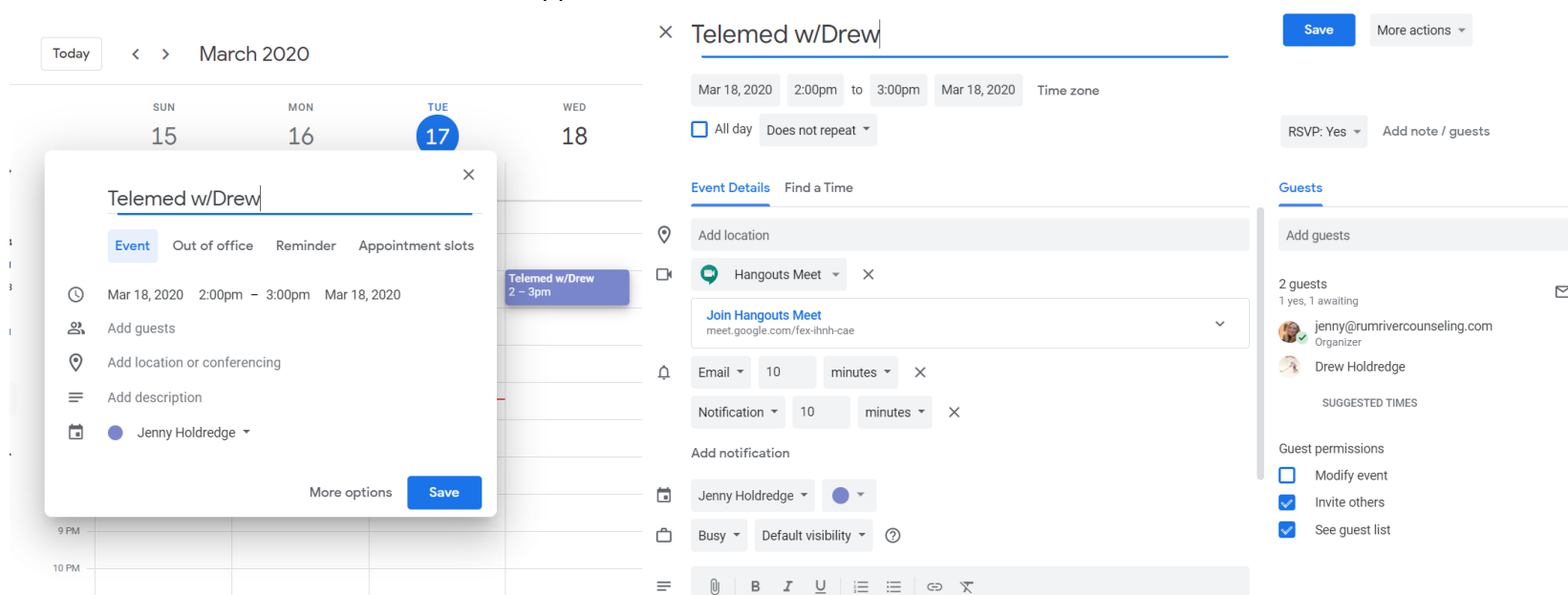
How to: Telemedicine via G Suite

Note: This How To provides an overview and, depending on how your rumrivercounseling.com email account is set up, you may notice some differences from what I am showing here.

1. Login to your RRC Email account as usual and click on Google Apps in the upper right hand corner of your screen (see below):

