Mental Health Assessment (MHA)

Completed By:

It is within the scope of practice for the following providers to complete all sections of the MHA:

- Physician (MD or DO)
- Physician Assistant/ Nurse Practitioner
- Licensed/Waivered Psychologist (post doctorate)
- Licensed/Registered/Waivered Social Worker (ASW/LCSW) or Marriage and Family Therapist (AMFT/ LMFT)
- Licensed/Registered Professional Clinical Counselor (APCC/ LPCC)
- Clinical Trainee (with co-signature)

It is within the scope of practice for the following providers to complete the MHA except for: Domain 7, diagnosis and the Mental Status Exam (MSE) and with a co-signature:

- Registered Nurse (RN) - (no co-signature needed)
- Medical Assistant (MA)- (no co-signature needed)
- Licensed Psychiatric Technician/Vocational Nurse
- Mental Health Rehabilitation Specialist
- Registered PsyD/Ph.D.
- Paraprofessionals / Other Qualified Providers

Compliance Requirements:

- Initial Mental Health Assessment- Should be completed within a clinically appropriate timeframe.

- Updated Mental Health Assessment – Programs should utilize their clinical expertise to complete subsequent Assessments as expeditiously as possible, in accordance with each member's clinical needs and generally accepted standards of practice. Assessments shall be updated as clinically appropriate, such as when a member's condition changes.

    - *Some SMH services, such as residential levels of care, STRTPs, etc are subject to licensure or certification requirements that include additional standards for member assessments and those standards remain in effect. (BHIN 23-068, Enclosure 1b.)

- All Domain fields must be completed. The seven (7) assessment domains are identified below w/ specific elements that should be included in each:

    - Domain 1: Presenting Problem(s), Current Mental Status, History of Presenting

Problem(s), Beneficiary-Identified Impairment(s)
  - Domain 2: Trauma
  - Domain 3: Behavioral Health History, Comorbidity
  - Domain 4: Medical History, Current Medications, Comorbidity w/ Bx Health
  - Domain 5: Social and Life Circumstances, Culture/Religion/Spirituality
  - Domain 6: Strengths, Risk Behaviors, and Safety Factors
  - Domain 7: Clinical Summary and Recommendations, Diagnostic Impression, Medical Necessity Determination/Level of Care/Access Criteria

- Access Criteria Medical Necessity Criteria shall be substantiated as per BHIN 26-002

- ICD-10 Mental Health Diagnosis shall be substantiated.

- Providers who serve children/youth shall ensure that all children/youth are assessed for eligibility to receive ICC or IHBS services during the assessment process. Membership in the Katie A class or subclass is not a requirement for receiving medically necessary ICC, IHBS or TFC.

  - BHP's are obligated to provide ICC/IHBS services to all children and youth under the age of twenty- one (21) who are eligible for full scope Medi-Cal and who meet medical necessity for these services. The determination of medical necessity must be in accord with the guidance provided within the Medi-Cal Manual for ICC, IHBS and TFC Services for Medi-Cal Beneficiaries which states that BHPs must make individualized determinations of each youth's need for ICC/IHBS based on the youth's strengths and needs.

- These services are appropriate for children and youth with more intensive needs who are in, or at risk of, placement in residential or hospital settings, but could be effectively served in the home and community.

- Youth should be entered into the appropriate *Special Populations* category in SmartCare which will link the appropriate required modifier (HK) to the service for billing purposes as well as allowing for tracking of these youth/services.

  - Special populations "ICC/IHBS" is used for any youth receiving ICC/IHBS services.

  - Special populations "Katie A ICC/IHBS" is used for any youth that would have been considered "subclass" under previous PWB criteria. Determination of class or subclass is no longer required, however the State recommends that counties continue to track these youth.

Documentation Standards:

- Co-signatures, when required, must be completed to be considered a completed assessment.

- Assessment Contributions by Non-LPHA staff: Per BHIN 23-068, both licensed and non-licensed providers, including those not qualified to diagnose a mental health condition, may contribute to the assessment consistent with their scopes of practice, as described in the State Plan.

    - The MHA cannot be completed in full by a non-LPHA/LMHP staff as it is out of scope. Providers may gather information that supports assessment domains within their scope of practice and enter into their progress note and claim for the **Assessment by Non-LPHA** procedure code.

    - This progress note requires an approved review and co-signature by a licensed/registered/waivered staff.