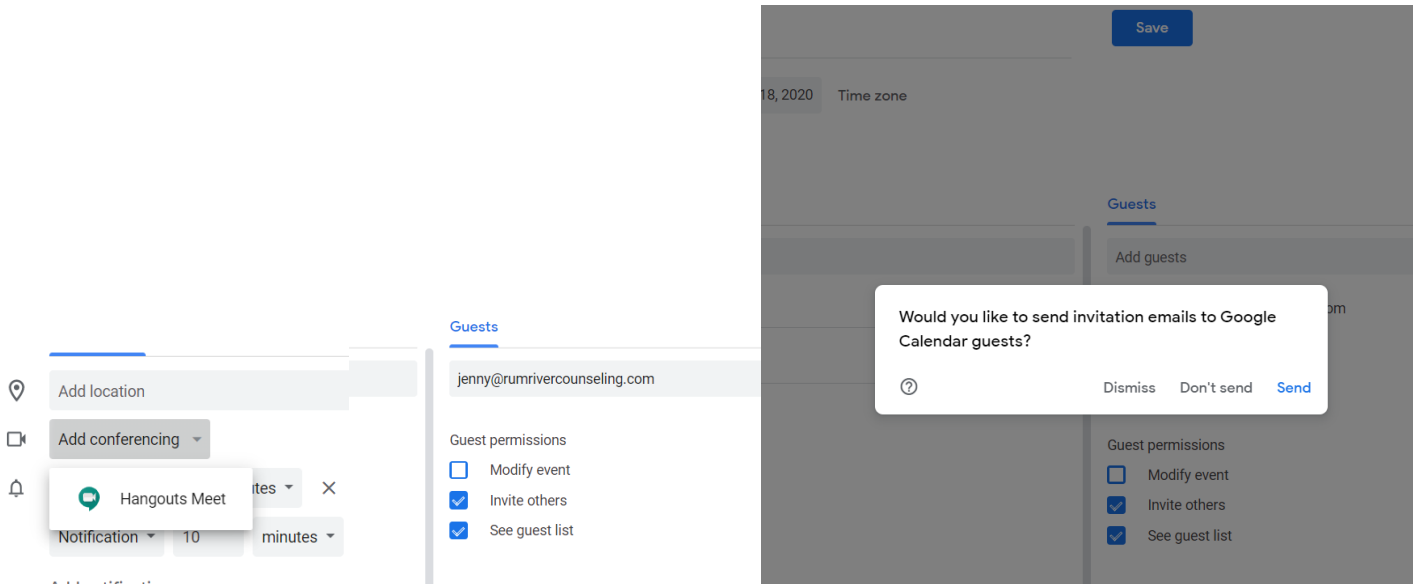


2. Click on the Calendar to create an appointment.



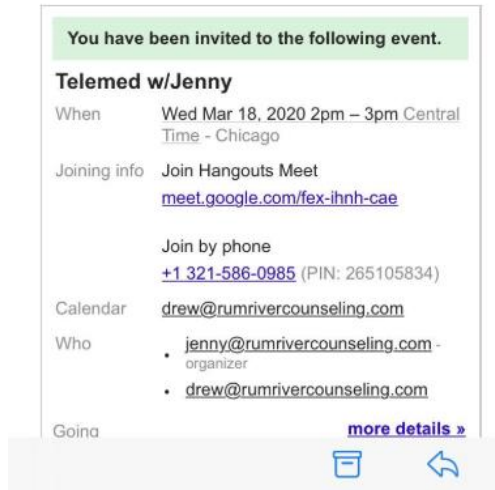
3. Select the date and time to create the telemedicine (TM) appointment. Then click **More Options** and an appointment box will pop up so you can do the following:
 - **Edit in Calendar**, on this screen you can manually adjust the minutes.
 - Title the appointment (for example: "Telemed w/Drew")
 - Click **Add Conferencing** then select **Hangouts Meet**
 - Under **Guests** put in the email address of the recipient you are doing the TM with

- A reminder will also be sent 10 minutes prior to the appointment to the client. Be sure that **Invite Others or Invite external guests** is checked, as this will allow the client to be invited.
- It will then ask if you want to send an invitation to guests, click on **Send**

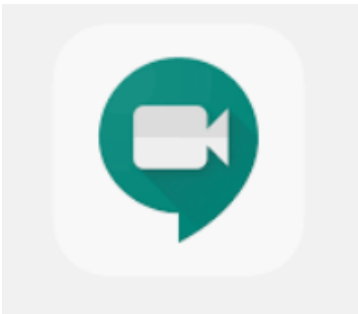


4. Client will receive and email saying for example **Invitation: *whatever you title the appointment* @ Wed Mar 18, 2020 2pm-3pm**

**Invitation: Telemed w/Jenny @
Wed Mar 18, 2020 2pm - 3pm
(CDT)
([drew@rumrivercounseling.co
m](mailto:drew@rumrivercounseling.com))**



5. In the email they will click on a link to **Join Hangouts Meet**, or may go directly to the telemedicine meeting page, then click **join meeting**. You may need to agree to enable camera and microphone, the device you are using will prompt you if needed.
6. If you or the client would like to use an iPhone or iPad, then download a Google Hangouts app (iPhone)



7. On the video screen you can choose to turn off the mic or camera, as needed, or end the session when finished.

RRC Tablet Guide

From the home screen swipe down to access chrome. In chrome you can type in Gmail.com

Login to your RRC email.

In the email find the notification reminder for the appointment (it will automatically be sent to you 10 minutes prior to the event)

From this email click on the link to Join Hangout Meet

If the tablet hasn't been used for telemed yet a window to download Google Hangout will appear and you will download the app and Continue from there to join the meeting.

From here if asked agree to video recording and audio recording so the client will be able to see and hear you.

At anytime during the meeting you can tap the screen to bring up the option to mute or pause video feed if needed, also the option to end the meeting when finished.

To logout of your email account click on your email address in the bottom left corner this will give you the option to sign out so the next person to use it won't see your email.

Home Internet Access

If you are bringing a table home to use to login to your Wifi

Login to the tablet 4002

From the home screen swipe down and select settings.

In the settings screen select connect

Then select your home wifi and enter the password to connect.