    - An LPHA/LMHP may review the assessment information in the progress note and copy this information into the relevant domains of the Assessment and complete the assessment, claiming for their face-to-face time. The LPHA/LMHP should indicate: "*Information obtained by provider Name, Credential*" for any information that was copied over to assessment from the non-LPHA/LMHP progress note.

Domain 1- Presenting Problems/Needs:

- Include a summary of the member's request for services including his/her most recent baseline. Describe events in sequence including precipitating factors that led to deterioration/behaviors.

- Describe member-identified problems, as well as history and impact of presenting problems. Include member identified level of distress, disability, or dysfunction important area(s) of life.

- Include mental status exam of the member's presentation.

Domain 2- Trauma: Describe any current or past exposure to trauma.

Domain 3- Behavioral Health History/Co-Occurring Substance Use: Previous history of symptoms and/or mental health treatment.

- Describe in chronological order (to the best of your ability) - where, when, and length of time of acute and chronic conditions.

- Include providers related to any previous community-based treatment, including providers, therapeutic modality (e.g., medications, therapy, rehabilitative interventions, etc.) and response to interventions.

- Include prior psychiatric inpatient admissions and/or crisis-based admissions.

- Co-Occurring Disorders (if applicable)- Document exposure/substance use including past and present use; previous community-based treatment and response to interventions and intoxication/detox/ withdrawal management-based admissions. Describe how the member's substance use impacts their current life functioning and behavioral health symptoms.

Domain 4- Medical History/Current Medications/Co-occurring Conditions:

- Describe any relevant current or past physical health conditions, history of medical treatments and response(s) to treatment, as relevant include: significant prenatal and perinatal events, and/or significant developmental history.

- Address if the member has a Primary Care Physician. If not, ask if they would like to be referred.

- Document current medications and history of medications.

Domain 5 Social and Life Circumstances/Culture/Religion/Spirituality:

- Describe any social concerns and how they are related to or impact their behavioral health and functioning.

- Describe current living situation and list all individuals living in the home with the member.

- Provide relevant family history and current family information – include domestic violence, substance use, neglect/abuse, family involvement and structures and level of support.

- Considerations may include: language of member /family, primary language spoken at home, religious, spiritual beliefs, family structures, customs, moral/legal systems, life-style changes, socio-economic background, ethnicity, race – including tribal, BIPOC affiliations, LGBTQ affiliations, immigration history/experience, age, and subculture (homelessness, gang affiliations, substance use, foster care, military background), exposure to trauma, violence, abuse and neglect, experience with racism, discrimination, and social exclusion.

    - For Child/Youth, document juvenile justice involvement or involvement in the child welfare system.

    - Describe unique cultural and linguistic needs and strengths that may impact treatment.

    - Cultural information includes an understanding of how the member's mental health is impacted.

Domain 6 -Strengths/Risk Behaviors/Protective Factors:

- Describe member strengths related to their mental/behavioral health needs and functional impairments. Describe how these strengths will support treatment goals.
    - Some examples: personal motivation/drive/interest, resilience and coping skills, strong religious, cultural, or inherent values against harming self/others, social support system, availability of resources and opportunities, positive planning for future, engagement in treatment, care giving role (people or pets) and strong attachment/responsibility to others or activities (routines/social hobbies) or family/community.
- Describe history or current risk for self-injury, suicidal ideation or attempts and any risk of violence or past violence.
- Describe any protective factors.

Domain 7- Clinical Summary and Recommendations/Diagnostic Impression/Medical Necessity Determination/LOC/Access Criteria:

- Summary of clinical and diagnostic impressions, diagnostic uncertainty (i.e. provisional or unspecified diagnosis), clinical complexity, impairments, level of care, medical necessity determination, and service recommendations for treatment episode.
    - It is out of scope for a MHRS/LVN/LPT to complete diagnostic impressions- this section must be completed by a licensed/registered/waivered clinician.

Additional Information:

- The assessment may be completed in one or more sessions.
- Paper forms are only to be completed when the EHR is not accessible, the information should be scanned into the EHR as promptly as possible.

Resources:

- CalMHSA Documentation Guide
- Optum Website > *OPOH* tab
- CALMHSA Documentation Guide- Appendix III (pg. 39)
- BHIN 23-068
- CalMHSA- CalAIM Assessment